Out-of-Illness Experience: Hypnotically Induced Dissociation as a Therapeutic Resource in Treating People with Obstinate Mental Disorders

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Psychological dissociation is commonly perceived by mental health professionals as the pathological splitting of consciences or as an impairment in adaptive integration. In hypnotherapy dissociation is considered one of the most significant features of hypnosis, constituting a major therapeutic resource. In the present article, we use hypnotically induced dissociation (HID) to treat patients with obstinate mental disorders (OMD). These disorders are characterized by persistent, problematic behaviors, thoughts, and feelings that become organizing principals of identity and form enduring psychopathologies. To promote psychological change in patients with OMD, we use HID to enhance dissociative processes that enable the differentiation of health from pathology and allow the emergence of experiences previously overshadowed by pathological personality patterns. Three clinical cases of OMD (chronic depression, obsessive-compulsive disorder, and a personality disorder) illustrate the effects of HID as an effective therapeutic tool that facilitates emotional processing, consolidates therapeutic achievements, and secures therapeutic results.

KEYWORDS: dissociation; hypnosis; hypnotherapy; obsessive-compulsive disorder (OCD); mental disorders

. . . the opportunity hypnosis gives the patient to dissociate himself form his problems, to take an objective view of himself, to make an inventory of his assets and abilities, and then, one by one to deal with his problems

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instead of being overwhelmed with all of them without being able to think clearly in any direction

(Erickson, 1945/1980, p 34.)

INTRODUCTION

From time to time, most clinicians confront patients who are difficult to manage and appear as untreatable or chronically ill. Their psychopathologies are rooted deeply in their personalities, derived from constitutional traits, and reinforced by environmental and developmental factors. In this paper, we refer to this group of patients, who sometimes fail to meet distinct diagnostic criteria but are well known by professionals in clinical practice, as having obstinate mental disorders (OMD).

A fundamental problem in the psychotherapy of people with obstinate mental disorders is the identity-like feature of their psychopathology. In patients with OMD, persistent and problematic behaviors, thoughts, and feelings become central traits that evolve into the organizing principals of their personalities (McWilliams, 1994). Patients with OMD often find it difficult to remember premorbid functioning, and thus lack faith that life can be different. This point of view impedes them from engaging in new, nonpathological and unfamiliar ways of living (Hollander, Kwon, Stein, Broatch, Rowland, & Himelein, 1996). Some of these patients develop psychopathology before or during identity formation (around adolescence) or in the course of one of the developmentally sensitive periods of life (Kroger, 2004). In these cases, the obstinacy and persistence of the psychopathology is even more protruding (Burke, Burke, Rae, & Regier, 1991). This problematic feature has to be addressed in order to enhance the efficiency of therapy with patients who have OMD, while taking into consideration aspiration for steady and long-term outcomes.

An association with the functioning parts of the patient's personality enables the therapist to establish a therapeutic alliance that serves as a foundation to the treatment process. At the beginning of the therapeutic process, the procedure of dissociating the pathological aspects of identity from the healthy ones is essential for allowing patients to align their psychological resources, gather hope, and set appropriate goals for therapy. In the middle phases of therapy, dissociation promotes both insights and changes in deep psychological structures (Lemke, 2005; Meyerson & Gelkopf, 2004; Edgette & Edgette, 1995). Finally, towards the conclusion of therapy it can help secure therapeutic results (Meyerson & Gelkopf, 2004). Dissociation can also serve as a preface for ego strengthening

techniques that are particularly significant during therapy with chronic and obstinate mental disorders (Frederick & McNeal, 1999).

In the present article we propose that hypnotically induced dissociation (HID) can function as a major therapeutic resource in treating patients with OMD. By enhancing dissociative processes, HID differentiates health from pathology, allowing the emergence of a new experience overshadowed by the obstinacy of persistent and enduring pathological personality patterns.

On the Nature of Psychological Dissociation

The subject of dissociation has been discussed in psychiatric literature for more than one hundred years, beginning with the ideas of Janet (1889). Later Freud (1895) elaborated on this concept in an attempt to explain the psychical mechanisms involved in hysteria. Both Freud and Janet saw dissociation as a *splitting of consciousness* related to the *exclusion of unpleasant memories and/or ideas from awareness* and having a deficit or defensive quality (Freud 1895, Janet 1889). By the end of the 19th century, the study of "dissociation," which at that time was a central concept especially in the understanding of hysterical symptoms, declined, and for most of the 20th century there were almost no references to dissociation in the psychiatric and psychological literature. In the 1980s, there was an upsurge of interest, amounting to a paradigm shift (Ross, 1996), owing to an increased focus on childhood trauma and abuse and studies of post-traumatic stress in Vietnam veterans. Contemporary studies of dissociation, while no longer connecting it to hysteria, have been greatly inspired by Janet's tradition (van der Hart & Friedman, 1989; Kluft, 1996; Van der Kolk, McFarlane, & Weisaeth., 1996; Nijenhuis, Van Der Hart, & Steele, 2004), subscribing to the view that dissociation expresses a failure of synthesis and integration in, or breakdown of, cognitive processing. Today much of the psychological and psychiatric literature focuses on the pathological aspects of the phenomena. The DSM-IV views dissociation as a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment or as a lack of normal integration (APA, 1994); of thoughts, feelings and experiences into the stream of consciousness and memory (Putnam, 1985; Atkinson, Atkinson, Smith, Bem, & Nolen-Hoeksema, 2000). A number of studies, focused on psychopathological aspects, provide solid documentation that dissociation relates to threatening and overwhelming events interfering with integrative mental capacities. These studies demonstrate a link between psychological trauma and dissociative symptoms (Marmar, Weiss, Schlenger, Fairbank,

Jordan, Kulka, & Hough, 1994; Chu, 1998; Van der Hart, Van der Kolk, & Boon, 1998. For a review, see Marmar, Weiss, & Metzler, 1998). However, some theorists view dissociation as a process that exists on a continuum, ranging from normal everyday experiences, such as daydreaming, to psychiatric disorders, such as psychogenic amnesia and multiple personality disorder (Bernstein & Putnam, 1986). Evidence supporting the concept of the dissociative continuum comes, for example, from studies of hypnotizability by Hilgard (1986) and Spiegel (1963), which demonstrate how hypnotizability, a correlate of dissociation, exists along a continuum from minor to major degrees. From this point of view, dissociative symptoms, such as amnesia, may be viewed not only from a disruptive and psychopathological perspective, emphasizing disturbance, but also from an adaptation, process-oriented one (Loewenstein, 1996). From a developmental viewpoint, dissociation may be understood as a normative, regulating process by which an individual modulates internal states (e.g. intense emotion) and external input (e.g. aversive stimulation) by refocusing attention (Wolff, 1987; Cole, Alexander, & Anderson, 1996).

Watkins and Watkins (1997), creators of "Ego State Therapy," took a step forward in their view of dissociation by proposing that dissociation and differentiation are natural organizing principals of the psyche that give human beings the ability to adapt, think, act and respond. Ego state theory, which stems from writings by Paul Federn, claims that the personality is not simply a collection of perceptions, cognitions, and affects but rather a complex organization structured in clusters called "ego states" (Frederick, 2005) described as:

> . . .an organized system of behavior and experience whose elements are bound together by some common principal, and differentiated one from another by boundaries that are more or less permeable. . . . .They may or may not reach consciousness and directly affect behavior (Watkins & Watkins, 1997. p. 25)

From this point of view, 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 among the dissociated parts.

Dissociation in Psychotherapy and Hypnotherapy

As mentioned earlier, dissociation is closely linked to the concept of trauma and that is why most of the therapeutic efforts that have been made in order to cope with dissociation are within the framework of the treatment of traumatic events and posttraumatic stress disorder (PTSD).

In this context, dissociation is viewed as a central mechanism that disintegrates subjective experience by creating an interruption in the cohesion of the self and in most cases, a disturbance at the level of emotional experience. Because of this, most psychotherapies attempt to deal with dissociation by attempting to integrate the fragmented parts of the personality, creating a new integration (Van der Hart et al., 1998).

Hypnosis has been found to be an effective tool in the treatment of dissociative disorders and dissociative symptoms (Alladin, 2008; Spiegel, 2003). Since dissociation is a main component of hypnotic trance, it generally is used as an effective instrument for diagnosing and controlling dissociative symptoms (Kluft, 1996; Edgette & Edgette, 1995; Yapko, 1995). In the context of hypnotic interventions, Yapko (1995) 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" (p. 115). In this framework, hypnotically induced dissociation is used in hypnotherapy for dissociation of conscious from unconscious functioning, for regulating sensitivity of internal and external stimulation, and for removing attention from negative ruminations. Dissociation also can be used as a resource (Phillips & Frederick, 1995) for promoting therapy with deeply rooted dynamic, psychosomatic, and identity related issues (Lemke, 2005; Meyerson & Gelkopf, 2004; Edgette & Edgette, 1995; Brown & Froom, 1986). This last utilization of dissociation in the context of hypnotherapy is much less known and rarely used by therapists. In the present paper, hypnotically induced dissociation (HID) is presented as a valuable tool for psychotherapy for patients with OMD. Clinical cases presented are offered as illustrations for some of the ways dissociative interventions can be applied in hypnotherapy and in psychotherapy in general.

Case I: Early retired Bob

The use of "out-of-illness experience" for promoting losses processing in a chronically depressed patient.

Bob's psychiatrist, who had provided him with medication maintenance during the past 20 years of treatment for depression and anxieties, referred him to the first author (J.M.). The 62-year-old, divorced, former businessman had on his checklist of life events, a 32-year-old daughter, a few relationships, early retirement and a lot of therapeutic venues. His massive use of defenses helped him repress on a daily basis his worries about his deteriorating health, his inability to maintain relationships, and his boredom and feelings of worthlessness from early retirement. In spite

of constant and controlled treatment with medication, during our initial session Bob claimed that for the past few months he had been feeling a terrible lack of stability, low self-esteem, frequent heavy moods, and loss of energy. These made everyday activities very difficult, damaging his social functioning.

During the hypnotic session, some of his repressed emotions arose, which was difficult for him to handle. He commented that in previous psychotherapies he focused on changing his actions while avoiding looking at his psychological and emotional processes. To help him handle this deep self-exploration, we applied ego strengthening techniques (Frederick, 2005), but it was extremely difficult for Bob to find reliable positive resources either in the past or in the future. At this stage, he was invited to participate in an "out-of-illness experience" introduced as a hypnotic intervention that might help him more easily face confusing feelings that might surge. It was advised to him that later on he would be able to use this experience as an auto-hypnotic resource. He was guided him:

> Now, you can imagine that you are deep-sea diving. . . .Can you?. . .You have all needed equipment and you dive naturally and easily. . . . deep . . . . down. . . . And as you go deeper and deeper, now you can see, feel, and hear that all these depressive thoughts, feelings, and sensations are washed away from you. . .to the surface. And as you continue to dive you are accessing a "problem clean place." You can enter this area only after the filtering door does not detect in you any part of the depressed moods, thoughts, and behaviors. . . .

After a few trials, he succeeded in entering the place and staying there, feeling a "strange but pleasant" experience. In next sessions he felt much better "almost as if I was healthy again," and the therapist could work successfully with his full cooperation on issues connected to his life losses. He spoke about his parents' deaths, which occurred 16 years before, his divorce, and his feelings of unfulfillment. These issues had not been addressed or processed by him during his previous therapies. We can argue that this particular application of HID enabled the progression of therapy by relieving depressive symptoms and consequently, allowing the working through of deep intrapsychic matters.

Case II: Teenage Jill

The use of "out-of-illness experience" for consolidation of therapy achievements in a case of severe OCD.

After being diagnosed with OCD, Jill, a 14-year-old girl, was referred for treatment by her high school psychologist. Jill is the younger of two

sisters and was described by her parents as very tidy and clean since she was a baby. According to Jill's parents, as a child she never enjoyed activities that involved coloring or playing in the sandbox along with other children. At age four she had trouble separating from her mother to attend kindergarten, and at present she refuses to stay alone at home after dark. Her father describes her as being very sensitive and very fond of order and symmetry. Her OCD is comprised of obsessive thoughts revolving around her family, especially her mother. Jill fears that if she fails to perform one of her many rituals, something bad might happen to her mother. She is occupied with recurrent thoughts for the greater part of the day. For the past year, she has missed school because she prefers to stay home and engage in compulsive behaviors, such as mentally repeating a "special" sentence every time she notices the digit six showing on her watch. She also imagines a string attaches her body to her mother's and each time someone crosses behind her, she imagines the string might rip and her mother might stop loving her. Because of this thought, she prefers to stay at home alone for 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 and expresses high motivation for therapy because she feels here condition has exacerbated in the past year.

After completing a 12-session cognitive behavioral therapy protocol for the treatment of OCD (Salkovskis, 1988), Jill showed significant improvement. She began to attend school regularly and was able to overcome most of her compulsive behavior and reduce the intensity of her obsessive thinking by using a variety of mindfulness techniques (Kabat-Zinn, 1990). Jill felt satisfied by her accomplishment but at the same time she was worried that because the OCD has been "a part of her personality since she was very young," she would not be able to succeed any further in her struggle against her symptoms. In one of the sessions, Jill pointed out that she did not know herself without the OCD. At this stage the therapist (A.K.) decided to introduce hypnosis to elicit an "out-of-illness experience" that would enable Jill to experience herself without her symptoms. A hypnotic trance was induced in which Jill, using her love for the ocean, was encouraged to imagine herself diving into the sea, ". . .deeper and deeper, feeling relaxed and calmed. . .". It was suggested to her that the deeper she submerged herself, the more her OCD would wash away until it completely vanished. She was then instructed to picture herself swimming to a nearby island and sit on its beautiful beach to feel and sense how life could be without her OCD. While sitting on the beach, Jill started to cry and commented that she never felt "free and light as she feels now,"

and we instructed her to anchor this feeling so she could recreate it at will after she left the session. The following week Jill reported another improvement in her condition and said that her mind was much more at ease. The "out-of-illness experience" was recreated in two consecutive sessions, allowing Jill to talk about her identity as a teenager, her fear of being rejected by her schoolmates, and her conflicted feelings towards her mother. Not only did her symptoms diminish almost completely, but she also could talk about her emotions and thoughts without engaging in obsessive fears and anxieties.

Case III: Rigid Paula

The use of "out-of-illness experience" for securing therapeutic results. Paula, a 55-year-old, gratifyingly married, highly skilled manager, sought therapy for her constant feeling of diminished self-worth, her rigid and unusually formal relationships with those around her, and her problematic relationship with her mother. During the course of therapy, which lasted for almost a year and a half, therapeutic work was aimed at helping her transform her self-image from that of a "little defected child" to accepting herself as "hard-working, intelligent, adequately self-fulfilled, and human, loving woman." In the course of therapy, she discovered that her rigidity was a result of her mother's persistent, narcissistically fueled criticism, her childhood self-experience as an overweight and squinting girl, and her background of having grown up in a country governed by a dictatorial regime. Her subsequent life experiences helped her straighten her defensive rigidity of character. In the concluding phase of treatment, she told the therapist (J.M.) that although she conceives herself very differently after completing the therapy—more worthy, more open, and untroubled by her relationship with her mother—sometimes her rigidity took control of her and her behavior. She said she wanted ". . .to find a way to separate myself from it completely." Paula was invited to participate in a hypnotic session using dissociative techniques to help free her from her habitual rigidity. "And now you can start diving, feeling all the particles connected to the rigidity fall from you as you go deep down. . . ." As she arrived at the "free-of-rigidity place," her pleasant body-mind state was held in place by a multilevel anchoring procedure. After the hypnotic part of the session was completed, Paula told me that during the session she decided not to follow rigidly my suggestion of diving, creatively changing my metaphor for dissociation to a metaphor she constructed. She had seen herself inside a container filled with a cleanser liquid, much like one used for cleaning a kettle filled with scale after being overused with dirty water. The liquid

cleanser separated her from the scaly parts that didn't allow her to move freely. In the end, after cleansing herself she felt more flexible and ready for action.

This therapeutic session added an improved ability to be in new situations with other people without her habitual rigidity, to the list of her firm therapeutic accomplishments.

DISCUSSION

The "psychiatric adaptive paradigm"(Seligman & Kirmayer, 2008) links together trauma and dissociation, thus rendering dissociative behaviors, in concurrence with the opinion of the majority of mental health clinicians, as pathological. While dissociation can be a consequence of a traumatic experience, some of the dissociative phenomena and tendencies are common within the normal population and do not seem to carry high levels of distress (Michelson & Ray, 1996). Current research suggests that far from being inherently distressing, dissociative experiences may often be associated with pleasurable or playful recreational and creative activities. Individuals who spend a large amount of time engaged in reverie or other forms of absorption may exhibit a good capacity to adapt to daily life (Rauschenberger & Lynn, 1995; Butler & Palesh, 2004; Seligman & Kirmayer, 2008). Watkins and Watkins (1997) propose that healthy dissociation differs from pathological dissociative processes in terms of genesis and in terms of the flexibility and controllability of the boundaries between the dissociated parts. It is possible then that productive dissociation is an inborn, culturally determined, developmentally useful quality of human beings (Watkins & Watkins, 1997) induced by different psychological, physiological, and socio-cultural means during the course of development (Seligman & Kirmayer, 2008).

The understanding of dissociative processes as inherent developmental qualities can be traced to early psychoanalytic writings. These writers attempted to understand the development of defense mechanisms that aid the cognitively and emotionally immature child deal with the vicissitudes of reality. Freud (1940), in his paper "Splitting of the Ego in the Process of Defense," describes a mechanism by which the ego, at the verge of a conflicting encounter with reality, is divided into separate parts. This division permits the person to keep the two sides of the conflict apart, an act that enables the denial of the inconsistency created by the psychic conflict. Klein (Ogden, 1986) developed this idea further and maintained that the splitting of the psyche in the face of a frustrating reality is a developmental mechanism that allows the child to organize an otherwise

chaotic and unpredictable world that threatens to overwhelm him. This organization constitutes the building blocks of identity, differentiating between what is experienced as internal and external as well as what is experienced as self or other (Matte-Blanco, 1988).

Hypnosis has been used for centuries as one of the natural, nontraumatic and stress-free procedures for the induction of prolific psychological dissociation (Gezundhajt, 2007). Hypnotically induced dissociation can be elicited using direct and indirect suggestions. Direct suggestion should emphasize different kinds of divisions (Yapko, 1995) and promote the dissociative use of language (Edgette & Edgette, 1995). Indirect strategies include metaphors, confusion techniques, and other Ericksonianian 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 hypnotic and psychotherapeutic expertise (Meyerson & Gelkopf, 2004; Edgette & Edgette, 1995; Brown & Froom, 1986).

In OMD the differentiation between the "healthy" parts of the personality and the "pathological" ones is unclear. With the aid of HID, the patient is able to reorganize the different parts of the personality to create a more adaptive and flexible organization. This process is enhanced by an "experience of self" that is distinct from the obstinate one. This new experience facilitates psychic transformation through a process of "learning from experience" that was viewed by Bion (1991) as the ability to encounter reality in a state of openness without preconceptions. This "unsaturated" encounter with either external or internal reality serves as an opportunity for the creation of a new psychic experience that, with the aid of the therapist, may be incorporated into a new organization of the self.

In Bob's case, HID intervention enabled him to promote in-depth exploration and processing of his life losses without being overwhelmed by anxiety. In this occasion, the "out-of-illness experience" served as an "ego strengthening facilitator" and succeeded in advancing therapy to a phase in which chronic depression could be transformed to a more treatable dysfunction. In the case of Jill, HID was introduced after cognitive-behavioral therapy reached an impasse attributed by the patient to the confusion between the remaining manifestations of the OCD and personality traits. The "out-of-illness experience" enabled Jill to reacquaint herself with aspects of her personality long overshadowed by her symptoms. She began to deal with identity questions, which in turn, allowed a

new organization of personality. Paula's habitual rigidity was the last obstacle keeping her from enjoying positive personality changes achieved during prolonged, intensive therapy. Hypnotically induced dissociation, adapted by her creatively by introducing personal meaningful images, enabled Paula to assimilate this significant personality transformation.

We can deduce from these case presentations that HID interventions can be used in diverse phases of therapy and can be administered as an integrative part of any psychotherapy, regardless of the theoretical orientation of the therapist (i.e. cognitive, psychodynamic. etc.). We reiterate that although hypnosis has been used for centuries as a natural, nontraumatic, and stress-free procedure for the induction of prolific psychological dissociation, the therapist should be cautious in utilizing HID techniques, especially with dissociative and psychotic patents. During introduction of HID procedures, the therapist should keep in mind that these techniques are intended not to promote defensiveness or fragmentation but to encourage and to stimulate flexibility and adaptability of patients' personalities.

In the present article, we attempted to emphasize the distinct contribution of nonpathological dissociative experiences in developmental processes in general. The clinical cases presented emphasize the role of HID as a natural and effective therapeutic resource for treatment of patients suffering from OMD. We believe in teaching patients during the hypnotic trance to use controlled dissociative strategies to separate themselves from persistent and problematic behaviors, thoughts, and feelings that, during years of illness, become organizing principles of their identity. By doing so, meaningful personal transformation can be enhanced.

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