INTEGRATING ERICKSONIAN HYPNOSIS AND SYSTEMIC COUPLE THERAPY IN THE TREATMENT OF CONVERSION DISORDERS

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ABSTRACT

Focusing on a systemic view of conversion disorders, this paper presents a particular system of family and couple interactive patterns that we have called *narrative relationships*. This theoretical framework is illustrated through a case example and the verbatim transcript of a hypnotic couple session, in order to demonstrate how systemic psychotherapy and Ericksonian hypnotherapy can happily meet and perfectly integrate.

The hypnosystemic approach is based on the assumption that patterns of behaviour that take place in a family or couple system are not independent from the individual thinking of its members, and vice versa. Conversion disorders seem to be the context in which the individual and family drama provide the greatest evidence, to the point of making the story prevail over any subjective or intersubjective authenticity.

The narrative relationship is characterized by: (1) communication patterns centred on the presence of 'secrets'; (2) a fantastic and dramatizing facade built on everyday life events; and (3) a pervasive tendency to transform all experiences into a narrative to be told continuously to interested and unconcerned listeners.

The results of our clinical experience confirm that the therapeutic intervention demonstrates effectiveness mostly when the basic conflict and the symbolism embedded in the disorder is understood in terms of a specific system of relations.

Key words: systemic psychotherapy, Ericksonian hypnosis, narrative relationship, couple therapy, conversion disorder

Therapists approaching the treatment of conversion disorders (CD) should consider the broader context as an unfailing resource. Although most reports are anecdotal, a growing number of prospective clinical trials conclude that family therapy interventions are a valuable support for both the subject and the family in recognizing and addressing crucial issues in the development of conversion symptoms (Griffith et al., 1998; Ryan et al., 2005). At the same time, neuroimaging data seem to support the hypothesis that conversion symptoms and hypnosis share common neural pathways, and the high hypnotizability levels found in these patients invites the use of hypnosis in their treatment. A study of 44 outpatients with conversion disorder (Moene et al., 2003) randomly assigned to hypnosis or to a waiting list found greater improvement at three months with hypnosis. However, other studies comparing a comprehensive treatment programme comprising intensive group therapy,

social skills training, creative therapy, sports therapy, and physical therapy with or without hypnosis, showed no added benefit from hypnosis for resolving conversion symptoms and didn't assign to hypnotizability any predictive value for treatment outcome (Moene et al., 2002). Conflicting results like these lead to the conclusion that a comprehensive approach to CD is likely to be most effective (Stonnington et al., 2006). Hypnosis, particularly brief hypnotic therapy, by itself may reduce conversion symptoms but have less impact on overall psychopathology and dysfunctional relational patterns.

The integration between hypnosis and family therapy presented in this paper originates from these observations, which form part of a series of publications starting in the 1980s with the proceedings of the First International Congress of Hypnosis and Family Therapy (HFT) (Loriedo et al., 1987) held in Rome in November 1985. One of the main acknowledgements of the Congress was the ability of two models, like Ericksonian hypnosis and family therapy (more specifically symbolic-experiential family psychotherapy), to meet and perfectly integrate. Since then, progress has been made in research and clinical practice (Loriedo, 2008), giving rise to a commonly shared practice that has been successfully applied in other areas, such as depression (Loriedo & Torti, 2010).

FROM INTRAPSYCHIC CONFLICT TO NARRATIVE RELATIONSHIP

According to DSM-IV-TR, the diagnosis of conversion disorder is based on the presence of symptoms that suggest a neurological or other medical condition related to psychological factors (APA, 2000). The same methodological approach is maintained in the provisional formulation of criteria of DSM-V which will be published in 2013 (APA, 2010). The criteria of 'evidence of internal inconsistency or incongruity recognized with neurological or medical disorder' (APA, 2010) is extremely useful for clinicians when differentiating conversion disorders from organic disease, but it offers neither indication on the organization or functioning of these patients, nor does it provide a solid and shared foundation for a specific and effective therapeutic intervention.

A *conflict* can be described as the interference between psychic functions. Recent neurofunctional studies indicate conflict is linked with specific mental activity, particularly in patients with motor-type CD. Conflict seems to correlate with enhanced activity of the anterior cingulate cortex whose intensity can bring severe perturbation in this region, which is the location of the integration of cognition, emotions, and motor planning (Van Veen et al., 2001; Raz, 2005). In this way, conflict is able to activate a 'somatic dissociation'; that is, segregation between the cognitive, volitional, and motor functions due to interference with the activity of an intact cortical region. These functions reflect some characteristic features of dissociative symptoms. Patients with functional motor disorders, as well as psychogenic amnesia, sensory disorders, and pseudocrisis, often maintain proper functioning in some usual and automatic operations (e.g. to shift so as not to fall, to move away from a dangerous stimulus, or to remember a familiar phone number) (Kerns et al., 2004). For a long time, these phenomena have been regarded as evidence of some degree of simulation; today they confirm the prevalence of volitional rather than executive functions in the genesis of the disorder. In other words, rather than having faulty limbs or memories, what appears to be compromised is the ability to convert will into psychical action. Other studies have compared the neuroimaging of patients with hysterical conversion with subjects in which paralysis was induced as a hypnotic suggestion; and patterns of activation significantly overlap (Oakley, 1999; Raz, 2005).

However, as often happens with experimental research findings, these studies show us the presence of conflict but tell us nothing about its nature. The psychoanalytic tradition posits that the fragmentation of mental functions is the result of childhood trauma, which is unacceptable to the conscience and therefore is relegated to the unconscious. Its reappearance is the root conflict between unconscious and conscious. But this theory has been proved at least partly wrong. Trauma is present in many patients but not enough to justify a causal relationship, and the effect of trauma appears to correlate more closely with the severity of conversion symptoms rather than its prevalence (Roelofs, 2005).

From a systemic point of view, Minuchin et al. (1980) describe the 'psychosomatic family', suggesting that a psychosomatic disorder could develop in a dysfunctional family which is characterized by *rigidity*, *enmeshment*, *over-involvement*, and *conflict avoidance* or *lack of conflict resolution*. However, although the theory outlines the quality of relationships within the system, it does not indicate how that relational style turns into a systemic disease.

In our experience with more than two hundred patients with CD, families in which this disturbance takes place present what we have called a *narrative relationship*. This is characterized by: (1) communication patterns centred on the presence of 'secrets'; (2) a fantastic and dramatic facade built on everyday life events; and (3) a pervasive tendency to transform all experiences into a narrative to be told continuously to interested and unconcerned listeners.

Family and couple communication seems to centre around one or more confidential bits of knowledge, which take precedence over any other area of communication. At the same time, the boundary between reality and fiction is lost, although it remains vaguely alive. In this 'family romance' (Freud, 1908), the drama has more weight than the family roles, and the symptom bearer becomes its narrator who continuously tends to put more emphasis on the story than on the personal or experiential dimensions. When describing the CD patient condition, we use the term 'invisible storyteller' because the drama prevails to the point of making the real person disappear. The partner and the other family members are initially seduced by the fantastic narration, but later they gradually become detached and uninterested. The narrator is then obliged to increase the emphasis placed on the story adding, one by one, new surprising elements and/or mysterious physical symptoms. The seductive narration that in the beginning was regarded as a source of interest and attraction, later becomes a reason for the person to be ignored, since the fantastic world that fills their everyday life tends to cancel out the real individual and their authenticity. The relationship between the invisible storyteller and the rest of the family is based on a great confusion of roles (real and fantastic) and on a general ambiguity.

Consequently, the only yardsticks for adult behaviour are selectively rejected, devalued, and disqualified, rendering unsuccessful any model of growth or of weaning and autonomy. Family rigidity, enmeshment, and over-involvement appear as consequences rather than causes of this peculiar organization. The need for visibility, idealization, ambiguity, imitation, and seduction guides the invisible storyteller in his/her narrative relationships.

The content of the secrets appears less important than their use to attract and manipulate, and in fact their *concealment* is not hidden but is frequently displayed with pride. Sometimes the impression is created that the secret doesn't exist at all or is invented on purpose, as an attempt to obtain ambiguous visibility, and it is dramatized until it becomes a fiction.

A patient with pseudocrisis once said, 'Sometimes I feel as if I have the opportunity to hold my symptoms back, but I am afraid of the consequences.' The interference between the psychic functions—which we define as 'conflict'—is the 'visible' consequence of similar contradictions.

Secrets and conflict are involved in a chain of symbolisms that are to be taken into account in order to establish an effective therapeutic intervention. The most important objective however should not be ascertaining the 'truth', but rather understanding the relational meaning that underlies the conflict that generates reciprocal ambiguity and fantastic narration.

HYPNOSIS IN A SYSTEMIC PERSPECTIVE

Assuming that behaviour patterns taking place in a system are dependent on its members' individual thinking, patients with CD play a role in the family and couple context, forming what we have called a narrative relationship. Obviously working with a whole family is not the same as working with a group of individuals. Activating change in the reciprocal interactions that connect every family member to each other becomes essential for attaining therapeutic goals. Hypnosis as a refined tool of communication can provide an effective means of promoting multi-level communication and enhanced relationships (Erickson et al., 1976; Yapko, 2003).

The induction of hypnosis with a couple or family enables the activation of spontaneous systemic changes, particularly if the couple or family members participate together in the hypnotic process. Both intrapersonal and interpersonal changes are greatly potentiated by the shared context of multiple individual inductions. The term 'systemic hypnotic patterns', described in detail elsewhere (Loriedo, 2008), suggests that reciprocal responses spontaneously arising in hypnosis can be redirected in order to reduce or resolve interpersonal conflicts or miscommunications. Further, automatic and unconscious repetitive patterns in couples and families have hypnotic qualities that can be acknowledged and utilized in treatment. Salient features of systemic hypnotic patterns include the following:

1. *A reduction of spontaneous interactive exchanges*. Conjoint hypnotic induction can decrease the number of interactive exchanges between the couple by encouraging a greater focus on the self. As a result, the couple's interactions are performed more slowly and, as a side effect, automatic interactions tend to diminish or even disappear.
2. *A synchronicity of responses, both physical and emotional*. A couple in harmony may develop synchronous behaviours ranging from parallel postural shifts to changes in breathing and blood pressure (Kendon, 1979; Iacoboni, 2008). Similar responses are usually produced simultaneously by the partners if they undergo hypnosis together. The sense of harmony is, in turn, reinforced by the synchronization of their emotions and feelings and, during a simultaneous experience of hypnosis, a couple can develop a greater ability to work and perform together as a team.
3. *A reduced reactivity to other family members*. Being absorbed in hypnosis can decelerate reciprocal reactivity. By including pauses in hypnotic communication we can create time to think in order to prepare a more well-considered and appropriate response. Moreover, despite the partner's presence, hypnosis can allow each individual to focus more on his or her inner self. Thus, individual autonomy receives support and interpersonal boundaries are more easily enforced.

4. *A reduced attention to the couple's relationship level*. The amount and type of attention paid to the relationship level can be considered an indirect measure of dysfunctional conflicts in the couple (Watzlawick et al., 1967). Excessive interpersonal focus or rumination about the relationship can have deleterious effects. Hypnosis tends to reduce the degree of focus by redirecting attention to more constructive areas.
5. *An increased attention to the content of communication*. Often, the couple in conflict focuses more on how they feel about what was said than what was actually said. Conjoint hypnosis fosters greater attention on the communications content. In contrast to the pattern described above, this pattern is considered an indirect measure of the couple's ability to solve conflicts and communicate effectively.
6. *An increased responsivity to the therapist*. Both members of the couple in hypnosis tend to become progressively more responsive to the therapist's suggestions. Erickson, Rossi, and Rossi (1976) characterized the hypnotic subject's increased responsivity as 'attentive responsiveness'. Couples therapists generally know how difficult it can be to obtain this effect in a more traditional (i.e. non-hypnotic) couples therapy setting where each partner's attention is typically distracted by his or her own relational dynamics.

Michelle Ritterman (1986) shows how we can work on different levels—individual and systemic, or hybrid—by referring to the principle that the views of individuals modulate crucial family interactions. For the authors, hypnotic technique operates largely unconsciously, intervening to create a deep crystallization of mind. It is an extraordinarily useful tool for bringing together members of a separate dyad, both disjointed and abnormally fused.

A CASE EXAMPLE

'HIS PACE WAS NEVER LIKE MINE': A PARALYSING CONFLICT

The following commentary was the first and only hypnotic session with a couple treated with the brief hypnotherapy protocol for conversion disorder (Loriedo et al., 2010). The patient (here indicated as P.) was referred to our centre for a progressive legs hypotonia, culminating in paraplegia in a six-month period. She also consulted many other specialists, such as a neurologist, a psychiatrist who prescribed her Fluoxetine, 20 mg/day, and a psychoanalyst.

During the gathering of her clinical history that preceded the present session, P. described a long and complex series of family problems. She emphasized an infinite array of details and seemed to enjoy finding emotional words to catch the attention of the interviewers. According to her, the present problems were caused by the rude and dysphoric attitude of her husband. She particularly disliked his daily assaults of outbursts of anger and vulgarity aimed at her. The husband, identified in the transcript as H., was former military, five years older than P. He retired early from the military after a serious argument during which he had been verbally assaulted by a colleague and had reacted badly, hitting the attacker in the face. For this reason he was condemned by a military court and the court sentence led him to early retirement.

They married early—respectively 21 and 26 years old—and they had two children, a boy, 24, suffering from serious mental retardation, and a girl, 29, married. At the time of the visit, P. was 56 years old. She had developed leg hypotonia five years previously and in the last year paraplegia had developed; since then she had been confined to a wheelchair. The disturbance onset had occurred after a flu syndrome. In the following days she had gradually experienced a feeling of heaviness in her legs, evolving into a worsening weakness. A few weeks before the session, she had been hospitalized in a neurology clinic where she had received a diagnosis of myelitis and was then discharged with a diagnosis of motor-type CD.

In our evaluation visit she was partially able to lift or move her legs, but she could not stand upright or walk. There were no sensory or motor deficits in other areas. Her husband accompanied her to our centre and, after pushing the wheelchair with his wife into the room, without saying a word, he sat in the next room, close to the door. In the interview that preceded hypnosis, P. described, with endless richness of verbal details, visits and treatments performed to date as well as her current symptoms. Despite the abundance of the narration, explanations on the nature of her disorder given by various specialists were frequently mixed up in an ambiguous and confusing way. According to her, the disorder was both 'medical and emotional'. The communication style was redundant and baroque with many detailed, circumstantial descriptions. Her husband participated very little, speaking only if required by the therapist, and most of the time, in a sarcastic and disqualifying tone of voice.

DEALING WITH AMBIVALENCE

T: How long did the marriage last?
H: Too much, it lasted too much.
P: Thirty-five years.
H: And only a separation could heal ...
T: A divorce? And could a divorce really heal?
P: I think ...
T: So what is the problem?
P: You know ... now it would be a problem. I could have done it some time ago. But now the right moment is passed, and we didn't break up because of the family and because of stupid principles ...
T: And now?
P: Now, in the midst of all this mess, I am fighting with all my strength because I see these families that destroy themselves in an instant. I live my memories, and he [referring to H.] is just a memory for me. Although recently, after my paraplegia, he seemed to be changed, different. He looked like another person I have to say ... And I'm sure, I am sure I recovered completely ... although I had a myelitis ... I'm sure I recovered thanks to his change.

This short passage highlights one of the few constants of the couple's communication patterns: *ambivalence*. While P. claims to 'live my memories', and regrets divorce was not

effected at the proper time, at the same time she appears to be grateful to her husband for the fact that she recovered after the first paraplegia episode.

Bleuler described ambivalence, in schizophrenia, as a state in which 'contradictory feelings and thoughts run side-by-side without influencing each other' (Bleuler, 1911). Freud described ambivalence as a recurring element in neurotic patients in *Totem and Taboo* (1913). He focused on the 'unconscious affective ambivalence' of these patients, ignoring the volitional and intellectual form described by Bleuler.

Strictly speaking, the term ambivalence should be reserved to cases in which two antonymic behaviours share the same object, or are simultaneous in time, thus revealing contrasting attitudes, affects, ideas, or tendencies. Hence, despite the different positions of Bleuler and Freud, 'ambivalence always means conflict, whether conscious or unconscious' (Bleger, 1967).

In systems theory terms, ambivalence arises in individuals who do not have access to the concept of *complexity*. Complex systems are made up of different levels, and the contradiction that sometimes emerges on one level can be solved by referring to the superior (or meta) level. Thus a conflict develops when, in the presence of opposite feelings, ideas, or attitudes, the subject is unable to reach the meta-level that could make the opposites compatible.

To solve a conflict in a therapeutic sense means to make the meta-level accessible so that a synthesis and a complex understanding of the antonymic tendencies can be reached. Hypnotic intervention in a conflictual and dysfunctional system becomes effective when the ambiguity of an individual, couple, or family can be solved through access to a meta-level that allows the opposites to be consilient, thus allowing togetherness and synchronicity among the system members through a shared experience of trance.

> *T: So what would happen if we do hypnosis with him and he then goes back to the same attitude he had when you left the clinic?*
> *P: That would be marvellous …*
> *T: [To the wife] It could be good for you too:* tension would decrease, you would be more quiet, and you would feel better or even healed. *So why not do hypnosis to him directly? Moreover, on the basis of what you've said to me, he went through a difficult time too!*
> *H: [Shrugs and nods wryly, adding sarcastically] Okay! I'm here!*

INTERSPERSING HYPNOSIS FOR BOTH MEMBERS OF THE COUPLE

The question 'If we do hypnosis with him …' plays a dual role. Firstly, it openly suggests expanding the hypnotic context to H., and secondly it brings in the idea of a shared disorder (a topic that will be resumed during the session).

The therapist's second sentence contains some interspersed suggestions [in roman] that are preparing for the hypnotic session: *tension would decrease, you would be more quiet, and you would feel better or even healed,* with the implied directive that a hypnotic experience for one of them will be beneficial for the partner as well. Direct suggestions to one person will likely have indirect effects on the other. In other words, in this passage we are introducing hypnotic therapy for couples.

P: [Looks at her husband warily] Do you know what's going on right now, professor? I become a naughty person. I'm cruel. And if I know I can hurt him, I will.
T: But does he get hurt?
P: I don't know! I hope he is able to listen to something, because something is true.
T: But as you said, when you hurt him, he becomes vulgar. Then you hurt him even more, and thus he becomes even more vulgar ...
P: Yes. It's a vicious circle!
T: So, I have to do hypnosis with you, with him, or both?
P: Maybe both.
H: [Sarcastically] Why not with the whole family?
P: [Irritated] Let our sons alone. They have their own problems!
T: [Referring to both of them] So, let's start with you!

The couple's response is still ambivalent, but they do not openly refuse the hypnotic therapy, and this is taken as a sign of cooperation. The best possible cooperation for the current state of their relationship is a partial agreement that does not mean sharing (Fisher, 1999).

When P. stated: 'I don't know! I hope he is able to listen to something, because something is true', she seemed to express her worries about *being seen* and *listened to* by her husband, and at the same time, the phrase contained the admission of her fantastic production when she implied that 'not all is true'. The way P. described her situation as a result of her husband's behaviour, even if it was in a linear way, indirectly indicated the importance of their relationship. The obvious conclusion the couple could not deny is that the hypnotic intervention should include both of them. This cyclic nature of their conflict appeared evident to them both, but P. described it in an explicit but contradictory way. It is not clear who is really the 'villain'. The awareness of a clearly redundant pattern is not enough. The partners should also be able to communicate in such a way that they become aware of the incongruent nature of their messages (Visser, 2007).

A RAPID FORMAL INDUCTION

At this point it was possible to use a formal induction for both of them.

T: Are you ready? Make yourself as comfortable as you can.
P: Yes ... [She closed her eyes, then she opened them again] Are you sure that while in hypnosis, we will not beat ourselves up?
T: If you are able to stand up and go over there to beat him, the problem will be solved.
P: That's my hope ...
T: Now, close your eyes. [Referring to H.] Close your eyes too. [They both close their eyes. Pause] Now, you haven't to do anything special, just listen [Pause] without saying a word ...

'Make yourself as comfortable as you can' is the beginning of a short induction, and also a proposal to share together the experience of therapy. Sharing becomes the essence

of the couple induction as well as of many other therapeutic moments. The same attitude was elicited when both were invited to close their eyes, not to do anything special, and to listen without speaking. The systemic approach is not a dichotomous 'either/or' perspective; rather, it is an inclusive 'both/and' orientation. Thus, from a systemic point of view, both the individual and the larger system of which the couple is part are the focal point of the therapeutic intervention.

The objection of P. is of some interest. Can hypnosis reveal the conflict to the point that violence can result? With an immediate response, the hypnotic conflict is reframed as a path to success.

With this specific couple the request of silence had a peculiar relevance. The redundant tendency of P. to transform every dialogue into a monologue interferes with the idea of hypnosis as a shared experience. Moreover, speaking easily activates in the couple the cycle of naughtiness and vulgarity. In the hypnotic context, silence has the added value of facilitating fantasies, and in this case fantasies are better than the couple's everyday reality. The therapist contributes to the silence by slowing down the rhythm of words by making abundant use of pauses. The pauses become 'a message interpreted in terms of the effect of previous breaks. It is "not saying" that conditioned her' (Erickson et al., 1959b). Another important contribution to demonstrating the limited importance given to words is the fact that the therapist only used two phrases to complete the induction.

INTERSPERSING CONJOINT DEPTH

> *T: This type of hypnosis allows people* to solve *their* problems without any special suffering. *And you've had already a lot of suffering. Probably too much. [Long pause] And the truth is that* you've had enough. *From this point of view [Pause]* you are tired. *[Pause]* You have a great ability to face difficulties, *but* all those efforts made you morally tired. *[Pause]* So you have to rest *and this will be the first part of our work*. Rest so deeply as ever. *[Pause] This way of r*esting will absorb every point of your mind and body. Every single cell in the body *[Pause] and* in the brain *[Pause]* can rest, *but* in the most comfortable position. *[H. smiles, but with a sardonic expression] Rest,* giving the body a feeling of well-being that was missed for a long time, *that now is necessary to [Pause]* break the cycle of contrasts and suffering, of naughtiness and vulgarity that drained all of your resources *away and made you unable to* share beautiful things. *The need to* rediscover that shared experience again, that pleasure denied for such a long time. *For a long time* everything was suffering, pain, sorrow, and discomfort. Now it is time to rest, *[Pause]* deeply, *[Pause]* very deeply.

During the initial interview the couple showed a great sense discouragement and defeat. Frequently paralytic symptoms in CD come out when a feeling of impotence results in a serious risk of violence. Fromm (1973) describes this risk of aggression as 'evil-destructive aggression', a feeling which he considered 'necrophilic' because it tends toward self-destruction. The recognition of the couple's emotional paralysis allows the therapist to underline the subsequent 'moral tiredness'. The next passage concerns the obvious necessity for rest that is introduced to the couple both in direct and indirect ways. The direct speech of the therapist brings in closeness and empathy—a reflection of their interactional stalemate. The indirect technique (indicated in the text transcription by the words in roman), invented

by Milton Erickson and defined by him as the 'interspersal technique' (Erickson, 1966), allows the therapist to intersperse significant elements and strategic solutions.

Paul Watzlawick (1978) describes the interspersal technique as follows: 'Imagine a page of a book that seems to contain no more than a long, irrelevant, boring, soporific description; however, some words are underlined. Now, if these words are read in the order in which they occur, they offer an entirely different meaning from that of the page. ... Perception of a hidden image should be a skill of the right hemisphere. Thus the interspersal technique became a means of access to this hemisphere' (1978: 65). In the interspersal technique, new associations are the result of a steady, *restructuring intervention*. The subjects have the opportunity to absorb some of the implied meanings and, if they like, apply them to their lives.

> *T: [Long pause] All* tension *[Pause]* can be released. *We know the muscles of the body tend to contract and they contract especially in times of stress, discomfort, fear, worry. So even if we do not notice it, tension increases and it affects basic parts of the body, making them useless. Now,* we need these parts of the body to rest*, now* they can really loosen *[Pause] a*ny tension that they have had up to now*, until* the tension completely disappears. *And it's true for the body, but also for the mind. A subtle need of* freedom from all the tensions of the past and replace them with a smile*, just raised, just raised. [H. continues to smile, but now in a relaxed way. P. seems ready to cry and moves her lips as if trying to speak] It is the beginning of a* new, different, way to face the reality of everyday life you will live from now on. *It will be possible to live in a* moment of complete and deep rest.
>
> *But even in peaceful moments like this,* pain and sorrows can reappear on the surface and try to ruin everything. *[H. stops smiling]*
>
> *No wonder if people want to* free themselves from the returning of unpleasant memories. This can be done in a form of natural discharge. *[P. starts crying] [Long pause] And there is* no necessity of speaking, or to give unnecessary responses*, just to* express in a natural way, natural feelings that are released.

In this section the therapist begins to approach the symptom, and the intervention becomes more specific and tailored. The symptomatic effects the conflict has on the body and its functions ('to make them useless') are addressed. Although the couple seems to be engaged in shared activities, the endless disagreement is still visible through the nonverbal expression of their feelings. While her husband openly smiles, the patient begins to cry. Once again, a complex intervention is needed to solve the apparent contradiction. Both members of the couple can get rid of their suffering if each accepts the invitation to *express in a natural way, natural feelings that are released*.

Conflicting positions are implicitly reframed, as expressing in different ways the same type of shared emotions. Having access simultaneously to the same solution, it is possible to *release them naturally*.

The need for visibility, and the predominance of narrative, is clearly expressed by the more authentic participation of the couple in the session during hypnosis. There is a difference between the intensity of emotional expression during the trance and the narrow range of emotions that appeared during the conversation.

> *[P. continues to cry. H. keeps a straight face]*
> *T:* You could forget *what happened*. Or it will be possible to overcome everything, but saving memories. *When you are deeply wounded, the wound can be cured in the best possible way, but it will leave a sign in the form of a small scar, [Long pause] and the scar* allows us to remember. *Anger, naughtiness are signs of the wound. Yet, when* the wound will not be painful any more, *it will* become just part of each one's personal experience. *Pain will only leave a trace—the scar—and* there is no pain left, *and it* will remain only learning.

A further step is introducing the theme of memory. P. said: 'I live on memories, and he is just a memory for me.' Even the most unpleasant events in their life didn't erase their shared experiences. During an interview P. said: 'We lived very bad experiences together. But I think they bound us. They almost destroyed us, but they bound us tougher.' Ambivalent memories are common to all human beings, but under given conditions they can prove useful. Joëlsa et al. (2006) found that experiences of crisis allow the activation of new resources, and therefore of new learning. In neurotic patients, this integrative function of memories, however, seems to be lacking. A recent neuroimaging study indicated that cued recall of clinically repressed events was associated with a reduction in the activity of the motor cortex of a patient with a conversion paralysis (Kanaan et al., 2007). Since our intervention is intentionally non-explorative, the therapist does not delve into the patient's ambivalent memories, but focuses instead on a higher level to work out such experiences. The reduction of suffering and the activation of resources are implicit objectives of each hypnotic psychotherapy, as observed by Erickson (1964).

FINDING AND USING THE COUPLE'S METAPHOR

> *T: For all this time,* you carried a weight. *Now imagine this weight [Long pause] wide, annoying, and heavy. Imagine it lying on the point of the body where you can feel it more. And imagine it heavy like it actually is, and like it was in the past. And then* imagine it begin to slowly fall down. *More and more.* And it becomes a black and heavy ball*, like a cannonball or* a heavy bowl that slowly drops down. *[Long pause]* It drops down and it doesn't weigh any more on the head, or on the chest, on the arms, or on the legs. *[Long pause]* Doesn't weight any more on the body. *[Pause]* You've had enough of weights. And now it is just there, in front of your feet*: two large bowls are at your feet.*

Up to this point, the intervention has followed the implicit goals of therapy, working mostly on the couple's conflict and on their painful memories. To deal with the conversion symptom necessitates a metaphorical translation of the primary problem underlying it. The theme of *heaviness* relates to a dull way of moving in the world and burdensome experiences. In the very first meeting, P. repeatedly described the situation she was living in as one of 'heaviness', and as Zeig and Munion (1999) say: 'an effective metaphor often draws upon familiar aspects and ideas in the patient's life, and is therefore personally relevant' (1999: 65). So the *tension*, the *weight* are bound to these aspects of the couple's relationship, and we can say that this is *their* metaphor. The metaphor is actualized into a real object, a 'weight' preventing movement. But the object can 'drop down' and free the couple

from their physical and emotional paralysis. The term 'cannonball' brings many evocative associations for this couple. It is however also something unfamiliar, something that is easy to give up. The idea of healing is implicitly introduced. The conversion of the conflict in a symptom is a process of symbolization (Viederman, 1995; Witthöft & Hiller, 2010) and the therapeutic metaphor completes the process through a symbolic treatment that brings the couple back to the story of the conflict.

According to Erickson and Rossi (1981), a metaphor should 'talk' to the right hemisphere directly, dissolving the conflict by an implicit symbolization, while the left hemisphere is ensnared by its literal meaning.

> *T: But be careful. Since you freed yourself, we have two main requirements. [Long pause] The first is not to stumble into the ball at every step you take, the second is do not forget. [Long pause]* We have to learn from past experiences *otherwise you'll make the same mistakes and you'll fall back again into the same suffering. So, we have to move these bowls; [Long pause] to move them from here, without forgetting. Therefore, let me ask you to imagine that each one will now* put your own bowl in a safe place. *And for a safe place I mean a place where* your burdens can quietly rest. *[Long pause] Thus,* in case it is needed, they can be retrieved, just like memories that can prove useful to prevent mistakes and suffering. *[Pause]* As soon as you feel you have settled your burdens, *I would ask you to* give me a sign of your assent.

PROTECTING THE SUBJECT AND SEQUENCE RATIFICATION

The advantage of a physical metaphor is to respond concretely to a physical symptom. But in some cases, another therapeutic advantage is the possibility of moving it outside of the body. But what is really important, when working with CD, is to demonstrate genuine attention to the real person. Attempts by this type of 'invisible' patient to be seen usually fail because their unreliable request is based on seductive or symptomatic behaviour. Partner and family members, as well as many doctors, tend to ignore those behaviours. As result, the patient activates more dramatic productions from time to time.

The suggestion to bring the heavy bowl to a 'safe place … *where your burdens can quietly rest … just like memories that can prove useful to prevent mistakes and suffering',* is not only directed towards the symptom to make it disappear, but takes into account the individuals' relationships both with their past and with their future. The 'weight' has been part of the couple's life, and for this reason it can be removed from the body, but not 'deleted'. The primary problems, the symptom and the related conflict, will have another *spatial* location, more distant, less important, less emotional. But in the future they will still have an important function; they will remain as a keepsake, a scar that will continue to teach the couple a story, and its moral.

As Erickson was explaining already in 1952, the *need to protect the subject* is a central point in the psychotherapeutic application of deep hypnosis. And as he specified, the protection should be applied both to the hypnotic and to the waking state. The hypnotist who demonstrates to the subject interest in future developments, apart from the symptom, gives a clear message of real interest and protection. These elements are relevant to all hypnotic subjects and should be considered essential for the treatment of CD. This attitude is essentially what they are looking for: a sincere and authentic interest in the real person who usually hides under their colourful but inconsistent appearance.

The 'metaphorical task' (Haley, 1976) proposed by the therapist is reinforced by the open request for ideomotor signalling. Asking for '*a sign of your assent',* does not only reinforce, but it also gives an important *ratification* of the sequence of the therapist's interventions. If the sign is performed by the couple, all the therapy steps that took place previously will be confirmed:

1. The acceptance by the couple that their conflict can be described in terms of a huge burden.
2. The acceptance that the burden was blocking P.'s legs and was responsible for the paralysis.
3. The acceptance that the burden could be removed and free the paralysed parts of the body (as well as remove the emotional paralysis).
4. The acceptance of the real weight and paralysis removal.
5. The acceptance of the suggestion to place the bowl in a safe place for relapse prevention and general self-protection.

As Jeffrey Zeig underlines, ratification is part of the utilization approach, and is an implicit confirmation, both for the subject and therapist, of the therapeutic sense of what is going on: 'The utilization method of ratification has the implicit meaning, "You are responding, you are showing desirable changes" ' (Zeig, 2006: 80).

> *T: [There is a long latency before P. nods yes, giving the requested assent sign, then immediately the husband nods yes too]* Now you are free from this heavy burden*, and we know* it will rest in a safe place. *Since now a*ll the parts of your body are no longer committed to bear unbearable burdens, you can find again yourself *[Long pause] moving. And* you can even discover the capacity to *[Pause]* move in a nimble and enjoyable way. There are many things to do and to discover which require movement and agility. *[Long pause] So,* in a minute, I will allow you to open your eyes. *When I give you the signal,* you will *[Pause]* discover a new ability of motion that you have lost a long time ago. *[Long pause] When I give H. the opportunity,* he will stand up, will come closer and reach out his hand to P. as an invitation *to lean on him rather than on the wheelchair. Now, I'll count from three to one and H. will open his eyes and reorient himself. [Pause] [H. opens his eyes]*
> *T: [To H.] Are you able to give your hand to P.?*
> *H: I do ... [H. stands up and joins his wife. He takes her hand in his own]*
> *T: Now P. may open her eyes too and look around. [Pause] [P. opens her eyes] Now H. can give P. the other hand and see if P. is able to pull herself up.*

After the ideomotor signalling by both members of the couple, the therapist is much less cautious than he was in the previous part of the session. When P. and H. nodded 'yes', the previous therapeutic sequence was ratified and, at this point, the expectation for a positive result appeared well grounded. Nevertheless the therapist didn't decide to ask P. to stand up and move, because this was not an individual session. When working with a couple, especially when systemic therapy is integrated with hypnosis, it is important to continue focusing on the relationship, even when the symptom is about to be solved. For this reason, the therapist invited the husband—not in hypnosis but in a waking state—to

physically help his wife to stand up. In this way he can demonstrate a new and unexpected attitude: he is able to see her and to recognize her peculiar needs; he can and will want to help, not with the dangerous words he was used to, but with a gentle and passionate touch.

He can also demonstrate his ability to face the symptom by going beyond the old paralysing conflict. Physical contact becomes the new way of being in relation with P., and she can have this concrete proof before deciding to abandon her symptoms.

The lack of sweetness, availability, and harmony in the couple are tested in the experiential space of therapy. This step is the essence of the systemic nature of the hypnotic therapeutic intervention.

> *[P. gets up very slowly. She is able to stand without support, but only holding her husband's hands. Her face is suffering and her body is tense. She keeps standing for a couple of minutes, then T. says: 'Being the first time, it is enough …' P. sits down again and bursts out crying. H. returns to his seat]*
> *P: [Tries to speak but she seems to have some difficulty uttering words. After some effort, she is able to ask the therapist in a very feeble voice] Can I believe in his change?*
> *T: Not yet, not completely.*

P.'s last question: 'Can I believe in his change?' is not only a way to test the husband—it is also a test for the therapist. The implicit questions are: 'Is he honest?' and 'Are you honest?' Once again the response is designed to protect the patient, without losing her trust. So the response is: 'Not yet, not completely.' The message is: 'He could be better, but don't close your eyes. Be careful and protect yourself.'

Another central aspect when integrating hypnosis with couple therapy or systemic therapy is the fact that the therapist considers each individual's change as closely related to the other individual's change.

> *T: Well, now sit back again [Pause] comfortably. Close your eyes. Now, the pleasure of* lightness begins to get inside both of you *and you will begin to realize its presence in yourselves, every day a little more, [Pause]* and it will become part of each one of you. *[Pause]* Whatever the other does or says, the sense of lightness will prevail. *Although some doubt will still remain and a bit of diffidence will persist, you* will notice that the sense of lightness *that has been established [Pause]* shall prevail over all …

When results are good but not good enough, they can be improved using the procedure described by Oskar Vogt (1885) as 'fractioned hypnosis', a method that has been known since the time of James Braid (Kroger, 2007). This technique is commonly used during induction in order to deepen trance, by dehypnotizing and reinducing the trance several times, reactivating trance phenomena each time. Besides the effect of deepening trance, fractioned induction can also be a therapeutic tool. Erickson (1959a) attributes the therapeutic effect of this approach to the expectation for stability that the repeated moving in and out of the trance tends to create. When the subjects are reawakened, reorientation is not complete and suggestions and restructuring are best accepted.

Since we are now in the phase of *reconstruction*, fractioned induction is dedicated to *lightness*, as opposed to *weight*. The meaning of the word has to do with an easier way of standing up and walking, but it also contains a suggestion of a lighter, less conflictual

and dramatic relationship. Similarly, the lightness will be the result of their interactions, and will take place 'whatever the other does or says'.

> *T: Now I'll count from three to one [Pause] and I will ask each of you to open your eyes, [Pause] to refocus completely, and again [Pause] you will now be allowed to speak to each other, but I'm going to ask both of you to* reduce the number of daily words *until we will meet again. [Pause]* Fewer words, much closer contact.
>
> *Three ... two ... one ...*

The conclusion reverts back to the previous suggestion of silence. During hypnosis, silence allowed the suspension of reciprocal habitual responses and brought in a deep sense of togetherness and sharing. Silence allowed a focus on the content rather than on the rigid relationship. It is a condition that attempts to reverse the dysfunctional model of the narrative relationship, and focuses on the importance of actions rather than appearance, participation rather than visibility. '*Fewer words, much closer contact*' is in itself a synthetic phrasing designed to reinforce and sum up the whole hypnotic work.

After reorienting both of them, and before ending the session, the therapist asks P. to try to get up again with the help of H. The aim is not only to check whether the fractioned induction facilitated a better motor performance in the waking state, but also whether or not husband and wife are able to interact in a truly different and more functional way.

> *[H. Gets closer to P. and offers his hands. P. accepts, and stands up with more confidence and less tension than she did previously. Now she openly smiles]*
> *T: Do you want to take a walk?*
> *P. & H.: Yes, I do ... [responding together]*
> *[P. moves some steps forward gently sustained by H. She walks carefully, but the movements are tentative. Long pause. H. and P. walk together back and forth for a while, without speaking]*
> *T: What's up? What do you think?*
> *P: [Walking on] You ... You know, professor ... I'm taking these drugs that give me some problems. Then I see an analyst too. Maybe ... so I was thinking... should I have to suspend them?*
> *H: [Overlapping] Should we suspend them?*
> *T: I don't know. We follow our own way. And try to do it quickly.*
> *P: Yes ... Yes. [She stops for a moment] We have already lost so much time. Now I'm in this situation since five years ...*
> *T: Come on then, continue your walk.*
> *P: Yes, let's try.*
> *H: Are you sure? Let's try!*
> *[P. wobbles dramatically, then finds her balance with the help of H. and starts to walk again side-by-side with him, holding his hand]*
> *T: Slowly, slowly ...*
> *P: I feel a little bit rusty.*
> *T: I believe that. You haven't walked in quite a long time. [Pause] Please H., go at the same pace as P.*

P: What a wonderful thing you said, professor! Because that was *one of our more frequent fights. His pace* was *never like mine.*

This last passage contains several elements that deserve to be analysed. In the first place the effect of repeating the induction (Vogt's effect), seems to help with the mood of P., who now smiles and appears to be more confident and less tense. After walking together with H., she surprisingly mentions her intention to give up some of the other therapies she has 'collected' in her long career as patient, and this too seems to be an indirect sign of confidence in the hypnotic treatment results. It can be considered a surprise because it is spontaneously offered and CD patients do not easily renounce their clinicians' attentions. But at the same time, the question sounds like an attempt to seduce the therapist, since she asks him whether or not he would advise quitting the other, current treatments. The therapist's response, 'We follow our own way', dismisses the attempt at seduction, allowing the patient the freedom to follow whatever she considers as useful in complete autonomy. Also, the therapist will be allowed to continue to work autonomously. Furthermore, a short response to such a complex question enforces the leading idea that in the present situation only few essential words are to be used (*Fewer words, much closer contact*). Thus the focus can be maintained on the movements that wife and husband are successfully performing together.

TRUSTING THE MINIMAL CUES

Now the wife seems to trust the husband more, and she makes a long walk with him smiling, without expressing the doubts she raised in the previous walk. Nevertheless when the therapist asks him to slow his pace, she thanks the therapist and immediately takes the opportunity to blame the husband for his inability to proceed at her pace. As a *minimal cue*, a small but meaningful detail, it is interesting to note that now, for the first time, the patient uses the past tense to describe a criticized husband's behaviour.

Erickson (Erickson et al., 1976) used to operate on his patients' patterns of thought by emphasizing individual terms in a sentence, a mechanism defined as a 'semantic shift in the pragmatics of communication'. The difference between 'will' and 'can', between past and present, is a watershed that clearly separates old and new reference skills. In conclusion, after so much suffering, conflict and symptoms are now summarized into a memory that belongs to the past, 'His pace *was* never like mine,' and could be substituted by the new hope that, from now on, it will be possible for the couple to walk together.

Dramatic changes are certainly possible with CD patients, yet it is essential for a therapist to ask for more secure, reliable, almost unnoticeable, cues that demonstrate deep and authentic roots in the subject's way of thinking.

After the session transcribed above, no other hypnotic session was required, since after a few weeks of exercises walking together, P. was able to walk on her own and enjoyed moving and travelling with her husband. They continued for about six months to use fewer words and to seek much closer contact. Then, after common agreement, they decided 'not to ruin their delicate and precious new harmony' and asked for a brief 'supportive' couple therapy that was concluded to their satisfaction within ten months.

CONCLUSION

Although Erickson rarely worked with families, he was always sensitive to his patients' system of relations. Many of the technical skills taught by the great masters of family therapy, in particular the work of Haley, Minuchin, Montalvo, Watzlawich, Weakland, Fish, and Madanes, was largely inspired by Erickson's approach to family and couples systems (Kaslow, 2010). The two approaches, hypnotic-naturalistic and family-systemic, demonstrate how to integrate methods in a comprehensive manner. Hypnosis acts on the mechanisms underlying the disorder, the dissociation and symbolization of the conflict, whereas the systemic approach allows intervention on the dysfunctional aspect of the systemic relationship. This article emphasizes several features of integrated intervention in the treatment of CD that can be summarized as follows:

1. Communication patterns and reference models typical of hysterical organization, which underlie most CDs, are summed up in the model of the narrative relationship:
   - The centrality of the secrets and strategies of revelation and concealment.
   - The symbolism and the power of narrative utilized as a seductive and manipulative instrument.
   - The need for visibility.
   - The overwhelming prevalence of the story of the individual who narrates it.
2. Although rigidly redundant in family relationships, this communication model is dysfunctional and inherently imperfect, and it gradually tends to make interpersonal exchanges more and more superficial, based on appearances and not satisfaction. Ambivalence and conflict are stable features of these systems, and despite the day-to-day apparent benefits, in the long run they make the relationship inauthentic. It becomes the endless repetitive interaction of fantastic personages so that the real people disappear.
3. The systemic hypnotic intervention with couples can be summarized as follows:
   - *Transform the hypnotic induction in a shared experience* that offers the couple unusual closeness.
   - *Develop some conjoint activities* that can make the shared trance deep enough to reduce or lose contact with the habitual rigid patterns.
   - *Intersperse the need for change*, novelty, and the pleasure of freedom from conflict and symptomatic behaviour.
   - *Deal with ambivalence and conflicts*, transforming them into a meta-concept that can be shared by both partners and become a guide for reaching their common goal.
   - *Find a metaphor* that the couple can use to describe their present conflict and use it as the meta-concept that can give them a way out of the symptom.
   - *Build a sequence of steps* that will be ratified by an ideomotor signalling.
   - If a symptom is dramatically resolved, *give more importance to more reliable minimal details* that will be more authentic and secure in revealing what is a real change, rather than a simple willingness to seduce the therapist.
   - *Protect the subject and the partner*, demonstrating attention and interest not only for success, but also for preventing unexpected risks.
   - *Develop the real persons* that the narrative relationship tends to hide.

4. The work of redefining the motivations and interventions on associations should always take regard of the resources of the patient and the system (family, couple, or individual), which is necessary for a good clinical outcome in these patients. Therefore, it is not only changing the associations or motivations but also reframing and respecting them that will make therapy effective from a relational point of view. Hypnosis is an excellent tool in the hands of a therapist able to stimulate the patient to grasp the creative part of his mind that the symptom seems to suspend. As another great family therapist, Carl Withaker (1987) said: 'The microcosm of psychotherapy makes the identification and belonging as well as the change from identification to belonging an exercise in interpersonal folly, through an altered state of consciousness, designed to survive to the family and the culture' (1987: 42).

REFERENCES

American Psychiatric Association (APA)(2000). *Diagnostic and Statistical Manual of Mental Disorders*, *Fourth Edition, Text Revision* (DSM-IV-TR). Washington, DC: American Psychiatric Association.

American Psychiatric Association (APA)(2010). Proposed Draft Revision to DSM Disorder and Criteria. Available at www.dsm5.org/Pages/Default.aspx (accessed 4 July 2011).

Bleger J (1967). Psychoanalysis of the psycho-analytic frame. *International Journal of Psycho-Analysis* 48(4): 511–519.

Bleuler E (1911). *Dementia praecox* (Ital. transl.). Rome: Il Pensiero Scientifico, 1985.

Erickson MH (1952). Deep hypnosis and its induction. In Le Cron L (ed) *Experimental Hypnosis*. New York: Macmillan, pp. 70–114.

Erickson MH (1959a). Hypnosis in painful terminal illness. *American Journal of Clinical Hypnosis* 2: 117–121.

Erickson MH (1959b). Further clinical techniques of hypnosis: Utilization techniques. *American Journal of Clinical Hypnosis* 2: 3–21.

Erickson MH (1964). The confusion technique in hypnosis. *American Journal of Clinical Hypnosis* 6: 183–207.

Erickson MH (1965). The use of symptoms as an integral part of therapy. *American Journal of Clinical Hypnosis* 8: 57–65.

Erickson, M H (1966). The interspersal hypnotic technique for symptom correction and pain control. *American Journal of Clinical Hypnosis* 8: 198–209.

Erickson MH (1979). *Tecniche di suggestione ipnotica*. Rome: Astrolabio.

Erickson MH, with Haley J, Weakland JH (1959). A transcript of a trance induction with commentary. *American Journal of Clinical Hypnosis* 2: 49–84.

Erickson MH, Rossi E (1981). *Experiencing Hypnosis: Therapeutic Approaches to Altered State*. New York: Irvington.

Erickson MH, Rossi E, Rossi S (1976). *Hypnotic Realities: The Induction of Clinical Hypnosis and Other Forms of Indirect Suggestion*. New York: Irvington.

Fisher JV (1999). *The Uninvited Guest: Emerging from Narcissism towards Marriage*. London: Karnac. (Ital. transl. *L'ospite inatteso: Dal narcisismo al rapporto di coppia*. Milan: Cortina, 2001.)

Freud S (1908). *Il romanzo familiare dei nevrotici*. In *Opere*, Vol. 8. Turin: Boringhieri, 1974.

Freud S (1913). *Totem and Taboo*. Vienna: Hugo Heller.

Fromm E (1973). *The Anatomy or Human Destructiveness*. New York: Holt, Rinehart and Winston. (Ital. tr. A*natomia della distruttività umana*. Milan: Mondadori, 1975.)

Griffith JL, Polles A, Griffith ME (1998). Pseudoseizures, families, and unspeakable dilemmas. *Psychosomatics* 39: 144–153

Haley J (1976). *Problem-Solving Therapy: New Strategies for Effective Family Therapy*. San Francisco, CA: Jossey-Bass.

Iacoboni M (2008). *Mirroring People: The New Neuroscience of How We Connect with Others*. New York: Farrar, Straus and Giroux.

Joëlsa M, Zhenwei O, Wiegerta P, Oitzlb MS, Krugersa-Trends HJ (2006). Learning under stress: How does it work? *Cognitive Sciences* 10(4): 152–158.

Kanaan RAA, Craig TKJ, Wessely SC, David AS (2007). Imaging repressed memories in motor conversion disorder. *Psychosomatic Medicine* 69: 202–205.

Kaslow FS (2010). A family therapy narrative. *American Journal of Family Therapy* 38(1): 228–231.

Kendon A (1979). Movement coordination in social interaction. In Weitz S (ed) *Non-Verbal Communication: Readings with Commentary*. New York: Oxford University Press, pp. 119–134.

Kerns JG, Cohen JD, MacDonald AW, Cho RY, Stenger VA, Carter CS (2004). Anterior cingulate conflict monitoring and adjustments in Control. *Science* 303(5660): 1023–1026.

Kroger W (2007). *Clinical and Experimental Hypnosis in Medicine, Dentistry, and Psychology*. Philadelphia, PA: Lippincott, Williams & Watkins.

Loriedo C (2008). Systemic trances: Using hypnosis in family therapy. *Family Therapy Magazine* 7(4): 27–30.

Loriedo C, Angiolari C, Martini L (1987). *Il modello terapeutico di Milton Erickson, Atti del Congresso Internazionale di Ipnosi e Terapia della Famiglia*. Naples: L'Antologia.

Loriedo C, Di Leone F, Bilardi G (2010). Problematiche tradizionali e nuove acquisizioni sui Disturbi di Conversione: verso un protocollo per un approccio ipnotico breve. *Idee in psicoterapia* 3(1): 87–102.

Loriedo C, Torti C (2010). Systemic hypnosis with depressed individuals and their family. *International Journal of Clinical and Experimental Hypnosis* 58(2): 1–25.

Minuchin S, Rosman BL, Baker L (1980). *Famiglie psicosomatiche, l'anoressia mentale nel contesto familiare*. Rome: Astrolabio.

Moene FC, Spinhoven P, Hoogduin KAL, Van Dyck R (2002). A randomised controlled clinical trial on the additional effect of hypnosis in a comprehensive treatment programme for in-patients with conversion disorder of the motor type. *Psychotherapy and Psychosomatics* 71: 66–76.

Moene FC, Spinhoven P, Hoogduin KAL, Van Dyck R (2003). A randomized controlled trial of a hypnosis-based treatment for patients with conversion disorder, motor type. *International Journal of Clinical and Experimental Hypnosis* 51: 29–50.

Oakley DA (1999). Hypnosis and conversion hysteria: A unifying model. *Cognitive Neuropsychiatry* 4: 243–265.

Raz A (2005). Attention and hypnosis: Neural substrates and genetic associations of two converging processes. *International Journal of Clinical and Experimental Hypnosis* 53(3): 237–258.

Ritterman M (1986). Exploring relationships between Ericksonian hypnotherapy and family therapy. In de Shazer S (ed) *Indirect Approaches in Therapy*. Rockville, MD: Aspen Publishers, pp. 35–47.

Roelofs K (2005). A cognitive account of conversion and somatization disorder. Commentary on Merskey and Maj somatization and conversion disorders: A review. In Maj M, Akiskal HS, Mezzich JU, Okasha A (eds) *Somatoform Disorders*. WPA Series Evidence and Experience in Psychiatry 9. Chichester, UK: Wiley, pp. 44–47.

Ryan CE, Epstein NB, Keitner GI, Miller IW, Bishop DS (2005). *Evaluating and Treating Families: The McMaster Approach*. New York: Routledge.

Stonnington MC, Barry JJ, Fisher RS (2006). Conversion disorder. *American Journal of Psychiatry* 163: 1510–1517.

Van Veen V, Cohen JD, Botvinick MM, Stenger VA, Carter CS (2001). Anterior cingulate cortex, conflict monitoring, and levels of processing. *NeuroImage 14*(6): 1302–1308.

Viederman M (1995). Metaphor and meaning in conversion disorder: A brief active therapy. *Psychosomatic Medicine* 57(4): 403–409.

Visser M (2007). System dynamics and group facilitation: Contributions from communication theory. *System Dynamics Review* 23(4): 453–463.

Vogt O (1885). Zur Kenntnis des Wesens und der Psychologischen Bedeutung des Hypnotismus, Teil I. *Zeitschrift für Hypnotismus* 3: 277–340.

Watzlawick P (1978). *The Language of Change: Elements of Therapeutic Communication*. New York: Basic Books.

Watzlawick P, Beavin HJ, Jackson DD (1967). *Pragmatics of Human Communications: A Study of Interactional Patterns, Pathologies and Paradoxes*. New York: Norton.

Withaker K (1987). Relazione tematica. In Loriedo C, Angiolari C, Martini L (eds) *Atti del congresso internazionale di ipnosi e terapia della famiglia*. Naples: L'Antologia.

Witthöft M, Hiller W (2010). Psychological approaches to origins and treatments of somatoform disorders. *Annual Review of Clinical Psychology* 6: 257–283.

Yapko M (2003). *Trancework: An Introduction to the Practice of Clinical Hypnosis* (3rd edn). New York: Routledge.

Zeig JK (1980). *A Teaching Seminar with Milton Erickson*. New York: Brunner/Mazel.

Zeig JK (2006). *Confluence: The Selected Papers of Jeffrey K. Zeig,* Vol. 1. Phoenix, AZ: Zeig, Tucker & Thiesen.

Zeig JK, Munion MW (1999). *Milton Erickson*. London: Sage.

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