Jones, E. (1907) Spinal synaesthesia. Brain, 1907.
Kandinsky, W., & Marc, F. (1915). Der Blaue Reiter. Almanach.
Kennedy, H., Bullier, J., & Dehay, C. (1989). Transient projection from the superior temporal sulcus to area 17 in the newborn macaque monkey. Proc. Nat.Acad.Sci., 86: 8093-8097.
Mark, L.E. (1978). The Unity of the Senses. Academic Press.
Melzack, R. (1975). The McGill Pain Questionnaire: major properties and scoring methods. Pain, 1:271-299.
Modell, A.H. (1997). The synergy of memory, affects and metaphor. J.Analytical Psychol., 42: 105-117.
Paulesu, E., Harrison, J., Baron-Cohen, S., Watson, J.D.G., Goldstein, L., Heather, J., Frith, C.D., Frackowiack, R.S.J., & Frith, C.D. (1995). The physiology of coloured hearing: a PET activation study of colour-word synaesthesia. Brain, 118: 661-676.
Rainville, P., Carrier, B., Hofbauer, R.K., Bushnell, M.C., & Duncan, G.H. (1999). Dissociation of sensory and affective dimensions of pain using hypnotic modulation. Pain, 82: 159-171.
Ramachandran, V.S., & Ramachandran, D. (1996). Synaesthesia in phantom limbs induced with mirrors. Proceedings of the Royal Socidty of London, Series B: Biological Sciences, 263: 377-386.
Schiltz, K., Trocha, K., Wieringa, B.M., Emrich, H.M., Johannes, S., & Munte, T.E. (1999). Neurophysiological aspects of synestetic experience. J. Neuropsychiat. & Clin.Neurosci., 11: 58-65.
Treede, R-D., Kenshalo, D.R., Gracely, R.H., & Jones, A.K.P. (1999). The cortical representation of pain. Pain, 79: 105-111.
Werner, H. (1948). Comparative Psychology of Mental Development. New York: International University Press.

Dissociative disorders and hypnosis: The problem of the historic truth and the narrative truth

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This study is aimed to explore the debate, which is currently gaining importance particularly in Anglo-Saxon countries, on abuse and retrieved memories of abuse, and on related Dissociative Disorders. In this debate hypnosis seems to play a key role. The knowledge of the characteristics of both positions (historical truth vs. narrative truth) involved in this debate appears to be useful to improve the "clinical" awareness of the psychotherapist in order to treat abuse with a more and balanced attitude. A similar attitude can be reached only by renouncing to useless theoretical extremism and warnout interventions.

1. Introduction

In the last decade, particularly in the United States, an increasing interest in child abuses has occurred (A.M.A., 1995; Lowenstein, 1994). The debate around this subject has not been addressed only in the scientific literature, but also - and above all - in the mass media, so that we have reached the point where we don't even know if the emphasis placed on the subject is cause or effect of the increased number of cases of people who remember having been abused during their childhood (Spence, 1994).

Many authors posit a close causal relationship between abuse and the devel-opment of dissociative disorders of consciousness in adults (Bliss, 1986; Bryant, 1995; Ganaway, 1995; Levitt & Pinnell, 1995; Nagy, 1995; Yapko, 1994). This hypothesis underlines some controversial aspects of contemporary psychiatry, such as the nature of memory and dissociation, the impact of trauma in human development, the difference between historical and narrative truth.

In this regard hypnosis not only offers hypotheses and confirmations on the mechanisms of memory (Dywan, 1998; Kihlstrom, 1994; Spiegel, 1998; Tulving, 1972; Woody et al., 1998) and of dissociation (Bliss, 1986; Bowers, 1991, 1992; Ducci, 1995; Liotti, 1993; Hilgard, 1986; Ross, 1995), but it also plays a fundamental role in the therapeutic approach to dissociative disorders (Lynn & Nash, 1994).

In this study we will observe in a synthetic way the relationship between hypnosis and dissociation and between hypnosis and memory. Subsequently the two positions,

"gullible" and "skeptical", towards the memory of abuse will be compared. Finally we will discuss Ericksonian strategies of intervention in the DDs and their usefulness in resolving the controversy between these two positions and in overcoming old therapeutic positions. This will allow practitioners, and above all those who work with hypnosis, to focus their attention on topics of a more clinical and theoretical utility as, for instance, the concept of change in therapeutic contexts, the role of the therapist and the use of his/her resources and his/her personal characteristics as therapeutic tools, the research within the processes of influence, of the hypnotic phenomena, and of the effectiveness-efficiency of interventions in psychotherapy.

Table 1. Dissociative Disorders (from DSM IV)

- **Dissociative Amnesia:** one or more episodes of inability to recall important personal information, usually of a traumatic or stressful nature
- **Dissociative Fugue:** sudden, unexpected travel away from home or one's customary place of work, accompanied by an inability to recall one's past and confusion about personal identity, or the assumption of a new identity
- **Dissociative Identity Disorder:** presence of two or more distinct identities or personality states, that recurrently take control of the individual's behaviour
- **Depersonalization Disorder:** persistent or recurrent feeling of being detached from one's mental processes or body that is accompanied by intact reality testing
- **Dissociative Disorders Not Otherwise Specified:** disorders in which the predominant feature is a dissociative symptom that doesn't meet the criteria for any specific Dissociative Disorders

Table 2. Dissociative Disorders: Pathogenesis

- The consciousness and memory discontinuity makes up an inborn defense of mind for traumatic psychological events.
- The repetition of the trauma cycle: dissociation, creation of imaginary worlds and identities more tolerable than the real ones, can constitute the base for the development of a DD.
- We need to have an inborn (high score in SHSS) or acquired predisposition *(detachment and multiplicity of the representative self-models*, Main, Aisworth; *désagrégation,* Janet*)* for the development of a DD.

2. Hypnosis and dissociation

The relationships between hypnosis and dissociation have been the object of study since Janet and Binet. It is obvious, therefore, that patients suffering from a dissociative disorder are good hypnotic subjects. This ability makes possible a psychotherapy developed in a state of trance; as a matter of fact hypnosis is considered the treatment of choice for these forms of psychopathology.

There are two basic psychotherapeutic strategies used by clinicians to treat Multiple Personality Disorders, the best known among the Dissociative Disorders. The first one consists in the attempt to mold and to integrate these different aspects of the self of the patient. The second consists in trying, slowly and with care, to make the principal personality aware that there are other personalities that live together in the same body, so that all of these begin to communicate and to collaborate among themselves (Madeleine, 1992).

3. Hypnosis and memory

Memory, like perception, is not objective and doesn't provide a precise picture of what happens or has happened. Nowadays we know that memory involves an active cognitive process in the phase of storing, that memories suffer a notable influence from the importance-congruence-incongruity of the material, that they are distorted by interpretation-embellishment-distortion-knowledge-beliefs that vary according to the context in which they are recalled, that they can degenerate or disappear (Kihlstrom, 1994; Lynn & Nash, 1994).

Two systems of memory are very important for the clinician, the "semantic" and the "episodic" (Tulving, 1972); they are formed between two and five years of age. There is also a "procedural memory," also defined "implicit memory" (Spiegel, 1998); this system is supposed to code information about recurrent configurations of sensorial stimuli and behavioral answers that structure some models, or representations of interaction, that have been generalized (Stern, 1987), and that will work throughout the whole life span regulating daily behavior.

About the topic of the historical truth and the narrative truth of memories of patients, however, we maintain that the first two systems of memory are more important.

The semantic memory codes the oral representations of experience. As for words, it can be supposed that these models are at the beginning, built starting from the generalizations offered by others. There is no need to say that these precocious semantic models represent reality from the point of view of the parental figures. For example, the precocious semantic models of the self are partly based on the statements made by mothers to their children when it is said that they are good, bad, etc. (Crittenden, 1994).

The episodic memory consists instead of specific episodes of experience (for instance: "the day in which...", and not "every day..."), coded by multiple channels like oral, auditory and visual. These memories are recalled as sequentially ordered episodes with characters, movements, sounds, and smells.

As the semantic memories, the episodic ones are susceptible to distortion. Because of their misinterpretation of propositive nature of the words, that is that the words can represent things that don't exist, "preoperatory" children are easily misguided. The kind of question about the events can change their memories of the event, or also create memories of events that have not taken place. Also stories, desires and dreams can be coded as memories. The result is that the most precocious memories can contain as-

pects of desires, fears, exaggerations, expansions and other people's experiences (Crittenden, 1994). If we also consider the fact that only unique and particularly important events are stored in the episodic memory it follows that these events are selected because they activate at an affective level. Since the more activated events are those unresolved, the episodic memory will contain traumatic experiences and, for some children, experiences that they are prevented from expressing (Crittenden, 1994). Among the memorized ones, these types of episodes are more subject to systematic distortions.

Table 3. Memory Systems

1. Semantic memory: it codes the verbal representations of experience
2. Episodic memory: specific episodes of experience coded by multiple means (verbal, auditory and visual) and vulnerable to systematic distortions
3. Implicit or procedural: models of representations of interaction that have been generalized

Table 4. Hypnosis and memory

- Hypnotic amnesia selectively impairs free recall, while the implicit tasks remain intact.
- Recall procedures of episodic memory undergo a frontal supervision system that operates through checking processes, preliminary description and relevance analysis.
- In dissociation and in hypnosis, there is a lack in control functions of this same supervision system.

Studies on memory have therefore underlined that the consequent difficulty children have in distinguishing between perceived and imagined data, can bring them to a certain confusion among memories of experiences really lived, those of imagined events and those built on the base of stories of experiences of other people.

The research on hypnotic amnesia suggests that a supervision system plays a very important role in some trials of the memory (Dywan, 1998; Spiegel, 1998; Woody et al., 1998). Particularly, the assignments of the episodic memory would require procedures of recall directly submitted to a system of frontal supervision that operates as higher level modulators of the lower level routine processes, through mechanisms of verification, preliminary description, and analysis of the importance. In fact, hypnotic amnesia selectively inactivates the free recall, while the assignments of implicit memory, as the word associations, remain intact; the accuracy of the memory decreases because it fails the discrimination between correct and false memories (Spiegel, 1998). This deficit of the functions of control is the fundamental element of the dissociation. The conclusions that can be drawn are fundamentally three:

1) the child doesn't lie when he/she says to remember to have lived an event that in reality has only been imagined;

2) children in preschool age, much more than the adults, can be brought by a person (mother, psychotherapist, police officer) to believe to have lived non-real events, and to do this with a conviction and a neatness that increase in time;

3) the psychotherapist cannot discern between the false stories and those that are true based only on the data found during the clinical interview (Ceco et al., 1994).

4. The gullible point of view: the historical truth

The position of those who believe in the historical truth foresees that the memories reported by patients, especially if obtained by hypnosis, are true; that there is a place called the unconscious where such memories are repressed and that there is a hypnotic state where it is possible to remember them; that memories, their pathological effects, and the consequent diagnosis are immune from cultural influences or from the procedures used in therapy (for more details see Ganaway, 1995; Nash, 1994; Yapko, 1994).

For the clinician the importance of this position is in the fact that it is theorized - in reality it is only hypothesized and not verified (Ganaway, 1995; Levitt & Pinnell, 1995) - that there exists a cause-effect relationship between an abuse experienced during infancy and a series of psychopathologies: anxiety, depression, use of drugs, somatizations, posttraumatic stress disorder, learning difficulties, behavioural problems, difficulty in interpersonal relationships, eating disorders, problems in the sexual sphere, and above all dissociative disorders. This happens because those events that are perceived and stored unconsciously tend to form those behaviour-thought-emotion-preference-attitudes that characterize the psychological problem the patient is experiencing in the present. The therapeutic process will consist, therefore, in making it possible for the patient to remember such memories with the purpose of being able to face them in a more adaptive way, that is without being crushed by them and at the same time without denying their importance, to be able to find new non-symptomatic solutions. In reality even the con-nection abreaction-improvement has not been proved (Levitt & Pinell, 1995).

This is the position that puts much attention on the safety of patients that are indicated as false negatives, that is, those patients who don't remember having been abused (Nash, 1994).

The role developed by hypnosis in this position is surely among the most remarkable. The studies on the reversibility of the amnesia constitute an example of it. But even more important are the hypotheses of the dissociation and on fantasy proneness, considered as natural defensive methods against physical, psychological, and relational pain, and contemporarily as psychological mechanisms that are basic in the DD.

The concept of fantasy proneness originated from the research of Wilson and Barber (Rhue & Lynn, 1987a, 1987b) on high hypnotizable subjects who seem to share a

similar constellation of experiences of life and traits of personality and who fundamentally have a notable ability to get involved in their own imaginations. These people, defined as fantasy prone personalities, report spending a lot of time absorbed in their imaginations. They say they have had paranormal experiences, and sometimes they find a certain difficulty in differentiating reality from their imagination. These subjects have, if given the Rorschach, an intact reality testing, a rich affective and cognitive life, a cognitive and emotional versatility. The same subjects, examined with the MMPI, get a rather worrisome score (Rhue & Lynn, 1987b). The early experiences that point some people toward the characteristics of the fantasy prone personalities are of three types: the first one is about the encouragement to allow themselves to be carried away to their imaginations by meaningful adults; the second is related to play activity (to dance, to play musical instruments, to recite) that indicate an involvement in the level of imagination; the third connect the excessive use of imagination to the loneliness, to the isolation, and to a hostile family environment. The fantasy prone subjects remember, more than other subjects, a higher number of punishments and report they have been physically abused when they were children (Rhue & Lynn, 1987a).

It also seems that when abuse has been experienced early in life, the level of fantasy proneness is higher (Bryant, 1995). In addition, while a tendency to get involved in imagination is not pathological by itself, a history of abuse associated with fantasy proneness can predispose these subjects to serious problems of adaptation in adult life; besides, fantasy prone women report they have been abused by people not belonging to their family more often than generally do moderately fantasy prone women (Lynn & Nash, 1994).

Even the interpretation that is given to this frequent use of imagination is similar to the one we have found about subjects with multiple personality disorder given by Bliss (1986): the imagination (self-hypnosis for Bliss) is a tool that helps the patient to defend him/herself, to run away, to minimize the physical pain and the psychological suffering, and to preserve as much as he/she can a positive opinion, or at least relatively positive, of the environment, especially of the family (Bryant, 1995).

Table 5. Historical truth

- Memories reported by patients, especially those obtained with hypnosis, are seen as truth.
- Such memories are repressed in the unconscious and hypnosis permits their recall.
- Memories, their pathological effects and disorders that emerge, are immune to cultural influence or to the procedures used in therapy.
- The resort to dissociation is directly proportional to abuse severity and to fantasy proneness level.
- The adaptive reappropriation of repressed or dissociated memories is the therapy.

5. The sceptic point of view: the narrative truth

This second position posits that memories reported by the patients, also those obtained by hypnosis, are potentially false and that repressed memories, their hypothesized pathological effects, explanatory diagnoses and psychotherapy methods are largely influenced by cultural factors, by the psychotherapist's model of reference of clinical psychology, by his/her preconceptions and by his/her beliefs (for more details see Lynn & Nash, 1994; Yapko, 1994).

For the clinician the importance of this position lies in the fact that it is turned down as being too superficial the linear causal relationship between trauma and psychopathology: there are also people really abused during the infancy that have never suffered psychic problems (Levitt & Pinnell, 1995); that the concepts of dissociation, repression, unconscious are only metaphors and that therefore they must not be considered concrete; that there is not a "hypnotic state" but only a psychosocial context (Sarbin, 1995). The therapeutic process is therefore based on the suffering of the present since it is possible that the current symptomatology has other meanings besides the one hypothesized as the effect of an abuse (Yapko, 1994). This is the position that is concerned about safeguarding the therapists from diagnostic mistakes, the patient's false positive (those that remember -without having really experienced - an abuse) from their false memories, and above all the family members of these patients from the unfounded accusations (Nash, 1994).

The research on development psychology and the one on memory, which we have already discussed, are fundamental to confirm the position of the "skeptics".

Data from research in developmental psychology is important especially because many cases of abuse we find in scientific literature concern an age between two and five years. It can be useful, for instance, to remember that the strong emotional discomfort felt by these children and the enormous difficulties that they must face be-cause of any kind of abuse can bring them to search forms of control of reality even when the possibilities are outside of their real ability. Among these forms of control the one tied to magical thinking is surely among the most effective: it quickly allows, following particular causal connections and a peculiar logic ("pre-logic"), to reach what we desire (Piaget, 1966). It's interesting to notice that the difficulty to differentiate reality from imagination manifested by some fantasy prone subjects is similar to the concept of "realism" and of "egocentricity" (Piaget, 1966), two characteristics of the pre-logic way of thinking that we find in children among two and five years of age (Spence, 1994). We also know that fantasy prone children, more than other boys and girl of the same age, like to play alone and to engage in imagination. This, together with the problem of a rejecting mother and of a low stimuli environment, could be compared to the experiences of depersonalisation and derealisation that are experienced during moments or situations in which there are few sensorial inputs. In these cases it is possible to feel a "presence" (spiritual beings, apparitions of corpses) or "to feel two selves" ("out-of-body experiences"). Such transpersonal experiences, above all those lived in the age between two and

five years, have often been quoted and studied by many authors, among which Freud (1929). The interpretation of these phenomena is not unequivocal, but interesting: it has been hypothesized that they can point out an abstract cognitive ability (post-formal intelligence based on imaginative ability) or a defensive mechanism that is used against the pain of a trauma or a family having a deficit.

This mixture of magic, prelogic, imagination, auto-hypnosis, desires and needs that remain unsatisfied, traumas and abuses, is placed in a psychological picture that is characterized by symbolic thinking that, between two and five years of age, is not in contact with the reality; by a "pre-logic" symbolization in which there is always a comparison of two extremes always in contrast (the fairy and the witch); by a physiological need of strong tones, (good-good, white-white, the wolf that is ugly and bad, etc.); by a tendency to make extreme the assumption of roles; by a kind of universal culture made of rhymes, histories, repetitive gestures.

Table 6. Narrative truth

- Memories reported by patients, even those obtained with hypnosis are potentially false.
- Repressed or dissociated memories, their hypothesized pathological effects, the explanatory diagnosis and treatment methods, are greatly influenced by cultural factors, by the therapist's psychological models of reference, by his preconceptions and beliefs.
- There does not exist a linear cause-effect relationship between trauma and psychopathology.
- Prelogical symbolization of child from 2 to 5 years old does not allow to differentiate reality from fantasy.
- There does not exist a hypnotic state, but rather a psychosocial context.
- Therapy centers on present suffering.

Table 7. Ericksonian hypnosis and Dissociative Disorders

- Trance: daily common experience
- Utilization: observe, know and utilize the subject's hypnotic capacities to elicit the subject's resources
- Tailoring: personalize every intervention, refusing standard techniques and methods
- Rapport: unique, empathic, binding relation characterized by a reciprocal tuning in

6. Ericksonian hypnosis and dissociative disorders

The innovative elements introduced by Erickson in hypnotic practice represent an extraordinary resource in the therapy of the DDs.

But to the goals of this discussion on the narrative and historical truth, great importance is given to the concept of "co-narrated" truth as the expression of a meaningful therapeutic relationship that elaborates the emotional and the cognitive elements of the actual and the past experience, introducing new affective ties that develop the function of biographical integration (Ducci, 1993; Erickson, Rossi & Rossi, 1976; Erickson & Rossi, 1979; Erickson & Haley, 1967; Zeig 1985a, 1985b, 1987).

7. Conclusions

Even if many authors, following Erickson, have started to emphasize that in the therapeutic context the fact that memories are or are not true has little clinical utility (Levitt & Pinnell, 1995; Lynn & Nash, 1994; Nash, 1994), the majority of the scientific papers on the matter are focused on traps of memory, of the processes of influencing and of the psychotherapeutic models of reference, indirectly underlining the importance in clinical practice of insight, the traumas and the causes of the past. Even when there are complaints that clinicians rarely report proofs and checking that support the memories of their patients (Ganaway, 1995), and therefore it is advised to look for an objective verification or concrete proofs that can disconfirm the experience brought by the patient (A.M.A., 1995; Kihlstrom, 1994; Lowenstein, 1994; Lynn & Nash, 1994), in conclusion, the only thing done is to exchange the clinical context with the forensic one.

It is necessary, instead, to go out of an obvious and desired linear causality, also because this pushes us toward two positions, "faith" (historical truth) and the "skepticism" (narrative truth), of which the literature on the paranormal phenomena is full. The hypnotherapist must know the processes of influence, he/she must be aware of the importance of the context in which one works and of the relationship with the patient, he/she must be "secular" towards his/her own theory of reference, more than his/her colleagues that work with other models must or could do.

Table 8. Conclusions

- In a therapeutic context, the fact that memories are true or not has little clinical value.
- Therapeutic context is not to be confused with a forensic one.
- It is necessary to leave behind the linear causality that generates antithetical positions: belief and skepticism.
- It's necessary to move interest from causes to solutions, from the past to the future, from deficits to resources.
- The therapist is no longer the depository of an explanatory theory, the vehicle of suggestions, the user of techniques.
- The therapist, using his own history and his own resources, is the actor of a relationship that allows for new definitions of the patient's problem.

Regarding the clinical priorities it seems important to us to emphasize, especially from an Ericksonian point of view, the importance of the shift from the analysis of the causes of the problem brought by the patient to the therapeutic solutions, of the passage

from a theoretical point of view centered on the past to one focused on the future, of the move of interest, especially in the earlier phases of a psychotherapy, from deficits to resources of the patient.

Finally, continuing on this line, it would be desirable that the debate could move (also inside the model of hypnosis) on the therapist's role, a therapist no more seen as the depositary of an explanatory theory or as the vehicle of suggestions or simple series of techniques, but as the one which, using his/her history and resources, to foster new definitions of the presenting problem.

References

American Medical Association (1995). Report on memories of childhood abuse. International Journal of Clinical and Experimental Hypnosis, 2, 114-117.

Atkinson, R. P. (1994). Relationship of hypnotic susceptibility to paranormal beliefs and claimed experiences: implication for hypnotic absorption. American Journal of Clinical Hypnosis, 1, 34-40.

Bànyai, E.I. (1987). Correlazioni psicofisiologiche della interazione tra ipnotista e soggetto. Rivista Italiana di Ipnosi Clinica e Sperimentale, 2, 9-13.

Barach, P.M. (1991). Multiple personality disorder as an attachment disorder. Dissociation, 4, 117-123.

Bliss, E. (1986). Multiple Personality, Allied Disorders, and Hypnosis. Oxford University Press, New York.

Bowers, K.S. (1991). Dissociation in hypnosis and Multiple Personality Disorder. International Journal of Clinical and Experimental Hypnosis, 39, 155-176.

Bowers, K.S. (1992). Immagination and dissociation in hypnotic responding. International Journal of Clinical and Experimental Hypnosis, 40, 253-275.

Boyd, J.D. (1997). Clinical hypnosis for rapid recovery from Dissociative Identity Disorder. American Journal of Clinical Hypnosis, 40, 97-110.

Bryant, R.A. (1995). Fantasy proneness, reported childhood abuse, and the relevance of reported abuse onset. International Journal of Clinical and Experimental Hypnosis, 2, 184-193.

Ceci S.J., Loftus, E.F., Leichtman, M.D., & Bruck, M. (1994). The possible role of source misattributions in the creation of false beliefs among preschoolers. International Journal of Clinical and Experimental Hypnosis, 4, 304-320.

Crittenden P.M. (1994). Nuove prospettive sull'attaccamento. Teoria e pratica in famiglie ad alto rischio. Guerini, Milano.

Ducci, G. (1993). L'ipnoterapia ericksoniana dei disturbi dissociativi. In: Le discontinuità della coscienza. FrancoAngeli, Roma.

Ducci, G. (1995). Il contributo dell'ipnosi ai disturbi dissociativi della coscienza. In: Una sola moltitudine. Melusina, Roma.

Dywan J. (1998). Toward a neurophysiological model of hypnotic memory effects. American Journal of Clinical Hypnosis, 40, 217-230.

Erickson, M.H., & Rossi, E.L. (1979). Hypnotherapy. Irvington, New York. (Trad. it. Ipnoterapia. Astrolabio, Roma 1980).

Erickson, M.H., Rossi, E.L., & Rossi, S.I. (1976). Hypnotic realities. Irvington, New York. (Trad. it. Tecniche di suggestione ipnotica. Astrolabio, Roma 1979).

Erickson, M.H., & Haley, J. (1967). Advanced techniques of hypnosis and therapy. Grune & Stratton, New York. (Trad. it. Le nuove vie dell'ipnosi. Astrolabio, Roma 1978).

Erickson, M.H. (1980). Collected papers. Irvington, New York. (Trad. it. Opere. Astrolabio, Roma, 1982, e seg.).

Frankel, F. H. (1994). The concept of flashbacks in historical perspective. International Journal of Clinical and Experimental Hypnosis, 4, 321-336.

Freud, S. (1929). Il disagio della civiltà. In: Opere. (1980). Boringhieri, Torino.

Frischolz, E. (1985). The relationship among dissociation, hypnosis and child abuse in the development of MPD. In: Kluft, R. (Ed) Childhood antecedents of MPD. American Psychiatric Press, Washington, D.C.

Ganaway, G. K. (1995). Hypnosis, childhood trauma, and dissociative identity disorder. International Journal of Clinical and Experimental Hypnosis, 2, 127-144.

Haley, J. (1973). Uncommon therapy. W.W. Norton, New York. (Trad. it. Terapie non comuni. Astrolabio, Roma, 1976).

Hilgard, E.R. (1986). Divided consciousness: multiple controls in human thought and action. Revised edition. Wiley, New York.

Kihlstrom, J. F. (1994). Hypnosis, delayed recall, and the principles of memory. International Journal of Clinical and Experimental Hypnosis, 4, 337-345.

Kluft, R. (1993). Clinical perspectives on multiple personality disorder. American psychiatric Press, Washington, DC.

Levitt, E. E. & Pinnell, C. M. (1995). Some additional light on the childhood sexual abuse-psychopatology axis. International Journal of Clinical and Experimental Hypnosis, 2, 145-162.

Lewicki, P. (1986). Nonconscious social information processing. Academic press, Orlando.

Lewis, D. & Putnam, F. (1996). Child and Adolescent Clinics of North America: Dissociative Identity/Multiple Personality Disorder. Saunders, Philadelphia.

Liotti, G. (1993). Le discontinuità della coscienza. Etiologia, diagnosi e psicoterapia dei disturbi dissociativi. Franco Angeli, Milano.

Liotti, G. (1992). Disorganized/disoriented attachment in the etiology of the dissociative disorders. Dissociation, 5, 196-204.

Lowenstein, R. (1994). Diagnosis, epidemiology, clinical course, treatment and cost effectiveness of treatment for Dissociative Disorders and MPD: report submitted to the Clinton Administration Task Force on Health Care Financing Reform. Dissociation, 7, 3-11.

Lynn, S. J. & Nash M. R. (1994). Truth in memory: Ramification for psychotherapy and hypnotherapy. American Journal of Clinical Hypnosis, 3, 194-208.

Madeleine, M. R. (1992). The interface between multiple personality, spirit mediumship, and hypnosis. American Journal of Clinical Hypnosis, 3, 168-177.

Miller, S. D. & Triggiano, P. J. (1992). The psychophysiological investigation of multiple personality disorder: review and update. American Journal of Clinical Hypnosis, 35, 47-61.

Mulhern, S. (1994). Satanism, ritual abuse, and multiple personality disorder: a sociohistorical perspective. International Journal of Clinical and Experimental Hypnosis, 4, 265-288.

Nagy, T. F. (1995). Incest memories recalled in hypnosis. International Journal of Clinical and Experimental Hypnosis, 2, 118-126.

Nash, M. R. (1994). Memory distortion and sexual trauma: the problems of false negatives and false positives. International Journal of Clinical and Experimental Hypnosis, 4, 347-362.

Ofshe, R. J. (1992). Inadvertent hypnosis during interrogation: false confession due to dissociative state; misidentified multiple personality and the satanic cult hypothesis. International Journal of Clinical and Experimental Hypnosis, 2, 125-155.

Piaget, J (1966). La rappresentazione del mondo nel fanciullo. Boringhieri, Torino.

Rhue, J. W. & Lynn, S. J. (1987 a). Fantasy proneness and psychopatology. Journal of personality and social psychology, vol. 53, 327-336.

Rhue, J. W. & Lynn, S. J. (1987 b). Fantasy proneness: Developmental antecedents. Journal of personality and social psychology, vol. 55, 121-137.

Ross, C.A. (1995). Current treatment of dissociative identity disorder. In: Cohen L. et al. (Eds) Dissociative Identity Disorder. Jason Aronson, Northvale NJ.

Sarbin, T. R. (1995). On the belief that one body may be host to two or more personalities. International Journal of Clinical and Experimental Hypnosis, 2, 163-183.

Spence, D. P. (1994). Narrative truth and putative child abuse. International Journal of Clinical and Experimental Hypnosis, 4, 289-303.

Spiegel, D. (1998). Hypnosis and implicit memory. American Journal of Clinical Hypnosis, 3, 231-240.

Steinberg, M. (1993). Structured Clinical Interview for DSM-IV Dissociative Disorders. American Psychiatric Press, Washington, DC.

Stern, D. (1987). Il mondo interpersonale del bambino. Boringhieri, Torino.

Tulving, E. (1972). Episodic and semantic memory. In: E. Tulving & W. Donaldson (a cura di) Organization of memory. Academic Press, New York.

Van der Hart, O. et al. (1993). The treatment of traumatic memories: synthesis, realization and integration. Dissociation, 6, 162-180.

Weitzenhoffer, A.M., & Hilgard, E.R. (1962). Stanford Hypnotic Susceptibility Scale. Cons. Psych. Press, Palo Alto.

Woody E. et al. (1998). Dissociation in Hypnosis and Frontal Executive Functions. American Journal of Clinical Hypnosis, 40, 206-216.

Zeig, J.K. (1985a). Experiencing Erickson. Brunner & Mazel, New York.

Zeig, J.K. (1985b). The clinical use of amnesia. In J.K. Zeig (ed.) Ericksonian Psychotherapy , vol.1. Brunner & Mazel, New York.

Zeig, J.K. (1987). Therapeutic patterns of Ericksonian influence communication. In J.K. Zeig (ed.) The Evolution of Psychotherapy. Brunner & Mazel, New York.

Yapko, M. D. (1994). Suggestibility and repressed memories of abuse: a survey of psychoterapists' beliefs. American Journal of Clinical Hypnosis, 3, 163-171.

Integration of values into Ericksonian hypnosis and psychotherapy

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Values are integral aspects in the personality and adjustment of all individuals. Recent research has systematized knowledge regarding values and their universal influence across age, gender, culture, and other variables. This research allows clinicians to utilize values in psychotherapy to harness vital motivational forces in their patients' lives. Milton H. Erickson implicitly did so, as is illustrated in several of his well known cases. Recommendations are provided for ways in which therapists can in-corporate values into intervention and treatment planning in both hypnotic and nonhypnotic approaches.

The utilization approach of Milton Erickson has generated some of the most important innovations in the history of psychotherapy. Models of treatment which incorporate the utilization perspective - including Ericksonian, strategic, interactional, solution-focused, and others - stand at the forefront of contemporary therapy. The manner in which psychotherapy is being conducted is changing dramatically throughout the world and utilization is the fuel that is propelling much of that change.

The purpose of this chapter is to elaborate the variety of ways in which the utilization of values can enhance the delivery of psychotherapy. The study of values has progressed significantly during the past 15 years and these dimensions of human endeavor are more systematically available to clinicians than ever before. A number of themes will be developed that provide a rationale for the incorporation of values into treatment. This can be accomplished by practitioners from many theoretical orientations for, as the reader will see, the language of values is universal.

Erickson was often interested, sometimes amused, when students and colleagues explained his techniques to him in terms of principles from social psychology, linguistics, alternate therapeutic modalities, and other perspectives. Though he rarely addressed values explicitly, Erickson implicitly utilized values to a great extent in his work. The field continues to explore Erickson's boundless creativity by explaining his methods in terms of empirically demonstrated processes and constructs. Erickson laid the foundation for this investigation by exemplifying the cardinal feature of utilization: Everything can be utilized.