Therapeutic Hypnosis with Children and Adolescents

Edited by William C. Wester, II, EdD, and Laurence I. Sugarman, MD

In this comprehensive volume, the editors have gathered together some of the most outstanding contributors in the field of pediatric medicine to examine the wide-ranging applications and promise of the use of hypnosis with children and adolescents.

In Part 1, the broad framework of hypnosis is presented. The concepts, developmental considerations, approaches to induction, hypnotic ability, hypnosis with families and ethical considerations are thoroughly reviewed. Parts 2 and 3 focus on key psychological and medical applications of hypnosis. The medical section describes the integration of hypnosis from acute care settings to the operating room. Throughout the book, clinical vignettes help the reader understand the hypnotic encounter while supportive evidence, strategies and caveats provide insights.

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Our deepest fear is not that we are inadequate. Our deepest fear is that we are powerful beyond measure.¹

Children are developmentally in motion both physiologically and psychologically. They live in a land of discovery where ideas realize themselves and imagination prevails. Children are always in a creative and imaginative trance-like state. They epitomize the truism that all hypnosis is self-hypnosis. We see this in their on-going play and as mommy or daddy kiss the “boo-boo” to make it better. In our therapeutic encounters with them, our goal is to interact with this on-going process, go with the flow and the child, and begin a journey of allowing children to do whatever is necessary to heal themselves. Those of us in this specialized field of human interaction have been strongly influenced by Milton Erickson whose utilization of naturally occurring psychophysiological responses makes it clear that our role as therapist and healer is to use whatever the child brings to the therapeutic encounter as we semantically work with the child to accomplish his goal.

We have brought together a cadre of distinguished authorities in the field of hypnosis with children and adolescents. These experts examine ways in which a variety of medical and psychological problems can be treated with this wonderful therapeutic interpersonal process. The reader will clearly begin to understand the significant differences between treating adults and children and will be exposed to marvelous varieties of approaches by these leaders in the field. Individual styles may vary, but the underlying premise of a creative patient-centered approach will be obvious. It’s not a matter of using a direct or indirect approach. It’s not a matter of developing highly creative metaphors since children will bring

their own. It’s not a matter of asking children to remove symptoms. It’s a matter of joining therapeutically with a children who are already well on their way to using their own creative imaginative processes to help themselves. We offer them guidance and confidence while having fun, being playful, and watching them develop their capacities for resilience.

Each chapter includes clinical vignettes, definitions of terms, working diagnoses, a review of relevant literature, a description of clinical strategies, and important caveats. We intend this book to be both well-grounded and clinically practical. The clinical examples are designed to illustrate the principles derived from literature and the authors’ experiences. These vignettes are more than illustrations. We hope they enthuse the reader to interact creatively with the young people in therapy.

Of course, one cannot learn to implement clinical skills from a textbook. This volume is designed to stimulate or augment professional clinical training in hypnosis. The reader is also referred to the excellent texts cited in the list of references, many of which provide basic information on the fundamentals of hypnosis. Before clinicians can introduce hypnosis into their practices, they are advised to participate in professional courses, workshops, and supervision. In addition to university sponsored curricula and courses, The Society for Clinical and Experimental Hypnosis and The American Society of Clinical Hypnosis (with its component sections) provide superb training for licensed professionals in the US. Around the world, professional training is sponsored by national hypnosis societies, which are brought together by their affiliation with the International Society of Hypnosis. These organizations regularly include advanced workshops with a special focus on hypnosis with children and adolescents as part of their annual and regional meetings. Since 1987, the Society for Developmental and Behavioral Pediatrics has offered workshops in hypnosis with children at basic, intermediate, and advanced levels as part of its annual meeting. We encourage readers who have not availed themselves of such training opportunities to do so not only to develop the necessary clinical skills but also to enjoy the camaraderie and encouragement of like-minded professionals.
This collection of clinical exploration and discussion comes at a time when psychobiology is blossoming. In the nearly 250 years since Franz Anton Mesmer began using what he termed “Magnetisme Animal,” the conjoined fields of psychophysiology and hypnosis have been evolving with accelerated speed. Over the past fifty years, increasing evidence of brain-body interactions with the peripheral immune, endocrine, and other somatic systems have begun to provide the intercellular evidence for what we have always known: the brain and body are powerfully connected. Even more, we are beginning to understand the neuroscience of consciousness and the psychobiology of gene expression explicated by Rossi’s “psychosocial genomics.” This new information about how our experiences and memories structure our brains and psychophysiological reflexes supports novel therapies that promote brain plasticity and growth. Clinical hypnosis is proving to be such a therapeutic probe. This new science holds its greatest promise for its preventive potential with young people. It will inform our clinical work in helping children and adolescents develop resiliency and physiological self-regulation. In a sense, we are in the process of learning a better way to help children “mind.”

A note about Clinician-Therapists: Many clinicians (physicians, surgeons, nurse practitioners, physician assistants) are not regarded as therapists. Similarly, mental health therapists (psychologists, social workers, marriage and family therapists) do not work in clinical settings as such and are not characterized as clinicians. Hypnotherapy, however, is a skill set and strategy that bridges both physiological and psychological in both intent and outcome. Therefore, to be inclusive, we will use the terms clinician and therapist interchangeably throughout this text.

We liken this text to a well-documented cookbook with no recipes, only enticing combinations of ingredients and descriptions of

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Children are wonderful to work with because of their very creative and active imaginations. When they are experiencing a problem, children generally want assistance and look forward to learning a variety of skills that will help them resolve it. Most children have heard about hypnosis and, like adults, children need to learn about it.

The therapist must take time to introduce the hypnotic process to the child and parent(s). This preparation can start even before the first session by sending the parent(s) a copy of a brochure entitled, “Questions and Answers about Clinical Hypnosis” (Wester, 1982/2002). This brochure was first published in 1982, and revised in 2006. It contains a definition and brief history of hypnosis, information on professional training for therapists, myths and misconceptions about hypnosis, and other information typically discussed during the initial interview. When you first interview the child and parent(s), the therapist must allow time to develop rapport and answer any questions the child or parent(s) may have.

When the child arrives for the first session, the therapist can provide the parent(s) and child with additional reading material about hypnosis. An excellent resource to have available is My Doctor Does Hypnosis (Elkins, 1997). This short book is of great value, especially for the younger child. The story is about a girl who goes to a therapist who uses hypnosis to liberate her from her hurt feelings. She learns how to do self-hypnosis by relaxing and utilizing her imagination to help herself feel better. Finally, she
learns that other people also use hypnosis to help themselves feel better.

I hope that your referrals come from colleagues who have already set the stage for hypnotic treatment based on their knowledge of hypnosis and your reputation. If you are asked to see a child in the hospital, make sure the staff, nursing staff, and any other professionals know why you are there and what you are trying to accomplish. You do not want to do really good hypnotic work only to have what you’ve done undermined by some inappropriate negative statement such as, “I don’t believe in this stuff.”

There are many other factors that the therapist can evaluate prior to hypnotic treatment. Crasilneck and Hall (1985) identified seven questions to consider during the initial intake interview:

1. Why has the child come for treatment at this time?
2. Who sent/referred the child?
3. Is the child sufficiently motivated to give up the symptom(s)?
4. Is the symptom being used to manipulate others?
5. Is the symptom organic or psychogenic?
6. What is the child’s degree of impulsivity and what is the child’s level of frustration?
7. What is the child’s general personality or history?

Even though you do a thorough evaluation, there are a variety of factors that can go wrong, such as parental pressure, shyness, hyperactivity, lack of attentiveness, and general defensiveness. Remember that these factors may be the child’s way of telling you something. Find ways to deal with these barriers. For example, if a child sits in my chair covering his or her face with his or her hands and will not speak, I simply say, “That’s okay, you don’t have to talk—I guess you don’t want to see the magic marble.” At this point the child always lifts at least one hand to look and rapport begins. A simple magic trick follows and the child gets to keep the marble.

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Induction Techniques

The hypnotic treatment outcome will be greatly enhanced if the therapist builds rapport and carefully assesses the child. The next step, based on all of the pre-hypnotic information obtained, is to select a suitable induction technique that takes into account the child’s chronological age, intelligence, and emotional/maturity level. Table 5.1 is an excellent way to illustrate this point (Wall, 1991).

Olness and Kohen (1996) divide induction techniques into visual imagery, auditory imagery, movement imagery, storytelling, ideo-motor, progressive relaxation, eye fixation, distraction, and utilization (the use of videotapes, audiotapes, or the telephone). I offer the following induction techniques to provide the reader with a variety of induction techniques and specific verbalizations.

Clinical Vignette

Butterflies

S.P.

The vignette is that of a 12-year-old boy, S.P., who presented with separation anxiety. He described his anxiety as “butterflies in his stomach” and was unable to spend the night at a friend’s home. This is the second session, and he states that he has gotten better but still cannot fully spend the night at a friend’s house without having butterflies, even though this feeling is less intense than it was before. There was a strong family history of anxiety disorders. The therapist uses a learning model and combines several induction techniques, which also act as an intensification technique, with a great deal of reinforcement and reframing. S.P. sits in a recliner and props his feet up.

W. Wester [WW]: Just close your eyes and keep your eyes closed as I talk with you [direct approach used only because I knew this child and the fact that he was 12 years old]. Look at the next few minutes as a very special time that you have set aside for yourself. This is a
Chapter Ten

Hypnotic Treatment of Anxiety in Children

William C. Wester, II, EdD, ABPP, ABPH

What is anxiety? Anxiety is “a state of apprehension, uncertainty, and fear resulting from the anticipation of a realistic or fantasized threatening event or situation, often impairing physical and psychological functioning” (American Heritage Dictionary, 4th ed., 2000, p. 590). The words “uncertainty,” “fear,” “anticipation,” and “threatening event” are key words for the child or adolescent (hereafter referred to as the child) experiencing symptoms of anxiety. It is generally agreed that anxiety involves a psychological and physical response to a perceived danger, with the differences being the type of danger and whether the response is appropriate.

The medical community should “rule out” neurological factors, respiratory factors, metabolic factors, endocrinology factors, or other medical causes of the symptoms. Psychological symptoms are rarely entirely ruled out. There is no question about the body-brain connection when dealing with anxiety. The nervous system is brought into action and triggers the “flight or fight” response we all learned about in general psychology.

Anxiety disorders are not necessarily connected with a specific external danger and, therefore, give the symptom(s) a unique quality. In many situations, the child knows that there is no specific reason for his or her response, and, as a result, feels not only anxious but less in control (Eppley & Tepe, 1990). Hypnosis has been used to treat anxiety disorders in children, with one of the earliest published accounts being Mason’s 1897 report of treatment of a child who was too frightened to cooperate with medical treatment (Schultz, 1991).
I believe that anxiety needs to be quickly reframed and dissociated from the otherwise normal child. Children become identified with their symptoms by family and peers. An example would be parents who refer to their child as “my anxious child” or peers who give their best friend a variety of names such as “freak,” “buzz,” or “hyper.” Everyone seems to forget that the child has a name and is a person who happens to be experiencing symptoms of anxiety.

During or at the end of my clinical intake interview, I ask the child if it is okay to refer to his or her symptoms in a different way. He or she is happy to do this, and as I pull an ugly looking monster toy from my desk I say, “I would like you to meet the “It Monster.” From that point forward I refer to his or her anxiety symptom(s) as the “It Monster.” This dissociative technique automatically reframes the anxiety and increases his or her sense of control and provides the child with an opportunity to change the symptom.

I usually do not use the “It Monster” term with very young children without first checking out their perception of a monster. As one young child said to me, “We can call it the ‘It Monster’ because monsters only live in books.” This obviously gave me another opening as well in terms of his treatment. Most children look at the ugly model and think it is cool to rename their symptom. This is all part of the fun and game playing when working with children. I explain the rationale for doing this and how looking at things in a different way will be helpful to them. Once this new pattern is established the next step is an easy one: namely asking, “Would you like to learn how to control the ‘It Monster’ instead of the ‘It Monster’ controlling you?” I then introduce the concept of hypnosis and discuss any myths and misconceptions.

I review the child’s motivations, which I obtained during the initial interview, and consider incorporating them later into the hypnotic procedure. Even though children do not have the same misconceptions as adults, they still watch television where they see a variety of misconceptions related to hypnosis.

It is important to present the learning model, skill building, and team approach. “I am going to be helping you learn a very special skill so that when the ‘It Monster’ tries to raise its ugly head, you
will be in control and use your skills to help destroy the ‘It Monster.’” I give the child a handout entitled, “Destroy the ‘It Monster’” to take home. I discuss the handout with the child and share it with his or her parent(s). Then I ask the child to find the hidden message in the handout and share it with his or her parent(s) and then with me at the next visit. (The first letter of each statement spells out “Self-Hypnosis Now.” A copy of the handout is at the end of this chapter.)

Both children and adults feel out of control and unprepared when their symptoms strike. I want the child to know that he or she now has a plan to deal with the anxiety. Having a plan is far better than not having a plan. In addition, it is important to talk about his or her need to try out his or her plan, which includes self-hypnosis and confronting the “It Monster.”

My typical comment is, “Every time you confront the ‘It Monster’ it gets weaker and you get stronger.” For the child who needs to see something happening, I use an imagined 10-point scale or switch technique (dissociative technique). Ten represents the highest level of anxiety he or she has ever experienced and zero is little or no anxiety. The child is in charge and in complete control of the scale or switch.

At the beginning of the session, he or she is asked to identify the level of his or her anxiety at that time. At the end of the session, following the hypnotic intervention, the child is asked once again to identify his or her level of anxiety. The post-hypnotic level is always lower and helps the child learn that what he or she has been doing has been helpful, and that he or she is really gaining control. This is an important experiential step versus taking the therapist’s word that there will be a change.

Finally, I ask them to give themselves a pat on the back and to verbalize at least three cognitive reframing statements. Examples of such statements include, “I did it,” “It worked,” “Wait till I tell my therapist about this,” “I made more out of my anxiety than it was worth,” “It’s getting better each time I do this,” “I’m pleased with me,” “I changed the 8 to a 4,” or “Come and try to get me ‘It Monster,’ I now have a plan to deal with you.” Both the “It
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