# Hypnotherapy in Child Psychiatry: The State of the Art

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# Hypnotherapy in Child Psychiatry: The State of the Art

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ABSTRACT

**Children are more easily hypnotized than adults, and hypnotherapy as a method responds to the general developmental needs of children by addressing their ability for fantasy and imagination. Hypnotherapy and self-hypnosis are tools with which to assess and develop protective factors, and enhance positive adjustment. Meta-analyses and overviews have demonstrated the effect of hypnotherapy in paediatric disorders like asthma, chronic and acute pain, and in procedure-related distress in cancer patients. We wanted to examine the use and benefits of hypnotherapy when applied to child psychiatric disorders. A review of a literature search from PubMed, PsychINFO and the Cochrane databases revealed 60 publications, mostly case reports based on 2–60 cases, addressing the use of hypnotherapy in various child psychiatric conditions. Findings indicate that hypnotherapy may be useful for a wide range of disorders and problems, and may be particularly valuable in the treatment of anxiety disorders and trauma-related conditions. In conclusion, knowledge of hypnosis is useful in clinical practice and hypnotherapy may play an important role as an adjunctive therapy in cognitive-behavioural treatment and family therapy. Additional qualitative and quantitative studies are needed to assess the place for hypnosis/hypnotherapy in child psychiatry.**

KEYWORDS

*adjunctive therapy, anxiety disorders, child psychiatry, hypnotherapy, trauma-related conditions*

CHILD MENTAL HEALTH workers assess children and adolescents with a broad array of complex and highly co-morbid disorders. Because knowledge of co-morbidity is increasing, clinicians want to tailor their treatment to the individual and developmental needs of each child. Complexity and co-morbidity often imply the use of two or more treatment methods, which should be flexible and adjust to each other. The need for cost-effective methods with fewer side effects has also been in focus of late (Chambless & Hollon, 1998).

Hypnosis means sleep in Greek, and can be defined as a state of heightened concentration in which a patient who is willing and motivated may experience alterations in

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sensations and perceptions and may be more responsive to suggestions from the therapist that are consistent with the patient's own wishes (Olness & Gardner, 1978). Whereas hypnosis is an ability or a mental state, hypnotherapy is a treatment modality with specific therapeutic goals and specific techniques used when the patient is in the state of hypnosis.

Meta-analyses and overviews have demonstrated the effect of hypnotherapy in paediatric disorders such as asthma (Hackman, Stern, & Gershwin, 2000), in chronic and acute pain (Blanchard & Scharff, 2002; Holroyd, 2002) and in procedure-related distress in cancer patients (Genuis, 1995; Holden, Deichmann, & Levy, 1999; Liossi & Hatira, 1999; Milling & Costantino, 2000; Richardson, Smith, McCall, & Pilkington, 2006). A recent review examined the benefit of using hypnosis in various paediatric disorders and some psychological conditions like Tourette's syndrome and sleep-terror disorder (Gold, Kant, Belmont, & Butler, 2007). In addition to investigating how hypnosis helps children cope with objective or subjective physical symptoms, researchers have also been interested in the effect of hypnosis on length of hospital stay (Lambert, 1996), the use of staff time and staff stress (Butler, Symons, Henderson, Shortliffe, & Spiegel, 2005) and the amount of drugs used, e.g. corticosteroids (Anbar, 2003) and midazolam (Calipel, Lucas-Polomeni, Wodey, & Ecoffey, 2005). No overview or meta-analyses concerning hypnotherapy in child and adolescent psychiatry have been published (Milling & Costantino, 2000).

The aim of this article is to describe the basic elements of hypnosis and hypnotherapy in children, to present an update of the literature concerning the use of hypnosis/hypnotherapy in child and adolescent psychiatry, and to discuss the possible place of

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hypnosis/hypnotherapy in child psychiatry based on clinical experience as reported by case descriptions and empirical findings.

## Method

An online computerized inventory was carried out in the PubMed, PsychINFO and the Cochrane databases using the search terms *hypnosis* (or *hypnotherapy*) and *child* (or *adolescent*) in combination, with no limit on the time span. Publications in English, French, German and Scandinavian languages were included. In October 2006, a total of 1919 references were identified in PubMed, 693 in PsychINFO and 44 in Cochrane.

Papers concerning child psychiatric diagnoses were studied in detail. A second, manual search of selected references cited in identified publications was carried out.

In January 2008, an additional online search in PubMed disclosed three new publications of relevance for this article.

### *Hypnosis and hypnotherapy*

The hypnotic state is achieved using an induction procedure**.** Clinical hypnosis usually starts by introducing relaxation and mental imagery. For this reason, and because of the stigma attached to the word, hypnosis has been termed relaxation–mental imagery by some authors (Smith & Womack, 1987). Because the induction part of hypnosis includes aspects of relaxation, relaxation is sometimes considered to be a very simple form of hypnosis (Hackman, Stern, & Gershwin, 2000). However, hypnotherapists also use mental imagery, both in the induction part and in the suggestions. In contrast to other therapeutic methods (e.g. cognitive-behavioural therapy; CBT), a therapist using hypnotherapy will be particularly interested in the child's altered state of consciousness. Owing to the patient's concrete way of thinking and increased suggestibility when in a trance, the therapist will be very attentive to their choice of words and metaphors (Evans, 2000).

Suggestions follow when the patient is in the hypnotic state. Suggestions are verbal communications and differ from everyday instructions in that they imply a 'successful' response and are experienced by the subject as having a quality of effortlessness (Evans, 2000). Suggestions may be concrete, imaginative, regressive or ego-strengthening (Gardner, 1974; McNeal & Frederick, 1993). They can be seen as 'therapeutic key messages'. A hypnotic trance may be defined not as the state of one person, but as a special type of interchange between two people, often called 'the hypnotic relationship' (Haley, 1973). The terms 'susceptibility' and 'hypnotizability' both describe hypnotic responsiveness, but the term 'hypnotizability' is now preferred (Spiegel & Greenleaf, 2005).

The specific hypnotherapeutic techniques used depend on a dynamic understanding of the presenting problem, the patient's goals and characteristics (age, interests and medical conditions), the therapist's theoretical orientation and the clinical setting. Any psychotherapist using hypnosis will do so according to his/her theoretical frame of reference and professional belief system (Vandvik, 1988). Hypnotherapy in child psychiatry can be presented as a step-by-step model, as shown in Table 1.

The first step is often a didactic session in which the child's and parents' prior ideas, e.g. fears and worries, about hypnotherapy are solicited and understood, misconceptions are clarified and myths are laid to rest (Olness & Kohen, 1996). In child psychiatry practice an individual assessment of the child is usually carried out to assess the need for other types of interventions before hypnotherapy is offered (Diseth & Vandvik, 2004; Kaffman, 1970).

*Table 1*. Hypnotherapy: typical hypnotherapeutic steps

**Step 1: Assessment of child psychiatric problems, hypnotizability and motivation**
- General child psychiatric assessment
- Assessment of hypnotizability and motivation
- Assessment of favourite activities and distress/problem
- Subjective self rating scale and monitoring (diary)

**Step 2: An information session about hypnotherapy**

**Step 3: The clinician and the child choose induction method**
- Visual imagery techniques: favourite place, favourite activity, television fantasy
- Auditory imagery: favourite song, listening to music, playing an instrument
- Movement imagery: flying blanket, sports or playground activity
- Storytelling techniques, made up by the therapist and/or the child, from (pop-up) books
- Ideomotor techniques: hands moving together, arm lowering
- Progressive relaxation techniques: following breathing, teddy bear (indirect suggestions)
- Eye-fixation techniques: coin techniques, looking at a point on the hand (e.g. a face painted on the nail of the thumb), stereoscopic viewer

**Step 4: Suggestions are being made when the child is in a trance/hypnotic state**
- Extended initial suggestions for using one's imagination; intended to enhance the subject's responsiveness to the suggestions to follow
- Direct suggestions e.g. for one hand to help the other in trichotillomania
- More general suggestions: 'safe place' in traumatized children, 'imaginary journey' in terminally ill adolescents, 'area of comfort and inner mastery' in school-phobic children
- Post-hypnotic suggestions to practise self-hypnosis

**Step 5: Teaching self-hypnosis**

The second step involves the assessment of hypnotizability. This can also be viewed as a 'practice session' in which the child experiences and learns about hypnosis. The most commonly used method to measure hypnotizability in children is the Stanford Hypnotic Clinical Scale for Children (SHCSC) which was designed for clinical use (Morgan & Hilgard, 1978). Other tools like the 'hypnotic trauma narrative' are used in children with post-traumatic stress disorder (PTSD) following bereavement (Iglesias & Iglesias, 2005). The degree of hypnotizability or the depth of the trance does not seem to have implications for the treatment outcome (Lynn & Shindler, 2002).

The second part of the assessment often includes an evaluation of the child's motivation for change (Hammond, 2005). This may be based on the results of the SHCSC or finger-signalling (Olness & Kohen, 1996). User-friendly questionnaires like the Imagery/Discomfort Questionnaire are available to assess both the patient's favourite activities and his/her level of distress (Olness & Kohen, 1996). The questionnaires help the therapist to tailor the induction and suggestion according to each child's interests and needs.

The third step is to choose an induction method according to the results of the previous assessment. The format of induction methods varies widely from brief, simple instructions to complex and lengthy rituals. Both the child's comments and the therapist's observations of non-verbal signs (body posture, breathing and facial expressions) influence the choice of induction technique. With younger and more agitated children, informal induction techniques like storytelling and suggestions of calmness or soothing imagery are effective.

The fourth step first consists of a reflection time during which the therapist chooses the suggestions or key messages that seems important to communicate to the patient.

The therapist then meets the child regularly and they work with the inductions and suggestions, often in combination with other therapeutic approaches.

The fifth step is to teach the child self-hypnosis. This is particularly indicated when problems relate to recurrent difficulties or discomfort (Olness & Kohen, 1996). A record of the session on tape or CD may help the rehearsal.

In 1970, Kaffman stated that 'When hypnotic suggestions are adequately adjusted to psychodynamics and conditioned to the patients' free will and ability to carry them out, only minimal or no side effects to hypnotherapy are to be expected'. However, there are some absolute contraindications to hypnotherapy, e.g. risk of physical endangerment, aggravation of emotional problems, 'hypnosis for fun' or a request for hypnotherapy based on misdiagnosis (Olness & Libbey, 1987). There are also some relative contra-indications for hypnotherapy, usually based on inappropriate timing of the referral, e.g. the need for immediate medical or surgical treatment, or when the symptom provides significant secondary gain for the child. As a rule, one should not attempt to treat a problem with hypnotherapy unless one is also competent to assess the problem and recommend other therapies if appropriate. For example, the use of hypnosis by a professional lacking the necessary expertise to treat traumatized patients can be potentially damaging for the patient.

At times the therapist will decide that hypnotherapy is not the method of choice, for example, because of a lack of motivation and/or psychosocial stress, and the therapist may then choose another therapeutic method, e.g. family therapy. Sometimes what seems like 'resistance' may simply represent a mismatch between therapist and child. In such cases, rather than abandon the potential use and value of hypnosis, the therapist may opt to refer the child to a colleague with whom the child may 'connect' more easily or positively (Olness & Kohen, 1996).

To date, extensive training and experience in hypnotherapy has mainly been provided by national hypnosis societies, and has, to our knowledge, not been included in the medical curricula of national universities outside Australia (Dane & Kessler, 1998; Wicks, 1993). This may be one reason why hypnotherapy is not well known by mental health workers.

## Results

Sixty publications, including two books (Olness & Kohen, 1996; Wester & O'Grady, 1991), addressing the use of hypnotherapy in various child psychiatric conditions (except substance abuse) were found. Studies describing children with problems that a child psychologist or child psychiatrist might meet when working in a paediatric setting, e.g. coping with chronic disease or pain, were also included. The literature describing the use of hypnotherapy in child psychiatry consists of clinical experiences mostly published as case reports based on 2–60 cases. Most studies have between one and five participants. The studies differed widely in their focus, methods and outcome measures, the methodologies were unclear and control groups or the random allocation of participants were rarely reported.

In the following we present, in an alphabetical order, the various child psychiatric conditions for which hypnotherapy has been described as useful.

### *ADHD and conduct disorder*

Calhoun and Bolton (1986) report successful results of a hypnotic induction technique as an adjunct to medical treatment (methylphenidate) in 11 hyperactive children. Sommers-Flanagan and Sommers-Flanagan (1996) describe a general approach entitled

'Wizard of Oz' hypnotherapy for children with inattentive, impulsive and oppositional characteristics. They used this approach as an adjunct to CBT individually and in a small-group format for 8–13-year-old children. The authors concluded that this procedure improved the therapeutic alliance, heightened the young clients' interest in therapy procedures and improved overall cooperation with treatment. Short-term hypnotherapy used in adolescents with severe conduct disorders is described by Benson (1984). Subjective reports from the participants were very encouraging, and hypnotherapy was described as useful in pointing the child in right direction by focusing on anxiety-relief and ego-strengthening techniques.

### *Anxiety disorders/emotional disorders*

Sakai (1997) claims that autogenic training is a form of self-hypnosis. His clinical study investigated the effects of autogenic training for anxiety disorders (panic disorder, social phobia, obsessive-compulsive disorder [OCD], general anxiety disorder and simple phobia) in 55 patients aged 14–58 years (40 of whom were in high school). Autogenic training/self-hypnosis had been taught as a technique to control anxiety and as a skill for coping with anxiety reactions, most often in combination with exposure. Forty-two patients (76%) had a successful outcome. Goldbeck and Schmid (2003) investigated the effect, measured using the Children Behavior Checklist (CBCL), of autogenic relaxation training in 50 children. Compared with a control group, the intervention had an effect on both emotional and behavioural symptoms.

Aviv (2006) reports positive results of using hypnotherapy in 11 adolescents with school phobia/separation anxiety disorder, describing a therapeutic approach, tele-hypnosis, that involves using known hypnotic techniques but rehearsing them via the telephone. Olness and Kohen (1996) describe hypnotherapy helping a 15-year-old girl with social anxiety. After three sessions of hypnotherapy, the girl reported feeling more comfortable in social situations, and she continued to do well at a 6-month follow-up. H. Baker (2001) describes eight hypnotherapy sessions as an adjunct reducing anxiety in a 16-year-old girl with complex problems.

### *Autism-spectrum disorders*

The use of hypnotherapy/self-hypnosis by a mildly autistic 16-year-old adolescent is described by Gardner and Tarnow (1980). The target of the specific behaviour change was finger-biting, but gains in social and cognitive skills were also reported. No other article reporting the use of hypnotherapy with autistic children has been found. Olness and Kohen (1996) caution that severely autistic children with little capacity for interpersonal relationships are not likely to respond to hypnotic induction.

### *Dissociative (conversion) disorders and PTSD*

There are different models for the use of hypnosis in the treatment of traumatized children (Diseth & Christie, 2005; Friedrich, 1991; Rhue & Lynn, 1991). Friedrich presents a model in which hypnotherapy may be used in three general ways for children with PTSD: (1) symptom stabilization and removal, (2) uncovering and (3) integration. These approaches may be used separately. A positive outcome of hypnotherapy is illustrated by four case histories based on changes in CBCL scores. Friedrich concludes that both the assessment and establishment of a therapeutic relationship can be readily accomplished with hypnotherapy in traumatized children. He specifies that hypnosis speeds up the development of a positive working alliance, but also reduces agitation, enhances compliance to a behavioural regimen and enables the therapist to 'put away' until later the patient's negative affect and intruding thoughts.

Rhue and Lynn (1991) describe effective therapeutic interventions with 32 victims of sexual abuse. In this model, hypnotherapy proceeds in a stepwise fashion from the building of a sense of safety and security, through imaginative sharing, to the introduction of reality events. To illustrate the use of hypnosis in the treatment of traumatized children, Kluft (1991) gives three case examples. He describes how the use of hypnosis allows gradual working through of the painful material in a manageable manner, rather than experiencing one's self at its mercy, vulnerable to being abruptly overwhelmed. Diseth and Christie (2005) describe the use of hypnotherapy in combination with cognitive therapy and psycho-education.

The treatment of conversion disorders presents other challenges. Bloom (2001) describes using hypnotherapy to treat two adolescents hospitalized with conversion disorder–motor type. It is reported that hypnotherapy was considered by the family and the patient as neither a strictly medical treatment nor a purely psychological modality. The author argues that the use of hypnosis in the treatment of conversion disorders represents a unique opportunity to create an alternative solution to life problems in an acceptable context for change. Williams and Velazques (1996) present historical considerations and case examples, concluding that as part of a comprehensive treatment plan, hypnosis can provide a powerful resource to help the patient understand and reverse the process of dissociative symptom formation.

Self-cutting behaviour is considered by some to be a dissociative symptom (Malon & Berardi, 1987). Malon and Beradi describe the use of hypnotic techniques combined with psychotherapy for nine young women (aged 13–27 years). A technique called 'neutral hypnosis', defined as not telling the patient that the name of the technique used was hypnotherapy, is described as counteracting the frightening depersonalization that may have lead to cutting.

Regarding multiple personality disorders, Kluft (1985) describes the successful experience of combining hypnotherapy with family intervention in five cases.

### *Eating disorders*

Gross (1984) reports the successful use of hypnotherapy in the treatment of 50 patients with anorexia nervosa. However, only 10% of their 500 patients agreed to be treated by hypnotherapy. The remainder expressed a fear of losing control of the ability to lose weight or maintain their weight loss. Gross describes six anorectic cases (four adolescents) in whom hypnotic interventions were successful for the treatment of hyperactivity, distorted body image, failure of introceptive awareness and feelings of inadequacy. He concludes that hypnotherapy can be an excellent tool in the therapy of anorexia nervosa if used in a non-authoritative way. E. L. Baker and Nash (1987) describe a comprehensive hypnotherapeutic approach used in conjunction with motivation and insight-oriented therapy, and occasional conjoint sessions with families, as a successful treatment approach for 36 young women with anorexia nervosa.

Torem (1991) describes in detail how hypnosis is used in various ways in the treatment of patients with eating disorders. He uses hypnosis as a relaxation technique, as an ego-strengthening technique, to give healing suggestions and to perform cognitive restructuring and reframing. He also concludes that it is clear that the technique has been underused by administrators of formal eating-disorders programmes.

However, Olness and Kohen (1996) emphasize that it is difficult to work with severely ill anorexic adolescents until nutritional rehabilitation has begun.

### *Enuresis, encopresis and urine retention*

Banerjee, Srivastav, and Palan (1993) compared hypnotherapy and the drug imipramine in two groups of 25 children with enuresis. At a 6-month follow-up only 24% of the imipramine group had maintained a positive response, compared with 68% in the hypnosis group. Olness and Kohen (1996) describe in detail how to use hypnotherapy to help enuretic children gain control of their bladders. The model was used, with good results, by Diseth and Vandvik (2004) in the treatment of 12 boys.

Both Williams and Singh (1976) and Olness and Kohen (1996) report the effective use of hypnotherapy in helping children with encopresis as well as urine retention.

### *Learning disorders*

The effects of hypnosis on improving the reading ability, academic achievement, self-concept, academic behaviour and number reversals are the focus of 10 studies assimilated and critically reviewed by Russell (1984). According to Russell, most of the studies demonstrated impressive results, but methodological flaws seriously limit empirical interpretation and the possible generalizability of the findings.

### *Obsessive-compulsive disorder*

Hypnosis as an adjunct to a cognitive-behavioural approach is described in the successful treatment of homicidal obsessions in a 12-year-old boy (Kellerman, 1981). Taylor (1985) reports a brief, but successful intervention using a combination of hypnotic techniques and imagery in a female adolescent (18 years) with obsessive preoccupations concerning her parents' health and sexuality. Trichotillomania (hair pulling), considered by Zalsman, Hermesh, and Sever (2001) to be an OCD, is reported for three adolescents who responded to treatment with imaginative hypnotherapy.

### *Pain: Headache, abdominal pain and acute pain*

Gysin (1999) offered five sessions of hypnotherapy and self-hypnosis to a group of 18 children aged 8–18 years who presented with headaches. Compared with a control group of seven children, hypnotherapy/self-hypnosis seemed to be superior not only in terms of the frequency and intensity of headaches, but also concerning patients' abilities to keep their headaches and their wellbeing under control. In a 5-year follow-up study, the authors demonstrated that training a group of 178 children and adolescents in self-hypnosis was associated with a significant long-lasting improvement of chronic recurrent headaches (Kohen & Zajac, 2007).

According to the results of a randomized controlled trial in 53 paediatric patients with functional abdominal pain or irritable bowel syndrome, gut-directed hypnotherapy is highly effective (Vlieger, Menko-Frankenhuis, Wolfkamp, Tromp, & Benninga, 2007). Unfortunately, children with psychological problems were not included in the study.

Kuttner (1988) describes using favourite stories as a hypnotic pain-reduction technique for eight young children with acute pain. The method, tailoring a favourite story to each child, when measured using a behavioural checklist, was significantly more effective than behavioural distraction and standard medical practice for a control group of eight children.

### *Psychotic disorders*

Plapp (1976) described the use of hypnosis in order to engage a 17-year-old psychotic patient who had been in therapy for 17 years and develop an understanding of the interpersonal aspects of his difficulties. No other article reporting the use of hypnotherapy with psychotic children has been found.

### *Sleep disorders*

Jacobs (1964) interprets sleep problems as being due to anxiety, implying that the child is not at peace with his or her environment. Hypnotherapy was used successfully in three cases with suggestions reassuring the children (aged 6–9 years) of their parents' love and bolstering their feelings of self-confidence and self-esteem. Levine (1980) describes the success of using indirect suggestions through personalized fairy tales for the treatment of childhood insomnia in two children. Kramer (1989) describes the successful treatment of a 10-year-old boy suffering from night terrors (of 6 years' duration). He used a finger-lowering technique combined with suggestions for not dropping too quickly into an extreme deep stage of sleep.

### *Tourette's syndrome*

Culbertson (1989) presents a 16-year-old male in whom a four-step hypnotherapy model was applied, leading to the cessation of tics after nine sessions without the use of medication. Kohen and Botts (1987) report success teaching self-hypnosis/relaxation–imagery techniques to four children with Tourette's syndrome. Diminished frequency of tics was noted almost immediately by both patients and their families and improvements were sustained over time, often with a reduction of medication.

## Discussion

### *Research results*

Our literature search revealed no randomized or controlled trials or prospective, planned research studies using hypnotherapy for child psychiatric disorders. Only two randomized controlled trials were found; one investigating the effect of autogenic relaxation training, which is considered by some to be a simple form of autohypnosis (Goldbeck & Schmid, 2003), the other showing a very positive outcome for children with abdominal pain (Vlieger et al., 2007). The publications found were mainly based on clinical experiences published as case reports. Although it is not possible to draw scientific conclusions from the existing literature, we chose to present the findings hoping to inspire readers to learn hypnotherapy and introduce this in clinical trials and systematic studies.

### *Clinical recommendations*

The existing publications indicate that hypnosis/hypnotherapy can be useful for a wide range of child psychiatric disorders. Although hypnosis/hypnotic trance does not appear to be the same process as pathological dissociation (Diseth & Christie, 2005), hypnosis has a special place in the treatment of traumatized children so that 'the adaptive aspects of dissociation during trauma may be productively employed to aid recovery' (Friedrich, 1991). Thus, hypnotherapy is an approach that has significant potential for the treatment of trauma-related disorders, although robust empirical support for its efficacy is lacking, and further rigorous studies are needed (Robertson, Humphreys, & Ray, 2004). Cardena (2000) argues that there are specific reasons to suspect that hypnosis would be of particular value in the treatment of post-traumatic conditions because these patients seem more hypnotizable. Hypnosis can also specifically target a variety of symptoms related to PTSD, namely, post-traumatic dreams, dissociative symptoms and pain. For patients with conversion disorders, hypnosis can help by giving the patient a way to get better without having to decide if a problem is psychological or physical in origin. Hypnosis in the treatment of conversion disorders is therefore of special interest (Bloom, 2001). Autogenic relaxation training, a simple form of self-hypnosis, may have a significant

effect on emotional problems. Particularly when it is difficult for the child and/or the parents to see the link between a sleep problem and an emotional problem, hypnotherapy may be proposed as adjunct to psychotherapy and medication. It is also probable that hypnosis/hypnotherapy has a special place as an adjunct in the treatment of OCD, especially trichotillomania, and in the treatment of tics in Tourette's syndrome, but further studies are needed to confirm this (Zalsman et al., 2001). In an overview of complementary treatments for children with attention-deficit hyperactivity disorder (ADHD), Baumgaertel (1999) argues that hypnotherapy may help coping with secondary ADHD symptoms such as sleep problems and tics, and can help children play a more active role in their treatment. Hypnosis seems to be an excellent first-choice treatment for monosymptomatic nocturnal enuresis, but if after three or four treatment sessions, hypnosis is not effective, other approaches can be employed (Olness & Kohen, 1996).

There have been quite a few issues and controversies concerning the use of hypnosis in psychotherapy with psychotic patients. In a review, Scagnelli (1980) states that hypnosis is both viable and safe for psychotic persons, as long as the therapist has the psychotherapeutic skills, ability and sensitivity to work safely with psychotic patients in general. Furthermore, according to Diseth and Christie (2005) patients with the diagnosis psychosis/schizophrenia may have been misdiagnosed, and findings indicate that a certain percentage do not actually have psychotic symptoms but dissociative symptoms.

In paediatrics the positive effects of the use of hypnosis/hypnotherapy in coping with disease/procedural-related anxiety and chronic pain are well documented. Consultation–liaison child psychiatrists and paediatric psychologists are often asked to help children and adolescents to cope with pain, procedural anxiety or more general aspects of having a disease. It has been shown that the use of relaxation, mental imagery or self-hypnosis in patients with needle anxiety, reduces the anxiety significantly (Kohen, Olness, Colwell, & Heimel, 1984). Wicks (1993) reported his experience as a visiting medical officer specializing in hypnotherapy with children. He presents guidelines for the use of hypnosis in emergency and non-emergency situations in a children's hospital and provides case vignettes. Harper (1999) has used hypnotherapy as a technique to help adolescents who suffer from terminal or chronic medical illness to gain a sense of comfort and control over their lives. Hypnotherapy in combination with family therapy has been reported to have an effect on the symptoms of chronic disease in some children (Negley-Parker & Araoz, 1986). Moore (1981) describes four case studies in which induction techniques of relaxation and visual imagery were effective in helping patients, families and hospital staff cope with different situational traumas such as car accidents or surgery for a brain tumour. Even though there may be a difference between children in paediatric settings and children met in child psychiatry settings, it is our opinion that these results can be transferred directly to the child psychiatry setting. We therefore emphasize that children with anxiety disorders and/or chronic pain seen in child psychiatry settings can profit from hypnotherapy. In addition, meta-analyses of various clinical conditions in adults have indicated that adding hypnosis to cognitive-behavioural or psychodynamic interventions increases their efficacy (Cardena, 2000).

### *Research recommendations*

To demonstrate the efficacy and effectiveness of hypnotherapy in the child psychiatry population, we need both randomized, controlled clinical trials and qualitative studies. Cardena (2000) suggests that establishing empirical support for a therapy does not necessary require randomized, controlled clinical trials. Careful and systemic interventions and time series evaluations, well within the reach of most clinicians and

researchers, for example, single-case designs, may suffice. There is now increasing recognition of the importance of including both common and non-specific factors in psychotherapy research (Spaulding & Nolting, 2006). It is also increasingly recognized that small-scale, qualitative studies, involving non-specific factors, are essential to help understand how things work in the 'swampy lowland of practice' (Kam & Midgley, 2006). It may be of particular interest to use studies to investigate whether hypnotherapy as a method has a specific benefit on the therapeutic relationship.

### *The place of hypnotherapy in child psychiatry*

Compared with CBT, family therapy, individual therapy or pharmacotherapy, hypnotherapy is not appropriately disseminated in child psychiatry. Too few children are offered hypnosis as part of their treatment. This may be due to lack of knowledge and interest. The children seen in child psychiatry may not be easily hypnotized, open, confident, and automatically perceiving the adult as a helper, but rather emotionally disturbed children who avoid new experiences or do not relate easily to adults (Gardner, 1974).

The professional practising hypnosis needs both creativity and ability to be able to focus intensely on the patient. This is even more true with child psychiatry patients, and may be another reason why hypnosis is underused in this field (Vandvik, 1988).

Gardner's (1974) statement remains relevant: 'The child psychiatrists' caution may be understandable given a) the absence of adequate research evidence as to the superior benefit of hypnosis when compared with other treatment approaches to childhood problems, b) the tendency of child hypnotherapists to emphasize successful cases rather than to discuss their results in a balanced way so as to generate new hypotheses or provide a more sophisticated basis for using hypnosis or c) the lack of theoretical formulations and definitions which are sufficiently cohesive to explain clinical data'.

### *The specific benefits of hypnotherapy*

In general, children respond more to hypnosis than adults (Gardner, 1974; Milling & Costantino, 2000), as shown in Table 2. Children's greater overall hypnotic hypnotizability may be a result of a natural unbiased observation of the world, free of the mind–body split that adults apply to perception (Cowles, 1998). Although children may at times manifest marked anxiety and resistance to hypnotic induction, this occurs less frequently than in adults and is usually overcome more easily (Kaffman, 1968).

Knowledge of developmental levels in childhood is actively used to formulate and utilize the hypnotic interventions at their most effective and constructive level and to provide maximum therapeutic benefit to the patient (Wall, 1991). Hypnotherapy for children is therefore specifically suited for the developmental needs of children, and is an alternative to the 'child as a smaller adult' way of thinking.

Hypnotherapy is easy to combine with other therapy methods. The therapist working with children should use hypnotherapeutic techniques as part of a comprehensive approach based on diagnostic evaluation and assessment of the relevant treatment modalities. Hypnotherapy can be combined with family therapy (Haley, 1973; Lind, 1990), psychotherapy (Iglesias, 2004; Peebles-Kleiger, 2001; Williams & Singh, 1976) and CBT (Hutchinson-Phillips, Gow, Gow, & Lumsden, 2005; Kirsch, Montgomery, & Sapirstein, 1995), and used within inpatient multidisciplinary treatment programmes (Aronson, 1986). Furthermore, hypnotherapy is goal-oriented in focusing on the child's resources and seems to be a cost-effective method.

Hypnotherapy can also be a tool to assess and develop coping by focusing on the child's interests and resources (Aronson, 1986; Vandvik, 1988). The main goal in

*Table 2.* Why children respond more to hypnosis than adults (Gardner,1974)

| *Factor type* | *Factors* |
|---|---|
| The cognitive factor | ■ Children easily intertwine fantasy and reality<br>■ Most children have a love of magic and fantasy<br>■ Children focus more on the immediate present<br>■ Children are usually entirely absorbed in what they are doing, learning with all their senses at once<br>■ The tendency towards concrete, literal thinking facilitates acceptance of appropriately worded hypnotic suggestions |
| The emotional factor | ■ Children can often move from one intense feeling-state to another with only minimal assistance<br>■ Children are generally open to new experience and eager to explore, unless they have significant anxiety around these issues<br>■ In hypnosis a child is usually comfortable with the naturally occurring regressive phenomena |
| The interpersonal factor | ■ Children usually do not have the intense conflicts around issues of control and submission that interfere with many adults' ability to utilize hypnosis<br>■ Children are also less likely to have the usual adult misconceptions that hypnosis involves being entirely controlled by another, giving up one's will and so on<br>■ Children naturally strive toward mastery of their own bodies and autonomy to the environment. They are likely to be intrigued with the idea of hypnosis if it is presented as an opportunity for them to learn a new skill. Adults, on the other hand, are more likely to fear that they will fail |

hypnotherapy is often to teach the patient an attitude of hope within the context of mastery. The development of hope is finally considered an important factor in psychiatry (Nunn, 1996)

Assessing a child's hypnotizability and favourite activities can also be a powerful means of establishing a respectful therapeutic relationship because the hypnotic relationship has a particular intensity and dramatic colouring. However, counter-transference is inevitably intensified in hypnosis work, especially in trauma victims (Peebles-Kleiger, 1989).

Practising hypnotherapy will increase general psychotherapeutic skills. This happens by increasing the skills of observing children and training in using concrete terminology, being aware of intonations and body movements (Evans, 2000; Vandvik, 1988). A person trained in hypnosis can easily grasp the idea that subjective feelings and perceptions change with a change in relationship (Haley, 1973). Knowledge about hypnosis is therefore useful for any psychotherapist, even if he or she does not apply these skills directly (Vandvik, 1988). The therapist has to pay close attention to the patient's report of his/her subjective experience. During suggestion there is always a monitoring process going on in the patient and the therapist. Even though it may seem remote from the conscious awareness, one has to be very alert to the patient's state of awareness and mind.

## Conclusion

Hypnotherapy is a method whose intrinsic qualities and values make it possible to tailor interventions according to both the developmental and individual needs of the child.

Because of its flexibility, hypnotherapy can be used as an adjunct to other therapies (psychotherapies and pharmacotherapy). Clinical experience reveals that hypnotherapy can be cost-effective and have fewer side effects than other treatment methods. There are specific reasons to assume that hypnosis would be valuable in the treatment of various child psychiatric conditions, but it seems to be particularly valuable in anxiety disorders and trauma-related conditions.

Research on hypnotherapy with children seen in a child psychiatry setting is in an early stage of development, and additional research, both controlled randomized quantitative and qualitative studies are needed to confirm the effectiveness and efficacy of hypnosis/hypnotherapy in child/adolescent psychiatry.

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