Trauma Prevention: Hypnoidal Techniques with the Chronically Ill Child

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■ *The demanding array of medical procedures, hospitalizations, and medication regimens combined with the emotional and social sequelae of their illness, make the chronically ill youngster at greater risk for traumatization than the average healthy child. The prevention of trauma with the chronically ill pediatric population can be achieved with the careful interfacing of the principles of development, the understanding of the trauma model, and hypnoidal techniques for empowerment, mastery and ego-strengthening. The types, the timing and the implementation of hypnoidal interventions will be illustrated in two case studies.*

There is a popular activity in the American schools called Show and Tell, in which young children are invited to bring items from home to talk about with their classmates. Show and Tell is one of the few curricular events in the young child's academic life which addresses their affective needs while in an educational setting. The wise teacher knows that when Billy or Susie bring their prized possessions to school to share with their classmates, they almost always choose something of great significance. It has been my observation that in the simple act of showing and telling youngsters often work out what have been frightening experiences for them - either mastered or in the process of being mastered. Susie shows her boo-boo, Billy the tooth which fell out. The opportunity to share out loud the little scares and worries is often sufficient to calm the young child. It is a time when both emotional support, in the form of sympathy and cognitive support, in the form of information about other's similar experiences is provided. In the constant "logging on" of experiences into the developing child's mind, "I fell down last week, too, and see my boo-boo needed 5 stitches" or "I wish my tooth fell out, my daddy pulled my tooth out and it really hurt" are examples of the sharing which brings emotional and cognitive input that often allows the fruitful processing of upsetting events. The acknowledgment and exploration of these little upsets leads to the integration of these experiences in the child's developing personality. Show and Tell, like therapy, can process many events which might otherwise remain traumatic for a youngster. The relational aspects of trauma relief are highlighted by the model of

Show and Tell. Human beings do well when they have others with which to share and compare their experiences.

While we most often define trauma as a major emotional shock that produces substantial damage to an individual's psyche, trauma also refers to the overwhelming, uncontrollable experiences that psychologically impact upon a person by creating in them feelings of helplessness, vulnerability, loss of safety and loss of control (James, 1989). When we apply this definition to children, we are reminded that many of the daily events adults cope with are, in fact, scary and traumatic to the young child.

The most common fears of childhood such as lightening and thunder, spiders and snakes, or the dark, are fears which the average adult either no longer experiences or has adequate means with which to cope. (And when they don't have those means, they present in our offices with phobic symptoms.) Natural weather events, insects and animals in the environment, the cycle of light and dark are all cognitively understood by the adult, and yet the extremes of these very same events are what we list as the trauma events. Consider the earthquake of Kobe, a natural disaster, which traumatized the citizens of an entire country. Clearly, there is a continuum for traumatic events, but broadening the definition of trauma is useful to the clinician wishing to treat the youngster with traumatic symptoms. To remember the increased vulnerability of children to most events about which they have little cognitive information and with which they lack emotional experience will increase the clinician's ability to perceive as the child perceives.

I have spoken so far about children in general. Let us now look at the chronically ill child. These are the youngsters who suffer from diseases such as sickle cell leukemia, cystic fibrosis, diabetes, severe asthma, or genetic disorders, to name just a few. The chronically ill child is at risk for more traumatic experiences than the average healthy child. While it is true that there are experiences common to the lives of all children which may be disturbing and potentially traumatizing, for example, divorce and physical abuse, chronically ill youngsters are subjected to repeated clinic and hospital visits, frightening and painful medical procedures, as well as social and emotional sequelae to their illness, on a vaster scale than most children. The adult who is diagnosed with cancer, who receives his/her radiation or chemotherapy in company with other oncology patients who are sometimes physically deformed by their cancers, express how frightening it is to go for treatments. Numerous questions they ask reveal the trauma that is experienced by these clinic visits. Will my cancer progress like that? Will I look deformed? Will I experience more pain, more hair loss? What is it like for the youngster who cannot even articulate his/her fears into questions, but feels only the physical sensations - of dread, of panic, of fear?

While those chronic illnesses that may lead to early deaths, i.e. before adolescence, have received much attention in the "death and dying" literature, with numerous suggestions for helpful interventions, little has been explored about either the traumatic effects on psychological and characterological development for those youngsters whose adaptation to chronicity takes them into adulthood, or the psychological tech-

niques which can be applied to assist their accommodation to their illnesses while lessening the emotional cost. Hypnosis is one of those techniques well suited to the treatment of traumatic symptomology.

In the past two decades we have learned a great deal about trauma and the PTSD it produces. Much of our learning is through the retrospective studies of traumatized adults, with insight, in depth therapy examining their childhood pasts. Lenore Terr (1985) is one of a handful of clinician researchers who has focused on children's traumas. She has had the opportunity to study these youngsters shortly after their trauma, but most of her contributions to our understanding of trauma are limited to the most extreme kinds of events such as the burying alive of a school bus full of children - which even few adults would ever experience. Still, little has been reported on the more common types of traumas which children experience.

Events which are considered of a traumatizing nature have been categorized as:

1) Physical or sexual abuse;
2) Accidents;
3) Chronic illness, medical procedures;
4) Death - loss of parent or sibling;
5) Divorce;
6) Natural disasters;
7) War.

A discreet single event that is traumatic seems to be less damaging than some forms of trauma, such as physical and sexual abuse which are often of long duration. We know that the risks for a more serious degree of post-traumatic stress disorder increases with the duration of exposure to trauma, among other factors. Therefore, it would seem that the implications for children with chronic illness is that they are at risk for a greater degree of PTSD than youngsters who experience a single distressing acute medical event. The research by Yehuda Nir which looked at PTSD in children with cancer, certainly supports this (Nir, 1985). She found that simple stress reduction techniques or other procedures such as anesthesia, which served to circumvent the traumatic nature of a medical procedure, did not allow for the working through of the trauma, and led to greater PTSD symptoms.

As with all psychological illness or symptoms there are usually multiple determinants. No two children are alike, and each will react in his/her own unique style to the same medical procedure. Some of the other factors which predispose children to psychic trauma include temperament, biological factors, experience with nuclear family, prior experience with trauma, and developmental stage.

This last factor, developmental stage, is a primary one in allowing some prediction for the degree of trauma any event may incur, but is often misunderstood, forgotten or ignored. The tendency to expect a child's reaction to be like those of an adult, reminds us of Randall Jarrell's quote: "One of the most obvious facts about grown-ups, to a

child, is that they have forgotten what it is like to be a child" (From *The Man Who Loved Children*). Of importance in this statement is that many experiences which would not be traumatic to an adult, are to a child. An example of this is the three-year-old child's fear that he/she will be flushed down the toilet. It is the "undeveloped" nature of the child which is a major factor in their reactions to many experiences producing PTSD behaviors.

At the same time, what might be considered very traumatic to an adult, may not be at all traumatic to the younger child who has no concept of the experience that would place it in a traumatic category. An example of this would be the two-year old's reaction to a "Flasher," someone exposing their nakedness publicly. To the two-year old there seems to be no trauma context in which to place this behavior. Instead, it is simply interesting like so much of the world they are learning about. Beverly James' work on childhood traumas, and traumagenic states, illustrates how complex the relationship is between developmental state and the psychological response to trauma (James, 1989). And when a trauma occurs even before language is fully developed, at very early stages of development, there may be no conscious memory for the trauma and yet psychological and somatic manifestations of the post-traumatic states may be present. It is in this context that we understand the meaning of Lenore Terr's words that "perception is more basic than cognition" (Terr, 1985, p. 67). "Once a traumatic perception is taken in, it may forever remain an indigestible part of the growing young personality" (ibid., p. 67).

There are several popular models for understanding the responses to trauma. The work of Horowitz (1986) emphasizes the symptoms, the intrusion/warding-off process. The work of Bessel van der Kolk (1987) emphasizes the biological component of responses. Bennett Braun's (1988) work emphasizes the dissociative inducing quality of trauma. Ann Burgess's work primarily based on physically and sexually abused children, emphasizes the phasic nature of trauma (Burgess & Grant, 1988). This is not an exhaustive lists of models but is included to remind the listener of the extent of research on trauma now available to the clinician.

While it is beyond the scope of this paper to explore the need for long term studies on the nature of trauma in childhood, it is clear that a model that combines childhood developmental principles with what is known about PTSD is still lacking. This paper hopes to assist the process of bringing such a model closer to fruition.

The prevention and treatment of trauma in chronically ill children can be achieved when the empowerment, mastery and ego-strengthening which comprise the vital defenses for surviving are both fostered and bolstered by hypnosis. Hypnosis lends itself well to the therapeutic treatment of these youngsters because of three elements which are common to the hypnotic experience: relaxation, imagery, and dissociation. Unlike play therapy, which is an extremely useful therapy modality with the child population, hypnosis is often quicker in achieving symptom relief and often allows direct and indirect suggestions to be accepted into the conscious and unconscious mind

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with less resistance than those made outside of the hypnotic state. It is not always possible, nor is it always necessary to induce hypnosis in a formal manner, especially with very young children - hence the term hypnoidal techniques. I have adopted this name to refer to those techniques which are hypnotic in nature and are introduced when a youngster is in a naturally occurring altered state. This permits the sensitive use of these techniques in a well-timed manner. While I write from the perspective of the clinicians office, where treatment of trauma is more often the focus than is the prevention of trauma, these techniques are easily transferable to the medical setting where prevention of trauma may become the focus.

In fact, I would like to note that while my current practice is that of the private clinician, my introduction to hypnotic techniques occurred 20 years ago, and in the medical setting. I consulted with a pediatric burn unit, a kidney dialysis unit, an oncology unit and a cystic fibrosis unit in two large hospitals of an urban city. It was in these settings that I observed the quality and degree of trauma to which youngsters were exposed, all within a context of "helping" these youngsters. To fully appreciate the relief which hypnoidal techniques can bring to a child, it is helpful first to examine the post-traumatic symptoms they may experience.

The symptoms which characterize PTSD fall into three categories:

1) Those of reexperiencing the trauma - the intrusive symptoms such as flashbacks and distressing dreams,

2) those of numbing and avoidance, such as restricted affect or inability to recall trauma, and

3) those of increased arousal and hyperalertness such as difficulty sleeping or concentrating.

The 1994 DSM IV definition of PTSD by the American Psychiatric Association includes some characteristics of symptoms specific to children.

Treatment begins with careful assessment. The nature and degree of post traumatic symptoms present in a chronically ill child is a first step to planning an intervention strategy. There are many signs of PTSD in youngsters, but I will summarize the major signs to be recognized: sleep disturbances for more than several days; separation anxiety or clinging behavior and other regressed behaviors such as a return to bed wetting, to thumb sucking, back to the parental bed; phobias about distressing stimuli that remind a child of a traumatic event; conduct disturbances at home and/or school; irritability; doubts about self, including comments about body confusion, self-worth, and desire for withdrawal. In other words, similar signs of reexperiencing the trauma, emotional numbing, and/or hyperalertness (as in the adult) may be present relative to the child's developmental stage. It is much easier to imagine a discreet trauma for the acutely ill, such as an unplanned surgery or an invasive medical procedure.

This past summer, my cousin's daughter visited our family, and I was reminded of just such an event. This 11-year old shared her experience of a tonsillectomy the pre-

vious year. Her parents, both surgeons, had thoughtfully prepared her for the surgery. They explained the necessity of the procedure, the anatomy involved, the steps in the surgical procedure. She understood that the repeated (chronic) illness she experienced would decline following the surgery and was highly motivated by this knowledge. As she described the pain following the procedure, the doctors who lied and told her she could eat all the ice cream she wanted, but in fact, she could eat none, because of her acute pain, I heard the trauma described from the child's perspective. I was reminded of my exact same words following my tonsillectomy 3 decades earlier. "It hurts too much to eat this ice cream, why did the doctor lie to me?" This had been a traumatic experience for her, as mine had been for me. Mine had been further complicated by the need to stay in the hospital overnight, without a parent. I did not sleep well for months following my surgery. In the intervening years between my surgery and hers health professionals at least have eliminated the need to add separation fears to the already traumatic event of tonsillectomies. But the surgery experience remains traumatic to some. This is an example of the discreet traumatic event.

What is the effect on a youngster when the traumatic events are layered, as in the chronically ill? When they are exposed to spinal tap after spinal tap, when they have blood drawn daily, or weekly, when they receive injection after injection, how do they perceive these repeated mini-traumas. Some would argue that the repetition leads to desensitization. Others would argue that the secret life of the child keeps hidden the real trauma of these events. I do not believe we yet have an answer to this question. We only can conclude that the intensity, the frequency, the duration of these experience are powerful influences in the child's development.

Any treatment which may successfully integrate the child's traumatic experience into his/her developing personality, his/her understanding of the meaning of life, is welcome. Those which promise quicker results are even more desirable. Hypnoidal techniques can be woven into treatment of these youngsters in both the clinical and medical setting. There are three areas of focus in child treatment. These are empowerment, mastery and ego-strengthening. One may begin with those techniques which empower the child. Child development teaches us that building trust and establishing control are basic human needs. The sense of trust may be disturbed in the chronically ill child who, for example, is told well-meaning, but untrue platitudes by health professionals. "This won't hurt a bit" is a common statement. The other side of this is the well meaning extremely honest physician who unwittingly suggests discomfort. The physician who says "I'm sorry I have to give you this injection and it will hurt," hardly appreciates the heightened suggestibility of the frightened youngster, who by his/her very frightened state is most likely already in a trance state. The physician who describes the impending procedure, describes the wide variety of responses other youngsters have exhibited in response to the procedure and then invites the child to consider how he/she might respond, challenges the child to set a positive expectation and finally to observe his/her own response is demonstrating the use of hypnoidal technique. This is

an expanded version of Show and Tell which can place the child in the driver's seat with the adult. It is empowering for the youngster. The child's attention is focused, his/her motivation is increased, an hypnoidal suggestion is made and the child's trauma is minimized or eliminated.

A child's control of their environment, their emotions, their relationships may be disturbed by repeated exposure to painful procedures. Restoring both their sense of trust and mastery can be done through supportive suggestions. Again this can be hypnoidal, without need to induce a formal trance. Suggestions for relaxation are useful, especially within an environmental context that is relaxing. A quiet room, painted in a peaceful color is a far better setting than a busy waiting room. Suggestions for rhythmic breathing modeled by an adult can also be useful. The more advanced dream alteration techniques also enhance control. This involves teaching a child to change the ending of a bad or scary dream to the ending they would prefer. In adults we have learned the power of this technique when used with lucid dreams, those the dreamer knows is a dream as it is being dreamed. With children, just the suggestion that their dream can end the way they wish it to, enhances their sense of control and mastery.

While there is no intrinsic hierarchy in the choice to focus on empowerment, mastery or ego-strengthening, as in most therapy the relationship is pivotal, and hypnoidal techniques which enhance trust can be focused on first. In some instances this may be all that is needed to resolve the PTSD in children. For the physician who is thinking in terms of prevention of PTSD symptoms, empowerment and mastery will be the primary focus. Strengthening of ego-boundaries can come later and is usually under the purview of the treating clinician. The young child's personality is not even considered established until about the age of 7, so ego-strengthening has a different meaning than with the adult. Imagery and storytelling are useful to strengthen ego-boundaries and help to modulate affect. Once some trust and increased control has been restored in the traumatized chronically ill child, then some uncovering work can proceed to deal with the stored affect of fear, sadness, and anger. Internalizing protective, soothing imagery, or inserting a benign adult can be done through storytelling and imagery which makes it safer to express feelings. And establishing a healthier world view through hypnotically mediated cognitive therapy can lead to greater adaptation, along with hypnotic storytelling which gives purpose and meaning to the traumas.

I would like to illustrate these techniques through the following case studies. It is important to note that several principles guide my therapeutic work. My focus is on the relationship, it is client-centered in so far as I believe the child knows what it needs emotionally, and it is educational. The latter is characterized by providing cognitive input about their chronic illness and about the experiences of other youngsters like themselves.

Case one

Wendy (not her real name) at the time of her referral for treatment was an 11-year-old female with Cystic Fibrosis disease. Cystic Fibrosis (CF) is a chronic hereditary illness of the pancreas

and lungs characterized by an inability to fully digest foods and difficulty in breathing. Certain cells of the body secrete large amounts of mucus, which block the lungs and pancreatic ducts. Medical treatment may include medication to aid digestion, physical therapy to dislodge the mucus of the lungs, and antibiotics to reduce infection. The disease occurs with varying degrees of severity and can be life threatening.

The presenting problem for Wendy was anxiety and separation difficulties, described by the parents as her inability to be by herself in the home after school. Wendy came from an intact family, a first marriage for both parents. There was one sibling, a brother age 15. Wendy's birth was unremarkable, but within 24 hours she was having green spit, and was hospitalized for 12 days with "Meconium ilius" (blocked intestine) from which she recouped well. CF was ruled out at that time. She continued to thrive although mother noted bronchitis at two months, and copious smelly stools. When she was fully weaned at 24 months further problems were noted, and again CF was investigated. At age 2 years, 8 months the diagnosis was confirmed. She was again hospitalized for 4 days, during which time the family received training in Pulmonary Therapy (PT). Her early childhood seems to have been warm and supportive, as this bright and sociable youngster adapted easily to school, had many friends and coped well. An antibiotic regimen was started in first grade. By third grade, the parents noticed a youngster who had major bouts with depression and anxiety which moved in waves. Wendy had grasped the meaning of death and its permanence, and the threat of her own illness. According to her parents she had latched on to the metaphor of "AIDS" to describe her future with CF, and asked a "million questions about CF." In 4th grade Wendy was admitted to the hospital overnight for what was described as unmanageable asthma. She had developed phobias about germs, and struggled in a love/hate dependent relationship with the pulmonary therapy and her mother. There were frequent bad dreams, which she described as not being able to differentiate from reality. The parents feared that her dreams were "almost psychotic," that Wendy was too fragile, and needed a way to nurture herself. She was skipped into 6th grade, where she had more friends and better support system. She was also begun on a Swedish system of PT which utilized a PET mask machine which she could do by herself. The parents felt that was vitally important to encouraging independence. Anxiety symptoms had kicked up when Wendy began this independent treatment for her lungs. In summary, she was a preadolescent exhibiting symptoms of PTSD seen as related to the history of CF. Therapy was begun.

Mother had kept a careful journal of events in Wendy's life over the years which proved very helpful to treatment. (Not to mention to mother's coping ability.) She had never fully addressed the issue of fatality with Wendy but had written in her journal the kinds of questions that Wendy had asked on the topic, mostly oblique ones.

Wendy began treatment willingly, and described her "problem" as "worrying too much about getting sick," and having too many fears.

After establishing rapport, and expectations for therapy, I began to teach Wendy relaxation and imagery techniques. No formal hypnosis was induced, instead, Wendy was invited to take a journey with her imagination and to travel to the "perfect place" in the universe. Wendy spontaneously closed her eyes, and with suggestions from me about what kind of places she might journey through and to, she settled into a quiet reverie. I suggested an inner guide might appear on this journey, human, animal or of any other living form, and that she could ask difficult questions of this inner guide. No questioning or ideomotor signaling was done. After Wendy was finished with her journey, and returned to an alert state, she shared her wonderful imaginary trip. Her journey had been beautiful, full of waterfalls, beautiful hedges and flowers. Her inner guide had been a tiny green tadpole-like creature with suction cups for feet. How perfectly natural for a child with CF - a creature which can live in water, is mucus green, and suctions.

Wendy was then encouraged to go back on her journey to her perfect place, even magical

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place, while I inserted ego-strengthening suggestions about the independent, capable young adult who could journey on her own in the world at large. She was encouraged to repeat her journey every day, and change it as she wished.

At the next session, Wendy began discussing her bad dreams, complained of her parents being around too much, and told me of plans for a co-ed Halloween party. I suggested she finish one of her bad dreams the way she would have liked it to have ended. She described a different ending, and I then suggested she picture the ending in her mind. She spontaneously closed her eyes, and then reopened them. I also suggested she imagine the party, a few weeks away, just the way she wanted it to be. Watching for behavioral manifestations of an altered state, I was able to make further ego-strengthening suggestions to which she was very receptive. Such behavioral manifestations include focused or narrowed attention, an absorption into the emotional moment, what Ernestine Hilgard labeled in younger children the capacity for "imaginative involvement" (LeBaron & Hilgard, 1984) and/or a dissociation from the surroundings, as the youngster is turned more inwardly. Sometimes eye closure, although this is less frequent in younger children, may also be present.

After 5 sessions, Wendy and her parents noticed a significant change in her behavior. She was more relaxed, less anxious, more self-confident, and able to stay at home by herself comfortably. There was no report of bad dreams. Play therapy was continued. It was during this time that her thoughts about her future and her anxieties about dying were explored. Such exploration must be done sensitively. The youngster is aided in finding the names to describe the feelings which accompany the fears. After another ten sessions, Wendy contracted the flu, and became very ill. Her CF complicated her recovery, but after about a week she returned for therapy. She was mildly depressed, and expressed upset with the doctors, for she learned some facts about her condition that had not been shared with her before. She had a drop in lung function, prior to her flu, which she did not know about. After expressing her anger, she reported that her relaxation tape, which we had made at the fifth session, helped her to get through the scary times when she couldn't breath. After 23 sessions, Wendy stopped regular treatment, and all PTSD symptoms had subsided. At a 6th month follow-up she continued to be doing quite well.

Beverly James has documented the need for staged treatment of traumatized youngsters (James, 1989, p. 5). Sequencing treatment to meet the varying requirements of different stages of development allows issues to be revisited as the growing child adds new or different meaning and understandings to past traumas. This serialized style of therapy, dissimilar to the uninterrupted treatment most often practiced with adults, encourages the traumatized child to keep some form of contact with the therapist throughout the child's development, at critical developmental stages or when a new trauma is experienced.

Wendy returned for treatment 2 years later, due to a new trauma. Now aged 13, she was fully adolescent in her presentation. This time her trauma was non-medical, her parents had announced they were divorcing. Her major symptom was depression. She denied any depressed feelings, in fact denied feeling anything at all about her parents' announcement. She complained about not liking school, some teachers who caused her difficulties, and the wish to change schools. As she was engaged in talking about her peer life she shared many stories about her close friends who were having family difficulties. It was not necessary to make conscious this parallel between her problems and her friend's problems, for Wendy responded well to the hypnoidal technique of describing what advice she would give these friends. This technique when done in formal hypnosis asks the client to see on a TV screen, movie screen or on a stage his/her problem now the problem of the neighbor, or a friend. The client is then asked to advise the neighbor or friend what to do to resolve the problem. It is a useful technique to find out what the client needs for his or herself. Wendy knew exactly what each of her friends needed. She was full of advice. Wendy became noticeably more animated by the conclusion of this first session.

Although the first session had been at the insistence of Wendy's mother, Wendy requested another session. In fact she continued for 10 more sessions over the course of 6 months. The parents were still living in the same home, and were planning to have the last Christmas together with relatives in another state. I was concerned about the numerous "endings" which Wendy would be experiencing and how that might recapitulate her old fears about dying from Cystic Fibrosis. Her previous ego-strengthening, however, seemed to be intact and she weathered all of these events without any other PTSD symptoms. Her mood improved rapidly, she even had a friend accompany her to therapy, and ended saying she was sure she would do better than her friends in handling her parents impending divorce. After exploring many other schools at my suggestion, she decided to remain at her current school keeping a good support system for herself.

At age 13, Wendy now had to deal with such peer issues as illicit drug use and sex. She reported that she had no interest in smoking marijuana because it would compromise her lung function too much. She was able to tell her peers this openly without fear of rejection. During her earlier treatment, we had worked on disclosure of her CF to her friends. They understood her disease and supported her decisions. Similarly, her budding interest in sex was also intertwined with her chronic illness. If the reader will remember her earlier metaphor for her illness was AIDS. She tentatively asked questions about the genetics of her disorder and I laid the groundwork for future work as she continues to mature.

Case two

The next case is about a 15-year-old male, whom I will call Keith, with PKU (Phenylketonuria) a metabolic disorder which can lead to mental retardation if untreated. Keith came from an intact family, of parents each in their 2nd marriage. He had two half sisters, much older, and had been raised like an only child. Keith's diagnosis was made 7 days after birth, and he was started on the PKU diet by 10 days of age. Proper dietary interventions reduce the likelihood of retardation.

Keith was in the hospital at the time of referral because of noncompliance with medication, fairly common with adolescents who are struggling with being independent, and feel invulnerable. His social worker thought that hypnosis might make him more compliant. No one had been able to help him manage his regimen, and I was the "last ditch effort." He was considered a behavioral problem by his parents, by the clinic, and at times, by the school. He had, for example, told off the Driver Education teacher, and been thrown out of the classroom, went into the hallway, and hit a locker so hard, his hand required bandaging for a week.

When Keith came for his first visit, he made it perfectly clear that he was having none of this hypnosis stuff, and was only here because he had no choice. I agreed with him. I commiserated about his having no choice, how unfair it was that so many people were telling him how to run his life, and he probably wouldn't be a good hypnotic subject anyway. This surprised him and established a good rapport quickly. We then discussed how I might be able to be of help, but it was his choice. He agreed to work with me for 5 sessions, with the goal of being able to drink his awful medication.

This youngster was above average in intelligence, enjoyed sports, had a small close group of friends, and showed signs of Attention Deficit Hyperactive Disorder (ADHD). His father had a serious heart and arthritic condition, was unable to work and had recently gone on disability. Mother was the primary breadwinner, worked hard and traveled a great deal for her job.

Keith agreed to bring his medication to the first session. He arrived with a brown paper bag, and shook the bag (like a milkshake) for quite a while before announcing that he had brought "the stuff."

"Do you want to smell it? It's really foul!," he told me.

"Sure, let me smell" I replied.

"See how thick it is, and this awful purple color - I suppose it's supposed to be like grape

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juice," he continued.

"Can't they make it look and taste like Pepsi?" I asked.

Keith stopped, looked long and hard, and said, "Yeah, why couldn't they?" He appeared to be quite focused, and I saw an opportunity for my first hypnoidal suggestion. "Let's have a smell."

He unscrewed the lid and I smelled - "Yuk, you gotta drink this stuff? I'd hold my nose, if I were you - have you ever tried that?"

"Now - I just drink it, but it's so thick it gets stuck," he said.

"Yeah, like a milkshake, they're so cold, and thick, sometimes I have to hold my nose to drink them" I replied. (I physically held my nose.)

Keith was engaged at this point. I moved on to my next suggestion. "Gee, if I had to drink that stuff, I'd want to do it quickly and be done with it." (Keith was known to have taken as long as an hour to drink just 10 ounces.) "Let's see how quickly you can get this awful stuff down. Want to play beat the clock?"

Keith said yes, and we settled on a time. I suggested three minutes, he thought he could do it under two minutes. And he did. For the next several sessions, with the distraction of racing the clock, Keith did wonderfully with his dietary supplement. His lowest time was 49 seconds. He felt increased confidence, and was reported doing better in school. I suggested he might imagine himself after having just successfully drunk the supplement, letting that wonderful feeling fill him, to practice in his mind like the athletes do, before their flawless performances.

Keith responded to showing and telling his story. He had been a victim of his PKU, of the neurologist, and was afraid of the seriousness of his father's illness. Now he felt like a hero. His anxiety and depression decreased. Conduct disorder at home and school stopped. His phobic behavior toward his supplement lessened. His friendships with peers improved. He agreed to another 5 visits, and another and another, 20 in all. This youngster moved on to do work on his anger at having to take his supplement, the stress of his father's illness, and the pressure to do well in school, to please his parents. He vented tremendously about his anger at the neurologist, who he described as terrifying him over the years, and bullying him into watching his diet. "When you feel that anger, Keith, get a picture of the doctor on one side of the TV set, then a picture of you feeling strong and in control of your life, with the same intensity as your rage on the other side of the TV set," I said. He used this technique successfully to redirect his anger more positively. He expressed how much he hated hospitals, and shared the scary things that he had seen happen there. When Keith saw his father hospitalized during Keith's treatment with me, it reminded him of his own fears in the hospital. "What can you say to your father to make him feel better? What do you wish people had said to you?" I would ask. "Just imagine you are saying those things right now," I would suggest.

As with Wendy, these suggestions were made when Keith exhibited behavioral manifestations of a trance state.

Keith pursued his driver's license, and a job. He quickly became a responsible member of the family, helping with his ill father. Some of his other PTSD symptoms continued, particularly his hyperarousal behaviors, but when he stopped treatment he said he was doing so because he felt better. Unfortunately, he also decided to stop going to hospitals for blood tests, to stop his supplement, and to just use dietary control. (The recommended age at which to do this is a matter of some controversy, with the current research suggesting it could be for the duration of life.) At a 6th month follow-up, he was doing well in school, had kept his job in the pizza parlor, and reported managing better with his parents, especially now that he was driving. He even told me that maybe someday he'd be back to learn about that "hypnosis stuff." Eighteen months following treatment I received a phone call from Keith's father, reporting how well they both were doing. Keith was preparing for school exams, had received very good school grades, and was set on going to college. Because of his ADHD diagnosis he qualified for an untimed test. His results

on the tests were so good, the family once again called to report the news to me.

Comments

These two cases illustrate the use of hypnoidal intervention in the psychological treatment of trauma in youngsters with chronic illness. The value of hypnoidal techniques is often unrecognized. They are an underutilized resource for the clinician working with chronically ill children. Children's easy movement between reality and fantasy, their capacity for imaginative involvement, and the rapidity with which they become entranced allow the use of hypnoidal techniques. When these techniques are interjected in treatment in a developmentally appropriate manner for empowerment, mastery and ego-strengthening these youngsters can experience a rapid resolution of PTSD symptoms. Like Billy and Susie who benefited from Show and Tell at school, the chronically ill youngsters can benefit from showing and telling their stories.

References

Braun, B. (1988). The Bask model of dissociation. Dissociation, 1 (2), 16-23.

Burgess, A. & Grant C. (1988). Children traumatized in sex rings. Washington, D.C.: National Center for Missing and Exploited Children.

Eth, S., & Pynoos, R. (1984). Post traumatic stress disorder in children. Washington, D.C.: American Psychiatric Press.

Gardner, G.G. & Olness, K. (1981). Hypnosis and hypnotherapy with children. New York: Grune and Stratton.

Horowitz, M.J. (1986). Stress response syndromes (2nd ed.). Northvale, NJ: Aronson.

James, B. (1989). Treating traumatized children. Lexington, Mass. D.C., Heath and Co.

LeBaron, S. & Hilgard, J.R. (1984). Hypnotherapy of pain in children with cancer. Los Altos, CA.: William Kaufmann, Inc.

Nir, Y. (1985). Post Traumatic Stress Disorder in children with cancer. In S. Eth & R. Pynoos (Eds.), Post Traumatic Stress Disorder in children (pp. 121-132). Washington D.C.: American Psychiatric Press.

Terr, L. (1985). Children traumatized in small groups. In S. Eth & R. Pynoos (Eds.), Post Traumatic Stress Disorder in Children (pp. 45-70). Washington D.C.: American Psychiatric Press.

Van der Kolk, B. (1987). Psychological trauma. Washington D.C.: American Psychiatric Press.

Wester, W.C. & O'Grady, D.J. (Eds.) (1991). Clinical hypnosis with children. New York: Brunner/Mazel.

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Preparation of Patients for Stressful Medical Interventions

Some very simple approaches

Christel J. Bejenke

■ *Physicians who treat somatic conditions usually assume that hypnosis is not applicable to their practices because of the time required to learn and to apply it, and because they believe that their patients would be neither interested nor benefit sufficient to justify such efforts. The author shows that patients about to undergo medical interventions are exceptionally receptive to approaches derived from, or related to hypnosis. She gives examples of those approaches which require no additional time with patients and no special training for physicians. These are applicable to practically all medical specialties and can be of significant benefit to patients and physicians.*

The degree of distress patients experience in the period surrounding medical interventions is often underappreciated: Many patients are fearful, bewildered, overwhelmed, and feel intimidated. They may experience a sense of helplessness, dependence, and loss of control. They frequently see themselves as victims of their illness, of a 'hostile system', and as passive recipients of complex medical technology.

Our patients deserve to have strategies available which can alter these perceptions. But physicians who treat somatic conditions are reluctant to consider hypnosis even when they believe that hypnotic approaches might be beneficial:

1. They don't have the time to learn sophisticated hypnotic techniques.
2. They believe that much additional time must be spent with patients in order to achieve the desired results; yet such time does not exist in our practices.
3. And finally: our patients don't come to us to be hypnotized! They consult us to have somatic medical needs taken care of.

My experience as an anesthesiologist who has used hypnotic strategies with over 3000 patients, has taught me that benefits can be achieved surprisingly quickly and much more easily than is commonly assumed. In fact, in order for our patients to benefit,

1. We do *not* have to have extensive training in hypnosis.
2. We do *not* have to spend much additional time with our patients.