

**ERICKSONIAN HYPNOSIS AND  
HYPNOTHERAPY: A CASE STUDY OF TWO  
PRIMARY SCHOOL CHILDREN  
EXPERIENCING EMOTIONAL DIFFICULTIES**

**RENÉ ALICE DANIELS  
BA, BA HONS (Psych)**

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**SUPERVISOR: Prof R. NEWMARK  
CO-SUPERVISOR: Dr S. BADENHORST**

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# DECLARATION

I the undersigned, hereby declare that the work contained in this assignment is my own original work and had not previously in its entirety or in part been submitted at any other university for a degree.

.....  
**Signature**

**Date**



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# SUMMARY

This study aims to explore the utilisation of hypnosis and hypnotherapy in providing therapeutic support to two primary school children who experience emotional difficulties. The purpose of this study is to ascertain what the emotional experiences of children are during the process of Ericksonian hypnosis and hypnotherapy. I attempted to utilise an Interpretive/Constructive paradigm, as it acknowledges that individuals construct their own realities based on their personal experiences and perceptions. In line with this perspective, the Ericksonian approach accepts and utilises whatever individuals bring with them into therapy in a respectful and gentle manner. The research design consisted of two case studies. I requested that parents of both participants complete a background questionnaire. This was followed by an unstructured interview with the parents and class teachers. Another unstructured interview was warranted in both cases.

I utilised the assessment criteria according to Geary's Process model to identify the various hypnotic phenomena in each case. I used the hypnotic phenomena to assist with structuring therapeutic goals. The symptom behaviours and beliefs also impacted on other aspects of the participants' lives. Various themes emerged and linked with the therapeutic use of these phenomena, I attempted to address the problems by utilising the process model of Ericksonian hypnosis. The themes that emerged during data analysis were verified and categorised during data production. A variety of hypnotherapeutic techniques was utilised to help participants gain mastery and control of their respective realities. The Ericksonian Diamond model was utilised to tailor all interventions to the unique needs and developmental level of each participant. The findings of this study indicate that Ericksonian hypnosis and hypnotherapy is a powerful intervention strategy that yields positive results in a relatively short period of time with young children. It was found that this therapeutic strategy could be utilised as a main course or an adjunct to other therapeutic interventions. My study concludes by acknowledging the limitations and provides recommendations for future research.

# SAMEVATTING

Hierdie studie poog om die benutting van hipnose en hipnoterapie te demonstreeer in die terapeutiese proses van twee primêre skool leerders, wat emosionele probleme ervaar. Die doel van die studie is om te bepaal wat die emosionele ervaringe van jong kinders gedurende die proses van Ericksoniese hipnose en hipnoterapie is.

'n Interpretierende/Konstruktiewe paradigma word gebruik, wat impliseer dat individue hul eie realiteit, gebaseer op persoonlike ervarings en persepsies, skep. In ooreenstemming met dié perspektief, gebruik en benut die Ericksoniese benadering op 'n respekvolle en sensitiewe wyse, ook alles wat die individu na die terapie saambring.

Hierdie navorsingsontwerp bestaan uit twee gevallestudies. Albei ouer pare van die leerders is gevra om 'n agtergrondsvraelys te voltooi, opgevolg deur 'n ongestruktureerde onderhoud met die ouers en klasonderwysers van beide deelnemers. 'n Bykomende ongestruktureerde onderhoud was in albei gevalle geregverdig. Data-analise het my voorsien van tentatiewe temas. Die integrering van die datavoorsienende fases het tot die bevestiging en uitbreiding van die data gelei.

Die assesering is gedoen ooreenkomstig met die Geary Proses model, om sodoende die hipnotiese fenomene in albei gevalle te identifiseer. Hierdie fenomene is benut om die doelstellings vir terapie te struktureer. Die simptome gedrag het ook ander aspekte van die leerders se lewens beïnvloed. Die temas, wat ook verband hou met die fenomene, is aangewend binne die raamwerk van die Ericksoniese Proses model. Verskeie hipnoterapeutiese tegnieke is gebruik om gevoelens van kontrole en bemeestering te bevorder. Die Ericksoniese Diamant model is gebruik om die intervensies aan te pas by die unieke behoeftes en ontwikkelingsvlakke van elke kind.

Bevindinge dui aan dat Ericksoniese hipnose en hipnoterapie in 'n relatiewe kort periode met sukses aangewend kan word by jong kinders. Hierdie terapeutiese strategie kan primer, of met ander terapeutiese prosesse aangewend word. Hoewel hierdie 'n beperkte studie is kan dit moontlik verdere navorsing aanmoedig.

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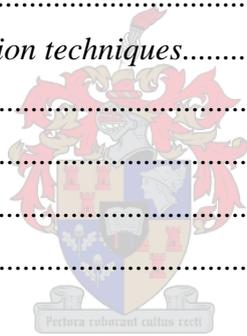
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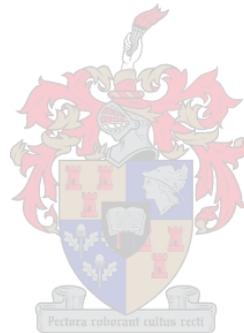
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# CHAPTER ONE

## CONTEXTUALISATION AND ORIENTATION OF THE STUDY

### 1.1 INTRODUCTION

Geldard and Geldard (2002:5) claim that when working with children, psychologists cannot use the same methods as with adults. If we want to engage children to talk freely and openly about painful issues, we need to use verbal skills in conjunction with other strategies such as metaphorical stories. Gilligan (1987:vii) argues that therapeutic communication, the appropriate use of language and the way the message is conveyed can have an immense effect in instilling hope in clients. According to Wright and Wright (1987:4) the fundamental premise of psychotherapy is that problems can be alleviated, by using language to communicate feelings and ideas. Language encompasses both verbal and non-verbal communication through the use of sounds, gestures or signs that have symbolic meaning. Landreth (1991:50) suggests that play is the symbolic language of children and it provides a way for them to express their experiences and emotions in a natural, self-healing manner.

Hypnosis has been used with children and adolescents for over 200 years. One of the first publications concerning child hypnosis was a paper in *Science* an American journal, entitled "Suggestion in Infancy" (Baldwin, 1891 in Olness & Kohen, 1996:15). Baldwin did not focus on hypnosis per se but rather on hypnotic phenomena. Even though one finds evidence of child hypnotherapy dating as far back as the 18<sup>th</sup> century, there are still many professionals that are of the opinion that hypnosis is not appropriate treatment for children (Hartman, 1995:1). Hilgard (1970 in Ioannou, 1991:164) described hypnosis with children as an "intense involvement in imagination". Imaginative involvement and hypnotisability in children are probably related to several aspects of emotional and cognitive development (Gardner, 1974 in Ioannou, 1991:164). Many antecedents in childhood play such as fantasy and imaginary playmates in the developing child make children good responders to

hypnosis. Children are regarded as good subjects for hypnosis and hypnotherapeutic interventions with trance-like states common to their experience. Given their closeness to internal imagery and readiness to pretend or make believe, children are more responsive than adults (London & Cooper, 1969 in Hartman, 1995:6). Most children love to fantasise, pretend or imagine things are different from what they really are. This absorption and immersion in fantasy is actually what hypnosis really is.

Hypnosis is best understood as an "altered state of consciousness or awareness" (Ludwig, 1966 in Brown & Fromm, 1986:3). Most people agree that this state of consciousness differs both from the normal waking state and from any of the stages of sleep. It resembles various kinds of meditative states, especially with regard to focussed attention, primary process thinking and ego receptivity (Fromm, 1977 in Brown & Fromm, 1986:4). Orne (1959 in Brown & Fromm, 1986:4) also found that characteristic of deeper levels of trance is trance logic. Hypnosis is sometimes indistinguishable from physical and mental relaxation, and both adults and children may enter an altered state spontaneously during the course of a day.

In this study I will attempt to explore the emotional experiences of two primary school children during the process of Ericksonian hypnosis and hypnotherapy. In this chapter I will be focussing on the paradigm which underpins this study. The motivation will be discussed as well as the research problem and the research methodology that will be applied in this study. Various key concepts relating to this study will also be briefly discussed.

## **1.2 PARADIGM**

Fouché and Delpont (in De Vos, Strydom, Fouché & Delpont, 2002:265-266) emphasise the importance of having a frame of reference or a paradigm which underpins research. According to Babbie and Mouton (2001:42) a paradigm "is the fundamental model or frame of reference we use to organise our observations and reasoning". A paradigm is essential as it guides the researcher's method of inquiry (Mertens, 1998:2). Mouton (2001:56) refers to the aims and data required to address the question as the research design and is thus viewed as "the research plan".

Valle, King and Halling (in Huysamen, 1994:167) believe the following when doing research: "In the truest sense the person is viewed as having no existence apart from the world and the world as having no existence apart from the person. Each individual and his or her world are said to co-constitute one another". In essence, to truly understand the person one has to put oneself in his or her shoes to gain true understanding of his or her life world ("lebenswelt"). It is therefore imperative to consider all the factors influencing the person's wellness and acknowledge and appreciate the context in which the person lives when studying human behaviour.

The paradigm I chose to conduct my study in is that of the Interpretive/Constructivist approach. According to Dovey and De Jong (1990:1) individuals are in control of creating and constructing their own worlds by attaching meaning to their personal experiences. Mertens (1998:21) reminds us that in the past there was a distinction made only between quantitative and qualitative research methods. She goes on to explain that the Interpretive/Constructivist approach grew out of Edmund Husserl's phenomenology and Wilhelm Dilthey's understanding of hermeneutics as well as the system's approach from Bronfenbrenner (Mertens, 1998:11).

It is the opportune time to discuss briefly the constructivist approach. Gergen (1994 in Donald, Lazarus & Lolwana, 1997:40) states that constructivism, as a theoretical approach to learning and development, has been receiving a lot of attention in the field of psychology. Constructivists believe that individuals construct their own reality and attach meaning to their personal experiences. Donald *et al.* (1997:40) assert that individuals are responsible for shaping their own development which occurs through their own personal experiences within the social and physical environment in which they find themselves. Constructivism can occur at two levels, either at a personal or social level (Mertens, 1998:11). So if I understand correctly, constructivism recognises the vital importance that personal experience and meanings attached to it, play in moulding people's understanding and perceptions of their social environments. Donald *et al.* (1997:40) believe that people are responsible for shaping their own development through their experiences with their world. On the other hand, the positivist/traditional approach claims to emulate reality and people are regarded as things (Le Grange, 2000:192). This scientific method of research is concerned with prediction and control as predetermined by set rules (*ibid*). According to Donald *et al.*

(1997:34) the constructivist approach is concerned with "how individual people and groups at different levels of the social context are linked in dynamic, interdependent, and interacting relationships". The Ecosystemic approach takes constructivism a step further in that it not only acknowledges the individual but the different systems that impact on the individual. Engelbrecht, Green, Naicker and Engelbrecht (1999:4) describe an individual or situation both as a system on its own with various other subsystems that interact with each other and with other levels of a system. Important here is the understanding of the context and the relationship between individuals and their environments. It is possible to intervene at different levels of the human ecosystem to initiate change. However, one also runs the risk of intervening at an inappropriate level and effecting more harm, as the real cause has not been addressed (Orford, 2000:7). What is crucial is that change can begin with the individual and have a ripple effect on the rest of the system or environment. Educational research is social in nature and therefore humans should be understood considering all the systems that influence their lives as meaning is constructed in their natural setting taking into account their context.

A closer look at the Interpretive/Constructivist approach reveals that the environment in which people operate in their daily lives influences their perception of that reality. This implies then that people's knowledge is constructed subjectively and would bring to this research environment their perceptions of what constructs their reality (Mertens, 1998:11). It is therefore of paramount importance that I, as the researcher try to understand and accept what the clients bring and perceive to be their reality. It is my task as the researcher then to describe what the participants experience and try to understand their thinking as they live and experience it. The Interpretive/Constructivist paradigm acknowledges that the researcher and the participants are intertwined in the research process and inevitably would influence one another (Mertens, 1998:12). The research product would then be influenced by my own values, as it cannot be totally independent from them.

The Interpretive/Constructivist paradigm allows me as the researcher to create an environment in which the participants in this case study could share their lived experiences and attempt to support them with a hypnotherapeutic mode of

intervention. These experiences would then be described and rich descriptions would be provided.

### **1.3 MOTIVATION OF THE STUDY**

As an employee of the Western Cape Education Department, I often deal with children at both a primary and secondary level. My workload includes serving 30 primary and 9 secondary schools in the Education, Management and Development Centre (EMDC) of the Central District. As we, as an EMDC, strive to work preventatively, most of the input is given to primary schools. Frequent reasons of referral include trauma either emotionally due to divorce or grief, various forms of abuse including sexual abuse as well as those learners experiencing barriers to learning.

Due to the enormous workload, therapeutic services are limited and brief therapy of at least four to six sessions can only be offered after which referral to other agencies are made. Most of the school-communities served are from the disadvantaged population group and outside referrals are regarded as a luxury. It is with this in mind that hypnosis and hypnotherapy was considered as a brief and effective mode of therapy.

According to Olness and Kohen (1996:29) hypnosis and hypnotherapy have been utilised successfully with various childhood difficulties such as for example anxiety, enuresis, emotional trauma and learning difficulties. It is the researcher's belief that hypnosis and hypnotherapy can have far reaching positive implications for individuals and groups referred to the researcher via the EMDC. This therapeutic tool can be used as an adjunct to other therapies and more importantly can be brief and highly effective.

### **1.4 RESEARCH PROBLEM**

The central question of this study is: What are the emotional experiences of children during the process of Ericksonian hypnosis and hypnotherapy?

The focus of this study is children who experience emotional difficulties. Children generally encounter difficulties when growing up (Brendtro & Du Toit, 2005:3). There are some children who are unfortunate to encounter multiple traumas. They

may be physically or psychologically scared in turbulent environments such as abusive homes and family violence.

Human behaviour is motivated by feelings of pain or pleasure. Greenspan (1997:25) indicated that before children are able to speak, they can experience emotions from anger to joy. By eighteen months, children have developed the capacity to "size up a new acquaintance as friendly or threatening, respectful or humiliating, supportive or undermining in order to behave appropriately" (ibid., 25). By school age, they can also detect a full range of positive and negative emotions in others (Benson, 2003:51).

Traumatic life events may lead to stress, a state of physical and psychological arousal that signals some challenge or difficulty (Lazarus & Folkman, 1984:67). Stressful events make up the fabric of normal life. When stress becomes too intense, it leads to pain and emotional turmoil, which may result in acting out behaviour or the anger and pain are inverted. Many stressors impact on children's lives such as physical stressors for example abuse, hunger and aversive environments amongst others. Social stressors may interfere with relationships, learning freedom and respect. Emotional stressors may produce psychological pain as manifested in feelings of fear, anger, shame, guilt and worthlessness (Lazarus & Folkman, 1984:25). Stress in the family may interfere with parenting and impact negatively on parent-child relationships. This includes frequent moves, lack of relatives or social support, single-parenting, inadequate child-care, substance abuse and neglect. School stressors such as fear of failure could disrupt learning. Inadequate discipline strategies could also increase stress (Barber, 2002:105). When children's basic needs are frustrated they may experience chronic stress. Kaufman (1999 in Brentro & Du Toit, 2003:12) believes that the inability to cope underlies most emotional and behavioural problems experienced by children. Pervasive stress produces pervasive symptoms. According to Kaufman (1999 in Brentro & Du Toit, 2003:12) children experiencing pervasive stress often display both inner emotional disturbance and outward social maladjustment. Children would rather choose to be healthy than ill. Children would gladly trade maladaptive patterns for ones "that serve the same purpose in a more constructive and truly self-satisfying way" (Olness & Kohen, 1996:5-6). This is where the role of hypnosis and hypnotherapy can be utilised, as inner healing can occur using the symptoms and transforming it into solutions.

I have noticed that there is no literature available in South Africa with regard to hypnosis and hypnotherapy with children. This and my interest in Ericksonian hypnosis and hypnotherapy motivated me to do research in this field.

### **1.5 AIMS**

In this study I aim to explore the utilisation of hypnosis and hypnotherapy in providing therapeutic support to young, primary school children who experience emotional trauma. It also strives to show that metaphorical story telling and other methods of creative play could allow for trance states to develop without necessarily inducing formal trance. The emphasis would be on the uniqueness of each individual and how therapist flexibility could assist in tailoring therapy for clients. Lastly, by focussing on these therapeutic experiences an awareness of the process of Ericksonian hypnosis and hypnotherapy will be highlighted.

### **1.6 RESEARCH DESIGN AND METHODOLOGY**

Merriam (1998:11), Babbie and Mouton (2001:72) as well as Denzin and Lincoln (2000:34) are in agreement that research conducted in the social sciences and educational fields are qualitative in nature. Of importance is that the participants should be studied in their natural environments as far as possible. However there are divergent meanings as to what actually constitutes qualitative research. Harding (in Le Grange, 2000:194) distinguishes between method and methodology. Method is referred to as the strategies the researcher uses to gather information and methodology to the interpretive framework that guides the research process. Furthermore, Babbie and Mouton (2001:74) refer to research design as "a plan or a blueprint" the researcher will use and methodology refers to the "research process and the kinds of tools and procedures" that will be used in implementing the study. What is essential is that the researcher works in a specific paradigm and use the instruments most appropriate for data production. Mouton (2001:56) also suggests that the processes and actions used in the implementation of the data production would refer to the methodology applied by the researcher.

Another important factor is that the researcher should know what is going to be observed and analysed and know why and how the phenomena is going to be observed (Babbie & Mouton, 2001:72). This study will be an inductive case study in

which two primary school children, who experienced emotional trauma, will receive psychotherapeutic intervention with hypnosis and hypnotherapy as a treatment modality. The four to eight therapeutic sessions will all be conducted at the primary school. Parents will also be required to complete a background questionnaire and unstructured interviews will be done to ascertain reason for referral and collect more information that may influence these young children's lives. It is envisaged that all the therapy sessions will be tape-recorded and extensive field notes made, as soon as sessions end. The necessary consent forms will be completed after permission has been obtained to utilise hypnotherapeutic interventions. Careful observations will be noted and the therapeutic process will be outlined and findings will be discussed in chapter 6.

## **1.7 KEY CONCEPTS**

### **1.7.1 Hypnosis**

According to Battino and South (1999:30), Milton Erickson is regarded as the father of an interpersonal communication approach to hypnosis and hypnotherapy. Erickson explored the parameters of communication, especially indirect communication. He believed that words could be used to influence and maximise previously dormant potentials as well as foster therapeutic change (Battino & South, 1999:30). Haley (1973/1986 in Battino & South, 1999:30) defined hypnosis as being "essentially a communication of ideas and understandings to an individual in such a fashion that he will be most receptive to the presented ideas and thereby be motivated to explore his body potentials for the control of his psychological and physiological responses and behaviour".

### **1.7.2 Hypnotherapy**

According to Olness and Kohen (1996:87) hypnotherapy is the treatment modality, with specific goals and techniques, which is used while the client is in the state of altered consciousness or hypnosis. Hypnotherapy implies therapeutic intervention by the therapist or by the client through self-hypnosis. Hypnotherapy also implies focussing the client's attention to clarify and promote the client's interest and to engage unconscious and conscious resources for an increased sense of well being and

desired change. Wright and Wright (1987:15) hold that hypnotherapy is the therapeutic use of the hypnotic state of consciousness as part of the therapeutic intervention in order to enhance the effectiveness of the child's utilisation of psychotherapy.

Hypnosis is a highly subjective experience and not everyone will present with the same behaviours when in an altered state of consciousness. In this trance state, one's perception of and interaction with the external environment are different from those in a waking state. In this state there is an absorption in a unique internal experience, the fading of awareness of one's surroundings and alterations in perception and cognition (Brown & Fromm, 1986:4). Behaviours such as immobility, eye fixation, slowing pulse rate and change in breathing are a few behaviours that can be referred to as the hypnotic constellation when in a trance state (Edgette & Edgette, 1995).

### **1.7.3 Hypnotic phenomena**

It is believed that a client will present his or her problem in a particular way with the manifestation of specific physiological attributes (Edgette & Edgette, 1995:3). These behaviours form part of normal everyday behaviour but it can also become pathological if one becomes stuck in a particular way of thinking and behaving that may then be detrimental and negatively impact on the person's functioning (Edgette & Edgette, 1995:13). It is therefore crucial as a therapist to utilise the manifested hypnotic phenomena to tailor and gift-wrap the solution. In the Ericksonian therapeutic model, these presenting phenomena form an integral part of the therapeutic process and intervention. Gilligan (1988 in Edgette & Edgette, 1995:17) believes that the therapist should "validate the phenomena and pave the way for their transformation into a psychologically more adaptive solution". The therapist should assist the client to deframe his or her perceptions so that the symptom phenomena are shaped into a hypnotic skill to become part of the solution (ibid., 17). Edgette and Edgette (1995:28) claim that hypnotic phenomena come in complements. Hypnotic phenomena can be used isomorphically (same) or complimentary (opposite) to initiate the desired change. Hypnotic phenomena will be discussed in detail in chapter 2.

Given the above information, this assignment will be structured in the following way:

**Chapter 1** provides an introduction outlining the background to the study, the research problem and the aims of the study.

**Chapter 2** contains an extensive review of the literature. Various definitions of hypnosis, the history of hypnosis and hypnotherapy, process of Ericksonian hypnosis and the hypnotic phenomena will be discussed.

**Chapter 3** outlines the developmental stages, discuss hypnotic responsiveness and various induction techniques with children as well as the Ericksonian Diamond and ARE models.

**Chapter 4** outlines the research methodology utilised in this study. It also provides information of both participants and the manner in which data was collected.

**Chapter 5** the results are presented and reported.

**Chapter 6** outlines the general discussion of the findings of both case studies. In addition, the limitations of this study, as well as recommendations for future research are discussed.

The study concludes with a **Summary** and some **Concluding Remarks**.

## 1.8 REFLECTION

This chapter includes an introduction to this research topic, which provides background information as to why children experience emotional difficulties. The theoretical framework was outlined and the motivation for this study and research problem were included. The research design and methodology were briefly discussed and relevant key concepts outlined. The following chapter will address these key concepts in more detail. In the next chapter the history and theories of hypnosis, the various principles of Ericksonian hypnosis, hypnotic phenomena and the process of Ericksonian hypnosis will be discussed in detail.

## CHAPTER TWO

# HISTORY OF HYPNOSIS AND HYPNOTHERAPY WITH CHILDREN

### 2.1 INTRODUCTION

In this chapter various theories of hypnosis will be discussed. The reader will also be guided through a brief history of hypnosis with specific reference to children. In this chapter the various myths and misconceptions that therapists have to explain to clients before commencing therapy will also be discussed. The principles of Ericksonian hypnosis, the hypnotic phenomena as well as the process of Ericksonian hypnosis are discussed in detail.

### 2.2 THEORIES AND HISTORY OF HYPNOSIS

There have been several attempts at defining and theorising about the nature of hypnosis. Each of these theories and models describes certain aspects of hypnosis but "none can be considered the word in either describing the process or the experience of hypnosis" (Yapko, 1995:24). Zahourek (2002) contends that research in hypnosis with its many individual and uncontrollable variables is like researching psychotherapy itself.

Despite the fact that hypnosis and specifically interest in child hypnosis, has been popular there is still no unifying and common accepted definition or theory of hypnosis (Lynn & Rhue, 1991:3). Hall (1989 in Lynn & Rhue, 1991:3) argued that hypnosis is a collection of techniques in need of a unifying theory. Rossi (1986 in Hartman, 1995:4) also bemoans the fact that since the inception of hypnosis more than 200 years ago, it has been impossible to find general agreement among experts on just what hypnosis is. Hilgard (1979 in Hartman, 1995:4) also agrees that a universal definition of hypnosis is still elusive. Although experts agree that hypnosis is an altered state of consciousness, there is still no simple, single definition. The Ericksonian school, generally accept Yapko's (1995:3) definition of hypnosis "as

skilled influential communication". Despite divergent theories, a brief synopsis of the various theories will now be discussed.

### **2.2.1 Trance as energy channelling**

Franz Mesmer (1734-1815) (Battino & South, 1999:1) is frequently credited with fathering modern theory and practice of hypnosis. He was an Austrian physician who recognised this ancient healing phenomenon and incorporated into a theory of animal magnetism (Olness & Kohen, 1996:7). Mesmer (1779 in Erikson & Rossi, 1976:2) defined animal magnetism as a "force which is the cause of universal gravitation and which is, very probably, the foundation of all corporal properties, a force which actually strains, relaxes and agitates the cohesion, elasticity, irritability, magnetics, and electricity in the smallest fluid and solid particles of our machine". This theory holds that all objects in the universe are connected by and filled with a physical fluid having magnetic properties. If disequilibrium develops in the magnetic fluids, disease results. He believed that when magnetic forces were channelled to the sick person the equilibrium would be restored through a convulsive healing crisis. This is in direct contrast to the relaxed concept associated with trance.

Despite the fact that no evidence supports the existence of this cosmic fluids and animal magnetism, he had tremendous success as demonstrated with two 18 year old female patients (Lynn & Rhue, 1991:23-25). The Franklin Commission appointed in 1784 by King Louis XVI, to investigate mesmerism concluded that Mesmer was a fraud. They believed that the theoretical fluid did not exist and that whatever healing occurred was purely the imagination of the patient (ibid., 26). Mesmerism indicated the dramatic effects and therapeutic potential of imagination, suggestion and the interpersonal therapeutic relationship. Mesmer also understood the importance of the interrelationship between the patient and the magnetiser, known as rapport (Lynn & Rhue, 1991:25). He emphasised that the emotional component in the relationship was crucial during the therapeutic process. The reverse was recognised too, and the term "magnetic reciprocity" was used in 1784. These concepts led to the important therapeutic findings of transference and counter-transference, especially through the work of Sigmund Freud (ibid., 25).

### 2.2.2 Trance as sleep

One of the first investigators that thought of trance as sleep was Jose Faria (1755-1819) (Gilligan, 1987:33), a Portuguese priest, who lived in Paris. He was originally a practitioner of animal magnetism. He advanced a theory of *somnambulism* that theorised that the hypnotised subject entered a state of *lucid sleep*. He believed that this occurred due to the subject's ability to focus attention and concentration. Faria also claimed that subjects had extraordinary abilities such as dissociating from surgical pain. He was one of the first theorists to give credit to the subjects to develop trance and not the magnetiser.

James Braid (1795-1860) (Gilligan, 1987:33), a Scottish surgeon, was another proponent of modified sleep theory. In his many investigations, he requested that his subjects gaze steadily at a spot above eye level. Through his investigations he could give mesmerism a scientific explanation. The above condition was called *neurohypnotism* and later shortened it to *hypnotism*, which comes from the Greek word "hypnos" meaning sleep. Later on he called this sleep-like nature of trance, a state of mental concentration which he later referred to as "monoidism" (having one dominant mental idea) (Gilligan, 1987:33). Braid was impressed with the manner and swiftness with which individuals could go into trance, and paid special attention to those instances in which no formal trance induction produced trance states. He recognised the power of the mind and that children were especially "sensitive" in this regard. Braid also believed that the more a person is hypnotised, the easier it was to induce trance. He also believed that a person could not be hypnotised against their will, and could not be induced to perform acts that they ordinarily would not do when awake (Battino & South, 1999:13).

James Esdaille, another Scottish surgeon, was directly influenced by Elliotson's writings and became an advocate of mesmerism that he called *magnetic sleep*. He performed major operations such as limb amputations using hypnosis as sole anaesthetic (Battino & South, 1999:7). Another advocate of this theory was Ivan Pavlov (Gilligan, 1987:33). He called the trance state as *incomplete sleep*, resulting from the hypnotic suggestions. These suggestions allowed the subject to dissociate from the external world and focus hypnotic communications. According to Gilligan

(1987:34) a trance as sleep is different from the hypnotic trance state, as the latter resembles a relaxed awaking state.

Another advocate of this theory is Ivan Pavlov (1849-1936) (Gilligan, 1987:33).

### **2.2.3 Trance as pathology**

Jean Martin Charcot (1825-1893) (Gilligan, 1987:34) was a distinguished neurologist who studied hypnosis in 1878. His descriptions of hypnosis in neurological terms gave it a new measure of scientific respectability. He owned a clinic but did very little work himself, especially with children. After many investigations with female patients at the Salpêtrière Hospital, he explained hypnosis as a pathological state, a form of neurosis or somnambulism. He theorised that there were three levels of trance; which are catalepsy, lethargy and somnambulism. Charcot however, failed to check the work of his assistants and never personally hypnotised anyone (Tinterow, 1970 in Olness & Kohen, 1996:13).

### **2.2.4 Trance as suggestibility**

Auguste Liébault, a country doctor (1823-1904) (Gilligan, 1987:34) and Hippolyte Bernheim (1840-1919), a student of the former (Gilligan, 1987:34), was the first to regard hypnosis as a natural phenomenon based mainly on suggestion and imagination, clarifying and extending earlier speculation of Braid (Olness & Kohen, 1996:14). They concluded that the hypnotic state occurs as a result of a variety of induction methods "acting upon imagination". They believed that everyone possessed suggestibility and their psychological theory holds that trance is a state of enforced suggestibility due to suggestions given (Gilligan, 1987:35). Both Liébalt and Bernheim found that children were easily hypnotised, as long as they were able to pay attention and concentrate, and understand the instructions. They also recognised individual differences in response to hypnotic suggestions and that hypnosis manifested at varying degrees of depth and that it is not an all or none phenomenon.

### 2.2.5 Trance as dissociation

Pierre Janet (1849-1947) (Gilligan, 1987:34) was one of the first proponents of this theory. He described it as "a state in which the subject's subconscious mind executed cognitive functions away from conscious awareness" (Gilligan, 1987:34). He introduced the term subconscious to avoid the term unconscious. The term subconscious as used by Janet was very close to the notion of the unconscious as Erickson used it. Erickson believed that the unconscious have the ability to carry out intelligent, autonomous and creative activities, the same way Janet believed the subconscious to be.

Ernest Hilgard (1977 in Gilligan, 1987:37) reviewed and revised Janet's dissociation concepts. The neo-dissociation theory describes the hypnotic experience as a temporary detachment by the subject from the usual conscious planning and monitoring functions. By operating independently from reality testing, the subject become less critical and able to develop dissociative experiences such as amnesia, hypnotic deafness, pain control and automatic writing.

### 2.2.6 The 20<sup>th</sup> Century

According to Watkins (1987:17) Freud rejected hypnosis due to the mystery and lack of explanation surrounding the nature of hypnosis. He also underestimated the value of the relationship and abandoned hypnosis after a female patient awakened from her trance state and embraced him. Although his experiences with hypnosis brought him to the discovery of unconscious processes, he later preferred free association and dream analysis. Jung also abandoned hypnosis after he considered the outcome of what happened to three cases he treated successfully. He felt that hypnosis had transference complications, was too authoritarian and too directive (Frederick & McNeal, 1999:24-25). Instead he used a strategy called active imagination. He remained interested in hypnosis and recognised that any traumatic event could precipitate a spontaneous trance state in individuals. During the 20<sup>th</sup> Century there was an upsurge in behaviourism at the same time they rejected it. While interest in hypnosis declined during this period, after World War II interest was renewed as hypnosis was demonstrated as an effective treatment in war neurosis, dental patients

and obstetrical cases. In the 1950s, the British and American medical societies both formally recognised hypnosis as a valid treatment modality (Gilligan, 1987:36).

### **2.2.7 Trance as regression**

Most contemporary theorists reject physical and neurological explanations in favour of psychological models emphasising suggestion, imagination, motivation dissociation and role-playing (Gilligan, 1987:36).

Many theorists have interpreted the hypnotic experience in terms of Freudian and neo-Freudian concepts of regression and transference. Kris (1952 in Gilligan, 1987:36) advanced the concept of **trance as regression** in the service of the ego. Gill and Brenman (1959 in Gilligan, 1987:36) also likened the hypnotic trance state to that of regression.

### **2.2.8 Trance as acquired learning**

Clark Hull (1933 in Gilligan, 1987:37), an American psychologist, in his classic work, *Hypnosis and Suggestibility*, postulated that hypnotic phenomena were acquired responses similar to other habits. In his view, hypnosis is based on the laws of formal learning theory such as associative repetition, conditioning and habit formation.

### **2.2.9 Trance as motivated involvement**

T.X. Barber (1965 in Gilligan, 1987:37) criticised the metaphor of trance as an altered state of consciousness. He advanced a cognitive-behavioural viewpoint that assumes trance experiences to result from "positive attitudes, motivations and expectations toward the test situation which lead to a willingness to think and imagine the themes that are suggested" (ibid., 38). He believed that everyone is capable of developing hypnotic phenomena and that formal induction of trance is unnecessary.

### **2.2.10 Trance as role enactment**

This perception focuses on the social psychological aspects of the hypnotic situation. White (1941 in Gilligan, 1987:38) "described trance as a goal-directed state in which the subject is highly motivated to behave like a hypnotised person". Sarbin (1950 &

1955 in Gilligan, 1987:38) emphasised the enactment of a role and placed hypnotic behaviour along an orgasmic involvement continuum (ibid., 38).

As can be seen from the above discussion, there are divergent theories of hypnosis. Each one has something to contribute to one's understanding of hypnosis and hypnotic phenomena. It also depends on one's framework and orientation to psychotherapy and this will then guide one to the approach, which is just right for one.

### **2.2.11 Milton H. Erickson (1901-1980)**

Erickson's career spanned more than 50 years. He graduated in 1928 at the University of Wisconsin, obtaining an M.A degree in psychology and a M.D. degree simultaneously. He became interested in hypnosis while observing a demonstration by Clark Hull as an undergraduate student at the University of Wisconsin. His first paper, *Possible Detrimental Effects of Hypnosis*, was published in the *Journal of Abnormal and Social Psychology* in 1932, while still employed at the Worcester State Hospital as the Chief Director. His next appointment was at the Wayne County Hospital in Eloise, Michigan as the Director of Psychiatric Research. He later became the Director of Psychiatric Research and Training. This afforded him the opportunity to do various experiments and research on the nature and reality of hypnotic phenomena. He favoured the dissociation model and believed that trance is naturalistic and an individual experience. In 1948 he accepted the position of Clinical Director at the Arizona State Hospital and resigned a year later, giving numerous lectures to psychologists, psychiatrists and dentists as well as conducting a private practice. Haley brought attention to Erickson's perspective when he published his book, *Advanced Techniques of Hypnosis and Therapy, Selected Papers of Milton H. Erickson, M.D. (1967)* and *Uncommon Therapy, The Psychiatric Techniques of Milton H. Erickson, M.D. (1973)*. Erickson received many honours throughout his lengthy career for his outstanding contributions. He especially appreciated the Benjamin Franklin Gold Medal by the International Society of Hypnosis in 1977 and a special issue of *The American Journal of Hypnosis* commemorating his 75<sup>th</sup> birthday (Erickson, Ryan & Sharp, 1983 in Battino & South, 1999:16). The Milton H. Erickson Foundation was established in 1979. There have been numerous Ericksonian institutes and societies created throughout the world after his death in 1980, to promote an interchange of knowledge among practitioners utilising clinical hypnosis

(ibid). The 97<sup>th</sup> Milton Erickson Institute of South Africa (MEISA) was established in 2001.

Milton Erickson has been considered one of the most influential and innovative therapists of the twentieth century. Battino and South (1999:16) believed that he was to the practice of psychotherapy what Freud was to the theory of human behaviour. Erickson suffered many illnesses in his lifetime such as colour blindness, tone deafness, and dyslexia. He also suffered two attacks of polio at the ages of 17 and 51. Many of his followers believe that his personal strife to rehabilitate led to the rediscovery of many hypnotic phenomena and how to use them therapeutically. He revitalised the field of hypnosis by developing a non-authoritarian, permissive and indirect approach to suggestion with or without hypnotic trance.

Zeig (1987 in Lynn & Rhue, 1991:275) maintains that he explored the parameters of how communication, especially indirect communication, elicit and maximize previously dormant potentials and foster therapeutic results. His orientation to hypnosis can be described as naturalistic, permissive and or co-operative (Gilligan, 1987). Erickson emphasised utilising the ongoing experience of the client to foster responsiveness and client-based change. This interpersonal communication system unique to each individual client aimed at tapping unconscious capabilities and resources within the client to effect change. Erickson rejected the notion of insight therapy and instead focused on symptom modification. He emphasised that one must trust one's unconscious to operate, as it will take care of everything in a positive way. He originated the use of anecdotes, metaphors, symptom prescription and various other non-hypnotic tactics (ibid). Because Erickson was atheoretical and did not systematise his work, it was left to others to write up and interpret his work.

### **2.3 MYTHS AND MISCONCEPTIONS OF HYPNOSIS**

It is important to dispel any myths and misconceptions a client might have before embarking on hypnosis and hypnotherapy. There are many myths about hypnosis due to its association with mysticism and the supernaturalism. Hypnosis is often misinterpreted by the public as it is being kept alive by stage hypnosis and television programmes and what they read in "reputable" books. Misconceptions are constant and predictable because of stereotypical viewpoints such as mind control, form of

sleep, weak-willed subjects, altering the mind, creating abnormal personalities and so forth (Battino & South, 1999:19). Battino and South (1999:19-20) hold that one should discern any myths beforehand and that the therapist should spend sufficient time with clients discussing and listening to their viewpoints and expectations. Misconceptions can be a hindrance to the therapy process and should be dealt with professionally to avoid issues of control. The therapist should emphasise the naturalistic nature of hypnosis through the use of everyday examples taken directly from the client's reality (Yapko, 1995:15).

- ***Misconception: Hypnosis is caused by the power of the therapist***

Since the time of Mesmer, the public believed that the hypnotist has the power or can exert power or control over the subject. If the therapist avoids addressing this issue of control or power, it could lead to resistance or create anxiety in the clients and they may become involved in a power struggle (Yapko, 1995:16). Gilligan (in Yapko, 1995:16) said that therapist should strive to explain the goal of therapy as a co-operative relationship. Haley (1963 in Yapko, 1995:15) gave clients the following message: "I can only hypnotise you by you hypnotising yourself; I can only help you by you helping yourself". This explanation tries to convey a shared responsibility during the therapy process.



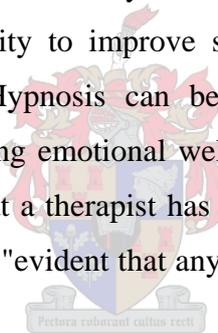
- ***Misconception: Only certain kinds of people can be hypnotised***

Battino and South (1999:20) maintain that hypnotic susceptibility concerns are common amongst the public. A commonly held misconception, is that "25% of the population make excellent subjects, 50% are average subjects, and 25% cannot be hypnotised" (Battino & South, 1999:20). These results have been determined by experimental studies done using hypnotic susceptibility scales such as the Stanford Hypnotic Susceptibility Scale, the Stanford Profile Scales of Hypnotic Susceptibility, the Harvard Group Scale of Hypnotic Susceptibility, the Children's Hypnotic Susceptibility Scale and the Hypnotic Susceptibility Scale (ibid., 21). The instruments used in these experiments rely on standardised scoring criteria in response to certain suggestions. However, the Barber Suggestibility Scale does not depend on standardised scoring. It is a test of suggestibility and relies on the subjective conditions in which an individual responds to suggestions rather than the hypnotic

state. "Barber's research suggests that the most consistent and important variables regarding hypnotisability are the subject-hypnotist relationship" (ibid., 21). Battino and South (1999:21) suggest as a guideline that mentally challenged and those suffering from organic brain disorders, paranoid disorders and schizophrenia do not make good subjects. Using the idea that trance is a common, naturalistic everyday experience, should explain that anyone can be hypnotised if they are prepared to allow themselves to cooperate with the therapist.

- ***Misconception: Being hypnotised can be hazardous to your health***

Hypnosis itself is not harmful; rather an incompetent and unethical practitioner can do more damage due to ignorance about the complexities of the mind or through lack of respect for the integrity of persons (Yapko, 1995:18). It is not hypnosis that may cause emotional harm in therapy but could be related to the difficult content in the therapy session or to the therapist's inability to effectively guide the client. Hypnosis and hypnotherapy have the ability to improve self-control and self-confidence in clients if used appropriately. Hypnosis can be a powerful means of resolving emotional problems and enhancing emotional well-being. Yapko (1995:18) believes that it is essential and crucial that a therapist has ample knowledge and skills to use hypnosis effectively because it is "evident that anything that has an ability to help has an ability to hurt".



- ***Misconception: One inevitably becomes dependent on the hypnotist***

Hypnosis as a therapeutic tool does not foster dependence. Everyone has dependency needs, a need to rely on someone to a certain extent. When clients come to therapists, they are seeking assistance because they are vulnerable and in pain. They depend on the therapists to help, to comfort and to care. However, the goal of any therapeutic treatment is to instil self-dependence and self-reliance. Hypnosis used correctly can help clients to find inner resources within themselves gained from their own life experiences and utilise these experiences therapeutically. Teaching the client self-hypnosis is another powerful way to enhance self-reliance and greater control. There is an old saying: "If you give a man a fish, you have given him a meal. If you teach him how to fish, you have given him livelihood" (Yapko, 1995:19).

- ***Misconception: One can become stuck in hypnosis***

Hypnosis is a state of focused attention, either inwardly or outwardly directed. Hypnosis is controlled by the client who can choose to terminate or initiate the experience at any time of his or her choosing (Yapko, 1995:19).

- ***Misconception: One is asleep or unconscious when in hypnosis***

Hypnosis is not sleep. The experience of formal trance may resemble sleep from a physical standpoint such as, decreased activity, muscular relaxation, slow breathing. The client may seem relaxed but is in fact totally alert. There is always a level of awareness of what is going on even when in deep trance (Weitzenhoffer, 1898 in Yapko, 1995:19).

As mentioned before, it is absolutely important to deal with any misconceptions before attempting to use hypnosis and hypnotherapy with clients as it can impede the psychotherapeutic process. It is now the opportune time to discuss Ericksonian Therapy.

#### **2.4 THE ERICKSONIAN APPROACH TO HYPNOSIS**

Milton Erickson has had a profound influence on human attempts such as anthropology, medicine, psychotherapy, family therapy, and clinical hypnosis. His personal struggle with various illnesses such as polio and colour blindness for example, probably contributed to his life being associated with mastery (Frederick & McNeal, 1999:49). He rejected all notions that therapy could be standardised. It often appears as if he was atheoretical and did not systematise his approaches, but left it to others to interpret his work (Frederick & McNeal, 1999:50). Currently, there exist different versions of the underlying principles of Ericksonian hypnosis. All these scholars such as Gilligan (1987), O'Hanlon (1987) and Zeig (1991) for example, have devised their own understanding of Ericksonian hypnosis, but agree about general principles contained in Erickson's work.

Some of the general principles of Ericksonian hypnosis will now be discussed and are as follows:

### 2.4.1 Each person is unique

In society where conforming is encouraged our uniqueness as individuals is often lost. Frederick and McNeal (1999:50) believe that "cookbook therapy is preferred and that many professional organisations invest a lot of energy in "practice guidelines" basing treatment programmes on a medical model.

What does it mean to regard a client as unique and special? According to Frederick and McNeal (1999:50) "it means that each one of us is the dynamic expression of a particular combination of objective and subjective influences that cannot be duplicated". We each have our own set of fingerprints, own DNA code, own personality traits, own psychological defences, and have our own position in the family with its unique dynamics. Within each one of us, there are aspects which cannot be measured. Each one of us has his or her own goals in life and his or her own individual spirituality that sustains him or her.

Erickson's principle of uniqueness probably developed because of his realisation of how completely special and unique he himself was. He appreciated how all the things that went into his personal make-up, with his problems, contributed to his enjoyment of life and contributing to his masterful development as a therapist.

Erickson always stressed that therapeutic communication should not be based on preconceptions or attempts to place the individual within a theoretical framework. The emphasis should rather be on observation of the individual's patterns of self-expressions such as language, belief, behaviour, motivation and symptoms. Gilligan (1987:14) remarked that, "This is a truly remarkable proposition in that it requires therapists to begin each therapy in a state of experiential ignorance". This implies that therapists become "aliens" seeking a pristine close encounter with the client's "reality" and utilising and accepting it as presented by the client. Gilligan (1987:14) reminds us that we must learn to set aside our old models and develop a receptive state of experiential deframing and become a learner to learn a new client's reality. Zeig (1991:284) holds that utilising and accepting the client's reality would convey acceptance and respect, promote therapeutic alliance as well as provide the platform on which effective interventions could be built.

### 2.4.2 Each person has generative resources

Ericksonian scholars believe that each individual has resources which are inherent in and around each person in his or her environment (Frederick & McNeal, 1999:52). These resources are all available to the client to be utilised in problem solving and healing. Resources can either be external such as family members, friends or medication or it can be internal. When Erickson mentioned resources he specifically referred to internal resources. Erickson maintained that all human beings have resources that come from their past experiences, their present circumstances and even their futures (Yapko, 1990 in Frederick & McNeal, 1999:52). Resources are both conscious and unconscious processes that are inherent within each individual and can be accessed in many ways. Other resources are instinctual, some learned through normal development or in response to stress. Some resources are natural endowments such as intelligence, training and education, quality of upbringing and life successes. Resources can also include life failures such as divorce, unemployment, separation caused by death and inborn challenges. It is believed that it is more difficult to use negative life events as resources, but if properly utilised these negative resources can become sources of strength and confirm the client's uniqueness (Frederick & McNeal, 1999:52).

Although Ericksonian practitioners acknowledge these resources within the client, the client is not always consciously aware that they exist. Gilligan (1987:16) stresses that when clients come to therapists, they are often dissociated from their resources. The therapist task is to activate and elicit latent resources so that they become functional in their lives as well as in the healing process. Some clients, however, may have inadequate resources because of inadequate parenting, sexual abuse, inadequate social and cultural environments, developmental disabilities and so forth. Due to inadequate resources or lack of diverse resources, the therapist may sometimes have to "fill the glass" with resources using ego-strengthening or other therapeutic techniques to assist the client to develop resources (Phillips & Frederick, 1995 in Frederick & McNeal, 1999:53). Ericksonian practitioners should gather as much information as possible from the client as this can be utilised to facilitate healing and change. Using client resistance as a resource to facilitate healing should also be used. Thus any information obtained from the client's immediate environment or past life experiences should be

utilised to create interventions that would facilitate growth and healing. Erickson firmly believed that therapists should use whatever the client brings to therapy, it should be perceived as valuable and helpful in the therapeutic process. And as mentioned earlier, the therapist should also activate unknown resources that reside within the client's unconscious mind.

The manner in which these internal resources are activated are numerous because Ericksonian therapy can be both subtle and complex as it emphasises the use of multi-level communication. Therapeutic communication can be direct and indirect, verbal and non-verbal, anecdotes, metaphors and stories. It embodies the notion that unconscious communication is constantly occurring and that these communication methods should be used in order to bypass the conscious mind. Once these conscious or unconscious resources are mobilized, they can be applied to the presenting problem (Zeig, 1991:283).

#### **2.4.3 Ericksonian approaches orient to course-alignment rather than error correction**

Erickson focussed on attaining goals and needs of the present self, not understanding the past, though important. His approach was a positive one in that the "past signifies multiple learnings, most of them forgotten and some framed in self-devaluing ways, yet all are valuable resources: the present offers endless possibilities for new leanings and self-appreciation: the future holds many potential ways to further self-development" (Gilligan, 1987:19). Any of the client's current or past life experiences are utilised to attain goals whether their learnings are assets or deficits. The therapist's task is to accept and respect the client's worldview and belief system and use these to facilitate self-healing. Because Erickson believed that clients have self-generative resources and self-healing abilities, this natural biological course of personal evolution and errors are regarded as deviations from that plan. Problems are seen as necessary yet secondary aspects of self-development, with solutions or growth as the primary aspect (Gilligan, 1987:19).

#### **2.4.4 The co-operation principle**

This implies that the therapist always adapts to the client. The therapist does not utilise standardised methods nor demand client co-operation. The therapist should

accept the client's reality, as this attitude of acceptance will align the therapist with the client and promote therapeutic rapport (Gilligan, 1987:98). It is the therapist's task to co-operate with the client and not vice versa. The therapist should accept and utilise the client's history, context, behaviour patterns, language, speech and any symptom behaviour the client may present in the therapy session. This should facilitate and promote co-operation from the client and is the basis of the co-operation principle (Gilligan, 1987:99). This is accomplished by pacing and leading the client's experiences in the therapy session. Pacing communications feed back the client's expressions, whether verbal or non-verbal to him or her. No new content is added to the content. This allows for therapeutic alliance and rapport to develop between the therapist and the client. It also enhances the therapists understanding and empathy for the client (ibid). Brown and Fromm (1986 in Frederick & McNeal, 1999:56) also agree that pacing is closely related to attunement and resonance. Gilligan (1987:93) holds that "pacing is essential for effective communication" it establishes a "community" context in which autonomous systems can co-operate within an experientially unified field". Battino and South (1999:48) assert that one of the primary goals of pacing is to lead the client to other states, feelings or postures. The therapist also leads in that new ideas are introduced yet consistent with the client's beliefs and goals. The therapist then tries to lead the client to the desired goal in therapy.

Freud believed that unconscious communication between the therapist and the client is essential for an alliance and analysis to develop (Gilligan, 1987). He believed that "the therapist must turn his own unconscious like a receptive organ toward the transmitting unconscious of the patient. He must adjust himself to the patient as a telephone receiver is adjusted to the transmitting microphone" (Freud, 1912/1964 in Frederick & McNeal, 1999:59). Erickson also had the same sentiments as Freud about the unconscious (Erickson & Kubie, 1940 in Frederick & McNeal, 1999:59). Gilligan (1987:73) also strongly recommends that the therapist adopts an externally oriented interpersonal trance. This allows the therapist's unconscious mind to tune into the clients unconscious feelings, needs and messages. When the therapist enters into his own receptive trance while the client is experiencing trance, an interactive, interpersonal state of high resonance is present. By resonating with clients in this way, the therapists set aside their own conscious processes and are better able to meet the client's unconscious needs in order to provide healing experiences consciously or

unintentionally. According to Watkins (1992 in Frederick & McNeal, 1999:12) "resonance is that inner experience within the therapist during which he co-feels (co-enjoys, co-suffers) and co-understands with his patient, though in a mini form ... it is a "subject" or self-relationship, one in which he commits himself as a full fledged ally with his patient. When resonating, the therapist replicates with his own ego as close as he can a facsimile of the other's experiential world ... and identifies with that replica. Resonance, therefore is a temporary identification established for the purposes of better understanding the internal motivation, feelings and attitudes of the patient".

Furthermore, Gilligan (1987:99) asserts that successful leading depends on successful pacing. Pacing and leading should occur in a naturalistic and non-manipulative manner for it to be effective. Applying both resonance and pacing and leading facilitates healing in a very respectful and gentle manner.

Resistance in therapy is not regarded as bad or that the client is not co-operating. It implies that the therapist should pace other aspects of the client's experience until he or she feels secure enough, because the client's defences may not allow him or her to conform to the therapist's expectations and therapeutic goals as yet.

#### **2.4.5 The utilisation principle**

Yapko (1990 in Frederick & McNeal, 1999:58) succinctly stated that Ericksonian hypnosis is to "accept and utilise". Utilisation is the cornerstone of Ericksonian hypnosis and hypnotherapy. Erickson (1979 in Frederick & McNeal, 1999:49) maintained that, "Each person is a unique individual. Hence psychotherapy should be formulated to meet the uniqueness of the individual's needs, rather than tailoring the person to fit the Procrustean Bed of a hypothetical human behaviour". Zeig (1992 in Zeig, 1994:298) defines utilisation as "the readiness of the therapist to respond strategically to any and all aspects of the patient or the environment". The therapist should work with the client's verbal and non-verbal self-expressions in therapy. This implies that anything the client presents with in the therapy session other than his or her symptoms, his behaviours, language, speech, motivations, social context, fears, transferences, resistances and state of health should be utilised to facilitate healing, growth and change. Furthermore, utilisation requires an intense focus on the clients' views of their concerns, their goals for therapy and their ideas about change. The

focus includes an uninhibited determination to work within and respect the client's frame of reference. Erickson (1980 in Du Plessis & Woudstra, 2003:8) stated that, "The therapist's task should not be a proselytising on the patient with his own beliefs and understandings ... What is needed is the development of a therapeutic situation permitting the patient to use his own thinking, his own understanding, his own emotions in the way that best fits him in his scheme of life".

The staff at the Mental Research Institute (MRI) in California has been studying the processes of psychotherapy especially with regard to logical analysis (Battino *et al.*, 1999:146). The Mental Research Institute (MRI) developed the notion of therapist position or client co-operation in therapy. The MRI recommends quick assessment of the client's position so that the therapist can tailor all intervention to fit the client. In utilising the client's theory of change, it can enhance the therapeutic relationship, increase client participation and most importantly facilitate positive therapeutic outcome (Duncan, Hubble & Miller, 1997 in Du Plessis & Woudstra, 2003:8). Utilising the client's theory of change, proactively builds a strong alliance by promoting therapist agreement with the client's beliefs about change, as well as about the objectives and tasks of therapy. The client and the therapist take joint responsibility for constructing strategies that will fit the client's experience and understanding of the problem. Thus, the strategies represent instances of an alliance in action and also promote utilisation by interactive trance.

#### **2.4.6 Trance is naturalistic and potentiates resources**

In the Ericksonian approach, the naturalistic use of trance processes plays a pivotal role. Haley (1986 in Battino & South, 1999:30) defines hypnosis as "essentially a communication of ideas and understandings to an individual in such a fashion that he will be most receptive to the presented ideas and thereby be motivated to explore his body's potential for the control of his psychological and physiological responses and behaviour". This definition subsumes the "common everyday trance experiences that people enter throughout the day (Erickson & Rossi, 1980 in Battino & South, 1999:30). Often people enter trance spontaneously several times a day. People enter a trance whenever attention is focussed inward for example when reading an interesting book, watching television or even daydreaming. Thus, common everyday trance is

when "attention is fixed and absorbed in some matter of interest that is either inside or outside ourselves" (Battino & South, 1999:31).

What is evident is that one does not need formal induction to enter a trance experience as believed by traditional hypnotists. However, the therapist must know when the client is experiencing a trance state by observing any of the hypnotic phenomena. When trance is induced, the experiential involvement is intensified and extended for a longer duration for a specific purpose. Since the trance state is a natural skill, it allows the therapist to use whatever the client brings to therapy to induce trance by using naturalistic communications. Zeig (1994) asserts that using the client's self-consciousness as a means to induce trance, facilitates the process in which the client enters the trance state.

"The induction and maintenance of a trance serve to provide a special psychological state in which patients can reassociate and reorganise their inner psychological complexities and utilise their own capacities in a manner in accord with their own experiential life" (Erickson, 1980 in Zeig, 1991:281). The task of the therapist is to activate a process of inner resynthesis from which positive outcomes may result. The therapist's task is to create an atmosphere in which clients can be stimulated and guided into action so that experiential learning can occur to allow the client to discover, through his own efforts, a new understanding of his life. Erickson also maintained that all hypnosis is self-hypnosis and that clients receive something from themselves in this process as they try to develop their unconscious potential. To define self-hypnosis is difficult as people define it differently. "Self-hypnosis is an experience of active learning on an unconscious (inner) level when the quality of the relationship (with yourself or someone you trust) is utilised to develop creatively what you already have" (in Du Plessis & Woudstra, 2003:15). It implies relaxing mind-body interaction in which suggestions are responded to favourably resulting in feelings of empowerment as well as enhancing self-valuing and acceptance and self-care.

#### **2.4.7 The corrective emotional experience**

A corrective emotional experience often occurs in psychotherapy and appears in psychodynamic literature. This process implies that the therapist sometimes has to

insert corrective experiences to enhance ego-strengthening in order to facilitate healing in clients. Erickson was fascinated by this concept and believed that corrective emotional experiences occurred more frequently with hypnosis than without (Rossi, 1989 in Frederick & McNeal, 1999:68). The purpose of a corrective emotional experience is to facilitate the development of a new identity for the client. Erickson maintained that this experience was the result of a "complex restructuring of the individual's subjective orientation toward, or understanding his own subjective experience" (ibid). The necessity for this experience may be revealed by an abreaction or identification with or during interaction with the therapist or any other reason. As mentioned before Erickson did corrective work in the case known as the February man which will now be briefly discussed as taken from Frederick and McNeal (1999:68-69).

"Milton Erickson was asked for help by a woman who was married to a physician on his hospital's house staff. She was pregnant for the first time, and she was concerned that she might not know how to be an adequate mother to her child, because she herself had had such an unhappy childhood. She had been unwanted. Her mother repeated to her many times that her pregnancy with the patient had worked devastation on her figure, and her mother had had little time for her. The patient spent much of her early years alone in her nursery. Later she was sent away to various private schools and special camps. She seldom saw her mother, who led a very active social life and travelled quite a bit. She had a warm relationship with her father, and he made time in his busy schedule to have outings with her.

Eventually the patient rebelled against her mother's social plans for her and married a physician still in training. Now, that her baby was on the way, she wondered if hypnosis could be an instrument that would help her in some way to relieve her anxieties from the past and make up for its deficiencies.

In her next session, described by Erickson as cathartic, she was quite distraught. She let Erickson know that memories and feelings concerning her childhood experiences were causing her to develop symptoms, and she wondered if he could really help her. He told her that he would have worked out a plan by the next time they met.

In the following session the patient was informed that there was now a plan and that it would involve hypnosis. She would not consciously have to know about it. Then Erickson spent 5 hours with the patient to train her in hypnosis. Erickson took the patient through a series of hypnotic age regressions. He began with having her recall their previous session ... In subsequent sessions, he continued to age regress her farther and farther back in time, and he offered her "rapport protection", a cue that would allow her to feel comfortable with Erickson no matter what kind of material they encountered. Her repertoire of regressions expanded, and they would be able to serve as a matrix or background into which new, positive material could be interpolated.

Eventually the patient was regressed to the age of 4. Then Erickson introduced himself to her as a friend of her father's. She was then allowed to have a period of hypnotic sleep. This was followed by another visit from her father's friend. And so forth. Erickson gave the patient a series of hypnotic experiences in which he interpolated himself into her life periodically as a friend of her father who visited her every February. During each visit he built on the previous visits, constructing for them a history of their relationship that had never existed in the real world. The patient began to experience Erickson as a regular, reliable, supportive visitor "and trusted confidant to whom she could tell her secrets, woes, and joys, and with whom she could share her hopes fears, doubts, wishes, and plans".

As the process continued, the patient was able to do a considerable amount of uncovering work in trance and obtain insights. The February Man had become a significant parenting figure to her, and she was able to leave her bitter experiences with her mother behind her. Erickson produced amnesia in the patient for the hypnotic work.

The patient terminated with Erickson after he gave her training in obstetrical anaesthesia. Subsequently she had her baby naturally and without pain. Two years later she visited him for a brief "refresher" course. She was once more pregnant."

#### **2.4.8 Hypnosis is an experiential process of communicating ideas**

Ericksonian hypnosis is about communicating meaningfully with the use of word to influence clients to change and promote self-healing. Using multi-level influence

communication is a characteristic of this approach. It is a way of talking at multiple levels of meaning and influence, with the goal of indirectly effecting change in the client's behaviour, feelings and thinking (Zeig, 1994:15). In using multilevel communications, Erickson showed his commitment and flexibility in designing unique ways to unleash potentials and creating expectancy and hope for healing in his clients (Lankton in Zeig, 1994:123). This approach appeals to therapists to use words and phrases of suggestions so as to appeal at one level to the client's conscious mind by matching its understanding and association of things, while simultaneously providing possibilities of new understanding to the unconscious mind. Erickson frequently uses metaphors, stories, anecdotes, jokes, seeding, interspersals and confusion techniques to activate and elicit action for change in clients. These are all indirect methods of communication but Erickson could also sometimes be authoritarian in his indirect way. However, he tended to use indirect methods more frequently because he simply allowed for the possibility of a response from the client rather than demanding it.

## **2.5 HYPNOTIC PHENOMENA**

Hypnotic phenomena can be described "as natural behavioural and experiential manifestations of the trance state" (Edgette & Edgette, 1995:12). They include both subjectively experienced psychological events such as remembering, forgetting, time distortions, alterations in perception as well as observable events such as arm levitation and automatic writing. Lankton (1982 in Edgette & Edgette, 1995:12) asserts that hypnotic phenomena not only develop during formal hypnosis but in other therapies as well. This is the result of trance eliciting communication patterns and concentrated internal attention.

There are numerous somatic and mental features characteristic of the hypnotic state. These include lack of physical movement, verbal inhibition, muscular relaxation, changes in pulse and heart rate, changes in breathing, pupillary changes or eye fixation if eyes are open, spontaneous eye closure, flattening of facial muscles, changes in skin colour, time lag to respond, spontaneous ideomotoric behaviour (finger twitches, arm levitation), and dissociation from the present scenario (Gilligan, 1987, Edgette & Edgette, 1995). These behaviours are also known as the hypnotic constellation.

Erickson also believed that suggestibility, literalness and the phenomena of catalepsy, amnesia, sensory changes and posthypnotic suggestibility are characteristic of the trance state (1952/1980 in Edgette & Edgette, 1995:13). Edgette and Edgette (1995:13) maintain that these are categorically different from hypnotic phenomena which are usable for therapeutic purposes. There is a clear distinction between mental mechanisms used for therapeutic healing and those physiological and mental indicators of trance. Not all clients will present with similar or all hypnotic phenomena. Edgette and Edgette (1995:18) state that hypnotic phenomena will vary in degree as it depends on the client's innate personality style and natural endowment. According to these authors the depth of trance may also impact on the manifestation of the phenomena. However, Erickson believed that no specific hypnotic phenomena belonged to any one particular level of trance, and that each individual person would manifest these phenomena in their unique way (1952/1980 in Edgette & Edgette, 1995:22). It is therefore crucial that the therapist be aware of the client's affective state as the interpersonal dynamics of the psychotherapeutic setting could also impact on the presentation of the hypnotic phenomena.

Specific phenomena often occur or manifest with the problem or pathology and prevent the client from healing. Edgette and Edgette (1995:25) stress that we should use the hypnotic phenomena in which the client gift wraps his problem. In this way, the therapist tailors the induction and therapy goals immediately and utilises the prepackaged problem and turns it into a solution, turning the symptom into allies for solutions. In using the manifested hypnotic phenomena, the therapist applies the principle of utilization and would therefore receive cooperation, as what is used, is directly relevant to the client's reality and social context. Edgette and Edgette (1995:26) also recommend that therapist induce trance involving relaxation. This should immediately create a sense of safety for the client and the therapist can observe any other hypnotic phenomena and later utilize it in the intervention. They also suggest that the most appropriate hypnotic phenomenon to use is to utilise the direct opposite of the one creating the problem. Thus one can also use the hypnotic phenomena isomorphically (same) or complimentary (opposite). They maintain that hypnotic phenomena come in compliments, almost "like one side of a coin with its matching opposite" (ibid., 28). A list of hypnotic phenomena and their opposites can be found in Addendum 1. The various hypnotic phenomena are:

Amnesia – Hypermnesia

Time Condensation – Time Expansion

Age Regression – Future Progression

Anesthesia –Analgesia- Hyperesthesia

Negative Hallucinations – Positive Hallucination

Dissociation – Association

Catalepsy – Flexibility

Pre-hypnotic suggestion – Post hypnotic suggestion.

The hypnotic phenomena will now be briefly discussed.

### **2.5.1 Amnesia-Hypermnesia**

Amnesia can be described as an experience of forgetting something or a loss of memory (Yapko, 1995:111). This phenomenon can be used as the primary solution to the presenting problem. Edgette and Edgette (1995:41) believe that amnesia can be used whenever the client indicates that he or she uses it in everyday life. They suggest that the therapist pick up on minimal cues that the client forgets during a therapeutic session for example, the client may keep on misplacing the car keys or favourite toy. Amnesia could also be utilised when the client uses it in a counterproductive manner in everyday life, thus contributing to the problem. The client is then educated to redirect it towards a more purposeful function in his or her daily functioning. Clients who have experienced severe trauma for example sexual abuse, can be educated that their dissociation and amnesia prevented psychological breakdown and was the body's way of protecting them against painful memories. By repressing hurtful memories they survived emotionally. In hypnosis, amnesia can be used as a tool to help the client to remember during the therapy sessions. Amnesia can be given as a posthypnotic suggestion so that the client does not remember outside of the session or until the client indicates that he or she is ready to deal with the painful memories. Amnesia can be utilized when clients suffer from chronic pain. Amnesia is then utilized to circumvent the pain. Also people suffering from a poor self-esteem or who struggle with feelings of inadequacy or failure could benefit with using this strategy to forget. Amnesia could be used to extinguish memories of failure and inadequacy.

Yapko (1995:111) as well as Zeig (1985 in Edgette & Edgette, 1995:45-46) stress the use of indirect suggestions in facilitating amnesia. If direct methods are used, it should be done in a permissive manner such as using confusion techniques for example.

According to Edgette and Edgette (1995:53) **hypermnesia**, "involves vivid, near photographic remembering", such as Post-Traumatic Stress, disorder where the client continually re-experiences the incident. Hypermnesia is the opposite of amnesia, to remember vividly. Edgette and Edgette (1995:53) warn that this phenomenon is often confused with age regression. However, hypermnesia can be part of an age regression experience. One can be age regressed and not remember in minute detail or one can remember but without any emotion being present. With hypermnesia the characteristics of nostalgia and familiarity should be present.

Hypermnesia can be utilized to undo counterproductive use of amnesia. This phenomenon is especially beneficial in eliciting positive images of the self. By helping the client to remember times when success occurred, where the depression was not present for example, can seed hope for the self and the future of the client. Seeding hypermnesia can be easily achieved by using naturalistic situations and permissive language. Edgette and Edgette (1995:58) assert that permissive language needs to be utilized to prevent the "gun-to-head approach" as it could be quite counterproductive for the client if he or she is not yet ready to remember a traumatic event.

### **2.5.2 Time condensation – time expansion**

According to Edgette and Edgette (1995:89) and Battino and South (1999:245) time distortion is a frequently experienced hypnotic phenomenon. Gilligan (1987 in Edgette & Edgette, 1995:89) refers to it as "an alteration in one's subjective experience of time, wherein it becomes dissociated from standard measures". Therefore time distortion allows the client to experience a distortion in real "world clock" time meaning it either shortens or lengthens time. According to Edgette and Edgette (1995:89) "**time condensation**" refers to a feeling that time has passed more quickly and "**time expansion**" to a feeling that time elapsed seems longer than the clock time.

A naturalistic example could be waiting for the kettle to boil or waiting in a queue or to the time in the doctor's waiting room when it seemed as if time flies. Time distortion could be utilised with clients who suffer from anxiety, sport performance, terminal illnesses such as cancer and those suffering from chronic pain (Edgette & Edgette, 1995:95-96). According to Edgette and Edgette (1995:97-99) there are various ways in which the therapist could seed time distortion. They also suggest that a therapist could induce this phenomenon during the induction phase by making reference to the time. They also recommend that the therapist use indirect as well as direct methods to elicit this phenomenon. The use of metaphors, symbols and naturalistic examples in the client's life could facilitate the phenomenon of time distortion developing in a trance state.

### 2.5.3 Age regression-future progression

According to Yapko (1995:107) "**age regression** is an intense utilization of memory". This phenomenon involves taking the client back in time to some experience in order to re-experience it. A naturalistic example of this is looking through a photo album. This is also called revivification. The client experiences the situation as if it is happening in the here and now. The client could also be asked to go back in time to simply remember the experience as intensely as possible, also called hypermnesia. Erickson (1980 in Edgette & Edgette, 1995:104) defined **age regression** "as the tendency on the part of the personality to revert to some method or form of expression that belonged to an earlier phase of development. True age regression was described as being not just an experience of memory, but rather a total reorientation in attitude, affect, and/or behaviour". In revivification, the client is totally immersed in the experience, reliving the memory as it actually occurred at the time. A pathological example in children is encopresis, enuresis and dependency. Hypermnesia is when the client is in the present but remembers vividly all the details of the memory (Edgette & Edgette, 1995). Age regression allows for an opportunity to go back in time, either recent or distant past, in order to work through old issues or to recover repressed memories, to eventually reach new conclusions (Yapko, 1995:107).

When using this phenomenon, therapists need to be cautious not to ask leading questions to retrieve a memory. This phenomenon can be used to take the client back to a traumatic event in order to release pent up emotions. It could also allow the client

to look at the situation in a different way and assist in releasing destructive influences from the experience that the client might still be lingering on. The client can also be asked to go back in time to reconnect with resources and abilities that were used in the past in similar or different scenarios. Often when clients come for therapy, they are unaware of their dormant abilities and resources. In reconnecting with their own personal past experiences, the client can find more adaptive ways of dealing with their current difficulties (Yapko, 1995:108).

**Future progression**, means, guiding clients towards the future and then allowing them to experience themselves there. It is one of the hallmarks of Erickson's utilization approach (Edgette & Edgette, 1995). Eric Fromm (1955 & 1956 in Edgette & Edgette, 1995:126) stated that, "man is not just grounded in the here and now but simultaneously aware of his past and also aware of his future including the inevitability of his own death". Erickson also mentioned that using this phenomenon, the client can experience desired goals as actualities already achieved (1980 in Edgette & Edgette, 1995:125). This phenomenon can be experienced in or out of trance. In a naturalistic way, the client can for example look forward to a long deserved holiday. In a pathological way, the client can anticipate that something might happen when travelling causing anxiety. However, if experienced in trance, the client could achieve an entirely new phenomenological world of time, sensation and experience of the self and therein lies the function of this phenomenon as a therapeutic aid (Edgette & Edgette, 1995:129). Due to the client moving out of the current problem, for the time being, it can frequently catalyse a process of movement from previous rigid thinking or behaviour, to eventual flexibility leading to change. Yapko (1990 in Edgette & Edgette, 1995:129) in his work with people suffering with depression, uses this technique to create positive expectations of the future. He also uses this method to orient clients that continuing the negative behaviour could lead to negative consequences in future. Gilligan (1987 in Edgette & Edgette, 1995:129) also mentions that this strategy could facilitate the unconscious mind in starting to plan and redirect its energies. Yapko (1995:110) thinks of future progression "as encouraging hindsight while it is still foresight".

Therapists can either use direct or indirect methods to guide clients toward the future. When using direct methods, the therapist should use a "special vehicle" to transport

the client into the future, for example watching a movie screen about the future or a collection of photos about the future are some of the structured ways in which clients can be projected into the future. Indirect techniques include seeding by using metaphorical stories, using conscious-unconscious double binds and presuppositions.

#### 2.5.4 Dissociation – association

**Dissociation** is defined as the "Ability to break a global experience into its component parts, amplifying awareness for one part while diminishing awareness for the others" (Yapko, 1995:115). Edgette and Edgette (1995:145) refer to dissociation as "one part of a person's mental or physical experience functioning distinctly and independently from another part". It is important to understand that dissociation is a mental mechanism that can be used either productively or counterproductively. It is also important to realise that all people generally dissociate in normal, productive ways to cope with life's daily demands. According to Edgette and Edgette (1995:146) when people use the term "automatic pilot" to describe their functioning in their daily lives, they refer to dissociation being used adaptively in their lives.

Often therapists perceive dissociation as pathological but hypnosis involves using dissociation as a therapeutic tool. By using dissociation, the client can go through the motions of an experience but not necessarily be attached to it in the present. The conscious mind can drift off to whatever has its attention and the unconscious mind is free to respond in any way it chooses to promote healing. Edgette and Edgette (1995:151) as well as Yapko (1995:116) believe that the deeper the hypnotic state, the greater the degree of dissociation leading to even greater opportunity for unconscious responses. Dissociation allows for automatic and spontaneous responses such as automatic writing or the hand lifting automatically during the hypnotic state. The therapist can facilitate the development of this phenomenon by using direct and indirect communications. By using metaphors, confusion techniques or evocative language, dissociation can be suggested (Edgette & Edgette, 1995:151-152).

Dissociation can also be used therapeutically when it is the **opposite** of the phenomenon that causes the problem. When a client is too **associative** with his or her internal and external worlds it could lead to difficulty with dissociating in functional ways in the real world as he or she is too involved in their own world (Edgette &

Edgette, 1995:148). For example, a client who constantly worries about something or someone needs to be guided to dissociate in order to deal with the issue. Dissociation can also be used therapeutically when the client already does it in everyday life, for example, when one goes to work after having a heated argument with a significant person and is able to push those thoughts and emotions aside in order to be productive. Dissociation is also valuable for a client who is depressed and becomes stuck in a sense of helplessness. Dissociation then becomes a wedge between the depressed client's self-image and his current feelings about himself in order to allow the latter to stop compromising the former (Edgette & Edgette, 1995:149). Another example is that of victims of sexual abuse who have learnt to dissociate their feelings and thoughts to help them cope with their situation.

### 2.5.5 Catalepsy - flexibility

Yapko (1995:114) defined **catalepsy** "as the inhibition of voluntary movement associated with the intense focusing on a specific stimulus". More technically Kroger (1963 in Edgette & Edgette, 1995:173) refers to it as "an involuntary tonicity of the muscles" or as "suspension of voluntary movement". According to Erickson and Rossi (1981 in Edgette & Edgette, 1995:174) this phenomenon reflects a state of heightened sensitivity and receptivity to suggestion that is very adaptive for therapeutic work. Cataleptic responses may include a fixed gaze, general immobility and waxy flexibility usually associated with catatonic patients, slowing down of reflexes such breathing and pulse rate. Though the client may seem inattentive, the unconscious mind is actually active and expectant. Edgette and Edgette (1995:174) believe that suspended physical movement is mirrored internally by a suspended awareness that organises quickly around a new idea or mental experience. An example of this is when you freeze when someone frightens you or when you are in a state of shock and immobility when in an accident.

Catalepsy can be considered one of the basic features of hypnosis as it is associated either directly or indirectly with most hypnotic phenomena. Catalepsy can be applied directly as an intervention strategy or indirectly as a vehicle for communicating something relevant such as the warmth of the hand or other bodily sensations towards obtaining the therapeutic goal (Edgette & Edgette, 1995:177). **Flexibility** on the other hand refers to impulsive behaviours, restlessness, fidgeting, talking rapidly without

stopping between sentences and general overactivity. When these kinds of behaviours are observed in clients for example, catalepsy can be used in a complimentary manner to help them remain relaxed and become less active.

### 2.5.6 Positive hallucination - negative hallucinations

According to Yapko (1995:116) "hallucinations created hypnotically are suggested experiences the client can have that are clearly removed from current, more objective realities". A hallucination is a sensory experience that does not arise from external stimuli. Hallucinations can be positive or negative. A **positive hallucination** occurs "when a client perceives something in the physical environment that is not there in reality", for example someone who is experiencing phantom limb pain or someone who has never been able to develop self-soothing positive self-statements as well as anxiety (Edgette & Edgette, 1995:245). A **negative hallucination** is when the client is **not** experiencing or perceiving something that is physically present in the environment, for example looking for keys and unable to find it (Edgette & Edgette, 1995:259). Negative does not refer to something being unpleasant or unproductive. The client will involve sensory experiences such as visual, auditory, kinesthetic, olfactory and gustatory facilities in both positive and negative hallucinations. In facilitating hallucinations the therapist is altering awareness for sensory input and guiding clients to experience themselves or the world differently which increases their range of experiences and taps into valuable new resources.

With the utilization of seeding either direct or indirect suggestions, hallucinations can be developed. Sometimes hallucinations occur automatically in the hypnotic state.

### 2.5.7 Anesthesia – analgesia - hyperesthesia

According to Yapko (1995:111-112) "hypnotically induced analgesia and anesthesia are on a continuum of sensation of pain, allowing associated sensations (e.g. pressure, temperature, position) that orient the client to his or her body to remain". **Anesthesia** refers to a complete or near complete elimination of sensation in all or part of the body. **Analgesia** on the other hand, refers to the diminishing rather than the elimination of sensation. Yapko (1995:113) asserts that any method that shifts the client's attention significantly away from awareness of the body's sensations has a direct analgesic effect. These phenomena are both used for clients who experience

pain. Yapko (1995:112) cautions that therapists need to approach the client in pain sensitively because it often involves anxiety, fear, feelings of helplessness, depression, increased dependency and restricted social contact. Hilgard (1987 in Edgette & Edgette, 1995:209) notes that when these phenomena are applied pain will still follow its natural course but at a fraction of its original intensity. Kilstrom (1985 in Edgette & Edgette, 1995:209) also states that the client will experience a dramatic reduction in both physical (sensory pain) and psychological (subjective suffering) aspects of pain. This phenomenon is used where the client's problem is caused by inadvertently applying anesthesia such as nail biters, self-mutilators, lip and cheek chewers and hair pullers (trichotillomania). Seeding by utilising both direct and indirect suggestions could elicit these phenomena during the hypnotic state. The most famous technique used by Erickson is that of glove anesthesia (Edgette & Edgette, 1995:216). The therapist could use the extended hand induction and then suggests numbness in one arm or hand until it becomes cold and numb (Battino *et al.*, 1999:372).

**Hyperesthesia** is the compliment of anesthesia. In this phenomenon the client would experience heightened sensitivity to touch and other bodily sensations (Edgette & Edgette, 1995). According to Edgette and Edgette (1995:230) this phenomenon provides "a hypnotic compliment to a psychological rather than a physical state of anesthesia". Hyperesthesia uses enhanced sensation as a symbolic antidote to a mental reality. This phenomenon can be elicited in the induction phase already by utilising direct and indirect modes of suggestions right from the start of therapy to create change.

### **2.5.8 Prehypnotic suggestion - post hypnotic suggestion**

Posthypnotic suggestion refers to the client's ability to respond at a later time to a suggestion given during trance (Edgette & Edgette, 1995:68). Posthypnotic suggestions can be directed towards behaviours, attitudes, affect and many more. The posthypnotically suggested state can be one of relaxation, having a sense of control or can involve any other hypnotic phenomena. For example, the client may believe that he is a loser or failure. This phenomenon is based on the principle of associations. Hypnosis undertakes to effect change and therefore the goal is to extend the hypnotic learnings, new insights and associations into active transformation of everyday

experiences. According to Gilligan (1987 in Edgette & Edgette, 1995:68) the posthypnotic context is where the responsiveness of therapy is brought to life. Authentic posthypnotic suggestions occur spontaneously, without conscious awareness. Erickson (1941/1980 in Edgette & Edgette, 1995:69) once wrote in an article, "that a special, albeit brief, state typically develops spontaneously with the initiation of the posthypnotic act: It is somewhat of a dissociated act, one that interrupts and breaks through the stream of consciously directed activity". Erickson believed that the therapist should keep the posthypnotic suggestion unconscious as this makes it more difficult for the client to resist.

Posthypnotic suggestion is one of the classic hypnotic phenomena. Seeding from the posthypnotic context to everyday reality can occur by using this phenomenon. This phenomenon can also be seeded with direct or indirect suggestions. This phenomenon is effective if the message has been delivered in many different ways at many different times throughout the hypnotic experience. Edgette and Edgette (1995:75) also stress that this phenomenon should be based on something that is noticeable or observable that the therapist knows for certain will happen such as when the sun rises ...

When a client has a preconceived idea of fear or inability to do something this is referred to as a **prehypnotic suggestion**. When a client's negative suggestions becomes part of that person's problem because he or she keeps on reminding himself or herself of a negative experience, this leads to counterproductive thoughts. The person has programmed himself or herself to think in negative ways about himself or herself or a situation. These counterproductive suggestions allow the client to respond to earlier suggestions to do or remember or experience something as if it is real. By using the post hypnotic suggestion, the therapist can orientate the client to the future by reframing the negative into positive statements (Edgette & Edgette, 1995:75).

Hypnotic phenomena play a crucial role in creating change and healing in clients. The therapist should utilise any hypnotic phenomena present during the assessment phase to inform therapeutic goals and adapt therapeutic interventions to address the problems.

## 2.6 THE PROCESS OF ERIKSONIAN HYPNOSIS

There are five stages in a hypnotherapeutic session. These will now be discussed but one should be mindful that these stages are not static and do not always follow in a logical sequence as it often overlaps. A schematic presentation of this process is included in Addendum 2.

The *Prehypnotic or initial assessment phase*, "lays the groundwork" for comfort, safety and generative associations (Geary, 1994:322). While gathering information, the therapist should observe hypnotic phenomena, establish the values of the client and notice the themes that may emerge. The therapist should pay careful attention to any symptom words, which may describe the problem. Attention should also be given to the client's use of figures of speech, as it may be relevant to the specific problem and culture of the client. These symbols will give the therapist insight into the client's world and provide cues the therapist can use to gift-wrap the solution. Another assessment tool is that of sequencing. Problems should be perceived as dynamic processes although it may be a discrete event. Any problem has something that triggers it. It then manifests in specific behaviours, perceptions, attitudes, affect and relationship patterns. The therapist should be cognizant of these sequences as it could later be utilized in either the induction or therapy goals. In this early phase of the therapeutic process, the therapist should start seeding. According to Geary (1994:320) the purpose of seeding is to activate associational processes and make the client more "response ready" for later interventions. Zeig (1990 in Geary, 1994:322) equates seeding in the assessment phase to providing a "fertilized bed" in which therapeutic interventions can later flourish in the therapy process. Seeding as a therapeutic technique "sets the table" for psychotherapy.

During the *Induction phase*, seeding should address the issue of how the induction can seed the proposed intervention. In order to seed suggestion the client should be absorbed in a memory or any of the symbols. Zeig (1990 in Geary, 1994:324) referred to these seeding interventions as, "building toward the desired goal in small steps. A central idea behind seeding is to build therapeutic momentum by starting slowly and then building up steam en route to a goal".

In the *Utilisation phase*, seeding is geared toward enhancing previous seeding, and now cues can be offered to harness and develop within the context of the interventions themselves (Geary, 1994:324). This stage forms the backbone of the hypnotherapeutic process as the majority of therapy occurs during this stage. During the *termination phase*, the client is guided from the hypnotic state to the waking state. The therapist and client agree on ways of returning to the present. During the posthypnotic phase, posthypnotic suggestions are utilized to effect change in the client's current life. A posthypnotic suggestion occurs when the client actively does something in his everyday life after an instruction was given during the hypnotic session or termination phase (Geary, 1994:326). The aim is to extend the learnings, associations and hypnotic insights into active real life experiences for the client.

## **2.7 REFLECTION**

In this chapter the history of hypnosis and hypnotherapy were outlined and various theories were briefly discussed. This was followed by a discussion of the myths and misconceptions about hypnosis. The principles of Ericksonian hypnosis were discussed in detail to provide the reader with an opportunity to come to understand what Ericksonian hypnosis is all about. These principles form the backbone of the process of Ericksonian hypnosis. Lastly, the hypnotic phenomena were outlined as it is used in the process of therapy to assist the client to find solutions to problems. The next chapter will deal with developmental issues and various hypnotic induction techniques for children.

## CHAPTER THREE

# HYPNOTIC INDUCTIONS FOR CHILDREN

### 3.1 INTRODUCTION

This chapter will outline the stages of development pertinent to the primary school child, the Metamodel which is also referred to as the Ericksonian Diamond and ARE models. When doing hypnotherapy, it is important to consider the child's developmental level and intellectual functioning, as the techniques used should be adapted and tailored to meet the unique needs of the child. It is therefore crucial to peruse literature with regard to the development of children so that age-appropriate intervention can occur. The various hypnotic interventions and inductions will also be discussed.

### 3.2 DEVELOPMENTAL CONSIDERATIONS

No discussion can be complete without considering the development of children. Research indicates that development peaks during childhood and wanes in the later part of life (Brems, 1993:45). Any therapist working with children should genuinely appreciate and understand the rapid changes and milestones children must attain during the early years. Development should be perceived as a never ending, continual process that is also influenced by the individual's experiences in his or her environment. For those working with children, it is beneficial to understand where the child is in terms of his or her development, so that therapeutic interventions are suitable and age-appropriate.

Both Piaget and Erik Erikson postulate that the completion of a stage allows for internal or structural redefinition and thereby continued growth (Wester & O'Grady, 1991:5). Both Piaget and Erikson require that children master particular criteria within a specific stage of development. Only once the criteria have been mastered would the child be able to transcend successfully to the next phase of development.

The ensuing discussion will focus on both Piaget and Erikson's stages of development with specific attention given to those cognitive and linguistic functions necessary for hypnotic intervention. For the purposes of this study, only the developmental stages applicable for the participants in this study will be highlighted.

### **3.2.1 Pre-operational period (Early childhood: 2-7 YEARS)**

The pre-operational stage of cognitive development includes the completion of the second and the third stage as described in the Erik Erikson stages (Wester & O'Grady, 1991:5). Autonomy in the sense of protecting oneself develops during this stage. The ability to develop a sense of autonomy with little conflict from shame and doubt and the development of hope develop simultaneously to provide a lasting sense of self-control without the loss of self-esteem. Stage III starts at three to five years for Erikson. It is a time when the child establishes a sense of initiative and enthusiasm for exploring the world rather than clinging to the autonomy of the previous stage. The child should learn to separate his or her infantile instincts, which previously enhanced growth that will increase self-observation, guidance and punishment. Erikson regarded the balance of infantile moralism of guilt, as one of the most deeply rooted aspects of human development (Feldman, 2000:201).

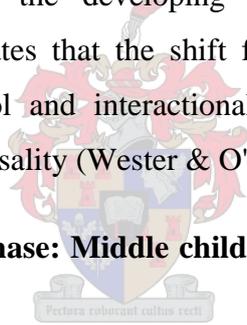
During the pre-operational stage many more changes occur in the child's life. The child's social environment changes dramatically as he or she now enters school, has a broader peer group, systematic instruction in linguistics and abstract symbols starts, and parental expectation shifts to encourage independent and self-care skills. Cognitive development is characterized by absence, the absence of mental operations, which are defined as the internalized representations of an action (Feldman, 2000:228).

For Piaget, perception, memory and imagery are not mental operations as they occur passively without interpretation. Mental operations require concepts of reversibility in the form of negation or compensation. Egocentrism is most important during this stage of development. Egocentrism does not imply selfishness but to the extent to which children perceive themselves as the centre of reality (ibid., 228). Any behaviour suggesting that children have trouble distinguishing what "I" think from what "you" think or feel may be termed egocentric. As the process of decentering

gradually unfolds, the child starts to differentiate the self from others and becomes prepared to enter the next developmental period of concrete operations (Newman & Newman, 2003:259).

Causality continues to develop during this stage. In the pre-operational child, the two forms of causality, psychological and physical; are still immaturely developed. These two forms of causality are not differentiated yet and the "why" questions address both issues simultaneously (ibid). The child seems to believe that every event happens as a result of a specific cause and may be unable to accept the view that some events simply occur accidentally or are chance occurrences. For pre-operational children reality is constructed according to a grand set of blueprints. The young child is less perceptually tied into the thinking process as he or she moves towards the concrete operation level. This is observed in responses to perceptual visual input and the ability to express more abstract forms of causality. The shifting from perceptual dependence to internal functioning marks the developing cognitive capacity for internal representations. Research indicates that the shift from passive (external) to active (internal) perceptions of control and interactional influences in the environment relates to the development of causality (Wester & O'Grady, 1991:12).

### **3.2.2 Concrete operational phase: Middle childhood (Approximately age seven to puberty)**



The Piagetian concrete operational phase includes Erikson's stage IV, industry versus inferiority. This stage differs from the preceding developmental stages in that it does not involve conflict of moving from internal to outer mastery. It is a latency period, before the onset of adolescence when earlier drives reappear in new combinations (Wester & O'Grady, 1991:30). The child receives some form of systematic instruction which occurs in all cultures, either at school or in communities. This implies that the child gets an opportunity to discover and acquire new skills in preparation for adult life. The child learns to master new skills and this flows into societal norms of work. If the child is unsuccessful in acquiring the competencies, he or she may not develop a sense of identification with them. On the other hand, the child could identify too strongly with his or her work and that which works becomes a yardstick for being worthwhile. The child now possesses the internal mental operations and the external

physical performance skills to attain accomplished interaction with and mastery over the environment (Newman & Newman, 2003:259-260).

At this level, the child utilises operational thought, which is tied to concrete realities as well as abstract or hypothetical thought processes. There are two categories of concrete operations which are logico-arithmetic operations, that process discrete data and spatial operations, which process continuous data. Logico-arithmetic operations include contents of conversations, relations of ordering and classification, referring to relations of belonging (Feldman, 2000:307). Spatial operations are the contents of Euclidean geometry; projection, which allows us to localize and order objects and to determine distances from one another; and typology, which allows pure categorical information with no description of localization or distance between objects (Webster, 1991).

### **3.3 HYPNOTIC RESPONSIVENESS IN CHILDREN**

Much research focussed on the hypnotisability of children for the past 60 years. According to Olness and Gardner (1988 in Olness & Kohen, 1996:18) hypnotic ability is limited in children below the age of three with a peak during the middle childhood years of seven to fourteen with a decrease during adolescence. London (1962/1963 in Olness & Kohen, 1996:19-20) assessed children's hypnotisability by developing the Children's Hypnotic Susceptibility Scale (CHSS). His findings correlate with previous results that children are more susceptible than adults. Cooper and London (1976 in Olness & Kohen, 1996:22) also found a correlation between hypnotic responsiveness and EEG alpha when children's eyes were open. According to Jacobs and Jacobs (1966 in Olness & Kohen, 1996:22) children with abnormal EEG's showed poor responsiveness. Morgan and Hilgard (1979 in Olness & Kohen, 1996:22) devised the Stanford Hypnotic Clinical Scale for Children (SHSC-C). The significance of the test results lie in the fact that the score was obtained on a short scale and only takes twenty minutes to administer. Their studies reflected the same results as previous studies. Most of the current available scales do not cater for the preschool child. There is however some evidence that hypnotherapy is effective with the preschool child for diverse problems such as enuresis, encopresis, reducing pain and distress and asthma (ibid., 29). Gardner (1977 in Olness & Kohen, 1996:30) emphasises the relationship between fantasy and hypnotic ability. She worked with

small children below the age of four years and found that they have developed the ability to sooth themselves such as rocking, or talking rhythmically. In further studies, she found that children as young as two years of age have the capacity for fantasy and rapport as well as the intrinsic desire for mastery (Olness & Kohen, 1996:30).

It becomes evident from the above discussion that children are naturally good responders to hypnosis more so than adults. As mentioned previously, fantasy and imagination play an important role in hypnosis and hypnotherapy with children. It is therefore of paramount importance that the therapist use a variety of therapeutic strategies as vehicles to gift-wrap phenomena. They could utilize metaphorical stories, imagery, art, creative play, toy symbols and rituals.

### **3.4 THE METAMODEL OF ERICKSONIAN HYPNOSIS / THE ERICKSONIAN DIAMOND (ZEIG, 1992)**

Zeig (1992 in Zeig 1994:298) defines utilization as the "therapist readiness to respond strategically to any and all aspects of the patient or the environment". Any aspect of the client can be utilized including his language, dress, style, mannerisms, history and family environment. The therapist can use the client's symptom, symptom pattern, words and resistances as well as his social context. Utilization is a central facet in Ericksonian hypnosis. Because utilization is a goal-directed activity, the therapist should think ahead about actualizing a specific target. In order to attain these targets in therapy, Zeig (1992 in Zeig, 1994:295-313) devised a meta-model consisting of five pivotal choice points. The purpose of the choice points is to assist the therapist when he becomes stuck in one of the facets of the diamond so that a change can be made in any one of or combination of these facets (Zeig, 1994:301). A guiding question is the basis of each facet which will now be discussed. The meta-model is also referred to as the Ericksonian Diamond and is attached in Addendum 3.

#### **3.4.1 Goal**

The goal question the therapist has to answer is "*What do I want to communicate?*" Induction goals might differ from the therapy goals. Goals may also be divided into smaller parts. The client and therapist can co-create therapy goals. The therapist can ask the client to describe the goal and what he would look like if the therapist should

see him on television for example. In this way the therapist gets the client to concretise the problem and the goal as well as gain insight into the client's psychological world. Ask the client what he would be like if the problem is resolved and how "we" together can achieve this goal. In this way the therapist creates resonance and therapeutic "we-ness", important for building trust and rapport as well as creating hope for the future and the notion that change is inevitable. When therapists utilize, they are focused on the intended goals. In Ericksonian therapy there are both induction and therapy goals. The Ericksonian approach to hypnotherapy is essentially "R" and "R" (Zeig, 1994:301). The induction goals are concerned with eliciting *responsiveness* and the therapy goals are oriented to develop *resources* that can be harnessed within the client and facilitate change. Zeig (1994:301) holds that induction goals can also include modifying attention, increasing intensity and promoting dissociation. Therapy goals can also include providing new information to the client.

### 3.4.2 Gift wrapping

After the therapy goal has been formulated the therapist needs to ask, "*How do I want to present the goal?*" The method for packaging the goal is called "gift wrapping". The goal can be gift wrapped within a story, metaphor, anecdote, systematic desensitisation, confrontation, ego state therapy and any other intervention techniques. I agree with Zeig (1994:302) who asserts that: "Techniques are merely formats for presenting therapeutic objectives. It is a philosophical error to think that techniques cure". In the same vein hypnosis does not cure, it is merely a vehicle of gift wrapping information. Zeig (1994:302) also maintains that gift wrapping is a recursive process. The goal should not be presented only once but in a repetitive fashion either with direct suggestion or indirect suggestion within a story within hypnosis. The purpose is to present the goal in varied ways to strengthen and develop the thematic goal. In gift wrapping the communication is judged by the response and not by the cleverness of its structure. Zeig (1994:302) holds that clever gift wrapping techniques are valuable only when they elicit desirable and constructive responses. For Erickson, psychotherapy is all about reorganising the internal life of the person. The client may represent and gift wrap his problem within a symptom. The therapist's task is to gift wrap the solution using the same gift wrap the client used for his problem. Once again

it is about utilising the client's theory of change and facilitating healing by gift wrapping solutions for clients in any of the techniques that would effect change. The more the client co-operates with the therapist, the more direct you can be but the more they resist, the more indirect suggestion should be.

### 3.4.3 Tailoring

While considering goals and gift wrapping, the therapist should also consider how to individualise or tailor therapy to the unique aspects of the client. The therapist needs to ask, "*What is the position that the patient takes?*" It is essential to ascertain what the client values as this can be utilised to get the client to cooperate. Utilisation of all aspects of the client's frame of reference, including his social context should be of benefit in tailoring therapy for the client and meeting his or her unique needs. In this regard Erickson believed that clients differ in personalities and that the therapist should customise techniques to fit the individual's needs and contexts (1980 in Zeig, 1991:283). This is an important fact to remember, as the therapist should not force techniques onto the client if he cannot relate to it, but rather tailor therapy to suit the client.

### 3.4.4 Processing

After deciding on the above choice points, the therapist has to decide, "*How do I present the tailored and gift wrapped goal?*" This is referred to as processing (ibid). According to Zeig (1994:303) processing occurs in three stages: Setup, Intervene and Follow-Through (SIFT). By using the SIFT method the therapist livens up the therapy process by creating drama and enhancing the process into a significant emotional experience. Processing occurs in three stages. The *setup* includes prehypnotic suggestions, seeding and eliciting motivation. Hypnotic inductions can also be used to elicit intrapsychic and interpersonal responsiveness to empower future suggestions in clients. After the main *intervention* is presented in a form of a technique, be it a metaphor, reframing, anecdote or symptom prescription and so forth, the therapist must *follow-through*. Follow-through techniques include ratifying changes, induced amnesia and homework assignments (Zeig, 1994:303). The intervention is "sandwiched" between the setup and the follow-through and is not presented in isolation, instead it is presented in various ways over time, seeding hope. The

therapist needs to decide how he is going to gift wrap the solution, when he is going to deliver the intervention, with an element of surprise, during the hypnotic process. Is the therapist for example going to present the hypnotherapeutic intervention as an entrée, main course or dessert. Seeding occurs right from the beginning in a strategic manner as the aim is to seed hope and change. By seeding the therapist remains focused on the treatment goal and works toward achieving that goal (Haley, 1973).

### **3.4.5 Position of the therapist**

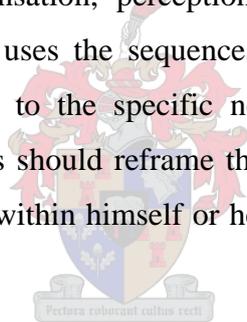
Before, during assessment and intervention the therapist might wonder, *"What position do I, the therapist take?"* Zeig (1994:304) believes that the position the therapist takes is far more important in determining treatment outcomes than the clever techniques the therapist might utilise. The therapist can take the position of being kind, confronting, curious intellectual and so forth. "Each therapist has a "lens" (perceptual set), "heart" (emotional set), "muscles" (action patterns), and "hat" (social role)" (Zeig, 1994:304). The lens, heart, muscles and hat represent two different varieties, be it professional and personal characteristics of the therapist. The position of the therapist is crucial in determining the goals, gift wrapping, tailoring and the processing. The position refers to the orientation the therapist ascribes to, for example a humanistic or behavioural orientation. The orientation of the therapist will determine the way the goal will be gift wrapped. The psychoanalyst would use interpretation, confrontation and clarification. The strategic therapist would utilise symptom prescription and reframing, never even considering interpretation and insight. Zeig (1994:305) cautions that this model is a mere skeleton and not prescriptive in terms of a linear psychotherapeutic process. The five aspects of this meta-model are choice points. If the therapy becomes stuck, the therapist can change the goal, gift wrapping, tailoring and or the processing as well as the position of the therapist. A strategic therapist, who takes the position of utilisation, is flexible and can adapt any facet of this process to meet the unique needs of the client.

### **3.4.6 Selecting what one might utilise**

Zeig (1994:305) states that the therapist using the utilisation approach will naturally assume a particular posture. The therapist will immediately work towards utilising the goal, focus on strengths and resources to emphasise the positive in a given situation as

well as orient towards multi-level communication. The therapist in this orientation will utilise whatever the client presents in the therapy session, be it sequences, symptom words and figures of speech.

When a therapist starts with a session, she would immediately start assessment and intervention. When clients present their problem they see it as a static entity. The therapist should be aware of the dynamic process of the problem, perceiving it as a sequence. A sequence can start with a trigger, followed by certain behaviours, perceptions, emotions, attitudes and so forth. The question the therapist needs to ask is "How does the client do the problem?" The purpose would be to clarify how the client gift wraps the problem in order to utilise it in either the induction and or therapy goals. If the problem can be regarded as having six steps that lead to negative states, the same steps can be utilised to create a positive state. The therapist would therefore use the sequence for induction purposes to elicit unique experiences in the client. Clients can be absorbed in sensation, perception, hypnotic phenomena, fantasy, memory and sequences. If one uses the sequences as presented by the client, the therapy is immediately tailored to the specific needs of the client. In using the sequence of the client, therapists should reframe the sequence so that the client can experience constructive healing within himself or herself and tap into his or her own personal resources.



Another assessment tool is using the client's symptom words. Once again the therapy is tailored to the client's needs and the symptom words now become part of solution words to achieve the therapy and induction goals. Lastly, the therapist can use figures of speech the client presents with in the session, as it forms part of his or her social context. Spoken language is filled with idioms and proverbs and is either culturally determined or similar across cultures. Utilising the client's language patterns would facilitate the induction as well as the therapy goals. The therapist should always be interested to create dynamic internal experiences unique to the client, utilising the client's theory of change.

### **3.5 THE ARE MODEL**

There are five stages in the process of Ericksonian hypnosis which are information gathering, induction, utilization, termination and posthypnotic suggestion. However,

in this utilisation doctrine of hypnosis these stages are not fixed, yet they are necessary to ascertain relevant information to be utilised right from the start of the therapy process. The therapist is flexible, hypnosis permissive and the therapy client-based. It is thus important to understand the phenomenological characteristics of trance.

The ARE model devised by Zeig, Geary and Erickson, is an induction structure to assist in harnessing the hypnotic experience. A is for absorb, R for ratify and E for elicit (Zeig, 1994:24). It is advised that the ARE method is used in a sequential manner. When inducing the client both absorption devices and absorption techniques can be used. An absorption device might include involving the client in a sensation, fantasy, perception, memory, metaphors, anecdotes, stories and or hypnotic phenomena. The selection of the absorption device is dependent on the characteristics of the client and the goal to be achieved in both induction and therapy. By using change in tone of voice, pauses and changes in voice alterations, these secondary techniques can help with inducing trance. It is also very essential that the therapist utilises possibility words, speaks in the present tense and comprehensive details. All the aforementioned techniques should enable the client to focus attention, direct attention internally and experience sensations more or less vividly (Zeig, 1994:25). Once the absorption stage is created, it allows for multi-level operations to be accomplished such as achieving both the induction and therapy goals.

During the ratifying stage, the therapist uses a few statements and sentences to ratify the trance by reflecting and acknowledging changes that occur in the induction phase (Zeig, 1994:25). When the therapist acknowledges the hypnotic constellation, it facilitates the process of induction. By using indirect suggestions such as truisms and the yes-set for example, the client can become more absorbed in internal functioning and thus also intensifies the hypnotic experience. This can also lead to sensations of dissociation, either feeling "a part of or apart from" or sensations of automaticity, as if things "just happen". Once the clinician responds to the client's hypnotic constellation such as "I've noticed that changes have occurred, your breathing has slowed down, arms are resting comfortably in your lap, your swallow reflex has changed", it implies that the client is experiencing hypnotic alterations correctly. The next phase is to elicit dissociation, responsiveness and resources in the client. The therapist can use indirect

suggestions to elicit dissociation as it forms an integral part of hypnotic phenomena (Zeig, 1994:28). When the therapist elicits responsiveness in the client, the suggestions could establish a fertile climate of responsive co-operation in which hypnosis can occur. Once the therapist has elicited responsiveness to minimal cues, the process of induction is over. Resources can be accessed through the use of direct and indirect suggestions. These techniques guide the client to elicit the phenomenology of change and thus the induction paves the way for indirectly eliciting the hypnotic phenomenology. In this conceptualisation, the "hypnotic induction is a bridge between the land of the problem to the land of solutions" (Zeig, 1994:29).

### **3.6 HYPNOTIC INTERVENTIONS WITH CHILDREN**

According to O'Grady and Hoffmann (1984 in Hartman, 1995:13), the use of hypnosis can be divided arbitrarily into six phases: preparation, induction deepening, suggestions, posthypnotic suggestions and termination. Suggestion and Posthypnotic suggestion will not be discussed as it was discussed previously in chapter 2.

#### **3.6.1 Preparation**

In emergency situations, this phase is deferred. Usually the therapist would inform parents of hypnosis as the treatment modality, deal with any misconceptions and myths, review the child's ideas about hypnosis and deal with any relevant issues the parents may have. During this phase, the child's likes and dislikes, important life experiences, fears, hopes and comforts are ascertained. Crasilneck and Hall (1985 in Hartman, 1995:14) identified seven questions the therapist should consider during this initial assessment phase:

- Why does the child come for treatment at this time?
- Who sent the child?
- Is the child sufficiently motivated to give up the symptom (s)?
- Is the symptom being used to manipulate others?
- Is the symptom organic or psychogenic?

- What is the child's degree of impulsivity and what is the child's level of frustration?
- What is the child's general personality or history? (Wester & O'Grady, 1991:35).

Preparation of the child varies with age. With children between five and six years of age discussion about hypnosis is usually counter-productive. Before reaching puberty, children can understand explanations and are more accepting of adult direction. Adolescents and older children can now manage misinformation, misunderstandings, anxieties and expectations. For the younger child absorption in a favourite activity or imaginative play could facilitate the therapeutic process. For older children from approximately, eleven years of age to adolescence, the concepts of imagination and relaxation can be introduced.

Important at this stage is whether the parents would be present during the hypnotherapy session. The therapist should take her cue from the child in the initial session and follow the child's preference. If the child wants the parents in the session, the therapist should brief the parent properly and later fade the parent into the background. The therapist could also utilise the parent's presence, actions and verbalisations to facilitate the hypnotherapeutic session. As the child becomes more comfortable in the therapist's presence, it is preferable that the child continues on his or her own once rapport has been established.

### **3.6.2 Tailoring**

A therapist needs to consider various variables before initiating hypnotherapy with children, to enhance the responsiveness at each phase of the hypnotherapy process. The culture, age and or developmental level of the child influence the selection of a formal or naturalistic trance. Before the age of four years there is no formal trance as children are naturally prone to imaginative involvement. For children younger than seven years of age, there is no formal induction as it was found that their attention span is too short. Therefore, the therapist should use story-telling and metaphors in fairytales as the preferred methods of developing the hypnotic state. Other variables to consider include the child's cognitive level of functioning; educational status; language and vocabulary; imagery in terms of the child's interests, fears and wishes; responsiveness in terms of their acceptance and complete involvement in the process.

Once the child's interests, likes and dislikes and or favourite activity have been established, the therapist can begin to select the appropriate techniques for the child. Each technique should be tailored to the unique needs and developmental level of the child (Olness & Kohen, 1996:76). The therapist should then decide whether to use direct or indirect methods of suggestion to facilitate the therapeutic process (Olness & Kohen, 1996:55).

Olness and Kohen (1996:78) give several other ideas about tailoring interventions for children with special needs. They suggest that as far as possible that clients should be allowed to become involved with the therapeutic process right from the start. These clients should be allowed the opportunity to choose the induction methods as this creates a sense of mastery, empowerment and control. This would then allow for greater motivation, co-operation and ownership of the process of healing and growth or acceptance.

### **3.6.3 Hypnotic induction techniques for children**

According to Olness and Kohen (1996:53) "the purpose of therapy is always to ease the child's control of a desired feeling or behaviour, and any induction that emphasises loss of control can only inhibit therapeutic progress". In Ericksonian hypnosis, the induction and therapeutic process is individualised to meet the needs of the client. When working with children, the therapist should adapt induction procedures and suggestions to the age of the child. The therapist should also consider developmental issues such as adapting the language to the age of the child as well as cognitive and perceptual skills at various ages. Olness and Kohen (1996:55-77) divide induction techniques into visual imagery, auditory imagery, movement imagery, story-telling, ideomotor, progressive relaxation, eye-fixation, distraction and utilisation (the use of video and audio-tapes or the telephone) techniques. An example of each of these techniques will be briefly discussed as taken from Olness and Kohen (1996:55-77).

#### **3.6.3.1 Visual imagery technique**

*Multiple Animals.* "Do you like animals? Good. Which do you like best? Fine. Just imagine that you can see yourself sitting in a very nice place with a puppy (or whatever animal the child has chosen). It might help to close your eyes or leave them

open if you like or leave them open until you close them or until they close by themselves. Feel that puppy's soft fur (kinesthetic imagery) and see its colour (visual imagery). Now, just for fun, pretend it is another colour or striped or polka-dotted. Let it be anyway you like, and the puppy is happy too. You can change the colour anytime you choose *because* (this is the motivating portion of the suggestion) it's *your* imagination, and you are the boss of your imagination. And you can imagine a second puppy just like the first, the same colours, the same soft fur. Two puppies, and you can see yourself playing with them. Now, you may choose three puppies and change their colour back to the first colour or to another colour. You can tell me of the puppies if you like (Olness & Kohen, 1996:57).

### **3.6.3.2 Auditory imagery**

*Listening to music.* "You said you liked music. What kind of music do you like to listen to? Exactly what piece of music would you like to hear now? Good. Just imagine yourself hearing that very clearly now, as loud or as soft as you like. You might want to turn it up ... and then down ... You may imagine watching the musicians too. You can let me know that the music has ended". For this activity the child could be asked to bring along a tape recording with the favourite music to the session, as some children may find it difficult to imagine listening to it or if the therapist is aware of the specific piece of music, could bring it along herself (Olness & Kohen, 1996:60).

### **3.6.3.3 Movement imagery**

*Flying Blanket.* "Imagine that you are going on a picnic, going with your favourite people to a special place for a picnic. You have your favourite things to eat and drink. You can see and smell and taste them. You can enjoy playing games with your family and friends. Then when you are finished eating and drinking and playing games, you see a blanket spread out there on the ground. It's your favourite colour, smooth and soft. You may sit on it or lie on it. Pretend it's a flying blanket, and you are the pilot. You are in control. You can fly just a few inches (centimeters) above the ground, just above the grass or higher, even above the trees if you want. You're the pilot. You can go where you want and as fast or as slowly as you wish, just by thinking about it. You can land and visit your friends or you can land at the zoo or wherever you like. You're

the pilot and you're in charge. You might fly by a tree and see birds in a nest. You can speed up and slow down. Enjoy going where you want. Take all the time you need to feel very comfortable. When you are ready, you can find a nice comfortable landing spot and land your flying blanket. When you have landed, let me know by lifting one finger". Olness and Kohen (1996:60) also recommend that one could also suggest, "When you are ready to learn more about how your inside mind can help your body or the way it can help with those problems that have been bothering you, then you land your blanket". This method is not recommended for children who have a fear of heights or flying (Olness & Kohen, 1996:60).

#### **3.6.3.4 *Storytelling technique***

The therapist may decide to absorb the child in a story or anecdote that corresponds to the child's needs. The personalised story is entirely dependent on the creativity and ingenuity of the therapist in an attempt to provide solutions to the child's presenting problem or symptom. The therapist could take full responsibility for the story or it could be a mutual storytelling experience.

#### **3.6.3.5 *Ideomotor technique***

*Hand Levitation.* "Let your hand and arm rest comfortably on the arm of the chair. Notice and feel the texture of the fabric beneath your fingers. Now imagine that there is a string tied around your wrist and that big, bright helium-filled balloons are tied to the other end of the string, the kind of balloons that float up by themselves. Lots of balloons, your favourite colours, just floating, so light, so easy. Effortlessly. As you focus on the lightness of those balloons, you may notice how that hand begins to feel light too". Note the shift from "your hand" to "that hand" in order to facilitate dissociation. "Soon one of the fingers may begin to feel especially light. One of the fingers may begin to lift up". Notice carefully which finger moves and comment accordingly, for example, "Good, I see that finger moving, I wonder what will move next. Yes. Good. Now another finger is moving. Now the whole hand. Just focus on the balloons and on the feeling of lightness in that hand. And the higher it goes, the lighter it can feel, and the lighter it feels, the higher it goes. Just floating up all by itself. Drifting higher and lighter and higher and lighter. Now imagine a soft breeze. That hand may float over toward your lap, or it may float higher, or it may just stay

where it is now. Very comfortable, very relaxed all over. You can let that hand (or arm) float, or, if you choose, you can let the string loosen and the balloons float away and let that hand slowly drift back down to a comfortable resting place, *because* it's fun and because it feels good to do ... So easy. Just effortlessly." If the child seems to be having difficulty, the therapist can first induce a hand or an arm catalepsy and then suggest further movement (Olness & Kohen, 1996:65).

### **3.6.3.6 *Progressive relaxation technique***

*Following Breathing.* "Focus your eyes easily on some point on your lap or anywhere you like, and pay attention to each time you breathe out. Notice what happens to your shoulders *automatically* while you breathe out ... they go down, don't they? Good. That's the mind and the body working together all the time; even without thinking about it, every time we breathe out we relax automatically. That feeling is relaxation. When you breathe out you loosen your chest muscles. Each of us does about 10 or 12 times each minute. Pay attention to breathing out, and each time extend your own relaxation feeling a little further. Past your chest and into your tummy muscles. Next time you breathe out, let the comfortable feeling move down into your hips and your upper leg muscles. Relax your lower leg muscles now and feel the flow of comfort, loosening relaxation feeling from your chest muscles down to your ankles, your feet, and your toes. Go at your own pace and your own speed. When you're ready, focus on your lower back muscles, and let them feel very comfortable. Loosen your upper back muscles. And now let a flow of relaxation spread past those shoulders that were already relaxing, down into your upper arms, gradually past your elbows and into your lower arm muscles, into the small muscles of your wrists, hands, and even the little muscles of the fingers. When you're ready, allow your neck muscles to become more comfortable than they were already. Loosen them but just the right amount to keep your head very comfortable. Let the flow of relaxation move into your cheek muscles, your forehead, around your eyes, even to the tiny muscles of your head and scalp, and even into your hair muscles. When you're nice and comfortable all over, please give me a signal by nodding your head or raising a finger. You can tell me if there is any part of your body that doesn't seem ready to be comfortable yet, and we can do some other things so that you can be even more comfortable all over" (Olness & Kohen, 1996:67-68).

### 3.6.3.7 *Eye fixation*

*Coin Technique.* Present a coin and ask the child to hold it between the thumb and first finger. For some children, attention is heightened by first drawing a smiling face with a coloured marking pen on their thumbnail. Younger children may prefer to have their favourite stuffed animal holding a coin, sometimes in a "paw", sometimes under a nose. Whether they fix their eyes on the coin held by themselves or by the stuffed animal is immaterial. "Just look at that smiling face on the thumb that's holding the coin (or just look at that coin) real easy. That's good. After a while the fingers (or paws) begin to get a little tired of holding it, and after a while the coin can slip down to the floor (or sofa or bed). It will be safe there. You can get it later. When it falls, that is your signal to yourself to just let those eyes close by themselves. That's right" (Olness & Kohen, 1996:68-69).

### 3.6.3.8 *Distraction and utilisation techniques*

These methods are especially helpful with children who are scared or in chronic pain. The therapist tries to distract attention from a negative to a positive focus. The success of this technique depends on the therapist's creativity. An example of this is "It hurts, and it's going to hurt a while longer. It will probably keep on hurting, until it stops. (the child hears "it stops") I wonder if it will stop hurting in 5 minutes or 7 minutes or 30 seconds or right now?"

### 3.6.4 **Teaching self-hypnosis**

Olness and Kohen (1996:80) advise that self-hypnosis is important for children as it gives them a sense of control and mastery and that the desired behaviour is reinforced by the frequent repetition of visual imagery exercises. They also recommend that self-hypnosis can be taught in the first hypnotic experience especially when coupled with Eriksonian suggestions, ego-strengthening and future-orientation (ibid., 83). After induction and deepening of hypnosis, suggestions for and training in self-hypnosis are provided along with post-hypnotic suggestions before the end of the hypnotic experience:

"Before you come to the end of what you have learned so well today, be sure to congratulate yourself for how well you've done; and be proud of how your brain and

body are learning to talk to each other so well. It's nice before you finish to remind yourself of what you did to help give yourself the good feelings you have now, so that when you practice this one or two times each day for 10 or 15 minutes, you'll know exactly how to do it. So, just picture in your mind where you might sit at home when you practice, and then see yourself doing the fingers-together game (or whatever induction was used) to start off your self-hypnosis (self-relaxation and imagination or whatever words were used). Great ... now notice that as your eyes close and you start to get comfortable that you can imagine about anything you want ... perhaps it will be about playing soccer or (add choices of several of child's favourite activities) ... and you can notice everything about it ... and when you practice this at home in this same way, you'll be able to notice just as you have today and now the way your muscles relax as you breathe out. And you can allow the relaxation feeling to move down your body all the way ... that's right ... and then, just like today, as soon as the relaxation has gotten all the way to your head or toes), then you can let your head nod (or finger lift), and that will be the signal to yourself that you are as comfortable as you want to be for that practice time. And then, before you finish practicing, make sure you give your mind and your body any directions or new ideas you want them to have (substitute her any hypnotherapeutic suggestions specific to the child and his or her problem(s). And the last thing you need to know when you practice at home and here, is that if you happen to be practicing at bedtime, you don't have to even finish, you can just let your self-hypnosis practice finish by falling asleep. And if you happen to be practicing at some other time, then when you're finished, you'll be done, and you can open your eyes and bring your good feelings back with you" (Olness & Kohen, 1996:83-84).

It is essential that the child be informed that this exercise is for his or her use only and that it should not be taught to other children. The child should be informed that this exercise should be used when he or she may experience recurrent difficulties while not in therapy, as a means of coping until the problem has been resolved. With regular practice, desired behaviour is reinforced, but it has been found that this wanes after a few months, once the problem has been solved (ibid., 81). Self-hypnosis allows for self-care in between sessions, creates a sense of mastery and control and reinforce desired behaviour with appropriate imagery (ibid., 80). It is also advised that parents assist their children if they are between the ages of five and six years of age. Olness

and Kohen (1996:80) advise that children five and older should preferably do this self-hypnosis exercise on their own, without parent interference, as it fosters independence.

It is important to remember the word "sleepy", "drowsy" and "tired" may have negative connotations for younger children and should be avoided during induction procedures (Olness & Kohen, 1996:53). Children may also resist closing their eyes and the therapist should be flexible in this regard and let the child know that it is all right to keep it open as it is their choice after all. The duration of the sessions would vary depending on the child's ability to concentrate. It is the therapist's task to observe when the child has reached his limit. Generally, younger children will have shorter sessions than an adolescent who may require the full hour.

As can be seen from the above, there are various techniques therapists can use to induce the hypnotic experience. Olness and Kohen (1996:77) have divided these induction techniques into specific age groups and is included in Addendum 4.

### **3.6.5 Deepening**

Although controversy exists about deepening of the trance state, it is rarely necessary as children are found to be sufficiently involved in images of a story. Deepening is another way of saying involvement. During the induction, children are guided to become more involved in their imagination. Hammond (1987 as cited in Wester & O'Grady, 1991:40) describes the following techniques to enhance the depth of the hypnotic state:

- Fractionation. The child is alerted and rehypnotised several times.
- Downward Movement. Movement such as walking down a staircase or moving down an escalator could facilitate deepening.
- Interspersing the child's motivation and needs. "And you are relaxing deeper and deeper because you ..."
- Contingent suggestions. "With every breath you take, you will relax more and more ..." or "With the sound of my voice, you can drift deeper and deeper ..."
- Breathing and Counting. Counting backwards from ten to one with interspersed suggestions or focussing on breathing with deepening suggestions can be included

as a deepening technique. One should remember that any technique could be used as a deepening technique.

Therapists should bear in mind the child's developmental level and use language that is age-appropriate.

### **3.6.6 Termination**

Sometimes termination happens spontaneously but at other times the therapist needs to guide the child to return to an alert and refreshed state in the here-and-now, the present. The therapist could count or simply change the tone of his or her voice to signal the return to the usual mode of awareness. Sometimes the child may resist returning to the present. This then should be used as an opportunity to discuss which techniques are the most appropriate for subsequent use. This would actively involve the child in the healing process and could give rise to feelings of empowerment.

## **3.7 REFLECTION**

This chapter outlined developmental stages of cognitive and linguistic abilities, as it is pertinent to tailoring hypnotic interventions age appropriately. The various models of hypnosis were discussed though one should bear in mind that in a real therapeutic setting these phases overlap considerably. Various hypnotic interventions were outlined involving all the senses, as the therapist should assess suitability for each individual child and tailor induction to meet the child's frame of reference. This implies utilising whatever the client brings to the therapeutic situation and adapting interventions for each child client. The following chapter will discuss the research design and methodology applied in this study.

## CHAPTER FOUR

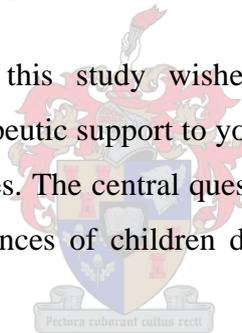
# RESEARCH DESIGN AND METHODOLOGY

### 4.1 INTRODUCTION

This chapter will focus on the research design and methodology applied in this study. The various instruments used in data production as well as the methods of data analysis and interpretation will be discussed. The themes will be categorised and coded for each participant. A brief synopsis of the themes that emerged for each participant will be given.

### 4.2 RESEARCH PROBLEM

As mentioned in Chapter 1, this study wishes to explore the utilisation of hypnotherapy in providing therapeutic support to young, primary school children who experienced emotional difficulties. The central question as mentioned in chapter 1 is: What are the emotional experiences of children during the process of Ericksonian hypnosis and hypnotherapy?



### 4.3 AIMS OF THE STUDY

The aim of this investigation is to create an awareness and understanding of the emotional experiences of primary school children during the process of Ericksonian hypnosis and hypnotherapy. It strives to explore various hypnotherapeutic techniques such as metaphorical story telling, without inducing formal trance. The participants will also be taught self-hypnosis strategies, which could be practiced at home to help them cope when not in therapy. Emphasis on the uniqueness of each child will be valued and therefore therapist flexibility will be prized. The Interpretive/Constructivist paradigm as discussed in chapter 1.2 is applied in this study.

#### 4.4 RESEARCH DESIGN AND METHODOLOGY

According to Merriam (1998:2) the precise nature of research is guided by the researcher's paradigm. She defined qualitative research as "an umbrella concept covering several forms of inquiry that help us understand and explain the meaning of social phenomena with as little disruption of the natural setting as possible"(Merriam, 1998:5). There are five types of qualitative research found in education. They are basic or generic qualitative study, ethnography, phenomenology, grounded theory, and case study. Babbie and Mouton (2001:279) narrow this down to three main qualitative designs, namely ethnographic studies, case studies and life histories. Babbie and Mouton (2001:279) claim that they all share four common characteristics which are "a comprehensive encounter with the object of study, the selection of a limited number of cases, an openness to various sources of data and flexibility". Merriam (1998:12) also believes that most qualitative research share the following characteristics, "the goal of eliciting understanding and meaning, the researcher as primary instrument of data collection and analysis, the use of fieldwork, an inductive orientation to analysis, and findings that are richly descriptive". Babbie and Mouton (2001:279) share the same sentiments. They also suggest that the difference between these studies lie in the boundaries. Ethnographic studies would generally focus on larger units of analysis, such as communities, life histories would focus on life histories of individuals while case studies focus on examining specific units of analysis such as individuals (ibid., 279). I chose to conduct this study in the case study research design.

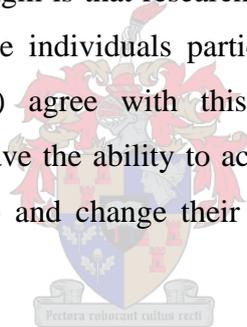
The fundamental assumption of qualitative research is that reality is constructed by individuals interacting with their social environments. Qualitative research is primarily concerned with "experience as it is lived or felt or undergone" (Sherman & Webb 1988 as cited in Merriam, 1998:6). Constructivism on the other hand also supports this in that individuals are responsible for shaping their own development through their personal experiences within the social and physical environment (Donald *et al.*, 1997:40).

Another element that is of crucial importance to qualitative researchers is that of understanding phenomena from the client's perspective also referred to as the "emic"

perception, the insider view (Merriam, 1998:6). Patton (1985 as cited in Merriam, 1998:6) succinctly stated:

*"[Qualitative research] is an effort to understand situations in their uniqueness as part of a particular context and the interactions there. This understanding is an end in itself, so that it is not attempting to predict what may happen in the future necessarily, but to understand the nature of that setting, what it means for participants to be in that setting, what their lives are like, what's going on for them, what their meanings are, what their world looks like in that particular setting-and in the analysis to be able to communicate that faithfully to others who are interested in that setting ...The analysis strives for depth of understanding".*

In the Interpretive/Constructivist paradigm individuals are in control of creating their own worlds by attaching meaning to their personal experiences (Dovey & De Jong, 1990:1). According to Mertens (1998:11) the basic assumption of the Interpretive/Constructivist paradigm is that research is underpinned by the belief that knowledge is constructed by the individuals participating in the research process. Babbie and Mouton (2001:28) agree with this line of thought in that they acknowledge that participants have the ability to actively and continuously construct their own meaning and develop and change their everyday interpretations of their worlds.



Another factor in qualitative research is that the design should be emergent and flexible as well as be adaptable to the changing conditions of the study as it occurs (Merriam, 1998:8). It is of paramount importance for researchers to be flexible as many extraneous variables could impact on the study over which the researcher would have no control. It is with all the above in mind that the researcher strives to conduct the study in an ever changing environment.

#### **4.4.1 A case study**

Merriam (1998:19) defines case studies as a means to "gain in-depth understanding of the situation and meaning of those involved". The goal of a case study is to gain understanding about specific phenomena. According to Stake (1995 in De Vos *et al.*, 2002:275) the function of a case study is to create an "opportunity to learn". The phenomena are the starting point and the case study, allows for the study of the

phenomena and the subsequent generalisations about them. This study however, does not intend generalising the findings but rather focus on the emotional experiences and process of hypnotherapy for young primary school children.

Furthermore, Denzin and Lincoln (2000:436) as well as Smith (1978 in Merriam, 1998:19) regard case studies as a "bounded system" such as an individual, group, community or event. Yin (1994 in Merriam, 1998:27) defines it as "an empirical inquiry that investigates a contemporary phenomenon within its real life context, especially when the boundaries between the phenomenon and context are not clearly defined". He perceives case studies in terms of a research process. I am interested in the process and the outcomes of the intervention, in the context rather than a specific variable, in exploring participants' experiences of the hypnotherapeutic process rather than confirming theories. In practice, the end result is also important, as one needs a resolution to the presenting problem.

Miles and Huberman (1994:25-26) graphically present the case as a circle with a heart in the middle. The heart is the focus of the study (the case) while the circle defines the edge of the case (what will not be studied). Babbie and Mouton (2001:281) propose that the most defining feature of a case study is its emphasis on the individual. However, Vera (1990 in Babbie & Mouton, 2001:281) acknowledges that a case study could explore more than one individual unit. For the purpose of this study I chose two individual children who experienced emotional difficulties to participate in this study. This would also allow for more credibility and validity of the findings (this would be discussed later in this chapter).

Mark (1996 in De Vos *et al.*, 2002:276) refers to three types of case studies namely intrinsic, instrumental and collective case studies. According to Denzin and Lincoln (2000:437) an intrinsic case study refers to the fact that the researcher would genuinely like to better understand the case. An instrumental case study refers to studying the specific case to gain insight of a social issue or is used to elaborate on a theory. A collective case study furthers the understanding of the researcher about a social issue or population being studied. Cases and concepts are compared as well as extending or validating existing theories (De Vos *et al.*, 2002:276). Miles and Huberman (1994:29) also believe that by looking at more than one case study, it would strengthen the precision, validity and stability of the research findings. I

applied an intrinsic case study, as one of the aims of this study is to explore the experiences of the participants during the process of Ericksonian hypnosis and hypnotherapy. Although the interest is in creating awareness of the process of hypnotherapy, both the participants were treated with the utmost respect and received the best possible treatment that I could provide.

#### **4.4.2 Participants**

According to Babbie and Mouton (2001:132) the aim of sampling in social research is to produce a representative selection of a population. Mertens (1998:4) suggests that those making up a sample are usually referred to as subjects or participants. In line with the Interpretive/Constructivist approach, I would refer to the cases as participants. On choosing a sample Mouton (1996:132) cautions that the way a sample is selected greatly affects the conclusions that can be drawn from analyzing the content.

A sample could imply the simultaneous existence of a population or universe of which the sample is a smaller section. According to Arkava and Lane (1983 in De Vos *et al.*, 2000:199) a sample only includes "elements of the population considered for actual inclusion in the study". We study a sample because we would like a better understanding of the population but most importantly to help us explain some facet of the population. There are two kinds of sampling namely, probability and non-probability sampling. According to Merriam (1998:61) probability sampling allows the researcher to generalise the findings of the study. However, Merriam (1998:61) argues that non-probability sampling is the preferred method utilised in qualitative research. There are two types of non-probability samples, purposive and convenient sampling. I chose a purposive sample for this study. Singleton (1988:153 in De Vos *et al.*, 2002:207) explains that a purposive sample is based entirely on the judgement of the researcher. This also means that the sample should contain certain characteristics or typical attributes of the population. According to Merriam (1998:61) a purposive sample is based on the assumption that the researcher wants to "discover, understand, and gain insight". It is therefore crucial that the researcher selects a sample and the site from which the most can be learned. Patton (1990 in Merriam, 1998:61) supports this viewpoint, as he believes that appropriate selection of cases should be information-rich. For the purpose of this study two cases were purposively selected.

Before embarking on purposive sampling, I set specific criteria for the selection of participants. The criteria were (1) that the participants should be attending a primary school in EMDC: Central in the Cape Town area and (2) should experience emotional difficulties. Both participants met the criteria and were therefore included in this study. The participants will be discussed in detail in chapter 5.

## **4.5 METHODS OF DATA PRODUCTION**

I have chosen to use the term data production instead of data collection due the Interpretive/Constructivist paradigm that outlines this study. Gough (1999:264 as cited in Le Grange, 2000:80) argues that this reflects the notion that no absolute reality exists instead it is constructed according to the individual's unique perceptions and experiences. Therefore, as the primary researcher, my own subjective reality which was formed by my own life experiences, would influence the way in which I produce the data. Bearing this in mind, I have chosen five data production techniques that will now be discussed.

### **4.5.1 Interviews**

This investigation is an experiential account of cases in their natural settings therefore knowledge obtained will be socially constructed and reported in rich and particularistic descriptions (Denzin & Lincoln, 2000:646; Merriam, 1998:8). Unstructured interviewing provides a greater breadth of information than other types, given its qualitative nature. Qualitative researchers usually differentiate between in-depth (ethnographic) interviewing and participant observation. However, Lofland (1971 in Denzin & Lincoln, 2000:652) argues that these two types of interviewing go hand in hand. Schwand (1997 in Denzin & Lincoln, 2000:663) notes that, "It has become increasingly common in qualitative studies to view the interview as a form of discourse between two or more speakers or as linguistic events in which the meanings of questions and responses are contextually grounded and jointly constructed by interviewer and respondent".

An unstructured interview was conducted with both parents to elicit more background information to gain useful family history, which may have impacted on the child's current crises. Another unstructured interview was conducted after the last session to

ascertain whether any change occurred and how it has manifested in their relationship with their child. Unstructured interviews were also conducted with their respective educators to ascertain their perceptions of the presenting problem as well as gain feedback after completion of therapy.

#### **4.5.2 Observation**

Another source of data production was that of observation. Babbie and Mouton (2001:282) emphasise multiple sources of data collection as it provides not only thick descriptions but also ensures reliable results when studies are replicated. The process of observation could contribute significantly to providing detailed descriptions in qualitative research. Breakwell, Hammond and Fife-Schaw (1997:213-215) believe that observing non-verbal data is just as important in the process of data collection as any of the other sources of data collection. Non-Verbal data could include expressive movements such as facial expressions, bodily movements, and the use of language as well as exterior physical signs such as clothing (Babbie & Mouton, 2001:293-295). These phenomena were all important in the process of tailoring therapy for the participants as it was utilised to demonstrate the hypnotherapeutic process.

De Vos *et al.* (2002:280) define participant observation "as a qualitative research procedure that studies the natural and everyday set-up in a particular community or situation". The researcher should possess the ability "to listen, to see, to inquire, to observe and to write notes" (*ibid.*, 281). Data were collected with the use of field notes, tape-recording and observations. I contracted for at least four to eight therapy sessions, on a weekly basis, which were conducted at the school.

#### **4.5.3 Field notes**

When doing research it is important to record as much information about the situation as possible. Researchers should take notes while in the setting or very soon thereafter. De Vos *et al.* (2002:285) suggest that notes should be made of everything that is seen and heard. Breakwell *et al.* (1997:223) also assert that field notes should not only describe an event and behaviour but the researcher should interpret aspects of the situation which are of interest to the research study. De Vos *et al.* (2002:285) argue that keeping notes could assist researchers to stay on track and help with distinguishing relevant from non-essential information. Reflections after each session

are included in this study which would describe observations made during the therapy sessions.

Another form of producing data is completing a clinical assessment. Clinical assessment is regarded as an important aspect of any support programme (Barlow & Durand, 1995:77). According to O'Connor and Ammen (1997:76) an assessment is crucial as it guides the support process given to a client. I attempted to do psychometric assessment but in both cases the participants were too traumatized to complete the exercise and it was therefore abandoned. In the Eriksonian approach one's assessment criteria are utilising the hypnotic phenomena with which the client presents in therapy. The assessment criteria were discussed in chapter 2.6. This would include the client's values, beliefs, language, behaviours, social context, fears and culture. By doing this, the principle of utilisation is applied in that all aspects of the client and his or her environment are used in order for the therapist to respond systematically and strategically (Zeig, 1994:294).

#### **4.5.4 Questionnaire**

A self-report questionnaire was given to each parent to complete the relevant background information including the developmental history of each participant. Although self-report questionnaires are quicker to administer than an interview, the respondents might not be entirely honest (McLeod, 1994:65). Another factor researchers have to consider when using a questionnaire is the literacy level of respondents. This questionnaire formed part of the unstructured interview with the parents. During the initial interview issues that were unclear or left out, were then dealt with.

#### **4.5.5 Tape recording**

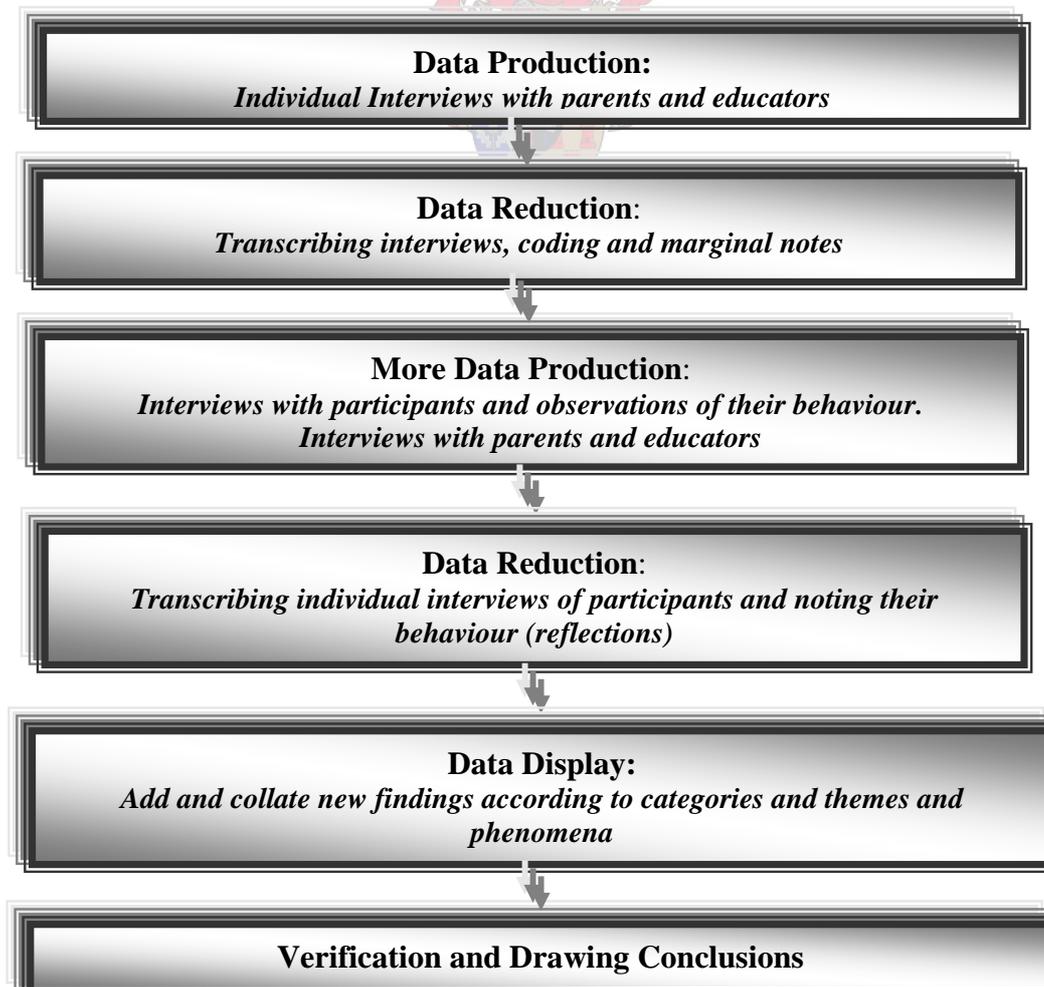
If recordings are used of any nature, permission should be obtained from the participants (De Vos *et al.*, 2002:304). De Vos *et al.* (2002:304) maintain that video or tape recording allows the researcher to concentrate optimally on the interview and less on taking notes. However, this method of data collection could also hamper the participant's ability to respond spontaneously in the session. It is suggested that the tape recorder be placed inconspicuously so as not to unnerve the participant (*ibid.*, 304). The tapes were transcribed for more detailed analysis.

#### 4.6 DATA ANALYSIS

De Vos *et al.* (2002:339) argue that qualitative research should be supplemented in many ways because descriptive data are used. Qualitative research relies on thick descriptive data of phenomena being studied as it leads its audience to understanding of these phenomena. According to De Vos *et al.* (2002:339), data analysis is the process of bringing order, structure and meaning to the mass of collected data". By using assessment criteria as mentioned in 4.4.2 and the data production techniques discussed earlier, tentative themes emerged. De Vos *et al.* (2002:286) describe the process of data analysis as "data reduction, presentation and interpretation". I used a simple method of data analysis as suggested by Miles and Hubermann (1994:11). They suggest the following three activities; data reduction, data display and verification.

The following figure (4.1) attempts to show the route I took:

**Figure 4.1: Process of Data Production and analysis**



In the process of data analysis, tape recorded sessions were transcribed verbatim and listened to repeatedly to gain better understanding while keeping the research problem in mind. Themes emerged due to beliefs and behaviours of participants during sessions, and this was verified by talking to their educators and parents. Keeping the Interpretive/Constructive perspective in mind, these beliefs and behaviours were verified by asking parents how it manifested at home or any other areas of their lives. These beliefs and behaviours (phenomena) were then used in the process of tailoring the therapy for each participant.

In the process of data analysis these patterns of behaviour and units of meaning were coded, categorised and clustered while systematically sorting through the data. I tried as far as possible, to make marginal notes as I sifted through the data. Miles and Huberman (1994:66) refer to this process of making marginal notes, as reflection. According to these authors reflection allows the researcher to be more alert during the coding process. According to De Vos *et al.* (2002:346) coding allows "data to be broken down, conceptualized and put back together in new ways". After data was collected, I attempted to identify patterns of behaviour and experiences which Engelbrecht, Swart and Eloff (2001:258) refer to as identifying units of meaning. It was therefore of paramount importance to listen attentively to understand what was communicated, be that verbal or non-verbal communication, during the entire research process. These clusters were labelled and coded to determine what themes emerged. These were then used to cluster certain sentences and phrases as well as the behaviour used by the participants during the sessions, and categorising the phenomena presented. Categorisation in qualitative research allows the information collected to be interpreted and helps with creating understanding and analysis of the phenomena being studied (De Vos *et al.*, 2002:344). The following figure provides the codes for identifying the various categories:

**Figure 4.2: Key for categories used in transcribing interviews and observations during the sessions**

<b>FD</b>	Family Dynamics
<b>OF</b>	Overall Functioning
<b>SS</b>	Social support
<b>PhFl</b>	Phenomenon of Flexibility
<b>PhCat</b>	Phenomenon of Catalepsy
<b>PhAss</b>	Phenomenon of Association
<b>PhHyp</b>	Phenomenon of Hypermnesia
<b>PhAmn</b>	Phenomenon of Amnesia
<b>PhRgres</b>	Phenomenon of Regression
<b>PhPre</b>	Phenomenon of Prehypnotic Suggestion

In applying content analysis, I was able to identify recurring patterns of meaning and themes that emerged during the sessions and interviews. Merriam (1998:160) believes that all qualitative data analysis is content analysis because the content taken from interviews, field notes and documents are analysed.

The following figures 4.3 and 4.4 will highlight the manner in which I coded and categorised themes for each participant.

**Figure 4.3 Themes which emerged for Sara**

CATEGORIES	CODES	THEMES
<ul style="list-style-type: none"> <li>Divorce</li> <li>Marital relations</li> <li>Parent child relations</li> <li>Impact of learning difficulty</li> </ul>	FD MAR PAC IMP	Family Dynamics Prehypnotic Suggestion
<ul style="list-style-type: none"> <li>Anxiety</li> <li>Lack of Self-esteem</li> </ul>	ANX SELF	Phenomena of Catalepsy, association, hyperamnesia & amnesia
<ul style="list-style-type: none"> <li>Parental Support</li> <li>Educational support</li> </ul>	PS ES	Social Support
<ul style="list-style-type: none"> <li>Scholastic Performance</li> </ul>	ACA	Overall Functioning

**Figure 4.4: Themes which emerged for Travis**

CATEGORIES	CODES	THEMES
<ul style="list-style-type: none"> <li>Divorce</li> <li>Marital relations</li> <li>Parent child relations</li> <li>Impact of the separation from mother</li> </ul>	FD MAR PAC PhHyp	Family Dynamics Phenomenon of Hyperamnesia
<ul style="list-style-type: none"> <li>Insecurity and uncertainty</li> <li>Talking too fast</li> <li>Concentration</li> <li>Fidgeting</li> </ul>	PhRgres PhFl Con PhFl	Phenomenon of Regression Phenomenon of flexibility
<ul style="list-style-type: none"> <li>Parental Support</li> <li>Educational Support</li> </ul>	PS ES	Social Support
<ul style="list-style-type: none"> <li>Classroom behaviour &amp; Scholastic performance</li> <li>Spending time with the father</li> </ul>	ACA PF	Overall Functioning

The themes and categories were identified during the process of this study. The information obtained were the result of all the interviews with parents and educators as well as the sessions with the participants. The means in which data was collected were interviews, observations and field notes and all the tape-recorded sessions with the participants. The themes that emerged throughout the research process forms the basis of the discussion and can be summarised as follows:

#### **4.6.1 Family dynamics**

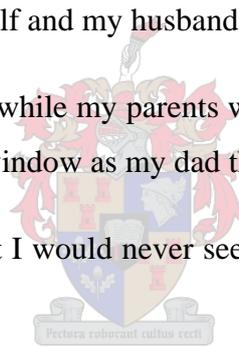
Both participants were from single-parent families due to divorce. Both divorces were described as "messy" with verbal and physical abuse. This theme also dealt with the participants' relationships with their parents after the divorce. Examples of some verbatim responses are:

"She used to stand between myself and my husband" (Sara's mother)

"I used to sit on my bed and cry while my parents were shouting at each other" (Sara)

"I looked through my bedroom window as my dad threw my mom clothes out" (Sara)

"My father and gran told me that I would never see my mother and sister ever again"  
(Travis)



"I sometimes kicked and fight with my dad when I was angry" (Travis)

"I'm scared that my dad won't let me see my mom again" (Travis)

"Travis would play peacefully in his room but would check up on me and his sister"  
(Travis's mother)

"He tends to be restless when I'm not around even at my mom's house" (Travis's mother)

#### **4.6.2 Social support**

This theme dealt with parental and educator support to both participants. Some examples are:

"I start shouting at her when she just sits and stares at her work" (Sara's mother)

"I sometimes complete her homework because I get so frustrated with her" (Sara's mother)

"I know she struggles with maths" (Sara's mother)

"She just sits and stare at her work" (Sara's educator)

"She doesn't ask for my help" (Sara's educator)

"He doesn't let me out of his sight" (Travis's mother)

"He gets restless when I leave him for too long at his grandmother's house" (Travis's mother)

"He tends to fidget with his hands and pencils even though his work is not completed" (Travis's educator)

"He cannot stay focussed on one task for long" (Travis's educator)

"He gets annoyed when he struggles with his phonics" (Travis's educator)

### 4.6.3 Overall functioning

This theme dealt with classroom behaviours after completion of therapy, as well as behaviours between parents and their children. Some examples are:

"She would put up her hand and ask for help" (Sara's educator)

"I've noticed that her eyes are not as huge anymore" (Sara's educator)

"She progressed well this term and did well in her performance tests" (Sara's educator)

"She would ask me to just sit with her while she does her maths homework" (Sara's mother)

"She would show me how to solve a problem" (Sara's mother)

"She now wants to do her homework" (Sara's mother)

"He doesn't ask me to phone his mother anymore" (Travis's educator)

"He now completes his work and check it" (Travis's educator)

"He went to his dad for the Easter holidays and he was fine" (Travis's mother)

"He only phoned me once while he was there" (Travis's mother)

"He is looking forward to spending the June holidays with his father and grandparents" (Travis's mother)

#### **4.7 VALIDITY AND RELIABILITY**

Several researchers, such as for example Merriam (1998:198) recognise the importance of research being trustworthy in the qualitative research paradigm. This implies that the research is considered valid or reliable to the extent that it has been accounted for. Validity and reliability take on various forms in qualitative studies than in quantitative research (Denzin & Lincoln, 2000:391). Research conducted in an ethical manner is part of ensuring validity and reliability. According to Merriam (1998:199) irrespective of the kind of research conducted, validity and reliability can be addressed through careful deliberation of the research study's conceptualisation and the manner in which data was collected, interpreted and analysed. In scrutinising literature about research, one becomes aware that there is no uniform way of ensuring validity and reliability in qualitative research (Denzin & Lincoln, 2000:393; Merriam, 1998:167). Lincoln and Guba (1985 in De Vos *et al.*, 2002:351-352) propose alternative constructs to internal validity, external validity, reliability and objectivity. They claim that these constructs are inappropriate in qualitative research. The preferred names for these constructs in qualitative research are credibility, transferability and dependability. These concepts will now be briefly discussed as they were applied in this study.

##### **4.7.1 Credibility/Internal validity**

The goal of credibility is to "demonstrate that the inquiry was conducted in such a manner as to ensure that the subject was accurately identified and described" (De Vos *et al.*, 2002:351). This then refers to the way in which I portray the perceptions and reality as lived by the participants in the study. In this regard the setting, population and theoretical framework play a vital role as it defines the parameters in which the

study was conducted. According De Vos *et al.* (2002:352), the limitations and boundaries placed on the study makes it valid. However, Wolcott (1990/1995 in Denzin & Lincoln, 2000:393) reminds us that qualitative researchers are concerned with describing people, places and events. He believes that validity in the qualitative paradigm is concerned with descriptions and explanations and whether or not these explanations fit the description. He argues that qualitative researchers do not claim that there is an absolute way of interpreting a situation, there is no one correct interpretation. However, there are ways of ensuring credibility which will now be discussed.

#### **4.7.2 Triangulation**

Denzin and Lincoln (2000:443) state that triangulation is a process of applying multiple methods of data collection to "clarify meaning, [and] verify the repeatability of an observation or interpretation". This was achieved by identifying various ways the phenomena were perceived.

In this study triangulation was achieved through the use of multiple methods of data collection such as background questionnaires, interviews and observations during the therapeutic process. Multiple data sources were used namely the different interviewees such as the participants, two educators, the parents and the principal of the school. The study also includes a description of two cases in which hypnotherapy was applied. The findings of this study were also discussed with other psychologists working at the EMDC as well as with peers who received the same training as I did. Mertens (1998:183) reminds us that triangulation also involves checking one's information that has been collected from different sources to ensure relative consistency of evidence. By using peer examination from those who received similar training as I did, triangulation could be achieved.

#### **4.7.3 Transferability/External validity**

In the quantitative research paradigm, external validity refers to the degree to which one can generalise the results to other settings (Merriam, 1998:207). In qualitative research the aim is not to generalise findings, but to provide a unique detailed description of a case and its phenomena. Denzin and Lincoln (2001:394) assert that any one who attempts to generalise an individual case study could do more harm to

that individual. What the researcher can provide is thick descriptions of the case as it occurred in its natural context. It is left to the audience to make judgements about the case on the basis of the information provided. However, De Vos *et al.* (2002:352) recommend that multiple sources of data as well as multiple cases could strengthen the appropriateness of this study to other settings. In this study two participants were used to illustrate the process of Ericksonian hypnosis and hypnotherapy.

#### **4.7.4 Dependability/Reliability**

In quantitative research, reliability refers to the extent to which research findings can be replicated and is based on the assumption that the universe is unchanging, yielding consistent results (Merriam, 1998:204; De Vos *et al.*, 2002:352). However, this perception is not shared in the qualitative paradigm. Reliability then refers to the consistency or stability of the research over time (De Vos *et al.*, 2002:352). Denzin and Lincoln (2001:394) believe that the value of a case study is in its uniqueness and regard replication as pointless. They maintain that psychometrics decontextualise and depersonalise the individual being studied. Due to the afore-mentioned factors, thick and rich descriptions should capture the lived experiences and context of the participants, including their stories. Given the fact that the Ericksonian approach considers everything about the client to be valuable, the utilisation and cooperation principles should be applied in all interventions.

### **4.8 ETHICAL CONSIDERATIONS**

When doing research in the social sciences, one needs to remember that the respondents are not in a laboratory setting but human beings in the real world. Various authors stress the importance of confidentiality and anonymity (De Vos *et al.*, 2002:354; Mertens, 1998:24). Participants including the parents and teachers were assured that pseudonyms would be used and that the school name would not be mentioned. Of importance is that participants should be respected and protected from physical and or mental harm. In this regard, preparation and planning of sessions were discussed with colleagues and the recorded session scrutinised with the researcher. Due to the participants being minors, their parents consented in written form that they could participate in the research study. The therapy was explained to the participants

and their respective parents as well as dealt with any misconceptions they may have had about hypnosis and hypnotherapy.

#### **4.9 SUPPORT PROCESS**

The support process included intake and termination interviews with the parents of the two participants. During the first interview, information was obtained from both parents about the children's development, current scholastic performance and any relevant information which could have contributed to the current crises they were experiencing in school. The initial reasons for referral were explored. The two educators were also interviewed to ascertain their concern about the participants' scholastic performance. At the time, more emphasis was placed on scholastic and academic development. Another interview was warranted for both cases, as both participants could not complete the individual assessment due to an abreaction. The second interview with Travis's mother was more specific in terms of gaining knowledge about the circumstances around the divorce. It was during this session that his mother conveyed the real circumstances as it unfolded at the time of the divorce. She requested therapeutic intervention. Hypnosis and hypnotherapy was explained and she consented to the therapeutic intervention as well as participating in the research study. Sara's mother on the other hand, was shocked to hear how her daughter responded and requested therapeutic assistance. Once again the treatment modality was explained though to a lesser extent, as the mother was familiar with hypnosis due to her own therapeutic experience several years ago and consented to the intervention plan and participating in the study. The educators of both participants were then interviewed to gain information about their presenting behaviours in the classroom. The school principal was interviewed and permission was granted that these children and the school could participate in the study.

After the above interviews were conducted, the support process commenced. The support programme for both participants included eight sessions of hypnotherapy, one was used for attempting the individual assessment and the rest for psychotherapeutic intervention including termination of therapy. Parents were then interviewed to ascertain whether there was any change in their behaviour and the educators were asked how it manifested in the classroom.

#### **4.10 THE CONTEXT**

Babbie and Mouton (2001:282) point out that in order to understand and interpret case studies, the researcher needs to understand the context in which the research was conducted too. All the research was conducted at the preparatory school in the Western Cape. The school has one reception, two grade one, two grade three and two grade three classes. The school is situated close to the beach with the most remarkable scenery. The school is fully equipped with additional support staff such as a learning support educator, an occupational therapist and speech therapist. The additional support staff uses the school facilities and in return they do pro bono work for the school if learners from disadvantaged communities require specialist intervention. The school has a wonderful inviting and warm atmosphere in which one automatically feels welcome. The children seem to be happy and excitedly lines up after each interval. The secretary plays a huge role in organisation and support to the educators.

In my capacity as school psychologist for EMDC:Central, I travel to the school and do all the assessments, therapy and case discussions at the school. This school is one of thirty schools to which I render psycho-educational support. All the interviews with parents and educators and the therapeutic support were conducted at the school. The times and dates were arranged with the school via the principal who also acts as the Teacher Support Team Coordinator. Unfortunately, I could not use the same room to conduct the interventions and was shifted and at one time, there was no space available to conduct the therapy and the session had to be postponed till the following week.

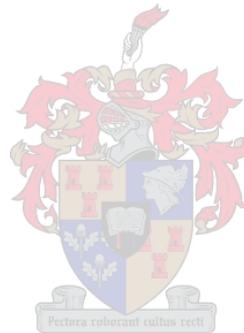
#### **4.11 THE THERAPIST**

I was the only therapist in this study. I am an educational psychology intern who has a keen interest in hypnosis and hypnotherapy. I was introduced to hypnosis and hypnotherapy in 2003 when I commenced my training with the MEISA institute. The training was completed in December 2003. While receiving my training in hypnosis and hypnotherapy, I also attended monthly discussion groups where various concepts and techniques were discussed and demonstrated. While receiving training, I realised that of the psychologists attending the training courses very few felt comfortable working with young children. My training in educational psychology and the many

other Play therapy and Sand Play workshops I attended in 2002 and 2003 put me in good stead to conduct research using young children and applying the hypnotherapeutic techniques. While still in training many of the skills learned were applied in my daily work and discussed at the training sessions.

#### **4.12 REFLECTION**

In this chapter the aims, research problem and theoretical framework were discussed briefly. The research design and methodology including the various instruments of data production and method of data collected were outlined. The method of data analysis was examined as well the therapeutic setting and ethical issues were highlighted in this chapter. The next chapter will focus on the implementation of the study.



## CHAPTER FIVE

# IMPLEMENTATION OF THE STUDY

### 5.1 INTRODUCTION

In this chapter the implementation of the two case studies will be discussed. Both cases will be discussed in terms of the clinical assessment and individual therapy sessions. This will include therapist reflections after each session. The phenomena as identified, would be discussed to illustrate the process and efficacy of hypnosis and hypnotherapy with young children.

### 5.2 CLINICAL ASSESSMENT OF THE PARTICIPANT: SARA

Details of the assessment are provided to contextualise the case of Sara.

#### 5.2.1 Reason for referral

Sara was initially referred for experiencing difficulties with numeracy (mathematics). However, Sara's reaction to the Number Problems subtest on the Senior South African Individual Scale-Revised (SSAIS-R) prompted the researcher to attend to her therapeutic needs.

#### 5.2.2 Background Information

**Family:** Sara is an eight year old and only child of divorced parents. She attends a primary school in Cape Town. She lives with her mother and her partner and visits her biological father every weekend and school holidays. Her parents divorced when she was six years old. According to the mother, Sara has a good relationship with her partner. Before the divorce, the household was volatile due to continuous verbal abuse. Sara witnessed this and often tried to intervene. The mother also mentioned that towards the end of the marriage, her spouse became aggressive towards her. Sara often tried to protect her mother by placing herself between them. After the divorce, Sara was at first ambivalent about visiting her father. The mother maintained that the

two of them are at least civil towards each other now and this has increased Sara's willingness to visit her father. According to the mother, Sara has a good relationship with her father's partner. Sara and her mother have a very close relationship.

As a single parent, it is difficult for her to devote a lot of time with her daughter as she often works until very late. By the time she gets home it is late and then she still has to supervise homework. She mentioned that Sara would often just give up when she becomes stuck on a mathematical problem. She explained that Sara would just sit and stare at her work without making any attempt at solving it, it is as if she "freezes". This often leads to shouting and sometimes she would even complete the homework for her. They share the love for animals and spend a lot of time taking them for walks or playing with them.

**Birth and Development:** According to the mother, the pregnancy was unplanned but welcomed. Except for the labour that was induced because Sara was one week over due, the pregnancy was normal. All developmental milestones were age-appropriately developed.

**Behaviour:** Sara's mother described her as being a sensitive, happy and obedient child. She could also be attention seeking at times, especially when she worked extended hours. She also mentioned that Sara becomes quite lonely, as there are no peers her age group living close by. Sara would occupy her time by drawing, reading and watching her favourite videos. The mother also mentioned that she becomes quite anxious when she has to write a test and when having to do mathematics homework. She also noticed that Sara started biting her nails, especially when doing homework. Sometimes Sara dreaded going to sleep at night because of tests. The mother also mentioned that she finds it difficult to get Sara into routine after spending a weekend with the father because as she put it "there is no routine and everything goes".

**Socialisation:** Sara loves playing with her friends at school and the mother tries to invite her friends over whenever possible. Sara is involved in gymnastics and karate. These extra-mural activities are offered at the school. Sara is also a keen swimmer and loves outdoor activities especially walking and playing with her dogs in the park.

**Scholastic:** Her mother reported that Sara struggled with numeracy in her previous grade as well. Her educator reported that Sara had still not mastered some of the basic

mathematical concepts taught in grade one. She mentioned that Sara's overall performance is of average ability except for numeracy. The educator mentioned that Sara would not put up her hand to ask for assistance, often just stared at her work and sat as if frozen. She also mentioned that she was aware that her mother sometimes completed the mathematics homework. Sara would also not ask for assistance from her buddy who sat next to her.

**Previous Support:** The mother reported that Sara had never received any specialist intervention with regard to mathematics. The mother was aware of her daughter's anxiety and other emotional issues related to the divorce but could not afford therapeutic intervention.

**Behaviour and Observations during assessment:** Sara appeared slightly anxious in our first meeting. She sat with a rigid upright posture and continuously fidgeted with her fingernails. Her eyes became huge when she heard that the "games" we were going to play involved numbers. These behaviours were presented when I attempted to administer the SSAIS-R. She became extremely anxious on the Number Problem subtest. On giving the instruction, she already appeared to sit up even more rigidly and sucked in her breath. She eventually, held in her breath for such a long time, that she started turning blue in the face with her hands on her lap. This abreaction caught me totally off guard. I had to immediately do a relaxation exercise and abandon the individual assessment.

### 5.2.3 Initial assessment according to Geary's process model

Sara did not like doing homework that involved numeracy or number concepts. According to the mother, she tended to "freeze" when that mathematics became too challenging and this would lead to the mother shouting at her. The mother also reported that it seemed as if Sara stopped breathing at times especially when she became frustrated at not being able to solve the mathematical problem. The class teacher verified this behaviour and mentioned that Sara is not confident enough to ask her or put her hand up in class when she does not understand. The teacher mentioned that she noticed that Sara's eyes would become huge and it was as if she "kept in her breath" when faced with a difficult mathematical problem. These behaviours can be classified as the **phenomenon of catalepsy**. She is focussing on a specific stimulus

when this occurs namely, mathematics and then she inhibits voluntary movement by "freezing". An example of this happening with me was when I attempted a formal assessment. While attempting the psychometric assessment, she became extremely anxious when she had to complete the Number Problems subtest on the Senior South African Individual Scale-Revised (SSAIS-R). She became more and more anxious after each item, sitting up straight with her eyes opened wide. After the third item, she sat up even more rigidly and I noticed that her breathing stopped and she started getting blue in her face. I had to abandon the formal assessment and changed my strategy into a therapeutic one to address the anxiety to enable her to cope and take control of her breathing and the situation. In doing the relaxation exercise, she started breathing normally again and I seeded the idea that there is hope of her taking charge of herself and developing the ability to acquire the skills to master mathematics.

Sara also informed me that she does not like numeracy and that she sometimes just sits and stares at her work not knowing what to do or who to ask for help. It was as if she "can't move". Sara mentioned that she sometimes "pulls in my breath" when she cannot solve a mathematics problem. The statements "can't move" and "just sits and stares at her work" led to the identification of the **phenomenon of dissociation**. While busy with mathematics and becoming anxious about not being able to master it, she detaches herself from her present stressful situation.

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She also mentioned that she "is sick of maths homework" as she was "not able to do it anyway". Sara also does not believe that she can ever master mathematics. She is not confident about her ability to learn the skills necessary to complete mathematical problems successfully saying, "I don't like maths" and "I can't do this". When faced with a maths problem, she would give up saying for example, "it is too difficult" and not even attempt to solve the problem. These kinds of beliefs can be classified as being the **phenomenon of pre-hypnotic suggestion**, where she already had a negative belief about herself and her abilities. This results in having a low self-esteem and impacts negatively in her school life. Also, the fact that she does not like mathematics could mean that she associates mathematics with failure. This leads to the **phenomenon of association** to be identified. These beliefs also lead me to believe that every time she has to complete a mathematics task, she remembers all her previous unsuccessful attempts vividly, leading her to believe that she can never

master mathematics. This can then be termed as the **phenomenon of hypermnesia**. At the same time, she also forgets that she has had some successes with mathematics in the past, for example she achieved most of the outcomes for numeracy in grade 1. This can then be identified as the **phenomenon of amnesia**.

The various phenomena identified during the assessment phase, informed the therapeutic goals. These were verified with Sara as being part of her problem that needed to be addressed in therapy.

#### **5.2.4 Therapeutic goals**

It seemed as if Sara's emotional state impacted negatively on academic performance. It was therefore recommended that individual therapy be conducted to address her anxiety for mathematics and test situations. Emotional issues that related to the divorce and acceptance of her current life situation would also be addressed during therapy. In addressing these issues it was envisaged that it would improve her overall functioning at school and at home.

#### **5.2.5 A summary of the therapy sessions: Sara**

The therapy sessions will be discussed and my reflections given after each session.

##### **5.2.5.1 Session One**

The interview with the parent was conducted at the preparatory school. The principal arranged the interview and a venue for the assessment. The background questionnaire was used as a starting point for discussion. My role as school psychologist from EMDC: Central was explained as rendering a support service to the school community. The goal of the interview was to ascertain detailed information with regard to Sara's development, family structure and general academic functioning at school. Special attention was given to her behaviour and attitude towards mathematics. Sara was also included in the discussion. She mentioned that she really does not like mathematics and that she really struggles with it. She mentioned that she is tired of doing so much mathematics homework. Her mother also stated that Sara becomes totally frustrated with her homework and that she would sometimes refuse to do it. She explained that refusing meant just sitting in front of her exercise book not

even lifting the pencil or attempting to do the exercise. She would just stare in front of her and all the screaming and shouting did not help. The purpose of the psycho-educational assessment was explained. Consent was given to do the psychometric assessment only.

The first session also included a separate interview with the class educator and looking at some of her class exercises. The educator remarked that Sara would sit at her desk, her eyes huge staring blankly and not asking for assistance. She related that if she did not check up on her, she would never come to her to ask for help. She mentioned that Sara lacked confidence in asserting herself to do the afore-mentioned.

The principal brought Sara to the designated venue, the occupational therapist's office. Sara seemed nervous while I explained the process of the assessment. The goal of this session was to determine her general level of functioning and whether she experienced any barriers to learning. When she heard the games involved number problems as well, she asked whether it was really necessary to do it. She was assured and encouraged to only try her best. She was slightly hesitant to do the Draw a Person (DAP) and Kinetic Family Drawing (KFD) but with a little encouragement and reassurance she complied. Although she participated on the first few subtests on the SSAIS-R there was a measure of uncertainty and dread. After each of the first three subtest on the Verbal scale she asked when we were going to do the activity involving mathematics. When it was time to give the instruction on the Number Problem subtest, she was already sitting up straight and fidgeting with her fingernails. She was also chewing her bottom lip. After each of the first two test items, she became more and more anxious, her breathing was erratic and her eyes were huge. After giving the question to item three, she first said that it was too difficult and I encouraged her just to try her best. The more she struggled to get to the answer, I noticed that she was holding her breath. I tried to encourage and motivate her and suggested that we could leave that one and attempt another one. She kept on holding her breath until she turned blue in the face with her hands clasped tightly on her lap, her fingernails biting into the palms of her hands. I immediately did a relaxation exercise using directive therapy. We went for a walk outside and as we came closer to the venue again she started breathing heavily again. I told her that we did not have to go back and continue the activity. We went to her classroom, where I requested that she be

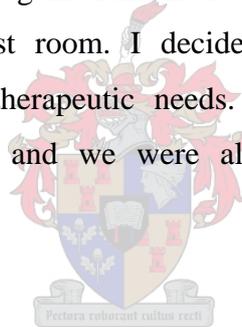
allowed to eat her lunch. The educator was informed of her vulnerable emotional state and to give some time to collect herself before commencing with the class routine.

The class educator was asked again about her behaviour in class towards mathematics and she relayed the same information as in the first interview. I requested from the principal, who was also the Teacher Support Team (TST) co-ordinator, to contact the mother to arrange another appointment for the following week at the school.

- ***Therapist reflections***

I felt comfortable about performing the task of psychometric assessment at the school. I felt competent to deal with the reason for referral as many of the referrals I receive deal with scholastic learning barriers.

I was dismayed at the intensity of Sara's anxiety. My immediate concern was to calm her enough to breathe normally again. I instinctively applied a relaxation technique and removed her from the test room. I decided to abandon the psychometric evaluation and focus on her therapeutic needs. I discussed this case with my colleagues and my supervisor and we were all in agreement that therapeutic intervention was required.



#### ***5.2.5.2 Session Two***

I met with the mother and informed her about what happened. The mother was also shocked to hear this and requested therapeutic assistance. She was informed about the treatment modality of hypnosis and hypnotherapy and asked for permission to allow her daughter to participate in the research study. The mother revealed that she also received therapy soon after the divorce where hypnosis and hypnotherapy were used. She had a few more questions about the treatment modality, which were dealt with and consented to participating in the study and to the use of the audio-tape during the therapy sessions. We also contracted for at least four to eight sessions of therapy to be conducted on the school premises. The school principal and the class educator were also asked for permission to participate in the research study to which they consented.

Sara was once again brought to the occupational therapist's office by the principal. I explained to her that we were not going to play number games anymore and that we

were going to do far more interesting activities. She was much more relaxed and told me that her mother informed her about the fact that we were going to work together on other issues she may be experiencing. She was quite comfortable and talked to me easily and spontaneously. She told me that her favourite movie was Barbie and Swan Lake. She also informed me that she had various books about Barbie and that pink was her favourite colour. She also liked the story of Aladdin and Jasmine. She had two dogs and a cat at her mother's and a dog at her father's house. She loved playing with them in the park. I asked her about what she thinks she's might be experiencing problems with. She relayed difficulty with mathematics and that she dislikes the fact that her parents are divorced. She relayed that her mother spoke to her about the divorce and how it would affect the living arrangements. I asked her what she did when she experienced difficulties with mathematics and she presented me with the sequence of events.

- ***Therapist reflections***

I was pleased at the outcome of the above interventions and strategised the implementation of the therapeutic intervention with my peers who also did the training with me. The case was also discussed with my supervisor.

### ***5.2.5.3 Session Three***

Sara was accompanied by the principal and looked quite tense. She outlined the sequence of how she becomes anxious when faced with mathematics. I asked her if she knew what it meant to use your imagination and she responded by saying "you think of something in your head and imagine it is real". I explained hypnotherapy as taking an imaginative journey just like her favourite animated characters such as Aladdin and Barbie and Swan Lake. She was then introduced to hypnotherapy using one of the movement imagery techniques. Instead of the "flying blanket", it was adapted to the "flying carriage". The script is as follows:

We are going to take a magic journey in your imagination to a very special place. You can invite your favourite animal with you, do you have your kitty with you? Maybe your kitty is on you lap or maybe it is sitting next to you. You and your kitty are sitting in a beautiful carriage, with pink seats in a white and gold trimmed carriage ready for take off. And as the carriage slowly lifts off the grass you are filled with

excitement. And as it lifts the two of you off the ground, you gently stroke your kitty. Can you feel the fur between your fingers, how soft it feels? And as you float up into the blue sky towards your special place, you notice something familiar as you look down. You hear something that sounds like a dog barking. Yes, to your surprise, it is your dog wagging his tail and barking because he wants to come on this journey too. You slowly direct the carriage to go down to fetch the dog. Now that your two favourite animals are with you, you are filled with happiness. With your one hand you stroke kitty and with the other hand you stroke the dog. And as the carriage floats through the air towards your special place, you feel a gentle breeze on your face and your hair lifts from your shoulders (utilising hyperesthesia isomorphically). You put your face out towards the sky and enjoyed the gentle coolness of the breeze on your skin. And as you enjoy this, the carriage started moving down slowly. You noticed something very familiar as you looked down ... and there in a distance you saw the park, the place you love to play in with your animals. And as the carriage moved slowly down, down until it stops on the grass you were filled with excitement at the idea of spending time with the animals in the park. When you looked out you also saw the most beautiful castle, maybe it is the castle where Barbie lived. I don't know what it looks like but maybe you could just take in all you can about this majestic castle. And as soon as the carriage landed the animals were out and chasing one another (utilising catalepsy isomorphically). You and your animals are really enjoying playing together. And you can take all the time you need in the next minute of clock time to play with your animals in the park. And when you are ready, you and your animals could get back into the carriage and take a slow magical ride back ... first you drop off your dog and then slowly float back to your bedroom, snuggling up with you kitty. And when you are ready, you can come back here and now in this room ... NOW.

She reported that she really enjoyed this exercise and that it was easy to use your imagination. She seemed much more relaxed and stretched out her arms as if waking from sleep and yawning. Then we proceeded with the "follow the breathing exercise". The purpose was that of relaxation of the muscles in the body. The script is as follows:

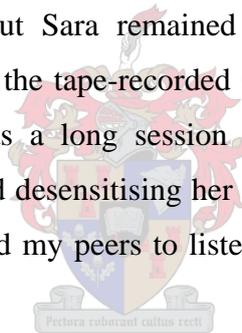
I would like you to sit comfortably in the chair and feet on the ground (utilising association isomorphically). I would like you to breathe in deeply and then blow it out

through your mouth. Take a breath in and then slowly breathe out ... again and again ... that's right, you are breathing in and out slowly ... and as you breathe in and out I notice that you are sinking deeper, more comfortably into the chair ... and I notice that your shoulders are becoming more and more relaxed. I notice that your eyes are open but that is OK just as long as the rest of your body is comfortably relaxed and your breathing is slow. And as you breathe in and out you become calm, peaceful and relaxed. I would like you to notice how relaxed your shoulders are becoming as it moves right down, down until it is comfortably relaxed. And as your shoulders become relaxed, your arms are also getting heavier ... notice that your hands ... and fingers are also becoming more and more relaxed. And as the calmness spreads through your body, you notice how your fingers rest gently on your lap (utilising hypersthesia, association and analgesia isomorphically). Notice, as you breathe in and out, how relaxed your one finger becomes, I don't know which one is now more relaxed. But as it relaxes, every time you breathe in and out, another finger gets more and more relaxed until the entire hand is now relaxed. And as you continue breathing, your tummy also feels relaxed, I can see that your eyes are blinking and that maybe it also feels relaxed and heavier and maybe you would like to close your eyes ... but, if you prefer, it could remain open just as long as the rest of your body is totally relaxed. And as you breathe in and out slowly, you can notice the calmness spreading to your legs, your knees, your feet and even your toes. And now you feel completely relaxed and your whole body is feeling calm, relaxed and peaceful. And now you know, Sara, that you are in control of your breathing and that you can relax any time you choose too. You can now enjoy the sensation of being relaxed and breathing in and out slowly for a little while longer ... and when you are ready you can become aware of the seat you are sitting on and how your feet are resting comfortably on the ground and when you are ready you can come back here, come back now to the sound of my voice ...

We practised the "follow my breathing" technique again. She was then taught how to do self-hypnosis using this technique. She revealed that she could practice this once in class in the morning and at night before going to bed. The purpose of self-hypnosis, is mastery and control when in a crisis if not in therapy.

- *Therapist reflections*

I was pleased at the outcome of this session. She easily went into a trance state and I noticed that she presented with change in skin colour and immobility while in this altered state. Using an informal way of introducing her to hypnotherapy still had the desired effect. At first I was concerned that she might resist, as she didn't want to close her eyes. This made me feel a bit uncomfortable but I soon realised that some young children, prefer to keep them open. By giving her truisms, acknowledging what I observe happening to her, allowed her to go even deeper into trance. I also realised that building rapport and utilising what the client brings to therapy could enhance the therapeutic alliance even more. In using her favourite characters first put her at ease and allowed her to experience this imaginative journey as being a non-threatening experience. I also realised that resonating with your client allows you as therapist, to almost go into mutual trance with the client. An educator entered the office while doing the breathing exercise but Sara remained focussed not even noticing the educator. Only after listening to the tape-recorded session did I actually hear myself go through the script. This was a long session because I had to pace her very carefully. In this session I started desensitising her to dealing with difficult situations and remaining in control. I asked my peers to listen to the recording and assist with planning for the next session.



#### **5.2.5.4 Session Four**

The principal brought her and she seemed happy and smiled. She was talkative and told me about her weekend. She volunteered the information that she had been practising the breathing exercise everyday. I asked her to draw her problem. She drew a girl sitting at her desk with a book in front of her. I asked her to tell me a story about the girl in the picture (utilising association and catalepsy isomorphically). She told me a story about a friend in her class who struggled with mathematics and what she does when she can't do the work. She would sometimes help her when she needs help. She said that she also has the same problem but now she would visualise the numbers and the problem in her head and sees herself doing the work. She now sees the numbers in sequence and tries to work it out. Sometimes she goes to sit on the mat in the classroom to look at the number board, check where the numbers are and tries to

figure out the problem. She would sometimes ask her teacher for help by putting up her hand or she would ask her friend. She doesn't get stressed anymore if the work is difficult but would rather try first and then request help from the teacher.

I then did the breathing exercise asking her to do it herself. I then focussed on the first day she started school and that all the numbers and letters looked difficult to write and remember. But now she knows that a 6 is not a 9 and a 9 is not a 6 even if it stood on its head. Now she knows that an A is an A and a B is a B and that she now knows all the letters of the alphabet and the sequence of all the numbers. Posthypnotic suggestion was given of "I am in control even in difficult situations" and that she can learn and that some things are just more difficult than others but that she can persevere and master it no matter what the situation or problem. She smiled as she left and looked much more self- confident.

- ***Therapist reflections***

Using the same sequence of her story allowed her to become immersed in the story and relate to it on a personal level. She spontaneously went into trance while telling the story and presented with the hypnotic constellation. Her mouth was slightly open. Her eyes were open but fixed and her breathing was slow and controlled. She did not notice when an educator entered the office. I was worried that she might disturb the process but the participant remained focussed.

#### ***5.2.5.5 Session Five***

She started talking about her parents and the fact that they are not together. She mentioned that she would like them to be to be a family again. She seemed distraught about the separation. I decided to use the colour my world technique and asked her to use different colour to depict her feelings. She chose her favourite colour, pink to indicate happiness, red for sadness and blue for feeling angry. I asked her to colour in the worksheet on which there was a circle. I asked her to focus on her family as it was before the divorce, and then use the colours to represent how she felt at the time. The colours would indicate the different feelings she had at the time. The circle was more than half coloured in with blue, representing anger, pink filled a quarter of the circle, representing happiness and red the rest, representing sadness. She explained that she felt angry at the fact that they didn't love each other enough to stay together. She felt

happy because she loved being part of the family with a mother and a father and that loved her too and sad because they always shouted and swore at each other and sometimes they fought with in front of her utilising regression isomorphically). She would sometimes get between them begging them to stop or run to her room and cry on the bed because she couldn't understand why they were being so nasty to each other. We then spoke about her current living arrangements and how happy she is at both houses. She now had two homes where she feels loved and cared for. Her mother and father never stopped loving her no matter what happened between them. I asked her to mention the advantages of her parents living separately. She responded by saying that they don't fight any more, can still talk to each other without arguing and still care for her separately. She has animals at both homes that she cares about and that she gets a lot of attention from both of them. I asked to do another activity but now she had to focus on her current life situation (utilising future progression isomorphically). The circle was now more than half coloured in with pink, with a small red line and the rest of the circle blue. She explained that she felt happy now since her mother and father "made a deal with me that I could spend every weekend and school holidays with my father and live with my mother for the rest of the week". She still felt a little sad but at least they were now talking with each other. She also felt a little angry because they are still not together but that she can't do anything about that, it is after all their decision. I then told a story using her sequence of life events ending with the idea that the girl is now even happier than before as there is now peace. When she left, she seemed more at ease and happy.

The purpose of the activities used was to allow her to visually see how she felt, understand why she felt the way she did and eventually resolve to accept what she cannot change.

- ***Therapist reflections***

I felt comfortable utilising what she brought into therapy as this situation could also have contributed to her high levels of anxiety. This emphasised that therapist flexibility is important and that the therapist should allow the client to lead at times. She had a need to address this unresolved issue and try to accept the reality of the divorce. I noticed that she shared the information freely and felt that she trusted me enough to share what was troubling her. This indicated that therapeutic alliance was

crucial and that trust was an important ingredient in the relationship between therapist and client. She was totally immersed in the story and gave a slight smile when it was done. While telling the story she represented with the hypnotic constellation. No formal induction was necessary to achieve results and that using what the client brings to therapy only enhances the therapeutic experience for the client.

#### **5.2.5.6 Session Six**

I asked her to draw a rosebush anywhere on a worksheet. I asked her questions about her picture. The information I gained from her about the picture was indirectly linked to her own life situation and I used the information to create a story. I told a story about how a small rosebush had all it needed from caring adult plants to grow into a beautiful rosebush. These adult plants provide her with fertilised soil to grow and nurture its still shallow roots. As this rosebush grows, it develops thorns of its own to protect itself from strong winds and people that want to pick a flower. The rosebush knows that as it grows stronger and bigger, it would become more and more independent, more self-assured and can take control of any situation. The rosebush is aware that there would always be caring adult plants who would protect her, separately, whenever she needs help and that as it grows she becomes more in control of herself (utilising regression complimentary).

The next activity involved clay work. I requested that she make an animal. She played with the clay for a while before she commenced with the activity. She created a small Kuala bear resting in a tree in full view of me. I asked her if she would like to tell me a story about the bear. She explained that the bear was waiting for her mom and dad to return with its food. The mom and dad brought food separately. The mother was the first one to bring her some food. The bear was happy because her mother brought food that she liked. Then the father brought some food too and she ate only a little because she didn't really like the food and didn't want to hurt his feelings. The bear family went to sleep and she went to sleep next to her brothers and sisters. The little bear felt safe because her parents were keeping a watchful eye over them. Although her parents slept at separate ends of the nest, she felt safe and knew that are still a family, it's just that they do things differently. I ended the session by informing her that the next session would be the last one. She was accepting of this idea and

mentioned that she was going on holiday with her father to visit her paternal grandparents in England in the June school holidays.

- ***Therapist reflections***

I was directive in an indirect Ericksonian way in this session because I wanted to know whether she felt secure enough to deal with crisis situations. She was comfortable with this new approach and talked freely. Once again the sequence was used to gift-wrap a solution to her problem. The metaphoric storytelling also allowed her to accept her situation and it seemed that she now accepted her family structure. The posthypnotic suggestion instilled the idea of control, responsibility and mastery that could lead to developing into a more confident girl. I thought that it was time to terminate in the next session.

#### ***5.2.5.7 Session Seven***

I noticed that she looked very tired. She revealed that they just moved into a new house and she had to get up earlier than before because she now lives very far from the school. She also mentioned that she is looking forward to the school holiday and spending the three weeks with her paternal grandparents and father in England and meeting all her old friends. She also informed me that she was doing well at school. She apparently got her test results back and got full marks for mathematics and reading. Her teacher also told her that she progressed and improved a lot. She was all smiles and very pleased with herself when she told me this. I asked her to practice her breathing exercise again, which she did easily. Once I noticed that she was relaxed I told her a story of a train who went on a journey (utilising regression complimentary). In the beginning the train had to stop regularly to make sure that all the parts were working and that it was on the right track. Once the train was certain that he could move on to its next destination, he moved ahead. This went on for quite a while, and as he became more confident, he just kept on going full steam without stopping, knowing that what he has learnt is right for him right now and that when he needs to, he could stop anytime to ask for help and guidance from the right people. He knows that these people would help him prepare and learn all the skills he needed to have to carry on and venture forward take on a new journey. He feels confident and happy and knows that he would be able to take charge of any new situation... The session

was concluded and Sara seemed happy and confident to be given the opportunity to explore her new felt confidence.

It was interval at the school and asked whether I could have a short interview with the educator in the classroom. She informed me that she was impressed with the progress Sara has made with regards to her schoolwork. She mentioned that Sara would now put up her hand if she wanted assistance or move to the number board, use the counters or ask her buddy much more readily. She also mentioned that Sara does not seem to stress as before when faced with a problem. She also noticed that Sara would breathe in and out slowly when she was struggling with something, be it reading or mathematics. Her teacher said that Sara's performance improved in both mathematics and reading.

- ***Therapist reflections***

Sara now had personal experience of success in the classroom and this was utilised to keep her focussed and forward thinking. I used her new confidence to foster the idea that she can achieve success in the future and that she remains in control, stopping and reassessing when she needed help. The educator's report indicated that Sara is now more flexible and would ask instead of "freezing". It also seemed as if the self-hypnotic breathing exercises, provided her with a skill to remain focussed on the task at hand.

### **5.3 CLINICAL ASSESSMENT OF THE PARTICIPANT: TRAVIS**

Details of the assessment are provided to contextualise the case of Travis.

#### **5.3.1 Reason for referral**

Travis was initially referred for reading and concentration difficulties. His teacher was also concerned about his emotional well-being as he tends to ask for his mother during the school day. However, his reaction to the projective tests required that this be altered and attention was given to his therapeutic needs.

### 5.3.2 Background Information

**Family:** Travis is the youngest of two children. He is seven years old and attends a preparatory school in Cape Town. His older sister attends a nearby primary school. His parents have been divorced since 1999. The mother and his sister relocated the family to the Western Cape from Swaziland soon after the divorce. According to the mother Travis's biological father kidnapped him from his home. Travis and his father lived with his paternal grandparents where he was constantly told that he would never see his mother and sister again. He was only three at the time and returned to his mother a year ago. The mother had to battle to get Travis placed in her custody. The mother revealed that it was a "very messy" divorce. Prior to the divorce, the situation at home had become violent and the children were stuck in the middle. Currently, they live in a flat and live close to their maternal grandparents. They are a close-knit family and spend most of their spare time together. The children would visit their maternal grandparents over weekends. She mentioned that her relationship with her ex husband is civil and that things have been "sorted out". The children visited their father who lives in Durban at arranged times, sometimes a weekend and part of the school holidays.

**Birth and Development:** According to the mother, the pregnancy was normal and that he was delivered by Caesarean section. Developmental milestones were reached within normal limits.

**Behaviour:** Travis's mother described him as being an obedient and sensitive child with a good sense of humour. He is also described as being very compassionate and easy to discipline. He loves outdoor activities such as swimming and riding his bicycle. He can play on his own at home and has a wonderful imagination when playing by himself or with his sister. He loves playing with and taking care of his hamster. He loves playing with his friends when he gets the opportunity over weekends. He also has a good attitude toward school and loves going to school.

**Socialisation:** He loves playing outdoor games with his friends. He used to do swimming as an extra-mural activity but due to financial constraints had to stop. He spends most of his time with his immediate family and maternal grandparents.

**Scholastic:** The mother reported that Travis had difficulty with reading and remembering sight words since grade one. He is very good at mathematics and his overall performance is in the average range. His mother mentioned that he is verbally very strong but finds it difficult to write as he had not mastered some of the basic reading skills yet.

**Previous Support:** Due to financial constraints he has not received any form of support.

**Behaviour and Observation during assessment:** Travis is a very friendly and talkative little boy. He seemed totally comfortable with me and conversed spontaneously. He spoke quickly and jumped from the one question to another. He constantly fidgeted in his chair and with his hands. He readily did the DAP and KFD. He however became tearful after drawing the family in which his father was drawn as big and threatening. He then started telling me about his experience of being taken away from his mother and how fearful he gets when he is visiting with his father. He also enjoyed talking about his hamster and sister.

### 5.3.3 Initial assessment according to Geary's process model

Travis presented with behaviours such as fidgeting with his hands and feet all the time while talking in the first session. He spoke like a run away train and it seemed that he did not even stop between sentences. He did everything impulsively without checking his work. His mother and class teacher reported that he did everything very quickly and needed to be kept busy all the time. The mother also mentioned that he seemed "restless" when he was not with her as he could work very peacefully, all on his own as long as it was in her presence. She mentioned that he would display these "hyperactive" behaviours at his maternal grandparents' house if she were not present. These behaviours can be identified as the **phenomenon of flexibility**.

His teacher also reported that he finished his work quickly and then constantly asked whether it was time for his mother to pick him up. The teacher was concerned because Travis would "cling" to his mother in the morning when she had to drop him off at school. She also mentioned that he would think of reasons to contact his mother during the school day so that he could check whether his mother would pick him up at the arranged time. According to the teacher, the aftercare personnel reported that

he constantly runs to the gate to see whether his mother has arrived to pick him up. His mother also reported that he became clingy and did not want to let her out of his sight, even in the confines of the flat. She said that he "follows me wherever I go in the apartment". She mentioned that he would sometimes play with his hamster in his room and then quickly run to check up on her and his sister. These clingy behaviours could be identified as the **phenomenon of regression**, where he reverted back to infantile behaviours in an earlier phase of development to seek attention and being dependent on the mother for assurance and comfort.

The mother mentioned that Travis's father kidnapped him shortly after the divorce and he went to stay in Swaziland with his paternal grandparents and his father. According to Travis "my daddy and my gran keeps on telling me that I will never see my mom again". The mother revealed that he seemingly dreaded going to his father for the holidays, as "he is afraid that he would be taken away from me (mother) again". Travis has been reunited with his mother for the past twelve months only and still fears that he would be taken away from his mother and sister. Travis mentioned that he loves his father and looks forward to the holidays with him but he is always scared that he might not come back to his mother and sister. The mother also mentioned that although Travis loves spending time with his father, he tends to be hesitant and sometimes become tearful and anxious when he has to go on holiday. This kind of behaviour would be displayed while with his father and he would phone his mother up to six times a day asking her whether he would be coming home on the arranged date. These kinds of behaviour fit with the **phenomenon of hypermnesia** as Travis can vividly remember the kidnapping by his father and therefore fears him. Also, Travis is so focussed on remembering the kidnapping that he forgets that his father returned him to his mother since holidaying with him now that he was living with his mother again. This is what **the phenomenon of amnesia** is all about.

The various phenomena identified informed the therapeutic goals. This was verified with Travis as difficulties that needed to be addressed.

#### **5.3.4 Therapeutic goals**

It was concluded that Travis required therapeutic intervention to deal with his unresolved emotional issues. It was believed that his emotional difficulties affected

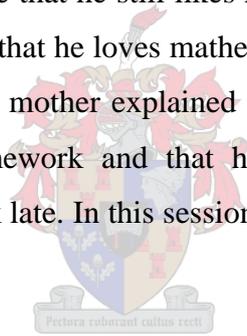
his behaviour and scholastic performance negatively. The individual assessment was abandoned until therapy was concluded.

### **5.3.5 A summary of therapy sessions: Travis**

The therapy session will be discussed and my reflections provided after each session.

#### **5.3.5.1 Session One**

The interview with the parent was conducted at the preparatory school and was arranged by the principal. The background questionnaire was used as the starting point of the discussion. My role as school psychologist was explained. The goal of the interview was to gain insight into Travis's family structure, development and general academic performance. Special attention was given to his scholastic performance especially his attitude towards reading and phonics. Travis was also included in the discussion where he informed me that he still likes reading but finds it difficult when he has to write. He informed me that he loves mathematics and helps other children in the classroom who struggle. His mother explained that he usually co-operated when he had to do his reading homework and that his sister sometimes assists with homework when she had to work late. In this session consent was granted only for the psychometric assessment.



This session also included an interview with his class educator and perusal of his workbooks. She explained that he works hastily and constantly has to be reminded to check his work. She mentioned that he is a well-mannered boy who loves talking. He usually participates during oral discussions but his written work seems to be a problem. According to the teacher, he performs well in his mathematics and usually volunteers to assist others.

The principal brought Travis to the designated venue for the assessment. He seemed comfortable and relaxed and conversed easily. He fidgeted all the time and spoke rapidly. He readily did the required tasks but started to cry after completing the KFD. He spoke about his father and what had happened to him. He requested for his mother to fetch him and I had to try to comfort him. The psychometric assessment was abandoned and arrangements were made for a second interview with the mother.

- *Therapist reflections*

I was really touched at the depth of his emotions. I felt somewhat helpless to think that this small child had experienced such trauma in his young life. I believed that his therapeutic needs had to be addressed first before any psychometric assessment could yield beneficial results. I discussed this with my supervisor and colleagues, as this was the first time something like this happened to me. We were all in agreement that therapy would be essential and that the assessment had to be postponed till a later date.

### 5.3.5.2 *Session Two*

I met with the mother at the school where I informed her about the incident. The mother also became tearful and requested support. She then opened up and told me of the hardships during the marriage and after the divorce. I informed her about the treatment modality that will be used in therapy, misconceptions were dealt with and she consented to participate in the research study. We also contracted to at least four to eight sessions of therapy. The principal as well as the class teacher were consulted and consent given. All the stakeholders consented that therapy sessions could be tape-recorded.

He seemed slightly nervous and rubbed his hands together and didn't want to look at me, before we commenced. We discussed what happened in the previous session, as he felt embarrassed about the incident. After discussing the incident, he seemed to calm down and focussed on telling the stories as the cards were presented to him. At times, he spoke so fast that I had to ask him to slow down. We also spoke about his hobbies and interest. He was also informed that I would be seeing him once a week for at least four to eight sessions. He was also asked about the tape-recording of the sessions and consented to it.

- *Therapist reflections*

I was pleased at the outcome of this session and that everyone agreed to participate in this study. I consulted with my supervisor and peers to help with planning of the intervention. I found that this session allowed me another opportunity to build rapport with the client important for therapeutic alliance.

### 5.3.5.3 *Session Three*

He was brought to the designated venue by the school principal. He seemed relaxed and happy and conversed easily. He spoke eagerly about his hamster. I asked if he knew what it meant to use your imagination. He responded positively and explained that he always pretended to be Dragon Ball Z who protects the world. The hamster's name is Speedy Gonzales. His mother bought it for him when he came to live with her again. I requested that he draw a picture of his hamster in the cage (utilising flexibility isomorphically). While he was drawing, he kept on talking about the hamster and how funny it was to see it run on its wheel for long periods of time. I then told him a story about Speedy and his hamster family.

The hamster mother and father lived happily in their cage and were happy to have two such lovely hamster babies. The hamster mother loved taking care of the children while the father went out to work. At night the family would play games and the father and the baby boy, called Speedy ran on the wheel until they fell down from exhaustion. After a while, the hamster mommy and daddy started shouting and screaming at each other. The children were very scared when this happened and little Speedy would run on his wheel while they were arguing. Then, one day, the father saw that someone had left open the gate of the cage and walked out on the family. The mother was sad but at the same she was happy because there was now peace in the house. The hamster children could now spend more time with their mother and there was no more fighting. One day, the hamster father came back and took little Speedy, who was still playing on the wheel, without telling his mother. Speedy thought he was just visiting his daddy and that he would be going back to his mother soon (utilising hypermnesia isomorphically). Speedy now lived with his hamster father and grandparents in another cage far away from his mother. His father bought him another wheel, as it was his favourite toy. His father and grandmother kept on telling him that he would never see his sister and mother ever again. Speedy missed his mother terribly. He would sometimes bite and scratch his father when he felt angry and sometimes he would just lie on his bed and cry. Then one day, someone left the gate open to his father's cage and Speedy ran away to look for his mother and sister. He was very scared to be alone in a strange place but there were many kind people who

helped him to get to his mother's house. His mother and sister were so happy to see him that all of them cried together (utilising regression complimentary).

The hamster mother contacted the hamster father and told him that little Speedy was now where he belongs and that he will stay with them. Speedy was so excited that he sometimes didn't want to fall asleep, as he was scared that it was just a dream. He also didn't play with his favourite toy anymore because he was too scared that his mother would vanish out of his site. After a while Speedy realised that he would not be taken away from his hamster mother and sister ever again. He sometimes misses his father and would phone him. But for now, all Speedy wants to do is to enjoy feeling safe and loved by his mother and sister.

While telling this story, he sat quite still and his eyes were fixed on me. As he left the room he was smiling and waved goodbye before he closed the door.

- ***Therapist reflections***

At first, I was anxious to tell this story because I was concerned that he may abreact again. This story was based on his life story and I watched him closely for any negative reaction. I was surprised at my ability to make up a story without having a script. Even though no formal induction was introduced, Travis became totally immersed in the story and presented with the hypnotic constellation. His hands were resting comfortably in his lap and he sat as if immobile. I discussed this with my peers and we agreed that using something that he likes, his hamster could facilitate in the process of healing.

#### ***5.3.5.4 Session Four***

He seemed happy and conversed spontaneously. He was still fidgeting in his seat. I asked him to focus on the time he lived with his father and how he felt (utilising amnesia isomorphically). I asked him to do the colour my world activity. He chose blue for happiness, orange for being angry and purple to represent sadness. He coloured the circle more than half in orange, a third blue and the rest purple. He said that he was very angry at the time with his father for taking him away from his mother and sister. He still remembered how he fought with his father and cried in his room. He also remembered how angry he got with himself for not being able to remember

his mother's telephone number. He was also angry with his paternal grandparents for saying that he would never see his mother and sister again. He felt a little happy because he liked being on the farm and spending time with his dad (utilising amnesia complimentary). He felt sad because he didn't see his mother and sister at all and could only listen and speak to her on the telephone when his daddy allowed it. He remembered how much he missed his mother and sister and that he would often cry himself to sleep. We then went on to talk about how things are now. I asked him to colour the worksheet again focussing on how he now feels. Most of the circle was coloured in blue, and only a small part was coloured purple. He explained that he feels extremely happy to be with his mother and sister and that they visit their maternal grandmother once a week as well as weekends. He can still speak to his father on the phone and visited him once before. He still fears that if he visits his father, he would not be able to return to his mother and sister. He also would like to know whether his mom and dad could get back together again. We then spoke about different types of families and asked him to choose what he preferred. He replied that he would prefer to have parents like his even if they have to live separately. He knows that he is loved by both and has grandparents on both sides whom he adores (utilising regression complimentary). We also spoke about things that sometimes are out of the control of children and that the adults need to sort out the differences that exist (utilising catalepsy complimentary in story below).

I then told a story called "A hamster in the cage" and is as follows:

Once upon a time there was a hamster, who lived in a cage. The door of this cage was locked from the inside. The hamster spent all of his time running on his exercise wheel. He ran and ran and ran, but he never got anywhere and he wasn't really happy. One day the hamster decided that he was tired of being in a cage and running and running without getting anywhere. He found a way to unlock the door and get out of his prison where he had kept himself. He felt free and confident that it is time to unlock the door, leave your cage, and find that leaving is an adventure. He discovered that he has all the skills he needs to feel safe.

- *Therapist reflections*

Utilising what was familiar to him allowed him to enjoy and relate to the story. While talking about his past experience with his dad, he seemed really unhappy and used a hard grip on the crayon when he coloured in. In the next activity, he smiled while colouring in, as he felt happy being united with his mother and sister again and that the situation has changed. After the story, he smiled quietly, and nodded his head. I felt that it helped him to free himself to trust the environment and circumstances of his family as is now.

### 5.3.5.5 *Session Five*

He talked excitedly about going to visit a family friend on a farm and the possibility of hunting with them. We proceeded to do the rosebush activity. He drew a small rosebush on a farm right next to an oak tree (utilise regression complimentary). I did a visualisation exercise using the holiday to the farm and seeing this beautiful small rosebush next to a big oak tree. This rosebush feels protected because he gets all the nourishment and protection from this oak tree. The branches of the oak tree protects the small, growing rosebush from strong winds and prevents the winds from blowing away all the petals. The oak tree also tries to protect it from any danger. He knows that he is safe as all the plants around him look out and provide for him. He knows that he is special and unique and that he has everything he needs to continue to grow into a big, strong and beautiful rosebush with many beautiful gifts he can share with those he love dearly. This rosebush would eventually grow its own thorns to protect himself but for now he has so many loving plants caring for him in their own unique way.

- *Therapist reflections*

This session occurred in the principal's office. The phone kept on ringing and I had to ask the secretary to take the phone off the hook. I utilised what he brought to the session. In using his reality, a future orientation could be established in terms of developing confidence and trust in those significant persons in his life. He once again enjoyed the story and was involved in a fantasy experience and at the same time built up expectations that things would improve for him.

### 5.3.5.6 *Session Six*

He talked happily about his planned holiday in Durban with his father and grandparents. This time his sister would go with him and it made him feel happy. We spoke about the things he could do if he missed his mother. He would be able to use his sister's cell phone to contact his mother at least once a day. I used an arm lowering technique to facilitate the idea that he could take control of his healing process and to focus his attention on this new adventure in his life. He easily went into an altered state and presented with the hypnotic constellation (utilising catalepsy complimentary and regression isomorphically). A posthypnotic suggestion about being safe and secure was given. This was also the last session and he mentioned that he could now manage on his own.

I also visited the class teacher to ask her about his behaviour and progress in school. She remarked that he seemed much more confident and that he doesn't ask to phone his mother anymore. His overall performance in school was good and there was improvement in his ability to concentrate and focus on his reading.

- ***Therapist reflections***

This was the first time that a formal induction was used. He went into trance and presented with immobility and he closed his eyes when his arm lowered. He took a while to re-orientate to the room again. He referred to the fact that his parents have sorted out all their problems and that he now feels much better about visiting his father.

This session was done the day before the end of the school term in the principal's office. There was a continuous buzz of a phone ringing and people talking. The noise did not seem to distract Travis from focussing his attention. The secretary entered while doing the induction, but Travis remained focussed. I was agitated with the hustle and bustle at the school but I also needed to remain focussed.

#### **5.4 THE USE OF HYPNOSIS AND HYPNOTHERAPY DURING THE SESSIONS**

The parents were both informed of the treatment modality during the second unstructured interviews. For the most part, metaphorical storytelling was used to immerse participants in an indirect way and allowed them to create and attach their own personal meanings. Sara was introduced to a more formal induction process and movement imagery was used extensively to address the phenomenon of catalepsy. Travis on the other hand, was introduced to a more informal way to hypnotherapy and the phenomenon of flexibility was addressed. Both of these techniques allowed the participants with the opportunity to create their own unique meanings and allowed them to make sense of those metaphors as it related to their personal worldview and experiences. Self-hypnosis was introduced as a tool to use when not in therapy. During all the sessions, I utilised what they brought to the therapy session and tailored and gift-wrapped the problem into a solution. The sequences in which they "did" their problem were also utilised extensively in the therapeutic process. In observing the participants closely, pacing and leading statements were applied to facilitate the therapeutic process to the desired needs of each participant. Creative play and drawings were used to help them identify and externalise their problems.

#### **5.5 REFLECTION**

In this chapter, the implementation of this research study was explained. The assessment criteria were used as prescribed by Geary and individual therapy sessions were discussed and thick descriptions were provided. The following chapter will provide a general discussion of the process of Ericksonian hypnosis and hypnotherapy sessions and how it contributed to change and healing for each participant.

## CHAPTER SIX

# DISCUSSION OF FINDINGS

### 6.1 INTRODUCTION

The purpose of the study was to explore the emotional experiences of children during the process of Ericksonian hypnotherapy. In this concluding chapter, a summary of all the chapters will be given. The process of therapy will be discussed using the phenomena identified for each participant. This will then be linked to the themes which emerged in the study while discussing the hypnotherapy process. Lastly, the limitations will be outlined, recommendations for future research given and some concluding remarks briefly discussed.

### 6.2 SUMMARY OF THE STUDY

In **chapter 1**, I discussed the Interpretive/Constructivist paradigm that underpins my study and motivate why I think it is important to explore the experiences of two case participants. The central research question was what were the emotional experiences of two primary school children during the process of Ericksonian hypnosis and hypnotherapy. The research design and methodology as well as the key concepts relating to one's understanding of this therapeutic intervention, were also outlined.

In **chapter 2**, the history and theories of hypnosis and hypnotherapy were outlined. Here, I also dealt with the myths and misconceptions about hypnosis and hypnotherapy. I also included a detailed discussion about the various Ericksonian principles that form the cornerstone of this therapeutic intervention. The various hypnotic phenomena were discussed as well as its therapeutic application.

In **chapter 3**, the developmental phases applicable to primary school children were outlined. The Ericksonian Diamond and the ARE models were discussed to show how strategically and systematically an Ericksonian hypnotherapist has to work if positive outcomes are to be achieved. A variety of hypnotic interventions with children were

discussed where the emphasis is on adapting and tailoring interventions for children considering their developmental and intellectual level.

In **chapter 4**, the research design and methodology were discussed in detail. Methods of data production were discussed and the context given for this collective case study. Data analysis was discussed and figures provided for the coding and categorisation of themes. The themes were discussed and the phenomena for each participant were also discussed.

In **chapter 5**, the focus was on the discussion of each case in detail including each session with the participants. Reflections after each session were included as well.

In this concluding **chapter 6**, both cases were discussed. I tried to illustrate the emotional experiences and the process of the intervention applied. I also tried to illustrate how therapists could use the phenomena therapeutically. Also, attention was given to highlight the process of Ericksonian hypnotherapy in my attempt to answer the research question. The limitations as well as recommendations for this study were outlined as well.

### **6.3 DISCUSSION OF SARA**

Sara presented with cataleptic behaviour such as freezing and stopping to breathe, as well as dissociative behaviour, the inability to move as she sat rigidly, in the first session when the psycho-educational assessment was attempted. It was important to ensure that she was taught coping skills to master her anxiety and deal successfully with mathematics in the classroom. A safe, non-threatening atmosphere needed to be created for her. The focus was on relaxation and containment. In using a relaxation exercise, she became contained enough to return to the classroom and continue with her normal classroom routine. The phenomena of catalepsy (used complimentary), was immediately addressed by doing this exercise and safety restored. The phenomenon of dissociation (used complimentary) was also addressed in that she could move and control her breathing and her body now when she experiences anxiety. As mentioned before, the psycho-educational assessment was abandoned.

During the second session, a therapeutic alliance was strengthened, by enquiring into her interests and hobbies. Showing genuine interest and accepting her unconditionally

allowed for a trusting relationship to be established essential for rapport. This also allowed for gathering information with regard to her anxiety. The sequence as she experienced it, was obtained and later utilised and gift wrapped as part of the solution. Even though a trance state was not induced, seeding was used to get her response ready for later interventions. The first two sessions allowed me to identify some of her values, beliefs, behaviours and symptom words she used to maintain her problem, anxiety. This is a crucial part according to Geary's assessment model. Identifying for example the themes and hypnotic phenomena, is referred to as the prehypnotic or initial assessment phase which forms the first part in the process of Ericksonian hypnosis and hypnotherapy (Geary, 1994:322). This information allowed me to form the therapeutic goals.

She was then absorbed in an activity called "the flying carriage" using her favourite movie, "Barbie and Swan Lake" and her animals. This also allowed the opportunity to tap into her senses, mainly visual and kinaesthetic to be utilised in this imaginative exercise. This activity set the scene for future hypnotherapeutic interventions and as Zeig (1990) stated it allowed for a fertilised bed in which future interventions could flourish. As she experienced this activity as non-threatening and enjoyable, it allowed for a more formal introduction to hypnotherapy. The "follow my breathing" technique was applied to help her achieve self-control and mastery over her breathing and anxiety. This exercise was practised twice, implying that she was rehypnotised.

Fractionation allows for deepening the hypnotic experience (Hammond, 1987 as cited in Wester & O'Grady, 1991:40). By pacing the client, I indicated that I was in tune with her and would allow her to lead the dance. This allowed me as a therapist to go into mutual trance with the client, indicating that I have empathy and truly resonate with her as well as being genuinely interested in her. The experience was intensified by using truisms and ratifying her behaviours in the trance state. For example, referring to her slow breathing and her shoulders as she sinks deeper into the chair.

Pacing and leading is paramount in the therapeutic process because I fed back to her the things she was already displaying allowing her to co-operate with the suggestions given (Gilligan, 1987). Pacing allowed me to give her suggestions which led her to other states and feelings (Battino & South, 1999:48). The tone of my voice and the rate of speech also contributed to creating the opportune atmosphere for

hypnotherapeutic intervention. In doing this and using seeding, a trance state could develop in which internal healing could occur as the conscious was bypassed and learning could occur optimally in the unconscious. Both exercises were immediately tailored for her, as each activity was adapted to meet her unique needs for example using her own sequence of how she does anxiety to start the desensitisation process. The vehicles in which the solution was gift wrapped were metaphorical story telling and a progressive relaxation technique called the "follow my breathing technique" which was adapted for her (Olness & Kohen, 1996:67-68). The utilisation and co-operation principles were applied at all times, to enable internal healing to occur. This reflected to her that I had the utmost respect for her beliefs and her reality. She was taught self-hypnosis and practised in the session to give her the necessary coping mechanism when not in therapy. A post hypnotic suggestion was given of being in control of her breathing in all situations. The sessions were terminated by my change in voice tone and alerting her to her present circumstances.

In the next session, we continued with the "follow my breathing" exercise but started desensitising her by using her first school day as a starting point. The early learning set was used to create a "yes set" setting the client up for success and more suggestions of achievement, mastery and control. I used truisms and the yes set to allow for responsiveness to minimal cues via metaphorical stories, clay work and drawings. Further discussion was warranted at this stage to explore achievement in other school-related activities and extra-mural activities. Gradually the participant was introduced to the concept of mastery and control in the classroom especially when dealing with mathematics. Externalising her problem, by drawing it and then allowing her to create a story also allowed her to perceive the problem as being only a small part of her that needed to be dealt with.

Using her story to find possible solutions to the problem, allowed her to relate to issues that had specific significance for her. The idea of continued practice and assertiveness was embedded in a suggestion of mastery and control. Seeding formed a very important part of the intervention process in getting the client response ready and setting the table for future interventions (Zeig, 1994). Seeding has been described by Phillips and Frederick (1995 in Frederick & McNeal, 1999:62) as "the subtle introduction of ideas in minor key before they are faced in a major way". Seeding of

ideas gives clients a sense of hope in their troubled state, that healing and change are inevitable. The purpose of seeding is to activate associational processes in the client getting the client response ready for ensuing interventions. Seeding also gives a client hope for the future and creates safety and mastery in the client. According to Gilligan (1987) seeding should occur throughout the therapeutic process so that momentum and continuity can be achieved and effect healing and growth in the client. In helping her to remember past successes, the phenomenon of amnesia was addressed. At the same time the phenomena of association, prehypnotic suggestion and hypermnesia were addressed, as her beliefs that she is a failure, "can't do maths" and would never succeed in mathematics impeded her ability to cope. She needed to be reminded by her own unconscious mind that she has had past successes and that she had the ability to acquire the skills to master mathematics. Once again, the phenomenon of dissociation was addressed to reinforce her ability of being in control of herself and her situation.

The participant's reality was used most of the time to gift-wrap the solution. Metaphorical storytelling was used extensively in the therapeutic process. Metaphorical stories allowed the client to move from the "land of the problem to the land of solution" (Zeig, 1990:29). Most of the stories used, were stories from her own world allowing her to take from that story that which was necessary for her to heal or solve her problems at that time. I tend to agree with Battino and South (1999:297) that stories allow clients to make their own connections and bridges as they can immerse themselves in fantasy and imaginative involvement taking out only those things that fit with their world. Although a plethora of hypnotherapeutic scripts are available, the most effective ones are those that develop spontaneously while in interpersonal trance with the client as the unconscious mind of the therapist resonates empathetically with the client's unconscious mind making the metaphor more meaningful and helpful (Gilligan, 1987:205-206). Gilligan (1987) and Oaklander (1978) amongst many theorists, agree that stories encourage unconscious processing and ultimately lead to internal, unconscious learning and healing.

In dealing with the phenomena of catalepsy and dissociation (both used complimentary) in this way, both the parent and the educator mentioned that change occurred especially in Sara's attitude towards the numeracy tasks at home and in the

classroom. The educator reported more assertive and positive behaviours and that she noticed that Sara did not freeze any more but that she would do breathing exercises, put up her hand when she was uncertain and generally performed better in her numeracy tasks. This contributed to an overall improvement in academic work and improved test results as the educator also reported improvement in reading as well. The mother reported that Sara became more confident in doing the numeracy homework. She did not freeze but would persevere and ask for assistance. The mother also mentioned that Sara was now sleeping better too.

Dealing with her anxiety towards numeracy also improved her relationship with her parent when doing homework. The other issue Sara needed to come to terms with was accepting the divorce and how it made her feel. In session five, Sara brought up the issue of the divorce. This was dealt with by using drawing, colouring and clay work. Clay work, poetry and art as well as drawing forms part of the various forms of fantasy material that are used to involve children in imaginative play (Oaklander, 1978:12). These mediums allow the child to become involved in fantasy play because the reality of her world was too difficult to face. Using these mediums of communication allow therapists to get a view of the child's inner life, what she has kept hidden and allows the child a respectful, non-threatening way of communicating those things that she had trouble admitting to herself (ibid., 11). Considering the child's developmental level, the "colour my world" technique allowed Sara to express her feelings in various colours that represented different feelings. Because this created a safe and comfortable environment, she could easily talk about her past and her present. She was taken through a process of focussing only on her past and then discussing it and afterwards to reveal to herself visually and verbally, her feelings about her present circumstances. Once again a story was used in which she made her own connections and bridges to those aspects that related to her reality. Once again the phenomena of amnesia and hypermnesia (both used complimentary) were addressed to remind her of the good times when the family was still united and the bad parts that caused the divorce. She needed to become conscious that she was not the cause of the divorce and that she still shared a special place in both her parents' lives.

We then continued with the Rosebush technique in which my approach was direct in an indirect Ericksonian way. This allowed Sara to speak freely about her own reality in an indirect way. Utilising her own reality in the story gave me the opportunity to seed the idea that she had the necessary support systems, such as her parents and school educator. Seeding the idea that as she matures and develops she would develop the skills in future to become independent and self-reliant and that it was all right now to ask for assistance from the educator and parent. The clay activity allowed her to externalise her feelings about her current life situation in a non-threatening way. Although she still felt vulnerable, she also felt special that two parents were caring for her, though separately. Because rapport and trust was already established early in the therapeutic relationship, she felt comfortable to build her character in full view of me. This technique allowed her with an opportunity to come to terms with her reality and accept it.

During the last session, a visualisation exercise was done to reintegrate all her new learnings and seed hope for a better future. Once again a metaphor of a journey was utilised, as she was about to go on holiday to her paternal grandparents with her father. I was very aware of the importance in utilising her reality and adapting all activities to meet her unique needs. Sara seemed to have benefited from the interventions, since her mother reported that she now got along better with her father and did not try to get them together any more. The mother also revealed that she did not harp on the fact that they should get together again.

It seemed as if focussing on the phenomena identified in the initial assessment phase, assisted her healing process, as family dynamics as well as her overall functioning at home and at school improved. During the entire intervention process, I was acutely aware of utilising whatever she brought to the therapeutic process, adapting, tailoring and gift wrapping the interventions to meet her needs and seed hope for the future of mastery and control. In keeping with the Interpretive/Constructivist perspective, focusing on the problem as was presented by her and treating her as the "basic systemic unit" that informed all other "treatment units", the resolution had a ripple effect in terms of the various systems in her life such as family harmony and academic achievement (O'Connor & Ammen, 1997:5). In this regard, I tend to agree with O'Connor and O'Connor (1997:2) that, "the way we know and operate in our

world (is) always subject-dependent ... from everything we understand and experience about our world is always from the perspective of ourselves as participants in and observers of our experience in that world". It is crucial in Eriksonian hypnotherapy that the principles of utilisation and co-operation are applied as it not only honours the client's internal state but also allows the client to lead the therapy process, to start at the point the client is most comfortable with at the time therapeutic intervention takes place and asks of the therapist to be flexible and adaptable so that the client is valued at all times.

#### 6.4 DISCUSSION OF TRAVIS

The first session with him and his mother was used to gather information. I used this opportunity in the initial assessment phase to identify the various phenomena of flexibility, regression, hypermnesia and amnesia. The behaviours, symptom words and themes that emerged were then used to inform the therapeutic goals. More information was obtained from the class teacher which was also taken into consideration in the therapeutic process.

I decided to focus on the phenomenon of flexibility to address all the other phenomena because of the speed in which he did things such as talking fast and restlessness. Travis was introduced to hypnotherapy by using metaphorical stories as a vehicle in which the solution could be gift wrapped and tailored to his needs. The first story was that of a hamster family sketching a similar scenario if compared to that of his own. The next story, "The gerbil and the cage" was adapted for Travis from Nancy Davis's book called "*Therapeutic stories that teach and heal*" (1996:87). The purpose of both stories was to allow him with an opportunity to identify with and use what was necessary for him to cope in his own situation (used hypermnesia isomorphically and complimentary).

According to Mays (1990:423) "metaphors in psychotherapy refer to a way of speaking in which one thing is expressed in terms of another, shedding new light on the character of what is being described". I am in agreement with Mays (ibid., 427) in that metaphors deal with unconscious processes of association, image, emotion, memory and analogical thought". Erickson and Rossi (1976:448) also share this belief as well as the idea that metaphors are in some ways deeper, more potent, and more

easily remembered" by clients. Metaphors allow the therapist to communicate in more indirect and possibly deeper ways with the client, making the intervention more personalised and meaningful for the client. The idea of safety and security was also given indirectly as a post hypnotic suggestion. During the induction phase he was immersed in metaphorical stories. This I used as a vehicle to seed hope and "building toward the desired goal in small steps" (Zeig, 1990 in Geary, 1994:324).

I then proceeded to do the Rosebush and the Colour my world techniques. These techniques are part of the alternative mediums to allow the client, in a non-threatening way, to address the problems he experienced. These strategies allowed me to address the phenomena of regression, amnesia and hypermnesia. He needed to be reassured that he was safe and secure in his current life circumstances. He also needed to become aware of the many life stressors that he had overcome and that he still had the ability to be independent and trust as well as receive support from his caregivers. He needed to be reminded that his father was the one who brought him back to his mother after the kidnapping and that his life situation had now stabilised. He also needed the opportunity to remind himself that he already went on holiday after returning to his mother and that his father always returned him to his mother irrespective of what his father and paternal grandmother may have told him. The information he shared with me was then utilised to form a story to instill hope that he had all the necessary support he required to feel safe and secure. Seeding in this activity focussed on a future orientation of developing confidence and trust that he could rely on those significant people in his life to protect and keep him safe. The importance of story telling was discussed in the previous case and the same would apply for this discussion.

Lastly, an arm lowering exercise was applied to address the phenomenon of flexibility (used complimentary). This exercise also allowed him to integrate all his new learnings and develop a strategy to cope when away from his mother. A story was also used in this session using a metaphor of a journey. The focus was on making him aware of the skills he possesses to look after himself, feel safe because his sister would protect him and that he should feel assured of returning to his mother. In all the exercises that were utilised, the co-operation and utilisation principles were applied. These principles form the cornerstone of Eriksonian hypnotherapy. Even though, a

formal hypnotherapy technique was only used in the last session, I still feel that he benefited from this experience. All the other methods also induced a trance state and could be observed in the changes in his body such as eye fixation and involuntary movement for example.

In my opinion he benefited from hypnotherapy in a short time period because his mother and teacher reported changes in his behaviour. These changes manifested in the classroom as well as in his relationship with his mother and father. The mother reported that she noticed that he seemed more confident and that she could now leave him alone at his maternal grandmother's place without him asking for her continuously, meaning that he now felt safe and secure enough to trust his significant caregiver. He would play alone in the flat without constantly checking up if his mother was present. The teacher reported that he seemed more focussed in his work, would check his work and did not once ask her to call his mother.

## **6.5 LIMITATIONS OF THIS STUDY**

This study was conducted in one primary school and therefore the findings cannot be generalised to the entire population group. The participants were both young children. Follow-up sessions were not possible due to time constraints. The study included participants from one cultural group only and therefore I don't know to what extent it would be feasible for any other of South Africa's cultural groups. I was the only researcher in this study. Although I tried as far as possible to be objective, I don't know to what extent researcher bias and subjectivity influenced the findings of this study.

You must have thorough training in Ericksonian hypnosis and hypnotherapy before commencing in this kind of research. This training can be very expensive. Training should be received from a registered organisation such as the Milton Erickson Institute of South Africa in order to apply this therapeutic approach. Continuous practice and supervision is crucial. The researcher should have sufficient knowledge and skills, as well as be completely familiar and comfortable before attempting to apply this approach. This approach requires one to become a life long learner so that one stays up to date with any new developments and practices.

Another difficulty that I experienced is finding appropriate research material. Most of the research material is not available in the libraries. I had to join an online library to access one resource book and this cost a fortune. Since it was difficult to find recent literature, I used many secondary sources taken from the few primary resources that I had. Even though I used many secondary resources, I feel confident that the concepts discussed in this study were dealt with accurately and adequately for the purposes of this study. Doing research in hypnosis and hypnotherapy needs to be a funded study in order to access the most recent journals and articles.

## **6.6 RECOMMENDATIONS**

It is recommended that a next study include participants that would reflect the multicultural society in South Africa. More participants from different primary schools and communities should be included to reflect diverse communities. A possible study with adolescents should be considered to explore to what extent this therapeutic model would be effective for this age group in South Africa. In my opinion, follow-up sessions should be timetabled in another study in order to ascertain whether the change is sustained within a six-month period. Also, a more focussed subject matter such as sexual abuse victims should be considered in another study. It would also be interesting to see whether hypnotherapy is as effective in a group counselling rather than individual therapy sessions. Perhaps a qualitative research study with a pre- and post-test could be implemented to ascertain the efficacy and duration of the change during therapy.

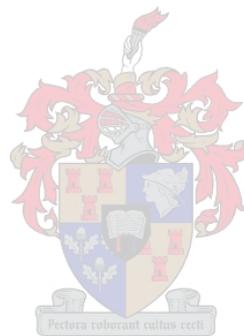
It is advised that the researcher also receives training in Ego-State therapy, as this could support and strengthen hypnotherapeutic intervention.

## **6.7 REFLECTION**

In this study I attempted to explore the emotional experiences of two young, primary school children during the process of Ericksonian hypnosis and hypnotherapy. The support programme for both these participants can be considered as short-term therapy. If one considers the workload of a school psychologist in the Western Cape Education Department (WCED), this approach seems like a feasible one to use. However, if this approach is used within the WCED, the department would have to provide the funds and allocate enough time for training and supervision.

I tried to work within an Interpretive/Constructivist paradigm, respecting and accepting the participants' worldviews and realities. This approach allowed me to understand their realities as they have constructed it. Using the Ericksonian hypnotherapeutic approach to guide participants to a new understanding of their worldviews, allowed the participants to construct new perceptions about their realities that are more healthy and productive. By using the process model of this approach to identify maladaptive hypnotic phenomena and using various vehicles to change these symptom phenomena into solutions they could use in future seemed to have benefited both participants.

In conclusion, one should not forget that support from parents, educators, a welcoming and warm school environment also contribute to the success of any intervention of school-aged participants.



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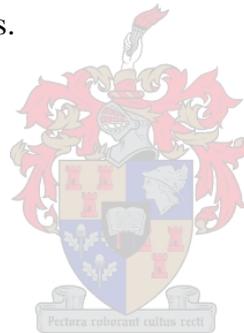
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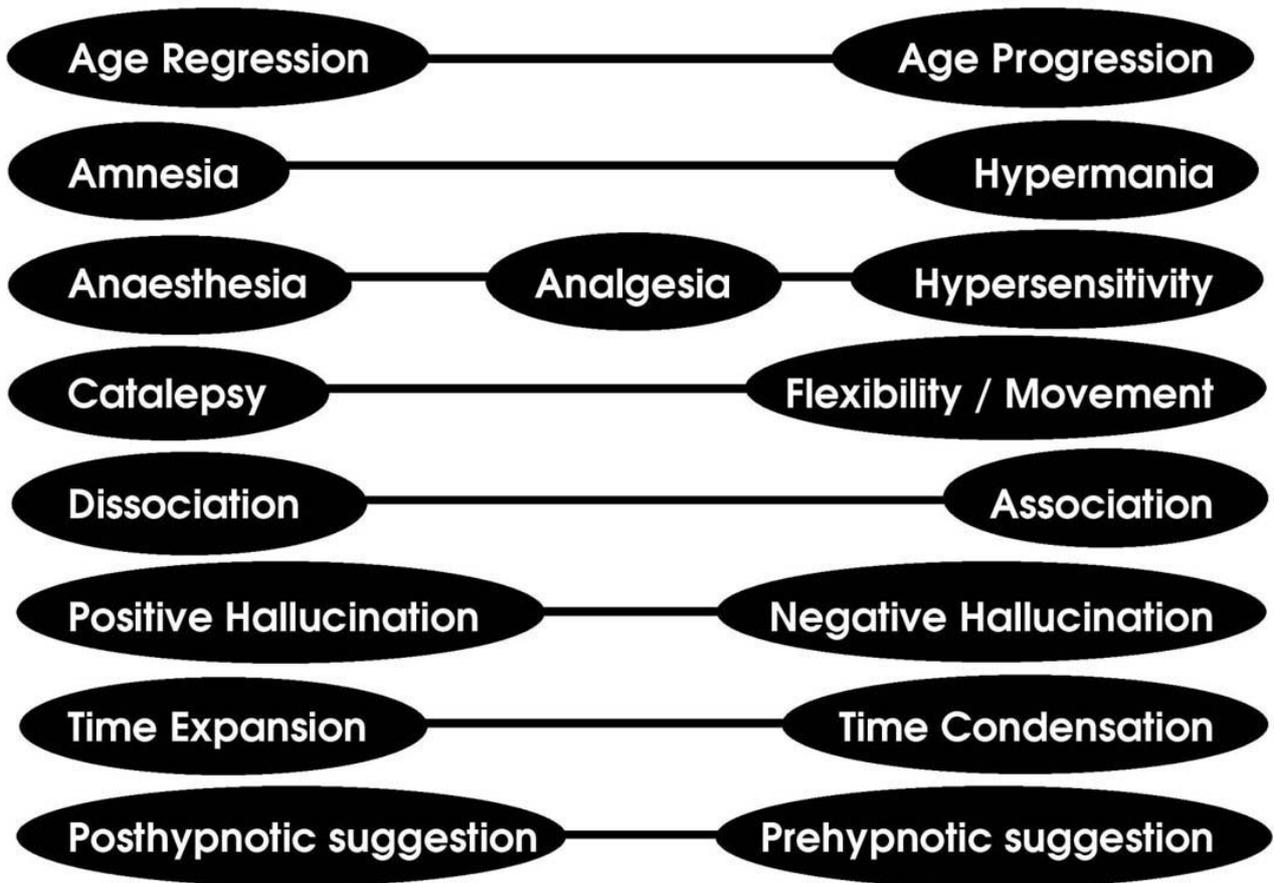
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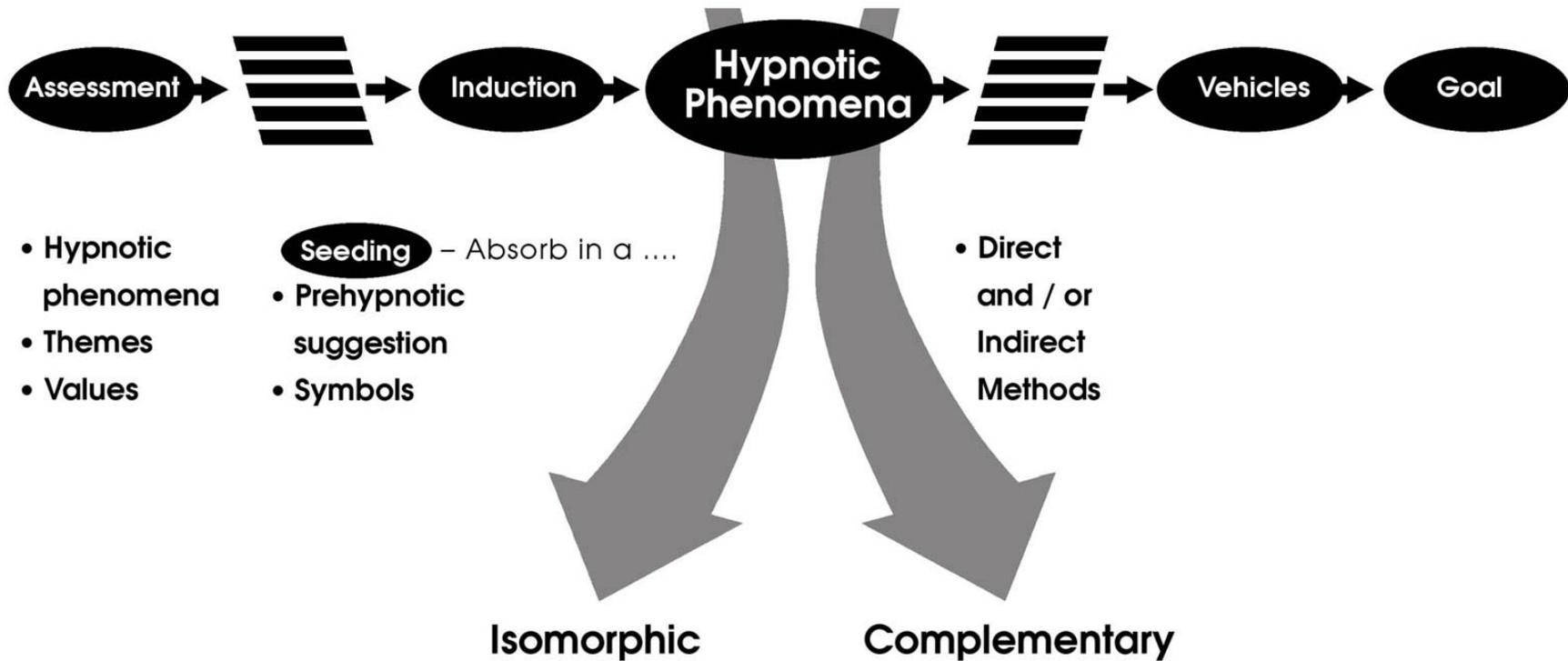
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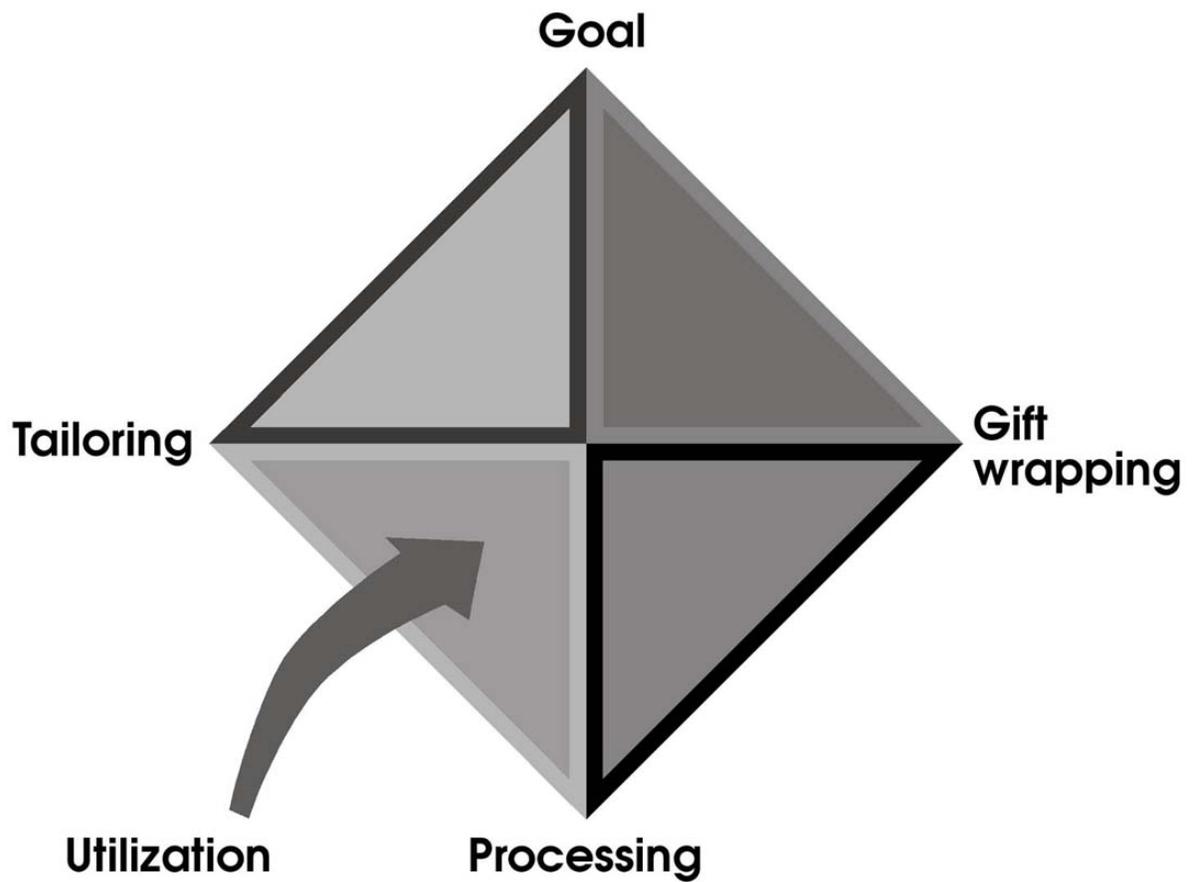
# CONTINUA OF TRANCE PHENOMENA



# THE PROCESS OF ERICKSONIAN HYPNOSIS



# THE METAMODEL/THE ERICKSONIAN DIAMOND (Zeig, 1992)



# INDUCTION TECHNIQUES BY AGE

## **Preverbal (0-2 years)**

Tactile stimulation, stroking patting  
Kinesthetic stimulation: rocking, moving an arm back and forth  
Auditory stimulation: music or any whirring sound such as a hairdryer, electric shaver, vacuum cleaner placed out of reach of the child  
Visual stimulation: mobiles or other objects that change shape, color, or position  
Holding a doll or stuffed animal

## **Early verbal (2-4 years)**

Blowing bubbles  
Pop-up books  
Storytelling  
Stereoscopic viewer  
Favourite activity  
Speaking to the child through a doll or stuffed animal  
Floppy Raggedy Ann or Andy  
Teddy bear  
Watching induction or self on videotape

## **Preschool and early school (4-6 years)**

Blowing breath out  
Favorite place  
Multiple animals  
Flower garden  
Storytelling (alone or in a group)  
Mighty oak tree  
Coin watching  
Letter watching  
Pop-up books  
Television fantasy  
Stereoscopic viewer  
Videotape  
Bouncing ball  
Thermal (and other) biofeedback  
Finger lowering  
Playground activity

## **Middle childhood (7-11 years)**

Favorite place  
Favorite activity  
Cloud gazing  
Flying blanket  
Videogames (actual or imagined)  
Riding a bike  
Arm lowering  
Blowing breath out  
Favorite music  
Listening to self on tape  
Coin watching  
Fixation at point on hand  
Hands (fingers) moving together  
Arm rigidity

## **Adolescence (12-18 years)**

Favorite place / activity  
Sports activity  
Arm catalepsy  
Following breathing  
Videogames (actual or imagined)  
Computer games (actual or imagined)  
Eye fixation on hand  
Driving a car  
Playing or hearing music  
Hand levitation  
Fingers / hands together as magnets  
Fantasy games (e.g., Dungeons and Dragons)

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## SAMPLE OF CODING

M-S: S does not like to do maths homework. She gets very frustrated when she gets stuck.	FD PhPre
Th: You say S becomes stuck. Would you like to explain to me what happens when she gets stuck?	PhCat PhPre
M-S: She would start her homework but when she finds the work too difficult, she would give up or just sit and stare in front of her at her books. Sometimes it even looks as if she is not breathing, because I can hear how she holds her breath.	PhPre PhCat FD PS
Th: What do you do to try and help her when she stares out at her books?	PhCat
M-S: I try to help get to the answers by using pegs and counters. Her class teacher, Mrs B, explained to me how to assist her but she gets so angry at times that she refuses to do her homework or she would just sit still as if she freezes, staring blankly in front of her. We usually end up shouting at each other. Sometimes I do the homework for her as I want to avoid an argument with her, and I know that this is wrong but I just can't handle this anymore.	PS OF ES SS FD FD PhCat PS SS FD
Th: I understand that this situation can become very tedious for you and S and that you would want to do anything to assist her. Tell me, how has this situation affected your relationship with your daughter?	FD SS
M-S: Because I come home late at night, we hardly see each other during the week. I try to make time for her at night but there is usually just enough time to get her to do her homework before getting her ready for bed. If it is not for the homework and me working late, we usually go for walks with the dogs in the park. I usually try to read her a story, Barbie and Swan Lake or we'd watch the video together.	PAC FD PS FD
Th: What time does she usually do her homework?	FD
M-S: We get home about half past six or seven o'clock. I give her about an hour to play with the dogs while I'm busy with supper or sometimes	PAC FD

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M-S: Sara's mother  
Th: Therapist

<p>she would sit at the kitchen table while I'm cooking. I'd say about eight o'clock. The children get so much homework these days, first it's the reading, then phonics and then the maths. I just think it's too much.</p>	FD
<p>Th: So, S only starts doing her homework round about eight at night,</p>	FD
<p>M-S: Yes. I wish this situation could be different. I'm thinking of resigning and finding other employment where I would be home at a decent hour to support S with her schoolwork.</p>	PAC
<p>Th: Yes. It is difficult when one is a single parent to juggle your time but I'm sure you are doing your best.</p>	
<p>M-S: I know but it is still hard on me and S. Since the divorce things have been very difficult for both of us especially for S. Her father and I both have other partners. S still wants us to get together again but that is simply impossible. The divorce was a messy affair.</p>	
<p>Th: You say the divorce was a messy affair. Would you like you explain that to me?</p>	FD PS
<p>M-S: My ex and I used to fight a lot. We would argue about petty things, shouting and swearing. Towards the end of the relationship, he got physical with me.</p>	FD
<p>Th: That must have been a difficult time in your life. How did the situation affect S?</p>	FD PAC
<p>M-S: She would often run to the room when we were arguing. She also used to stand between myself and my husband when things got really rough. Or she would run to her bedroom, sit on the bed and cry softly. She even sometimes just sat staring out the window in her room. I feel so guilty about all of this.</p>	FD
<p>Th<sup>1</sup>: Sometimes we cannot always control certain situations in our lives. We just try the best we can. You made the decision to leave the relationship behind and start afresh.</p>	MAR
<p>M-S: I think it was the best decision I could have made. He was really nasty during the divorce procedures, threatening us, coming to the house unannounced, arguing... I'm glad that's all in the past now.</p>	FD
<p>Th: Yes, sometimes it's difficult for people to accept things but we cannot always control how other people behave. Tell me, what was S's</p>	PAC FD
	ANX

reaction when her father arrived unannounced?

M-S: She usually waited for me to give her the go ahead to go to her father. She has a very good relationship with her father. I always try to be civil towards him and not to get involved in an argument. He spoils her a lot. My only concern is his current girlfriend.

Th: Tell me?

M-S: I suspect that his current girlfriend is anorexic. S came home once and said that she saw her vomiting in the toilet a few times that weekend. She is as thin as a reed, with pitch-black hair. She wears all these weird outfits. I'm also concerned about what goes on there on weekends, as I know that her father loves partying and uses drugs at times. S is always untidy when I fetch her on Sundays. I am very worried about her when she goes to him for the weekend.

Th: How often does she visit with her father?

M-S: Every weekend. She just loves going there because it seems as if there is no routine. She can go sleep anytime. He even got her a new dog and cat because she is so fond of animals.

Th: You must be very concerned about this. Did you try to talk to your ex about the situation?

M-S: I'm afraid that he might get angry again. I know I must talk to him but I don't know how to do it without getting into a fight.

Th: This must be very difficult for you. You have to however do whatever you possibly can to sort out this situation. By the sound of things, you need to do whatever possible to ensure your daughter's safety and that she is not exposed to things she ought not to be.

M-S: Yes, I think I'll speak to him the on Friday when he picks her up.

Th: I agree with you. Do you feel ok about it?

M-S: Anything to protect my daughter.

Th: Yes, as parents we would do almost anything to protect our children. At the moment you are considering changing your job so that you could have more time with S. A lot of sacrifices are made for our children, we have to make decisions, tough decisions for the sake of our children. But, you will find the answers for yourself when the time is right for you.

PHCAT

Now, the focus is on getting therapeutic support for your daughter.

M-S: Yes, I would really like her to get counselling to help her deal with the divorce and especially about her anxiety towards maths.

Th: Thank you for sharing with me. I'm sure that things would work out for both of you in the end. We have already contracted for 4-8 sessions of counselling. All the sessions will happen at the school. There will be no need for you to take off work as I'll be coming to the school to see S.

M-S: Thank you, that is so convenient.

