Therapeutic Hypnosis with Children and Adolescents

Second Edition

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

Praise for *Therapeutic Hypnosis with Children and Adolescents, Second Edition*

This second edition of this volume demonstrates that this book has evolved and matured into a classic. It is delightful to read and to consume the wisdom, love and dedication that the contributing authors have put into this hefty, revised and expanded volume The delight increases reading it again and consuming more. The authors demonstrate that therapy with hypnosis becomes empathically artistic, as it is beautifully tailored to the ingredients of the emotional responsiveness of the child.

—Eric Vermetten, MD, PhD. Associate Professor of Psychiatry, University Medical Center Utrecht, the Netherlands; Past President International Society of Hypnosis

Laurence Sugarman and William Wester draw our attention to the growing complexity of young people's lives today. They highlight the urgent need to empower children and adolescents to better manage the many challenges they face with focus and skill. Through the writings of the expert contributors to this outstanding volume, the merits of hypnosis in teaching skills in focusing, problem solving and self-regulation are obvious. Exposure to and instruction in hypnotic methods should be a part of *every* child's learning experience. By studying the methods in this book, health care professionals can learn a great deal about how to help ordinary kids use their innate resources to do extraordinary things to improve their lives.

—Michael D. Yapko, PhD. Clinical Psychologist, author of *Depression is Contagious* and *Trancework: An Introduction to the Practice of Clinical Hypnosis, 4th Ed*.

This second edition is an important addition to the library of any professional who works with children. Drs. Sugarman and Wester have again managed to bring together an impressive group of authors and have woven these updated contributions into a compelling text that will inspire health professionals to examine and utilize therapeutic language to empower children in all facets of living.

—Daniel Handel, MD. Chief, Division of Palliative Medicine, Denver Health Medical Center, Denver, Colorado

Transcending the popular view of hypnosis as a "psychological procedure" performed *by* professionals *on* patients, this second edition is a state-of-the-art, comprehensive resource for clinicians of *all* disciplines. This seminal work emphasizes how young people can alter their own mind-body interactions by activating and directing their intrinsic *ability* to control symptoms and situations that are associated with significant *disability*. Both scientifically grounded and evidence-based, this book details how children and adolescents (including those with somatic symptoms, anxiety, depression and developmental differences) can learn and utilize innate skills. Given the current rampant use of psychoactive medications in an attempt to control young people's symptoms and behavior, this volume is a welcome reminder that young people already possess intrinsic resources. This belongs on the bookshelf of anyone interested in young people being empowered to master situations that previously resulted in their feeling out of control.

—Richard E. Kreipe, MD, Professor of Pediatrics, Golisano Children's Hospital, University of Rochester School of Medicine and Dentistry

This second edition is a solid clinically-focused text that belongs on the bookshelf of any practitioner who uses or aspires to learn to use hypnosis to assist younger patients in overcoming medical or psychological difficulties. Children and adolescents possess an impressive and often inspiring resilience and capacity for growth and constructive change. The approaches discussed and illustrated by the authors of its many chapters demonstrate the power of hypnosis to facilitate those helpful processes. The case vignettes are well-selected and helpful. Here you find no magic or overenthusiasm.—Simply the keen appreciation by skilful clinicians of how the use of clinical hypnosis can enhance the efficacy of medical and psychological interventions and equip their young patients with powerful tools for the achievement of mastery, symptom relief, and self-control.

—Richard P. Kluft, MD, PhD. Clinical Professor of Psychiatry, Temple University School of Medicine

Here creative and distinguished editors and authors present theory, clinical vignettes and pertinent research on hypnosis for professionals all over the world. This latest edition is highly relevant for all clinicians who strive to facilitate the best communication, clinical interaction and therapy based on a holistic biopsychosocial understanding to health and functioning from a developmental perspective.

—Inger Helene Vandvik, MD. Professor Emeritus of Child and Adolescent Psychiatry, University of Oslo, Norway

This updated second edition is an excellent reference for child health professionals who teach children how to help themselves via hypnosis. Contributors share their substantial experience and expertise, leading to this fine compendium, which is both academically and clinically solid.

—Karen Olness, MD. Professor of Pediatrics, Global Health and Diseases, Case Western Reserve University. Coauthor of *Hypnosis and Hypnotherapy with Children, 4th Ed.*

This book is a treasure trove. Its readers will find their knowledge increased, their creativity stimulated, their imaginations rekindled, and their confidence enhanced.Sugarman and Wester, together with their notable contributors, provide a deep and broad mix of techniques, examples, and specific applications from their wealth of experience with pediatric clinical hypnosis. Throughout, their language illustrates their underlying philosophy of respect for their patients and trust in the abilities of children and adolescents. The rich vignettes are at least as valuable as the didactic material, as they illustrate the ways in which playful and collaborative hypnotic approaches empower our patients of all ages. The sophisticated, integrated understanding of the biopsychosocial model of illness will help many clinicians explain to children and their parents how and why hypnosis is so powerfully useful. This is a wonderfully readable contribution to the field.

—Sheryll Daniel, PhD. Past President American Society of Clinical Hypnosis, Family Psychiatry and Psychology Associates, Cary, NC

I loved reading and learning from this second edition of *Therapeutic Hypnosis with Children and Adolescents*. Drs. Sugarman and Wester have created a rich and vital compendium of creative strategies on how to be therapeutic with children and all of us who have been children. This book is an essential contribution to a necessary revolution in health and care that balances what we do *to* children with what they *can do for themselves.* It details and affirms the important work of all those who share concern about our children's futures: to foster their abilities know their own minds and steer their own lives. This text ought to be studied by all who strive to help children have the freedom of mind to face life's challenges.

—Steven A. Hassan, MEd, LMHC, NCC, author of *Freedom of Mind: Helping loved one leave controlling people, cults and beliefs.*

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Chapter One

Hypnosis with Children and Adolescents: A Contextual Framework

Laurence I. Sugarman, MD
William C. Wester, II, EdD

Hypnosis started when the first mother kissed it and made it better.
—F. Bauman, personal communication, September 21, 1996

He was seven years old and the youngest of five children. He hated having to be the first to bed each night when so much happened in the family outside his bedroom door. So, he would sneak out, sit at the top of the stairs, and listen to his brother and sisters argue and laugh, his parents' stern voices, and hushed phone conversations. He wanted to hear everything and figure out what was going on.

Somehow, his mother would always know he had escaped his room. She would send him scurrying back, while yelling up the stairs, "You stay in that bed!" This repeated sentencing to his room further fueled his resentment and his determination to dodge his bedtime restrictions.

One evening, as he lay seething in his bed, he suddenly realized that his mother only forbade him to leave his bed, not his room. He was inspired! Lying under the covers, he gripped the

mattress edges, focused his concentration, squeezed his eyes shut, and willed his mattress to float carefully out his second floor bedroom window. He was aloft! He hovered defiantly outside his parents' bedroom window, flying away just before they could see him. He zoomed over his house in the cool night air, grateful for his blankets. He sailed up over the rooftops, over his school, and down into the backyard of his best friend Stuart's house. Then he soared up high: over the trees and the park and his neighborhood. He flew for what seemed hours and hours. But he got tired and began to descend. It was as if his concentration was what kept him up. Breathing deeply, he landed, softly, back in his room just as he fell, peacefully, into sound sleep.

He woke in the morning refreshed, winning praise and extra cinnamon toast from his mother for staying in his bed after bedtime. After that, he got away with his escape every night.

After a time, he grew up, left home and became a man, husband, and father. He worked, traveled, and worried. He did all those hard things that grown-ups do. And, even when he was much older, when his worries troubled him and he could not sleep, he would know to lie in his bed, a seven-year-old, tightly close his eyes, calm himself by floating through his neighborhood, seeing his world from a different perspective. He'd make it back to his room just in time to fall, peacefully, into sound sleep.

His parents never found out.

What is hypnosis? What is different about hypnosis with children and adolescents? The fascinating, elusive answers to these questions are the subject of this text in general and this chapter in particular.

Ever since James Braid coined the term "neurypnosis" (Braid, 1843), ongoing debate has delayed consensus on a definition of this discipline. The 2003 American Psychological Association, Division of Psychological Hypnosis (Division 30) definition of hypnosis spawned a cacophony of criticism (Green, Barabasz, Barrett, & Montgomery, 2005–6; Barabasz, 2005–6; Woody & Sadler, 2005–6; Yapko, 2005–6; Spiegel & Greenleaf, 2005–6; Heap, 2005–6; Araoz, 2005–6; Rossi, 2005–6; Hammond, 2005–6; McConkey, 2005–6; Daniel, 2005–6). Is hypnosis a natural state along a continuum of normal waking pro-

cesses? Is it a socio-cognitive phenomenon manifested by role-enactment that is labeled hypnotic? Is hypnosis simply the "cultivation of imagination" (D.P. Kohen, personal communication, September 16, 1993), or is imagination less relevant to hypnotic processes than a sense of involuntary experience and subconscious activation? What are the important differences between reverie, self-hypnosis, and therapeutic hypnosis in a clinical setting? What is the validity of hypnotizability scales in clinical work? Is hypnotizability an innate trait or a self-limiting construct? Of the characteristics assigned to hypnotic experience or trance, which are most crucial: dissociation, suggestion, relaxation, absorption, or rapport? What is trance? What distinguishes hypnosis from the myriad of other mental states and human interactions that are not hypnotic (Lynn & Rhue, 1991)?

The essence of the debate is that, lacking some discrete, objective, exclusive device that measures when hypnosis has occurred, clinicians define hypnosis from within their individual frames of reference. What is hypnosis? As Michael Heap put it, "I suspect the answer will remain: 'It depends what you mean by hypnosis'" (Heap, 2005–6). It depends on context.

Neurodevelopment, Trance and Hypnosis

When we are born, our brains contain about 100 billion neurons (as many as there are stars in our galaxy). We maintain that number for most of our adult life, though our brains nearly quadruple in weight during its first two decades. This growth is due to the proliferation of synaptic connections from approximately 2,500 per neuron at birth to over 15,000 by age three. This is followed, throughout childhood and adolescence, by a reduction and intensification (i.e., synaptic pruning) of about a third of these connections in the adult brain. This fury of neurological activity is but an index of the psychophysiologcal development integrating motor reflexes, the conditioning of immune and endocrine systems, cognitive learning, emotional and social attunement, and more, all subsumed in "the mind."

This process is triggered by a number of hard-wired responses. The orienting response is a phylogenetically primitive reaction to novelty that pauses attention, searches memory, and shifts autonomic state to neutral (Porges, 2011). Humans are also hard-wired for emotional

resonance and attunement, such that both increased sympathetic tone ("fight or flight," vigilance for external threat) and its opposite (comfort and social receptivity) are contagious (Siegel, 2012).

Finally, our entire psychophysiological system is driven towards seeking familiarity, consistency, and pattern recognition. The brain-body networks that we call "experience" are constantly being revised based upon incoming perception, as if we are incessantly asking, "have we seen or done this before?" As Daniel Siegel explains, memory is simply the likelihood that a given neurophysiological network will "fire" again (Siegel, 2012).

An abundance of evidence from developmental neuroscience indicates that this process of growing our minds—shifting attention to novelty, checking social interaction, and integrating this new experience through memorization through repetition—is what is commonly called trance. Clinicians can use this word "trance" to refer to this complex process of neurophysiological change in response to novelty, intentional desire to learn, or absorption in imagination and reverie.

It is often noted that children are in trance all of the time. In childhood, the impetus for curiosity, novelty seeking, autonomy, and mastery are manifestations of this growing meshwork of psychophysiological reflexes. Imagination and dreams are the conscious representation of this subconscious psychophysiological development. Children use their imaginative capacities to rehearse skills, cope with fears and challenges, and set goals for themselves. They explore their psychophysiological terrain through mother's first touch, the comfort of satisfied hunger, the repeated surprise of peek-a-boo, balancing on two legs, balancing on two wheels, playing catch, and so on. Their drives for curiosity, novelty, autonomy, and mastery also foster creative social engagement, social learning, the sense of self/other, and the understanding of empathy (Hilgard, 1970; Olness, 1985). Current neuroscience research continues to confirm that the blossoming, malleable neurohumoral pathways that join sensory input, memory, and physiological response at these deepest levels of a child's mind evolve into the frameworks of adaptation for the rest of their lives (Fitzgerald & Howard, 2003; Jessell & Sanes, 2012). If clinicians can conceive of developmental tasks as psychophysiological imperatives that govern the formation of mind-body reflexes and behavioral response, then it is easy to imagine kids as always being in trance and

open to suggestion. It is not so much that children are "good at hypnosis," but rather that they live in the trance of intense psychophysiological development. Children *are* in the business of learning how their brains and bodies are connected. They are engaged, full-time, in the process of changing their minds.

The behavioral manifestations of both trance and intensified neurological change are the same. They include focused gaze, a paucity of extraneous motor activity, decreased peripheral awareness, prolonged periods of attention, repetition, and intensified attachment, to name a few. It is therefore useful and phenomenologically accurate to equate the behavioral aspects of trance to this process of intensified neurophysiological change.

The previously noted lack of consensual definition of hypnosis is hampered by the confusion of the terms hypnosis and trance. Since trance is a neurodevelopmental imperative that occurs without hypnosis, the authors think a useful and operational definition of hypnosis is: *the purposeful utilization of these nonconscious processes called trance for an expressed purpose with or without conscious awareness*. The purpose of that hypnotic engagement is determined by its context. Stage hypnotists use hypnosis for the purpose of entertainment. Sales programs use hypnotic elements to sell a product. Acute trauma enacts deep subconscious processes with the same, though alienating, hypnotic rudiments. The spontaneous dissociation experienced by a sexually abused child typifies this naturally occurring trance (Kowatsch, 1991). In the case of clinical hypnosis, the purpose is to help a client or patient alter a maladaptive, conditioned, psychophysiological reflex. As James Maddocks (personal communication, July 28, 1995) declared, "While all hypnosis is not therapy, all therapy is hypnosis."

This means that hypnosis refers to the application of a *skill set* involving interpersonal, multi-level communication—noticing, suggesting and responding—that is tuned to an individual. Self-hypnosis, as in imaginative play, purposefully uses one's own trance states to help one's self. Hetero-hypnosis is the skill set that uses interpersonal influence, often expressing more faith in the other than he or she has in him or herself. In this frame, it is not useful to refer to hypnosis as a *process* or *procedure.* These terms imply a ritual *done to* a person or to one's self and place too much emphasis on the social influence

aspect, as if hypnosis takes over trance. As Karen Olness has stated, the process belongs to the person who "owns the trance" (Sugarman, 2005). Similarly, *hypnotic* phenomena are more accurately labeled *trance* phenomena. This implies that one cannot be "under" or "in" hypnosis, but one can be involved in trance during which hypnotic skills are applied. Clinical hypnosis and hypnotherapy with children, then, involves a collection of competencies—communication skills, strategies, knowledge of response contingencies—that both utilize and guide trance in therapeutic directions for the purpose of healthy adaptation and expanding that young person's capacity for psychophysiological change. Hypnosis is how we utilize trance.

Doing Hypnosis with Children and Adolescents

Most professionals initially learn hypnotic technique as a series of discrete, ordered steps: (1) introduction, (2) induction into trance, (3) intensification, (4) therapeutic suggestions, (5) resumption of usual awareness ("de-hypnosis"), then, finally, (6) ratification and reflection. Teleska and Roffman (2004) have likened this to the "vessel" approach to hypnosis: the subject is dipped into the vessel full of hypnotic trance where some subconscious change occurs during immersion. Then the subject floats back up to the surface, is removed and wiped off. This view of hypnotic interaction has some utility in that it provides a good model to build from and is often all that is necessary with many adults.

Introducing a patient to hypnosis is like any first encounter. For medical students, their training tells them to follow the standard protocol. First take a complete history and then perform a physical exam, in that order, for every patient, every time. However, interacting with people in real clinical encounters quickly contradicts the learned procedure. History is, instead, unveiled in idiosyncratic layers as rapport with the patient grows. If they are paying attention, the students learn that how they respond to the patient will change both the symptoms and physical findings. They learn to revisit parts of the history and exam to discover their consistency and meaning. In time, they learn that there is never a complete history or physical examination, just an unfolding. Ultimately, they understand that the memorized protocol for history and examination has

little to do with actually interacting therapeutically with patients. The protocol is just a way to begin to learn the skills.

With children and adolescents, whom have been identified as constantly being in the trance of psychophysiological change, the adult vessel metaphor seems to break down and, typically, the protocols do not work. The young person's tenacious and self-protective autonomy dictates the order and flow of the therapeutic encounter. The child who comes into the office entranced by the pain of appendicitis, engrossed in his or her anxiety about receiving immunizations injections, the induction of previous experiences with the therapist, or simply still absorbed in the story from the previous night, does not require a formal hypnotic induction and may not cooperate with one. The therapist simply needs to join, with permission, in the flow of the trance. To the child entranced by the pain of a wound that requires sutures, the therapist can ask simply, "I wonder where you would rather be than here?" When the child briefly averts his or her eyes as evidence of his or her subconscious search for that place, the therapist can assist in the dissociation by saying, "Go ahead. Leave this hurt part here to heal up."

Following the instructions of Milton Erickson, who said, "Work primarily with, and not on, the child" (Erickson, 1958), the authors find that hypnosis works best with children and adolescents when it is not done *to* them but *with* them. To do this well requires flexibility, creativity, and adaptability on the part of the therapist.

> *Dr. Sugarman was conducting a small group practice experience at an introductory workshop on pediatric hypnosis. After receiving Sugarman's supportive, but critical feedback about the directive and authoritative tone of his suggestions to a subject, a young doctor stated, with some exasperation, "This is so hard because it is about giving up my control over the patient!" Sugarman could not help but respond, gently, "No. It is about recognizing that you never had it in the first place."*

Eye closure illustrates a common distinction between hypnosis with children and adults. Most children under ten years of age frequently do hypnosis best with their eyes open and tell us so (Kohen & Olness, 2011). Since therapists have learned to equate eye-closure with both the intensity of trance and validity of the hypnotic experience,

they can be uncomfortable with this, even mistaking it for resistance or opposition. Some children, on the other hand, may equate eye closure with loss of control, having to go to sleep when they do not want to, and/or not wanting to miss what is going on in the room while they use their hypnotic ability. As part of hypnotic induction, Dr. Sugarman asks children to do this experiment: "While you are (imagining, letting those balloons raise your arm, relaxing, etc.), find out if it is better with your eyes open or closed. Whatever is best for you and those eyes, let them stay that way because you know what is best." The child closes his or her eyes and either reopens them or leaves them closed. Whichever results, Sugarman says, "That's right." In one instance, a nine-year-old boy told him, "I think it's good to keep my eyes open because it helps to see colors better, because when I close my eyes all I see is black. I can see colors when I'm asleep but not when I'm awake." The child stated, implicitly, his understanding that (1) he can imagine with his eyes open, using his surroundings for inspiration; (2) he uses different capacities during sleep; and (3) he knows that hypnosis is not sleep.

Similar to keeping their eyes open, young people may feel far more comfortable and engaged in hypnotic experience while not physically relaxed. Physical relaxation is certainly a compelling respite for most adults, but is often too passive for children. "Relax" can be evocative of parental admonitions to "Calm down!" and "Be quiet!" It is far better to find how each child will help himself or herself be most comfortable and engaged in the experience. The child should have fun, which rarely, for them, means being relaxed.

> *In Dr. Sugarman's consultation room, a seven-year-old boy, with sleep disturbance, recurrent abdominal pain, and divorcing parents, happily imagined, and acted out, swinging back and forth on his favorite playground swing set. He moved vigorously back and forth on his chair while telling Sugarman he was going higher and higher. He abruptly stopped and looked side to side then sadly looked down. When Dr. Sugarman asked him what happened, he replied, staring at the floor, "There are two swings next to each other. When I am on one, I want to be on the other, and if I switch, I might fall off."*

The vessel analogy of hypnosis further confines therapeutic work with children because it assumes a controlling and detached facilita-

tor. Distinct from hypnotic elements of entertainment, sales, trauma, and storytelling, hypnosis in therapy engages the young person's subconscious in a co-creative act in which the therapist must be flexibly responsive to the subconscious clues or ideodynamic signals of the subject. This responsivity happens both consciously and subconsciously within the therapist. This ability informs what we may call intuition, which Erickson and Rossi (1989) call an "unconscious response to [the patient's] minimal cues" (p. 18). Doing hypnotherapy and responding to intuition requires therapists to recognize their own trance, their attentive focus on the subject of therapy.

> *An 11-year-old boy with anxiety glanced at a glass ball on a bookshelf upon entering Dr. Sugarman's office. This brief gesture led Sugarman to ask him if the rainy weather was ending outside. This, in turn, led to a discussion of weather, the rotation of the earth and, therapeutically, how we get a different perspective on our problems. How problems change like the weather when we see them from far above.*

A key to improving upon the vessel approach is to understand pacing and leading. Pacing is meeting the child or adolescent where he or she is and acknowledging that it is where he or she ought to be. Leading involves inviting, suggesting, or offering a therapeutic direction for change. Pacing includes direct empathetic statements such as, "You look pretty frightened!" or "You sure are good at screaming!" Pacing can also be subtle, such as the affirmation of saying "that's right," or silence. Leading involves the language of possibilities. Hammond (1990) describes a variety of phrases that can be utilized to assist the child (or adult) with their journey and "assist you (the therapist) in internalizing this new way of speaking." Examples might include: "and you will be surprised at . . . ," "I wonder if you'll decide to . . . ," "One of the first things you can become aware of is . . . ," and "It may be that you're already aware of . . ." (p. 40–41). Such phrases are subtle ways to help lead the child to discover more about himself or herself and his or her curious imagination. Leading and pacing are best synchronized by careful observation, focused attention, and listening for verbal and nonverbal cues (e.g., breathing patterns, body movements, and facial expressions). When we do this as therapists, perhaps in our own trance, we find ourselves going where the child needs to go. An example of pacing and leading toward therapeutic dissociation

in an emergency setting with a child in pain can be as simple and powerful as, "I bet you would rather be someplace other than here right now. Go there while I help you with this."

While this text is brimming with clinical examples of hypnotic interaction with children and adolescents, these vignettes are not intended to be scripts or prescriptive types of imagery. They are illustrations of interactive, co-creative processes. They originate from the unique personalities of the therapist and child dyad at that moment in development. These singular examples exist to support the notion of hypnotic interaction as adaptive, flexible, and child-centered. This is essential because this responsive process reifies the therapist's faith that the child and adolescent are endowed with the internal resources to help themselves.

Locus of Control

> *Healing consists in, and only in . . . allowing, causing, or bringing to bear those things or forces for getting better (whatever they may be) that already exist in the patient.*
>
> —Cassell, 1991/2004

It is certainly possible to do effective hypnotic work with children and adolescents in a directive, forceful, or authoritarian style. The early history of hypnosis records sparse, anecdotal reports of children, and little description of the technique used. However, we can glean from accounts of the mesmerists that rigid, directive techniques were aimed at children and adolescents who were to remain passive or swoon in abreaction (Mesmer, 1779). This history and culture has no doubt informed and reinforced images of hypnosis from cartoons and fairy tales in which wizards, witches, and evil queens cast spells. It is also possible to prescribe imagery and dictate solutions that involve metaphors the therapist finds poetic and elegant. Therapeutic stories can be comforting, familiar, and decrease alienation. Indeed, the therapeutic ritual of bedtime stories has soothed generations (Thomson, 2005). Kuttner's use of favorite stories with young children serves to support this strategy (Kuttner, 1988).

While a therapist may successfully command a child to change a symptom in a hypnotic context or assist a child to find relief in

"The fact that this book on the techniques and applications of therapeutic hypnosis is now in its second edition stands as an endorsement of the increasing usefulness of these strategies in clinical medicine. These techniques should be taught to clinicians."

Robert Haggerty, MD, Past President of the American Academy of Pediatrics

"This second edition is an excellent reference for both the novice and the expert. Medical and psychological concerns are comprehensively covered by 18 internationally distinguished authors. An essential resource for those working with children."

Jeffrey K. Zeig, PhD, Director, The Milton H. Erickson Foundation

"Firmly grounded in developmental science, replete with vivid clinical illustrations, and enriched with thoughtful discussion of psychotherapeutic principles, this second edition strengthens an already important contribution to the field that will enhance the use of hypnosis with children."

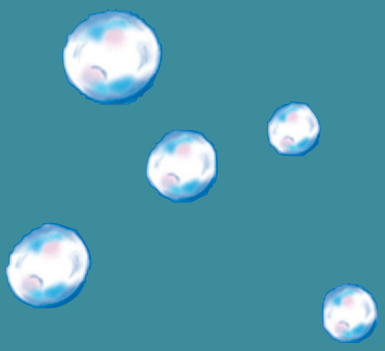
David Spiegel, MD, Willson Professor & Associate Chair of Psychiatry,
Stanford University School of Medicine
Co-Author of *Trance and Treatment: Clinical Uses of Hypnosis*

"This is an essential book for anyone who uses hypnosis with children. The very prominent and distinguished editors and authors have provided clinicians with a book that is both practical and scholarly, addressing the use of hypnosis with virtually all the important psychological and medical problems of children."

D. Corydon Hammond, PhD, ABPH, Past President,
American Society of Clinical Hypnosis

"If you work with children and adolescents and want to magnify your healing power — read this book!"

Carl A. Hammerschlag MD, Author of *The Dancing Healers* and *The Theft of the Spirit*



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Child Psychotherapy

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