

## CLINICAL HYPNOSIS AS AN EFFECTIVE ADJUNCT IN THE CARE OF PEDIATRIC INPATIENTS

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Clinical hypnosis is an established part of the comprehensive treatment of numerous problems in ambulatory pediatrics. Two cases illustrate its utility with pediatric inpatients. These cases demonstrate clinical hypnosis as a teachable, practical, and nonpharmacologic intervention that warrants further investigation in the inpatient setting. (*J Pediatr* 2006;149:563-5)

**P**ediatricians, especially during residency, are called on to help hospitalized children cope with the physical and psychosocial impact of chronic illness, hospitalization, and postoperative pain and anxiety. Self-hypnosis can be a practical and satisfying means to that end for both the pediatric practitioner and the patient. Clinical hypnosis has been used as an effective adjunct in the treatment or palliation of a variety of pediatric conditions including asthma,<sup>1,2</sup> recurrent headache,<sup>2-5</sup> cancer,<sup>6,7</sup> cystic fibrosis,<sup>8,9</sup> hemophilia,<sup>10</sup> sickle cell–related pain,<sup>11</sup> and terminal illness.<sup>2,7</sup> Published reports have not addressed its utility in the inpatient pediatric population.

### CASE I

A 16-year-old girl with spina bifida was seen in the hospital 3 days after an antegrade continence enterostomy procedure with concomitant bilateral ureteral reimplants and bladder augmentation. The patient was, according to her nurse's report to the on-call resident, (the resident involved in these cases had trained in a 20-hour "Introduction to Clinical Hypnosis" course prior to the first case and an 18-hour intermediate-level course prior to the second case, both sponsored by his institution's department of Continuing Medical Education and his state chapter of the American Society of Clinical Hypnosis), self-reporting pain rated 6 on a 0 to 10 scale that was unresponsive to intravenous ketorolac; the nurse suggested that the patient try intravenous morphine for relief. When the resident entered her room, the patient was sitting up in bed, alone and weeping. She explained that she could not sleep and was bothered by discomfort from her central line and nasogastric tube. Her examination was notable for a nasogastric (NG) tube, a right internal jugular intravenous line, an intact and granulating appendicostomy, and flaccid paraparesis of the lower extremities. Her vital signs were normal and stable.

After reassuring her, the resident asked the patient whether she wanted to try another analgesic medication in place of morphine, such as acetaminophen. She was hesitant, fearing an adverse reaction after having dealt with hallucinations and delirium from morphine during a prior hospital stay. She related the anxiety that was evoked when she thought about taking medications in general; she also talked about her loneliness in the hospital and her annoyance at the continuous invasive sensations of the NG tube and central line.

After listening to her concerns, the resident pointed out how, "... it's interesting how those lines can be more bothersome at night, when there may not be any distractions; and on the other hand how often we lose awareness of certain things in our surroundings unconsciously—for example, the sound of the fan in the hospital room." She understood and agreed with enthusiasm, as she shifted her visual attention abruptly to focus on the noisy ventilation system in her room.

The resident recognized the patient's response as an opportunity for intervention—a chance to teach her self-regulation skills. He asked the patient if he could show her a way to learn to use her mind to distract her body from those uncomfortable sensations; she agreed without hesitation. The resident suggested that she visualize her favorite comfortable place. She spontaneously closed her eyes and slowed her respirations. When asked where she was imagining she was, she replied, "In my own bed at home." To intensify the

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experience, further suggestions were given to allow her entire body to progressively relax. The resident then suggested that she could “go to that place, or any other place, any time she wanted to. . . kind of like watching TV.” She agreed to that and to other reinforcing statements including, “. . .how things that used to be annoying aren’t anymore”; the ease with which she could reach this state; and how it would get even easier when she practiced during the day. She spent 5 minutes in this state, imagining her home bed in detail, which she communicated both verbally and nonverbally (by having become no longer tearful, breathing through her nose past the NG tube, and turning her head back on the pillow away from the central line). She spontaneously opened her eyes, smiled broadly, said she was ready for sleep, and asked for a dose of acetaminophen. Less than 20 minutes total time was spent with the patient.

The next morning, the patient said that she had slept well and felt much better. Before discharge, she reported that she had told her parents about her new skills and spontaneously used what she had learned to facilitate coping with a particularly messy stoma change—again imagining being comfortable at home in her own bed.

## CASE 2

The patient, a 14-year-old boy with a 1-year history of recurrent enterocutaneous fistulae, had 2 days’ complaints of intermittent but severe sensations of sharp and cramping diffuse abdominal discomfort that he described as “hunger pains.” Three days previously, he was ordered strict NPO (non per os, nothing by mouth) status and began an 8-week course of total parenteral nutrition and intravenous antibiotics to treat the fistulae. He was afebrile and stable, and the fistulae showed signs of resolution since the initiation of therapy.

The resident taking care of the patient offered to teach him “a way to help yourself feel better using relaxation and your imagination. . . like daydreaming.” The patient responded with interest, and asked whether this would put him in a “trance.” The resident explained and demystified self-hypnosis for the patient, who understood a “trance” from movies and television as “zoning out” and a state in which he would not be in control of himself. The resident assured the patient that he would be in charge of his own “trance” and that “all hypnosis is actually self-hypnosis.” Smiling, the patient said, “I really want to learn this!”

When the patient was lying in his bed with an episode of his typical discomfort that afternoon, the resident, with the patient’s mother’s consent, taught him self-hypnosis in a manner similar to that in the first case. As the patient finished his hypnotic experience, he opened his eyes and said, “That was great!” He said he had imagined himself drinking from a coconut and eating “starfish-shaped” fruit from the trees on a beach, also noting that his “mouth was watering” and the hunger pain was now gone. Although the entire procedure took about 15 minutes, the patient reported feeling as if it had been 30 to 45 minutes. The resident asked the patient to

demonstrate how to enter his “trance,” which he did easily, reenacting the procedure and reorienting himself within the span of less than 1 minute.

The following day, the patient said that he had “practiced” using self-hypnosis several times, including right before sleep. He was discharged and encouraged to continue his practice. Two weeks later, on failure of medical management and readmission for surgery, the patient reported that he had been practicing “trances” with great success, both to reduce the severity and frequency of his hunger pain and to help himself fall asleep.

## DISCUSSION

These cases illustrate the effectiveness of hypnotherapy, as used by one pediatric trainee with two inpatients for relief of anxiety and pain. Both of these patients manifested behavior consistent with having endured invasive, painful, or frightening interventions. The patient in the first case expressed vague but severe “pain,” which, on reflection, was clarified as site-specific discomfort and anxiety. In the second case, a medically necessary therapy led to severe fasting-related pain, a problem for which there is no published standard of care.

The resident working with these patients recognized their signs of distress as opportunities to help them learn hypnosis for self-regulation. The therapeutic intervention consisted of hypnotic suggestions, both direct (instructive statements, for example, “you will”) and indirect (permissive statements, for example, “I wonder how it might feel”). The suggestions were for comfort; distancing and dissociation (altering bodily awareness); and distraction (engaging themes unique to the patient)—all obtained through mental imagery and relaxation. In both cases, there were objective signs of physical state changes: The first patient manifested altered visual fixation, slowed breathing, and less anxiety; the second patient demonstrated salivation and positive mood changes associated with a sense of time distortion that often occurs in the hypnotic state.

In general, clinical hypnosis can be beneficial even if the term “hypnosis” is not used with a given patient, although doing so may be more effective in some situations.<sup>12</sup> In the first case, given the acuity of the problem and the established rapport, the resident decided not to define the experience as “hypnosis” to the patient. Her subsequent response demonstrates how her perceptions about hypnosis (if any) were not relevant to her experience with it. Her comfort with the hypnotic state is illustrated by her independent utilization of it to help her with a different problem than that for which she had originally learned it. In the second case, the patient’s positive (albeit initially misguided) expectations about going into a “trance” may have set the stage for his own success at learning and practicing self-hypnosis; indeed, he continued to use the word “trance” to describe his practice weeks later.

The role of the physician in hypnotherapy can best be described as a teacher or coach.<sup>13</sup> Because the child chooses how, where, when, why, and whether to utilize this state, it is essential to understand that “all hypnosis is self-hypnosis.”<sup>14</sup>

As these cases demonstrate, self-hypnosis can efficiently and safely help some pediatric inpatients cope with hospitalization.

Clinical hypnosis is an effective nonpharmacologic intervention that has a well-documented role in pediatric pain control<sup>15,16</sup>; anxiety relief in emergency settings<sup>17</sup>; periprocedural coping<sup>4,18-22</sup>; and the integrative care of many other common pediatric problems.<sup>2,23,24</sup> Further research into its efficacy in the pediatric inpatient population is warranted. Given a strong future evidence base, teaching children self-hypnosis could be incorporated into comprehensive family-centered care during routine admissions to the hospital for problems as varied as acute injury, elective and acute surgery, chronic illness exacerbations and complications, or any medical problem necessitating invasive interventions. Training in clinical hypnosis is offered by numerous professional societies across the country and is a necessary prerequisite for physicians wishing to use these techniques with pediatric patients. (Clinical hypnosis is best learned in a formal workshop sponsored by the Society for Developmental and Behavioral Pediatrics (17000 Commerce Parkway, Suite C, Mt. Laurel, NJ 08054, Phone: (856) 439-0500, URL: <http://www.sdbp.org>), the American Society of Clinical Hypnosis (140 N. Bloomingdale Rd., Bloomingdale, IL 60108-1017, Phone: (630)980-4740, URL: <http://www.asch.net>), or the Society for Clinical and Experimental Hypnosis, 221 Rivermoor St., Boston, MA 02132, Phone: (617) 469-1981, URL: <http://www.sceh.us>).

Pediatricians and pediatric residents are encouraged to add clinical hypnosis to their "toolbox," increasing their own self-confidence and the satisfaction of their patients in the process. In so doing, those who care for children will be surprised and delighted as they discover just how creative children can be when using their imaginations to positively affect their own health and well-being.

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