Teamwork Approach to Clinical Hypnosis at a Pediatric Pulmonary Center

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The aim of this report is to demonstrate the success of a teamwork approach for providing instruction in self-hypnosis at a Pediatric Pulmonary Center. In order to add to the hypnosis service provided by a pulmonologist at the Center, the Center social worker learned how to use clinical hypnosis. During a 3-year period, she instructed 72 patients (average age 11.6 years) in self-hypnosis. Eighty-two percent of the patients reported improvement or resolution of the primary symptoms, which included anxiety, asthma, chest pain, dyspnea, habit cough, hyperventilation, sighing, and vocal cord dysfunction. The social worker and pulmonologist consulted with each other on a regular basis regarding their hypnosis work, and achieved similar successful results following their hypnosis interventions. Thus, clinical hypnosis at a Pediatric Pulmonary Center can be provided by a team of varied professionals. As a team, these professionals can support each other in their on-going development of hypnosis skills.

Keywords: Dyspnea, habit cough, hypnosis, social work, vocal cord dysfunction

Instruction in self-hypnosis is helpful in the management of pediatric patients with respiratory problems such as asthma, chest pain, cystic fibrosis, dyspnea, end-stage lung disease, habit cough, hyperventilation, sighing, and vocal cord dysfunction (Anbar, 2000; Anbar, 2001; Anbar, 2002; Anbar & Hall, 2004; Anbar & Hehir, 2000; Hackman, Stern, & Gershwin, 2000). Further, it has been shown that over half of adolescents referred to Pediatric Pulmonary Centers may benefit from psychological intervention (Anbar, 2005). Therefore, referral to individuals specializing in clinical hypnosis (such as developmental-behavioral

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pediatricians, psychiatrists, psychologists, or social workers) can be useful. One disadvantage of such a referral to individuals outside of Pulmonary Centers is that they may have little experience with respiratory problems that could be amenable to clinical hypnosis. Also, patients may resist referral to mental health providers because they may not believe they have issues amenable to psychologically oriented therapy.

Since 1998, patients at the SUNY Upstate Medical University Pediatric Pulmonary Center have been instructed in self-hypnosis by their pediatric pulmonologist, as described by Anbar (2002). As the demand for clinical hypnosis grew rapidly at the Center, a teamwork approach was needed in order to provide this service in a timely fashion. Therefore, in 2001 the social worker at the Pulmonary Center agreed to learn how to use clinical hypnosis with children in this setting. Subsequently, after medical evaluation by the pulmonologist, appropriate patients were referred to her for instruction in self-hypnosis.

The traditional work for social workers assigned to Pediatric Pulmonary Centers includes assessment of patients’ family structure and coping with their illness (including their adherence to prescribed therapies), academic performance, developmental and emotional issues, and financial concerns (Cystic Fibrosis Foundation, 1997). The social worker addresses these issues through provision of education and counseling to the patients and their families. The social worker may not be considered by pulmonologists or physicians referring patients to a Pulmonary Center as a staff member who might provide clinical treatment for patients’ respiratory symptoms. Therefore, we present the results of our experience to demonstrate the clear benefit of expanding the Pulmonary Center social worker’s role to include hypnosis for pulmonary symptoms amenable to a psychological intervention. Also, we demonstrate how the social worker and pulmonologist worked together as a team to provide essential service within a Pediatric Pulmonology practice.

Method

The social worker was an M.S.W., with a concentration in health care. She attended two 20-hour workshops regarding pediatric clinical hypnosis, which were approved by the American Society of Clinical Hypnosis. The pulmonologist, an M.D., had attended five 20-hour workshops regarding clinical hypnosis, and had used hypnosis in his practice for 4 years. Initially, the social worker’s supervision by the pulmonologist was conducted live. Within a month the social worker and pulmonologist began meeting for consultation on a weekly basis.

Patients referred for clinical hypnosis included those thought to have pulmonary symptoms attributable to psychological problems or concerns, (e.g., habit cough or anxiety-induced dyspnea as described by Anbar (2005), or fear of medical procedures).

Patients were instructed in self-hypnosis by the social worker in 30-60 minute sessions. A typical session consisted of the following:

(I) A pre-hypnotic interview about the presenting complaints.
(II) An explanation regarding the nature and utility of hypnosis, and concerns or misconceptions regarding hypnosis were addressed.
(III) A hypnotic induction and deepening based on patients’ aptitude and preferences. For example, an induction might have included imagery of helium balloons levitating an arm, imagining inhalation of air that was the patients’ favorite color, imagining a favorite
place, or relaxation of muscle groups progressively from head to
toes or toes to head. Indications that patients were in hypnosis
included observation of eyelid fluttering, catalepsy, and slowed
respiration.

(IV) Teaching patients to relax with the aid of hypnosis. For example,
this was accomplished by asking some of the patients to focus
on what they might perceive with each of their senses in their
favorite place. Some were instructed in how to employ imagery
specific to their symptom with methods such as changing the
appearance of their airways from abnormal to healthy. Generally,
patients were taught a triggering gesture that would cue their
relaxation response, (e.g., touching an index finger to their thumb
on one hand after that had been paired with relaxation).

(V) Following hypnosis sessions, the experience was discussed with
the patients, and validated by encouraging them to use their
triggering gesture to cue relief after the session. Typically, patients
were encouraged to practice their self-hypnosis techniques on a
nightly basis for at least two weeks. They were reminded that
improvements with hypnosis can take time and that with practice
further improvement could be expected (Anbar, 2000; Anbar, 2001;
Anbar, 2002; Anbar & Hall, 2004).

The results following instruction in hypnosis were determined by patients’ answers
to open-ended questions posed orally by the pulmonologist during follow-up visits, regarding
their subjective evaluation of the efficacy of their use of hypnosis. Also, the patients’
parents were interviewed regarding their children’s response to hypnosis.

As this report describes a retrospective chart audit without identification of patients,
it was eligible for and received exemption from review by an institutional review board.

Results

Table 1 shows reasons for which hypnosis was offered by the social worker over
her first three years of using hypnosis, and the outcomes reported by the patients and their
parents. The average age of the 72 patients was 11.6 years. With the exception of the 9
patients who had asthma, none of the patients received medical therapy in addition to self-
hypnosis instruction. In this patient population, 82% of the patients reported improvement
or resolution of their primary symptom, either immediately after the first session of hypnosis,
or after it was used for a few weeks.

Discussion

The improvements following self-hypnosis instruction were confirmed by parents
who observed the changes in dyspnea, habit cough, hyperventilation, sighing, or vocal cord
dysfunction. Moreover, the reported rate of improvement following work with the social
worker was similar to that achieved by the physician using hypnosis at the same Center in an
earlier study (Table 2).

As data were not obtained from a group of control patients who worked with the
social worker but did not learn self-hypnosis, it cannot be concluded on the basis of this
Table 1: Reasons for Instruction in Self-hypnosis*

<table>
<thead>
<tr>
<th>Symptom</th>
<th>No. of Patients</th>
<th>Average Age (yrs)</th>
<th>Symptom Resolved</th>
<th>Symptom Improved</th>
<th>Symptom Not Improved</th>
<th>Lost to Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>7</td>
<td>13</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Asthma</td>
<td>9</td>
<td>11</td>
<td>0</td>
<td>5</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Chest Pain</td>
<td>6</td>
<td>12.8</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Dyspnea</td>
<td>17</td>
<td>12.9</td>
<td>6</td>
<td>5</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Habit Cough</td>
<td>21</td>
<td>10.7</td>
<td>13</td>
<td>5</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Hyperventilation</td>
<td>2</td>
<td>15.5</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Sighing</td>
<td>1</td>
<td>9</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Vocal Cord Dysfunction</td>
<td>22</td>
<td>12.7</td>
<td>9</td>
<td>5</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

*Offered to 72 patients, including 12 who used hypnosis for more than one reason.

Table 2: Rates of Improvement Among Patients Who Returned for Follow-up after Hypnosis by the Social Worker or Pulmonologist*

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Social Worker</th>
<th>Pulmonologist**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>67%</td>
<td>87%</td>
</tr>
<tr>
<td>Asthma</td>
<td>71%</td>
<td>53%</td>
</tr>
<tr>
<td>Chest Pain</td>
<td>83%</td>
<td>100%</td>
</tr>
<tr>
<td>Dyspnea</td>
<td>92%</td>
<td>84%</td>
</tr>
<tr>
<td>Habit Cough</td>
<td>100%</td>
<td>89%</td>
</tr>
<tr>
<td>Hyperventilation</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Sighing</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Vocal Cord Dysfunction</td>
<td>93%</td>
<td>91%</td>
</tr>
</tbody>
</table>

*Values are percentage of symptoms that were improved or resolved.  
**Adapted from Anbar (2002)
report that hypnosis instruction was essential for the improvement. Controlled studies should be conducted in order to define the elements of an encounter that are essential for a successful intervention. The lack of a control group also allows for the possibility that the patients may have improved without any intervention. However, previous studies have documented that dyspnea, habit cough, and vocal cord dysfunction often persist for years despite medical therapy (Anbar, 2001; Anbar & Hall, 2004; Newman, Mason, & Schmaling, 1995). Thus, the patients with these diagnoses in this study were otherwise unlikely to have recovered spontaneously within a few weeks of instruction in self-hypnosis techniques.

This report documents that self-hypnosis at a Pediatric Pulmonary Center can be provided successfully by a team of varied professionals. As a team, these professionals can support one another in their ongoing development of hypnosis skills. In addition to physicians and social workers, other staff members who might be considered candidates to provide hypnosis instruction within Pediatric Pulmonary Centers include child life specialists, nurses, and psychologists (Morrow et al., 1992; Rusy & Weisman, 2000; Winsor, 1993).

References


