Tele-hypnosis in the Treatment of Adolescent School Refusal

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Abstract

Few studies have presented the use of hypnosis in the treatment of school refusal. These studies haven’t approached the problem of self-hypnosis during the stressful morning hours. This paper introduces a therapeutic approach, which utilizes known hypnotic techniques, but rehearses them via the telephone, while the patient is at his/her house or on the way to school and the therapist is at the office. Twelve school-refusal adolescents were treated with different hypnotherapy techniques. Equipped with cellular phones and with the therapist’s availability, these adolescents could benefit from hypnosis as an alternative coping strategy when the anxiety occurred. Results showed that 8 of the participants maintained full-time attendance, 3 showed partial improvement and 1 failed to improve his attendance. This study illustrates the benefits of self-hypnosis in the treatment of school refusal, while also enabling the patient to maintain the connection with the therapist so that the anxiety may be confronted when it arises.

Keywords: School phobia, school refusal, school attending difficulties, hypnotherapy, children; anxiety, telephone, hypnosis.

Tele-hypnosis in the Treatment of Adolescent School Refusal

School refusal (also known as school phobia, though a much more complicated phenomenon than a simple phobia) is defined as difficulty attending school associated with emotional distress, especially anxiety and depression (King & Bernstein, 2001). Children and adolescents with school refusal feel severe apprehension about attending school, often accompanied by physical complaints (dizziness, nausea, abdominal pains and vomiting) that disappear once they are allowed to remain home. The longer the child stays home the more difficult it is to return (Kennedy, 1965). While some children develop difficulties after they have left their home for school, others refuse to make any effort to go to school (Fremont, 2003). The majority of children who refuse school are between 8 and 13 years of age.

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Current thinking about school refusal suggests that most of the children refuse to attend school because of Separation Anxiety Disorder (Kearney & Albano, 2004; Last et. al, 1987). These children experience severe anxiety concerning separation from their attachment figures (DSM-IV, 1994). School refusal also has a high comorbidity rate with anxiety and depression (e.g., King et. al, 2001; McShane, Walter & Rey, 2001). School avoidance might be the result of several factors; among them an attempt to avoid uncomfortable feelings associated with school and the child may be reacting to both home and school stressors. In intricate cases, children might be absent from school for a long period of time. Since schooling is a situation encountered almost daily, school refusal can be severely disabling, and thus is a very serious problem that usually poses significant and adverse consequences, such as poor academic performance, family difficulties and peer relation problems. Reviewers have concluded that it occurs in approximately 5% of all school age children (Burke & Silverman, 1987; King & Bernstein, 2001).

Contemporary treatments for school refusal include educational-support therapy, cognitive behavior therapy, parent-teacher interventions and pharmacotherapy (Fremont, 2003), although there is little consensus in the literature about the best methods of assessing and treating this disability (Kearney & Albano, 2004). The most common treatment utilizes behavioral techniques that include systematic desensitization, relaxation training, emotive imagery, contingency management, and social skills training, while in cognitive behavior therapy children are taught to confront their fears and ways by which they can modify negative thoughts (Fremont, 2003). Several studies have found that exposure-based interventions are successful treatments for school refusal (e.g., Blagg & Yule, 1984; King et. al, 1998), while traditional educational and supportive therapy has also been shown to be effective (Last, Hansen & Franco, 1998). The difference between the two treatments is that the latter does not provide the school refusers with specific instructions on how to confront their fears, nor do the children receive positive reinforcement for school attendance (Fremont, 2003).

Hypnosis has been shown to be an effective treatment for phobia (e.g., Ginsberg, 1993; Walters & Oakley, 2003). Its effectiveness seems to be related to the often-high hypnotic responsiveness of phobics and their unusual capacity for imagery vividness, focused attention and flexibility in information processing strategies (Crawford & Barbasz, 1993). Children may especially benefit from hypnotherapy because of their ability to fantasize, their need for mastery over themselves and their environment, and their skill in utilizing the messages of metaphors and stories and making therapeutic gains (Brown, Summers, Coffman, Riddle & Poulsen, 1996).

Several cases of successful hypnotic treatment for school refusing children and adolescents have been reported in the literature over the past three decades (Epston, 1985; Brown et. al, 1996; Roberts, 1998). In some of these cases, the hypnotic intervention helped the therapists to shed some light on the origins and causes of the fears, which the children were unable to report consciously. The hypnosis in these cases was followed by different kinds of treatments and instructions for the parents or the teachers (Lawlor, 1976).

In other cases, the hypnosis itself served to relieve the anxieties and phobias of the school-refusing children and gradually enabled them to go back to attending school because of the children’s learned ability to relate to school with positive feelings and thoughts (e.g., Cowell & Franklin, 1983; Epston, 1985; Zoltan, 1988; Crawford & Barbasz, 1993; Brown et. al, 1996 and Roberts, 1998). The methods applied in the aforementioned treatments were progressive relaxation, imagery training and desensitization under hypnosis, according to
the unique needs and abilities of each child. In some of the cases, the child was also taught how to practice self-hypnosis at home. The age range of the patients in the cases cited above was 5 to 15 and they all resumed school attendance following the hypnotherapy.

As mentioned previously, the uniqueness of the approach utilized in the 12 cases discussed in this paper lay in the novel use of conducting hypnosis over the telephone, in treating school refusal (i.e., ‘Tele-Hypnosis’). Although in the past the telephone was limited to crisis situations, it now serves a multitude of therapeutic functions. Foremost but not only, is its function in facilitating the maintenance of ongoing treatment when distance or other factors prevent in-person sessions (Olness & Kohen, 1996). Thus, whereas the therapists’ or patients’ moving away once required the termination of treatment, this is no longer a necessity and treatment can be continued via the telephone. Furthermore, the telephone can provide a transitional space where the therapist is both “there” and “not there”, and can also help build a working alliance with the parents of young patients (Aronson, 2000).

Another advantage of the telephone, even more apparent in an era in which cellular phones are so commonplace is the ease of reaching the therapist when needed, so that the conflict aroused may be confronted when most accessible, “in-vivo”, and need not be postponed until the next scheduled appointment with the therapist. A telephone session can prevent this delay and consequent resistance, keeping the conflict and feelings more accessible.

Hypnotherapy over the telephone has been reported to be successful in treating various problems. These cases range in severity and complexity, and include treating a serious hiccup problem following surgery (Kroger, 1969), alleviating acute after-surgery pains (Cooperman & Schafer, 1983), guiding a patient through childbirth when no medical help or any other form of assistance were available and prevention of another patient’s committing suicide (Wollman, 1978), helping a former patient who had relocated to lose weight (Stanton, 1978) and helping a patient with severe dental phobia overcome her fears and get the treatment needed (Kingsbury, 1980).

The decision to apply hypnotherapy over the phone stems from different reasons. Some cases are emergencies where the patient needed the help of the therapist with no delay (Wollman, 1978; Kroger, 1969; Cheek, 1995), while in other cases the patient started in-person hypnotherapy but was no longer able to attend sessions in the clinic (Stanton, 1978; Cooperman & Schafer, 1983). In yet other cases, hypnosis by telephone complemented in-person hypnotherapy and was applied closer in time to the anxiety-evoking event (for example, the case of the patient with dental phobia, Kingsbury, 1980).

In Monnier, Knapp & Frueh’s (2003) review of telepsychiatry, which commonly utilizes videoconferencing, various advantages of this method are discussed, such as the ability to reach rural populations, elderly patients and prisoners who are incarcerated who are not always physically able to attend in-office sessions. Furthermore, reviews of various studies utilizing telepsychiatry have found a high satisfaction rate, by both the patient and the therapist (Monnier, Knapp & Frueh, 2003). Although this comprehensive literature search examined telepsychiatry, it is fair to assume that the advantages cited above (i.e., bridging distance and reaching those physically disabled who cannot attend sessions) apply also to hypnosis by telephone, if not more so. Furthermore, we posit that the telephone is a more accessible and common medium than videoconferencing, so that treatments utilizing this form of communication are bound to be more efficient.

One of the complicated problems of applying hypnotherapy with school-refusal patients, which has yet to be addressed in the literature, is the pragmatic difficulty of being
with the patient during the stressful early morning hours, on the way to school, and during the first couple of hours at school. As the morning hours before going to school are very stressing and anxiety evoking for school refusal children, the child might decide not to go to school if he/she doesn’t get some help during these hours. In other cases, the anxiety is aroused while the child is at school, which might make him/her leave school early.

Although self-hypnosis is a useful tool for school-refusal patients, the stress of the morning hours doesn’t always make it possible for them to induce it by themselves. In this paper, we will introduce a therapeutic approach, which utilizes known hypnotic techniques, but rehearses them via the telephone (“Tele-Hypnosis”), while the patient is at his/her house or on the way to school, and the therapist is at his office.

**Case history**

Twelve adolescents, 8 boys and 4 girls, aged 12 to 15, were referred for a treatment of school refusal. They were referred after being unsuccessfully treated with various psychotherapy and psychopharmacology techniques, to which their symptoms resisted. Some of the referred adolescents were absent from school completely, the worst case being of absence duration of 2-1/2 years. As all patients were psychologically screened, and did not show prodromal signs of schizophrenia, a psychotic state, deep depression or suicidal threat, we did not see any liability to the use of hypnotherapy.

**Description of treatment**

Before the beginning of treatment, all participants were screened for hypnozability using the Stanford Hypnotic Clinical Scales for Children (Morgan & Hilgard, 1978). Their scores ranged from 10-28, with $M = 19.4$ and $SD = 6.52$.

The techniques used in the sessions included hypnosis, relaxation, breathing training, guided imagery with suggestions for confidence building, anxiety reduction and positive reframing of negative associations. The latter treatment, positive reframing of negative associations, entailed the therapist and the patient together identifying the negative thoughts that produced anxiety. Next, while the patient was in trance, a positive association was made which dispersed the negative thought. A posthypnotic suggestion was made so that each time the negative thought arose the corresponding positive thought was automatically and effortlessly evoked. Other techniques included the patients’ imagining a picture of something that promotes feelings of confidence and mastery (e.g., sports such as a basketball or hockey game for the more athletically inclined participants or videogames and musical instruments for those patients interested in these activities). The specific techniques for induction were derived from the child’s world. In the first session, we discussed his/her favorite activities, and the situation and places in which they feel most relaxed using multi-sensory imagery techniques. In each of the techniques the patient’s active participation was emphasized. It is important to note that the patients were advised that the techniques taught could be utilized effectively even with their eyes wide open, while participating in their daily activities, and need not only be practiced when the patient was in a full hypnotic state, although an explicit direction was given during and after the hypnosis training to not use the techniques in situations were caution was required (such as riding a bike or climbing).

The suggestion for initiating the calls to the therapist entailed the therapist and the child determining a 10-point anxiety scale, where 1 indicated no anxiety and 10 - high anxiety. During the sessions they assigned degrees of anxiety and the patient’s ability to cope with this anxiety and remain in school or on her/his commute to school. Repeated suggestions
were made that the child should contact the therapist when the anxiety level reached 5. Other suggestions made were that the therapist is on the “other side”, is available, and can be reached by phone call. This suggestion empowered the children so that they could cope on their own. Anchoring was also used, where the suggestion that merely touching the preprogrammed therapist’s number (by quick dial) strengthened the child.

After practicing and familiarizing the patients with these methods, two cues were introduced and rehearsed. The first cue (usually the therapist’s forming of a ring with his left thumb and index finger) was intended to enable the patient to enter a rapid self-hypnotic, relaxed state. The second cue was the therapist’s voice, which was intended to help the patient induce that kind of hypnotic state. It is important to note that a hypnotic induction was not always used first, as we utilized gradation, i.e., the therapist’s voice, guided imagery and then induced hypnosis. The adolescents were then asked to rehearse the self-hypnotic cue, and the voice cueing of the therapist via the telephone, while they are at their homes and the therapist is at his office.

At the beginning of each therapy, the repeated suggestions that hypnosis is a method, which aids patients to return to school after no more than 10 sessions, were made. The therapist and each patient made the final decision of how many sessions would be required jointly. The number of sessions with each child (6 with 3 of the patients and from 7-11 with 9 of the patients) was decided by each individual child’s ability to travel to and remain in school, as was assessed by in-vitro simulations, where the anxiety level did not exceed 3. In-office sessions were not resumed unless a significant deterioration occurred and the child stopped attending school (this happened with only one participant who resumed school attendance but then suffered a relapse, following which two more office sessions were added).

All participants knew that the therapist was available to take their phone calls immediately from 7:00-9:00 in the morning, and that after 9:00 he would return their call no more than 40 minutes after hearing their message on voice-mail. On the morning of their resuming school attendance, hypnosis was exercised via the telephone (rehearsing 5-minute sessions until sufficient relaxation was obtained), after which the patients ascended their school transportation, equipped with cellular phones and the knowledge that the therapist is available for them over the next couple of hours. When required, “Tele-hypnosis” was induced during the journey and upon their arrival at school. The school counselor then escorted the adolescents to class, and the teachers were notified regarding the procedure (whether the self-hypnotic or the “Tele-hypnotic” procedures). It is important to note the active role of the school counselor, who acted as a liaison between the therapist and the teachers, and also between the therapist and the parents of the 12 patients. The school counselor provided the therapist with the information regarding the duration of school absenteeism prior to the initiation of therapy, and was also responsible for conducting a one-year follow up with all patients in order to assess relapse.

Results

As can be seen in Table 1, the duration of absence prior to the beginning of therapy was between 24-120 weeks (an average of 65 weeks). Three of the patients had been absent for less than 40 weeks, while the majority had missed school for a period of 60 weeks or more (7 patients). The improvement rate was quite dispersed; 7 patients who had missed school for 68 weeks or less all improved their school attendance, so that they missed only a total of 6 weeks of school (an average of less than one absence). The attendance of 5 patients
whose baseline absence was 76 weeks or more (an average of approximately 93 weeks) improved to 26 weeks of absence (an average of approximately 5 weeks).

During the first 2 weeks of attendance, 8 of the adolescents initiated cellular phone contacts with the therapist, while preparing themselves to go to school. Sixty-five percent of the calls were made from home during the early morning hours, 20% were made while commuting on the school bus, and 15% were made after the patient had reached school. Several of the participants claimed that just hearing the therapist’s voice on the voice-mail significantly reduced their anxiety. On average, each patient called approximately 5 times during the first 2 weeks. Most of the calls were made on the first week, steadily declining by the third week. During these phone calls, which lasted between 5 to 15 minutes, guided imagery was applied. Most of the patients did not call at the sign of anxiety unless they were not able to reduce it by using the techniques learned in the office sessions. Later on, “Tele-hypnotic” connection was no longer necessary for most of the patients in order to attend school. A follow-up of over a year has shown that eight of them maintained full-time attendance, and three showed partial improvement in their attendance. Only one patient failed to improve his school attendance; this patient showed significant improvement after his therapy, but the one-year follow up revealed that he went back to avoiding school.

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*Prior to current therapy (in weeks).
**In one year follow up (in weeks).
^Made in first two weeks

Discussion

The use of hypnotherapy in the treatment of school refusing children and adolescents has been shown to be effective, though reported in only a few cases. “Tele-hypnosis”, in treating various other problems, has been demonstrated as a very powerful tool. It was shown to be just as effective as the more common in-person hypnotherapy, though most therapists stated they wouldn’t replace it with in-person therapy because of the lack of human contact (Kroger, 1969; Stanton, 1978; Cooperman & Schafer, 1983).
Tolchin (2000) claims the telephone can be a natural and useful adjunct in psychotherapy with adolescents, as teenagers spend one-third of their day conversing, with 13 percent of those conversations taking place over the telephone. Combining in-person hypnotherapy with “Tele-hypnosis”, tailored to the needs of each patient seems to significantly improve the treatment of school refusal in more than one way. First and foremost, in any therapy and specifically when treating adolescents using the phone can catalyze the development of the therapeutic alliance, which is so crucial to the success of any therapy. For example, Kestenbaum (1978) utilized the telephone in treating female adolescents with separation problems, and found that phone contact served to make the therapist a real, available, trustworthy object during moments of separation anxiety. In general, as Kestenbaum detailed, it is useful to let adolescent patients know that the therapist is available by phone if any significant problem arises outside of the sessions, so that a supportive therapeutic alliance can develop. Even brief phone contact can be reassuring for the patient and decrease anxiety (Kestenbaum at Tolchin, 2000).

“Tele-hypnosis” also seems to decrease the time it takes for the patients to go back to attending school. In the reported school refusal cases previously discussed, some patients resumed attending school after only three sessions, after also practicing self-use at home (Brown et al., 1996), while others resumed after a full semester (Roberts, 1998). Needless to say, the time it takes to go back to attending school is dependent on several factors, among them the patient him/herself, the severity of the problem and the cooperation with the therapist. However, as described earlier in this paper, all 12 adolescents returned to school after only 6 to 10 sessions (though one of the patients relapsed with time). Decreasing the time it takes for a school-refusing child to resume attending school is very crucial to his later reintegration in the school environment; the longer the child is absent from school, the more difficulties he/she may encounter in school work and relations with peers once he/she resumes school attendance.

Having the therapist available for them at any time helped the patients, since they could contact him at the “true” moment of the anxiety, relieve it, and go to school rather than stay at home and deal with the anxiety in a later session with the therapist. What is more, as the patients themselves indicated, in many cases knowing that the therapist was available for them at any moment was very comforting for them, and all they had to do was dial the numbers. This knowledge empowered them and helped them deal with their school refusal more independently, as reflected by the fact that many patients did not feel the need to actually call the therapist. Although in the short term the cell-phone serves as a sort of “transitional object” and thus transfers these patients’ dependency on their attachment figures to the therapist, in the long term (which was not very long in this case), it freed them from their dependency and separation anxiety altogether, when they came to feel that they no longer needed the therapist’s help.

As was mentioned earlier, during the hypnosis induction, the patients were asked to imagine a picture of something that promoted feeling of confidence and mastery. This image served as an “area of comfort” which came to replace the image of the stressing and anxiety evoking area, which is in this case, the school. Zeig (1991) introduced the notion of area of comfort. He described the method of guiding hypnized patients to find an area of comfort inside themselves and asking them to remember it. The patients were able to imagine that area later on, in times of anxiety and stress, and were thus able to relieve the stress.

Stigma played an interesting role for many of the patients participating in this study. As it was an issue confronted in previous therapies, because of the form of their
illness and its effect on their school participation (a deviation from the social norm), it is interesting to note that most participants did not feel much stigmatized by their illness, and it played a less-significant role than what may be expected. Furthermore, although it may appear that their ability to use their phone to call the therapist may call attention to them, this was not found to be so. Moreover, the patients were able to utilize the techniques learned also in other domains that were anxiety provoking, such as for relieving test-anxiety. The school counselor, who was the liaison between parents and therapist, noted much cooperation between the teachers and the other school students. Furthermore, for most patients a welcome side effect of this treatment was noted, as evidenced by a gradual improvement in the patients’ social participation during the mid-day breaks.

Since the suggested therapeutic approach yielded positive results for 11 patients, consistent with the findings of prior research pertaining to the treatment of school refusal discussed earlier, we feel that there is some indication to the effectiveness of hypnotherapy in treating school refusal. However, since this study is not an experimental study, the causal certainty between the intervention and treatment result remains open but certainly suggestive. When “Tele-hypnotic” intervention was first introduced, more than a decade ago, this technique was very innovative as cell phones were less common than they are now, especially among adolescents. Applying this technique required equipping the patients with cell phones and providing explanations regarding this procedure to everyone at the school setting who might have been wondering about it. Nowadays, when cell phones are the property of almost every school age child it can be easier to apply “Tele-hypnosis” and it can also be accepted more “naturally” by the patient him/herself and by his/her peers.

Further research on this subject is needed and may include comparison studies between “Tele-hypnosis” and Cognitive Behavioral Therapy (CBT), or between “Tele-hypnosis” and psychopharmacology treatments. Furthermore, it may be interesting to investigate in future studies whether there are indeed differences between the number of visits with the therapist (as described earlier, this study utilized 6 and 10 visits), as well as the contribution of maintaining phone contact with the therapist once school attendance is resumed.

References


