Pediatric Suggestions: Using Hypnosis in the Routine Examination of Children

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Abstract

The recognition and utilization of trance phenomena in clinical pediatrics can energize the practitioner and be therapeutically beneficial for the child. The aim of this paper is to characterize and promote the purposeful inclusion of trance and suggestion in the routine pediatric examination. This includes, but goes beyond, the child-oriented examination skills customarily associated with being a “good,” child-friendly pediatrician. While this paper highlights trance recognition from a clinician’s perspective, emphasis is placed on utilizing spontaneous hypnotic moments whenever they occur to further the agenda of the encounter, diminish doctor visit anxiety, enhance self empowerment, and improve the milieu for pediatric care.

Keywords: Trance, pediatrics, examination, hypnosis workshops.

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Most pediatricians choose their subspecialty because they enjoy working with children. Entering the world of childhood, engaging in magic, distraction, blowing bubbles, doll play, stuffed animals, doctor kits, dinosaurs, Elmo and superheroes have long been intuitive or learned techniques in the pediatrician’s armamentarium (Goldbloom, 2002; Sugarman, 1997). Yet for many pediatricians, the pressures of contemporary medical care and lack of time have diminished our incentive and perceived ability to take our time to fully utilize these techniques with patients (Linzer, et al, 2000). This paper supports the notion that naturally occurring trance and hypnotic phenomena are easily utilized and incorporated into routine short patient encounters without unnecessarily prolonging the duration of the visit (Kohen, 1996; Sugarman, 1996).

It remains debatable whether signs of hypnosis in normal childhood activity (Olness & Kohen, 1996) constitute an objective finding or a subjective interpretation in the eyes of the beholder (Olness & Gardner, 1978). In the opinion of the author and others (Sugarman, 1996; Gall, 1990), such controversy belies what pediatricians see in their offices daily as children respond to the anxiety that attends well and sick child encounters. It seems safe to state that at the very least there is a strong association, a convergence, of sensitive, effective, compassionate pediatric examination practice and Ericksonian hypnosis principles. Furthermore, accepting the centrality of imagination to hypnosis, it seems appropriate to conclude that children have inherent self-hypnosis potential (Anbar, 2006; Barnes & Kohen, 2006). The successful utilization of hypnosis in the treatment of a host of pediatric disorders is well documented, (Olness & Kohen, 1996; Sugarman, 1996; Hall, 1999; Anbar, 2001; Anbar & Savedoff, 2005). But what about the routine well visit? The encounter over a sore throat? An embedded earring? A cut on the chin? The author here contends that the pediatrician’s purposeful, targeted choice of words and gestures may induce hypnotic responses to transmit positive suggestions to both the child and the parent (Marino & Kohen; 1996, Sugarman, 1996).

Recognizing and Inducing Trance

Although there remains no universally accepted definition of hypnosis, for the purposes of this paper it may be considered an altered state of consciousness induced by a heightened state of focused attention or concentration in which the subconscious mind is particularly open and responsive to verbal suggestions (Olness & Kohen, 1996). It is held by some that the child who has come for a sick visit or well examination is already in a hypnotic trance state when the doctor enters the room (Kohen, 1986; Sugarman, 1996). Suggestions offered to the child awaiting examination can be overt such as “Because you know what to do I bet you’ll lift your shirt up for my stethoscope” or embedded in another statement such as “Let me see where I put my stethoscope because I’ll need it when you lift up your shirt for me to hear your heart.” Ericksonian suggestions are often permissive, raising possibilities, but relying on the imaginative conviction of the subject to embrace and enact them (Olness & Kohen, 1996). It is the difference between “You will relax as you notice your breathing” and “It will be interesting to notice when your slower breathing allows you to relax.” As children advance to the teenage years, more direct suggestions may be more appropriate and effective.

Ericksonian principles have been applied to hypnotic interventions unique to children (Olness & Kohen, 1996; Sugarman, 1996). These incorporate elements of trance
recognition which, although not yet universally accepted by others, have nevertheless become the basis of application to pediatric illness, pain, and a variety of other disorders.

The reader may be quite familiar with classic signs of hypnotic induction. They include, but are not restricted to, fluttering of the closed eyelids, lowering of the head, slackening of facial muscles, slowing of the rate of respiration, tearing or other parasympathetic responses, muscle twitching, and catalepsy (Olness & Kohen, 1996; Sugarman, 1996). The pediatric subject in hypnosis may simply become entranced, gaze fixed, facial muscles loose, and limbs suspended or frozen in the midst of a particular action. Children are especially likely to display alert trance, their play or activity intensified, focused to the exclusion of everything else and everybody surrounding them (Olness & Kohen; 1996, Sugarman, 1996).

Pediatricians can learn to recognize this phenomenon. They may also notice a child’s tendency to go in and out of trance states, such that she need not necessarily be in deep formal hypnosis to respond to suggestions (Kuttner, 1988; Olness & Kohen, 1996; Sugarman, 2006). Whether such hypnotic moments constitute true hypnosis is arguable, but the debate seems irrelevant from a practical pediatric perspective (Olness & Gardner, 1978).

What signals these trance states? The child who is playing with a toy, perhaps repeating an action, unengaged with the adults around him and oblivious to them even when spoken to, is said by some to be in a hypnotic trance state (Olness & Kohen; 1996; Sugarman, 1996). One could say the same of the child who is playing, reading, watching television, daydreaming or absorbed in the computer and does not respond when called or react to a sudden noise or other intrusion (Sugarman, 1996; Anbar, 2006). The child who is crying intensely, “out of control” without apparent contact with surrounding events is also likely in trance, albeit a negative or paradoxical trance (Sugarman, 1996). Further, a child may be observed to enter and leave trance states repeatedly (Kuttner, 1988), perhaps because young children live much of their lives in such close proximity to fantasy and imagination. Younger minds are unencumbered by abstract reasoning and analysis, and unfettered by the complexity of what adults encounter in their daily lives (Olness & Gardner; 1978, Sugarman, 1996).

What then are the elements that weave principles of Ericksonian hypnosis into the relationship the pediatrician establishes with his patient? What sets the stage for the absorption of useful overt and embedded suggestions? Establishing rapport in a manner that is mindful of the clinical situation and developmental age of the child is always primary to encouraging trance (Kohen, 1986; Olness & Kohen, 1996; Sugarman, 1996). Noticing and evoking curiosity invites children to listen and attend. Humor and paradoxical comments, even confusing ones, can be engaging as well as relaxing. For example, “I hear breakfast in your tummy with my purple stethoscope, but it sounds like cereal and I think you probably had brown toast and a blue egg this morning, right?”

Statements that promote self efficacy and empowerment can give a sense of control and competence to the child, allowing the patient to become the “boss” and “direct” the examination rather than resist it as an imposition. Reframing any negative comments, whether uttered intentionally or not, can cast challenges in a positive light. Metaphors and stories can plant alternative possibilities or outcomes in the child’s mind (Thomson, 2005). Acts and words of synchrony place both the examiner and the patient in the same trance state, even if briefly (Sugarman, 1996). The natural tendency of children to be in states of trance and enchantment (Olness and Kohen, 1996) can be harnessed and used to great advantage by the pediatrician who is alert to their presence. On a daily basis, the author experiences opportunities to create and exploit focused attention at each step of the pediatric encounter.
**Pediatric Suggestions**

**Suggestion in the Initial Greeting**

Since the doctor visit may be anxiety provoking for children, it is not unreasonable to assume that the pediatric patient is already in a heightened state of concentration, even hyper-vigilance, from the start of the encounter (Sugarman, 1996). The first hello can establish the relationship the doctor expects to have with his patient. Properly framed, it allows the child to consider the possibility that the doctor is not just there to do something to him, but rather with him. A handshake, waving, joining in play with toys, bending down low, crouching or sitting in a chair at the child’s eye level all provide the intentional suggestion of parity heralding a shared rather than imposed venture. Some clinicians may think nothing of standing and greeting the parent without paying much attention to the child. But greeting a child by name, recognizing, or having her introduce her caregiver or a sibling present in the room establishes who is important and can empower the patient. Similarly, some humorous, confusing, or paradoxical statement can engage and capture the attention of the child, while extinguishing possible intimidation projected by the doctor such as “You’re Josh and are you three? Yes, it says you are three right here on my chart, and I’m checking you today, but it’s not your birthday, because you already had it.” Another way of using the greeting as a mechanism of empowerment is to involve the child in the process. “Hi Jen, is this your Mom? And what is her name? And who’s that next to her?” Or the parent may instinctively state the introduction and supply a suggestion, even in the case of an infant, lending the calm of her voice to the situation about to unfold: “Melanie, this is the doctor we talked about who is here to make you feel better.” To which you need only reply “That’s right.” In the pediatric office setting, the induction, if it has not already occurred by itself, can be secured by capturing the attention of the child (Kohen, 1986).

**Noticing and Engaging**

Putting aside the formal hypnosis setting, it has been the experience of the author that the best way to maintain a pediatric patient’s trance state is to continuously engage the child by noticing with genuine interest (Olness & Kohen, 1996; Sugarman, 1996). “Noticing” signifies singling out something special to focus attention and to capture that of the child in relation to establishing rapport. The pediatrician can remark on something unique about the child, his current activity, his shirt, hat or shoes or even by stating a truism such as “well here you are for your checkup, and look at how you’ve grown!.” Once the practitioner observes any sign of trance, such as cessation of activities, a captured gaze, slack facial features, frozen posture, he can immediately offer a direct, encouraging, suggestion, such as “and I bet you can enjoy our visit,” or with a younger child “that’s right,” or a prolonged “okaaaay,” or “wow.” In the case of an infant, smiling and gentle touch, echoing that of the parent, can provide the non-verbal suggestion that a comfortable, rather than intrusive, interaction is about to take place (Kuttner, 1988; Olness & Kohen, 1996).

Every individual and action in the examination room provides opportunities to notice, engage, and focus the patient’s attention toward trance states. To provide this is to observe both verbal and nonverbal cues displayed by the child and the accompanying parent, siblings or anyone else present during the examination (Sugarman, 1996). The trance opportunity may be that activity engaging the child right there when you walk in, or it may be an accompanying transitional object or borrowed book or toy, or something the examiner brings to the encounter. The pediatrician may choose to speak to the patient through a sibling, saying “Sarah, I’m going to ask your sister what she likes to do best just like I asked
you the last time you were here.” Or, “Do you remember how you laughed when I looked in your ears? I wouldn’t be surprised if the same thing happened with Jean here. (turning to your patient, Jean) Let’s see. Which ear do you think will tickle the most?!” An electronic toy, a transitional object, the choice a parent or the child has made between the examining table and a lap, are all potential material for indirect communication and embedded suggestions. All you have to do is notice and comment and your patient is given the opportunity to engage, even lead, the process. An important principle is to “go with the child” that is to utilize her activities and spoken words to foster trance-like interaction with the examiner (Sugarman, 1996). For example, if the child is playing with a toy, the pediatrician may join with her silently or comment about it. Or, he might combine a reflection about the history with his observation of what the child is doing. (To the parent, but the child is listening) “So your daughter is having some trouble paying attention at school (turning from parent toward the child) but look at how well she is sitting there quietly and drawing a picture while we are talking.” Such supportive comments recognizing the abilities of the child are also ego strengthening.

**Listening with Attention**

These days we often feel constrained to rush the history. When the doctor hears “ear ache” need he wait and listen for much more? Yet listening not only honors the patient or parent reporting, an absolute requirement for rapport, but emphasizes that the child is always more than “just another ear ache.” In a tangential corner of the history may lie a larger diagnosis. In a rambling tale may be buried information about the parent and her parenting skills, pertinent points of which the parent is unaware, or other data more important than the presenting complaint. Inattention or distraction on the part of the pediatrician can reverse the rapport that has been previously attained by suggesting “he’s not interested in me, my child or what I have to say.” If the history seems to be wandering, rather than interrupting with impatience, one can interject, “Let me summarize what I have heard so far,” as a reflection to the parent. This formulation also permits you to redirect the exchange by asking a more pointed question or indicate that further discussion needs to take place at a later time when you can devote proper attention to it.

But what can you do while the history unfolds to maintain rapport and engagement with the child? What if your patient now appears passive and removed because your attention seems to have shifted to the parent? First, recognize that he is listening, possibly in a hypnotic state, such that you may only need to reframe what is being said to draw him back in. You can also continue to engage sufficiently with the child if he appears to be losing interest. This can be accomplished by a hand on the child’s shoulder, a quick comment about what he is doing such as “great tower” or “cool drawing” followed, if necessary, by a quick, “but I need to listen to your Mom because she is telling me all about you”. The embedded suggestion to the child is: “You are so important that you are the focus of what your Mom is saying to me.” And if the child is old enough to participate in obtaining the history, it can be enormously empowering to address her directly: “What do you enjoy doing? What do you do best? What would you like to be doing right now? What do you do with your friends? What are your favorite foods? How are you sleeping?” “Tap dance?”, “Chess club? I bet you’re pretty good at that!” Whatever can be retrieved directly from the child as opposed to the parent gives the child the gift of your attention to her and can increase the sense of confidence and mastery she brings to the examination.
Reframing and Metaphors

Assuming that all words spoken in the framework of trance have hypnotic significance (Olness & Kohen, 1996; Sugarman, 1996; Havens, 2003), there is an ongoing opportunity to refine and alter the perceptions those words may impart. Reframing takes a negative comment and restates it in a manner that renders it a positive suggestion. Negative comments by physicians, nurses, or parents may block rapport or induce resistance. A most obvious example while awaiting immunization is: “Johnny, you’re going to get a shot, and it will hurt a little bit, like a pinch.” This sounds good, and as though the child is being “prepared” for the upcoming injection, but the suggested word heard by that child is “hurt”, which can lead to recoil and more anxiety (Kohen, personal communication). This can cause resistance to the injection in anticipation of the now inevitable “hurt.” So you can seize the opportunity to quickly reframe the parent’s statement by saying: “or it may not feel that way because nobody knows how it will feel for you” or alternatively “What your Mom meant to say is that some kids say they felt a pinch (removing at least the word ‘hurt’), but not everyone does, so you’ll have to tell me afterwards (reinforces that the immunization will happen) how it felt.” Vigilance is the watchword when it comes to reframing. Every word spoken by anyone during the patient encounter has the potential to convey a positive suggestion, or a negative one to be reframed by you. When a mother says, “She won’t eat her vegetables”, the pediatrician can respond with “So she hasn’t quite figured out which veggies she likes yet, but that may change soon.” If a parent says, “He doesn’t wet the bed that much, just twice a week,” intending a positive statement, the child likely hears and absorbs only the word “wet” with all attendant shame and negative reinforcing connotations. One can quickly reframe by saying, “So Peter’s dry most of the time and his body already knows how to be dry five nights a week.” The child then hears the word “dry” as an already achieved partial success, a statement that is ego reinforcing and anticipating mastery.

Words like yet, soon, and because can significantly alter perceptions by opening the door to a positive suggestion. But phrases stating “I know that you can, will, want, need, enjoy, dislike...” may be perceived as false or misleading, and promote resistance unless they are held to be true for the child because he himself has so stated.

Metaphors can provide embedded suggestions to address symptoms or troubled relationships in an indirect and non-threatening fashion. While seeing a child with chronic asthma who has improved on her medical regimen, an empowering compliment can be linked to a suggestive metaphor and embedded suggestion such as, “Isn’t it wonderful that you have learned how to use your inhalers so your lungs can be at ease and your breathing is easy like the clear air after the rain (or like the breeze blowing a sail, etc).” Or in the case of a warring teenager “When (expectant suggestion, as opposed to “if”) you figure out how to keep from yelling at her, your Mom may actually listen to what you have to say, just like a teacher calls on the student whose hand is raised and not the one who’s talking to his friends.”

Synchrony and Kinesthetic Trance

The word synchrony may be used to describe actions on the doctor’s part that join, mirror, or connect the doctor to what is happening to the child during the examination. Kinesthetic techniques employ touch to induce the trance state (Kuttner, 1988; Hall, 1999). Rocking can induce trance-like responses we see as “calming” the baby. Some parents instinctively add sounds that are repetitive or even similar to those made by the
infant to further the relaxation and trance. More formal kinesthetic approaches including the “magic glove” induction for hypnotic analgesia are well-documented (Kuttner, 1988), but improvised methods of appropriate touch can be both tension reducing and entrancing (author’s method). Another synchronic technique is that of sharing the examination with other non patients in the room. “I’ll put the flashlight in my ear first, then I’ll put it in Mom’s (or the stuffed animal’s) and then yours. “Just tell me which ear’s first because you’re the boss.” (Synchronic and empowering). Breathing with the child when examining the lungs is synchronic, as is a thump-thump sound when listening to the heart. One can focus attention on the ear exam with animal sounds while inserting the speculum, asking whether the child hears it and is it a bird sound or a squirrel sound (author’s method).

Further verbal synchrony may consist of sighs, linking statements such as “OK” or “that’s right,” a repetitive “good,” “good job,” or “wow” (Hall, personal communication). Many pediatricians have learned to do this of their own accord or by observing parents during the exam. Somewhat more radical is the idea of whimpering or “crying” with the child or saying, “You can cry louder if you want until it’s done and when it’s done you can stop because it will be over when it’s done.” (Kohen, Sugarman, personal communication). Such statements artfully combine synchrony, truism, confusion and empowerment.

Confusion and Dissociation

A patient’s behavior may imply he is ignoring or disengaging from what is taking place at the time. At the very least, this can be called coping by dissociation. Such behavior can be utilized by the pediatrician seeking to empower and lend comfort to the child. Words and statements that are confusing potentially interrupt whatever mental process may be causing anxiety by using humor or by inducing the child to follow and seek to understand a nonsense sentence. Saying, “There’s a little bird in your ear and when you hold still it may fly out of your ear and land in my hair” is a magical nonsense statement that is just possibly credible enough to the 3 to 6 year old child and sufficiently whimsical and funny to have him willingly allow the exam.

Dissociation is supported by words that impersonalize whatever promotes anxiety. The asthma, or diabetes, or vomiting instead of your asthma, diabetes, or vomiting. “I’m listening with my stethoscope to this part (stuffed animal)…..now this part……now this…. (shifting to the patient) …now this…and this.” Or for an abdominal exam, “I’m going to feel around just over this shirt….now above this belt. Interesting buckle, where’d you get it?” Another confusion and dissociation method is to hum or make nonsense sounds while moving the stethoscope or examining hand rapidly from one area of the body to another, suggesting amusing “non-examination” actions.

Time and place dissociation can help empower the child to imagine being in another place, doing another activity, having mental separation from any unpleasant procedure or examination that may be taking place at the moment. Metaphor, whether suggested or imagined by the patient alone, can achieve a level of dissociation necessary to produce relaxation and comfort. A typical formulation might be, “You look as though you’d rather not be here right now…is that right? Well then, imagine a better place, one where you are relaxed and comfortable. Maybe a place you love and have to been before, or would like to go. Maybe sitting on a soft cloud or huge pillow or a place you make up and, imagine yourself being there.” While the examination or procedure is taking place, you can help her expand imagery by pretending a particular time of day or night, envisioning the presence of others, engaging contrived or real props, and invoking the senses by assigning imagined colors, sounds and textures.
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Conclusion

The utilization of the trance phenomena in pediatric practice ultimately encourages patient mastery. Techniques mentioned here only represent a fraction of those available to the practitioner. Their moment to moment admixture forms the challenge, art and enjoyment of the approach described herein. The benefit to the child is the sense of retaining control and becoming a willing and allowing participant, rather than an invaded and discounted person surrounded by powerful adults. The reward is not only a better and more comfortable patient encounter, but the satisfaction of teaching your patient the gift of self regulation and empowerment. This new or newly recognized and reinforced set of pediatric skills can bring the physician a deep sense of accomplishment and joy.

References


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