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BRIEF REPORT

BRIEF HYPNOTHERAPY WITH PASSIVE CHILDREN

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ABSTRACT

This is a report of the successful use of hypnotic suggestions aimed at encouraging self-assertion and self-acceptance in 51 children aged from 6–15 seen in a general medical practice with psychogenic enuresis or abdominal pain, school phobias, behavioural problems or chronic anxiety. All children treated were passive, timid and unassertive. The psychodynamics of passivity and of assertive therapy are discussed. Thirty-nine children were rated at a two-year follow-up as completely recovered; twelve made no permanent improvement. The average total time spent on treatment was only one and a half hours so this approach to hypnotherapy may be of interest to general medical practitioners as well as child psychiatrists and therapists.

INTRODUCTION

Adult psychotherapy is time-consuming and often unrewarding: severe neurosis if untreated or unimproved by treatment may well become worse rather than better. The most important contribution to the mental health of the community lies in preventing or modifying neurosis in children. This article describes a brief and effective method of treating chronic anxiety and anxiety symptoms in children by post-hypnotic suggestion directed towards encouraging self-acceptance and self-assertion, two basic aspects of the process of self-realisation and growth.

MATERIAL

Fifty-one children (28 boys and 23 girls) seen in an urban working-class general medical practice and aged 6–15 years were treated. All children seen in the surgery with psychogenic enuresis or abdominal pain, phobias, behavioural problems or anxiety states were offered hypnotic treatment. All patients treated were of passive personality: they were timid ‘good’ children, who sought approval by being submissive and helpful, lacked confidence and worried unduly about school, homework and play activities. They cried easily, tended to cling to their mothers and were frequently irritable at home; they were unable to express their resentment adequately when abused or imposed on by their peers, being too anxious to risk involvement in friction or fights.

ORIGIN OF PASSIVITY

Faulty parental attitudes ranging from over-protectiveness and lack of firm and consistent parental behaviour to rigid authoritarianism were noted in some cases and

were discussed with the parents in the course of therapy. Horney (l945, 1950) has shown how, in an unhealthy environment, children attempt to relieve anxiety by becoming submissive and affection-seeking, rebellious and aggressive, or withdrawn and isolated. Inner conflict ensues between these solutions until one becomes compulsive: in passive children aggressive drives are repressed though constantly reinforced by resentment of what is felt to be inadequate parental affection and acceptance; when turned inwards they contribute to the development of self-hate and self-rejection. The more severe neuroses appear to be related to the repression of overwhelming aggression because of fear of 'annihilation' of the child or its parents during the early months of life and often fail to respond to hypnotherapy. The dependent child grows up feeling divided and lacking in confidence because compulsive submissiveness prevents awareness and free assertion of natural wishes and feelings and of repressed hostility. The resulting self-alienation, by blocking the development of self-acceptance and a feeling of identity, perpetuates anxiety and defensive compliance in all later relationships; self-directiveness and spontaneity are stifled.

Submissive children may attempt to compensate for the weakness and anxiety resulting from their dependency by forming and attempting to actualise an idealised image of themselves as being more truthful, 'good', helpful, punctual, hard-working or successful at school than any of their peers. Lack of confidence hinders their perfectionistic and over-conscientious efforts, and increasing self-rejection results from the pervasive feeling of being a failure because of falling short of their high standards.

METHOD

After initial examination, history-taking. and discussion with children and parents, hypnosis was induced by eye-fixation using a small torch. The technique was modified according to age and the usual induction involved suggestions such as: 'as you look at the light you will begin to feel very tired; your eyes will become very heavy and will want to close as you keep on looking at the light. You will become more and more drowsy just as if you were in a lovely warm bed tired out after playing all day'. The depth of hypnosis was then deepened by slowly counting up to ten with suggestions of increased relaxation and usually increased with practice, but even a light trance produced good results. Suggestions that the children would begin to feel that they were as 'good' and loving and lovable as anyone else at school, 'stronger' and more sure of themselves and braver and more able to stand up for themselves with others were made, and also that their present symptoms would improve. With younger children, suggestions were kept as simple as possible. In cases of enuresis suggestions were also made that during sleep the patient would waken on feeling bladder fullness and pass urine normally and quite soon would never wet the bed again. Each hypnotic treatment lasted for about 5 minutes; the average number of treatments was five, with a maximum of nine and a minimum of three. The first session was recorded on tape and played back by the patient each day between sessions.

RESULTS

At follow-up two years later, patients were rated (by myself) as significantly improved or unimproved following extended interviews with the children and their parents (see Table 1). Thirty-nine patients were in the first category, being symptom-free and exhibiting increased confidence, self-acceptance, assertiveness and spontaneity. Twelve patients showed no permanent improvement in symptoms or passive behav-

iour. In improved patients, behavioural change and symptom improvement were often considerable after one session, and were well maintained. School work improved as did participation and confidence in playing games. Patients became able to hold their own with their peers and began to mix more freely with them, particularly in the case of older children with the opposite sex, and became less over-conscientious and perfectionistic in outlook.

Table l. Results of treatment

Problem	Number Treated	Number Improved
Enuresis	26	18
Phobias (school etc.)	10	7
Behavioural problems (stealing etc.)	4	4
Recurrent abdominal pain	7	7
Chronic anxiety	4	3
Total	51	39

DISCUSSION

All the patients in this (unselected) series were passive as compared with 71% of those in an adult series of patients given psychotherapy (Browne, 1964). Passive patients respond to psychotherapy much better than authoritarian personality types (Ross, 1945), and this is particularly true of hypnotherapy in children in my own experience.

Direct instigation of assertiveness has been shown to be very effective in the treatment of neurosis (Browne, l964; Stevenson, l959; Wolpe, 1958). In passive children, hypnosis offers a potent therapeutic weapon for quickly increasing assertiveness and self-acceptance. Other factors which facilitate treatment in most children are the greater spontaneity and lesser degree of self-rejection and rigidity of defensive compliant traits, as compared with adults, and the much higher rate of successful hypnotic induction in children. The marked benefit of initiating assertive behaviour with the children's peers is due to the re-experiencing of the infantile conflict between dependency and aggression, with release of repressed hostility and its integration leading to healthy assertiveness and increased self-acceptance (Browne, 1964). Each assertion of the children's own feelings and wishes also diminishes their alienation from their inner resources and their self-rejection, factors that hinder the resolution of their inner conflicts. This new and healthier awareness of self is facilitated by hypnotic treatment of the kind described, which gives children an increased feeling of identity, spontaneity, inner certainty and involvement in their own lives. Very anxious children, in early therapy, need emphasis placed on increasing self-acceptance before they are able to develop their assertiveness. The presence of symptoms of anxiety from infancy in most of these cases, and the quick response to treatment, suggests that the improvement noted in this series can be attributed to therapy rather than to a process of natural remission. This conclusion is supported by the fact that personality change showing a marked shift to more assertive behaviour was considered a prerequisite of permanent symptom improvement, and was only noted in patients rated as permanently improved. Unimproved patients displayed a much higher degree of anxiety about expressing their aggressive feelings, and often failed to continue with treatment. The progress achieved (usually in less than 1.5 hours of therapy) would

seem to justify the wider use of this kind of hypnotherapy. In anxious children, good results with hypnotherapy have been reported by a number of child therapists, sometimes using self-hypnotic techniques (Kohen, Olness & Colwell, 1984; Olness, 1986; Wright, 1960). In my own practice, hypnotherapy of this kind has been of value in the treatment of a variety of other paediatric conditions such as asthma, eczema, recurrent diarrhoea, stammering, obesity, anorexia and faecal incontinence. Finally, the possibility of child abuse, especially sexual abuse, must always be borne in mind, particularly in those patients who are too anxious to accept treatment or who do not respond to it.

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