AN INTERVIEW WITH LEORA KUTTNER

LEORA KUTTNER

MARK P. JENSEN

ABSTRACT

This article summarizes the key points of a conversation between Leora Kuttner and Mark P. Jensen, during which Dr. Kuttner discussed her views of hypnosis and what she has learned to be most important and most effective as a clinician using hypnosis in her paediatric practice. She views hypnosis as a natural and effortless experience of focused attention that can facilitate positive outcomes. She begins using hypnosis from the moment she first meets her clients, and allows it to unfold within the relationship. She almost always makes 3- to 8-minutes recordings of hypnotic experiences to give to children to use for practice before school or during the day, noting that regular practice is often necessary for positive changes to occur in neuronal networks. She has found that being playful, engaging the child early in the process to motivate them, heightening positive outcome expectancies, providing hope, and having very clear outcome goals can all help to make the experience more effective. She finishes by describing some very specific techniques she has found to be very useful in her work with children with pain.

Key words: paediatric hypnosis, self-hypnosis, hypnotic language, headache, abdominal pain, bed wetting.

INTRODUCTION

Leora Kuttner is a clinical psychologist and clinical professor in the Department of Pediatrics, University of British Columbia, Canada. Hypnosis has been a central component of her therapeutic work for over 30 years, and she describes a fascination and passion to find more effective and elegant ways of adapting the hypnotic experience to address paediatric pain. This has intrigued and driven her since an early exposure in 1979 to the dismissal and under-treatment of children's pain. She has noted how closely intertwined both pain and anxiety are in the child's experience of pain, such that both need to be addressed simultaneously to achieve long-lasting pain relief. Beginning in paediatric oncology in 1982, she developed the first pain-anxiety programme in North America using hypnotic techniques like 'Favorite stories' (Kuttner, 1988) to ease children's pain and distress during invasive medical procedures. Earlier she had met paediatrician Dr Lonnie Zeltzer and psychologist Dr Sam LeBaron, and with their encouragement extended their hypnosis research during invasive medical procedures for oncology treatment (Zeltzer & LeBaron, 1982) to include a younger cohort—children under 6 years of age. These pre-school children have the highest incidence of leukaemia and were the

most neglected in terms of pain treatment options for oncology pain treatment procedures. During the 1980s there were very few options for making these painful procedures less traumatic: general anaesthesia, lorazepam or the DPT cocktail. Lumbar punctures and bone marrow aspirations had become such a significant clinical management problem that she obtained whole-hearted support for her year-long pain research programme. In 1983, children, parents, nurses and medical staff were all involved in changing the climate in the treatment room from fear and avoidance, to skill building and empowerment (Kuttner, Bowman, & Teasdale, 1988). Later she extended hypnosis as pain treatment into the rest of the hospital, particularly neurology, GI, emergency and palliative care.

Dr Kuttner is a popular teacher, providing training and workshops throughout Canada, the USA and around the world. Her workshops provide clinicians with training in interventions — including hypnosis—to alleviate paediatric pain and distress. She is also known for her training in the areas of interpersonal and language skills required to engage with a hurting, scared and distrustful child. Her workshop offerings include a 10-hour session for child psychiatrists to build their skills in chronic pain management and a 6-hour programme for paediatric dentists to develop their behavioural skills with children during dental procedures.

Mark Jensen: How does hypnosis fit into your clinical practice?

Leora Kuttner: I have found hypnosis to be an ideal 'fit' for my area of expertise, which is paediatric pain management. It's versatile and effective. I was fortunate to be trained in hypnosis in 1978 during my graduate studies in South Africa. When I moved to Canada in 1981, hypnosis was the key treatment in the pain and anxiety management programme I developed in the oncology department at BC Children's hospital, Vancouver, Canada, a first in North America.

Now, I work with children and teens suffering from complex, ongoing pain conditions, such as abdominal pain, chronic diseases, migraines and persistent headaches, and various musculo-skeletal conditions. Our medical system unfortunately often refers these children to me as a 'last resort', after numerous medical investigations and after analgesics have been tried and found wanting. This is far from ideal and leads to a corresponding loss of hope. Recent literature underscores the central nervous system adaptation to persistent pain, so that the pain continues to be generated by the brain-pain system (Melzack, 1999; Tracey, 2010). For relief, the patient must learn to engage, modulate and modify these neuronal pathways. In this process, analgesics and other medications can play a small role; however, in my experience hypnosis can play a much more important and powerful role. The earlier a child or teen with pain engages with a comprehensive therapeutic programme that includes brain–body integrative therapies such as hypnosis, the more quickly they will experience relief, and the better the overall outcome (Kuttner, 1988).

Initially, the challenge was how to use the natural occurrence of hypnotic attention (particularly when fear has taken grip) in a child under stress, in order to build resilience and to cope more effectively with a painful medical procedure, such as a bone marrow aspiration. Now thirty years later we have wonderful analgesic and conscious sedation options. Yet the need for hypnosis in children's pain management is still strong. We

need to use sensitive language, employ the child's imagination and, using surprise and hope, capture the child's focus to build coping skills and enhance comfort during medical treatment or ongoing discomfort and disease. It's compelling to work in that interface between mind and body and learn how to access and alter the messages between mind and body.

MJ: When were you first exposed to hypnosis?

LK: I first learned hypnosis for adults 1976 in South Africa during my clinical master programme from an eccentric and talented psychologist Professor George Wiehahn who had trained in Holland. That was the same year the child psychiatrist Josephine Hilgard presented her ground-breaking research on hypnosis with children (Hilgard & Morgan, 1976). This is nicely synchronistic, as Josie had influenced Lonnie (Lonnie Zeltzer) and Sam's (Samuel LaBaron) research, and I drew inspiration from them and Josie's writing to bring hypnosis into a Canadian Children's Hospital.

MJ: I understand that you were not always a clinical psychologist.

LK: That's right. My first career was as a documentary filmmaker for SABC Television while living in South Africa. I went on to do clinical psychology, then left the country on a doctoral fellowship to come to Canada and never thought I would ever make another film.

But life has surprises. I've had the opportunity to make five films on paediatric clinical pain. First was: *No Fears, No Tears* (Kuttner, 1986) on eight young children in the oncology pain programme. I explored how pain is managed in different areas of a paediatric hospital in the documentary *Children in Pain: An Overview* (Kuttner, 1990). Following up on the long-term impact of learning hypnosis when so young, in *No Fears, No Tears—13 Years Later* (Kuttner, 1998) and a film on paediatric palliative care, *Making Every Moment Count* (Kuttner, 2003) with the National Film Board of Canada. I'm now working on a short film *Dancing with Pain* loosely built on Melzack's 'Neuromatrix' on teens learning to manage their chronic pain. Children and teens are compelling when telling their own stories. Watching them on film allows the viewer to hear children's experiences directly providing them with a richer appreciation. Films are hypnotic! For that reason I always use DVDs when teaching.

MJ: Fascinating. And this thing we call hypnosis … what is your definition, how do you view it, how would you describe it?

LK: I experience and know hypnosis to be an extremely natural, effortless experience. It's a common feature of our lives and of children's lives; a natural state of focused narrowed attention. Children and teens move in and out of trances more easily than we adults do. I regard therapeutic hypnosis as engaging with that capacity to further a positive outcome, and develop the desired therapeutic change. With children, I need to pay close attention to my words because hypnosis starts from the moment of our first encounter. Here in Canada I have a foreign accent, despite over thirty years of living here. This puts me at a distinct advantage in using hypnosis as children tend to focus

on my different intonation. This immediately creates a different context in which to invite change. My foreign accent has made me even more sensitive to the fact that the moment I first say 'hello' is *the* moment that hypnosis and other possibilities for change begin.

As humans, we have different states of consciousness and absorption. Hypnosis is a state of greater absorption, narrowed attention and a temporary suspension of reality, such that inner experience becomes intensified, permitting mental, emotional and physical capacities to be optimized. During absorbed concentration, there is greater receptivity to suggestions that are syntonic, or longed for. Barriers that previously were active can be softened or eliminated through the accruing influence of the therapeutic relationship. The experience of time becomes elastic or distorted so that the experience is either lengthened or contracted; as a dissociation from present reality occurs—and this often occurs very quickly with children—new associations are created. *I think of hypnosis as a tacit agreement together to undertake this wanted change process by using imagination and focused attention, practising and refining this process until the goal or satisfaction is achieved*. In this process we need to be flexible, sensitive and attuned to the patient and to be versatile in using our own human creativity to promote change.

With children I find it beneficial to be quite direct. My language is simple, hopeful and positive. This leads me to restate the problem from the beginning into a workable goal. For example, with a young child who has daily headaches; 'So you want to have your head feel good and clear so that you can think easily and have fun … right?' In the first encounter I redefine the territory hypnotically by stating our therapeutic goal and their potential to get there; 'Remember when you didn't have any headaches? That's what we're going to help to happen again. We'll work together with you as the "chief detective" so put your detective hat on! I'll be your expert consultant and Mom or Dad will be the expert parent!' This means that hypnosis is not only the trance, a private or dissociated state, it's the moment of first encounter and is embedded in the growing relationship. Now, a small detour …

Today I saw three teenaged girls aged twelve, thirteen and fifteen, all with abdominal pain. I saw them all on the same day—such an interesting combination. Each girl presented in such a different way. Consequently I engaged with each girl differently. Their history and relationship with their pain varied. So how I used hypnosis by necessity had to vary. The 15 year old Sara, was an awkward little bookworm. When I made a cheeky comment about the book she had her nose in, she looked at me with some interest and then I used her book to segue into imagination. I started where she was and was reminded how versatile hypnotic communication can be, how healing can start idiosyncratically, and how critical the relationship is to carry it all forward.

MJ: So you start using hypnosis right away.

LK: Yes. I use hypnosis from the moment I first meet the child because hypnosis is in the relationship —as well as within one's relationship to self. A trance state can begin at first contact, if the conditions are right—with eyes open. Formal trance isn't needed, particularly with children. The focus of creating possibilities for change needs to be experienced from the moment of the first meeting. Later I may move to a more

formalized trance to establish the re-patterned change, and for use in home practice. But at the start I focus on a climate of calm, warmth and acceptance that heightens the child's absorption into an expectation that the distressing experience can change for the better. Therapy using hypnosis is then an interactional process of using that engagement to optimize change. It can take the form of progressive pain modulation, anxiety relief or creating greater confidence.

Hypnosis unfolds within the relationship. My task is to read, track and attune myself to the child at all times. As the creative potential unfolds through our conversation, I focus on developing a relationship of trust and openness. I feel alive in this process—it's amazing how much one can pick up in this process, like a highly tuned sort of instrument, attentive, absorbed, hearing information between the child's or teen's words and behaviour. I address it hypnotically, with language of understanding, hope and possibilities, using selected imagery that enhance absorption. Sometimes I will tell medical students, 'You use your stethoscope; I use myself.'

I redefine the territory by setting up the potential for change, sometimes with confidence, 'When this pain is down'; or with surprise, 'You didn't know, did you, that your brain and your bladder can talk directly to each other? Even when you're deeply asleep'; or with wonder, 'I'm wondering and I bet you're wondering how much more energy you'll have once your muscles relax and release. What will be the first thing you'll notice, I wonder?'

This means that hypnosis is not merely the trance—a private or dissociated state—but an agreement within our relationship to undertake this process of change that has been stated together with its desired outcome. 'I want to be able to go to school without any headache!'

I will not go into a formal hypnosis until I see a growing receptiveness, an opening in the child. Until then hypnosis is in the language, redefining the problem, exploring what is possible and creating different scenarios so that they come closer to the child's world of possibilities. I don't like tricks, rather I prefer to empower and build up hope and more details of how feeling better would look like, or feel like. I would rather spend more conversation time, exploring the child/teen expectancy to create this responsiveness, bringing closer the optimal change that had been distanced by despair or suffering.

Most of my referrals are now for complex pain, the kind of physical pain that has many overlays of emotional, cognitive and familiar issues that compounds the pain experience. There is often a history of successive failures and withdrawal from school or friends. Hypnosis is my most powerful therapeutic tool, and I want to use it at the most powerful time. First I will educate about pain and ask: 'Do you know how pain works?' They often shake their heads. 'Has anybody explained how pain is processed in the body?' Clinicians often don't have or take the time to explain the brain's role as a pain modulator to inhibit pain which is assessed as irrelevant. 'Let me tell you because it's fascinating!' I take out diagrams of pain pathways, anatomy books, charts and model of the brain, or draw on the white board —whatever is appropriate for the developmental age of the child or teen.

Here is a case that provides an example of my work. Cassandra had a strong three-generational maternal history of migraines. She expected to have migraines. But at 15 years her migraines had become debilitating. I spent considerable time exploring

how pain is processed by the brain and the various gating possibilities and she noted her triggers. She loves the theatre and in a hypnotic experience chose to travel to 'The Phantom of the Opera' to hear her favourite song, as her auditory modality was well developed. Doing diaphragmatic breathing to the music of 'Past the point of no return' she visualized her pain gates closing in her temples. This she practised twice a day so that within eight weeks she was able to interrupt the start of a migraine and influence the impact of her apparent genetic loading, and this has been long-lasting.

Younger children are divine to work with. Their capacity to understand their bodies (in simple terms) is often under-estimated. They can grasp the essentials of 'My brain is boss of my pain' so that they can cope better. I adore working with them, and they're easy-peasy [laughs] !

MJ: [Laughs] How old does a child have to be to be able to use hypnosis?

LK: I remember working with three-year-old Samantha, who was hypnotically talented with a vivid imagination. She required monthly bone marrow aspirations. Her sources of pain were multiple. There was tissue injury, nerve pain, bone pain as the needle broke through the periosteum, and pain from the negative pressure created as the marrow was aspirated out of her iliac crest. Yet she attained a profound physical dissociation when absorbed in her favourite story of 'Grandma Tildy and the Elephant' (Kuttner, 1988). Her eyes were wide-open and fixed on me, while adding necessary story lines, apparently oblivious to the procedure occurring in her iliac crest. She seemed to have made the decision that what was going on in her back was irrelevant and the story was more important, and she gave it all her attention. One of the most extraordinary hypnotic experiences I have ever witnessed. It humbled me because I was prepared for her pain. I thought she was going to cry out, and I was all ready to simply comfort her.

And there she was with blood and her bone marrow being extracted, teaching me how powerful a child's attention can be to transform her experience. I was stunned. So Samantha instructed me on human potential—the extraordinary capacity we have as human beings and particularly as young children to heal, change, repair, and transform. That keeps me using hypnosis—such an elegant, creative way to access this potential.

Right now, I'm working with a seven-year-old girl with enuresis. She's bright from a neurotic family in which everything was so clean that she was always in pull-ups at night and not given the opportunity to learn how to regulate her own brain–bladder feedback signals. Now at seven and a half, she's trained to go to bed in pull-ups, and the pull-ups have become her potty. Playing so that she wouldn't feel shamed and establishing that she would be ready, we created a hypnotic ditty about 'staying tight, tight, tight through the night, night, night! That's right!' ... and how nice it would be when she'd wake up and her pull-ups would be dry. In fact she may even want to give her whole pile of pull-ups away to somebody who *really* needs them. This is just talking conversation, all hypnotically driven. So hypnosis is a flexible tool in which direct or indirect suggestion, games, wordplay occurs before a formal experience.

I love the breath, but I often will combine that with an ideomotor induction, something I've come to call 'the friendly fingers'. Hands clasped together, thumb over thumb, fingers straight out ahead, 'These are your friendly fingers, and they are such

good friends. Can you feel how they are just coming together as friends do and connect up? And as you travel into your inner self you're connected with yourself.' Introducing induction, I talk about it as 'traveling inside—to a comfort zone, or favorite place'. I like to frame it as accessing inner self with comfort. So there's an ongoing theme of connection: connecting me with them that's open and flowing easily and connecting them with themselves. I don't spend time 'deepening' as it isn't necessary with children.

MJ: One of the themes that I've heard in conversations with other clinicians is a view of hypnosis as both an experience or state, and a connection or relationship. Is this your sense as well?

LK: Connection and relationship are totally congruent with my experience because I (my voice and my attention) accompany the child as they go inside. They discover new dimensions of their abilities through this experience. Tone of voice is very important in this process. Though I have a restless, speedy mind, I have a slow South African style of talking, which couldn't be better suited to hypnosis.

MJ: Are there other specific techniques or strategies that you have found helpful?

LK: RECORD THE SESSIONS FOR HOME AND SCHOOL USE

Children are part of the digital world, and now it's easy to record hypnotic sessions and know it's easy for children to follow through. I record 3- to 8-minute experiences, short enough to do before school or during recess. I use MP3s, CDs, or record onto their iPods or iPhones. Rare is the time I will now do hypnosis without recording it.

While one-time hypnotic experience can be profound, if I want to change established pain, the child needs to practise to reorganize neuronal pain networks. This can only happen with daily practice. Daily and repeated practices of 3 to 8 minutes will change entrenched pain patterns like migraines, abdominal pain, or pain-tension patterns. We're built for learning and change, so frequently accessed hypnotic focus achieves the learning more rapidly. With this foundation in place, when pain does occur, the capacity to down-regulate the pain is easily accessed and will reliably yield relief.

I learned this many years ago when working with Brian, a top-notch fourteen-year-old hockey player who sustained a severe concussion. What made his concussion horrible was that it was the third time he'd fallen on the ice. He should never have returned to the ice until completely recovered. His brain was so bruised and shaken that walking hurt. But he was highly motivated to get well. His hypnotic imagery was uniquely 'teen-male', revealing his courage. He saw himself on the top of a windy mountain. Removing the top of his skull, he described the cool breeze vigorously blowing across his brain and blowing away the dead cells, while cooling his brain down so that the swelling could shrink. He then reported experiencing the pressure and pain ease. Since he was home-bound for nine months, he practised different versions of this vigorous energetic hypnosis for three to five minutes, four or five times a day and in that year he made a full recovery. It impressed me that recovery from physical injury can be so well supported by an active brain–body practice. Particularly when physically incapable, active imagination during a hypnosis experience builds a bridge to recovery.

Each session we create another short recording dealing with the next step in the movement towards full healing. Dealing with complex pain, children will collect a

library with different names for each recording and will know which can be counted on to alleviate different aspects of their problem. There could be an MP3 for sleep when in pain, or after school when energy is low, or when homework needs attention and there is pain, or in the morning when it's hard to face the day. They let me know what works for when and we tailor a hypnosis experience to fit, so that they become more independent, relying on their growing resources and practice.

MJ: I'm sitting here smiling because I do the exact same thing with adults. We build a library; some two minutes, some five, some twenty, and the client can choose what they need when they need it.

LK: That's wonderful. I love the analogy of an athlete who is training her body to do something more effortlessly and automatic. The athlete only gets there through regular attention to what needs improving at different times in her practice.

MJ: So, what do you think is important for hypnosis to be as effective as possible?

LK: BE PLAYFUL

We all learn when we're engaged and enjoying it. Creating that emotional fascination is important. But, I learned a lot from a child who said, 'I like doctors to tell jokes, but I don't like the jokes where the doctor's the only one laughing'. [Laughs] Those are not child-focused jokes. So I'm not very jokey, but I do play … playing with evoking curiosity, engaging fun and inviting surprise, or playing with words—easy peasy, lemon squeezy. [Laughs]

INVITE THE CHILD TO HAVE THE HYPNOTIC EXPERIENCE

I introduce hypnosis with an invitation. 'Would you like to travel inside? I wonder what you'll see? Maybe it'll be a surprise, maybe it'll be so different that you start feeling more comfortable, and you'll certainly be surprised how easy and fun it is.' I'll do a lot to soften the environment, indirectly providing a message of safety and ease.

OFFER PLAYFUL AND ACTIVE EXPERIENCES INCONSISTENT WITH FEAR

Many paediatric pain problems are compounded by anxiety, poor sleep and accumulated sleep debt that snowballs into stomach aches, headaches, family distress, parental anxiety, disrupting the family. I sense their caution or fear when they first come in. Being playful facilitates a shift from fear, which inhibits and delays change.

MJ: What kinds of things do you find helpful to address this?

LK: Often I use physical objects like that ball on your left—it's a nice squeezy ball.

Or pick up that horse. See there's a little hole in this horse's tummy, and you could put your finger in, and then the horse becomes part of your finger. Or a telescope that shows how beautifully light is refracted. My favorite however is bubbles. I love bubbles! They emerged from my pain programme in the early '80s. I used puppets and pop-up books, but I needed a physical-action component. I was referred a little fearful three-year-old girl, who was entranced blowing bubbles in the bath. She loved it so much she wouldn't get out of the bath.

I brought the bubbles into treatment, and we started blowing. The child loved it and her parents were watching, fascinated by how she was blowing. Even the nurses were delighted to have these beautiful bubbles. All of a sudden there was magic in the treatment room, play, laughter and I looked at the head nurse, and said, 'That sort of worked, didn't it?' She replied, 'It's wonderful!' Bubbles engage breathing and therefore disperse anxiety. It's fun to catch bubbles, stomp on them, blow twin bubbles and track them as they float away. While it's play, it places and sustains breathing as central. Children will not sustain their breathing unless it's interesting and feels good. Bubbles sustain the child's focus, create a light hypnotic trance and bring a little magic in. Children feel the physiological easing immediately.

DON'T MAKE YOUNG CHILDREN CLOSE THEIR EYES

Children aged six and younger don't like closing their eyes. Closing eyes is reserved for sleep, 'Besides, what will you [the therapist] do when my eyes are closed?' So 'trance' with children is a different phenomenon to that of adults (Kuttner, 1991). It requires active playful absorption. The younger the child, the shorter the trance. The child's eyes will be open but often transfixed. Hypnotic work with little ones is active, expressive and lively.

HYPNOSIS WITH YOUNG CHILDREN HAPPENS QUICKLY

Once engaged I need to hold that created focus, but not too slow because if it's too slow it could become sleep, and they don't want that! It's a delicate balance between creating an intriguing fascination and their developmental capacity for focused attention. Josephine Hilgard and Arlene Morgan called hypnosis for children aged six and younger 'proto-hypnosis' or 'imaginative involvement', because the trance wasn't sustained. But within that shorter attention span and absorbed transient experience change does occur and often surprisingly rapidly. Remember the hypnotic rhyme from the brain to the bladder: 'Tight, tight, tight through the night, night, night.' It worked!

MJ: You mentioned that your most common referral is to help children manage complex pain problems. What do you consider a key factor in using hypnosis for complex pain?

LK: Hope, often repeatedly crushed for child and teens with complex pain, can be resuscitated, sustained and meaningfully developed through a hypnosis experience. Within a therapeutic relationship as well as in home practice, hypnosis as self-regulation mobilizes and regains function, reconnection with peers, participation in school and return to a meaningful life. This process provides a person-centred internal experience allowing the child to engage with the recovery process and draw on previously untapped personal resources. I've often noted young patients maturing through this process, so that they emerge wiser. Central to using hypnotherapy with this group of vulnerable youngsters is to provide accurate physiological information about what may be occurring in his or her body. Understanding how pain is processed by the brain–body networks using models, pictures and diagrams of the body–brain and pain processing areas provides the children with clear pictures and dynamics, to use hypnotically to modulate pain and distress, and enhance hope and function (Kuttner, 2010).

I was referred a 10-year-old boy, a talented tennis player with conversion reaction. He had pain in his shoulder which didn't respond to physical therapy. He saw a neurologist as the pain had progressed throughout his arm, which he could no longer lift. Initially there was concern that this may become complex regional pain syndrome, so it was urgently requested that I assess him.

Using an eye-roll induction, I focused on creating interest in his arm, and comfort, because it was already dissociated. I then explained to this bright, curious little boy, about nerves and how there's this network of nerves with gating capacity at every level in the body; at his fingertips, at wrist, at the little junctures where the nerves intersect to form junctions like railway stations, and then it goes up to major junctions in the shoulder; I provided lots of interesting details and messages and sensations, like trains travelling and then coming in and then changing cabooses. I said that they're not going to travel with so much weight, anything that bothers, you can close them down, and travel on. 'Think of it like closing gates.' So I intersected the physiological information with the suggestions for his arm working smoothly without 'digging out' whatever had triggered him to stop using his arm.

Hypnosis is creative in the moment. I knew it needed to be precise yet with a fascination. Travelling in, along the nerves to close the gate. My note says, 'He felt some connection with his bicep and could feel the gates closing. Receptive, likes being a scientist, understands muscles and tendons.' Next time I saw him after a negative bone scan, he was using his arm. He had no pain and commented 'But you know now I'm radioactive.' [Laughs]

MJ: [Laughs] A theme I've heard you suggest several times is that to make this work effectively you really seek to engage the person, either emotionally or with play or with your words. Would you say that's all of it or just one key piece of several?

LK: ENGAGING THE CHILD IS KEY

I'm glad you came back to this. What I'm doing is heightening the experience and the child's absorption in a therapeutic relationship dedicated to making life better. Change can happen quite quickly with hypnosis, so I heighten whatever will move the child through the door to her optimal outcome. I don't want to work with the same kid for 42 sessions! Short-term effective solution-oriented therapy is what is needed in the 21st century.

HEIGHTEN EXPECTANCY FOR A CLEAR OUTCOME

Together with the child we develop hypnotic experiences with specific details (supplied only by the child) of the desired result. This heightens expectancy and the clarity of the outcome. For example, 14-year-old Jay afflicted with severe dysautonomia wanted to get back to school, but was too dizzy, nauseous and dysregulated to get there. We created a hypnotic recording of him swinging his legs off the bed to the ground, slowly getting up, feeling balanced and steady, eating and retaining breakfast, putting on his uniform, and walking into school, along the corridor greeting his friends with a grin—all while feeling cool, calm and comfortable. He practised it ritualistically, which brought this future into his present, making it vivid and real. By September he was able to get to some classes each day.

HEARTEN THE PATIENT

Hypnosis is helpful even in palliative care. I'm now working with a divine little girl who is living with a relapsed astrocytoma. It's a disheartening, bumpy process living with a condition that is incrementally killing your brain's capacity to function. I use hypnosis to hearten children who come in despair to sustain their spirit and lessen suffering.

MJ: So, there's four things: the expectancy, motivation, the clarity of outcome, and heartening …

LK: Hypnosis allows us to bring the positive outcome into the experiencing present. When we select and experience this optimal future, we potentiate the present to change so that it is imbued with a new, enhanced meaning and in that we deselect the other less propitious futures.

For example to 14-year-old Jay: 'The experience of moving without discomfort is in your future. Instead of waiting for it, feel that fully now, while moving along the corridor greeting and joking with your friends … And as you do it, sense how balanced you are, with easy energy and a settled stomach … As you do this right now, know it can grow to become your established pattern. This is how your being, body, belly, back loves to be and loves it so much that you can enjoy it even longer, because it's continuing.' That's the heartening piece—actively experiencing hope.

I'm working medically with children who have experienced so many routine medical procedures with thoughtless automatic messages, 'Now this is not going to hurt …'

Or, 'Hold still, so we can get the bad part over!' Creating a negative trance with doomed messages, stated because of the misguided notion that honesty trumps competent preparation. So hope is bruised, if not damaged, if not incarcerated by understandable fear. [Laughs]

MJ: … tucked away somewhere.

LK: And starved. So I address that.

MJ: And how? Do you talk about that in terms of imagining yourself in the future, so comfortable?

LK: In creating a lively active relationship, I think that 'hope and heartening' replaces the established fear and anxiety. New experiences and coping skills are developed and sustained through the relationship, which often includes parents, and teachers … and becomes an open dynamic sustaining system.

This is not one-way. It's a dynamic human connection that opens up possibilities so that they could become new realities of being. This can be uplifting for all involved. I think that the feeling of connection, a caring loving attunement captures the heartening we spoke about, and provides motivation to carry on. When I sense it starting to happen, I know we're on the right path. I don't have to second-guess. I trust the process. It's profound. It can take you through everything including through the dying process.

MJ: *... the importance of the connection to the person for all the things hypnosis does—hope, expectancy, motivation—because if you have that for the person, that connection is there and fills them right up.*

LK: Yeah. Yeah.

MJ: *They can hear it, and they can absorb that. What I hear you saying is for that to happen, you engage the person, and use whatever is going to work with this person.*

LK: This is what Milton Erickson's named 'utilization' and thereby legitimized and explained how central it is to therapeutic work. It's part of the creativity of fostering change. After all that's what people come to us for—help to shift their experience and understanding so that life becomes less painful.

MJ: *For one child it may be the ball, for another child it might be the puppet.*

LK: I regard the ball, puppet and breathing as conduits to the working place. I will come back to them as bridges, and over time they may become part of the routine or ritual. I love rituals, little routines, like the ideomotor magnetic fingers. The repetition re-programs our body–brain systems, so that ritual becomes automatically effective.

MJ: *What rituals? You talked about the fingers becoming friends.*

LK: Yes and I use body-breath, allowing the breath to breathe the body, so that children in pain learn to passively allow a comfort zone to be created away from pain.

MJ: *How do you do that?*

LK: With my instruction to 'travel inside to where your comfort zone is'. I ask, '... and as soon as you find it wiggle your finger to let me know.' Most children have already learned to dissociate from pain, so it's quite easy for them to access. But then it needs to be imbued with what strengthens and enlarges the experience of comfort within the zone. Breath helps 'grow the space'. It's a physical experience and with the ease, warmth softening can dissolve pain and close pain gates. I like using the 'pain-switch in the control centre of the brain' (the thalamus they've explored in the pain diagrams). I support the child in locating it during an hypnosis experience and dial it down with deep diaphragmatic breathing. Children love relaying their inner experiences: 'Oh, I saw it! ... All these little switches and then there's this big red switch, and *that* was the switch, so I turned it down!' It's *in vivo*, alive and active. With children hypnosis is often not a relaxing hypnosis. *It's an alternate experience that dislodges the present negative one—and once imaginatively lived with vivid images and full body breathe, the child's reality is changed.* I don't tend to speak too slowly, even though my voice tends to be gentle, I'm not going for 'zoning out'. I find the kind of hypnosis that works with children and teens is an engaged, alive, and not a profoundly deepened altered state.

MJ: *In your work with children, you've indicated that you provide palliative care. How is hypnosis used with children dealing with a threat to life or at end-of-life?*

LK: Hypnosis has a very special role because one can so easily travel into a private metaphysical or meditative realm that isn't usually accessed, but at the end of life, or when facing a threat to life, seems more accessible. Children seem very receptive, especially if they desperately want to live or they desperately want the tumour to shrink. Early in my career I negotiated the issues of how to work with this uncertainty without giving false hope.

MJ: How did you do that?

LK: Oncology staff raised the concern: 'I'm really worried about Jenny, because she's putting so much into this hypnosis, and what if it doesn't work? Will she blame herself for not trying hard enough?' We'd discuss that it isn't about trying hard enough; it's about using everything to maximize the chance for comfort to gain peace of mind and spirit, and whatever healing can be obtained. The children do their own practice in the way that gives them meaning and contentment. When very ill, it's remarkable how wise children are—and we need to take the lead from them. Jenny, the teen I mentioned, had a diagnosis of Ewing's sarcoma, and had used hypnosis as part of her pain management over four years of treatment. One day she came to clinic and said, 'I was doing my hypnosis body scan for comfort and I saw something quite different'. I asked, 'Different how?' And she said, 'Well, I thought I better come in and have a bone scan'. She knew before anybody that something wasn't right, and through her regular hypnosis practice picked up a recurrence of tumour growth. So sad, but that developed connection with herself and her body gave her considerable internal strength and acceptance for the tough road ahead.

MJ: Early detection.

LK: Indeed it was. And the staff didn't ask, 'Are you giving false hope?' They saw how empowered Jenny had become and that helped all of us with the sadness of her approaching death. Jenny's dying was peaceful and at home. I think that hypnosis was one of her medicines together with the incredible loving family support that enabled her to choose to die at home. She knew she could get herself comfortable. She could go automatically to her comfort zone. In contrast to her earlier presentation when her huge, dark eyes were filled with terror. No, hypnosis didn't cure her. Chemo didn't cure her. Hypnosis became a personal vehicle to access her resources so that the terror left and her spirit healed.

MJ: Then hope isn't necessarily a hope for a cure, it's the hope that I can live my life and … handle this.

LK: That's right. She wasn't frightened. She could trust in a way she had not been able to trust before she developed her internal competency. I think the practice of hypnosis gives huge strength to people's spirit.

MJ: I have the tools I need to live my life.

LK: And not suffer … hypnosis has a certain 'magic' in that it trains us to access a subtle subconscious realm.

MJ: It's a natural magic. [Laughs]

LK: That it is! It's a natural phenomenon, and what we do as clinicians is take this subtle, powerful, imaginative, attentional process and invest it for the highest stakes—the wellbeing of our patients.

MJ: I understand what you're saying. The image I have is of a jazz musician, and they're just playing away, and always hitting the right notes. We activate parts of our brain to allow this magic to happen. Each of us clinicians finds our own way to that place.

LK: That place of simplicity of flow, of natural unfolding. When working with a child I am aware that I too am in that absorbed attention, we can call trance, but in a broader trance. I use everything I know in the service of this co-creation with the child, utilizing all of the facts, features, and facets of the person. This focus is powerful. It wouldn't be that potent if I too wasn't in a heightened, focused, absorbed state myself.

Like dancing without knowing the full score, trusting that you can keep rhythm and you can improvise and that you'll find the way. Consequently I'm quite fierce about not using a script because it closes doors, especially in the first years of practice. Provide a frame, useful phrases for different stages, connecting words. Clinicians have to be able to tolerate not knowing all and working with the patient, and within the patient's realm towards the desired outcome. This creates the knowing. Nice little paradox to finish on.

MJ: Very nice. Thank you!

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