HYPNOTHERAPY FOR CHILDREN & ADOLESCENTS: THE PERSPECTIVE OF SOUTH AFRICAN PSYCHOLOGISTS

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Abstract

Hypnotherapy has been utilised with children and adolescents for more than 200 years. Despite this fact, there has been no documented research on the use of hypnotherapy for children and adolescents in South Africa. This research focused on the perspectives of qualified South African psychologists on the use of hypnosis as a therapeutic technique for children and adolescents. The aim of the research was to expand on current knowledge and understandings of hypnosis and hypnotherapy, to explore how the technique has been adapted to a South African context and to identify drawbacks found in the use of this technique. The research sample comprised eight qualified psychologists who utilise hypnotherapy with children and adolescents. The research design for this study adopted a qualitative approach in which semi-structured interviews were utilised. Although the technique largely relies on foreign practises that have not been adapted to the South African context, it still proved highly valuable. While the psychologists opinions differed on the ages and conditions for which hypnotherapy could be applied, this seemed to be based on their personal experiences and success rates rather than on inherent limitations of the technique. The educational psychologists who specialised in treating children and adolescents found that there were no limitations on the use of the technique and they were confident in its application for all ages. There was also a prevailing belief, on the part of the psychologists, that black individuals appear to be more responsive to hypnotherapy than other races. The overall findings of this research study suggest that hypnotherapy is a beneficial therapeutic technique for children and adolescents in a South African context. The research aimed to further educational psychologists' knowledge on the applicability of this technique to children and adolescents. With an awareness of its benefits, training by these professionals may be undertaken or the opinions of specialists trained in this area may be sought.

Key Words: Hypnotherapy, Hypnosis, Therapy, Children and Adolescents and Hypnotherapy, Children and Adolescents and Hypnosis, Educational Psychologist in South Africa

Declaration

I, **Janine Kerri Leask**, declare that this is:

A Research project submitted in partial fulfilment of the requirements for the degree of **Masters in Education (Educational Psychology)** in the Faculty of Humanities, University of the Witwatersrand, Johannesburg, 23rd November 2012.

And that this research project is my own, unaided work. It has not been submitted before for any other degree or examination at this or any other university.

Signed: _____ Date: _____

Janine Kerri Leask

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Chapter 1: Introduction

Hypnotherapy has been implemented as a therapeutic technique since before the theoretical works of Freud. Yet despite the permanence of this approach, it has remained largely unused by psychological professionals when compared to other, more popular therapeutic approaches. However, this issue of underutilisation has decreased in recent years as hypnotherapy (including child hypnotherapy) has achieved "greater acceptance by health professionals and the general public" (Kohen & Olness, 2011, p. 95). The continued existence of this approach seems to imply that there is value in its methods that some professionals are perhaps unaware of (Kohen & Olness, 2011).

Hypnotherapy, more often than not, has had negative connotations and misconceptions attached to it due to varying ideas about its techniques and a lack of knowledge regarding its nature. However, an increasing portion of qualified psychologists have taken up this approach and incorporated it into their own practises and the underutilisation of hypnotherapy has perhaps given way to excessive enthusiasm and inappropriate utilisation (Kohen & Olness, 2011; Wester & Sugarman, 2007). Overseas, particularly in the United States, Europe and Australia, the increasingly positive reputation of this approach is evident in the growing body of research and increased use of this technique for therapy. Kohen and Olness (2011) report on the successful training and implementation of hypnosis and hypnotherapy for children in countries such as Germany, Norway, Sweden, France, England, Thailand, Bali and Canada, with many experts to be found in these countries, as well as in Australia, Italy, Indonesia, Saudi Arabia and Turkey. The professionals in these areas are reported to have "contributed substantial research related to hypnosis with children" and adolescents (Kohen & Olness, 2011, p. 400).

However, despite the fact that this technique is being utilised in South Africa by qualified psychologists, research into its use in South Africa appears to be severely limited. A lengthy search of SABINET, JSTOR and EBSCO Host revealed a total of five research articles written in South Africa over roughly the past three years. In addition, this search revealed that there are no documented research articles that have been completed in South Africa on the use of hypnotherapy for children and adolescents. This study was conducted with the aim of beginning to fill this current gap in documented research in South Africa. There are numerous reports from overseas, as mentioned previously, on how hypnotherapy

can benefit children and adolescents, not only psychologically but also academically (Kohen & Olness, 2011). If this proves to be true in the South African context as well, then hypnotherapy could be a very useful technique for educational psychologists to employ. Educational psychology focuses on how children learn and develop. If hypnotherapy proves beneficial in assisting children's academic improvement, as well as their psychological development, the training of postgraduate educational psychologists in the use of this technique could add to the effectiveness of their future interventions. Educational psychologists could also then refer to other psychologists who have specialised in this area when requiring further assistance.

The aim of this research was to explore the perspectives of eight qualified psychologists on the use of hypnotherapy for children and adolescents in the South African context, as well as to provide an in-depth view of the use of hypnotherapy by these psychological professionals. The findings of this study show that, as in other countries, hypnotherapy has proven to be beneficial when applied to children and adolescents. However, the level of training received by individuals that utilise the technique was seen as a crucial factor in its ethical applicability, and the psychologists who contributed to this study believed that only individuals trained in the psychology of the mind should be permitted to use hypnosis for therapeutic reasons. Additional findings will be discussed at greater length in further chapters in this report.

Chapter Two of this research report will analyse past and current knowledge on hypnosis and hypnotherapy. It begins with a brief background history of the uses of hypnotherapy before examining how it has been applied and adapted to use with children and adolescents. Chapter Three then provides an overview of the research methodology employed and discusses how the present study was operationalized. It begins with an explanation of, and motivation for, the selected research design. This is followed by discussion of the sampling and data collection procedures and a brief description of the sample. Finally, the data analysis procedures and the ethical implications of the study are examined. Chapter Four offers detailed analysis of the research findings, while Chapter Five provides a discussion of the implications of the findings of the research study. The limitations of this study and suggestions for future research are discussed in the concluding chapter.

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Chapter 2: Literature Review

This chapter provides an overview of the literature on hypnosis and hypnotherapy. This is done in order to appraise current knowledge on hypnotherapy by including substantive findings and theoretical contributions. The chapter begins with a brief history of hypnosis and hypnotherapy, and mentions a few of the misconceptions that have arisen in relation to this approach. Thereafter, the chapter turns to the application of hypnotherapy, paying particular attention to the ways in which children and adolescents' respond to this approach, the importance of developmental considerations in applying this approach and how this technique has been adapted to suit children and adolescents. Finally, this chapter examines how hypnotherapy techniques have been applied, what induction methods have been utilised and what factors need to be taken into consideration when attempting to apply this technique to children and adolescents.

2.1 History & Misconceptions

Hypnotherapy with children and adolescents is often regarded as a recent therapeutic development. However, this view is inaccurate, as hypnotherapy has been used with children and adolescents for more than 200 years (Fromm, 1987; Kohen & Olness, 2011). Kohen and Olness (2011) attribute this misconception to the recent increase in interest in the use of hypnosis in therapeutic work and the greater availability of training workshops in this field. The use of hypnotic techniques has an extensive history dating back to ancient times. Over time, hypnosis has been adapted into the form in which it is used today. A more modern history of hypnosis begins with Franz Anton Mesmer (Kohen & Olness, 2011).

It is believed that how individuals live, think and feel can significantly affect their health (Hartman & Zimberoff, 2011). Hypnosis, or an initial form thereof, was first developed by Mesmer more than 200 years ago. Mesmer believed that by influencing the magnetic forces in the human body, it was possible to heal diseased patients. This belief was based on Mesmer's theory of 'animal magnetism' (Gordon, 1967; Kohen & Olness, 2011; Onn, 2008). This theory posits that all objects in the universe contain a magnetic fluid, which connects all objects in the universe to each other. Disease in the human body is seen as the result of disequilibrium in this magnetic fluid. In order to cure his patients, Mesmer would employ various techniques to restore magnetic balance in the human body (Kohen & Olness, 2011). Mesmer's techniques ranged from the use of magnetic rods to simple hand gestures

with which he believed he could correct the magnetic flow in sick patients and provide a cure for their ailments. His methods became so popular that, in order to treat the thousands of patients seeking his aid, he placed his magnetic rods against a tree outside and declared it to be magnetised (Onn, 2008). In this way, he believed he could transfer this magnetic force into an inanimate object, which could then heal the patient. All that the diseased patients had to do to be cured was touch the tree; these patients became 'mesmerised' and his cure worked. There is, however, no evidence to suggest that the reason these patients were cured was a result of the magnetism in the tree. What was actually at work in curing these patients was the power of suggestion, a key aspect in hypnosis today (Elman, 1964).

Despite the successes of Mesmer's techniques with both adults and children alike, he was discredited by his colleagues who refused to acknowledge his discoveries (Fromm & Shor, 1972). Benjamin Franklin's remark on Mesmer's technique was that "if these people get well at all, they seem to get well by their own imaginings" (as cited in Elman, 1964, p. 23). It is the power of suggestion that played a key role in the cures Mesmer achieved (Gordon, 1967). However, 'mesmerism' continued to flourish, regardless of the continued criticism directed its way. It was argued that the cures mesmerism achieved were not a result of magnetism, but rather a result of the human imagination. James Braid (1843, p. 5) investigated mesmerism and wrote that,

> whether these extraordinary physical effects are produced through the imagination chiefly, or by other means, it appears… quite certain, that the imagination has never been so much under [the clinicians'] control, or capable of being made to act in the same beneficial and uniform manner, by any other mode of management hitherto known.

Braid (as cited in Kohen & Olness, 2011) rejected the theory of animal magnetism and mesmerism alike. He believed that imagination alone was not sufficient to produce a trance-like state, which for him resembled a type of nervous sleep. Thus, Braid coined the term 'hypnosis', derived from the Greek word *hypnos*, meaning sleep (Huynh, Vandvik, & Diseth, 2008). Hypnotism, or hypnosis, is defined as an "ability or a mental state" (Huynh et al., 2008) that has nothing to do with the everyday notion of sleep as we understand it. However, individuals who are not trained in hypnosis still compare hypnosis to sleep (Haley, 1973). On the other hand, 'hypnoanalysis' refers "to a combination of cathartic hypnosis and a somewhat didactic process of 're-education' " (Gill & Brenman, 1961, p. 355). However,

this definition was found lacking, and in recent years has been replaced with the term 'hypnotherapy'. 'Hypnotherapy' is defined as a treatment procedure with goals and techniques that are used when the patient is in a state of hypnosis, by a psychological professional, in order to assist the patient resolve a problem (Huynh et al., 2008, p. 377). Suggestions are offered during hypnotherapy in order to assist the patient in experiencing changes in sensations, perceptions, thoughts, feelings and behaviours (Yapko, 2003). Braid (as cited in Kohen & Olness, 2011) believed that hypnosis was achieved through both visual and mental fixations in which he required his patients to focus their eyes on a single object and directed them to clear their minds of all other thoughts. This 'eye fixation' technique was later incorporated by Charcot in order to achieve hypnosis.

Charcot assumed that hypnosis was a pathological state and would only work on psychotic or pre-psychotic patients; this belief was later found to be false (Elman, 1964; Gordon, 1967). Charcot did not perform hypnosis on any of his patients instead leaving this to his assistants. As such, data generated was restricted to only that which supported his theory. While Charcot's description of hypnosis in neurological terms gave the field a newfound scientific respectability, he was increasingly criticised due to the limitations of his experimental work (Fromm & Shor, 1972; Kohen & Olness, 2011). Charcot's teachings played a significant role in influencing the later works of Sigmund Freud (Gordon, 1967).

Freud began using hypnosis in his own practise. He incorporated it in two ways: first, he used it to remove patient's symptoms through direct suggestion, and second, he used it to analyse the past history of his patients (Gordon, 1967). He discovered what is perhaps the most significant factor in hypnosis – that when a patient is in a deep state of hypnosis, that patient can recall memories of traumatic events, called *abreactions*, that were not available to the patient out of this hypnotic state (Sadock & Sadock, 2007). The existence of these repressed memories was verified by Gorman (2008) and they were found to serve a defensive function. With Freud's encouragement, the patient was able to talk about the event and express emotions attached to the event (Ballen, 1997). Freud then further discovered that once the emotions tied to these events were fully expressed, the patient's symptoms seemed to disappear. Freud termed this process 'catharsism' (Gordon, 1967). However, Freud eventually discarded the use of hypnosis due to the fact that the removal of the patient's symptoms was often only temporary and because the symptoms would often return or be replaced by other symptoms (Gordon, 1967; Kline, 1958). However, it was discovered that

hypnosis can only directly remove symptoms if it is used in the same incorrect manner as Freud used it (Ballen, 1997).

There have been, and still are, many misconceptions surrounding hypnosis ever since Freud's dismissal of its therapeutic benefits (Kline, 1958). These misconceptions have played a significant role in limiting the use of hypnosis as a therapeutic intervention in subsequent years. However, the continued use of hypnosis in several, albeit few, therapeutic practices after Freud, suggests that therapists have found some benefit in the use of this technique; otherwise, logic would dictate that hypnosis would have been discarded by all therapeutic professionals (Gordon, 1967). Kline (1958) states that hypnosis has progressed since the days of Freud and that the reasons for which Freud rejected hypnosis no longer exist (Ballen, 1997). Kline (1958, p. 5) further argues that "it seems clear that the major motive behind the rejection of hypnosis by psychoanalysis… is the emotionally conditioned adherence to Freud's position, or assumed position, rather than self-investigation and critical evaluation". Kline (1958) goes on to suggest that contemporary hypnosis negates all Freud's objective reasons for abandoning hypnosis, such as his belief that hypnosis fails to produce lasting results and bypasses resistance.

Liebault and Bernheim's (as cited in Kohen & Olness, 2011) work on hypnosis opposed the ideas of Charcot and has been shown to be more accurate with regard to hypnosis as used today. Liebault and Bernheim's theories coincided with those of Braid. They viewed hypnosis as a normal occurrence in which suggestion and imagination were the primary tools. Hypnosis therefore increased patient's responsiveness to suggestions by using various induction techniques that worked with the patient's imagination. The hypnotic state is thus seen to require three essential components: *absorption*, which is the ability to reduce external awareness and which results in a greater focus on the task at hand; *dissociation*, which refers to separating out from conscious awareness elements of the client's identity, perceptions and memories; and *suggestibility*, which is the tendency of the hypnotised client to accept signals and information with relative suspension of normal critical judgment (Sadock & Sadock, 2007, p. 962). Liebault and Bernheim also recognised that individual difference is present in hypnotic inductions, and they recorded that children, especially those between the ages of 7 and 14, are more quickly and easily hypnotised (Kohen & Olness, 2011).

Further studies have confirmed that hypnosis can be beneficial for children and adolescents alike in treating a large variety of disorders. These disorders range from behavioural problems, such as stealing and lying, to enuresis and stammering, anxiety, poor memory and lack of concentration, night terrors, anaesthesia and many more discussed in further detail later in this report. Hundreds of compelling research studies and reports on children and hypnosis have been published in America, Australia and Europe, all of which are based on sound research procedures. Despite this, numerous misconceptions about hypnosis remain (Kohen & Olness, 2011). Table 2.1 (on page 8) lists a number of these misconceptions as well as the facts regarding each misconception (Yapko, 2003).

Perhaps the most prominent misconception about hypnosis is the impression that hypnosis weakens the patient's freewill or his or her ability for independent judgement (Kohen & Olness, 2011). However, the belief that hypnosis can manipulate and control the patient through the use of suggestion is erroneous (Erickson & Rossi, 1979). Erickson argues that "hypnosis does not change the person, nor does it alter his past experiential life. It serves to permit him to learn more about himself and to express himself more adequately" (Erickson, 1979, p. 8). The therapist merely acts as a guide to the patient. If the patient resists at any point, even the best hypnotherapist would fail to place that patient under hypnosis (Gross, 1984). During hypnotherapy, what occurs is that the patient, while in a trance or hypnotic state, is able to bypass his or her learned limitations and enter into a mind-set of selective thinking (Erickson & Rossi, 1979).

Erickson's ideas have significantly influenced the field of hypnosis and psychotherapy (Simpkins & Simpkins, 2008) with extensive literature analysing his successful treatments (Zeig, 1980). Erickson believes that patients have problems that they are incapable of solving because, over their lifetime, they have learned limitations that prevent them from utilizing their abilities to their full potential (Erickson & Rossi, 1979). These learned limitations can be seen as individuals' 'critical faculty', which informs what they see as 'right or wrong' and/or as 'possible or impossible' (Barnett, 1989; Boyne, 1989). These ideas may be false; but importantly, the individual believes they are true. For example, a female may believe she is overweight but this does not necessarily mean that she is or is not, especially in the case of females suffering from anorexia. However, no matter how many people tell a patient suffering from anorexia that he or she is not overweight, that patient's own belief (his or her critical faculty, which is based on past experiences and learning) tells

the patient that he or she is. In a hypnotherapeutic state, the patient's critical faculty (their disbelief that something is possible) is bypassed and they are able to accept new ways of thinking more readily (Milburn, 2011). The therapist utilises hypnotic suggestions (Mende, 2009) in order to help the patient reach a new understanding and provide him or her with new ways of thinking. This is done in order to aid the patient in giving up some of his or her learned limitations (Erickson & Rossi, 1979).

Table 2.1: Myths and misconceptions about hypnosis

Misconception	Reality
Only certain kinds of people can be hypnotised	Almost anyone can be hypnotised
Anyone who can be hypnotised must be weak-minded	Individuals with higher intelligence and stronger personalities will be better hypnotic subjects
Once one has been hypnotised, one can no longer resist it	If the client chooses not to go into hypnosis for whatever reason, then he or she will not
One can be hypnotised to say and do things against one's will	Client can accept or reject the suggestions given by the therapist. The hypnotist possesses no power over the individual
Being hypnotised can be hazardous to one's health	Hypnosis itself is not harmful, but an incompetent clinician can do some damage through ignorance of the condition to be treated
Hypnosis can't harm anyone	The clinician can cause harm when they are untrained to deal with the issues they bring to the surface; they must thus have a background in therapy
One inevitably becomes dependant on the hypnotist	Dependence can result from any therapeutic intervention. The goal of therapy is to promote client self-reliance and independence
One can become stuck in hypnosis	The client controls the session and can go into and out of hypnosis at will. It is impossible to become stuck in hypnosis
One is asleep or unconscious in hypnosis	Hypnosis is not sleep and the client is relaxed, conscious and alert
Hypnosis always involves a ritual of induction	Hypnosis does not have to be formally induced and can occur when someone becomes deeply absorbed in something and less aware of what is happening around them
Hypnosis is simply relaxation	Hypnosis involves the deliberate structuring of experiences and goes beyond mere relaxation. Relaxation is not necessary for hypnosis
Hypnosis may be used to accurately recall everything that has happened to you	Memories are stored based on perceptions and thus are subject to potential distortions. Hypnosis does not increase the probability of accurate recall

(Yapko, 2003, p. 32)

Suggestions, therefore, usually (but not always) follow the induction of a hypnotic state and are seen as "verbal communications … [which] imply a 'successful' response" and serve as the key messages in therapy (Huynh et al., 2008, p. 379). Suggestions do not have the power to control the subject (Wolberg, 1996) and can only be effective once the patient has an understanding of what psychological purpose his or her limitations have served. If a suggestion is unreasonable or displeasing to the patient, he or she has the ability to reject the suggestion, ignore it entirely or pull him- or herself out of the hypnotic state. The power rests with the patient to accept or reject a suggestion. "All hypnosis is essentially self-hypnosis" (Harford, 2010, p. 61). The difference with hypnosis, as compared to normal therapeutic interventions, is that, in hypnosis, the patient's critical faculty is bypassed. This means that, on condition that the suggestion is reasonable to the patient, he or she will accept the therapist's suggestions, despite the fact that under ordinary circumstances, the individual might believe it to be impossible. In this way, the therapist creates anaesthesia in the patient, or gets the patient to recall past events in vivid detail (Elman, 1964). Thus, events and feelings became more accessible as a result of the reduced resistance in hypnosis (Erickson & Rossi, 1979; Fromm & Shor, 1972).

Hypnosis is used in therapy as a means to discover the cause of patients' problems, from the very first event that caused it to appear, which is known as the initial sensitising event (ISE). The central idea is that when a traumatic event occurs, the individual may push that event out of his or her conscious awareness so that the event is no longer recallable. This is seen as a means of purposeful forgetfulness, termed 'repression' by Freud, which fulfils individual's need to avoid pain (Gordon, 1967, p. 261). However, even though the individual cannot consciously access this event, the individual still has the capacity to store the undesirable emotions linked to the event, which may cause damaging symptoms to surface. By assisting the individual to recall these events (the ISE), the individual is able to recognise the emotions that lie beneath their presenting symptoms and release these emotions, causing the symptoms to disappear. The symptoms are recognised by the patient for their true nature and as the real cause of the individual's problem (Gordon, 1967).

Freud argues that hypnosis bypasses any resistance the individual may have to recalling these painful events instead of dealing with this resistance (Kline, 1958). However, contrary to some beliefs, Freud did not discard hypnosis as a useful technique; instead, he

was opposed to the improper use of this method (Gordon, 1967). In addition, rather than completely bypassing the individual's resistance (which hypnosis is incapable of doing), hypnosis allows the individual to incorporate selective thinking in which the scope of his or her beliefs are expanded (Hilgard, 1965). Hypnosis is therefore a state of heightened suggestibility (Hull, 1933). This allows the individual to accept suggestions that are reasonable to them but which they may not usually believe possible outside of this hypnotic state. A key factor in hypnosis is thus the patient's motivation to cooperate (Haley, 1973). "Various hypnotherapeutic techniques can be used to reframe patients' past experiences that cause these inappropriate feelings" and have been linked to success in many psychological issues such as depression (Alladin, 2009, p. 252), eating disorders (Degun-Mather, 2003; Hutchinson-Phillips, Jamieson, & Gow, 2005), anxiety disorders (Frankel & Macfie, 2010), somatoform disorders or post-traumatic stress disorder (Mende, 2009).

The appeal of clinical hypnosis largely lies in its seeming ability to accelerate treatment outcomes; but research suggests that this benefit accrues from combining hypnosis with other forms of treatment, such as Eye Movement Desensitisation and Reprocessing (EMDR) (Harford, 2010), family therapy (Scroggs, 1986) as well as Cognitive-Behavioural Therapy (CBT) (Hutchinson-Phillips & Gow, 2005; Hutchinson-Phillips, Jamieson, & Gow, 2005; Simpkins & Simpkins, 2008). Whether through hypnosis or through other forms of therapy, the main concern lies not in the technique but in the misuse of that technique. In many forms of therapy, including hypnosis, problems occur when the therapist steers the client by asking him or her leading questions and by giving them suggestive statements that create false memories. Hypnosis does not result in memory confabulations as long as the therapist is not suggestive or directing when exploring patients' experiences (Harford, 2010). Kohen & Olness (2011) state that a hypnotherapist is primarily a therapist, and that the practice of hypnotherapy should be left to those individuals who have had advanced training in psychology and the assessment of problems. Therefore, the practice of hypnotherapy with children should be the domain of "professionals who typically assume primary responsibility for treating children's problems" (Kohen & Olness, 2011, p. 90).

2.2 Children, Adolescents and Hypnotherapy

2.2.1 Hypnotic ability in children and adolescents

While "historically neglected, hypnosis has now increasingly been recognised as an effective tool for children of all ages – including the very young" (Wester & Sugarman, 2007, p. 25).

Kohen and Olness (2011) state that it is commonly acknowledged that hypnotherapy is underutilised in the treatment of children and that, too often, it is only considered as a last resort. They continue by arguing that this is despite the fact that it might have several advantages over other therapeutic techniques such as "few risks and side effects, frequent rapid response to treatment and the fact that hypnotherapy fosters attitudes of independence and mastery in coping with problems" (Kohen & Olness, 2011, p. 95).

Additional research has confirmed that children are more susceptible to hypnosis than adults (London, 1962), due to their increased capacity and willingness to take part in fantasy, play and imagination (Saadat & Kain, 2007). This is especially true for children between the ages of 8 and 12 years old (Gardner, 1977; Milling & Costantino, 2000). This may be because a child's mind is naturally more flexible than that of an adult and because children are highly imaginative, and eagerly use fantasy on a daily basis (Saadat & Kain, 2007). Also, children are generally more willing to accept the assistance of others and enter into an intimate and trusting relationship (Sarles, 1975). Table 2.2 (below) provides a list of cognitive, emotional and interpersonal factors that suggest further reasons why children respond better to hypnosis than adults do. Hypnosis is thus a helpful addition to the treatment of a wide range of emotional disorders in children and adolescents (Kohen & Olness, 2011).

Children under the age of 6 years are also capable of being hypnotised (Gardner, 1977) but not according to the same technique used for older children. With very young children, the therapist would use a method of distraction, called 'protohypnosis', in order to sooth the child; however, as the child is at a preverbal stage of development, this method would lack any suggestions for change (Frankel & Zamansky, 1978). Also, the methods used to induce a hypnotic state change according to the child's age. Younger children would require more sensory- and motor-based techniques, preschool-aged children would need more action-based, play-orientated techniques, and school-aged children would best be able to follow eye-closure and relaxation techniques that take on a more creative and imaginative stance (Wester & Sugarman, 2007). Gardner (1981) suggests that the child that shows two or more of the following behaviours can be considered to be in a state of hypnosis: (a) following soothing and repetitive stimulation, the child is quiet and shows focused attention; (b) he or she is involved in intense imagery; (c) the child shows changes in sensations and perceptions and (d) he or she shows a capacity to follow post-hypnotic suggestions.

Table 2.2: Why children respond better to hypnosis than adults do

Factor Type	Factors
Cognitive Factor	- Children easily intertwine fantasy and reality - Most children have a love for fantasy and magic - Children focus more on the immediate present - Children are usually entirely absorbed in what they are doing, learning with all senses at once - The tendency towards concrete, literal thinking facilitates acceptance of appropriately worded hypnotic suggestions
Emotional Factor	- Children can often move from one intense feeling-state to another with only minimal assistance - Children are generally open to new experience and eager to explore, unless they have significant anxiety around these issues - In hypnosis, a child is usually comfortable with the naturally occurring regressive phenomena
Interpersonal Factor	- Children usually do not have intense conflicts around issues of control and submission that interfere with many adults' ability to utilize hypnosis - Children are also less likely to have the adult misconceptions that hypnosis involves being entirely controlled by another, giving up one's will and so on - Children naturally strive towards mastery of their own bodies and autonomy to the environment. They are likely to be intrigued with the idea of hypnosis if it is presented as an opportunity for them to learn a new skill. Adults, on the other hand, are more likely to fear that they will fail.

(Huynh et al., 2008, p. 388)

Hypnosis in children "involves the absorption of the child into an altered state of consciousness in the service of creating a therapeutic change in perception, emotion, behaviour or experience" (Wester & Sugarman, 2007, p. 26). There are six conditions that must be met before hypnotherapy can be considered in the treatment of a child. These are: 1) if they respond to induction techniques, 2) if their problem is treatable by hypnotherapy, 3) if there is rapport between the child and the therapist, 4) if the child is motivated to solve the problem, 5) if parents agree to the treatment plan, and 6) if the use of hypnotherapy for the presenting problem would not harm the patient (Kohen & Olness, 2011). Practitioners have found hypnotherapy to be of value in helping "children remain focused, recall memories, identify core issues, change behaviours, and access a deep level of healing" (Geniti, 2004, p.

75). An important factor in working with children through the use of hypnotherapy, as already mentioned, is that parents must be fully informed about the process so that any of their misconceptions are eliminated before the therapy begins, as well as in order to prepare the child so as to eliminate anxiety (Geniti, 2004; Kohen & Olness, 2011).

Hypnosis has been linked to more rapid improvement in adolescents as it aids them in discovering the causes of their symptoms (Anbar, 2008). Researchers have found that hypnotherapy can aid both therapist and child with a variety of problems, both physical and psychological. These include Attention Deficit Hyperactivity Disorder (ADHD), conduct disorder, anxiety disorder, autism-spectrum disorder, dissociative disorder and Post-Traumatic Stress Disorder (PTSD), eating disorders, enuresis and encopresis, learning disorders, obsessive-compulsive disorder and sleep disorders (Huynh et al., 2008). Clinical studies in hypnosis have also found that hypnosis alleviates problems such as hysteria, asthma and pain in children. In addition, hypnosis has been beneficial in the treatment of children with anorexia nervosa when used in a non-authoritative manner (Gross, 1984). However, hypnotherapy is often used as an adjunct to other forms of treatment or when other therapeutic techniques fail (Kohen & Olness, 2011; Place, 1984).

2.2.2 Developmental considerations

During growth from infancy to adulthood, the human being undergoes numerous changes (Shaffer, 1999). These changes shape the individual, and how he or she perceives and interacts with their world. Human development occurs within three main domains: the physical, cognitive and psychosocial domains of development (Hook, Watts, & Cockcroft, 2002). Hook, Watts and Cockcroft (2002) add a fourth domain, the psychoanalytic domain of development, which focuses on the internal psychological processes of the individual and how both positive and negative unconscious experiences shape the individual's personality. An individual will present differently in each stage of development and, as such, it is important that therapists meet the individual at their unique stage of development (Lipsett, 2003). While hypnosis is an effective therapeutic technique for all ages, the hypnotic state presents itself differently at different developmental stages and it thus needs to be applied accordingly. Therefore, in order to implement hypnosis successfully, the therapist needs to be aware of what stage of development the child is at, and adjust their therapeutic intervention to the child's level of development (Wester & Sugarman, 2007).

Erikson and Piaget are well known for their theories on development, which provide a framework for understanding human behaviour (Watts, Cockcroft, & Duncan, 2009). Hypnosis is applied within the context of a child or adolescent's emotional and cognitive abilities; consequently, it is essential to be aware of the stage of development in which the child is currently functioning (Lipsett, 2003). Erikson (1963) sets out eight stages of psychosocial development across the lifecycle. For the purpose of this literature review, only the five stages relating to childhood and adolescence will be discussed. Erikson (1963) refers to the developmental stages as *crises*, a term used to refer to critical turning points in the stages of growth in which changes occur that shape the individual's personality. For Erikson, a successful transition into the next stage of development requires the individual to have effectively completed all prior stages. Failure to complete an earlier stage of development effectively will have an adverse effect on an individual's negotiation of later stages. The outcome of each stage is not set in stone, and an individual is capable of rectifying earlier stages later on in their development (Hook et al., 2002). For Erikson (1963), each stage is set between two alternate emotional struggles. Which side of the 'battle' the individual takes depends on how they are able to overcome each obstacle presented to them at each stage.

The first psychosocial developmental stage set out by Erikson (1963) is *basic trust versus basic mistrust*. It is at this stage that the infant, in its first year, learns to *trust, or mistrust,* their caregiver, on whom the infant is wholly dependent for their survival. It is when the infant's needs are left unmet that the infant will develop a sense of *mistrust* in those around them. However, if the infant's needs are met, adequately and consistently, and the infant displays an ability "to let [their] mother out of [their] sight without undue anxiety or rage", this then marks the infant's successful achievement of a basic sense of trust in others, him- or herself, and the world (Erikson, 1963, p. 222). Erikson (1963) suggests that the successful completion of this stage of development relies primarily on the quality of maternal care received by the infant. Through adequate completion of this stage of development, the infant not only develops a sense of trust but also, and more importantly, a sense of *hope* (Hook et al., 2002).

Erikson's (1963) second stage of psychosocial development is *autonomy versus shame and doubt*. It is in this stage that infants develop a sense of their own independence, and their own power to affect objects in their world. However, when their ability to do things on their own is constantly taken away from them or inadequately praised, they will develop a

sense of doubt in their own abilities. Receiving the approval of their parents when they show increased mastery in a skill allows the infant to develop confidence in their own abilities and strengthens their self-esteem. On the other hand, criticism of failed attempts will result in a sense of doubt in their own abilities and a lower self-esteem, which infants will then turn against themselves by over-manipulating themselves. A sense of control comes from the infant's capacity to decide whether to 'let go' or 'hold on', such as in their earliest achievement of toilet training, and thus fosters in the child a sense of control over their own *will* (Hook et al., 2002). Lipsett (2003) believes that Erikson's first two stages of psychosocial development link with Piaget's first stage of cognitive development, and that they occur at approximately the same ages.

Piaget (1952; 1953; 1980) theorises four stages of cognitive development. The first stage to be discussed here is the *sensorimotor period* seen from birth to 2 years of age. In this stage, cognitive development is achieved through basic sensory and motor actions and responses. As these reflexes adapt and develop, they become more complex and eventually lead to the ability of speech. It is also in this stage that the infant develops a sense of object permanence (the realisation that objects continue to exist even when they are hidden from sight) and an awareness of cause and effect relationships (the child's awareness that things occur as a result of their influence on them and therefore seem to happen by 'magic') (Lipsett, 2003).

When working with children below the age of 3, it is important that therapists take into consideration that these children are in the process of either developing a sense of trust in their world, or have progressed to seeking a sense of autonomy, and that they are thus prone to magical thinking (Lipsett, 2003). Table 2.3 (below) specifies the type of hypnotic technique best suited for children at this and each stage of development. The hypnotic techniques specified for children below the age of 3 involve simple repetitive movements, such as rocking or patting the infant or distracting him or her by making use of visual aids. Between ages 3 and 11, visual or movement stimulation is used to gain the child's attention, such as talking through a puppet or telling a story. Eye closure, for example, would entail asking children to close their eyes and pretend that their eyelids are so heavy that they cannot be opened. For children aged between 11 and 14, techniques best used include asking them to imagine that their arms are stiff as a board and cannot be bent (arm rigidity), or perhaps that they are in a car made out of clouds and that they are driving through the air or flying on a

magic carpet. For adolescents aged between 14 and 20, adult forms of induction can be used, in addition to techniques such as asking them to imagine they are playing their favourite sport (Wester & Sugarman, 2007). Further hypnotic induction techniques are discussed in more detail later in this chapter.

Table 2.3: Developmental stages and hypnotic interventions

<table>
<tr><th>Age</th><th>Jean Piaget</th><th>Erik Erikson</th><th>Hypnotic Intervention</th></tr>
<tr><td>0
1
2</td><td>0 – 2 years
Sensorimotor thought</td><td>0 – 1 year
Trust Vs. Mistrust
1 – 3 years
Autonomy Vs. shame & doubt</td><td>Rocking, patting, stroking, repetitious auditory input (singing or rhyming), visual distraction</td></tr>
<tr><td>3
4
5
6
7</td><td>2 – 7 years
Preoperational thought.
Includes initiative thought in 5 – 7 years</td><td>3 – 5 years
Initiative Vs. Guilt
6 years – puberty
Industry Vs. Inferiority</td><td>Visual/ movement stimulation while giving language input (e.g. talking through puppet)
Story telling
Eye Closure (over age 5)</td></tr>
<tr><td>8
9
10
11
12
13</td><td>Concrete Operational Thought</td><td>Adolescents
Identity Vs. role confusion</td><td>Arm Rigidity
Eye fixation
Arm lowering/ de-levitation
Special/ favourite place
Listening to music
Magic carpet
Cloud car</td></tr>
<tr><td>14
15
16
17
18
19
20</td><td>Formal Operational thought</td><td></td><td>Adult induction methods
Naturalistic/ permissive methods
Favourite sport
Use of physically based inductions
Use of more abstract, less consciously aware metaphor</td></tr>
</table>

(Wester & Sugarman, 2007, p. 94)

Lipsett (2003) indicates that the therapist may become the child's cause for distress if he or she makes use of hypnotic interventions that are beyond the child's understanding. Therefore, simple distraction techniques that "serve to hold the child's attention outside of [themselves] rather than trying to promote a sense of internal control over an event – [which]

the child is not yet capable of" – is more appropriate for a child between the ages of 0 to 2 years of age (Lipsett, 2003, p. 172). Techniques that incorporate sensory, motor and auditory skills are preferable. These techniques need to be simple, direct, repetitive and familiar for the child (Wester & Sugarman, 2007). Sleep-talk, whereby the suggestion is made by the child's parents when their child is asleep, has also proved beneficial (Kakoschke, 2007). It is thus essential to take into account the child's level of psychosocial development and cognitive development when attempting to implement a hypnotic intervention.

Erikson's (1963) third stage of psychosocial development is *initiative versus guilt*. During this stage, when the child is between the ages of three and five, he or she experiences a heightened level of activity and energy. This energy propels children forward into new ventures and expands their field of experience and expertise. However, it also often leads them into trouble and it is the parents' role, at first, to regulate their experiences and set boundaries for their behaviours. It is at this stage that the child develops a sense of moral reasoning as they are expected to learn right from wrong and then govern their own actions according to these rules. Guilt is thus the regulator of certain actions at this stage and the child's greater independence from their parents requires them to learn to heed this emotion and alter their current course, thus developing a sense of *purpose* (Hook et al., 2002).

Occurring alongside Erikson's stage of initiative versus guilt is Piaget's (1980) *pre-operational stage* of cognitive development, seen between the ages of 2 and 7. The child is not yet able to think in a logical and calculating manner and thus displays a very concrete thinking style. The child will have difficulty distinguishing between mental, physical and social realities. According to Lipsett (2003), it is at the pre-operational stage that the child seeks to establish a sense of control and mastery. Therefore, when implementing a hypnotic intervention, the therapist must take into consideration that the child is eager to learn and will want to keep his or her eyes open. Due to their concrete thinking style, these children respond well to stories or puppets (Lipsett, 2003). The best techniques at this age would be action-based, play-orientated, short, flexible and familiar (Wester & Sugarman, 2007).

Following Erikson's stage of initiative versus guilt is the stage of *industry versus inferiority*, which occurs from the age of six until adolescence. It is during this stage that the child gradually separates him- or herself from their family and seeks to increase his or her skills in order to be *industrious*. Greater importance is placed on the approval of their peers

and a need to prove themselves around others. When the child fails at doing this, he or she develops a sense of inferiority and thus a low self-esteem (Hook et al., 2002).

The final stage of psychosocial development to be discussed here is *identity versus role confusion*, which is seen during adolescence. This stage demands that children establish an identity for themselves. This is a difficult time for the adolescent and failure to form a solid identity can lead to role confusion in which the adolescent can over-identify with a group and lose him- or herself as a result; or he or she could form negative identities in which they go against the rules and regulations of their society. The direction the child chooses is largely influenced by his or her peers. Successful resolution of this stage is seen through the integration of the adolescent's various identities to form a true reflection of the individual in the absence of any disguises (Hook et al., 2002).

Piaget's (1952) stage of *concrete operational* thinking occurs between the ages of 7 and 11 years with *formal operations* following from 12 years and onwards. During the concrete operational stage, the child still exhibits a concrete thinking style; however, their thinking has expanded to enable them to reverse what has happened to objects in their minds. The child also shows an ability to identify the similarities and difference between two objects. During the formal operations stage, the child displays an increased ability to think in an abstract and logical manner (Ginsburg & Opper, 1969). It is at this stage that the individual exhibits an ability to solve abstract problems and displays a level of higher order thinking. However, it is important to note that many adults never achieve this level of cognitive development, according to Piaget (1953), or at times revert to more concrete means of thinking. During these stages, the therapist is able to work more abstractly and call on the child to use more of their imaginative abilities. However, the therapist must still be sure to keep the hypnotic intervention at the child's level and avoid making it too abstract that the child will not be able to understand it (Lipsett, 2003). Therefore, techniques that are creative, relaxing and that allow the child to practise at home are more suited to children of this age group (Wester & Sugarman, 2007).

To conclude, when working with children and adolescents, it is vital that the therapist take the child's psychosocial and cognitive developmental levels into consideration (Gardner, 1974a). Once the therapist has established the individual's developmental level, he or she is more capable of selecting an appropriate hypnotic intervention so as to achieve the best

outcome for the individual. It is also important to consider the fact that previous developmental levels may not have been adequately completed and that they may thus present negative outcomes at the child or adolescent's current level of development. The child, for example, in the *initiative versus guilt* stage who displays mistrust may have had adverse experiences that led to this emotion during their first stage of psychosocial development and, in such a case, this would be a significant indicator of the time at which this mistrust may have first developed (Lipsett, 2003). Therefore, the therapist's knowledge of the age at which the child's symptoms emerged will improve the therapeutic outcome (Wester & Sugarman, 2007).

2.2.3 Psychological applications

Evidence suggests that clinical hypnosis may be helpful for many different types of psychological and medical problems encountered in children and adolescents (Milling & Costantino, 2000). There are numerous psychological applications for which hypnotherapy can be applied; a few have already been mentioned. However, it is important to examine, in greater depth and specificity, how hypnosis intervenes in relation to psychological difficulties.

2.2.3.1 Hypnosis in the treatment of trauma

The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) defines Post-Traumatic Stress Disorder (PTSD) as the appearance of symptoms, such as fear, helplessness, hyper-alertness or agitation, as a result of being exposed to a traumatic event in which the individual's life was threatened or their personal integrity violated. This can occur in either a direct or an indirect manner (for example, witnessing or hearing about the event) (American Psychiatric Association [APA], 2000). According to reports from Statistics South Africa, the neglect and abuse of children is increasing at an alarming rate (Statistics South Africa, 2011). A child who has experienced trauma from which he or she was unable to escape or unable to resist may attempt to defend him- or herself by inducing an altered state of consciousness, known as *dissociation* (Mash & Wolfe, 2010). At times, it is not only their consciousness that can be disrupted, but also their memory, perceptions and identity. The individual may then repress their memories, affects, thoughts, and behaviours, as well as show signs of sleepwalking and depersonalisation (Wester & Sugarman, 2007).

There are many case reports that indicate the benefits of hypnosis in treating trauma (Harford, 2010) and PTSD (Mende, 2009). Wester and Sugarman (2007) argue that in order for a traumatised child to show any improvement, as he or she is being taught new ways of understanding, it is important that this child re-experience the same traumatic affects. They argue that hypnosis enables the therapist to re-activate these dissociative states and allows the child to deal with his or her trauma and negative affects from a 'safe' distance (Hull, 1933; Wester & Sugarman, 2007). Hypnosis can also make use of relaxing and containing techniques, which will reduce the child's feelings of anxiety and enable them to feel safe and secure (Rhue, 1991). Once this sense of security is achieved, the therapist can begin altering the child's negative thought patterns about him- or herself regarding the event and replace those suggestions with positive ones. Hypnotic containment techniques help to keep the child grounded in the present while looking at past traumatic material, and can be used whenever the child feels overwhelmed within the process. Hypnotherapy also shares many similarities with play therapy, as imagination and dissociations are common in both and can thus be used together successfully (Linden, 2003). Spiritual-hypnosis has also been found to be effective in the treatment of PTSD. Due to its ease of implementation and low cost, hypnosis, or more specifically, an adapted version of spiritual-hypnosis, has the potential to be successful in other cultures, as it takes into consideration the individual's spiritual beliefs (Lesmana, Suryani, Jensen, & Tiliopoulous, 2009).

Tables 2.4 to 2.6 list the hypnotic techniques that may be used when following the three stages set out by Janet for treating trauma (Van der Hart, Brown, & Turco, 1990). In phase one, *stabilisation* is important. This entails building rapport with the client and creating a safe space in which the client can express him- or herself. The therapist will use relaxation techniques, such as breathing exercises, while helping the individual to create a safe place. If the child is suffering from nightmares, the therapist may work with the child in altering his or her dreams through which the child is given control over the outcome of his or her dreams thus building up the strength of the child's ego. Phase two involves *uncovering* or *exploring* the trauma, wherein the negative feelings and memories are modified such that they no longer have an intense effect on the child. The 'garbage bag' technique involves the child filling a bag full of all the things he or she wants to "throw away", writing them down and then placing the piece of paper in the garbage bag. Phase three involves *reintegration,* in which the trauma is processed by working through the negative conflicts it produces and moving

forward. In this phase, children will rehearse scenarios in which he or she practises new behaviours for the future (Wester & Sugarman, 2007).

Table 2.4: Hypnotic techniques for stabilization, building rapport, & ego strengthening

Phase One: Stabilisation
- Relaxation exercise/ induction procedures (breathing) - Safe place/ sanctuary - Restructuring cognition (dream alteration, storytelling) - Problem-solving procedures (self-efficacy) - Ego enhancing (boundaries, modulation of affect)

(Wester & Sugarman, 2007, p. 150)

Table 2.5: Hypnotic techniques to uncover and explore trauma

Phase Two: Uncovery/ Exploration
- Metaphors – "Garbage bag" - Observing from a distance – TV set, puppet show, theatre - Learning to endure emotions – affect modulation, knobs and controls, structured regression - Ideomotor signals (for example, moving your little finger to respond yes or thumb to respond no) - Reframing – storytelling - Ego states - Substitution procedures – inserting benign adult, soothing imagery - Sandwich procedure (pacing the process to begin with safety, doing some uncovery work and ending with safety)

(Wester & Sugarman, 2007, p. 151)

Table 2.6: Hypnotic techniques for securing and maintaining gains

Phase Three: Reintegration
- Ego enhancing – construct purpose and meaning from trauma through hypnotic storytelling - Assertiveness procedures – establish healthier world assumptions through hypnotically mediated cognitive therapy, develop affirmations - Social skills building through metaphors or rehearsal - Future fantasies – hypnotic rehearsal of new behaviour using "future" imagery

(Wester & Sugarman, 2007, p. 151)

When working with a traumatised child it is important that the therapist remains constantly aware that the child is in a fragile state. The therapist needs to proceed slowly and first allow the child to feel safe and secure, and build rapport with the therapist. The therapist then needs to get to the emotions attached to the experience; otherwise, they will be unlikely to help the child (Wester & Sugarman, 2007).

2.2.3.2 Hypnosis in the treatment of depression, grief and bereavement

Wester and Sugarman (2007) used hypnotherapy to help a 6-year-old boy dealing with depression. They used the snowman induction technique (induction techniques for children are discussed later) in which the child pretended he was a snowman in order to get him to relax and enter a state of hypnosis. Through the therapy sessions, the client was taught self-hypnosis techniques in order to manage his behaviour and mood swings; overall, he showed a significant improvement (Wester & Sugarman, 2007). Depression is perhaps the most common, stubborn and restricting ailment among young people. However, it often goes unnoticed, as the symptoms do not present themselves in what could be seen as a typical manner, such as through constant sadness. Instead, depression in childhood and adolescence often presents through conduct disorders or irritability; as such, it may be overlooked. Depression is thus a largely hidden ailment in young people and its expression is diverse during each stage of development (Mash & Wolfe, 2010).

Mood disorders were previously believed to affect individuals only in their adult life. This belief coincided with the idea that, in adulthood, life stressors are elevated and support for these difficulties is not as easily available. However, recent research has enlightened clinical professionals as to the inaccuracy of this belief, and has illuminated the presentation of these disorders in childhood and adolescence (Mash & Wolfe, 2010). Mood disorders, also known as *affective disorders*, are seen in individuals where there is a pervasive disturbance in mood or emotional state. The inability to regulate one's mood adequately presents itself in forms of extreme unhappiness, or perhaps in variations between unhappiness and elation. When a child is identified as being constantly unhappy, shows little enthusiasm for any activity, is classified as moody and feels that life is not worth living, this child could be identified as having a mood disorder (Butcher, Mineka, & Hooley, 2007; Mash & Wolfe, 2010).

Depression, grief and bereavement may be identical to each other or overlap with each other and, as such, the therapist may at times work with them in unison. Alladin's (2009) research on cognitive hypnotherapy uncovered that this approach could be applied to a wide range of patients with depression, and PTSD (Fromm, 1987), with positive results. When implementing a hypnotic intervention it is important for the therapist to remember that the "suffering, hurting and sad [child] may already be in a hypnotic state" in which they are engrossed in their own feelings of sadness, loss and pain (Wester & Sugarman, 2007, p. 187). The clinician can then work with a child experiencing depression, who is already in a spontaneous hypnotic state, and assist them in moving from a negative to a positive focus. The child may benefit the most from self-hypnotic or self-regulation techniques that can be utilized by the child as soon as they feel agitated, worried or upset. Hypnosis can assist the child to become aware of their feelings, manage unpleasant feelings and unacceptable responses, and strengthen their ego (Alladin, 2009; Wester & Sugarman, 2007).

2.2.3.3 Hypnosis in the treatment of anxiety

Kohen and Olness (2011) report a successful case in which they aided a 15-year-old female to overcome her social anxiety disorder through the fixation induction technique. She was asked to imagine herself comfortable around others, and to envision herself performing in front of people who she liked and trusted. Six months later she was continuing to do well and her image of herself was greatly improved (Kohen & Olness, 2011). Anxiety is defined as "a mood state characterised by strong negative emotions and bodily symptoms of tension in which the child apprehensively anticipates future danger or misfortune" (Mash & Wolfe, 2010, p. 191). Anxiety can present itself in many forms. There are nine anxiety disorders set out in the DSM-IV-TR. These will not be discussed in any detail and, instead, anxiety as a whole will be examined.

Hypnotherapy can effectively treat numerous anxiety disorders (Frankel & Macfie, 2010), including anxieties related to exam stress (Nath & Warren, 1995) and academic anxiety (Woods, 1986). When working with a child suffering from anxiety issues, it is perhaps best to use a dissociative method so that the child will be able to form a sense of control over his or her anxiety. Hypnotic work with an anxious child will take the form of relaxation, followed by empowering techniques and ending with helping the child to distinguish irrational thoughts from ones that are more rational. Faulty thinking is then reviewed with the older child who may over-generalise, catastrophize, and so on. For the

child who has a specific social phobia, the hypnotic process will also use relaxation to begin with and then proceed to desensitising the feared object (Woods, 1986) by creating a safe space for the child and giving them control over what they previously felt was a helpless situation (Farnill, 1998). In general, the hypnotic process involved in treating anxiety can involve reframing, dissociation, changing irrational thinking into rational thinking (Lankton, 2010), anxiety reduction, skill building, ego strengthening and images of favourite places (Wester & Sugarman, 2007). Hypnotherapy serves to speed up therapeutic intervention in anxiety and makes the process less difficult for highly anxious children (Kuttner, 2009).

2.2.3.4 Hypnosis in the treatment of behaviour disorders

Kohen and Olness (2011) utilised hypnotherapy to aid a 10-year-old boy with behavioural disorders that manifested in frequent temper outbursts. The therapists used thermal biofeedback to make the client aware that he was in control of his own body and therefore could control his own emotions and temper. He was taught a breathing relaxation hypnotic induction technique and, months later, was found to no longer experience temper tantrums and was able to control his anger (Kohen & Olness, 2011). Behaviour disorders, such as Attention-Deficit/ Hyperactivity Disorder (ADHD), Conduct disorder (CD) and Oppositional defiance disorder (ODD), are seen as behaviours that disrupt social norms and expectations. Numerous studies have been conducted with children suffering from ADHD and the use of hypnotherapeutic techniques, which have indicated positive results. Relaxation, biofeedback and imagery/ visualisation techniques combined with suggestions for behavioural change are seen as most beneficial. However, more research that satisfies the requirement of empirical soundness is necessary in this area (Kilbride, 2009; Milling & Costantino, 2000). Hypnosis is rarely used as a technique on its own and the best approach appears to be a combination of several interventions (Wester & Sugarman, 2007). Milburn (2011), for example, effectively combined cognitive-behavioural therapy and hypnosis in treating low frustration tolerance, demanding behaviour and catastrophisation. He used hypnosis primarily as an adjunct to other therapies but stated that there is some evidence to suggest that hypnosis may be an effective treatment on its own. Nonetheless, more research in this area is needed in order to draw this conclusion (Milburn, 2011).

2.2.3.5 Hypnosis in the treatment of further psychological disorders

Hypnosis has proved beneficial in the treatment of eating disorders (Degun-Mather, 2003) especially when combined with CBT (Hutchinson-Phillips & Gow, 2005), as well as anorexia

nervosa (Gross, 1984; Meir, 1984), substance abuse (Gill & Brenman, 1961), enuresis, stuttering, obesity and sleep problems (Gardner, 1974a).

2.2.4 Adaptations

Working with children and adolescents requires flexibility on the part of the therapist. The therapist cannot expect the same hypnosis techniques to produce the same responses from children as they do from adults. This can be seen in something as simple as eye closure. When induced into a hypnotic state, adults will close their eyes to intensify the trance experience; this indicates to the therapist that the patient is undergoing a hypnotic experience. However, children, especially those under the age of 10 years, are able to enter into a hypnotic state without eye closure and thus will leave their eyes open. This will leave the inexperienced therapist feeling uncomfortable and unsure of the depth of the hypnotic experience the child has entered (Wester & Sugarman, 2007).

The best way to assist children in entering a hypnotic state is to work 'with' the child or adolescent and not 'on' them (Erickson, Rossi, & Rossi, 1976). This requires not only flexibility on the part of the therapist, but also creativity and adaptability. The therapist also needs to take the developmental level of the child he or she is working with into consideration. Children who refuse to close their eyes are doing so in order not to miss anything or because they associate this with going to sleep and thus become avoidant. The child that refuses to relax may do so because he or she associates relaxing with authoritarian control in which children are told to calm down and behave. The purpose of hypnosis is not to gain control over the child, and while it is certainly possible to take an authoritarian approach to doing hypnosis, this limiting technique should be avoided (Wester & Sugarman, 2007). The goal is to create a sense of mastery in the child through helping him or her discover their own ability to help themselves. In order to do this, the therapist first needs to meet the child or adolescent at his or her current level of functioning in an accepting manner – this is termed 'pacing'. Thereafter, the therapist can offer suggestions for ways in which therapeutic change can take place – which is called 'leading'. Finally, the therapist should allow the child or adolescent the freedom to decide whether or not to undertake the process of change. Each child has invested in himself or herself, his or her own ability for resilience in the face of hardship. It is the therapist's role to support this internal locus of control in order to provide the child with a sense of mastery (Wester & Sugarman, 2007).

2.2.5 Benefits, restrictions and limitations

- Hypnotherapy "with children [is used] as an opportunity to help them utilize and strengthen their own subconscious resources in pursuit of health and adaptation" (Wester & Sugarman, 2007, p. 16).
- Hypnotherapy is not a panacea in the therapeutic relationship, and it should not be used as the sole intervention when working with any given client. Therefore, hypnosis should be combined with other therapeutic techniques such as parent counselling, medication, cognitive behavioural therapy and so forth (Wester & Sugarman, 2007).
- The therapist must stay within his or her range of competency when treating a client. As such, not only should the therapist have extensive training in hypnotherapy but he or she should also have background training in the presenting problem. For example, if the therapist is not trained in the treatment of post-traumatic stress disorder (PTSD), then he or she should not attempt to treat PTSD with hypnosis, despite his or her training in hypnosis. Similarly, the therapist should not attempt to undertake hypnosis on children or adolescents without solid training and background experience in working with children (Wester & Sugarman, 2007).
- Hypnosis should not be used with children when further physical and emotional harm could result, when treatment that is more effective is available, and especially not for fun or entertainment (Kohen & Olness, 2011).

2.3 Techniques

"Hypnotherapy is a valuable technique to implement to have children remain focused, recall memories, identify core issues, change behaviours and access a deep level of healing" (Geniti, 2004, p. 75). A very basic overview of the process of hypnotherapy can be laid out in six basic steps. First, the therapist would *introduce* those involved to the hypnotherapeutic process and answer any questions that should arise (Wester & Sugarman, 2007). Starker (1975) emphasises how important the individual's 'attitude' and 'expectancy' is in enhancing the therapeutic outcome. Therefore, at this stage it is also important to educate the child or adolescent's parents on their role in the process and to respond to any misconceptions, rather than expecting the individual to follow the therapist blindly (Yapko, 2003). This is done in order to avoid them sabotaging the therapeutic process at a later stage, which will be discussed later in this chapter. In the second step, the therapist would select an appropriate *induction* technique to lead the patient into the trance state. This is followed by an

intensification procedure in which the level of trance is deepened. *Therapeutic suggestions* are given at appropriate stages before the patient is brought back to *conscious awareness* at the appropriate stage. Finally, a process of *reflection* on the hypnotic experience is undertaken (Wester & Sugarman, 2007). While these protocols prove very effective for adults, the therapist would be hard-pressed to follow this process when working with children and adolescents. Children often do not require a formal hypnotic induction; this is primarily because children enter more easily into a hypnotic state, among other factors (Wester & Sugarman, 2007). Therefore, induction techniques for children are different from those used with adults.

2.3.1 Induction techniques

Hypnosis is an altered state of consciousness (Starker, 1975) and "a distinct psychological state characterized by focused attention allowing one to dissociate perceptions and sensations, to attend with intensity and precision to thoughts and events, and to rally innate resources in unusual ways" (Harford, 2010, p. 63). Tchuggiel and Hunter (2008) question whether a trance state is induced or if such a state of consciousness is already active and available. They conclude that the therapist does not induce this state in the individual, but that they rather create an atmosphere in which the individual can allow him- or herself to enter this state and work with their experiences. Hypnosis can enhance the individual's accessibility to unconscious material such as 'hypermnesia' (increased memory accessibility) and 'revivication' (the reliving or re-experiencing of a memory) (Harford, 2010, p. 64). Erickson states that "it is the experience of re-associating and reorganising [ones] own experimental life that eventuates in a cure" (as cited in Lankton, 2010, p. 99). Hypnosis is achieved by the use of various induction procedures, which usually begin with making sure the patient is in a relaxed state through the use of imagery to initiate such relaxation (Huynh et al., 2008).

There are various induction techniques that can be used to place a client under hypnosis. What is essential with regard to these techniques is that the client's preferences are taken into account when selecting the type of induction to be used (Kohen & Olness, 2011). The scope of this research necessitates that focus be placed on induction techniques for children and adolescents rather than those used for adults. To select an induction technique, the hypnotherapist needs to be aware of the different stages of childhood development, as well as have some skill in working with children. In addition, the hypnotherapist should have some background knowledge of the child's culture as well as his or her general likes and

dislikes, comfort areas, language preferences, past experiences and future aspirations (Kohen & Olness, 2011). The process of gathering this information constitutes the pre-induction interview wherein the child's misconceptions of hypnosis are also clarified. The therapist needs to adapt his or her language to the child's level of comprehension without talking down to him or her or using overly complex language. What is perhaps even more important to the success of the induction technique selected is that all authoritarian or challenging methods are avoided not only because some children might rebel against this approach but also because this interferes with the child's own sense of mastery over his or her psychological problem (Kohen & Olness, 2011).

Therefore, gathering pre-hypnosis information assists the therapist in building rapport with the child as well as in selecting an appropriate induction technique based on the child's age and developmental level (Wester & Sugarman, 2007). Erickson (1979) points out that children often spontaneously enter a state of hypnosis without any formal induction. However, there are many induction techniques, tailored specifically for use with children that allow them to enter a hypnotic state. The various induction techniques that can be used include visual imagery, auditory techniques, movement imagery, storytelling, ideomotor techniques and eye fixation techniques (Kohen & Olness, 2011; Wester & Sugarman, 2007). A popular *visual imagery* technique is that of 'your favourite place'. The child is asked to imagine that he or she is in one of his or her favourite places or somewhere he or she would like to go one day. The child can also be asked to imagine playing with an animal of his or her choice or to imagine that he or she is in a flower garden picking flowers. Another popular technique is 'television or movie fantasy' in which the child is asked to imagine he or she is watching their favourite programme. What is appealing about this technique is that the child can be asked later to switch to his or her own channel where the child sees him- or herself on the television screen, how he or she is now or how the child would like to be (Kohen & Olness, 2011). *Auditory techniques* require the child to pretend to listen to their favourite song or music; while movement imagery requires that children pretend they are on a flying blanket, riding their bicycle, playing with a ball or walking down a flight of stairs, as in the *staircase induction*. For younger children, the *storytelling technique* is used as this allows the therapist to tell a story and for the child to listen and give input where they feel they would like to (Kohen & Olness, 2011).

Ideomotor techniques, for example, ask the child to imagine that there are balloons tied to their arms and that these balloons are slowly lifting the child's arm up into the air, as in the '*arm levitation technique*'. In the case of *de-levitation*, the child is asked to lift their arm and imagine that there is something heavy in their hand causing their arm to be slowly pulled downwards. When using the *eye fixation technique*, the therapist might ask the child to hold a coin in their hand and stare at it until they get tired of holding it and let the coin drop to the floor, letting their eyes close at the same time. Induction techniques can also begin by relaxing the client from head to toe, or vice versa, using *progressive muscle relaxation.* *Naturalistic inductions* allow the client to enter into hypnosis as they naturally would and without the therapist's assistance. In contrast, *rapid inductions* may be done simply by shaking the clients hand or some other instant method. As has been discussed, various visual, auditory and ideomotor techniques can be used successfully in inducing hypnosis in a child or adolescent. Table 2.7 (below) lists these induction techniques and indicates which would work best with specific ages. The majority of these techniques incorporate the child's imagination (for example: imagining he or she is a mighty oak tree, in a flower garden, bouncing a ball, watching clouds, driving a car, etcetera) (Wester & Sugarman, 2007).

Table 2.7: Induction technique by age

Age	Induction Technique
Preverbal (0-2 years)	Tactile stimulation (stroking or patting), Kinaesthetic stimulation (rocking or moving an arm back and forth), Auditory stimulation (music or any whirring sound e.g. hair dryer) Visual stimulation (mobiles or other objects that change shape), Holding a doll or stuffed animal.
Early Verbal (2-4 years)	Storytelling, Pop-up books, Favourite activity, Stereoscopic viewer, Blowing bubbles, speaking to the child through a doll or stuffed animal, watching induction or self on video tape.
Preschool and Early School (4-6 years)	Favourite place, Storytelling, Pop-up book, playground activity, stereoscopic viewer, blowing breath out, flower garden, mighty oak tree, television fantasy, videotape, bouncing ball, thermal (and other) biofeedback, finger lowering.
Middle Childhood (7-11 years)	Favourite place, favourite activity, blowing breath out, cloud gazing, flying blanket/carpet, video games, riding a bike, arm lowering, favourite music, listening to self on tape, fixation at point on hand, hands (fingers) moving together as magnets, arm rigidity.
Adolescence (12-18 years)	Favourite place, favourite activity, sports activity, arm catalepsy, following breathing, videogames, computer games, fantasy games, eye fixation on hand, driving a car, playing or hearing music, hand levitation, hands (fingers) moving together as a magnet.

(Kohen & Olness, 2011, p. 77)

The above are just a few of the induction techniques that one can use on children. It is important to note that these techniques must be adapted to the child's preferences. If a child is scared of heights then the therapist would not ask that child to imagine they are on a flying blanket, for example (Kohen & Olness, 2011). In selecting an appropriate induction method according to the child's likes and dislikes, it is also important to consider the child's age. Certain techniques are preferable to children of different ages due to their differing levels of development. Not only is the child's age important, but the therapist also needs to take into account any special problems the child may have, such as any physical difficulties, developmental delays, learning disabilities (Hughes, 2000), physical or sexual abuse or autism, and modify their induction technique accordingly (Kohen & Olness, 2011).

2.3.2 Training

In numerous accounts throughout the literature, authors have stressed the importance of sufficient training before attempting to use hypnosis for therapeutic purposes. The therapist must maintain a level of competency when working with his or her client, especially when working with children. Therefore, the therapist should not attempt to work outside his or her field of expertise. Before attempting to conduct a hypnotic intervention on a child or adolescent, the therapist must have received formal training in child psychology with ample supervision. This also requires formal training in hypnotherapy. Without such formal training, severe harm could come to the young client when faced with a therapist who has not been formally trained to manage the emerging phases of the therapeutic process (Wester & Sugarman, 2007). While hypnotherapy cannot be used to control the client, there is a power differential evident in all therapeutic relationships. The therapist needs to be aware of the presence of this factor and ensure that he or she constantly reinforces the fact that the power for change lies in the client and not in the therapist (Walling & Levine, 1997).

2.3.3 The role of the parent

According to Wester and Sugarman (2007), most parents have a positive outlook on the use of hypnosis with their children. However, parents can mistakenly foil any well executed and thought out therapeutic intervention. If parents seem hesitant in their child's hypnotic therapy, then the therapist needs to consider the fact that the parents may be experiencing negative feelings towards the therapist's progress with their child (Wester & Sugarman, 2007). In order to prevent parents from unintentionally harming the therapeutic intervention,

it is important to ensure that they are fully invested in the process (Gardner, 1974a). In order to achieve this, Gardner (1974b) suggests three basic steps. First, parents need to be *educated* on hypnosis, how it is identified, how it presents in children and how it will be used to assist the child (Geniti, 2004). Second, the parents may be allowed to *observe* their child utilising self-hypnosis once they have achieved confidence in their mastery of this skill. Finally, parents can engage in their own brief *experience* of hypnosis to better their understanding on a first-hand basis (Gardner, 1974b). When a child's parents have a positive view of the hypnotic process, it is more likely that their child will also adopt this positive outlook, and will thus achieve greater therapeutic success. Parents should also be made aware of the fact that it is up to their child to decide how much they are willing to engage with the process. Parents should not badger their children to practise or to perform at a certain level, as this will hinder the child's achievement of self-mastery (Wester & Sugarman, 2007).

2.4 Conclusion

"The goal of hypnotherapy is always to teach the patient an attitude of hope in the context of mastery" (Kohen & Olness, 2011, p. 90). The literature on hypnotherapy explains that hypnotherapy is a therapeutic intervention in which the therapist is able to assist the child or adolescent in achieving an altered state of consciousness or awareness. It is within this state that the therapist is able to offer the patient suggestions for therapeutic change or begin a process of psychoanalysis. There are also many other methods that the therapist can utilise while a child or adolescent is in hypnosis. The literature shows that hypnosis and hypnotherapy has proved beneficial for use with children and adolescents for a number of psychological problems. Children and adolescents respond favourably to the technique. It can be adapted to their age and developmental level and has been shown to have rapid results. However, there is still a lack of research on hypnotherapy and its uses for children and adolescents in South Africa.

Chapter 3: Methodology

This chapter provides a detailed description of how the present study was operationalized. It begins with an explanation of, and motivation for, the selected research design. This is followed by an explanation of the sampling and data collection procedures that were followed. A brief description of each of the study's participants will also be provided. Finally, this chapter discusses the data analysis procedures employed and comments on the ethical implications of a study of this nature.

3.1 Research Design

The aim of this research was to investigate the perspectives of qualified South African psychologists on hypnosis as a therapeutic intervention for children and adolescents. While research has been conducted on the use of hypnotherapy with children and adolescents in England, Bali, Canada, Australia, and many other countries, this research is the first to investigate hypnotherapy for children and adolescents within a South African context. It is envisaged that the findings will provide an initial view on the ways in which South African psychologists understand and make use of hypnotherapy in their own practises and in what way, if any, this approach has been adapted to fit the South African context. By conducting this research, it is intended that the field of knowledge in educational psychology regarding hypnotherapy in South Africa will be expanded.

The research design used in this study took on a qualitative nature. A qualitative design enables the researcher to gather a rich and in-depth understanding of his or her field of study (Terre Blanche, Durrheim, & Painter, 2006) as well as produce a vast amount of data. A qualitative approach thus allowed the researcher to gain an in-depth understanding of the uses of hypnotherapy and its practise, as well as individuals' perceptions, behaviours, attitudes and/or beliefs regarding hypnotherapy. Qualitative research also allowed the researcher to study the intricacies of social interactions in daily life and examine the meanings that the participants' themselves ascribe to these interactions (Marshall & Rossman, 2011). Therefore, qualitative research is "pragmatic, interpretive, and grounded in the lived experiences of people" (Marshall & Rossman, 2011, p. 2). A qualitative approach was specifically selected to trade generality of research findings for in-depth findings that provide a more detailed understanding of the phenomenon, as provided directly by the participants involved (Terre Blanche et al., 2006). A qualitative approach allowed the

researcher to discover the views that these psychologists hold regarding hypnotherapy and how they have implemented this technique in their own practise. In order to enable the researcher to retrieve and interpret the participants' understanding of hypnotherapy, semi-structured interviews were conducted and transcribed for analysis. Thematic content analysis was used to analyse the data as it provides for a flexible research tool, with the potential to provide a rich and detailed account of the participants' perspectives and the data collected (Braun & Clarke, 2006). Interpretation of the interviews was conducted in a systematic fashion through the six phases of analysis set out by Braun and Clarke (2006).

3.2 Participants

Qualitative sampling requires the selection of participants "who can best inform the study" (Fossy, Harvey, & Davidson, 2002, p. 726). The sample for this research comprised eight qualified South African psychologists who work with children and adolescents in their own practises. Qualitative sampling may involve a small number of participants, as the data gathered can still be quite voluminous. Therefore, there are no specifications on the minimum number of participants required for a qualitative study. If the number of participants selected offers sufficient depth to describe the research phenomenon in full, then further participants would be unnecessary (Fossy et al., 2002). A sample of eight participants provided an adequate range and sufficient quantity to conduct a valid research study. Theoretical saturation was met with eight participants and it was felt that the addition of further participants would not add any new or challenging information to the results (Terre Blanche et al., 2006). Further participants would cause some data to become redundant (Fossy et al., 2002). The psychologists interviewed were selected because of their use of hypnosis as a therapeutic technique in assisting children and adolescents resolve the specific issues brought into the therapeutic environment. They were therefore able to provide significant feedback on hypnotherapy and their own perspectives on it. Once ethical clearance was obtained from the University of the Witwatersrand internal ethics committee (see Appendix vi), the participants were contacted. Each participant was sourced from listings (in the phonebook or on the internet) of qualified psychologists that practise hypnotherapy with children and adolescents. They were then requested to participate in the research.

The individuals selected to participate in this study were selected by one of two means. First, a non-probability sampling method was employed, as the sample was selected based on convenience: those participants who were willing to participate were selected.

Second, a snowball sampling method was also employed, as some participants were selected based on contact with previous participants who identified their contacts as having knowledge on the current research (Terre Blanche et al., 2006). In order to avoid any sampling biases, every qualified psychologist found in the greater Gauteng area (Johannesburg, Pretoria, Springs, etc.) was requested to participate in the research. Those individuals who responded by indicating their willingness to participate were selected.

This study made use of semi-structured interviews to gather the perspectives of the psychologists on the value of hypnosis for children and adolescents. An introductory letter (see Appendix i) was handed out to the participants informing them of the nature of the study and requesting them to sign a consent form (see Appendix ii) to participate in the study, as well as to be audio recorded (see Appendix iii) for data collection purposes. The interviews took place at the psychologist's practise rooms at a scheduled time that suited the psychologist. The use of the psychologist's practise rooms ensured that the interviews were conducted in a fairly quiet and controlled space and were of the optimum convenience to the psychologists concerned. This allowed for the greatest ease of communication and convenience for the participants involved.

The interview questions (see Appendix i) were open-ended, and allowed the psychologist to respond in a flexible manner while providing greater depth of information. The interviews were audio recorded so as to allow the researcher the opportunity to listen to the participants without missing any essential non-verbal communications. The interviews ranged between 40 and 60 minutes and varied according to the participant being interviewed. However, 60 minutes was scheduled in order to allow enough time for each of the interviews to be conducted. The interviews were then transcribed verbatim.

3.2.1. Participant characteristics

Eight interview participants were selected and interviewed by the researcher. The sample comprised of qualified psychologists who utilise hypnotherapy with children and adolescents in their practises. On agreeing to participate, they were sent an information letter (see Appendix i) through which they could gain a more detailed understanding of the research being conducted. They were also, at this time, provided with the researcher's contact details in case any complications arose with the appointed interview time. Below, a brief description of each of the eight participants is provided. For the purpose of maintaining confidentiality,

the participant's names have been omitted. A pseudonym has been provided for each participant and they will be discussed here in alphabetical order.

The first participant is Alis. Alis is a counselling psychologist (previously an educational psychologist) who completed her post-graduate Master's degree at the University of Johannesburg (UJ). Alis' training was eclectic, and incorporated Cognitive Behavioural Therapy (CBT) and Cognitive Emotive Therapy. Alis has been practising for 16 years. She studied hypnosis and hypnotherapy at the South African Society of Clinical Hypnosis (SASCH) and has been using hypnotherapy in her practise for the past 14 years. She estimates that she has performed hypnotherapy on over 100 children and over 50 adolescents.

Charles is a clinical psychologist who completed his Master's degree at the University of South Africa (UNISA). His training was multi-dimensional, psychodynamic and behavioural. Charles has been practising as a psychologist specialising in hypnotherapy for over 35 years. He studied hypnotherapy at UNISA and at Utrecht in the Netherlands. While his client base for hypnotherapy is predominately adults, he has performed hypnotherapy on about 60 children and 40 adolescents.

Frank completed his post-graduate Master's degree in educational Psychology at the University of Johannesburg (UJ). His training was primarily social constructivist and trans-theoretical. He has been practising for four years of which he has practised hypnotherapy for two years. He received extensive training from the Milton Erickson Institute of South Africa (MEISA)/ South African Society of Hypnosis. He has performed hypnotherapy on around 20 children and 25 adolescents.

Joan is an educational Psychologist who completed her Master's degree at the University of Johannesburg (UJ). Her training was also trans-theoretical in nature. She has been in private practise for 1 year and has been using hypnotherapy for 2 years. She studied hypnotherapy at the Milton Erickson Institute of South Africa (MEISA) and has performed hypnotherapy on roughly 90 children and 150 adolescents.

Mara is a counselling psychologist who completed her Master's degree at the University of Natal. Her training took on a heart-centred approach. She has been practising for 11 years and has used hypnotherapy for 5 years. She studied hypnotherapy at the

Wellness Institute. She has performed hypnotherapy on over 40 children and more than 70 adolescents.

Marcie studied counselling psychology at the University of Johannesburg (UJ) where she obtained her Master's degree. Her training took on a holistic approach. She has been practising for 14 years and has utilised hypnotherapy for the past 5 years. She studied hypnotherapy at the Wellness Institute and in the United States of America (USA). She has performed hypnotherapy with around 10 children and well over 60 adolescents.

Mary is an educational psychologist who completed her post-graduate Master's degree at the University of South Africa (UNISA). Her training was primarily relational in nature. She has been practising for 13 years and has used hypnotherapy for 8 of those years. She studied hypnotherapy at the Milton Erickson Institute of South Africa (MEISA) as well as the American Heart Foundation. She has performed hypnotherapy on around 50 children and 50 adolescents.

Finally, Warren is a clinical psychologist who completed his post-graduate degree at the Medical University of Southern Africa (Medunsa). His training took on an integrative and eco-systemic approach. He has been practising for 14 years and has been using hypnotherapy for 13 years. He studied hypnotherapy at SASCH and has also attended various training workshops. He has used hypnotherapy on roughly 60 children and 140 adolescents.

3.3 Interview Procedure

3.3.1. Developing the research questions

This research aimed to investigate the perspectives of South African psychologists on hypnosis as a therapeutic intervention for children and adolescents. The following research questions guided the study:

- What is the participants' understanding of hypnosis and hypnotherapy?
- How do the participants view the uses of hypnosis and hypnotherapy for children and adolescents?
- What drawbacks if any do they find in the use of hypnotherapy?
- How have they adapted hypnotherapy to suit a South African context?

These broader research questions were used to form the semi-structured interview questions (see Appendix iv).

3.3.2. Developing the research interview schedule

Qualitative interviews enable two or more individuals to discuss a topic of mutual interest and provide the researcher with a large quantity of knowledge around the topic in a short amount of time (Marshall & Rossman, 2011). This study made use of semi-structured interviews in order to gather the perspectives of the psychologists on the value of hypnosis for children and adolescents. Semi-structured interviews make use of an interview guide in which questions are set out beforehand and are used to enable focused exploration of the research topic (Fossy et al., 2002).

30 open-ended interview questions were asked of each participant (see Appendix iv). These questions constituted a flexible guideline that the researcher could follow, but which did not restrict the participants or lead them in any way. The interview was conducted in an informal manner that allowed the participants to speak freely, but which also provided the researcher with a guideline as to how to structure the interviews. The interviews were semi-structured, thus allowing the interviewer to begin the interview with questions that had been preconceived while still allowing the freedom to pose other questions that may have arisen during the session. The interview questions were not posed in any particular order. Such a method of open-ended questioning allows participants to express their own opinions and beliefs on the topic in their own words.

A possible consideration that may have affected the interviews' internal validity is that the psychologists may have felt the need to adhere to socially acceptable behaviours or appear better than in reality; therefore, it is difficult to determine the degree to which participants were truthful. Another important consideration is that the inexperienced interviewer may have influenced the participants' responses. If the researcher showed favour towards any particular side of the argument, the researcher may have created a self-fulfilling prophecy (Breakwell, Hammond, & Fife-Schaw, 1995). The researcher thus needed to be cautious about guiding the participants towards relevant focus areas without shaping their opinions.

3.3.3. Interviews

On arrival at the participant's place of practise, at the scheduled time, the interviewer officially introduced herself to the participant. The researcher provided each of the participants with a printed copy of the introductory letter (see Appendix i) that served to inform them of the nature of the study. The researcher requested that the participants sign a consent form (see Appendix ii) to participate in this study, as well as a consent form to be audio recorded (see Appendix iii) for data collection purposes. The researcher then requested that the participants complete a brief pre-interview questionnaire (see Appendix iv). Once this process was completed, the researcher was free to turn on the audio-recorder and pose the open-ended questions (see Appendix iv) that were compiled beforehand and that allowed the participants to respond with greater depth of information rather than with simple yes and no answers.

3.4 Data Analysis

3.4.1. Thematic content analysis

"Thematic content analysis is a method for identifying, analysing and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 79). The goal of thematic content analysis is either to provide or enhance information about and understandings of the phenomenon being studied (Hsieh & Shannon, 2005). Once the data was collected, the audio recordings were transcribed and coded according to common themes that emerged from the interviews. Once this process was completed, the data gathered from the interviews was interpreted through a content analysis procedure. Content analysis is a technique for making inferences and identifying the common characteristics of messages (Krippendorf, 1980; Weber, 1990). A direct content analysis was selected as existing theories have already been formed and prior research has already been done on this topic in other countries (Hsieh & Shannon, 2005). However, research on the use of hypnotherapy for children and adolescents in South Africa has not been documented. The goal was thus to expand upon existing knowledge by offering research within a South African context. The researcher therefore developed the research questions in order to explore participants' understandings and experiences of hypnotherapy for children and adolescents in South Africa.

Using content analysis, the transcriptions were analysed in order to uncover underlying meanings beneath the surface content of the text. This allowed the researcher to work through the data gathered from the interviews and aided the researcher in discovering

and describing any trends and patterns that emerged. The researcher utilised Braun and Clarke's (2006) six phases of thematic content analysis: familiarizing herself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the report. This technique revealed each of the psychologist's views of hypnotherapy and the similarities and differences between their views. There are a few limitations of such content analysis, such as the fact that it can be time-consuming and research intensive. The researcher also needed to keep in mind the context in which the data was collected and be careful not to make generalisations that were not supported by the data (Krippendorf, 1980; Weber, 1990).

3.4.2. Analysis procedure

Braun and Clarke (2006) set out six steps for conducting thematic content analysis. Table 3.1 (below) outlines each of these six phases. Braun and Clarke (2006, p. 82) propose that a theme "captures something important about the data in relation to the research question, and presents some level of patterned response or meaning within the data set". Themes are not placed in any order of importance or marked as a theme based on how often that theme emerges in the data, but rather the researcher's judgement determines a theme. A theme therefore emerges by whether it captures something important in relation to the overall research question. Thematic content analysis therefore allows for a flexible approach when selecting a method through which to determine themes, provided that the researcher remains consistent in the method they select. (Braun & Clarke, 2006). Themes emerge from data at a gradual pace as the data is first read and reread in order to identify initial codes. Each code is then compared to the rest of the data in order to develop overarching themes throughout the data (Pope, Zeibland, & Mays, 2000). The researcher worked with the data transcriptions in this way, drawing out potential codes and themes. The similarities and differences between the participants' responses were also recorded. The researcher then made note of their clinical backgrounds and experiences in order to analyse what effect this had on their opinions, if any.

The researcher needed to be aware of certain pitfalls when using thematic content analysis. First, it is important that researchers thoroughly analyse the data and avoid simply stringing together random extracts. Second, researchers need to avoid using the interview questions as the themes of the analysis. Third, researchers need to strengthen their reports by ensuring that themes work together and do not overlap with one another. Fourth, it is

important to ensure that the findings obtained are consistent with the theoretical framework utilised. Finally, it is necessary to state all assumptions explicitly and to clarify the purpose of the research and how this purpose was achieved (Braun & Clarke, 2006).

Table 3.1: Phases of thematic content analysis

Phase	Description of the process
1. Familiarization with the data	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme
4. Reviewing Themes	Checking if the themes work in relation to the coded extracts (level 1) and the entire data set (level 2), generating a thematic map of the analysis
5. Defining and naming themes	On-going analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating the analysis back to the research question and literature, producing a scholarly report of the analysis

(Braun & Clarke, 2006, p. 87)

With these considerations in mind, the researcher began a thorough analysis of the research data following transcription. Each interview recording was transcribed verbatim via a typed MS-word document format. The transcriptions were then checked to ensure no content had been mistaken or omitted. The researcher followed Braun & Clarke's (2006) phases of thematic content analysis and spent a considerable amount of time reading and re-reading the transcribed data in order to become familiar with the material. In addition, whilst reading through the data, the researcher searched for meanings and patterns. Possible codes were marked down and highlighted in such a way that the data became structured into meaningful groups. A colour-coded highlighting system was used in order to identify similar ideas and/or arguments. All information relevant to each group was collected and placed

under prospective headings. These coded groups where then examined for potential themes. At this point nine main themes were identified, namely: Explanations of hypnosis, Advantages, Disadvantages, Use in South Africa, Adaptations to children and adolescents, Adaptations to context, Ethical practises, Methods, and Cultural difference. The quotes pertaining to each theme were highlighted or underlined according to the colour-coding system allocated to each main theme. Through a process of elimination the final themes where selected and mismatched themes discarded in terms of their relevance to the overall research question. Selected themes were reviewed and when themes proved incoherent, they were reworked or else discarded. For example, it proved beneficial to combine 'Advantages' and 'Disadvantages' together under one heading and 'Methods' were discarded as a theme on its own. It was also evident that the participant positions had an impact on their explanation of hypnosis and hypnotherapy and thus their understanding was shaped accordingly. This theme was adapted to represent the participants' understanding and perceptions of hypnosis rather than a pure explanation of its nature. The final themes where then refined and titled appropriately.

3.5 Quality Criteria

The constructs of validity and reliability are inappropriate when assessing the worth or "truth value" of a qualitative research report. As an alternative, the following four constructs have been proposed for the assessment of the quality of a qualitative research report: credibility/ authenticity, transferability, dependability and conformability (de Vos et al., 2011, p. 419). In order for the researcher to create a high level of worth and trustworthiness in the research findings, it was important to take these four constructs into consideration.

3.5.1. Credibility/ Authenticity

Credibility/ Authenticity is considered the most important criteria for assessing the worth of a qualitative research report and offers an alternative to internal validity. *Credibility/ authenticity* refers to the extent to which the research findings are an accurate reflection of the participants' views (de Vos et al., 2011). In order to ensure credibility, the researcher followed the six systematic steps for content analysis explicated by Braun and Clarke (2006). In this way, the researcher ensured that the research findings reflected the participants' views by familiarizing herself with the data, by checking with the participants that the researcher had understood them correctly (member checks) and by having her supervisor check that the reported results and research findings matched.

3.5.2. Transferability

Transferability provides an alternative to external validity and refers to the extent to which the research findings can be transferred and applied from one context to another (de Vos et al, 2011). This research has been designed to examine the perspectives of psychologists on hypnosis and hypnotherapy and, as such, it represents a limited section of the population. However, through the provision of an extensive literature review, it has been shown that research on hypnotherapy has been done in many different settings. Similarly, by following a formalised qualitative method, this study can be reproduced in many others contexts. By providing the reader with the complete details of the methods by which this study was conducted, the researcher allows readers to determine whether this study can be applied to other contexts and what possible results may appear.

3.5.3. Dependability

Dependability refers to whether or not the research procedures were coherent, well detailed, adequately reviewed and consistent over time. In this way, dependability offers an alternative to reliability (de Vos et al, 2011). The researcher has provided full details and descriptions of the research design and analysis process, as well as a list of the interview questions that were asked of the participants and a brief description of each participant who took part in the study. In this way, further research can be conducted, based on this study, in other contexts.

3.5.4. Conformability

Conformability refers to whether or not the research is objective in that it represents the true perspectives of the participants, and has not been shaped or distorted in anyway by the researcher's own perspectives (de Vos et al, 2011). To ensure that this research demonstrated conformability, the researcher has included direct quotations of the participants' views throughout the data. These have been reviewed by the researcher's supervisor.

3.6 Reflexivity

Researchers need to develop awareness of their own preconceptions so that their research findings are informed by the data itself and not by the researchers' own preconceived ideas (Fossy et al., 2002). It is thus important for researchers to be self-reflexive, as this creates an awareness of their own potential biases (Parker, 1994). The personal experience of the researcher during qualitative research is important (Terre Blanche et al., 2006). As a student

educational psychologist in South Africa, the researcher in this study needed to maintain an awareness of possible biases that may have arisen from her position and what effect these could have on the interview process. While the researcher may have had background information on the topic that contributed to an understanding of the material discussed, the researcher needed to be aware of any biases that could have arisen from this prior knowledge. The researcher's biases in favour of hypnotherapy may have caused the researcher to find evidence that supported the theory rather than evidence that undermined the theory (Hsieh & Shannon, 2005). Therefore, the researcher needed to bear in mind her potential to shape the research towards her own biases and away from a true reflection of the results. The researcher also needed to keep in mind her emerging understandings while taking part in the research process (Fossy et al., 2002). The researcher achieved this by completing a research journal from the commencement of data collection in which she documented all her thoughts, reactions and feelings throughout the research procedure. Any emerging assumptions or biases were examined. This included any thoughts, feelings and perception of the participants and the interview sessions. Any biases that emerged in this reflective process were discussed within supervision.

3.7 Ethical Considerations

The participants in this study were duly informed of what their participation entailed before the commencement of the interviews. If they signed the consent form, after they were fully informed of the research, they acknowledged their acceptance of the terms of the research. No foreseen and resulting risks were evident in their participation and their identities will remain confidential. Suitable pseudonyms have been provided for the research participants and any details referring to their place of work have been omitted. If, at any point, they were unhappy about the interview or needed to clarify an issue, they were provided with the researcher's contact details.

The interviews were scheduled in advance at times that did not conflict with the psychologists' own practise or business dealings. An audio-recorder was used for the purpose of recording the interviews and the participants signed a consent form acknowledging that they were willing to be audio recorded. The recordings are for the researcher and her supervisor only. No possible ethical concern emerged where there was a breach of psychologist-patient confidentiality, as the psychologists did not directly refer to their clients and their issues. This was ensured by requesting that the psychologists use pseudonyms for

all their clients and that they thereby avoid divulging the identities of their patients. Any identifying information that may have been given by mistake was omitted from the transcriptions or edited suitably.

The features of the study and the interview schedule were designed in order to avoid any harm, distress or discomfort to the participants. Written consent forms from each of the participants were obtained and are being stored for research purposes. The participants in this research were informed that they would be interviewed by the researcher at a time and place that was convenient for them. They were also informed that the interview would not last for more than one hour. With the participants' permission, the interviews were audio recorded in order to ensure accuracy. The participants were informed that their participation was strictly voluntary, and that no person would be advantaged or disadvantaged in any way for choosing to participate or not participate in the study. The participants were aware that direct quotes might be drawn from the interviews but that all of their responses would be kept confidential, and that no information that could identify them would be included in the research report. The interview material (recordings and transcripts) will not be seen or heard by any person in the organisation at any time, and will only be processed by the researcher and her supervisor. The data is being kept in a locked cupboard for a period of two years if unpublished and six years if published. The participants were made aware of the fact that they were free to refuse to answer any questions and were able to choose to withdraw from the study at any point.

Chapter 4: Results

This chapter provides an in-depth discussion of the themes identified within the data acquired from the individual interviews conducted by the researcher. Throughout analysis of the data, the researcher was guided by the four initial research questions, which needed answering. The core themes that emerged were grouped under six main overarching areas: An understanding of hypnosis, the perceived advantages and disadvantages of hypnosis, the application of hypnotherapy in South Africa, the ways in which hypnotherapy has been adapted to a South African context, the influence of cultural factors on hypnotherapy and finally, ethical practise.

4.1 An Understanding of Hypnosis

4.1.1 Individual views and perspective on hypnotherapy

Many of the psychologists spoke of the nature of hypnosis and what they felt it entailed. For Joan and Alis, hypnosis was seen as merely the "focus of attention… [which] internally absorbs the person in the process" of therapy. Alis' definition of hypnosis formed the basis for the advantages she saw in this therapeutic technique. Alis stated that "as soon as a person becomes internally absorbed they are also more in the process…you can bring [in] the emotional side, the physical, the senses are also involved. While if you are just using cognitive therapy, you are just talking and …it doesn't involve internal absorption. So… [with hypnotherapy] you'll reach more levels". For Alis, the benefit of hypnosis is this internal absorption, this focus of attention. Her definition of hypnosis not only shaped her understanding of hypnosis but also the way in which she utilised it. This is seen again later when Alis talked about the disadvantages of hypnosis. Alis felt that "the focus of attention is [also] a disadvantage, because [children] can't focus for that long". Therefore, from the psychologists' first definition we can infer an understanding of hypnosis as a focus of attention.

Frank expanded on this definition of hypnosis. He viewed hypnosis not only as the focus of attention but also as "an altered state of consciousness *with* focused attention, in which strategic communication can take place and influence" the young individual. From this, we can infer an understanding of hypnotherapy as being influenced and formed by yet another two factors. The first of these is the idea of the '*altered state of consciousness'*. It is in hypnosis, according to Charles, that "direct access to the unconscious mind" is made

possible. This understanding is shaped by the fact that hypnosis works beyond the level of the conscious mind. The second factor is the idea of '*strategic communication'*. Charles expanded on his definition by stating that "direct access to the unconscious mind… [is for the purpose of] either direct suggestion or for analysis". He felt that the advantage of hypnosis was that, "it's the only technique of its kind that allows you to implant information or suggestions directly into the subconscious". In summary, hypnosis allows individuals to access their unconscious mind in which they are able to achieve a state of focused attention. While in this state of 'trance', the therapist has the capacity to strategically communicate with the individual and offer them suggestions for therapeutic change.

Therefore, hypnosis accesses the "subconscious mind, in which [there] is a library of everything that you have recorded from birth. And the point of hypnotherapy is to access certain files [or]…memories that are locked" away. It is here that "there [are] core beliefs that have been created by [certain] events, by which the client is living" (Mara). These beliefs "impact their behaviour, their thoughts, [and] their emotions" (Mara). Warren felt that hypnosis can "bypass…the [individual's] critical faculty,…that part of the mind involving judgement,…[and] implant or communicate selective thinking" and, by doing so, change the core beliefs that influence an individual's behaviour. By accessing the core belief of the individual, through the events that caused them to be created, the therapist can challenge their validity by offering suggestions that counteract them. While the individual is in this heightened state of focused attention they are "more receptive to new ideas and behaviour", (Warren) and are more likely to alter their belief when they are shown to be based on false grounding.

Mara stated that hypnotherapy retrieves "repressed material where the core stuff lies" and "accesses emotions, sensations and conclusions that happened at the time" so that the individual can "relive…the experience in order to shift that pattern" of behaviours or, according to Frank, create a "corrective emotional experience that normally talk therapy cannot necessarily achieve". Thus, hypnosis involves accessing not only the event that created the core beliefs, but also the "emotions, sensations and conclusions that happened at the time of [the] event" (Mara). The psychologists thus believe that, by accessing these aspects of the experience, the individual is able to relive the experience and gain this corrective emotional experience as the individual comes to see the event as less provocative of anxiety than it should be or by providing the individual with tools to work with the event.

When the event becomes too much for the individual to handle, Warren posits a third factor of hypnosis, namely, a "high degree of relaxation" that can be used to calm the individual during these times.

Therefore, each psychologist provided a definition of hypnosis that forms the basis for his or her understanding of this therapeutic method and provided an understanding of hypnosis and hypnotherapy within a South African context. The psychologists all seemed to agree on four core factors of this method at some point throughout their interview: the focus of attention, access to the subconscious/unconscious mind, greater receptivity to positive therapeutic suggestions and a state of relaxation (however, relaxation is not always necessary for hypnosis to be present). Warren summed it up best by stating that there are "so many different views on [hypnosis and]...there's no …single agreement that [has] been reached about what the state is". However, the above definitions show that there is some agreement from psychologists in this regard.

4.1.2 The effect of age on the application of hypnotherapy

Half of the psychologists reported that there are certain ages for which hypnotherapy is appropriate and certain ages for which it is not. The remaining half of the psychologists felt that hypnotherapy is applicable to all ages. Table 4.1 is drawn from the brief pre-interview questionnaire filled out by each participant. The research findings uncovered a direct relationship between the amount of work the psychologists had undertaken with children or adolescents and how applicable they felt the technique was for each age group. Their beliefs or preferences regarding the age applicability of the technique were drawn from their comments throughout the interview.

Charles reported that "children in a sense… [are] easier subjects for hypnosis…they are less defensive, less suspicious and they are very susceptible to suggestion". He said that he is "less comfortable with adolescents because… [they] tend… to be rather hostile, defensive, suspicious, especially of adults…so it is difficult…to win their trust". On the other hand, Frank believed that "adolescents seem to enjoy [hypnosis] quite a lot, because it's weird and wonderful…. [and] when you do arm levitation with them…they go 'Wow, this really works' and that's good because then you can capitalise on it". Arm levitation is the hypnotic induction technique whereby the therapist suggests that the clients arm has been tied with balloons (for example) that will gradually raise their arm into the air. Joan agreed with

Frank and said that hypnosis is "a bit out there, so [adolescents are] all very interested in doing it… I've never had an adolescent look at me and say no". On the other hand, Alis argued that "teenagers are often bored in [the] process". This contradicts Frank and Joan's belief that adolescents display a significant interest in hypnosis. Alis and Charles seemed to show a preference for working with children, whereas Frank, Joan and Mary believed that "adolescents…really love" hypnosis and they show no preferences for either age group.

Table 4.1: Age preferences for the utilisation of hypnotherapy

Psychologist	Registration	University	Estimated No. of clients		Preference
			Children	Adolescents	
Alis	Counselling	UJ	100	50	Children
Charles	Clinical	UNISA	60	40	Children
Frank	Educational	UJ	20	25	Neither
Joan	Educational	UJ	80	120	Neither
Mara	Counselling	Natal	40	70	Adolescents
Marcie	Counselling	UJ	10	60	Adolescents
Mary	Educational	UNISA	50	50	Neither
Warren	Clinical	Medunsa	60	140	Neither

Marcie suggested that Hypnotherapy "doesn't work for all clients, especially with the little ones". She thus maintained that it is inappropriate for children "below age nine or ten". She continued: "children younger than that …don't always understand what you mean… and the instructions and following the script is a bit difficult…they are not able to follow the process…because their abstract thinking is not developed yet". Mara agreed with Marcie, arguing that "when adolescents go into hypnosis, when they are fully in, they're more…focused and able to communicate than the younger children". Some of the psychologists argued that hypnotherapy works with adolescents and not children, while others argued the opposite. Alis and Charles reported undertaking hypnosis with a much greater number of children as compared to adolescents. Their comments throughout their interviews favoured children for hypnosis. On the other hand, Mara and Marcie favoured working with adolescents, with whom they have conducted the most hypnotherapy. Thus, it seems that the psychologists' preferences shaped their view of the age group for which hypnosis is most appropriate.

Frank, Joan, Mary and Warren showed no preference for the application of hypnosis for either age. What is interesting to note is that Frank, Joan and Mary are all educational psychologists. While Warren is a clinical psychologist, he shared their view that hypnotherapy is applicable to all ages. Joan sums this point up aptly: "it depends on what you're experienced with or what you can do. I started out with adolescents and I loved it and I was unconvinced that this could actually work with children until I started doing it…I don't think there's an age that you can't use it with". Warren believed that hypnosis is "appropriate for everyone… [and] it's appropriateness is [not] on the basis of age". It appears then that the psychologists' preferences for working with specific age groups shape the way in which they viewed the applicability of hypnosis and hypnotherapy.

4.2 Perceived Advantages and Disadvantages

The psychologists that make use of hypnosis on an almost daily basis reported that hypnotherapy is a "wonderful tool" (Alis) that "can be used in many creative ways… [with] a very wide range of possibilities" (Charles). Some of the advantages they found in the technique is that it "works faster" (Joan), "saves time" (Marcie) "and money, and it's very powerful" (Charles). It creates a "safe place" for individuals where "they can …say things that they wouldn't normally" say (Alis). "You can really achieve dramatic results with it that [are] not possible with any other methods" (Charles). The psychologist "can work with past issues… [and] can also seed for the future …empowering your client" (Frank). They believed it is especially advantageous for children and adolescents, as children become "absorbed into [hypnosis] quite quickly" (Alis) and adolescents "really love it" (Mary) and are "very interested in doing it" (Joan).

One of the most significant benefits of hypnotherapy, which the psychologists agreed upon unanimously, is the speed in which it presents positive results. Marcie reflected that South Africa does not "have a wonderful health system, [and] most people can't afford therapy, so [the therapist needs to] try and make the biggest impact in the shortest amount of time". For those who cannot afford long-term therapy, hypnotherapy "saves time and [is] effective" in producing results "almost immediately" (Charles). When asked what disadvantages they found in the technique, their responses varied and they were often unable to provide any disadvantages. When they did propose a disadvantage, they provided a counterpoint to that disadvantage thus negating the disadvantage and showing how it could

be avoided. For instance, Warren stated that "parents often have anxieties around hypnosis". However, with proper psycho-education these anxieties can be alleviated.

4.2.1 Psycho-education: An initial key to success

While the psychologists stated various disadvantages related to working with hypnotherapy, these disadvantages all seemed to result from the misuse of the technique for various reasons. The respondents reported that, with the use of psycho-education, in which those involved in the technique were fully informed about the process and what to expect at all times, these disadvantages could be negated. For example, Alis reported that parents appear to believe that hypnosis is a "magic cure" for their children's problems. At times, parents seem to believe that hypnosis would act like a "doorway into what's going on in the child's life". Such parents thus want to do hypnosis not "to solve the problem" but rather to help them "find the truth". While parents seem to avoid hypnosis themselves, based on the perception that it would control them, they were nevertheless open to sending their children for hypnosis so as to control their child. Alis gave an example of this occurrence where the parents would "phone and say – my child is [on] drugs…he said he stopped, but I want you to do hypnosis to find out if …he's still using or who told him to use". Alis reported that this perception is disadvantageous for the child when his or her parents request help from therapists for what appears to be the wrong reasons. However, Alis stated that she will then "explain to them", and through adequate psycho-education, this belief can be shown to be false and the parents misconceptions corrected.

On the other end of the spectrum, "parents often have anxieties around hypnosis" (Warren) and are unwilling to let their children participate in this therapeutic technique. Parents play a vital role in their child's therapy process "because they can create a lot of resistance [which]… can spread to the child". It is important to get the parents to "buy into the process" (Mara) and "set their mind at ease" (Joan). In order to do this, the parents need to be psycho-educated around the process of hypnotherapy and what they can expect. At first, the therapist may need to avoid "words like hypnosis, [or] trance [as they] have got very strong connotations" (Frank). However, the psychologists all agreed that despite the fact that some parents may be anxious at first, "most parents, if they can be convinced of the advantages and that it's in the interest of their children, and that there is no danger of any harmful outcomes…[are] quiet satisfied" (Charles).

Overall, none of the psychologists have found parents to be "really resistant" (Alis) and as soon as you do some "psycho-education they're quite fine and …turn out to be impressed with the whole process" (Frank). The psychologists have never needed to allow the parents to sit in on one of their child's hypnotherapy sessions, as they are able to build up rapport with the parents. "If [the parents] trust you and the therapy process and [the psychologist] has a relationship with them, then it's okay" (Alis). On the other hand, if it is "not dealt with in a very safe and confidence-inducing manner" then the parents will become "very suspicious and very hesitant" (Charles).

Parents' resistance towards hypnotherapy was reported as being particularly evident where there are "very strong religious beliefs" (Frank). Parents are reportedly concerned that "it opens doorways to other states of consciousness that might influence the child, which is the truth, but not in a negative way" (Frank). Some religious groups, as reported by Charles, warn against the use of hypnosis. They are misinformed and think "it's of the devil, or it's not religiously acceptable. Or it goes against faith" (Marcie). Marcie said that "some people usually have very strong beliefs about it, and then I usually show them what I do and they're quite relieved and open about it". The psychologists felt that it was important to address these misconceptions with parents and to educate them on the use and benefits of hypnosis. The psychologists stated that they have never had an experience in which parents refused hypnosis once they had been adequately psycho-educated. However, if the parents continue to refuse, Frank stated that, "one has to then respect" the parents' wishes.

When dealing with traumatised individuals, the process of hypnosis can leave those involved "very open [to]…the trauma" (Mara). This was reported as a negative side effect of any therapeutic process, in which the client experiences a process of "emotional detoxing". The therapist "needs to…tell [the client] what they can expect and what to do [and]…give them…tools to deal with it". Linked to this is Marcie's view that "hypnosis…is sometimes quite frightening, because of the depth at which you are working at [and the client can] sometimes catch a fright and they don't come back". She said that although this needs to be "managed carefully", it is "not a disadvantage". Once again, with proper psycho-education, the general opinion was that this outcome could be avoided.

Another possible negative outcome, as expressed by the psychologists, is the idea that hypnosis can create false memories. However, they felt that if the psychologist educated their

clients about the process, this would not become a problem. Mara reported that she told her "clients … be very careful that… [if] something comes to you … in symbolism, not really as a complete event…it could just represent a feeling, thought, idea in a picture form…and it didn't necessarily happen to you". She felt that it was important that the client knows not to "take everything at face value". In addition, Alis reported that, because of the elicitation of imagery, hypnosis can be seen, at times, as "not reality-based" for the client. The client can then manipulate the process and use hypnosis as an escape mechanism. However, she said that it is then important for the therapist to ground the process for the client. The therapist would do this by making it clear to the client how the imagery relates to their current lives.

In general, the psychologists all reported that there are no real disadvantages to hypnotherapy. To summarise, the psychologists showed that the disadvantages they have mentioned can be dealt with through adequate psycho-education and training. The psychologists expressed the view that anyone making use of this technique needs to have a high level of competence in order to avoid any harm coming to the patient. With proper training, the psychologist can be prepared for all eventualities. This applies not only in the hypnotic process but in the therapy process as well. Charles stated that if hypnotherapy is "done by a therapist within the context of therapeutic assistance" then he sees "no disadvantages" to the technique. The psychologists all agreed: when dealt with competently, there are no drawbacks to hypnotherapy.

4.3 Application in South Africa

The participants were asked various questions in order to explore how they made use of hypnotherapy for children and adolescents in the South African context. This section examines the induction techniques they have used, the methods they have combined with hypnotherapy and the psychological disorders that they have treated using hypnosis, as well as those they felt hypnosis was unable to treat. In this regard, the overall findings are that the methods used in South Africa are based on methods that have been developed overseas and that were taught to the psychologists during their training.

4.3.1 Induction techniques

The psychologists used many different induction techniques when working with children and adolescents in order to induce a state of hypnosis. Below, in Table 4.2, is a list of the induction techniques that have been utilised by the South African psychologists in this study.

An explanation of each of these techniques has been given in the literature review in Chapter Two. What is important to note is that the psychologists emphasised that the type of technique selected depended largely on the child's age and developmental level.

Table 4.2: Induction techniques

• Arm Levitation	• Storytelling/ metaphoric
• De-levitation	• Fixation point/ Eye fixation
• Naturalistic induction	• Staircase induction
• Rapid induction	• Television induction
• Favourite place	• Progressive muscle relaxation

Alis reported that when working which children, she would make use of the "fantasy world", whereas with adolescents she would not attempt to ask them to "go on a magic carpet ride" (Alis) as adolescents avoid "going back into fantasy, imagery…or regressing to childhood stuff" (Mara). Therefore, when working with children, the imagery becomes more "concrete" whereas "with adolescents you can use very abstract" imagery (Joan). It was also emphasised that the induction technique needed to be "tailored…to your client's needs" and that it should incorporate some of their interests in order to engage them more thoroughly. The techniques also need to incorporate familiar imagery that the child can engage with and, as such, if a child has "never been to the ocean before, to introduce that as an imagery would be futile" (Frank).

4.3.2 Hypnotherapy as an adjunct to other therapeutic techniques

The participants were asked what therapeutic techniques they used in combination with hypnotherapy. Their responses are listed in Table 4.3 (below). Charles believed that while hypnosis "is a very handy method on its own", it "can enhance almost all other techniques". The psychologists also reported that they would frequently teach their adolescent clients' self-hypnosis so that they are able to relax themselves and give themselves positive suggestions for change. The psychologists might also give them a recording of a section of their session in which the psychologist provided them with positive affirmations that would serve to boost their self-esteem. They found that by doing this, they empower the adolescent and their own drive for mastery.

Table 4.3: Adjunctive techniques

• Somatic experiencing	• Narrative therapy
• Solution-focused therapy	• Cognitive behavioural therapy
• Assertiveness training	• Creative expressive art
• Ego state therapy	• Play therapy
• Rational emotive behavioural therapy	• Sand tray therapy
• Ego strengthening	• Self- Hypnosis

4.3.3 Psychological disorders treated (and not treated) by hypnotherapy

The psychologists were asked what psychological disorders they used hypnotherapy to treat and what psychological disorders for which they found hypnotherapy to be inappropriate. However, it was discovered that there were contradicting views in this regard. Some of the psychologists believed that hypnotherapy was inappropriate or ineffective in treating Attention-deficit/ Hyperactivity disorder (ADHD), behavioural disorders such as conduct disorders, trauma and children with a lowered level of cognitive functioning. However, some of the psychologists found hypnotherapy to be effective in these cases. Below, in Table 4.4, is a list of the conditions the psychologists treated used hypnotherapy, those they found hypnotherapy should not be used to treat, and the conditions where they reported mixed success.

Table 4.4: Psychological conditions treated, not treated and treated with mixed success

Treated	**Not Treated**
• Enuresis & Encopresis • Bereavement • Anxiety (separation, performance) • Nightmares & Fears • Low self-esteem • Depression • Learning problems • Stress • Divorce	• Severely dissociated children • Asperger's syndrome • Severe autism • Attachment disorder • Epileptic children • Psychotic children • Oppositional defiant disorder
Mixed Success	
• Attention-Deficit/ Hyperactivity Disorder (ADHD) • Severe Trauma • Behavioural Problems (Conduct disorder) • Low Cognitive Function Children	

Hypnotherapy was used with great success by all of the psychologists in the treatment of enuresis, bereavement, anxiety, and so on. On the other hand, the respondents generally agreed that hypnotherapy should not be used to treat clients who are psychotic or severely dissociated as "it can actually destabilise the client" (Frank) who is already "not in touch with reality" (Warren). The consensus was that children suffering from Autism, Asperger's or Attachment disorders do not benefit from hypnotherapy perhaps because they are unable to form an attachment to the therapist or "can't create resources…[as] they're not interested in connecting with themselves" (Mara).

The psychologists argued that hypnotherapy "can be threatening" (Alis) to children who have been traumatised as these children are very "vulnerable" (Marcie). However, half of the psychologists found hypnotherapy to be beneficial for children suffering from trauma. Also, more than half of the psychologists found that it was possible and beneficial to use hypnotherapy with children suffering from ADHD. They believed that while these children "don't sit still…they work with it" and "if you allow them to fidget, they will focus" (Mara). While it may be "a bit of challenge" (Joan), these children can also benefit from hypnosis and "it works very well" (Marcie). There are also "scripts [available] for [children with] ADHD" (Mary). It was also argued that children who are function poorly on a cognitive level would not be able to benefit from hypnosis. However, Joan said that she worked in a remedial school with children who have special needs and she "found that they went in just as beautifully". More than half of the psychologists said that they do not use hypnotherapy with children with conduct disorders as "there are control issues, so they don't go under hypnosis" because they are unwilling to relinquish that control. However, Joan reported success with adolescents with behavioural disorders. Therefore, the psychologists expressed mixed success rates with these conditions.

4.4 Ways in which Hypnotherapy has been Adapted in South Africa

4.4.1 Adaptation of language

The psychologists all felt that the "language and metaphors [they] use…needs to be age appropriate and …incorporate the language of the child" (Alis). This is important so that the child is able to understand the hypnotherapist. The language that you use with very young children needs to be "very concrete… [and] very simple" (Joan), whereas when you are working with adolescents, the language the therapist uses can be more abstract. However, the majority of the psychologists felt that they did not need to adapt this language themselves as

they were provided with age appropriate scripts they could follow where necessary. In addition, certain techniques do not incorporate much language use and involved inductions, such as arm levitation and eye fixation. However, the psychologists were very aware of the necessity to adapt language, as each child's "developmental age is different" (Mary).

It would also be important to adapt American words to a South African context, such as "fall" to "autumn" and "gas" to "petrol" (Mary). While older children might understand the concept of an earthquake, children who are more concrete and who have never been exposed to an earthquake in South Africa are unlikely to understand metaphors around trauma that are represented by an earthquake. In addition, Marcie reported that "words like depression [are] difficult to put into an African context [as in their culture] there isn't actually a word for it". Instead, words like 'depression' need to be changed to words such as 'sadness'.

4.4.2 Adaption of induction techniques

When working with children, the psychologists said that they used techniques that were more "simplified", such as storytelling and metaphors. With adolescents, they could use music, poetry and methods that are more abstract. When adapting techniques to young individuals, the psychologists took into account the age of the individual, their developmental level and their interest. When asked how they adapted their techniques to a South African context, the response was largely that they did not feel they needed to. They felt that "the key factor [was] whether [they] were understood or not" (Charles). Therefore, if the child was familiar with the imagery, the psychologists felt there was no need to adapt the technique. Marcie feels that the psychologist needs to "make sure that [the technique is] appropriate to the environment that the child comes from. If it's a very deprived environment they aren't going to know what a superhero is" and, therefore, the psychologist would need to use a different technique.

The psychologists made sure, in their initial intake interview, to get a sense of the interests of the child and any superhero's they favoured. For example, "if you work with children that have very little exposure to stories like Aladdin… you would need to adapt" the technique and avoid techniques that incorporate the "flying carpet" as they "wouldn't be able to respond to that" (Frank). The psychologists ensured that their inductions are appropriate to the environment that the child comes from. Techniques such as "eye fixation works well for all kids" (Frank). Due to the increase in mass media, the psychologists felt that children are

increasingly exposed to western culture and ideas outside of South Africa and, as such, it is not as essential to adapt the techniques used. Joan reported one way in which she would adapt her technique to suit African children. She said that she would ask the client what his or her inner strength looked like and said "perhaps it's an ancestral voice, perhaps it's an ancestor". In this way, she would adapt the technique to include the individual's culture. Joan was the only psychologist to report an adaptation of this kind.

4.5 Influence of Cultural Factors on Hypnotherapy in South Africa

A significant finding was that five out of the eight participants who had experience in working with black individuals found that "black people in general are quite easy hypnotic subjects" (Alis) and they "respond very well to hypnosis" (Frank). They seem to "just go into a trance so much easier than other" races (Frank). Mary stated that "it's so much a part of their culture" that it seems to be far easier for them. It therefore seemed to "fit in quite well with the black culture, where they have rituals related to forefathers, [ancestors and trance]…and it fits into that perspective, it actually works very well" (Charles).

The therapists are also in agreement that hypnotherapy will be equally successful in the language of another race or culture and that it would perhaps be more beneficial if hypnotherapy was done in the individual's first language. Alis found that when using hypnotherapy with Afrikaans speaking clients "they will switch to [Afrikaans] when there is more emotional stuff" that emerges. Warren felt that "culture or language should [not] be a barrier to" hypnotherapy.

4.6 Ethical Practise versus Exclusivity

Alis stated that "maybe [the therapist is] not trained in ego state therapy, [and] it could happen that there are malevolent ego states that you can be activated by using hypnotherapy" and Warren believed that "if your clinical training is limited, the kinds of selective inputs you [are able to] give are very limited". Therefore, before attempting to do hypnotherapy, the participants unanimously agreed that the individual had to have a firm "grounding in psychology" (Frank).

All eight participants were strictly against individuals without any psychological background being allowed to use hypnotherapy and found this unacceptable. They felt that in order to do hypnotherapy, the individual "should be well-versed in the psychology of the

mind" (Charles). They believed that it is very dangerous when "people that are trained in hypnosis [and not in psychology or therapy]… use it therapeutically" (Joan). Although these individuals may be able to induce hypnosis and uncover traumatic events, they are often incapable of appropriately helping these individuals deal with their issues. They may be able to "open a can of worms, [which is] not difficult, but what [they] do with it requires clinical skills" (Marcie). The participants strongly expressed the view that the use of hypnotherapy by individuals untrained in psychology is highly unethical and dangerous, and reported "countless… clients who have come in from bad experiences with non-qualified hypnotherapists who are in pieces and some of them have been admitted and have breakdowns" (Mara).

Mara argued that this "is not [based] on ego[tistical ideals]….it's not about exclusivity of psychologists…it's at the end of the day an ethical human responsibility". She continued to say that even though she is a qualified psychologist, there are many things she is "trained in that [she doesn't] practise, because [she] is not so au fait with it". According to the participants, if an individual is not properly trained in therapeutic skills, then, from an ethical standpoint, he or she should not be allowed to do therapy. Without this therapeutic knowledge and skill, "they do damage" (Marcie). Charles offered a few simple examples in which a lack of training can cause harm:

> "One very simplistic illustration which is a real possibility:… someone untrained may say, "Okay, you're feeling pain, I will just give you a post-hypnotic suggestion to take away the pain." And then the pain was a significant alarm of some medical condition that needed urgent attention. So now the alarm is gone, the person [doesn't] experience any pain anymore and he may die as a result of that, because he's not getting medical attention…you can give someone a suggestion that is directly in conflict with some of his values… and send him away and he would have tremendous conflict. It may then result…in a terrific headache, or migraine, and he doesn't know where it comes from, so he doesn't come back …Now he just suffers from headaches. So, there are numerous possibilities like that if you don't properly bear in mind the context in which you're putting the post-hypnotic suggestion and the possible consequences, and that's only training that can prevent that."

4.7 Conclusion

The results indicate the perspectives and opinions of the psychologists who participated in this research. The psychologists each provided a definition of hypnotherapy that served as the foundation for their understanding of hypnotherapy in South Africa. Their opinions varied regarding the ages and conditions for which hypnotherapy could be used. These opinions seem to have been shaped by their own training and experiences. The psychologists also felt that, with adequate training and psycho-education, all possible disadvantages of the technique could be mitigated. They emphasised that individuals who had a background in the psychology of the mind should undertake this training and that damage to the client could result without such knowledge. The participants all felt that hypnotherapy was a useful tool to apply to children and adolescents in a South African context, using similar methods to those used overseas. They felt that they did not have to adapt the method to the South African context but did make minor changes to language and utilised imagery that the child or adolescent would recognise. Most of the psychologists felt that black South Africans were more responsive to hypnotherapy, and seemed to believe this was a result of their cultural backgrounds.

Chapter 5: Discussion

This chapter provides a discussion of the implications of the findings of this research and links these findings to previous work undertaken regarding the topic. The chapter explores how certain perspectives on hypnotherapy have shaped understandings thereof, how hypnotherapy has been applied in South Africa, how it continues to adhere to foreign practises, the cultural implications of its use and, finally, the influence of belief on the effectiveness of hypnotherapy.

5.1 Understanding Hypnotherapy and its Application: A Matter of Perspective

The word 'perception' is defined as the "mental process by which all kinds of data; intellectual, emotional, and sensory; are meaningfully organised" (Sadock & Sadock, 2007, p. 281). It is through one's perception of an object, concept, method or idea that one's view of that stimulus is shaped; this determines how one will perceive that stimulus. The meaning and significance of an object for each individual is thus framed by the individual's experience, knowledge, thoughts and emotions (Sadock & Sadock, 2007). Therefore, the individual's subjective realities are constructed out of their perceptions of their world (Mende, 2009). Throughout this study, it was evident that the participant psychologists' views regarding hypnosis and its potential application were shaped largely by their own perceptions, perspectives, beliefs, preferences and/or competencies.

From the literature, it is evident that hypnosis and hypnotherapy can be applied to children and adolescents of all ages. The methods by which it is applied, however, vary according to age group, and thus needs to be adapted (Kohen & Olness, 2011; Wester & Sugarman, 2007). Nevertheless, half of the psychologists interviewed as part of this study believe that there are certain age groups for which hypnotherapy could not be applied. On closer examination of their reasoning for this, it was discovered that the psychologists' views regarding the age-appropriateness of hypnotherapy correlated with their preference for utilising hypnotherapy for a specific age group. While this may be a direct result of their belief that hypnotherapy is not applicable to children outside of those age ranges, it seems equally likely that their beliefs have restricted their use of hypnotherapy to only those ages with which they apply hypnotherapy. Their own competencies, sense of comfort and confidence levels could thus be key in determining how they view the applicability of hypnosis and hypnotherapy. These learned limitations or restrictions do not reflect the true

limitations of hypnotherapy; instead, they have developed from their own training and experience. Their own beliefs thus appear to shape their practise.

The way in which their perceptions have shaped their practises is again evident when examining the psychological disorders for which they think hypnotherapy is applicable. The psychologists identified certain psychological disorders that they think are either treatable or untreatable with hypnotherapy. However, the data showed that there is not always agreement among the psychologists. The psychological conditions for which mixed success rates, or disagreement, were reported are: Attention-Deficit/ Hyperactivity Disorder (ADHD), severe trauma, behavioural problems (particularly conduct disorder) and lower levels of cognitive functioning. Some psychologists believed that these problems could not be treated with hypnotherapy, whereas others indicated that their experience demonstrated that these conditions could be successfully treated with hypnotherapy, albeit with perhaps greater difficulty. The literature review showed that hypnotherapy has been used with success in all four of the above-mentioned cases (Kohen & Olness, 2011; Wester & Sugarman, 2007).

Thus, the psychologists' perspective, training or experience seems to have shaped their views on the applicability of hypnotherapy, not only in terms of the ages for which they feel hypnotherapy is appropriate, but also for the presenting problems that it can be used to treat. This was evident in the mixed successes they reported. It is possible to argue that their own confidence levels and expertise in working with certain age groups and in treating certain conditions have shaped their beliefs. The educational psychologists interviewed in this study all felt that there was no age restriction on the application of hypnotherapy, and reported far fewer conditions for which it could not be utilised with success. Their specialised experience in working with children as part of their undergraduate degree studies may have enhanced their competence in working with children of all ages and all conditions. They have more specialised experience in these areas and this results in their belief that hypnotherapy is not as limited as the other psychologists believed it to be. Warren, a clinical psychologist, agreed with the view of the educational psychologists. His opinion may differ from the other counselling and clinical psychologists because he has partaken in training workshops more recently.

The psychologists' perceived limitations, which seem to be a product of their own level of experience and training, are not entirely negative, as they serve to ensure that the

psychologists refrain from working outside of their own level of competence. All the psychologists who were interviewed emphasised the importance of the fact that hypnotherapy should only be utilised by trained professionals who have expert knowledge in the psychology of the human mind. They noted that, without such competency, the practitioner could cause severe damage and even psychological breakdown, on the part of patients. They also noted that even qualified psychologists should not practise out of their own field of competence and should thus refrain from using therapeutic methods with which they are not completely proficient. This belief echoes that put forward by Wester and Sugarman (2007) in the literature. With further training, and greater mastery in the techniques of hypnotherapy, the psychologists may expand their views on the ages and conditions for which they believe hypnotherapy to be appropriate. Therefore, sufficient training in both hypnotherapy and psychology is essential for its proper use.

In order to pre-empt certain drawbacks, the therapist needs to have extensive training in hypnotherapy. As previously mentioned, the participants in this research all believed that the use of hypnotherapy by under-qualified practitioners should be strictly prohibited. The psychologists express this view not because they are attempting to keep hypnotherapy exclusively under their domain, but because of their awareness of the damage that can occur without such psychological and therapeutic training. They have had countless experiences in which individuals have come to them after suffering at the hands of under-qualified hypnotherapists. It appears that, in order to protect individuals, a minimum training requirement needs to be specified.

5.2 Use of Hypnosis in South Africa

This research has found that hypnotherapy is a beneficial tool that psychologists can utilise with children and adolescents in South Africa. It creates a safe space for individuals to express themselves. It is also rapid and thus reduces time in therapy. It can also bring about relaxation and alter negative behaviours and beliefs. Finally, it has been shown that adolescents love it and that children respond easily to it. The benefits that the participant psychologists have experienced, as reported in this study, correlate strongly with those suggested in the literature (Kohen & Olness, 2011; Wester & Sugarman, 2007). Therefore, the application of hypnotherapy in South Africa has been shown to be of value to those psychologists who apply this technique in their practises. The psychologists indicate that

there are no disadvantages to this approach if the psychologist is adequately trained and the client is sufficiently educated.

Half of the participants completed their postgraduate degree at the University of Johannesburg (UJ), two at the University of South Africa (UNISA), one at the University of Natal and one at the Medical University of Southern Africa (Medunsa). Therefore, the majority of the participants completed their postgraduate degree at UJ and went on to further their studies in hypnotherapy. However, no psychologists from the University of the Witwatersrand (WITS) were sampled. The University of the Witwatersrand adopts a psychodynamic training model, whereas the University of Johannesburg adopts an eclectic approach. Perhaps the reason for the majority of the sample being drawn from UJ graduates is the fact that the training UJ graduates receive includes multiple approaches which renders them more comfortable in seeking out and incorporating new and varied approaches. In contrast, the University of the Witwatersrand specialises in psychodynamic techniques; as such, psychologists qualifying from this university seek to expand their knowledge on psychodynamic techniques in order to enhance their expertise in this approach. They are, as a result, perhaps less comfortable working outside of this niche.

As discussed in the literature review, there are numerous misconceptions surrounding hypnosis and hypnotherapy. If not properly addressed, these misconceptions can negatively affect the therapeutic process (Kohen & Olness, 2011). The psychologists interviewed in this study experienced a number of these misconceptions in their own practises. For example, some of their clients may have felt that hypnotherapy could be used to control them. However, the psychologists felt that, through psycho-educating parents and their children, they were able to correct these misconceptions and build up client confidence in the technique. Through psycho-education, the participants believe they can: remove fears and anxieties, inform participants about the process and what to expect in order to prepare them, ensure that individuals do not acquire false memories, and rectify any other misconceptions that clients may have regarding hypnotherapy. All eight participants reported that hypnotherapy is extremely beneficial as an additional therapeutic tool in South Africa. Therefore, the acceptance of hypnotherapy for children by parents rests on the skill of the clinician in adequately psycho-educating them.

One of the most significant benefits of hypnotherapy within a South Africa context is the rapid pace at which positive results appear, for both children and adolescents. Some of the psychologists felt that health systems in South Africa are ineffective. Often, medical aid schemes do not cover therapy and, as such, individuals must pay for their own therapy, which becomes an additional and burdensome expense. Individuals who do not have surplus funds often cannot afford long term therapeutic interventions for their children. Therefore, the psychologists felt that, using hypnotherapy, they were able to provide their clients with significant results within the short amount of time they had available to them. In this way, hypnotherapy seems particularly suited to use in South Africa.

5.3 Adherence to Foreign Hypnotherapy Practices

The participant psychologists' understandings of hypnotherapy appear to be built on particular theoretical foundations. These foundations shape their understanding of hypnosis and the way in which it is used. It would appear that South African clinicians have adopted foreign practises rather than adapting these practices to suit the South African context. The psychologists interviewed as part of this study felt that they did not need to adapt hypnotherapy to the South African context to any significant degree. At times when they felt minor alterations were necessary, these alterations involved adapting their language according to the child's age, or using imagery appropriate to the child's experiences. Apart from this, it seems that the practice of hypnotherapy adheres to western practises and training methods. The psychologists followed scripts out of western textbooks (such as 'Harry the Hypno-potamus: Metaphorical Tales for the Treatment of Children' by Linda Thomson, and 'Scripts and Strategies in Hypnotherapy with Children' by Lynda Hudson); their induction techniques included standard arm levitations, storytelling, favourite places, eye fixations, and so on, as were set out in the literature (Kohen & Olness, 2011). Determining whether or not this is the best approach requires further research. However, it has been demonstrated that, despite their distant origins, these techniques remain beneficial.

However, adaptation of hypnotherapy and its techniques may prove even more beneficial in the South African context. The participant psychologists reported the use of induction techniques and adjunctive therapies similar to those used overseas with little, if any, adaption. For example, one psychologist reported that she might adapt the language of the scripts she used, changing American terms to South African terms, such as 'fall' to 'autumn' and 'gas' to 'petrol'. The psychologists also displayed an awareness of the need to

avoid metaphors that children may not understand, such as metaphors that incorporate earthquakes. Apart from these few examples, hypnotherapy seems to have been applied in a manner closely representative of the methods employed internationally. Wester and Sugarman (2007) emphasise the requirement that psychologists are flexible and creative in their approach in order to adapt techniques to children's developmental levels; however, specific adaptations for different countries and cultures have not been examined. While Kohen and Olsen (2011) report numerous studies conducted internationally, the application of hypnotherapy in these contexts has not been discussed. Nevertheless, South Africa is a diverse and multicultural society. Perhaps then, the development of techniques that are unique to the South African context will be more beneficial.

5.4 Cultural Implications

Three quarters of the psychologists interviewed as part of this study felt that black individuals are more easily hypnotised than other cultures and/or races. This finding needs to be explored in further research. The participant psychologists hypothesised that this may be a result of a cultural background, in which states of trance are utilised in order to converse with ancestors. However, it would be unfair to generalise in this way across all black individuals, and research needs to take into consideration the various African cultures that exist rather than make sweeping statements applying such findings to all black individuals. Perhaps one explanation for this is the question of belief. An individual's belief in the effectiveness and benefit of hypnotherapy can significantly improve their responsiveness to the technique. As seen in the literature, individuals who are resistant to hypnotherapy are unable to be hypnotised as a result of this resistance (Kohen & Olness, 2011). Again, the validity of this finding can only be demonstrated through further research.

A study conducted in Bali revealed that hypnosis was highly effective in the treatment of children suffering from Post-Traumatic Stress Disorder (PTSD); the authors thus concluded that hypnosis has significant potential for therapy in other cultures (Lesmana et al., 2009). Kohen and Olness (2011) conducted an investigation into the training of hypnosis in Thailand for the reduction of pain in children suffering from cancer, and related procedures, for whom anaesthesia was unavailable. This investigation found that hypnosis was successfully implemented in this culture and proved beneficial in that it helped Thai children manage their pain (Kohen & Olness, 2011). Many more studies have been conducted regarding the use of hypnotherapy in different cultures, including one conducted in China,

which showed that hypnosis allowed patients to overcome their aversion to dealing with their emotions (Huang, 2008). However, few of these studies report on the applicability of the technique to children and adolescents. While hypnotherapy has proven to be beneficial in many cultures worldwide, there are currently no documented reports on the varying degree of ease with which members of specific cultures enter into a hypnotic state.

5.5 Belief: Its Influence on the Acceptance and Success of Hypnotherapy

Kohen and Olness (2011) report on the successful implementation of hypnotherapy with children in countries such as Germany, Norway, Sweden, France, England, Thailand, Bali, Canada, Australia, Italy, Indonesia, Saudi Arabia and Turkey. Professionals in these areas are reported to have "contributed substantial research related to hypnosis with children" and adolescents all of which reports positive results in this regard (Kohen & Olness, 2011, p. 400). For example, a study conducted in Norway found hypnotherapy to be beneficial in the treatment of children suffering from enuresis (Diseth & Vandvik, 2004), and research in the United Kingdom confirmed that children and adolescents with learning disabilities were receptive to hypnotic techniques and could therefore benefit from this approach (Hughes, 2000). In addition, a study done in Australia emphasised that hypnotherapy could be applied to children and adolescents of all ages, as long as the technique was adapted to meet the child's developmental level (Lipsett, 2003). However, in South Africa, hypnotherapy is still developing and further research is needed. However, the findings of this research indicate that the benefits of hypnotherapy for children and adolescents, as experienced overseas, are also evident in South Africa. It appears then that the positive belief in the effectiveness of hypnotherapy for children and adolescents overseas is also found in South Africa. Therefore, South African children are responsive to hypnotherapy and show the ability to enter into a state of hypnosis, similar to children overseas. As demonstrated by the literature, individuals cannot be forced into hypnosis; instead, willingness to enter into such a state plays a significant role. A belief in hypnotherapy and its benefits is thus essential to its effectiveness.

Chapter 6: Conclusion

6.1 Research Findings

The findings of this study suggest that hypnotherapy is a beneficial therapeutic technique for children and adolescents in South Africa, as experienced by practising psychologists. The methods incorporated by these psychologists largely adhere to foreign methods of practise, and little or no adaptations have been made to these techniques for the South African context. Understandings of hypnotherapy and the way in which it is applied appears to be shaped by the psychologists' own perceptions and levels of competency. Some of the psychologists expressed the view that hypnotherapy was not suitable for use with certain ages or with certain presenting problems. However, other psychologists did not find this to be the case. Therefore, psychologists' own training and experiences seem to limit their practises rather than this being reflective of inherent limitations in hypnotherapy. However, these perceptions and experiences ensure that psychologists do not attempt to practise outside of their own level of competence and thus serve to maintain ethical standards of practise. The participants believe that insufficient qualification regarding the psychology of the mind and the practise of hypnotherapy can be extremely harmful to the client, and that such under-qualified individuals should not be allowed to practice. It was also found that, just as there are generally favourable opinions regarding hypnotherapy overseas, so too are such favourable opinions to be found in South Africa. Positive beliefs regarding hypnotherapy and its effectiveness are essential for the technique to be successful. More than half of the psychologists felt that black individuals are more easily hypnotisable and that this may be as a result of their own belief systems, which favour trance.

6.2 Limitations of Current Research

Although eight participants were sufficient to yield enough data for the purpose of this research report, a wider sample and a greater variety of participants may have generated markedly different themes. While the researcher discovered more than eight qualified psychologists who utilise hypnotherapy with children and adolescents in South Africa, the researcher struggled to find participants who were willing to participate in the study. A number of participants, after having first agreed to participate in the research, later withdrew from the research. They reported that they were too busy to participate in the research at that time. The individuals who did participate appeared to be more open to being interviewed and displayed enthusiasm for hypnotherapy. Because interviews rely on the honesty of the

participants, it could be argued that the psychologists' perceptions of the technique were biased in favour of hypnotherapy and they therefore may have omitted information that would present hypnotherapy in a negative light (de Vos, Strydom, Fouché, & Delport, 2011). A further limitation of one-on-one interviews is that the researcher may have asked questions that did not elicit the desired responses from the participants or that participants may have misunderstood the questions (de Vos et al., 2011).

Time constraints were also a limitation, as it was a requirement that this study be completed within a set timeframe in order to meet academic stipulations. The time limit thus directed the focus of the study to a significant degree. If the researcher had not been limited by completion time, it may have been possible to focus on specific aspects of hypnotherapy in South Africa, such as its use in the treatment of trauma or anxiety for children and adolescents. In addition, it may have been possible to interview individuals who had undergone hypnotherapy in order to gather their personal perspectives on the technique.

6.3 Suggestions for Future Research

There is a lack of documented research on hypnotherapy for children and adolescents in South Africa and, as such, there remains a significant amount of research that can be done in this area. While there are vast amounts of published research reports from overseas countries, it would appear that South Africa is falling behind in this regard. By extending the field of knowledge regarding hypnotherapy, further benefits of this technique may be discovered, which will assist South African educational psychologists in applying this technique to children and adolescents, but will also promote the training of the technique and recognition of its usefulness for therapy.

There are numerous directions for possible future research. One significant finding of this study is that black South Africans appear to respond more easily to hypnosis as compared to individuals from other race groups. Therefore, it would be of benefit to conduct further research on this phenomenon. Such research would uncover whether this is a result of cultural influences (such as an existent belief in trance-like states and communication with ancestors), or a result of experience with such states of trance, or the result some other, more significant factor. A comparison should thus be undertaken on hypnotic responsiveness of various cultures in South Africa in order to ascertain if significant differences in this regard exist. Not only would this improve the application of this technique for South African

educational psychologists and other practitioners, but it would also increase the benefits experienced by South African children and adolescents.

Future research should also be conducted regarding the use of hypnotherapy for more specific psychological disorders in children and adolescents and should focus, for example, on the use of hypnotherapy for trauma among South African children and adolescents. In addition, research should be conducted on the ways in which hypnotherapy can be adapted to the South African context in order to move away from foreign methods of hypnotherapy, where possible. Research could also delve into the harmful outcomes of hypnotherapy for children and adolescents when practised by under-qualified individuals.

6.4 Concluding Remarks

It was previously thought that children were unresponsive to hypnotherapy and that it was not an appropriate treatment method for them. However, research conducted over the past 200 years has proven this to be false. Countless studies on the success of hypnotherapy with children and adolescents have been conducted in overseas countries such as Bali, Turkey, Saudi Arabia, Australia, etcetera (Wester & Sugarman, 2007). However, there appears to be no documented research on the use of this technique with children and adolescents in South Africa. The findings of this research suggest that hypnotherapy is a beneficial therapeutic technique for children and adolescents in South Africa and has been applied as such by a number of psychologists. While the psychologists' opinions differed regarding the ages and conditions for which hypnotherapy could be applied, this seemed to be based on their personal experiences and success rates. The educational psychologists who specialised in treating children and adolescents found no limitations to the technique and were more confident in its application across age groups. Overall, "hypnotherapy is a valuable technique to implement to have children remain focused, recall memories, identify core issues, change behaviours and access a deep level of healing" (Geniti, 2004, p. 75).

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Appendix I: Participant Information Sheet

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Private Bag 3, Wits 2050, Johannesburg, South Africa
Tel: (011) 717-4500; Fax: (011) 717- 4559
Email:018lucy@muse.wits.ac.za

Dear Participant

Good day, my name is Janine Leask, and I am conducting research for the purpose of obtaining my Masters at the University of Witwatersrand. My research revolves around the use of hypnosis and hypnotherapy for children and adolescents. This technique has been largely unused to treat patients seeking therapy, yet the literature seems to suggest that there are numerous benefits to this technique. The research aims to explore the perspectives of qualified psychologists on the use of hypnotherapy for children and adolescents in their own practices and what experiences they might have had. We would like to invite you to participate in this study.

Participation in this research will entail being interviewed by myself, at a time and place that is convenient for you. The interview will last for approximately one hour. With your permission, this interview will be audio recorded in order to ensure accuracy. Participation is voluntary, and no person will be advantaged or disadvantaged in any way for choosing to participate or not participate in the study. All of your responses will be kept confidential, and no information that could identify you would be included in the research report. The interview material (recordings and transcripts) will not be seen or heard by any person in the organisation at any time, and will only be processes by myself. Once the data is collected it will be kept in a locked cupboard and kept for a period of two years if unpublished and six years if published. You may refuse to answer any questions you would prefer not to, and you may choose to withdraw from the study at any point.

If you choose to participate in the study, please fill in your details on the form below and return it to the researcher at you earliest convenience. I will contact you within two weeks in order to discuss your participation. Alternatively, I can be contacted telephonically at 072 013 3191 or via email at j9leask@gmail.com.

Your participation in this study would be greatly appreciated. This research will contribute both to a larger body of knowledge on hypnotherapy for children and adolescents, as well as to a broadened recognition of hypnotherapy as a therapeutic technique of value. This may help increase the comfort around and use of this technique in solving patient's issues. If you would like I can forward you a summary of the research report once completed on your request.

Kind Regards,

Janine Leask

Supervisor: Dr Zaytoon Amod
zaytoonisha.amod@wits.ac.za

Appendix II: Consent Form (Interview)

I_____ consent to be interviewed with Janine Leask for her study on Hypnotherapy for Children and Adolescents. I understand that:

- Participation in this interview is voluntary.
- That I may refuse to answer any questions I would prefer not to.
- I may withdraw from the study at any time.
- No information that may identify me will be included in the research report, and my responses will remain confidential.

Signed _____.

Date _____.

Appendix III: Consent Form (Audio Recording)

I_____ consent to be interviewed with Janine Leask for her study on Hypnotherapy for Children and Adolescents being audio-recorded. I understand that:

- The recordings and transcripts will not be heard by any person in this organisation at any time, and will only be processed by the researcher.
- All tape recordings will be destroyed after a period of two years if the research report is unpublished or six years if published.
- During this time, the recordings will be kept in a locked cupboard.
- No identifying information will be used in the transcripts or the research report.

Signed _____.

Date _____.

Appendix IV: Interview Questions

Brief Pre-interview Questionnaire

Name: _____

1) What is your category of registration?

   _____

2) Where did you study?

   _____

3) What model of training did your course take?

   _____

4) How many years have they been in practise for?

   _____

5) How long have you been using hypnotherapy in your practise?

   _____

6) Where did you study Hypnotherapy?

   _____

7) How many children have you used hypnotherapy on?

   _____

8) How many Adolescents have you used hypnotherapy on?

   _____

Interview Questions

Views on hypnotherapy

1) What is your understanding of hypnosis?
2) What is your understanding of hypnotherapy?
3) In your view, what are the advantage of hypnosis and hypnotherapy?
4) In your view, what are the disadvantages of hypnosis and hypnotherapy?
5) What ages, if any, do you find that hypnotherapy seems inappropriate?

   For example, 3 to 6 years old who have trouble expressing themselves verbally
6) In your view, what are the advantage and disadvantages of hypnosis and hypnotherapy for children?
7) In your view, what are the advantage and disadvantages of hypnosis and hypnotherapy for adolescents?
8) Do you believe anyone trained in hypnosis can use it for therapy on others?
9) Have you found that certain approaches in hypnotherapy may inhibit therapeutic progress

Methods Used

10) What techniques do you combine with hypnotherapy?
- For children?
- For adolescents?

11) What conditions in children do you find it in inappropriate to use hypnotherapy for?
- Are these the same for adolescents?

12) Have you experienced any difference in applying hypnotherapy with children as compared to adolescents?
13) Do you teach the patient self-hypnosis?
14) How do you adapt you language to children of different ages?
- Children?
- Adolescents?

15) In what other ways do you have to adapt your technique to children with different ages?
- Children?
- Adolescents?

16) What criteria do you look for to decide if a child is suitable for hypnotherapy?
- Adolescents?

17) What type of induction techniques do you use?

- Children?
- Adolescents?

Adaption to SA context/ Culture/ Language

18) Have you needed to adapt your induction techniques to a South African context?
19) What cultural difference have you encountered, if any?
20) Do you think that hypnotherapy is possible with patient whose first language isn't in English
21) Do you think hypnotherapy can be done in another African language

Views of patient & parents towards hypnotherapy

22) How much parental involvement is needed for therapy to be successful?
23) How do parents respond when you suggest that their children should undergo hypnotherapy?
24) What responses do you get from patients towards hypnotherapy

Issues encountered, advantages, disadvantages, usefulness

25) What sort of issues have you used hypnotherapy to treat?
- In children?
- In adolescents?

26) What sort of outcomes do you expect and over what period?
27) What issues have you encountered with the use of hypnotherapy
28) Is there anything that you need to specifically avoid when working with…
- Children?
- Adolescents?

29) What was your most significant experience when implementing hypnotherapy
- In relation to children?
- In relation to adolescents?

30) Can you provide me with a specific case example (leaving out any identifying information) in which through hypnosis you were able to find the underlying cause of the child's presenting problem? Adolescents?

Appendix V: Supervision Contract

Appendix VI: Ethical Clearance Letter