Hypnosis and Hypnotherapy with Children

Fourth Edition

Daniel P. Kohen and Karen Olness

Sample Chapter
Hypnosis and Hypnotherapy with Children

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## Contents

Note to the Fourth Edition vii

Introduction ix

### Part I  Hypnosis With Children

1 Scenes of Childhood 3

2 Early Uses of Hypnosis With Children 7

3 Norms of Hypnotic Responsivity in Children 19

4 Correlates of Childhood Hypnotic Responsiveness 35

5 Hypnotic Induction for Children: Techniques, Strategies, and Approaches 55

### Part II  Hypnotherapy With Children

6 General Principles of Child Hypnotherapy 89

7 Therapeutic Communication: Uses of Language and Facilitating Effective Hypnotherapeutic Relationships 101

8 Hypnotherapy for Psychological Disorders 113

9 Hypnotherapy for Youth With Autism Spectrum Disorders 159

10 Hypnotherapy for Habit Disorders 167

11 Hypnotherapy for Problems in Learning, Performance, and Attentional Disorders 207

12 Hypnotherapy for Pain Control 225

13 Hypnotherapy for Pediatric Medical Problems 245
Contents

14 Hypnotherapy for Pediatric Surgery and Emergencies 317
15 Hypnotherapy in Palliative Care, Grief, and Bereavement 347
16 Biofeedback, Other Mind–Body Interventions, and Hypnotherapy With Children 367
17 Self-Hypnosis: A Tool for Prevention and Prophylaxis 379
18 Psychoneuroimmunology 385
19 Applications of Hypnosis With Children Globally 397
20 Ethics: Legal Considerations, Children, and Hypnosis 403
21 Teaching Child Hypnotherapy 407
22 Looking to the Future 423

Appendices 435
References 467
Author Index 513
Subject Index 531
General Principles of Child Hypnotherapy

We will now review techniques and results of hypnotherapy for a wide range of childhood problems. Most published accounts of hypnotherapy for specific childhood problems include some general comments concerning principles, indications, contraindications, and pitfalls of this therapeutic modality. A few papers (Call, 1976; Erickson, 1959; Kaffman, 1968; Olness & Kohen, 1984; Williams & Singh, 1976; Wright, 1960; Wright & Wright, 1987) have focused directly on basic issues. To avoid repetition in succeeding chapters, we devote this chapter to a discussion of general principles of child hypnotherapy. Some of our thoughts are shared by most people in the field, whereas others will provoke varying degrees of controversy.

Definition and Boundaries of Hypnotherapy

Hypnosis and hypnotherapy are two different entities. Hypnosis is an altered state of awareness that may have certain temporary beneficial effects, such as tension reduction, but it is not in itself designed for that purpose. Hypnotherapy is a treatment modality with specific therapeutic goals and specific techniques utilized while the patient is in the state of hypnosis. We also distinguish between a hypnotist and a hypnotherapist, for these terms are often confused in the context of clinical work.* A hypnotist—often found listed in the classified advertisements of newspapers or in the yellow pages of the telephone directory under “Hypnotists”—may be a person with limited education whose only skill is the use of hypnosis and who accepts virtually everyone for treatment. Although such people may get some good results—otherwise they could not stay in business—they may engage in indiscriminate use of their one skill, sometimes with unfortunate results.

A hypnotherapist is, first of all, a therapist. A child hypnotherapist has advanced training in one of the child health professions and uses hypnotherapeutic techniques as part of a comprehensive approach to the diagnosis and treatment of certain disorders. In this context, it is a good rule of thumb that one should not attempt to treat a problem with hypnotherapy unless one

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* We do not mean to imply that the term hypnotist always has a negative connotation; for example, in research on various hypnotic phenomena, the scientist who does a hypnotic induction and explores the subject’s hypnotic behavior is a hypnotist, not a hypnotherapist. Use of the terms coach or instructor may be preferable to use of hypnotist.
is also competent to assess the problem and recommend other therapists if appropriate. When parents ask us about hypnotists, we do our best to educate them with regard to these distinctions.

We believe that the practice of hypnotherapy with children should be limited to health professionals who typically assume primary responsibility for treating children’s problems, including, for example, child psychologists, pediatric social workers, psychiatrists, dentists, pediatricians, pediatric nurse practitioners and clinical nurse specialists, child life specialists, and other physicians and surgeons who work with children. Other appropriate child health specialists who might well incorporate and integrate hypnotherapy in their therapeutic work include pediatric occupational therapists, pediatric physical therapists, speech pathologists, and nurse anesthetists. Furthermore, these professionals limit hypnotherapeutic work to their own areas of competence. This does not mean that a psychologist should never treat pain with hypnotherapy. It does mean that the psychologist who does so is also competent to treat pain with other methods (e.g., supportive psychotherapy or biofeedback).

Increasingly, nurses, physical therapists, speech pathologists, and other child health specialists utilize hypnotherapy in the context of their specialty practice, either in the context of a multidisciplinary team or practice or in an independent private practice. If their practice is performed under the supervision or responsibility of a physician, dentist, or psychologist, then their use of hypnotherapy should also be conducted under the direct supervision of a health professional with appropriate competency in the use of hypnotherapy.

Goals of Hypnotherapy

People who come to us requesting hypnotherapy begin by saying, “I have a problem.” Often they really mean to say, “A problem has me.” That is, they perceive themselves as having been rendered passive and helpless, the victim of a situation over which they have virtually no control. Previous therapeutic efforts either have been of limited value or have contributed to the patient’s passive–dependent stance by forcing continued reliance on external powers such as machines and medication.

The goal of hypnotherapy is always to teach the patient an attitude of hope in the context of mastery. The patient learns to be an active participant on his or her own behalf, to focus on creating a solution rather than on enduring a problem, and to discover and use resources for inner control as much as possible. The goal of mastery does not mean that the patient necessarily turns away from external aid, although this may sometimes be possible. An anxious child may no longer need tranquilizers; a child with asthma may no longer need a nebulizer. Often, however, the child successfully using hypnotherapy continues to require external help, albeit now in a different psychological context. Thus, a child in renal failure continues regular dialysis but has less
anxiety and depression, is more motivated to participate in treatment, and is more cooperative with necessary dietary restrictions. Because the child is now cooperative with the diet, the need for dialysis is reduced, and the child may perceive the machine as a useful aid rather than as an external imposition.

The so-called First Law of Hypnosis emphasizes that the patient must be able to define or perceive a desired therapeutic outcome. It is essential that the therapist also keep this in mind. Sometimes, the outcome desired by the parents or therapist is not the same as that desired by the child. This can be explored in various ways with children—for example, “We’ve been talking for a while. Am I right in understanding that what you want is to have all of your beds dry?” Or, during the first hypnotic induction the therapist can ask the child to indicate which finger represents “yes,” which represents “no,” and which represents “I don’t know.” Then, when the child appears very comfortable, the therapist can say, “I’ll ask some questions that you can answer with your fingers. Do you like chocolate ice cream? Do you like to go to bed at night? Do you like the color blue? Would you like to have dry beds at night? Do you like to eat pizza?” Occasionally, the ideomotor response will be “no,” and this is an indication that further work must be done before teaching the child self-hypnosis. It is also important in structuring suggestions to include future programming—for example, “Think of something you’re looking forward to next summer. You needn’t tell me what it is. Imagine that it’s next summer, and you are enjoying what you’re doing, just as if you were really there. And, while you are enjoying it, you can also enjoy thinking how nice that your beds are all dry because of your work, because you have become the boss of your bladder—and then you can continue to imagine you’re enjoying what you are looking forward to next summer.”

Recognizing Developmental Issues

That a child is not an adult seems obvious, but it is a fact sometimes overlooked in hypnotherapy. If a child patient is to achieve the goal of mastery through successful response to hypnotic induction and treatment techniques, language must be adapted to the level and interests of that child, being neither too complex nor too simple and patronizing. As in any therapy, the hypnotherapist must take into account the child’s perceptual and conceptual skills with respect to problems and possible solutions. For this reason, it is often best to let the child select some of the details of imagery used in hypnotherapeutic suggestions. The therapists might say, “Think of a way you can feel safe,” and then follow the child’s lead instead of suggesting a particular plan. If the child patient is seen at different points over a period of time, it is important to remember that techniques that were appealing and helpful at one age may have no value or even be aversive at a later age. The degree to which children mix reality and fantasy is often a cause of fears and other problems, but this developmental tendency can become an advantage in hypnotherapy. The child
may respond particularly well, for example, to imagery techniques such as rehearsal in fantasy, experiencing a new behavior first in hypnotic imagery and then quickly becoming able to make the transition to incorporating that behavior in reality situations.

Misinformation About Hypnosis and Hypnotherapy

Unfortunately, many children have developed misconceptions about hypnosis before they come to a medical office for hypnotherapy. This may come from television programs, movies, books, or friends. In the children’s book *A Dinosaur’s Story: The Wildest Show on Earth* (Hughes, 1993), two children are hypnotized by Professor Screweyes to join his Eccentric Circus. Such a story is frightening to many children. It is important that hypnotherapists learn what the child’s perceptions about hypnosis are, to explain hypnosis in the appropriate language, and to emphasize that the therapist will teach the child a skill that belongs to the child and over which the child has control.

Parental Involvement

In some instances, particularly when the parent has been overprotective or when the child needs greater autonomy, it is best to minimize the parental role in hypnotherapy. The parents may be asked specifically to refrain from reminding the child to practice self-hypnosis and to allow the child privacy during practice sessions. The therapist gives the parent a general explanation of the treatment program. The following vignette is an example of this approach.

Hugh N., age 7 years, suffered from severe asthma. Finding self-hypnosis very helpful, he became able to participate more fully in school and in sports and was especially proud of being able to help himself and not always have to rely on his parents for medication. Soon after hypnotherapy began, his mother said to the therapist, “When Hugh begins to wheeze, he goes to his room and closes the door. After about 5 minutes, he comes out, and he’s not wheezing, and I don’t know what he does in there!” The therapist answered, “I know what I asked him to do, but I don’t know what he really does in there, either. What is important is that Hugh is better.” The mother continued to allow her son the privacy and independence he needed.

In some cases, the child may need the parent’s presence either in the therapist’s office or during use of self-hypnosis in order to help focus on hypnotic suggestions or to provide reassurance. Ellen L., an adolescent girl, had difficulty sleeping because of chronic, progressive pain with associated anxiety. Although she learned self-hypnosis, the severity of her pain sometimes interfered with her ability to concentrate on hypnotic suggestions. Her mother willingly served as a surrogate therapist when needed, with the results that both the mother and Ellen got more sleep and felt more hopeful about Ellen’s condition.
Most parents abide by the therapist’s recommendations concerning the degree of their involvement. A few parents consciously or unconsciously sabotage the therapy. This seems to occur most often when the child is not improving at the speed at which the parent would have hoped or would prefer, or when parents have the mistaken idea that they are in charge of the child’s self-hypnosis practice. Thus, sometimes a parent, albeit well intentioned, will insist that the child “go practice self-hypnosis and relaxing, right now!” much as they might insist that the garbage be taken out or that it is now time for piano practice or homework. This usually comes to our attention as clinicians when the child is not improving, when progress seems to plateau, or when the parent complains that “it’s not working.” A careful review of the history will commonly reveal parental over-involvement or misconception and will lead to a thoughtful conversation (or more, as needed) regarding the child’s normal developmental and maturational needs, the significance of their belief in ownership of the self-hypnosis, and ways that the parent can and perhaps even should be involved that do not risk sabotaging a positive outcome.

Sometimes careful assessment points to the need for the parents or other family members to be involved, not just to support the child but as full participants in family therapy, with or without hypnotherapy. Just as in child psychotherapy, parents of children presenting for hypnotherapy may focus the pathology on the child when they also need help. If the parents refuse to participate in therapy, sometimes it is possible to make at least partial gains with the child alone. In such cases, the parents may be willing to be seen every few weeks for counseling or for a review of the current home situation. We prefer this “half-measure” approach to that of no therapy for the child. Sometimes the parents’ trust will eventually increase to the point that they enter therapy. At the least, it may be possible to teach the child more effective ways of coping in the family situation. We realize, however, that this therapeutic strategy may reinforce the parents’ conviction that the locus of the problem is in the child, making the parents even more resistant to treatment for themselves. There is the added risk, if hypnotherapy with the child is successful, that the parents may then find another target for the pathology, perhaps another child or even the marital relationship itself.

Types of Hypnotherapy
To say that a child is using hypnotherapy really tells us very little except that hypnosis is being employed somehow in the treatment program. Hypnotherapy refers to the use of a variety of hypnotic techniques in the context of some form of psychotherapy, using that term in its broadest sense. Thus, hypnotherapeutic methods may be employed in the context of relationship or supportive therapy, behavior modification, psychoanalysis and dynamic therapies, gestalt therapy, or cognitive behavioral therapy. Some hypnotherapeutic methods are common across several psychotherapeutic approaches, whereas others have
more limited application; for example, hypnotic relaxation is used to facilitate progress both in analytically oriented therapy and in behavior modification. Hypnotically induced dreaming, on the other hand, might be employed in the analytic approach but probably not in a behavior modification program.

The specific hypnotherapeutic techniques used with a particular patient are derived from the nature of the presenting problem, the patient’s goal, other patient characteristics, the therapist’s theoretical orientation, and certain situational factors such as the amount of time available for treatment. The numerous possible hypnotherapeutic techniques have many variations. Specific examples will be described in Chapters 7 through 15. At this point, we simply divide hypnotherapeutic methods into three broad categories.

**Supportive, Ego-Enhancing Methods**

The chief goal here is to help the child feel more worthy, more capable of dealing effectively with problems and challenges, and more able to contribute to his or her own well-being and to be in control of circumstances both internal and external. Patients who fear necessary surgery, who experience pervasive anxiety, or who manifest borderline or psychotic behavior often derive special benefit from supportive techniques. These methods may also be used prospectively in the course of routine pediatric care—for example, “I will look forward to your telling me about the fun things you do in kindergarten” or “Your muscles feel strong. I think you can use them to learn to ride your new bike.” Such supportive phrases may be applied appropriately in emergency situations, such as when a child arrives in the emergency room with a laceration.

**Symptom-Oriented Methods**

Here the therapeutic effort is directed at removing, altering, or alleviating specific symptoms, either physical or emotional in nature. Difficulties associated with phobias, pain control, and habit control, among many others, often respond to symptom-oriented approaches, especially if the patient is highly motivated to be rid of the symptom. These symptom-oriented approaches are contraindicated if the symptom serves as a major defensive purpose such as to protect the patient from severe underlying depression or the outbreak of psychosis.

**Dynamic, Insight-Oriented Methods**

Again the goals are symptom relief and ego strengthening, but now special methods are employed to help the patient understand issues that create and maintain problems, gain insight into and work through underlying conflicts, and achieve a more extensive shift toward personality maturation in broad cognitive, affective, and social spheres. Generally speaking, supportive and symptom-oriented methods are most often used with children, and dynamic methods are used to a somewhat lesser extent. For some child patients, hypnotherapy includes a combination of all three methods.
Indications for Hypnotherapy

Because the rest of this book is devoted to a detailed review of situations in which children can benefit from hypnotherapy, we limit this section to a few general comments. It is generally accepted that hypnotherapy is underutilized in the treatment of children. Moreover, hypnotherapy is too often considered as a last resort, despite the fact that it might have several advantages over other treatment modalities. These advantages include frequent appeal to and acceptance by the child patient, 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. A child can be considered a suitable candidate for hypnotherapy if: (1) the child is responsive to hypnotic induction methods, (2) the problem is treatable by hypnotherapy, (3) the child can relate positively to the therapists, (4) the child has at least minimal motivation to solve the problem and is willing to do self-hypnosis practice, (5) the parents or other responsible adults agree to the treatment plan, and (6) the use of hypnotherapy for the problem at hand would not harm the patient.

Contraindications

As child hypnotherapy achieves greater acceptance by health professionals and the general public, the problem of underutilization gives way to excessive enthusiasm and inappropriate utilization. Parents and other well-meaning adults sometimes put great pressure on us to use hypnotherapy as rapidly and forcefully as possible with child patients so as to eliminate troublesome symptoms. Children, too, sometimes make inappropriate demands for hypnotherapy. It is incumbent on us to resist this pressure.

We also see excessive enthusiasm about hypnotherapy in some health professionals who have just begun training in this subspecialty and have been exposed to accounts of dramatic cures. Sometimes these professionals think of their patients with the most difficult problems and conclude that hypnotherapy is bound to be the answer to their unsolved problems. Occasionally this is true; more often it is not. In detailed discussion of such cases, we tend to find either that the therapist has underestimated the patient’s degree of pathology or that the therapist has problems with a countertransferential need to be all things to all people. In such cases, we try to educate professionals toward more rational use of hypnotherapy.

The situations in which we believe hypnotherapy is absolutely contraindicated may be categorized as follows:

1. Granting the request could lead to physical endangerment for the patient.
2. Granting the request could aggravate existing emotional problems or create new ones.
3. The request is simply to “have fun” experimenting with hypnosis.
4. The problem is more effectively treated by some method other than hypnotherapy.
5. The diagnosis is incorrect, and the real problem should be treated some other way.

There are also some relative contraindications for hypnotherapy, usually based on inappropriate timing of the referral. In these situations, granting the request for immediate hypnotherapeutic treatment would involve overlooking a significant medical problem, overwhelming the patient’s ego, or trying to impose change on an unmotivated child. In such situations, hypnotherapy may be appropriate if utilized at a later time or in a manner different from what the patient or parent demands.

**Absolute Contraindication: Risking Physical Endangerment**

Eddie Y., a 15-year-old, admitted with some embarrassment that although he enjoyed playing football he became frightened when he was rushed by larger players. Convinced that anxiety impaired his running and passing skills, he asked, “Could you hypnotize me so that I couldn’t see these big guys, and then I wouldn’t be afraid?” Eddie was told that it might be possible for him to experience such a hypnotic negative hallucination, but that it was most inadvisable since he couldn’t dodge players if he couldn’t see them. He quickly understood that he would not only endanger himself by such use of hypnosis but would also quickly become a detriment to the team. He also agreed with the idea that a mild degree of anxiety can be appropriate and even beneficial to his performance. Reconsidering, he concluded that his anxiety was within normal limits. He felt assured that he could seek more appropriate kinds of treatment, with or without hypnotherapy, if ever his anxiety truly reached irrational and maladaptive proportions. He continued playing football without further difficulty.

**Absolute Contraindication: Risking Aggravation of Emotional Problems**

Cynthia N., an angry and depressed adolescent girl, telephoned the therapist to report a very unhappy experience with a boyfriend and requested one or two sessions of hypnotherapy for the sole purpose of developing amnesia for her entire relationship with him. The therapist explained that it was unlikely that she could achieve and maintain such an extensive amnesia; hypnotherapy could not produce such magic cures. Even if she could accomplish this goal, however, it was inadvisable because she might then develop much more serious emotional difficulties. For example, instead of learning skills for coping with this circumscribed problem, she might achieve only partial repression and then develop a maladaptive reaction such as general depression or anxiety, perhaps leading to deeper problems in relating to men. The therapist
suggested a longer course of psychotherapy that might include hypnotherapy, but not for the purpose of creating amnesia. Cynthia refused and insisted that she would continue her search until she found someone who would grant her request. We have no follow-up on this girl.

Absolute Contraindication: Hypnosis for Fun

Walter B., an adolescent boy who had recently met the therapist socially, asked to be hypnotized “just for fun.” The therapist denied the request and explained why hypnosis should be limited to research and therapeutic situations. Walter agreed with the decision after he understood that hypnosis is an altered state of consciousness in which he might have unexpected emotional reactions that could not and should not be treated in a brief social encounter. He was impressed by a few vignettes of professionals participating in hypnotic inductions as part of hypnosis workshops. Although the hypnotic suggestion was simply to recall and enjoy a pleasant experience, two persons developed unexpected grief reactions, and a third developed a mild paranoid reaction. Though such reactions are rare, they are unfortunate. Walter saw that one might choose to risk such a reaction as a participant in a hypnosis workshop or as a subject in a research study, but that there was no sense in taking such a risk when the only goal was “to have fun.”

Absolute Contraindication: Hypnotherapy Considered Not the Most Effective Treatment

Bobby A.’s mother sought hypnotherapy for her 5-year-old son to help him overcome an extreme fear of dogs. He refused to play outdoors for fear of meeting a dog, and his little sister was now beginning to share his fear. In an initial interview, Bobby demonstrated little fear when talking about dogs and cheerfully joined the therapist in playing with toy dogs. Further discussion with the mother soon revealed that it was really she who had a moderate fear of dogs and that Bobby was basically doing what she expected him to do, although he did have a mild degree of fear. The therapist counseled with the mother, who achieved rapid fear reduction. As a further means of helping her family move from inappropriate fear to adaptive enjoyment of dogs, she agreed to buy a puppy. A week later, the dog joined with the therapist, the mother, and her two children in a playful visit on the lawn outside the therapist’s office. Bobby and his little sister easily resolved their fear, and the boy proudly took charge of feeding his new pet.

Absolute Contraindication: Request for Hypnotherapy Based on Misdiagnosis

Tim, R., a 6-year-old, had trouble paying attention in school and failed to follow the teacher’s instructions, although he had at least average intelligence. When his mother requested that Tim have hypnotherapy for his “behavior
problem,” the therapist insisted on taking a careful history. She learned that Tim had had recurrent middle-ear infections and that his failure to pay attention was chiefly related to a previously undetected hearing loss. When Tim was treated for his medical problem, his “behavior problem” disappeared.

Relative Contraindication: Immediate Medical or Surgical Treatment Takes Precedence Over Hypnotherapy

Anne C., a 10-year-old, had a long history of complaints of vague abdominal pain associated with reluctance to go to school. One day, when the complaints became particularly severe, the mother requested hypnotherapy for Anne. The therapist insisted on a physical examination that resulted in a diagnosis of acute appendicitis and immediate surgery. Following Anne’s recovery from surgery, the therapist reevaluated her, and she successfully used hypnotherapy to resolve a relatively mild school avoidance problem.

The frequency of occurrence of such cases, in which the children referred for hypnotherapy were proved later to have biological bases for their symptoms, inspired a survey by Olness and Libbey (1987). Of the 200 children surveyed, 39 had unrecognized biological bases for their symptoms; within this overall group, 80 had been referred specifically for hypnotherapy and 20 of these had previously unrecognized organic conditions that explained their symptoms. Within this group of 20 patients, the average duration of symptoms prior to diagnosis was 18 months. All had been seen by physicians within 1 year before their referral to the clinic. Eleven had been in psychotherapy for periods ranging from 3 to 30 months; of these, 2 had been hospitalized for 6 to 12 months in inpatient units. Each child had a complete remission of the presenting symptoms with treatment of the underlying disease. Although it is important to recognize the psychological or behavioral aspects of many illnesses, it is also important to recognize a biological base for certain behavioral symptoms.

Relative Contraindication: Another Form of Psychotherapeutic Management Takes Precedence

Larry W., age 14 years, was hospitalized because of total body weakness and rapidly developing inability to walk. Finding no organic basis for the problem, the physician made a diagnosis of conversion reaction and requested hypnotherapy. In psychodiagnostic interviews, it became clear that Larry’s symptoms served as defense against psychosis. After consulting with the physician, the therapist refused hypnotherapy for symptom relief and urged the parents to admit their son to an inpatient psychiatric program for intensive treatment. The parents denied that their son could have such a serious psychological problem, and they took him home. Follow-up about 1 year later revealed that the patient had indeed developed a frank psychosis. It is possible that, at some
point in the course of intensive inpatient psychotherapy, hypnotherapy might have been a useful adjunct, but its use for abrupt symptom removal was clearly contraindicated.

Relative Contraindication: The Symptom Provides Significant Secondary Gain for the Child

Erickson (1991) described a teenage girl who was able to use hypnosis quite well to control the pain of her sickle cell disease; however, after several months, when she was hospitalized for crisis pain and the therapist came to see her, she refused hypnoanalgesia on the first day although she was in pain. The therapist stayed with her for half an hour, talking with her. On the second hospital day, she was willing to use her self-hypnosis skills. After several hospitalizations during which she demonstrated the same pattern, she was able to explain that everyone avoided her when she was in pain. Her therapist was the only person who was willing to be with her when she was in pain; therefore, she rejected helping herself because the presence of a sympathetic human being was more important than pain reduction.

Conclusions

This brief review of general principles is intended to provide a framework in which to consider management of the clinical problems presented in succeeding chapters. The following clinical material includes techniques that were utilized and why, what suggestions were given, and how the results were interpreted. We take the position that as long as a given hypnotherapeutic endeavor has not been shown clearly to be ineffective there may be at least some features of it useful to child hypnotherapists and their patients. We maintain this position even when we are critical of the claims made for positive results, departing from it only when it appears obvious that the use of hypnotherapy had no relationship to the results obtained. Given the scope and complexity of problems to be discussed, we have sometimes had to be arbitrary about including a particular problem in one chapter rather than another.