

Childhood Anxiety, Worry, and Fear: Individualizing Hypnosis Goals and Suggestions for Self-Regulation

Pamela Kaiser

Private Practice, Menlo Park, California, USA

Determining hypnosis goals and specific suggestions for childhood anxiety, worry, and fear can be enhanced by a developmental psychopathology perspective. This article examines underlying causal risk factors that guide a focused assessment and individualized interventions, targeting self-regulation of emotional, cognitive, behavioral, and psychophysiological arousal and reactivity. The author summarizes current knowledge about childhood anxiety disorders and outlines a hypnotic approach when encountering anxious children and youth, including strategies to use spontaneous trance states and enhance underdeveloped resources (e.g. locus of control, discrimination of realistic risk appraisal, coping capacities).

Keywords: anxiety, childhood, developmental psychopathology, fear, hypnosis, parents, psychophysiological arousal and reactivity, self-regulation

Anxiety, fear, and worry among children and teenagers are on a continuum from transient disruptions to clinical disorders. For example, when faced with the common stressor of an immunization or blood draw, a child might display momentary bother, then shift his or her attention. Another child's extreme fearfulness about upcoming threat and danger might prompt overwhelming anticipatory anxiety and catastrophic worry, followed by a panic episode and uncontrollable escape behaviors during the procedure, reflecting a clinical diagnosis of specific phobia.

It is unfortunate that most pediatric medical and mental health professionals receive little training on how to assess and treat children and teenagers with these challenges. The use of superficial, one-size-fits-all scripts or other global suggestions to "relax" or "get calm" are common approaches when using hypnosis for such young people. In contrast, determining specific goals and tailoring suggestions to the needs of a particular pediatric patient is the theme of this article. Leading experts in the field of pediatric hypnosis, Kohen and Olness (2011) emphasized the importance of empowering the client:

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 in 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 (p. 90).

Their stance is shared by other contributors to the pediatric hypnosis literature. Wester and Sugarman (2007) indicated that the hypnotic process “reifies the therapist’s faith that the child and adolescent is endowed with the internal resources to help themselves” (p. 11) and that such faith “can serve to model respectful relationships, demonstrate confidence, and invest in a child’s self-efficacy and mastery (p. 20). Similarly, Kuttner and Soloman (2003, p. 318) noted that “the psychological goal of hypnosis is to use the power of suggestion to shift the child from the relatively passive or helpless state of directly experiencing anxiety and pain, to a state of coping, empowerment and control.

Most salient for this article’s focus on tailoring approaches to the individual, Yapko (in press) emphasized the importance of determining specific goals while addressing the risk factors underlying the symptoms. Rather than a focus on the presumed meaning of the symptom, Yapko (in press) emphasized identifying the process of how the symptoms are produced and interrupting this problem sequence in a therapeutic way.

To individualize interventions for a specific child or teenager, clinicians need knowledge about multiple causal risk factors and developmental antecedents that can fuel the onset of anxiety disorders. The next step is accurately assessing which risk factors are relevant for a particular child. Clinicians can then determine the most salient goals and methods for treatment, which may include clinical hypnosis.

Several questions are relevant for clinicians who incorporate hypnotherapy into their treatment plans for anxious children and teenagers:

1. How can pediatric professionals help these young people shift from their typical vulnerable self-view to one of mastery and resilience?
2. How might clinicians design hypnosis encounters that enhances children’s resources to more accurately discriminate real danger from imagined danger, increase their capacity to better cope, and influence what happens?
3. How might hypnosis facilitate goals of fostering children and teenagers’ self-regulation of their psychophysiological and negative emotional arousal and overreactivity, catastrophic thinking, and avoidant behaviors?
4. How might clinicians use spontaneous trance states of highly anxious children and teenagers during assessment and treatment?

The remainder of this article incorporates vignettes and examples to address these clinical questions about the individualized use of hypnotherapy to foster self-regulation as it relates to the cognitive, emotional, and psychophysiological arousal and reactivity dynamics of childhood anxiety.

Prevalence and Trajectory of Anxiety Disorders

Research of community samples shows that anxiety disorders have the highest (15–20%) or second-highest prevalence of any psychological condition in young people (Curry, March, & Hervey, 2004), and are associated with substantial impairment. At the same time, the majority (79%) of those diagnosed with an anxiety condition have comorbid anxiety disorders (Kendall, Brady, & Verduin, 2001; Sweeney & Pine, 2004). Prospective studies have suggested that a child with an anxiety disorder is at significantly higher risk for developing other anxiety disorders and depression later in childhood (Feng, Shaw, & Silk, 2008) or adulthood (Hirshfeld-Becker, Micco, Simoes, & Henin, 2008). According to Harvard professor Ronald Kessler (2010), the results of the World Mental Health Study (of 30 countries) found that the three most prominent childhood disorders (i.e., specific phobia, separation anxiety disorders, and social phobia) predicted adults' risk of developing other anxiety disorders, even if these childhood disorders disappeared as individuals age.

Antecedents of Anxiety Disorders: A Developmental Psychopathology Perspective

A developmental psychopathology perspective explains potential pathways leading to the emergence of childhood anxiety (Bell & Deater-Deckard, 2007; Lewis & Miller, 1990; Spence, 2001; Vasey & Dodds, 2001). Most children begin their development of an anxiety disorder with one or more of the predisposing, and commonly synergistic, factors shown in Table 1.

Overarching Hypnosis Goal: Self-Regulation—Enhancing Attentional Control

A key societal expectation for children is their development of the capacity for self-regulation—the ability to control their inner states and external responses related to thoughts, emotions, behavior, and physiological reactivity. Developing attentional control, that is, shifting attentional focus, is critical to regulating arousal and effortful management of behavior (Bell & Deater-Deckard, 2007; Wilson & Gottman, 1996).

To create a developmentally appropriate hypnotherapy plan addressing the overarching goal to enhance the capacity for self-regulation in worried and fearful children and teenagers, some understanding about the typical acquisition of this skill is needed. A supportive parenting style that encourages independence, provides opportunities to problem-solve everyday stressors, and stipulates expectations to increasingly modulate/control arousal and reactivity is most central.

Self-regulation skills typically emerge by late infancy and expand as parents provide multiple opportunities during early childhood. For example, parents often use verbal and

TABLE 1
Predisposing Risk Factors for the Development of Childhood Anxiety

<i>Risk factor</i>	<i>Description</i>
Neurobiology/circuitry	Elevated stress psychophysiological arousal and reactivity, alterations in sympathetic-adrenal-medullary and hypothalamic-pituitary-adrenal systems (Bauer, Quas, & Boyce, 2002), elevated amygdala responses to threat-relevant stimuli with involvement of the hippocampus and insular cortex
Genetic predisposition	Heritability estimates of 40–50% (Thaper & McGuffin, 1995); offspring of parents with an anxiety disorder have a risk ratio of 2.5 for developing an anxiety disorder, compared to children of unaffected parents (Hirshfeld-Becker, Micco, Simoes, & Henin, 2008)
Temperament	Behavioral inhibition (extreme shyness) and negative emotions
Anxiety sensitivity	Extreme fearfulness of having physiological fear sensations, with the belief that the result will be physical demise or mental incapacitation
Information processing bias	Cognitive processes of attentional bias and memory bias toward threat-related stimuli, appraisal (i.e., evaluating and interpreting) of situations as threatening and catastrophic (Vasey & MacLeod, 2001). These biases reflect discrimination problems (i.e., the inability to distinguish real threats from imagined threats).
Coping style	Avoidance, escape, distraction, somatization, catastrophizing, rumination, emotion-focused (meltdowns), and demands for parental soothing and reassurance
Attachment	Enmeshment or insecure anxious attachment
Early control experiences	Lack of opportunities to develop independence and skills in problem-solving and coping with mild yet manageable stressors, resulting in poor sense of mastery and an external locus of control
Exposure to feared and common conditioned stimuli	If exposure to mildly fearful yet safe or controllable stimuli is limited or avoided, the result is reduced self-efficacy and increased fear of the stimuli or traumatic conditioning
Parenting style	Modeling anxiety and/or overprotective, overcontrolling, and intrusive pattern, inadvertently reinforcing child's avoidance and escape (Chorpita, 2001; Hirshfeld-Becker et al, 2008)
Parental psychopathology	Anxiety and/or depression diagnoses
Exposure to trauma or stressful life transitions or negative life events	Including divorce, hospitalizations, major illnesses, painful procedures, or family death
Self-regulation skills	Undeveloped or underdeveloped capacities to modulate and control cognitive, emotional, behavioral, and psychophysiological arousal and reactivity

visual distraction to stretch the 12-month old infant's tolerance for internal and external distress, in response to hunger demands. Older infants and young toddlers learn to manage separation anxiety sparked by momentary then increasingly longer disappearances of caregivers by shifting their attention and self-soothing by means of a growing attachment to transitional objects (e.g., blankets, stuffed animals) and solitary play. When learning to run, older toddlers are taught to literally and figuratively pick themselves up and move past their surprise, momentary disorientation, and possible mild discomfort. Preschoolers are expected to effectively cope, self-soothe, and master typical daily

stressors (e.g., sleeping alone, parental separation, novel and unfamiliar situations) and fears (e.g. loud noises, the dark, and strangers). By 7 years of age, children show even more conspicuous improvement in their ability to shift their attentional focus away from upsetting thoughts and emotions, thereby regulating arousal and controlling behavior (Bell & Deater-Deckard, 2007).

Thus, a child's ability to self-regulate is developed through titrated early exposure to and early control of feared (yet safe and manageable) stimuli coupled with a warm parenting style and responsiveness that supports the child's independence and mastery of age-appropriate normal stressors.

Parents' Unintended Influence: Fostering Poor Self-Regulation

Some parents inadvertently reinforce their child's poor self-regulation rather than provide ample opportunity to develop internal control by problem-solving fearful yet manageable situations. Repeated parental reactivity with expressed alarm, worry, and anxiety models reduced self-regulation, conveys that the world is unsafe, and communicates that the child is vulnerable and not capable of handling life's twists and turns. Overattention to a child's pronounced distress reinforces continued alarm. In general, these parents become external regulators of their child's fears and worries, unintentionally limiting their child's discrimination skills, self-soothing abilities, and internal locus of control.

Such underlying parenting dynamics can range from overidentification or enmeshment with their child to insecure attachment or parental clinical diagnoses of anxiety and depression (Chorpita, 2001). In my 21-year subspecialty practice treating young people with mind-body issues of anxiety and stress, the majority of parents have been caring and loving. Yet, they may view the child through the lens of their own anxious childhood and continued worries, fueling earnest motivations to spare him or her from similar angst and reduce his or her distress. As a result, they overprotect and too readily provide external regulation of their child's heightened reactivity, intense emotionality, repetitive worries and fears, and underdeveloped internal resources such as coping. Therefore, addressing these parenting style dynamics becomes an essential part of the treatment plan.

An Integrative Treatment Approach

An integrative approach for childhood anxiety is the recommended standard. Regarding the value of specific treatment components, individual or group cognitive behavioral therapy is widely considered the treatment of choice for these disorders (Chambless et al., 1996; Chambless & Hollon, 1998; Silverman, Pina, & Viswesvaran, 2008).

Hypnosis is one component of this larger treatment plan. It is unfortunate that there is a paucity of rigorous studies or even case reports about the integration of clinical hypnosis into a treatment plan for childhood anxiety, worry, and fear. Most research regarding childhood anxiety examines children's anticipatory fear related to medical procedures (Butler, Symons, Henderson, Shortliffe, & Spiegel, 2005; Kuttner, 2010; Kuttner, Bowman, & Teasdale, 1988; Lioffi, White, & Hatira, 2006).

Clinicians regularly incorporate self-regulation skills training with home practice (e.g., self-hypnosis, biofeedback, breath retraining, autogenic training, progressive muscle relaxation), as well as mind-body education, and potentially other psychotherapies (e.g., dyadic attachment work, parent counseling, family therapy), and other modalities (e.g., meditation, bibliotherapy, massage therapy, exercise consultation, clinical aromatherapy, school consultation, and pharmacotherapy; Richtsmeier-Cyr, Culbert, & Kaiser, 2003).

A multimodal intervention requires flexible decisions about which combination of approaches are best suited for a particular child and family. In this regard, clinicians need to determine whether the child's presentation and treatment needs are within their scope of professional license, training, and expertise. If not, referral to a mental health professional is warranted. Other bases for referral include the level of family psychopathology (including dysfunctional attachment); number of anxiety disorders; severity of symptoms and clinically significant distress; very limited self-regulation; and level of impaired social, academic, family, or intrapersonal functioning.

Clinical Hypnosis: Induction and Intensification

The utilization approach is the norm when incorporating hypnosis with children and teenagers, given its highly individualized, indirect, and permissive forum to maximize the fit with a particular child. This approach is described in more detail later.

Nonetheless, when using formal hypnosis for anxious and fearful children and teenagers who typically have atypical breathing patterns and vivid imaginations, *breath awareness induction* and *intensification with dissociation* (creating a safe and special place) are especially useful, as well as embedding suggestions regarding positive expectancies for internal control.

Initial Encounter: Utilizing Spontaneous Trance States

When initially encountering a highly anxious child or teenager, utilizing his fear state is clinically valuable. They are already in trance! The initial greeting of a fearful child or teen sets the stage for ensuing sessions. Rather than the typical introduction (i.e., handshake and questions intending to connect), it may be advisable to wait a few minutes

before acknowledging the child. A general conversation with the parent allows time as the child settles and observes his or her parent modeling a growing ease and trust.

Children who are younger than 8 years of age often prefer introductions that focus attention on bridging toys (e.g. a shy turtle finger puppet hiding in its shell). Brief preparation for parental separation is needed, because time alone with the child usually maximizes an accurate evaluation. For example, “Now that you’ve met Tommy the Turtle and shook his foot, his little friends want to meet you, too. When we visit my room . . .”; “My turtle’s friends want to meet you. When we visit my room in a moment, bring mommy’s jacket or gloves (i.e., transitional objects) while she rests until we’re done visiting?” (an implied directive for temporary separation and a suggestion of parental comfort with process).

Repeated direct and indirect suggestions and positive expectancy focused on safety are essential (e.g., “Your dad and you can start to relax now as he waits comfortably while you visit my room . . . because he knows that you are very safe here. When finished, you’ll leave together.”).

The Interview: Designing Hypnosis in the Encounter

In pediatrics, it is common practice to include the parent in an initial session, with the goal of reducing the child’s transient hesitation and wariness. Yet, with highly anxious children, this approach tends to yield an unproductive assessment. The child usually sits very close to the parent, whispering impatiently for the parent to respond for him to queries, while minimally engaging with the clinician.

In my experience, interacting with the child alone typically offers richer observations of his or her overall self-regulation and other resources to cope with an unfamiliar person and situation. It also gives the message about the clinician’s confidence in the child’s competence to manage the encounter. It is clear that the professional must create a safe and soothing “holding environment” (including a “warm-up” phase). A pleasant, calm, and respectful manner employing sensitive pacing and leading usually results in replies to questions about risk factors and presentation.

During this and future encounters, the flexible and creative clinician uses a child’s curiosity and natural capacity for intense focus and concentration on activities of interest. A particularly relevant strategy is designing these hypnotic “islands” via developmentally appropriate and absorbing materials. Shy or anxious young people often prefer to “gaze avert” during interviews, so accessible activities and objects (e.g., toys in a basket) are in order. Preschool students and early primary school students usually become readily absorbed in imaginative play props, whereas grade school students and even teenagers become highly focused on drawing and repetitive, monotonous visual and tactile stimuli. Strategically placed *moving milieu metaphors*, long known to trigger spontaneous hypnosis (e.g., pendulum clocks), can be used with older children

and teenagers as focal points for induction, use of therapeutic metaphors, and eliciting hypnotic phenomena.

Screening for Anxiety Disorders: Scratch and Sniff!

A clinical assessment must go beyond the child's (or parents') identified concerns of worry or fear, just as a primary care evaluation typically extends beyond the child's identified target symptom of a sore throat (i.e., status of the lungs, neck lymph nodes, and middle ear). This is necessary because, in general, the child has 2–5 concurrent anxiety diagnoses (Kendall et al., 2001); thus, clinicians must establish differential diagnoses. A child/teenager's age-inappropriate, marked and persistent fear and anxiety may be focused on any combination of the typically identified domains. Table 2 provides a partial summary of specific anxiety disorders in childhood.

How Questions: Identifying Patterns, Goals, and Suggestions for Self-Regulation

The HOW line of inquiry, emphasized by Michael Yapko in his (2007) in his comprehensive training courses in clinical hypnosis and strategic psychotherapy, identifies a child's patterns in thinking, feeling, and behaving. Rather than focusing on the *why* or *what* (the symptoms), HOW questions focus on the underlying processes fueling and maintaining

TABLE 2
Childhood Anxiety Disorders and Presenting Symptoms

<i>Stressor</i>	<i>Examples</i>
Specific situation or object	Needles, blood, weather, animal, planes, choking, or vomiting
Separation from parents	Bedtime, school, sleepovers, parents' date night
Performance in specific situation	Test, phone, classroom, performance
Panic attacks vs. disorder (PD)	Sudden onset, intense fear, physical and cognitive symptoms that may occur as part of any of these disorders
Social situations	Peers: eat with, meet new classmates; adults; novelty
Generalized worries	Health, weather, world events, perfectionism, punctuality
Obsessions and compulsions	Unwanted thoughts, urges, or images concerning contamination, sexual intercourse, aggression, symmetry, orderliness, morality
Traumatic event or stressor	"Experienced, witnessed, or was confronted with an event involving actual or threatened death or serious injury, or threat to their or others' physical integrity" (<i>DSM-IV-TR</i> ; American Psychiatric Association, 2000)
Anxiety caused by a medical condition	Thyroid, metabolic, respiratory (<i>DSM-IV-TR</i> ; American Psychiatric Association, 2000).

Note. PD = panic attacks that occur without a specific trigger. *DSM-IV-TR* = *Diagnostic and statistical manual of mental disorders* (APA, 2000).

the symptoms as well as how the child makes decisions in particular contexts. HOW questions guide the determination of goals and concrete suggestions best matching that particular child's profile (M. Yapko, personal communication, February 27, 2010).

When assessing these youth, clinicians should keep in mind the overarching goal to enhance self-regulation of their thinking, emotions, psychophysiology, and behavior. The following sections (a) demonstrate an assessment model that focuses on the processes underlying the symptoms and (b) offer clinical examples of how individual differences in children's replies determine specific goals and suggestions.

Goal: Realistic Discrimination of Appraisal and Cognitive Self-Regulation

Difficulties in self-regulation of thinking take the form of worries, reflecting preoccupation with the possibility of negative upcoming events and situations.

Studies (e.g., Vasey & MacLeod, 2001) have indicated that fearful and worried children reveal informational processing biases, reflecting poor discrimination skills in several areas:

- Unrealistic appraisal of risk (threat, danger);
- Faulty thinking patterns (e.g. catastrophizing, magnifying, pessimism);
- Reduced availability of internal coping resources;
- External locus of control;
- Attention (e.g. overfocus on negative stimuli); and
- Memory (e.g. recall of more negative than positive information).

Young people vary in their capacity—beyond the expected developmental shifts over time—to realistically appraise familiar and, in particular, novel situations and experiences. In contrast with those who make increasingly accurate assessments, some children and teenagers pepper their parents with repetitive “What if . . . ?” questions. Such questions underscore an overfocus on the future as well as problems in discrimination (i.e., overestimating risk, threat, and danger). Strong tendencies toward catastrophic thinking and pessimism further taint their assessment toward the probability for negative consequences. Additional critical discrimination difficulties are evident in children's underestimation of their internal resources, including their capacity to cope and manage themselves.

Internal locus of control is another potential resource, denoting that a person can influence and control events and outcomes in one's environment (Chorpita, 2001). External locus of control is evidenced by the belief that chance, luck, or powerful others control the outcome of such situations and experiences.

Research has shown that the same factors that are particularly salient in promoting a child's capacity for self-regulation are similarly critical to developing an internal locus of control. In particular, the aforementioned early childhood experiences, coupled with a nonintrusive and nonoverprotective parenting profile described earlier, are factors

that foster a child's internal locus of control and protect them from developing anxiety disorders (Barlow, 2002).

Depending on a child's presentation, such faulty patterns of negative and anxiety-provoking ruminations, intolerance of uncertainty, future time orientation, and poor discrimination strategies can become potential specific targets during hypnosis sessions that are related to the larger goal of enhancing discrimination strategies for appraisal.

HOW questions focused on the child's pattern in risk and threat appraisal gets at the underlying processes for discriminating imagined worry versus realistic thinking, evaluating inner resources, and modulating faulty thinking patterns. HOW questions regarding locus of control and coping capacity tap the child's view of him- or herself as having power or influence over situations (internal locus of control) versus assuming that chance, luck, or powerful others will determine the outcome (external locus of control).

The following case illustrations of a few 11-year-old boys presenting with Generalized Anxiety Disorder demonstrate individual differences in these risk factors.

- "How do you decide whether or not to believe your worries?" (discriminating appraisal of risk)
- "How do you stop your scary thinking?" (locus of control and capacity to cope)

Child A: "I know they're true, because terrible things really do happen all the time! I can't stop it, and it'll always be this way. Snuggling with mom while she reads to me helps."

These underlying cognitive patterns demonstrate poor discrimination between reality versus imagined threat, reduced capacity to cope, pessimism, and an external locus of control. Specific goals for his hypnotherapy would focus on discrimination of risk appraisal, shifting attention, compartmentalization, and internal locus of control.

Child B: "I try to tell myself that some of those worries couldn't really happen, but the worries keep growing and growing until I just know it'll be a disaster! The only way to get a break from this is to distract myself by playing computer games."

His underlying cognitive processes (fledgling efforts to discriminate threat, catastrophic thinking, magnification, and external locus of control) point to specific hypnotherapy goals: discrimination of risk appraisal, compartmentalization, cognitive restructuring, and internal locus of control.

Child C: "I just ask myself, 'How likely is that really to be true?' and argue in my head all the reasons it's just not real, until I turn down the jabber. I wish I could really conquer these fears."

This reveals resources of appropriate risk appraisal and internal locus of control. A specific goal is addressing his limited awareness of and confidence in his coping resources.

Table 3 lists possible suggestions that would address these specific hypnosis goals.

TABLE 3
Specific Goals and Hypnotic Suggestions for Self-Regulation of Cognitive Processes

<i>Goal</i>	<i>Suggestion</i>
Shift attention	STOP sign in your head, then GO on to something more pleasant
Discriminate: Realistic risk appraisal	Metaphors for “things aren’t always what they seem” (e.g., blind man and elephant, night shadows on wall, and various milieu metaphors such as optical illusions, kaleidoscope); be a detective; probability calculations; judge and jury: what’s the evidence?; dark versus clear glasses
Aware of resources to cope	Age progression (imagine managing the situation with calm, comfort, and control)
Cognitive restructuring	Computer control panel in brain: download good thoughts, delete unhelpful thoughts (worries), empty trashcan, open “Super-Control” file (with its “bag of tricks”); TV catastrophic versus coping channel
Compartmentalize and minimize	Milieu metaphors such a magnifying glass, binoculars, telescope; dimmer switch
Internal locus of control	Use child’s interests, activities, and ideas focused on empowerment, mastery, being in charge (e.g., panel switch, air traffic control, train engineer, captain of team, magic powers, hero helper, control room, super power, car driver, warrior and shield, dials)

Goal: Self-Regulation of Emotional Arousal and Reactivity

The development of emotion regulation expands significantly between the ages of 2 and 3 years. During this period, young children typically discontinue dramatic and repetitive bouts of behavioral disintegration. However, worried, anxious, and fearful children well into grade school may tend to cry easily and/or have extended meltdowns. These children often exhibit a striking dependence on parents and others to assist them in managing their arousal and reactivity. Beyond a pattern of avoiding, escaping, or suffering through anxiety-provoking situations, common behaviors include repetitively seeking parental reassurance and/or comfort, averting gaze, nervously picking and biting lips and nails, or sucking on clothes.

To illustrate individual differences in children’s underlying patterns of emotional arousal and reactivity, consider the responses of the aforementioned children (who were 11 years old with generalized anxiety disorder) to the HOW question, “How do you manage your feelings during recess?”

Child A: “I want to be friends, but that one mean kid says, ‘You can’t hang with us. Get lost.’ That scares me and I freak out! Mom told me to call her right away, then she picks me up.”

This reply reveals extreme emotional (fear) reactivity (overwhelmed by intense fears), illustrations of further external locus of control and possible enmeshed attachment, and coping by escaping the situation (also, further external locus of control). These risk factors become specific goals for hypnotherapy.

Child B: “I stay near the recess monitor and chew constantly on my sweatshirt sleeve to calm myself. When she’s busy I start to have a panic attack because that mean kid will bother me again.”

This underlying pattern of heightened emotional arousal (emerging panic), limited resources to calm and self-soothe, and coping by suffering through the situation suggests specific goals including reframing panic symptoms, learning to calm and self-soothe.

Child C: With tears he said, “I’m really, really shy, so have always just watched kids from a bench. Often I’m so nervous, I start to cry and can’t stop, so I go to the bathroom then the library.”

His description suggests risk factors of behavioral inhibition, lacking confidence to face his fears, and coping by crying and avoidance.

Table 4 offers various hypnotic suggestions that match specific goals identified in these cases.

Goal: Self-Regulation of Psychophysiological Arousal and Reactivity

Additional individual differences are evident in young people’s ability to adaptively modulate other internal reactions and responses to normal hassles and major life event stressors. From a psychophysiological perspective, those who are highly anxious and fearful typically have a lower sensory arousal threshold to anxiety-provoking stimuli (e.g., noise) and an exaggerated and more sustained reactivity level (Bauer, Quas, & Boyle, 2002). They often present with chronic low level activation of the fight-flight-freeze system, with symptoms of sleep disturbance, dysfunctional breathing patterns, hyperstartle and hypervigilance, and somatization (e.g., stomach aches, vomiting, headaches).

TABLE 4
Specific Hypnosis Goals and Suggestions for Self-Regulation: Modulating Emotional Reactivity

<i>Goal</i>	<i>Suggestions</i>
Reframe panic symptoms	Important to discover the early signals of a false alarm to remind you to use calming and relaxation strategies
Calm, comfort, and self-soothe	Self-repeating the reassurances that parent typically say; repeating empowering statements: “I’m so safe, safe, safe, so goodbye to the scaries.”
Distance from intense fears	Shrink the old fears and put into worry balloons, then let go; stroking one’s head while saying, “Let the fears go out my ears!”
Confidence to cope with and face fears	Coping self-talk: Brave means being scared, and doing it anyway. Brave means “facing your fears”. . . JUST DO IT! Repeat to self: <i>I can do this, I can do this, I CAN DO THIS!</i>
Refrain from crying	“Tears don’t continually fall down our face, because everyone has a tears faucet, to turn on and off as needed. Be a plumber and ‘fix the drips.’”
Separation-individuation (if enmeshed attachment)	Magnet play; The “younger you” versus “wiser ways”; parents and children alike enjoy and easily remember stuffed animals of parent–child Velcroed together, as the separation process briefly creates a noisy transition. More formal dyadic psychotherapy may be needed.

Many children are highly attuned to their activated physiology, and a subset develops *anxiety sensitivity*, that is, extreme fearfulness of having physiological fear sensations (“fearful of fear”), believing the arousal symptoms will result in negative physical, social, or mental outcomes such as heart attack, loss of control, insanity. The level of anxiety sensitivity when children are 7 to 14 years old predicts developing panic disorder between 17 and 30 years of age (Reiss, Silverman, & Weems, 2001).

Psychoeducation about the overaroused mind–body connection (i.e., hypervigilance, chronic worry, and rigid and catastrophic thinking triggering a false alarm, resulting in the fight–flight–freeze response) provides a foundation to demystify and depathologize psychophysiological symptoms. Even older preschoolers grasp rudimentary explanation (e.g., being “tricked into believing the false alarms”) in their mind.

Most anxious and fearful young people have a dysfunctional breathing pattern (e.g., rapid and shallow, mouth breathing, breath holding, or gasps and sighs). Paradoxical breathing (particularly during panic episodes) may dominate, that is, lifting the upper chest as the abdomen sinks in, which raises the diaphragm and results in decreased volume. An initial, practical intervention is breathing retraining, because it activates the parasympathetic nervous system, leading to a calmer state.

This final illustration of individual differences in children’s underlying symptom patterns examines psychophysiological arousal and reactivity. Ponder the responses of these same three children (who were 11 years old with generalized anxiety disorder) to the question, “How do you calm down your body when you need to before going to school?”

Child A: “I just can’t get to sleep at night because the worries just keep bothering me. I can’t relax because I keep thinking about being away from mom. Finally, I climb into mom’s bed, and drop off immediately!”

His insomnia and relaxation difficulties are again regulated by parental support (external locus of control), and underscore enmeshed attachment issues. These three become specific goals as foci in his hypnotherapy. Collateral parent counseling is also necessary.

Child B: “That’s really hard for me, because I feel my heart beating faster, and I feel really shaky inside, and it gets hard to breathe, then my heart just thumps hard I feel like my heart will explode! Then I really panic!”

Goals include raising his sensory threshold, dampening his high, sustained reactivity and anxiety sensitivity, as well as directly addressing the panic.

Child C: “I get a bad stomach ache every Sunday evening, and end up vomiting before school on Mondays. Other mornings I get a headache or my neck hurts a lot. I don’t know why or how to make those go away.”

His profile indicates the need to reduce somatization and to learn self-soothing strategies. Table 5 offers hypnotic suggestions that correspond with these individualized goals.

TABLE 5
 Specific Goals and Hypnotic Suggestions for Self-Regulation: Modulating Psychophysiological Reactivity

<i>Goal</i>	<i>Suggestions</i>
Dampen initial and sustained reactivity	Breathing retraining; reminding that it is time to no longer be tricked by false alarms; using your special control panel; turning down your 0–10 dial to a more comfortable number
Raise sensory threshold	Developing tolerance or habituation through repeated imaginal exposures while watching a movie of oneself no longer bothered by the fearful stimuli
Learn self-soothing strategies	Calming specific target organs, such as patting or circular rubbing the stomach, saying, “No need to say self-soothing strategies. You’re safe. I’m in control now.”
Reframe panic episodes	“Every episode (not <i>attack</i>) has a beginning, middle and an end. So if you are in one, you are already finished with the beginning, and almost to the end, then done.”
Discriminate panic symptoms (from impending death or an anaphylactic reaction)	“Those old body-responses are just false alarms that need the volume turned down, then just turn it shut off.”
Reduce somatization	“Remind the tummy that you’re in charge. You can tell that tummy to settle down now, and it’ll obey you more and more because you’re the captain of the body team.”
Relaxation training	Progression muscle relaxation, teaching self-hypnosis and anchor to a particular context for daily practice
Resolve sleep disturbance (and potential sleeping with parents)	Depending on age, ideas range from imagery (e.g., surrounding the bed with stuffed animals or strong and brave imaginary or real-life heroes), to dissociation (special place), to progressive muscle relaxation

Summary

Clinicians treating youth with anxiety, worry, or fear can best design specific hypnosis goals and suggestions that are individualized for a particular child when using a developmental psychopathology perspective and an assessment focused on the causal processes fueling specific symptoms. The use of HOW questions isolate underlying patterns in thinking, feeling, behaving, and psychophysiological responses, which then become the specific hypnosis goals to fit the presentation of each particular child. By focusing on underlying risk factors for childhood anxiety and difficulties with emotional, cognitive, behavioral and psychophysiological self-regulation, the efficacy of a targeted assessment and treatment plan can be maximized.

References

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- Barlow, D. H. (2002). The origins of anxious apprehension, anxiety disorders and related emotional disorders. In D. H. Barlow (Ed.) *Anxiety and its disorders* (pp. 252–291). New York, NY: Guilford.

- Bauer, A., Quas, J., & Boyce, W. T. (2002). Associations between physiological reactivity and children's behavior: Advantages of a multisystem approach. *Journal of Developmental and Behavioral Pediatrics, 23*, 102–113.
- Bell, M., & Deater-Deckard, K. (2007). Biological systems and the development of self-regulation: Integrating behavior, genetics, and psychophysiology. *Journal of Developmental and Behavioral Pediatrics, 28*, 409–420.
- Butler, L., Symons, B., Henderson, S., Shortliffe, L., & Spiegel, D. (2005). Hypnosis reduces distress and duration of an invasive medical procedure for children. *Pediatrics, 115*, e77–e85.
- Chambless, D. L., Sanderson, W. C., Shoham, V., Bennett Johnson, S., Pope, K. S., Crits-Christoph, P., et al. (1996). An update on empirically validated therapies. *The Clinical Psychologist, 49*, 5–18.
- Chambless, D. L., & Hollon, S. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66*, 7–18.
- Chorpita, B. (2001). Control and the development of negative emotion. In M. Vasey & M. Dadds (Eds.), *The developmental psychopathology of anxiety* (pp. 112–142). New York, NY: Oxford University Press.
- Curry, J., March, J., & Hervey, A. (2004). Comorbidity of childhood and adolescent anxiety disorders: Prevalence and implications. In T. Ollendick & J. March (Eds.) *Phobic and anxiety disorders in children and adolescents* (pp. 116–140). New York, NY: Oxford University Press.
- Feng, X., Shaw, D., & Silk, J. (2008). Developmental trajectories of anxiety symptoms among boys across early and middle childhood. *Journal of Abnormal Psychology, 117*, 32–47.
- Hirshfeld-Becker, D., Micco, J., Simoes, N., & Henin, A. (2008). High-risk studies and developmental antecedents of anxiety disorders. *American Journal of Medical Genetics Part C (Seminars in Medical Genetics), 148C*, 99–117.
- Kendall, P., Brady, E., & Verduin, T. (2001). Comorbidity in childhood anxiety disorders and treatment outcome. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*, 787–794.
- Kessler, R. (2010, March 4). *Anxiety as a gateway disorder*. Lecture, Annual Conference of the Anxiety Disorders Association of America, Baltimore, MD.
- Kohen, D., & Olness, K. (2011). *Hypnosis and hypnotherapy with children* (4th ed.). New York, NY: Routledge.
- Kuttner, L. (2010). *A child in pain: What health professionals can do to help*. Bethel, CT: Crown House.
- Kuttner, L., Bowman, M., & Teasdale, M. (1988). Psychological treatment of distress, pain and anxiety for young children with cancer. *Journal of Developmental and Behavioral Pediatrics, 9*, 374–381.
- Kuttner, L., & Soloman, R. (1993). Hypnotherapy and imagery for managing children's pain. In N. Schechter, C. Berde, & M. Yaster (Eds.), *Pain in infants, children, and adolescents* (2nd. ed., pp. 317–328). Philadelphia, PA: Lippincott, Williams & Wilkins.
- Lewis, M., & Miller, S. M. (Eds.). (1990). *Handbook of developmental psychopathology*. New York, NY: Plenum.
- Liossi, C., White, P., & Hatira, P. (2006). Randomized clinical trail of local anesthetic versus combination of local anesthetic with self-hypnosis in the management of pediatric procedure-related pain. *Health Psychology, 25*, 307–315.
- Reiss, S., Silverman, W., & Weems, C. (2001). Anxiety sensitivity. In M. Vasey & M. Dadds (Eds.), *The developmental psychopathology of anxiety* (pp. 92–111). New York, NY: Oxford University Press.
- Richtmeier, L., Culbert, T., & Kaiser, P. (2003). Helping children with stress and anxiety: An integrative medicine approach. *Biofeedback Magazine, 31*, 12–17.
- Silverman, W., Pina, A., & Viswesvaran, C. (2008). Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents. *Journal of Clinical Child & Adolescent Psychology, 37*, 105–130.
- Spence, S. (2001). Prevention strategies. In M. Vasey & M. Dadds (Eds.), *The developmental psychopathology of anxiety* (pp. 325–351). New York, NY: Oxford University Press.

- Sweeney, M., & Pine, D. (2004). Etiology of fear and anxiety. In T. Ollendick & J. March (Eds.), *Phobic and anxiety disorders in children and adolescents* (pp. 34–60). New York, NY: Oxford University Press.
- Thapar, A., & McGuffin, P. (1995). Are anxiety symptoms in childhood heritable? *Journal of Child Psychology & Psychiatry*, 36, 439–447.
- Vasey, M., & Dodds, M. (2001). An introduction to the developmental psychopathology of anxiety. In M. Vasey & M. Dodds (Eds.), *The developmental psychopathology of anxiety* (pp. 3–26). New York, NY: Oxford University Press.
- Vasey, M., & MacLeod, C. (2001). Information-processing factors in childhood anxiety: A review and developmental perspective. In M. Vasey & M. Dodds (Eds.), *The developmental psychopathology of anxiety* (pp. 253–277). New York, NY: Oxford University Press.
- Wester, W., & Sugarman, L. (Eds.). (2007). *Therapeutic hypnosis with children and adolescents*. Bethel, CT: Crown House.
- Wilson, B. J. & Gottman, J. M. (1996). Attention—the shuttle between emotions and cognition: Risk, resiliency and physiological bases. In E.M. Hetherington & E. Blechman (Eds.), *Stress, coping and resiliency in children and families* (pp. 189–228). Hillsdale, NJ: Erlbaum.
- Yapko, M. (In press). *Trancework: An introduction to the practice of clinical hypnosis* (4th ed.). New York, NY: Routledge.
- Yapko, M. (2007). *100-Hour comprehensive training in clinical hypnosis and strategic psychotherapy*. Personal communication.