

Working Hypnotically with Children on the Autism Spectrum

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Working with children on the autism spectrum is a challenge I have enjoyed for more than a quarter century. When I saw my first client with autism in 1980, I didn't know anything about autism. But, as a speech-language pathologist, I knew about language development and disorders and, specifically, I knew about pragmatic language problems or difficulty with social language. I was trained in the late 1970's and early 1980's when 'pragmatics' was the emphasis of a speech-pathologist's education in the United States. That pragmatics orientation was the beginning of learning to see my clients and the problems they presented as occurring within a social context. Over the years, I have come to appreciate the importance of understanding how the context or specific situation including (the people, the environment, the expectations, etc.) affects work with clients on the autism spectrum.

Children on the autism spectrum often do well in some situations but not in others. They may interact well with some people but not others, or function well in certain environments but not others. They may function better with particular sensory stimuli but not others, and so on. The point I am emphasizing here at the outset is that there is no formula, no "cookbook" approach that will be effective in working with all children on the autism spectrum, hypnotically or otherwise.

Defining Autism Spectrum Disorders

Autism or autistic spectrum disorders (ASD) though commonly used in publications, presentations and conversations, is not considered an "official" diagnostic label according to the diagnostic manuals in use today: the Diagnostic and Statistical Manual- 4th edition, text revised,

(DSM-IV-TR) (APA, 2000) and the International Classification of Diseases (ICD-10) (WHO, 1993). Autism spectrum disorders is used synonymously with the five developmental disorders that are officially called pervasive developmental disorders (PDDs) according to the DSM-IV-TR. These include autism or autistic disorder, Asperger's or Asperger's syndrome (AS), rett's syndrome, childhood disintegrative disorder, and pervasive developmental disorder—*not otherwise specified* (PDD-NOS). There is a great deal of overlap between these five conditions and others not mentioned in this group, but the common thread tying all of these conditions together is that communication, behavior and social skills are all affected to one degree or another. Furthermore, an individual's level of severity may range from mild to moderate to severe within each diagnostic label.

Asperger's syndrome (AS) is the diagnosis given to individuals who have a cluster of symptoms that affect qualitative impairment in social interaction (restricted, repetitive, and stereotyped patterns of behavior, interest, and activities) and who have no clinically significant delay in language, cognitive development, or adaptive self-help skills. The DSM-IV-TR criteria for Asperger's syndrome essentially describe someone "...who has difficulty relating effectively to others despite having adequate intellectual and linguistic abilities to do so. Individuals with AS are often described as eccentric or odd. They may also be described as "loners," even though they typically do want to engage with other people. They just do not have the sophisticated social skills necessary for effective reciprocal interaction. They have difficulty understanding or relating to other people's perspective, motives and intentions (often referred to as Mind Blindness or Theory of Mind deficits). Nonverbal communications (e.g., facial expressions, tone of voice or body language that may, for example indicate boredom) are typically either not noticed, incorrectly perceived, or are unimportant to the person with AS. They have difficulty

organizing themselves and maintaining their focus for things not of interest to them (an executive function deficit), they get “lost in the tree” (i.e., the details) and not “see the forest” (grasp the bigger picture), called a deficit in central coherence. And they are often compulsively stuck on their own favorite conversational topics, often highly idiosyncratic subjects that hold little or no interest for others.” (Yapko, D., 2005, pp. 235-236). Current definitions leave out some of the common characteristics of sensory issues, organizational problems, and co-morbid psychological conditions such as depression, anxiety and obsessive compulsive disorder that are often seen in this population.

There is some controversy about the diagnostic boundaries distinguishing between several of the PDDs, such as high-functioning autism, AS, and PDD-NOS, as well as other conditions outside the *DSM-IV-TR* PDD category, such as semantic-pragmatic disorder and nonverbal learning disabilities (NLD; Bishop, 1989, 2000; Klin & Volkmar, 2000; Rapin & Allen, 1983; Rourke, 1989; Szatmari, 2000). For the purposes of this chapter, however, the differences between these diagnostic labels can be considered primarily philosophical because ultimately it is the behaviors, abilities, strengths, and weaknesses of an individual client that must be addressed in therapy, not the person’s diagnostic label. Thus, my focus here is on the unique attributes of the higher functioning individuals on the ASD spectrum that represent targets for treatment as well as personal resources to employ in the therapy. Although I will use the term *Asperger’s syndrome* (or *AS*) in this chapter, the ideas and methods presented here are likely to also be relevant for those individuals who present with similar patterns and issues, even if the diagnosis of AS has not formally been made. One of the main points that will be repeated throughout this chapter is that the diagnostic label is not the determining factor regarding whether to work hypnotically with a client.

Prevalence of Autism Spectrum Disorders

Prevalance rates refer to how many cases of a disease or condition in a defined group of people exist in a specific time and area. Many studies have been conducted and results vary according to the diagnostic labels used and the areas studied. For years, autism and other ASDs were considered a rare conditon and the numbers cited in DSM-IV were used as the standard: 2-5 per 10,000 children (APA). More current studies indicate that ASD is no longer considered a rare condition and suggest that approximately 1 in 150 children is diagnosed with an ASD (Centers for Disease Control and Prevention, 2009, Fombonne, E. 2005, Fombonne, E, 2001).

The rising rate of ASD is widely accepted, but many people wonder why it seems to have increased so rapidly in just the last decade. Possible reasons include an increased awareness for the diagnosis, a broader definition of the conditions, and possible environmental and biological causes. Identifying the reasons for the increase are beyond the scope of this chapter, but there is no doubt that clinicians are now seeing more individuals who have these unique characteristics and needs.

In December, 2007, the United Nations declared April 2nd to be World Autism Awareness Day (WAAD) which was celebrated for the first time on April 2, 2008. The rationale for a WAAD was stated as follows: “This UN resolution is one of only three official disease-specific United Nations Days and will bring the world's attention to autism, a pervasive disorder that affects tens of millions. The World Autism Awareness Day resolution encourages all Member States to take measures to raise awareness about autism throughout society and to encourage early diagnosis and early intervention. It further expresses deep concern at the prevalence and high rate of autism in children in all regions of the world and the consequent developmental challenges” (www.worldautismawarenessday.org) . Thus, it is important for clinician’s

to learn about these conditions and to have a variety of clinical tools for working effectively with this population.

Defining Hypnosis

Few words cause people to generate more diverse interpretations than the word hypnosis. From its very beginnings in the professional literature, it had mystical connotations about the unconscious and sleep. In fact, the word “hypnosis” comes from the Greek word “Hypnos” which is the word for sleep and the name of the Greek God of Sleep (Gravitz, 1991). Hypnosis has nothing at all to do with sleep. In fact, a person does not need to even close their eyes to experience hypnotic phenomena (Banyai, E., Zeni, A., & Tury, F., 1993). That is just one of many misconceptions about hypnosis. It was particularly disturbing to surf the internet and find individuals with Asperger’s as well as family members looking for assistance and their perceptions and reports about hypnosis were often nothing more than the old views of hypnosis as brain washing, mind control or mere parlor tricks.

There are definitions by researcher and clinicians alike. Barnier and Nash (2008) differentiate “hypnosis-as-procedure” and “hypnosis-as-product,” sometimes referred to as the difference between hypnotic traits and states. Debates continue as to whether hypnosis is a therapy in and of itself called hypnotherapy, or whether hypnosis is as an adjunct to be used in combination with other therapies. Some people add a qualifier to the word hypnosis, such as medical hypnosis or dental hypnosis to define the context in which it is used. Others refer to the target population such as when the term pediatric hypnosis is used to describe the use of hypnosis with children or self hypnosis to refer to the use of hypnosis employed on oneself rather than with another person. There is also a distinction when describing research hypnosis versus clinical hypnosis. As you read through the chapters of this book, you may find that some authors

prescribe to one definition over another, favor certain terminology over another or emphasize the characteristics of one aspect of hypnosis over another. It makes it confusing for both professionals and the general public alike when there is so much ambiguity about the name hypnosis and what it means to the people using it.

The current definition of hypnosis by the American Psychological Association's Division 30 (Society of Psychological Hypnosis) is as follows:

“Hypnosis typically involves an introduction to the procedure during which the subject is told that suggestions for imaginative experiences will be presented. The hypnotic induction is an extended initial suggestion for using one’s imagination, and may contain further elaborations of the introduction. A hypnotic procedure is used to encourage and evaluate responses to suggestions. When using hypnosis, one person (the subject) is guided by another (the hypnotist) to respond to suggestions for changes in subjective experience, alteration in perception, sensation, emotion, thought, or behavior. Persons can also learn self-hypnosis, which is the act of administering hypnotic procedures on one’s own. If the subject responds to hypnotic suggestions, it is generally inferred that hypnosis has been induced. Many believe that hypnotic responses and experiences are characteristic of a hypnotic state. While some think that it is not necessary to use the word hypnosis as part of the hypnotic induction, other view it as essential...” (Green et al., 2005, p 262)

Additional definitions come from psychiatrist Dr. Milton Erickson, who defined the utilization approach to hypnosis and psychologist Dr. Michael Yapko, who defines hypnosis within a social influence model (Erickson, Rossi & Rossi, 1976, Yapko, 2003). The combination of Erickson and Yapko’s work has guided my work with the AS population for the past 30 years.

Specifically, it is the use of the interpersonal context (our relationship, the client's expectations and the rules governing our therapeutic relationship) along with the interests, strengths and abilities of each client which are utilized to make a change in the client's thoughts, behaviors and/or actions that will enhance their abilities to function more effectively. From this perspective, my view of hypnosis has no magical qualities or formal structure. In fact, I describe my work with children as "being hypnotic" rather than "doing hypnosis." As Lynn and Kirsch pointed out (2006), to be hypnotic you do need the suggestions. You just don't need the ritual of hypnotic induction in order for them to have an effect. How we present ideas and structure our interactions with clients to have the greatest therapeutic impact is the basis of the study of hypnosis (J. Barber, 1991; T. Barber, 2000).

Interventions for ASD

Historically, there have been many different therapeutic approaches developed for working with individuals on the spectrum (D. Yapko, 2003). These have typically been based on particular treatment models or philosophies. For example, behavioral approaches gained significant attention starting in the 1960's. These were based on the applied behavioral analysis research framework that psychologist Ivar Lovaas used in developing his *Discrete Trial Training* (DTT) approach at the University of California-Los Angeles (UCLA). Subsequently, other programs were developed from the initial behavioral models, including the approach of integrating more naturalistic language paradigms and parent training developed by psychologists Robert Koegel and Laura Schreibman in their *Pivotal Response Training* (PRT) programs (Koegel, et.al. 1989). More recently, programs have evolved with an emphasis on the interface between developmental, social-emotional factors and the unique characteristics of an individual. These include programs such as *Floor Time*, developed by child psychiatrist Stanley Greenspan

and psychologist Serena Wieder (Greenspan & Wieder, 2001), and the *Relationship Development Intervention RDI®* model developed by psychologist Steven Gutstein (Gutstein, Burgess & Montfort 2007).

Unlike the approaches above that have proven themselves to be scientifically valid or are currently being studied we have no rigorous research to date to suggest hypnosis is a viable treatment modality for individuals with Autism Spectrum Disorders. Scientifically, we are still in our infancy regarding this subject. To date, only anecdotal reports, single case studies and uncontrolled research are available in the literature (Byron, 2006; Gardner & Tarnow, 1980 D. Yapko, 2006). Interestingly, though there is an emergence of authors who have started to talk about ASD and the use of hypnotically based methods such as meditation, mindfulness, relaxation, deep breathing and visualization (Mahari, 2006; Mitchell, 2008; Rubio, 2008.). Additionally, we have various studies that have looked at the value of neurofeedback for the autism spectrum population (Jarusiewicz, 2007; Pineda, et al 2008; Scolnick, 2005), but again, the scrupulous nature of science warrants more study than is currently available to make these approaches meet criteria for an empirically supported treatment. Despite this, the literature on working hypnotically with children in general is expanding and the nature of how to work with children on the spectrum continues to grow. It is my hope that chapters such as this will continue to encourage the scientific community to develop the methodologies that could validate the clinical observations and suggested approaches about the merits of hypnosis in treating the symptoms of ASD.

Children and Hypnosis

The research on working hypnotically with children is not nearly as expansive as that of adults, but it has been steadily growing (Olness & Kohen, 1996). Hypnosis has been used successfully with children for medical, dental, psychological, educational and behavioral conditions (Olness & Kohen, 1996). These include: pain management in chronic and acute conditions as well as in procedure-related circumstances (such as undergoing medical tests), reducing or eliminating asthma symptoms, nausea and vomiting, eliminating enuresis, anxiety, phobias, and posttraumatic stress, dealing with speech and voice problems, managing learning disabilities, and tics, reducing or eliminating dermatologic problems, treating behavioral problems, and more (Gold, et al 2007; Olness & Kohen, 1996; Scott, Lagges, and Linn, 2008).

Despite the increasing literature base for using hypnosis with children formalized studies are limited. Milling and Costantino (2000) did a review of existing controlled studies of the efficacy of clinical hypnosis with children and found a limited number of such studies. The majority of research on children with hypnosis remains anecdotal case histories and uncontrolled research studies. The authors concluded that, “no child hypnosis interventions currently qualify as “efficacious” according to criteria for empirically supported therapies (EST).” Despite this, the authors believe there remains a value to using hypnosis with children and further study is necessary.

My goals in working with children are to continually be open to what I see, test out my interpretations rather than assume anything, and give every child the benefit of the doubt in wanting to do the best they can, avoid humiliation and be the best they can be. I learned early on to strive to minimize my prejudices from one of my first client, a teenage girl in a coma who had

sustained a closed head injury after falling from a horse. She was an in-patient at the University of California, San Diego (UCSD) Medical Center, where I worked at the time. My job was to stimulate this young girl's senses while she lay in a coma. So, I had her smell various fragrances and odors, listen to favorite music, and feel different textures. I told her mother to do these same things with her at various times throughout the day and to continue talking to her "as if" she could hear her. She had occupational and physical therapists who also came to work with her twice a day for several weeks. When this young girl eventually came out of her coma, I was surprised to learn she had remembered some of the stimulation techniques that her mother and I had used to engage her in her recovery.

Fortunately, we are expanding beyond our prejudices as to what children can experience in terms of symptoms and treatment modalities. Early on, it was thought that children couldn't be meaningfully hypnotized. Later it was thought that children might actually be better hypnotic subjects than adults because of their rich fantasies and imaginations. Now, there is some suggestion that there is little or no relation between imaginative capacity and being a good hypnotic subject (Nash, 2001). Our understandings go through revisions as new data emerge, and hopefully using hypnotic methods with the ASD population will eventually be recognized as a beneficial treatment tool.

There are many factors that contribute to the difficulty in scientifically controlling studies of children and hypnosis. These include: methodological issues, the individual nature of children and their responsiveness to particular hypnotic techniques and approaches, the interpersonal relationship and the expectancy that is invaluable to the hypnotic experience. Hopefully, more research interests will be stimulated to validate what so many clinicians and clients are finding helpful on about hypnosis.

The Need for Individualized Approaches

Many different theories and models have informed my use of hypnosis with children on the autism spectrum. Those that have had the most influence on my work are models that encourage seeing the individual client rather than having a rigid framework in which the client must fit. These include Jay Haley's definition of effective therapy as being complementary in structure to the client's symptoms (1973), Milton Erickson's utilization approach in which one accepts and utilizes a client's set of skills and interests (Erickson, Rossi & Rossi, 1976) and Yapko's social model of influential communication (2003).

Emphasizing a person's strengths while acknowledging their interests and personal experiences are key to working with the unique population of children on the autism spectrum. I have described this point in detail in other writings (D. Yapko 2006, in press) in which I emphasized utilizing the strengths that children on the autism spectrum possess rather than focusing on their deficits or weaknesses. The importance of recognizing what a child with ASD *can* do rather than what he or she *can't do* cannot be over stated. It is often by recognizing what a child can do we can create experiences for him or her to have success and make therapeutic gains.

There are probably few characteristics more important in working with children on the autism spectrum than to recognize them as individuals. Not all children on the spectrum are alike, nor are all children interested in the same things. It seems obvious, yet it is often the case that people employ hypnosis as a scripted approach as if all those with the same diagnostic label are essentially the same and will need or respond to the same process. The work I do with children could be no farther from this scripted framework. Anyone can read a script and then

claim that “hypnosis” did or didn’t work. But it is not the hypnosis that is “working” or “not working.” Rather, the therapist’s ability to uniquely tailor the hypnotic technique and language to the individual’s cognitive style, attentional style, and symptom patterns along with the quality of the therapeutic relationship and expectations determines whether or not the “hypnosis” worked (Yapko 1993). Simply put, the therapeutic power is not in the hypnotic suggestion. It’s in the client’s ability to incorporate and use the suggestion.

In the chapter by Scott, Lagges and LaClave (2008) in which they summarize the work they did with two patients (11 and 16 year old boys) they highlight the importance of listening to their patient interests. They wrote, “...listening carefully to the patient for important aspects of their personal lives, was the key to engaging the subject hypnotically. As a result, carefully choosing an induction or deepening technique was not of the utmost importance for either patient. Rather it was the relationship and the attention to detail of both of the therapist to notice what was of particular interest to each patient. This is an intentional part of the work that we do in hypnosis with our patients. In that sense we are not highlighting hypnosis, but rather sound therapeutic techniques. Solutions are discovered when we stop to listen to our patients, and it is noticing their striving to be competent and noticing their uniqueness that we find a therapeutic key to unlock solutions to their problems” (p.608). Although the children they treated were not diagnosed with ASD, theirs is the same premise that I use in my work.

Guidelines for Working Hypnotically with Children on the Autism Spectrum

There are unique characteristics one needs to be aware of when working with children in general and those with Asperger’s in particular. First and foremost is the language of the child. Language is a developmental issue and as a clinician, it is important to know what language is

age appropriate for your client. However, assessing language according to only the child's age can be somewhat confusing with the AS population because some of these children have vocabulary and grammatical skills well beyond what their chronological age would suggest. Yet, the ability to use their language in socially appropriate conversations is often underdeveloped, mechanized from routines or entirely absent. For example, children with Asperger's often have difficulty understanding the "give and take" of conversation, and they frequently lack skills in initiating, maintaining and terminating conversations appropriately or asking relevant questions to engage their communication partner and expand upon conversational topics not specifically chosen by them. Additionally, these children typically have limited abilities to understand abstract language, sarcasm and humor. Words that have more than one meaning can be difficult to interpret as these children do not necessarily use the context to determine the meaning but instead use their egocentric (and often limited) perspective for the meaning of a word. They are often concrete in their language, so abstract concepts and certainly metaphors can be difficult for these children to understand.

Regarding metaphors, it is important to note, that simply because these individuals can be very concrete in their thinking and language use does not preclude using metaphors and abstract concepts with them. Instead, it means that as a clinician you need to be aware of whether the child you are working with is able to understand the meaning that you are attempting to get across. For some, you are likely to have to explain the metaphor and make the connection for the child about how "this" relates to "that." The *Harry the Hypno-potamus* books (Thomson, 2005, 2009) provide a good introduction for some children to the ideas of story telling and metaphor.

In a previous publication (D.Yapko, 2006), I described the use of a fish metaphor to help a child with Asperger's understand how to focus on external factors (i.e., situational cues) to help

him change his behavior according to his circumstances rather than being internally absorbed and responding only to his own thoughts and feelings. Because he loved fish and the ocean, I was able to use this topic to talk about fish that adapt depending upon salt or fresh water, and those that are camouflaged but change to best suit their needs. The following is a brief sample of the transcript.

“...being in the right place...for a particular fish...is obviously very important to their survival...There are some fish that are very colorful and other fish that seem to be without any color...and as you ...go deeper...there are many more things in the ocean to notice...when you learn to notice...and you can learn to notice...them...so, there may be a rock...or what you think is a rock...that as you ...look closer...starts to move...yes, that’s right...just slight movements (responding to the child’s own movements)...and then you start to notice that it is not a rock after all...but a clever fish that camouflages itself...so that it can look...and act...like a rock sometimes...and at other times, it looks and acts like a fish... and isn’t it interesting that fish can adapt...as a way of protecting themselves...and as a way of growing and thriving...something you can think about when you need to adapt...and thrive..And I wonder if you will notice the fish that changes colors...a good reminder that change is possible...” (pp 258-259)

Another specific area that clinicians who work with children who have Asperger’s need to be aware of is their cognitive style. Many children with Asperger’s employ dichotomous thinking. That is, they tend to see things in extreme “all or none” or “black and white” terms. They have limited understanding of the gray areas in between the extremes. Thus, for these children, it is important to use concrete examples to help them understand how to figure out those areas of life that are more ambiguous. Using numeric scales can be helpful in this regard, an approach that has been described in the hypnotic literature (Kohen & Murray, 2006) as well

as in the autism literature as a means to help make cognitive-behavioral approaches applicable for this population (Buron, & Curtis, 2004). Both in and out of hypnosis, I frequently use number scales to help children understand ambiguous concepts (such as regulating one's emotional responses) as well as more concrete concepts (such as the volume of their voice). For example, helping children see on a scale from 1 to 5 (or 10, whatever you determine is most helpful) how their level of agitation or anger can start out low (1) and escalate to a high number (5) when they are highly anxious, out of control or aggressive teaches them there is a process taking place, one in which they play a role. The number scales concretize what are otherwise abstract feelings and concepts. By giving each number a relative value with words and behaviors associated to it, they can be used to help reduce the symptoms by decreasing the intensity on the scale, an imagery that encourages great self-regulation. Then, in hypnosis, these same numbers can be reinforced with examples such as going up or down in an elevator according to the number you push, the numbers on a thermometer, using the keys of a piano, the steps of a flight of stairs, or any preferred interests that the child may like to associate to the numbers. The following is a brief sample of what the hypnotic suggestions might sound like:

“and as you look around...you can see the numbers...maybe they are on the wall of the elevator...or maybe they are above the door...and I wonder what number you see right now...that's right...the numbers change... just like your feelings change....but you can start to choose...that's right...I wonder what number you will push... to begin...begin to feel calm...feel the elevator taking you down...the speed slows...your breathing slows...that's right... and you can choose to push the number you want...”

A third area of importance in working with this population is to understand these children often have narrow interests. One of the common characteristics of children with Asperger's is

their desire to only do and talk about those things that are of high interest to them without regard for their impact on others. These children often get stuck on certain topics that isolate them from their peer group either because the topic itself is less interesting to others or because they can't seem to monitor or control how much talking about that subject they do.

Using that special interest in working with these children is a great tool for a number of reasons. First, who doesn't like to talk about those things that interest them? Most of us do. If you're talking about what the child likes, then you're more likely to maintain his or her attention and interest in what you are saying. Second, most of these children are frequently being told to stop talking about that subject (whatever the subject is), so when you allow them to talk about it and you also talk about it, you've gained some credibility with the child. Third, their favorite topics are what they are thinking about anyways, so why not accept and utilize it?

One child I worked with had an obsession with elevators. He knew which buildings throughout the city had elevators and which didn't. He knew what the elevator's style was, when it was built, who the manufacturer was, how many floors the elevators went to, where they were located in the building and whether or not they were public or private elevators. For him, I used elevators as a means to address the issue of not always being able to do what you want to do. The elevator was used as a special topic of interest that allowed him to understand the concept of flexibility I was trying to teach him. The suggestions given in hypnosis were as follows:

“...I wonder what elevator you are thinking about now...as you sit there...that's right...comfortable...thinking about the elevators...and I don't know if it's the elevator in my building...or maybe another elevator...I wonder if it's one of those new ones...maybe a quite one....or maybe a noisy one (responding to noises in my office) ...I don't know what it looks

like...but you do...you know alot...and you can continue to know...about many different things...some buildings have stairs... and you want them to have an elevator... but you can't always get what you want...remember...like the Rolling Stones song... you know that they will not have an elevator...even though you want one.... you know...elevators go to many different floors...you may want to go all the way up to the top...that's right...your chest goes up and down like an elevator when you breath... that's right...and you want to go to the top...but someone steps in and pushes the button to the second floor...it's okay...you can wait your turn...that's right...I wonder if you will get to the top next...or maybe someone else will come in and you will need to make another stop...another floor...another person...that's okay...you can wait your turn...and sometimes...your turn will come when the other people are gone... you have to wait for everyone to get off at the right floor...and then it will be your turn... and just when you have your turn... the elevator will come down again...and maybe you will need to make some stops along the way...after all...there are other people on the elevator... and you know...you can wait your turn and enjoy the ride...

Experiential learning has been well documented as one of the best ways to learn and it is my experience that this is especially true for individuals with Asperger's. As a rule, they do not generalize well between situations; They learn things in one context that are not always applied in other related situations. By giving children with Asperger's hypnotic experiences, they have the opportunity to learn about situations beyond the therapy room where they can apply the skills you teach them. Employing post hypnotic suggestions that can be directive (“...and when you are in your classroom you can...”) for the purpose of helping to generalize skills is a valuable part of how hypnosis can be useful in this population. Simple language that helps the child

connect what they practice in therapy with another place (school or community), or person (friend, parent, stranger), is important for helping them to generalize their skills.

An example of experiential learning can be found in the following example. In the hypnotic literature, it is often said that what one focuses on, gets amplified (Yapko, 2003). I have often used this simple idea as a hypnotic induction with children by starting with the concrete handling of a magnifying glass. Children learn directly that when they see things through a magnifying glass, they get larger. I want them to understand this concept for a couple of reasons. First, in concrete terms, I want them to understand and experience the concept of magnification. Second, I want children to know they have choices and can choose what they focus on. This seemingly simple concept has huge implications for many of the common symptoms in children with AS, including depression, anxiety, obsessive compulsive behaviors, social and peer interactions, and limited interest in conversational topics beyond their own favorites as a few examples.

I have several different size magnifying glasses and encourage children to explore the therapy room as much as possible with the magnifying glasses. As they do, I start infusing hypnotic suggestions such as the following exploration into the process:

. "I wonder what you might look at next...it's interesting to make choices about what you will focus on...after all...you are in charge of what you choose to look at...that's right...you can explore the whole room and then move in a specific direction...it's so interesting...and calming...to make choices for yourself...to choose that you want to focus on that...and to see...that you can focus and sometimes things will seem much bigger than they really are...that's right...when you move the magnifying glass...that block becomes smaller...and yes...that's right

you can make it bigger again....or maybe smaller...and the more you... learn to focus...the more you ...can focus...that's right...focus on my words....focus on what you are looking at ...focus on making choices that will make you feel good...you can focus...on the choices that help you...when it is too big...you can shift...that's right...you can move...your attention...and make it not so big... you can choose..."

Another area of importance for clinicians to be aware of when they work with children on the autism spectrum is the unique sensory issues that many of these children experience. Our brains process the world through our senses but children on the autism spectrum often experience these senses differently than the rest of us. Experiences of touch that may be thought of as a positive, loving, connected experience may not be perceived that way by those with Asperger's and may even be viewed as painful. The sights and sounds in an environment may be overwhelming for some, resulting in their being less responsive to the external environment and possibly reverting inside themselves which in turn fuels their social disconnectedness. Certain textures such as the material of your office furniture, may be so bothersome as to distract them from more relevant information or experience in the therapy room. Some children have learned to compensate for some of their sensory issues by relying on constant movement or fidgeting to help them focus. Such focal points can be used in hypnotic inductions as you have the child squeeze rubber balls or use other hand fidgets to help focus and calm a child.

Summary

The underlying principles of my work with all children are to amplify the skills that a child already has, provide additional skills that they are missing or teach them how to more effectively use and generalize their skills in an ever growing array of contexts. Hypnosis has

been effective in helping children to achieve these goals. The “accept and utilize” principles of a more naturalistic (i.e., less structured) hypnosis in particular have shown themselves to be more adaptable to the individual child, perhaps because of the more fluid nature of children’s attention and behavior. Most children don’t sit still, they may not close their eyes, their attention is limited, they may spontaneously engage with you verbally during hypnosis, and may manifest other such seemingly “non-hypnotic” behavior. But, all of these things can easily be used and accepted without judgment in a utilization framework. For children on the autism spectrum in particular, who likely have characteristics that don’t fit well with standardized approaches, it is especially important to recognize their unique attributes and resources in working with them in any therapeutic context with or without hypnosis. A few of these characteristics were described in this chapter, including the clinician’s need to be cognizant of: the individual’s language capabilities, their level of understanding and ability to appreciate and benefit from the use of humor, sarcasm, and metaphors, their typically concrete thinking styles, their unique perspectives on how they see the world, and the sensory issues that may affect their processing of experience.

After almost 30 years of working with children on the spectrum, I continue to be fascinated by their perspectives and have to remind myself often not to assume anything about their capacities. In fact, sometimes it is the simple acts of playing a game and having a conversation that open up the perspective of the child for me to see how to best relate to him or her in a way that could never had been anticipated or scripted. In this chapter, I addressed just a few areas that could be therapeutic targets and suggestions for how to address them by integrating hypnotic principles and language. The number of possible hypnotic experiences to facilitate is as great as the individual clinician’s creativity and the uniqueness of each client.

Working hypnotically with children on the autism spectrum remains an area of uncharted territory. By writing about my clinical experiences and sharing anecdotal evidence of its utility, I hope it will bring hypnosis to a wider audience and encourage interested researchers to engage in further study of its merits.

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