Secrets of the River

Riding the Creative Wave in Pediatric Hypnosis and Family Therapy

Nathan Welch Kelley T. Woods

This book excerpt has been provided for HPTI students.

It contains only the first THREE chapters and the useful Appendix section.

To purchase the full book, please visit:
https://www.amazon.com/Secrets-River-Creative-Pediatric-Hypnosis/dp/1492384305/ref=sr_1_3?ie=UTF8&qid=1528850650&sr=8-3&keywords=secrets+of+the+river+woods

Cover Design by September Garland
Cover Photograph by Chuck Hilliard

Disclaimer and/or Legal Notices

The information presented herein represents the views of the authors and publishers as of the date of publication. Because of the rate at which information and conditions change, the authors and publishers reserve the rights to alter and update their opinions based on new information and conditions.

The contents of this book are for information purposes only and the author and publishers do not accept any responsibilities for any liabilities resulting from the use of this information. While every attempt has been made to verify the information provided here, neither the authors nor

the publishers assume any responsibility for errors, inaccuracies or omissions. Any slights on individuals, groups or organizations are unintentional.

DEDICATION

We dedicate this book to all of the children in our lives: our own marvelous biological ones and all of the delightful, creative, inspiring, and important ones we have had the honor of meeting in our work and play.

TABLE OF CONTENTS

FOREWORD

When Kelley and Nathan asked me to write the foreword to this book and sent me an advanced copy to read, I thought I would glance over the outline and then take time to read it over the next week or two. But that is not what happened. I opened the document, scanned the Table of Contents and immediately become engaged in the rock-solid topics they addressed. I then spent the entire day reading the book from cover to cover. Kelley and Nathan have clearly written what I predict will be the definitive guidebook on Contextual Hypnotherapy for kids.

Contextual Hypnotherapy has its roots in an evidenced-based treatment approach which stays in the present and teaches clients the skills needed not only to solve a presenting problem, but to avoid future problems by utilizing prior learning in hypnosis. So many hypnosis training books still focus on outdated Freudian ideas of finding a "cause" for every problem and then releasing it through catharsis. While some clients may find relief from that which is distressing to them through such a process, the vast empirical data has moved psychology treatment to a new approach of Mindfulness-based therapies such as ACT Therapy. It is great to see that hypnotherapy is also moving towards embracing a new way of problem solving and drawing from the incredible promise offered by third-wave behavioral strategies.

This book is a great resource for learning a foundation of methods that are based on a new approach to problem solving and this will force hypnotists to rethink the approaches they use with clients and challenge them to become better therapists. The initial chapters provide accurate information about working with children, hypnosis and children, detailing even the atmosphere, props and performance aspects of hypnosis with children. Successive chapters are equally valuable, presenting specific methods for significant issues such as Autism, ADHD and eating issues.

I was very impressed with the practical explanations of the tenants of ACT therapy, relational frames and the lesson on telling a mindful story. These are skills that will alter any hypnotist's professional practice, whether they work with children or adults. Every hypnotist reading this book will take away new strategies and new applications of Contextual Hypnotherapy. I learned a lot from this book myself and am looking forward to additional projects from Kelley and Nathan that will benefit parents, teachers and therapists.

Dr. Richard K. Nongard, LMFT

Scottsdale, AZ 2013

Introduction

The Power of Stories

Why are stories so effective in facilitating change? The answer to this question lies deep within our collective psyche because stories have existed for as long as we have been able to communicate, used as the vessel to carry the very fabric of our human existence. Tradition, culture, art, music, religion and entertainment all reside within us in story form.

When we first arrive in the world our own personal story begins, like a source of water bubbling up from the ground. As we progress, we take on other stories, tributaries adding to our life experience and, like a river of life, we also nourish those whom we encounter with our perspectives. Even after our eventual, final merging with the sea of eternity, our story is left behind to successive generations who will benefit, learn and possibly even laugh!

We think in deeply metaphoric and symbolic ways, carrying these representations into our interactions with others. Our own narrative is splashed with metaphorical icons of our values, beliefs and experiences, all of which comprise a bottomless pool of “who we are”.

The potent power of stories is contained in their ability to entice our imagination and thereby allow us to extract our own meanings and interpretations which then resonate, move, challenge and empower us on a subjective level.

Stories allow us to bend the time and essence of our cognitive landscape, guiding us down creative whirlpools to

rewarding inner worlds which, in turn, burst from us and impact positively on our outer worlds.

In stories we harness the two most important powers known to man: imagination and the unconscious mind, and with these open a new world of possibilities.

Working with children through stories and metaphor is a wonderful and empowering modality for experiential change. Stories enable us to access the imaginations and the subconscious minds of our clients - the very places where they build and expand upon their behavioral templates. This allows access to a sea of change where transformation can happen naturally, easily and most importantly, with the essence of fun! And all of this occurs at the fastest speed known to man: the speed of imagination.

We wrote this book, blending our unique experiences and perspectives, to provide you with not only insight and knowledge but to also ignite your creative imagination. We hope it motivates and inspires you in your work with children in your practice and also reminds you of the blessing of children in your life.

Please join us as we journey together into a world of new discovery and adventure, sharing and learning together...the Secrets of the River.

Chapter 1

Why Work with Kids?

"Never work with children or animals."
~ W.C. Fields

We won't be talking about working with animals, but as for playing with children, we highly recommend it! If you enjoy clients who have vast, creative imaginations and if you desire working in dynamic, free and innovative ways…you will find that including children and families will enhance your hypnosis/therapy practice.

Today's kids are struggling more than ever. Life is extremely complicated for all of us and our children are taking the brunt with the fall-out from:

- fractured family life
- over-booked schedules
- poor nutrition
- less physical activity
- ineffective school systems
- financial strain and stress
- lack of positive role models

When we work with a child, we have the honor of empowering them with a mindset which will serve them throughout their lifetime, influencing everyone with whom they come in contact. A well-conducted intervention with a child who is struggling may even detour them from a

potentially miserable and even dangerous life experience.

Because children are extremely receptive to hypnotic strategies, the rewards that arrive when working with them are quick and satisfying to both client and practitioner. Often, results are spontaneous or may even occur seemingly without much input…evidence of the power of subconscious problem-solving abilities.

Sessions with children are interactive and fun, allowing so much scope for innovation; did we mention that they are FUN?! There is no better feeling than helping families communicate and interact in positive and mutually beneficial ways as we help them to understand, accept and embrace individuals, ideas, beliefs and values.

The personal benefits of stepping into a child's world, activating our own child-like attributes and perspectives while using our adult knowledge and experience, can create a much-needed balance in one's life. To be reminded of what it is like to be young expands our minds and spirits, kindling a playful energy that too often is minimized in our daily existence as adults.

Whether you already have child clients or are interested in beginning to work with children, this book will help inspire you to view how you engage with them as an exciting and rewarding experience. Think of working with children as adding sparkles to your life…sparkles which need to be nourished and valued!

Myth Busting

In order to gain better perspective, it is important to begin by addressing some commonly held myths surrounding working with children. It's easy for all of us to fall into traps of stagnant thinking, clinging to absolutes in life. Our goal is to embrace the *growing* aspect of growing older and move into more flexibility in our work and in our lives in general.

With this in mind, we encourage you to use the word "should" with an increasing rarity and replace it with "could". Thinking of fostering choice over control will help you let go of the idea that theories and approaches are concrete and immovable forces that should always be utilized.

Myth #1: One can't work with very young children due to their disruptive behavior; that the process may be damaging or traumatic or that they will not be able to participate in any meaningful way because of their developmental limitations.

As parents and practitioners who work with young children we know that there exist good reasons to include and work with young children in partnership with their parents and caregivers.

From observation of the young child's play, artwork and interaction with other family members, we can gain access to a wealth of information that would be far less accessible through verbal communication and interviewing techniques. Often, children's artwork and play are a cognitive blueprint metaphorically for how they view themselves, family members and their environment.

Exploring these processes with other family members can open up family values, beliefs and dynamic. This provides a platform to explore what is working and not working for the family and to cultivate an environment of curiosity to explore the family narrative and design new solutions and story lines for experimentation between sessions.

Myth #2: Traumas in early life result in a child becoming a damaged or dysfunctional adult.

The fact is that many people have had trauma in their early lives which then follows them into adulthood. This is one of the most important justifications for early intervention. Lack of understanding and of a safe environment for the child to talk and share their trauma, should they wish to, is often what create the lasting effects, much more than the actual trauma itself!

This is also why resilience is one of the greatest attributes we can inspire in our clients and our children. By resilience, we mean "the maintenance of competent and value orientated functioning despite interfering emotionality". Another way to describe resilience is "the acceptance of feelings while being mindful and present…able to find and continue in value-orientated directions".

Children are remarkably adaptive and psychologically flexible. When working with young children, we can show them how to direct these skills with an optimistic attitude. By capitalizing on their natural, existing internal resources, we can introduce them to the power of choice in a solution-focused direction.

Myth #3: Big challenges require complex solutions.

What makes something difficult? This is a fairly small question, but think about it for a moment - what *is* it that makes something difficult?

Is it our client's perception, other adults' perceptions or perhaps even our own perceptions that lend a sense of difficulty to a case? Many times, there is a contagious belief of resistance. (See our take on resistance in Chapter 11).

The theme of this book is one which will help you guide not only children and their adults, but yourself out of limiting constrictions about what is difficult and into a free and wide realm of exciting solutions.

Myth #4: Children don't know what's best for them and should not be included in the formation and planning of interventions.

So often, professionals and parents exclude the child from the discussions and information gathering process in the critical early stages of sessions. To give children a voice from the beginning in the process is so incredibly important. We want the child to share their goals, expectations, perceptions, understandings and confusion. We want to explore the family dynamic, how individual members of the family connect and communicate and how the family as a single unit relates with their wider family, the community and society in general.

When children are included at this stage, we create an atmosphere of safety, self reflection and communication that allows them to feel heard, valued and empowered within the therapeutic environment. We establish common goals by

harnessing the power of a collaborative approach. Communication, understanding and meaning are all aired, shared and improved, which often is how 90% of our work is done. This process on its own can be hugely beneficial and positive for the child and the family as a whole.

Myth #5: The therapist or practitioner is an expert on the parents and their child.

This is one of the single biggest mistakes one can make. We can fall into the trap of believing that our training and experience means we know best and that we have seen it all before. It is best to avoid treating any one case the same, even when the presenting problems are the same.

This is also where we can become entrenched in a particular approach or technique at the expense of our clients.

The parents and the child are the experts on the parents and the child! Each will know the other in ways we never can. They will know each other's buttons and how to press them, along with the good and the bad in each other. This is just as true for foster caregivers as it is for biological parents. Parents and children need to be encouraged to share their expertise so that we can together find and apply effective and sustainable solutions.

These are just a few of many myths that are prevalent in our field and, of course, our take on them is not absolute. We offer them to encourage you to become flexible and mindful in all cases, which will result in your increased effectiveness as a practitioner helping children of all ages.

How to gain your child clients

There are multiple sources to help you build your clientele of young people. Here are some ideas:

Mental Health Professionals

Many therapists, like Nath, work with social services and schools through referrals. Qualifications as a licensed counselor are usually required to work in this manner. In some cases, a non-licensed hypnosis practitioner can receive a referral from one of these counselors, especially for cases such as habit control, enuresis, sleep problems, phobias, etc. We recommend you establish working relationships with pediatric counselors, along with child services agencies, in your area, letting them know of your hypnosis practice and your ability to help in these specific topics.

Your Adult Clients

Another great source of child clients is your adult hypnosis client base! When an adult has experienced success with you, they may wonder if hypnosis can help their child. Since you have already created a working relationship based on trust, it is natural for them to believe you can do the same for their child. Offering a discount for family members is a good marketing tool that will open the door for getting to work with the kids, but be careful not to minimize children by charging less for them.

Sports Clubs

Many hypnosis practitioners find clients in the sports performance arena. If you or a family member participate in a family-oriented sport, offer your services to fellow athletes.

If working with a team, always connect with the coach or head instructor and remember that it is not your job to dictate technique, but to help an athlete enhance performance. This will preserve your relationship with the coach and even get them referring your services.

Kelley:

Working with kids in sports performance is one of my favorite endeavors. I practice martial arts and have helped many fellow students get past self-limiting fears, increase focus and motivation for practice to take their martial arts to the next level.

Performance anxiety is an oft-presented issue when it comes to helping children with sports hypnosis. This is an area that is ripe for hypnotic intervention and even one session can work wonders.

Some of my kid clients have gone on to break state records in competitions such as swimming, pole vaulting, running, etc.

<u>Libraries, Children's Museums</u>

Many people don't realize that their city's public library usually has a children's program and often one designed specifically for teens. Library and children's museums event coordinators are always looking for interesting topic presenters and hypnosis is perfect for a workshop for teens.

Schools

While public schools may not be open to giving you access to students, there are instances where you can offer after-school test anxiety or study skill enhancement workshops. Presenting your work as visual imagery or even mindfulness instruction can make it more palatable to schools.

Alternative high schools have students who are in great need of our services and are often open to hypnosis inclusion in their curriculum. Private and charter schools are also worth approaching, especially if you arrive with a specific topic that speaks to their needs.

Children attend school to improve their I.Q.; it's important that people like us help them improve their E.Q. (emotional quotient)!

Kelley:

Don't assume that schools don't want your help! I've been engaged to present at several public schools, at different grade levels. A good way to approach them is to contact home school affiliations, many of which now work in conjunction with public schools.

One of my favorite days was spent at a local elementary school with the "home school" group, lying down on the library carpet as we imagined flying above the town. The staff members even joined us!

Performing Arts Groups

Not only is this an excellent place to offer your help for stage fright, memory retention and more, you will access an open-minded and creative pool of hypnosis candidates in a wide range of ages. Offer to give a workshop utilizing visual imagery for character enhancement or to reduce outside distraction during performance.

Think of not only acting groups, but private music instructors, art classes, etc. With budget constraints, many of these activities have moved out of the public school domain and are being provided privately. Operators of these schools and classes are interested in adding to the appeal and effectiveness of their programs and hypnosis fits right in!

Medical Professionals

And, of course, one of the best referral sources for pediatric hypnosis clients are your local doctors and dentists! These professionals are usually very busy and when they discover that you can help their small patients with things like needle or "white coat" phobia, pain relief, habit control, bruxism, eating habits, etc., they are happy to include you on your team.

As you can see, by focusing merely on one or two of these resources, you can quickly build a thriving pediatric hypnosis business…and have fun doing it. In case you haven't yet noticed, we are all about having fun!

Chapter 2

Child Protection and Safety Measures

Establishing child protection and a safe session for all is a very important subject and one that is often daunting, but if we have ensured that the necessary procedures and planning are in place, we can relax in the knowledge that we have prepared to keep everyone safe.

We will now discuss the purposes of paying attention to how you can make a session safe and appropriate; a later chapter will address the session structure, including how to make it safe, fun and user friendly.

Nath:

I personally never work with a child on their own; I either have a parent or caregiver present, or use one of my staff to sit in as an independent observer.

The reason for this is, I hope, obvious: firstly, should anything requiring agency investigation get disclosed or should there be any highly charged emotion, then there is someone else to have witnessed this. Secondly, this leaves no room or opportunity for anyone to make false allegations of inappropriate behavior, etc.

I record all sessions on audio and explain why I do this to the parents/caregivers and it's for the same reasons as above. If they prefer that the session not be audio recorded then I ask them if I can have one of my workers present in the room. If

they do not agree to these requests I personally do not work with them and they will be referred to another therapist.

Kelley:

As a clinical hypnotist working in a private practice, I sometimes work alone with a child. It is not always practical or necessary to have a second party present during a session and I find that having parents or caregivers present can even hinder our work.

That being said, I take great care in assessing the comfort level of all parties, including my own, before asking any adults to leave the room. Depending on the child and the issue, I may leave the door open so that the child can move back and forth between rooms. I may use my larger room to work in, setting the parent up with some helpful reading so that the child is reassured but also notices that the parent is not exactly involved in what we are doing.

In most cases with teens, I ask the teen what they want. Usually, they are happy to see the parent leave for a while!

While I do not record, audio or video, my sessions with clients, this is due to my own preference. I suspect that in general, female hypnotists have less incidence of what Nath was referring to: claims of inappropriate behavior. I have never had a parent worry about leaving their child with me but this may not be the case for everyone and I imagine offering them the security of a recorded session may offset any apprehension.

Find out as much as you can about the child and their family/medical history so you have all the relevant information you need. Make sure your client has access to any medication needed such as inhaler, etc., and that if they need help to take medicines that someone with authority to do this is on hand.

Nath:

I also have a Child Protection Policy which I have posted as Appendix A near the end of this book for you to use as a model for your own, if you desire. The reason I have these policies in place is because 80% of my clients are referred by social case or schools; often the children have complex issues and may be quite dysfunctional with fractured family lives, so these policies make for additional safety measures for both child and therapist.

Make sure that your insurance covers you for working with children. In the UK, all people who work closely with children and vulnerable adults need an Enhanced Criminal Records Bureau background clearance. If you live outside the UK, please research any laws and legislation relevant to you and your work with children.

Most states in the USA have guidelines which adhere to the 1993 National Child Protection Safety Act and require similar screening, but check your local jurisdictions for specific laws.

Kelley:

Yes, here in Washington State, for example, Registered Hypnotherapists undergo a background check prior to being issued their Department of Health registration credentials and are governed by general safety standards regarding working with children, but many states do not regulate hypnosis at this time, so check your local jurisdiction for details.

It is also suggested that you locate local social services offices and learn about their referral processes. Should you need to contact them quickly in case of a child protection issue, this will expedite the process. Expanding your network and becoming part of a team with these agencies is a wonderful way to help children and their families!

Once these policies and procedures have been installed, providing that protection for your child client and yourself, you are able to focus on actually getting to work and helping your client.

Chapter 3

Case Conceptualization (Intake Process)

A major difference in working with children rather than adults is that, in most cases, the client is not accessing therapy due to their own volition. Typically, a parent or primary career has initiated the therapy due to their concern over the child. In some cases, it may be schools or social services that have referred the client due to emotional and/or behavioral welfare issues.

No matter who has directed the child to therapy, it is usually a fact that they did not choose to come to therapy themselves. This can have obvious problems for the therapeutic relationship. Often, children can see therapy as another form of punishment and they can even expect it to be quite psychologically demanding as therapists automatically take on an authority presence. Children may even think they are in trouble when they first come in and as a result can be quite hesitant and reserved.

So, in order to diffuse any negative presuppositions, it is important to install the essence of FUN when working with kids. A fundamental part of our case conceptualization needs to have fun built in - from beginning to end.

One of the greatest tricks to have in our bag is case conceptualization; it guides not only our choice of techniques, but also their pacing and implementation. It allows us to evaluate progress and it gives us flexibility with our interventions. It helps us to know when and how to use our tools.

Nath:

Case conceptualization involves being very much like a detective and, in fact, I often use a Wardrobe of Wonder (see Chapter 17) to don the clothing of the world's greatest detective, Sherlock Holmes. At times like this, as I conduct my initial consultation, I observe via the eyes of Holmes. This also can be used as a good springboard to starting the process with the child: I explain we are detectives looking for the clues that will help us solve the case.

This type of strategy not only builds rapport, a team ethos between me and child, but sets the stage for some spatial and temporal linguistics which jumpstarts the therapy straight away. It also allows us to sow some seeds around self discovery, responsibility for actions and reframes for later use in the therapeutic alliance.

This process is dynamic and fluid, requiring us to generate and test hypotheses. The more we work with the child and find greater understanding of their intra/interpersonal world, the better we refine and revise our picture of the child and, most importantly, their subjective experience of reality.

When a child first comes to therapy, I like to think of their presenting issues as ingredients in search of a better recipe and that I may need to add a dash of this, or a hint of that, to the mix in order to come up with a new, tastier and satisfying recipe.

Then, in collaboration with the child, we cook up the new recipe and sit back and smile at the resulting, wonderful new creation. It still surprises me how all my recipes sound and taste like stories, with symbols and metaphor in their many flavors as the most commonly added ingredients!

Kelley:

Many hypnotists work from an eclectic point of view and rely on their own instincts to navigate a session. Approaching your work from within case conceptualization allows you to still operate as you like, but with a sound structure as a base, giving you stability and a foundation from which to proceed.

Often a child will be presented to us with an informal or formal diagnosis. It is often that a parent has claimed that their child has ADHD, ADD, etc., and when asked, "Okay, so they have been diagnosed?" the reply is, "Oh, no, not officially...but I know because he/she behaves just like so and so..." We may even hear that a parent believes that they, themselves, "suffer" from the same condition!

Our view on a diagnosis is that while it is important and useful when working with professionals in a TAF (team around the family) it is just a generic label - a description, not an explanation. When someone is labeled with ADHD, for example, that just describes what we consider them to have; it does not explain how it manifests itself in their physiology, emotions, behavior or in their interpersonal relationships.

We seek illumination of how and why the symptoms occur and how environmental, intra/interpersonal factors shape the symptom patterns. We consider how both subjectively and systemically the presenting issue affects the client, his or her primary caregivers and the wider community such as peers, school, clubs, etc.

Once we have a formal diagnosis made by a medical

professional, we can then look at the above factors in addition to how the child experiences their own subjective reality of the challenges with which they have been diagnosed.

So what we present below is a structure we use; we do this now without thinking about it, as many of you may already do. It is always useful from time to time to sit back and reflect upon how and what we do.

Presenting Issues

The first step is to define what is believed to be the presenting problem; we write "believed" because on occasions what may seem like the problem is not the problem at all. We have had cases where parents insists this is the problem… only to work with the child and discover in fact that it's not the problem at all…well, not for the child, at least!

We have to take the generic description of the problem, for example, low self esteem, and determine the specifics of what that means to the child. If we are not careful, it's easy to get caught in the trap of thinking we know what it means from our own clinical experience.

Treat all new cases as though you have never dealt with the issue before, so you do not contaminate it with how you think the child is experiencing it. After all we are working with people, NOT conditions, and we should strive to respect the fact that each person is wonderfully unique..

Physiological Aspects

A first consideration is to know if there are any medical issues or treatment that may impact upon therapy. We also want to ferret out if there are any somatic symptoms that appear with the presenting problem, such as stomach cramps, headaches, sweating, etc.. We also consider the relationship between the physiological and psychological aspects of the client's symptoms.

What are the benefits, what are the restrictions for the client, and how does it impact upon him/her and the family and even the wider community?

Nath:

I once worked with a very intelligent child who held complete control over the family through phantom stomach pains. Despite having been thoroughly checked out by medical doctors and clinical psychologists, none could find anything wrong.

The whole family's life was governed and ruled by the child's stomach cramps. The impact upon school, the family, and friends was huge and was also a key factor in my case conceptualization because I had to work with the parents, school and siblings to find a plan that would work.

The physiological symptoms in the above case were just as important to manage and work with as the cognitive ones; this is very much the systemic nature of our physiological and psychological functioning.

So, please always look for physiological behaviors and their relationship with the psychological aspects of the presenting problem, then look at it systemically via inter/intrapersonal levels. It's very rare for conditions to exist in isolation or in pure form.

We recommend that you also gain some knowledge of the physiology of behavior, neuro-plasticity and biochemistry. *The Physiology of Behavior* by Neil R. Carlson is a great reference tool.

Emotions/Thoughts/Behavior

Emotions, thoughts and behavior are all related to and support each other, even often existing due to one another. For the most part these are internal and subjective; however, they are shaped, triggered by and anchored to our environment and interpersonal relationships with people, animals, objects and places as well. They are deeply symbolic and metaphorical, often autonomous and seem out of the control to the child when in relation to their presenting problem.

So we want to determine: what are the dominant emotions, behaviors and thoughts in relation to the presenting problem? What are the differences from the pre and post emotions, behaviors and thoughts in relation to the presenting problem? What are the dominant emotions, behaviors and thoughts of the primary caregivers and wider family and community?

Why do we ask these questions? The answers reveal the emotional and behavioral range; the spectrum in which we are working. They allow us to see how the relationships blend and work in addition to any consequences of those relationships.

Besides being interested in the contexts in which the issues occur, we are curious about how and when they *don't* occur and even in *what else is present* when they don't occur!

Nath:

To demonstrate this idea I will mention a particular child who presented with severe behavioral issues and had, at a young age, already been excluded from school twice. He would not behave for anyone…or so it seemed. Through the process of case conceptualization, I discovered that he behaved well for Granddad and never gave him any problems.

My next step was to interview Granddad, after which I arranged an observation of Granddad and the child together. This taught me all I needed to know: I saw how Granddad and the child interacted; the rules and consequences and how and what they said to each other.

I then proceeded to teach the parents and teachers a refined "Granddad approach" that they integrated with their own personalities and relationships with the child and…bingo! God bless grandparents and their wisdom.

Utilizing case conceptualization gives us an insight into the

rules and values of individual members and groups with which the child has contact, in addition to what happens as a result of following or not following those rules and values. It allows us to see where commitment, consistency, care, compassion, love, nurture, etc., exists, both intra and interpersonally.

We gain insight into how a child forms their metaphorical and symbolic world, the internal conversations they have and how they structure meaning and understanding. It gives us the blueprint to the templates they use for creating their subjective reality.

We gather this information by listening to and observing the child, primary caregivers, siblings, wider family and school. We are looking for the environmental and relationship cues and triggers to the presenting problem, always on an intra/interpersonal level. We are looking for the narratives/stories people tell, both factual and fictional. What are the dominant stories, what do they contain and what happens as a result of their telling? We discover data from use of clean language, Socratic questioning and the use of drama and play both with adults and children.

And by gathering this information, we get ideas and inspiration for therapeutic, creative stories...a type of alchemy in which we utilize ingredients that may not seem particularly useful, productive or valuable on their own, turning them into narrative gold.

Words and actions are the stimulants of the mind. Just imagine that the mind has its own pharmacy and that our words and actions write the prescription, which the pharmacy then dispenses!

With this metaphor, if what we say and do results in the type of prescription the internal pharmacy gets, we receive the pills (biochemistry) that we asked for and this helps shape our subsequent emotions, behavior and thoughts. We continue to subscribe to this prescription until something else happens to break the pattern.

It is valuable to consider the types of prescription everyone is filling out with their words and actions, and also to observe what happens as a result. With this insight it is then possible to design collaborative approaches to not only break old patterns but to apply new, more effective and positive metaphorical prescriptions.

The Family Constellation and the Wider Community: Systemic Thinking

Ideally, a family therapist views a presented situation as a system of some sort and seeks to understand the relationship between people, objects and environments. The family dynamic and how it functions is of great importance to the process of therapy. In order to help children make positive changes, one nearly always needs to work in a systemic way.

To facilitate this, it's important to discover the makeup and structure of the family. Details to determine this might include:

Who are the primary caregivers

Who is considered "in charge"

Who is the disciplinarian

What rules the family follows and what happens as a result

What are the family values and what is the significance of these values

Does the family eat together and spend quality time with each other

What are the leisure activities, groups or clubs they belong to

The types of discipline, boundaries and consequences are in place and how effective are they

It is relevant to take into account socio-economic aspects as well as ethno-cultural ones.

Nath:

I live and work in a mixed heritage environment, my own children have Native American, Jamaican and Jewish heritage, I need to understand the cultural and religious aspects that could play apart in how and what I do in the therapeutic setting.

It is also imperative to be mindful of how the child interprets and integrates his/her ethno-cultural background. It is a good idea again to have a general working knowledge of different cultures and religions so we can be mindful and respectful in our work.

Kelley:

It's nearly impossible at this time in American history to *not* have clients of a diverse background. Although I don't currently work with social services–referred kids, many of my child clients are of diverse background and I make an effort to educate myself about their cultural influences.

Approaching our work from a more systemic viewpoint affords us, as therapists and hypnotists, deeper and more lasting results when working with children. Adults always have options of moving out or standing their ground, having generally far many more choices within a family setting than children enjoy. To really help a child change or even just learn to cope within a situation, we have to help the family change, too.

Challenges in families rarely exist in isolation as everyone, to some extent, is affected by the presenting issue or challenge. If we work from a systemic approach there is better chance that everyone concerned gets the help they need.

Developmental History and Milestones

When working with children, obtaining a personal developmental history is standard clinical fare. This informs us of any significant delays or advancements in the child's development. This can include habits of eating, sleeping, language, toileting and educational development in addition to any history of illnesses or accidents and participation in activities, groups and clubs. Delving into this history also provides information around the caregivers; their perception, accuracy and completeness of such details can be revealing.

Potential Obstacles to Therapy

The process of case conceptualization also lets us discover any potential obstacles to therapy. There are many variables to this: social, economic, ethno cultural, commitment, educational... the list goes on. Or simply, we may not be right for the client or perhaps the presenting problem is out of our range of ability or skill, and using the process allows us to recognize when it is appropriate to refer clients out to someone who is more qualified or suitable to help.

In Summary

The initial consultation and intake provides many opportunities to be a detective and paying attention to particular, key points is important. When conducting an initial consultation, whether it is in the office, school or in a home setting, consider the individual stories portrayed by noticing:

- Who is present, who is missing and why
- Who speaks and who remains silent
- What people wear

Keep in mind also how the environments in which they live, be that home, school or the wider community, affect their emotions, cognition and physiology.

When working with a school or with social services, a case file is normally provided which can provide further facts and insights. This information aids in shaping the intervention; guiding the practitioner when customizing therapy for the individual child. Clues from the intake narratives are incorporated in forming an approach to empower the child and family…with the goal to reframe understanding and meaning in a more supportive, positive light.

APPENDIX A Child Protection

Nath:

Below are my policies and procedures for Child Protection; you are welcome to adjust them for your own application and use.

Safeguarding *is defined as "protecting children and young people from maltreatment, preventing impairment of health and/or development, and ensuring that children and young people grow up in the provision of safe and effective care and optimizing life chances".*

What is Child Protection?

making children's welfare a priority

a responsibility for all those who are directly or indirectly involved with children

ensuring that all children, whatever their age, culture, disability, gender, language or racial origins, have the right to protection from abuse

understanding what constitutes child abuse

taking positive steps to prevent further abuse and dealing with all suspicions and allegations of abuse seriously and swiftly

developing child-centered policies and procedures

working in partnership with agencies qualified to address the issues (i.e. CSF, Police, NSPCC, CPS[US])

WHEN TO BE CONCERNED

The main categories of abuse are:

Physical abuse

Emotional abuse

Sexual abuse

Neglect

You should be concerned about a child if he/she presents with indicators of possible significant harm. (See Indicators of Possible Harm for details

Generally, in an abusive relationship the child may:

- Appear frightened of the parents or other household members (including siblings and even those living outside of the home)
- Act in a way that is inappropriate to her/his age and development (full account needs to be taken of different patterns of development and different ethnic groups)
- Display insufficient sense of 'boundaries', lack stranger awareness
- Appear wary of adults and display 'frozen watchfulness'

DEALING WITH A DISCLOSURE

Who is responsible?

It is recognized that a child or young person may seek you out to share information about abuse or neglect, or

spontaneously speak individually or in groups when you are present. In these situations you must:

- listen carefully to what is being said without displaying shock or disbelief. DO NOT directly question the child
- give the child time and attention and accept what is being said
- allow the child to give a spontaneous account; do not stop a child who is freely recalling significant events
- use the child's own words where possible
- explain that you cannot promise not to speak to others about the information they have shared
- explain that you are glad they have told you, stress that it was the right thing to tell and that
- they have not done anything wrong, what has happened is not his or her fault
- explain what you are going to next do
- do not make promises which may not be possible to keep
- explain that you will need to get help to keep the child safe
- DO NOT ask the child to repeat his or her account of events to anyone
- Avoid criticizing the alleged perpetrator(s)
- Make a written record of the information you have received, taking care to note the time, setting and any persons present, including the child's perspective as relayed. Retain this as it may be later needed as evidence in any legal proceedings.
- Pass information on the appropriate supervisor or authority without delay

Support

Dealing with a disclosure from a child, and a child protection case in general, is likely to be a stressful experience. The member of staff/volunteer should, therefore, consider seeking support for him/herself and discuss this with a supervisor or seek out appropriate assistance.

CONFIDENTIALITY

Child Protection raises issues of confidentiality that must be clearly understood. The reporting and recording of information relating to suspected child abuse should be conducted in a place where privacy and confidentiality can be assured. Not only is the information sensitive, but you need to realize the impact on yourself as custodian of this information.

You have a responsibility to share relevant information about the protection of children with other professionals, particularly the investigative agencies (Children, Schools and Families and the Police).

If a child confides in a member of staff/volunteer and requests that the information is kept secret, it is important that the member of staff/volunteer tell the child in a manner appropriate to the child's age/stage of development that they cannot promise complete confidentiality – instead they must explain that they may need to pass information to other professionals to help keep the child or other children safe.

If you believe a risk is present, it is your responsibility to divulge that information immediately to the proper agency.

RECORD KEEPING

- When a child has made a disclosure, you should:
- Make brief notes as soon as possible after the conversation
- Not destroy the original notes in case they are needed by a court
- Record the date, time, place and any noticeable non-verbal behavior and the words used by the child
- Draw a diagram to indicate the position of any bruising or other injury
- Record statements and observations rather than interpretations or assumptions

ALLEGATIONS INVOLVING STAFF/VOLUNTEERS

Whenever it is alleged that a member of staff/volunteer has:

- Behaved in a way that has, or may have harmed a child
- Possibly committed a criminal offence against/related to a child
- Behaved toward a child in a way which indicates s/he is unsuitable to work with children

The person receiving the allegation must take it seriously and immediately inform the relevant agencies immediately.

They should also make a written record of the allegation using the informant's words - including time, date and place where the alleged incident took place, what was said and anyone else present. This record should be signed and dated and immediately passed on to the relevant organization.

INDICATORS OF POSSIBLE SIGNIFICANT HARM

SIGNS OF POSSIBLE PHYSICAL ABUSE

Unexplained injuries or burns, particularly if they are recurrent

Injuries not typical of accidental injury

Frequent injuries even with apparently reasonable explanations

Improbable or conflicting explanations for injuries

Refusal to discuss injuries

Admission of punishment which appears excessive

Fear of parents being contacted

Bald patches

Withdrawal from physical contact

Arms and legs kept covered in hot weather

Fear of returning home

Fear of medical help / parents not seeking medical help

Self-destructive tendencies

Aggression towards others

Chronic running away

Frequently absent from school

SIGNS OF POSSIBLE EMOTIONAL ABUSE

Probably the most difficult type of abuse to recognize…an emotionally abused child is often withdrawn, introverted and depressed. In addition these may be present:

Admission of punishment which appears excessive

Over-reaction to mistakes

Sudden speech disorders

Fear of new situations

Inappropriate emotional responses to painful situations

Neurotic behavior (e.g. rocking, hair twisting, thumb sucking)

Self mutilation

Fear of parents being contacted

Extremes of passivity or aggression

Drug/solvent abuse

Chronic running away

Compulsive stealing

Scavenging for food or clothes

Continual self depreciation

Air of detachment – 'don't care' attitude

Social isolation – does not join in and has few friends

Desperate attention-seeking behavior

Eating problems, including over-eating or lack of appetite

SIGNS OF POSSIBLE SEXUAL ABUSE

Demonstrate sexual knowledge or behavior inappropriate to age/stage of development, or that is unusually explicit

Wetting or other regressive behaviors, e.g. thumb sucking

Inexplicable changes in behavior, such as becoming aggressive or withdrawn

Stop enjoying previously liked activities

Be reluctant to undress for PE

Become fearful of, or refuse to see, certain adults for no apparent reason; show dislike of a particular baby-sitter, relative or other adult

Draw sexually explicit pictures

Urinary infections, bleeding or soreness in the genital or anal areas

Soreness or bleeding in the throat

Chronic ailments, such as stomach pains or headaches

Take over the parental role; seem old beyond their years

Develop eating disorders, such as anorexia or bulimia

Depression, suicidal thoughts

Poor self-image, self-harm, self-hatred

Physical discomfort

Use drugs or drink to excess

Unexplained pregnancy

Memory loss

Frequent running away

Restricted social activities

Find excuses not to go home or to a particular place

Have recurring nightmares/be afraid of the dark

Be unable to concentrate; seem to be in a world of their own

Have a 'friend who has a problem' and then tell about the abuse of the friend

Sudden changes in school work habits, become truant

Withdrawal, isolation or excessive worrying

Outbursts of anger or irritability

Unexplained sums of money

Act in a sexually inappropriate/harmful or seductive way towards others

SIGNS OF POSSIBLE NEGLECT

Constant hunger

Poor personal hygiene

Inappropriate clothing, clothing in a poor state of repair

Frequent lateness or non-attendance at school

Untreated medical problems

Low self-esteem

Poor social relationships

Compulsive stealing

Constant tiredness

Emaciation

Destructive tendencies

Neurotic behavior (e.g. rocking, hair twisting, thumb sucking)

Chronic running away

Scavenging for food or clothes

In addition to all the above signs a child may disclose an experience in which he/she may have been harmed, or there may be any other cause to believe that a child may be suffering harm.

APPENDIX B

Autism Spectrum Disorder

A Guide for Practitioners

ASD is classified as a spectrum because the way in which people experience the condition differs greatly. With this in mind, the most important thing to remember is that we are working with a unique person, *not a condition*. ASD will manifest itself in behaviors and thinking that is totally unique to the subjective experiences of the client.

There will be common golden threads and these are explained in the triad of impairments, which gives a general understanding of the areas ASD effects. It does not, however, give you the multitude of variables that occur with each individual case. It is a good starting point to help you develop an understanding of some of the difficulties faced by those with ASD.

ASD is often described as a series of challenges and behaviors believed to be present from birth, although these will not always be immediately obvious. For example, language and social interaction difficulties may not be evident until certain developmental milestones are reached.

ASD is, under present understanding, a lifelong condition with no cure that impacts those with ASD significantly throughout their lives. Some find, with age, that they can manage and cope with ASD better; however, this is not always the case.

The impact it has upon immediate family members and the more extended family is also considerable and needs to be taken in to account. Providing support and advice in that area completes a holistic and sustainable approach.

The information provided is a guide and not set in stone, please remember that the ways ASD is experienced and its impact is totally subjective.

ASD share two key features:

Social communication difficulties

Narrow interests and repetitive actions and behavior

Autism and Aspersers differ in two key ways:

Aspersers IQ is at least average

There is no language delay

ASD Spectrum

Autism IQ can be anywhere on the scale and there is language delay. It may be useful to look at the subgroups of the spectrum and how they are classified:

Aspersers Syndrome IQ is above 85 and there is no language delay.

High Functioning Autism IQ above 85 and there is language delay.

Medium Functioning Autism IQ 71-84 with or without language delay.

Low Functioning Autism IQ less than 70 with or without language delay.

Atypical autism, either atypical late onset or atypical because of having only one rather than two of the core features.

Pervasive developmental disorder not otherwise specific, this is where the features are too mild to warrant a clear cut diagnosis of ASD but where the individual has more than the usual number of autistic traits.

The Triad of Impairments

Social and emotional

Language and communication

Flexibility of thought, imagination and behavior

Social Difficulties

Extreme lack of interest in other people

Atypical eye contact either none or very little or staring and too much, invading personal space.

Lack of sharing and turn taking

Preferring to be alone

Difficulties in anticipating how someone will feel or what they might think

Difficulties knowing how to react to another person's behavior

Difficulties reading other people's emotional expressions in face, voice and posture

Difficulties accepting that there may be other perspectives, not just a single correct perspective. Transductive logic: either/or thinking.

Communication Difficulties

Echolalic speech echoing phrases

Neologisms using idiosyncratic words instead of conventional names for things

Literal understanding of speech

Language delay of varying degrees

Using speech inappropriately for the social context

Repetitive Behavior and Narrow Interests

Hand flapping

Spinning of body

Obsessive interests, touching, collecting, memorizing, etc.

Lining things up

Spinning objects such as wheels or washing machines and becoming mesmerized by such spinning objects

Stimming (repetitive movement or vocalization)

Serve tantrums at change in routine

Need for sameness

Splinter skills or islets of intelligence

Unusual memory

Other areas to consider

Low IQ and other learning difficulties

OCD, ADHD, ADD, ODD, Dyslexia and Dyspraxia may also be present or suspected

Self Injury

Hypersensitivity to sounds, textures, tastes, smells and temperature

Areas looked at in diagnosis

Have they found it difficult to make and keep friends?

Have they found it hard to respond appropriately to other people's feelings?

Can they join in larger unstructured social groups and not

just one to one?

Are they social withdrawn?

Do they misinterpret other's intentions?

Do they make no eye contact or very little or too much and stare?

Do they show a lack of normal social awareness?

Do they appear oblivious to how they come across to others and what others think of them?

Would they spontaneously comfort another person?

Do they show empathy and an ability to notice subtle cues about other's feelings?

Have they always been more comfortable in solitary pursuits?

Does the person have a very literal understanding of language?

Does the person have difficulty understanding non literal language, jokes, sarcasm, irony and metaphor?

Is there a noticeable difference between the person's technical language skills, their syntactic ability and their pragmatic language skills; are they able to use language to match social context?

Does the person frequently say or do the wrong thing in a social situation?

Do they tend to give to little or too much information in their speech; can they judge what the listener needs to know?

Do they have trouble in turn taking in conversation and it becomes more mono than dialogue?

Do they become immersed and fixated on one activity or interest at the exclusion of all others?

Do they become experts on a singular topic?

Do they have a strong desire to do things over and over in the same way?

Would they become upset if they had to deviate from routine?

Do they go through the same sequence of actions when beginning certain activities?

Do they insist on wearing the same clothes, eating the same food or going to the same place over and over again?

Executive function is a term for functions such as planning, working memory, impulse control, inhibition and mental flexibility as we as for the initiation and monitoring of action.

People with ASD and ADHD are often deficient in one or more of these. This is known as Executive Function Deficit.

Some golden rules for working with ASD (Once you have built a relationship, these may change.)

Use structure and limit choices to be made

Have a beginning, middle and end

Let them know where to be, what to do, when it will finish and what to do next

Give clear rules and be consistent

Make sure you have been understood

Say what you mean and mean what you say

Use clear, simple and clean language

Tell them what to expect and then deliver that

Put things in writing such as tasks and to do lists

Use photos, symbols and drawings - be multi sensory

Have breaks; watch for sensory overload

Allow plenty of physical and personal space

Do not speak quickly

Do not be ambiguous

Have FUN!

A helpful guide, *Coping: A Survival Guide for People with Asperger Syndrome*, written by the late Marc Segar, is shared freely online. We suggest you read it, as its contents will give you much insight into some of the challenges an Asperger client may be dealing with.

Here is the link:

http://www-users.cs.york.ac.uk/alistair/survival/

RECOMMENDED READING

Therapy to Go by Clare Rosoman A collection of worksheets, handouts and homework for kids and families

Change, Principles of Problem Formation and Problem Resolution by Watzlawick, Weakland, Fisch w/Foreword by Milton Erickson

Flipnosis by Kevin Dutton

13 Steps to Mentalism by Tony Corinda

The New Peoplemaking by Virginia Satir

Trances People Live by Stephen Wolinsky

The Mindful Child by Susan Kaiser-Greenland

Planting Seeds: Practicing mindfulness with children by Thich Nhat Hanh and Wietske Vriezen

A Handful of Quiet: Happiness in 4 Pebbles by Thich Nhat Hanh

10 Mindful Minutes by Goldie Hawn

Child's Mind: Mindfulness practices to help our children be more focused, calm, and relaxed by Christopher Willard

The Relaxation & Stress Reduction Workbook for Kids by Lawrence Shapiro & Robin Sprague

Acceptance and mindfulness treatments for children and adolescents: A practitioners guide by Thomas H. Ollendick, Steven Hayes and Laurie Greco

Parenting Your Stressed Child: 10 Mindfulness-Based Stress Reduction Practices to Help Your Child Manage Stress and Build Essential Life Skills by Michelle Bailey

Baby Buddhas: A Guide for Teaching Meditation to Children by Lisa Desmond

Scripts and Strategies in Hypnotherapy with Children by Lynda Hudson

Hypnosis and Hypnotherapy with Children by Karen Olness and Daniel P. Kohen

ABOUT THE AUTHORS

Helping children and families improve their lives with hypnosis is a passion for Kelley. A mother of children and someone who was once a child herself, Kelley applies her warm personality and sense of humor in her work.

Kelley has operated a private clinical hypnosis practice for over a decade in Mount Vernon, Washington. She is a well-respected hypnosis mentor and educator and is considered a thought leader in Pediatric Hypnosis.

www.woodshypnosis.com

Nathan has taken an eclectic journey to becoming a child and family therapist; in fact he will be the first to admit it was never a plan to become one. It was much more a happy accident. Roles which Nathan has experienced have been as a Royal Marine, Prison Officer, College Lecturer, Personal Trainer and Youth Worker.

Whilst working with some of the most difficult and hard to reach young people and families, Nathan trained in systemic practice and narrative therapy. He has always had a love for stories, both as a story teller and enthusiastic listener. Nathan builds most of his approaches and interventions from an ACT and narrative therapy perspective. Always learning from his clients, Nath continues to work with very challenging young people and families in the U.K.

www.story-therapy.co.uk