ERICKSONIAN HYPNOSIS, PHARMACOTHERAPY AND COGNITIVE-BEHAVIORAL THERAPY IN THE TREATMENT OF ADHD

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Attention deficit hyperactivity disorder (ADHD) is currently one of the most commonly studied paediatric psychiatric disorders in the United States and represents one of the most commons reasons why children are referred to mental health practitioners. The use of stimulant medication in the treatment of this disorder is one of the most thoroughly researched treatment modalities in child psychiatry (Barkley, 1990).

Numerous studies have pointed out the enhancing effect of stimulant Pharmacotherapy on behavioral, academic, familial and social functioning. However, for these same reasons, protractors of Pharmacotherapy have argued against its use, noting these changes as "behavioral and personality alterations." They also point to side effects, and issues of state dependent learning (as yet unproven) as reasons for avoiding medication. In addressing this controversial issue, proponents of its use suggest that many of the reported side effects may in fact be due to inadequate monitoring of the medication regime (Solomon, 1973), and an under-utilization of objective quantifiable measurements for determining continuation and discontinuation of the medication (Gadow, 1981). Indeed many of the "side effects" reported in this earlier literature may reflect over-dosage or poor behaviorally determined titration of the medication.
The most common pharmacological intervention at this time consists of stimulants. This group primarily consists of Methylphenidate (Ritalin), d-Amphetamine (Dexedirine) an Pemoline (Cylert), with Ritalin accounting for approximately 90% of the stimulant utilization. Stimulants operate as sympathomimetic compounds structurally similar to certain brain neurotransmitters. It is generally believed that all these operate through the central nervous system, although their modes of operation are somewhat different. A review of the literature suggests that approximately 73-77% of patients show improvement, while 23-27% evidences no change or iatrogenic effects (DuPaul & Barkley, 1990). Due to its effectiveness with the least side effects, the initial stimulant of choice has been Ritalin, followed by Dexedrine and the Cyclist.

Ritalin is also the most thoroughly researched of the group. Specific situations in which stimulant medication is contraindicated include children under the age of four years or children with a family history or ongoing evidence of nervous tics or Tourette's disorder. Stimulants have also not been as effective in highly anxious or depressed children and may exacerbate through disorders or psychosis.

The second level of medication interventions are tricyclic antidepressants. Most typically, Imipramine and Disipramine. Antidepressants have demonstrated positive effects on inattention, hyperactivity and aggression in ADHD children (Riddle, Hardin, Cho, Wolston and Leckman, 1988).

Antidepressants may be slower acting, raise blood pressure and slow inter-cardial action. However they have been found to be effective in situations where stimulants have not.

Children who evidence anxiety disorders or depression may respond better to antidepressants (Plaszka, 1989).

Currently, Catapress is being utilized in cases where tics or Tourette's disorder symptomology is present. In most cases when tics occur, cessation of stimulants treatment leads to remission in the symptomology. However, cases have been reported in which symptomology did not diminish after cessation of treatment (Golden, 1988). It is still considered controversial as to the role of stimulants in undiagnosed Tourette sensitive patients. The use of Catapress is typically reserved for cases where stimulants and antidepressants are contraindicated. In certain cases increases in anticonvulsives can counteract the effects of medicine when seizure disorders are present.

Medication alone cannot modify or correct ADHD. A combination of stimulant medication and behavior modification has been demonstrated (Gittleman-Klein et al.,1980; Pelham & Murphy, 1986), with suggestions that cognitive behavioral programs in conjunction with medication may be required. Although some studies have suggested that cognitive behavioral interventions may not add to the effects obtained from the medication alone, others have suggested that "when significant others (peers, teachers and parents) provide positive feedback for a child's efforts and change their perceptions and attributions about the child, the child's behavioral change is likely to be maintained" (Braswell, 1991). As such, Braswell and Bloomquist (1991) conclude that cognitive behavioral programs need to place greater emphasis on the role of the parents and the family of ADHD children in their program implementation.

In fact an over-reliance upon medication to address the secondary social, educational, familial and psychological dysfunction which may result from ADHD symptomology (hyperactivity, inattention, impulsiveness and lack of motivation) is to deny the impact these secondary symptoms have had and continue to have on ADHD children and those around them.

Although psycho stimulants may be the most commonly utilized treatment, there are many reasons why pharmacological intervention alone is not enough, or may be contraindicated or provide a short-term solution at best. Once withdrawn, psycho stimulants rapidly dissipate and previous non pro-social behaviors may return (Giggleman & Kanner, 1986; Ialongo et al., 1983). In addition, historically, complicated with long-term medication treatment is relatively poor (Brown et al., 1987). This may be due to parents, concern about long-term medication side effects which need to be addressed as part of a parent counseling and training program.

However, perhaps of most acute importance is the simple fact that 20-30% of ADHD children do not respond to pharmacological interventions (Barkley, 1990) and that those who do respond show rapid regression when medication is removed unless other forms of intervention are provided. As such, psycho stimulants will not provide the child with appropriate skills and necessary pro-social behaviors which may require shaping, coaching and modeling. Children who have ADHD typically present additional secondary symptoms which have resulted from their behavior patterns.

Many have low self-esteem, poor self-image and a lack of confidence in their abilities. A majority has few friends as either other children or children's parents have begun to avoid the ADHD child. In addition, the ADHD child may have begun to incur various "labels" which alter the expectations of others toward that child, and so opportunities to demonstrate increased control are few or at best critically judged. In addition, medication does not automatically provide parents with the skills necessary to respond appropriately and positively to medication-induced changes, resulting in lost opportunities to reinforce pro-social, pro-academic behavioral and personal growths.

Parents, the child's peers and school personnel may have unrealistically high or low expectations for the child which may distort any progress or gains in control of pro-social behavior or motivation. Left untreated, ADHD children show higher evidences of conduct disturbances, depression, enuresis and encores. These problems do not remediate without specific attention focused upon apart from medication. And finally, medication alone will not significantly alter peer, sibling or parent's marital issues which have now begun to present themselves (i.e., financial stress, marital discord due to blaming each other for the child's behaviors, feelings of resentment from siblings who may perceive the ADHD family members as "ruining he harmony within the family" or of behaving "abusively").

Medication alone may in fact reduce negative behaviors or create windows of opportunity for change, however other forms of family and individual intervention will be required to bring about permanent changes in the child's self image and re-establish family intactness.

Historically, the triad used to define ADHD consisted of difficulties of hyperactivity, inattention and impulsivity. However a fourth element has been suggested. Noting that situation factors play a significant role mediating attention and hyperactive behaviors in ADHD, Berkley (1990) and others have proposed that motivational factors may play a strong role in ADHD behaviors (Rosenthal & Allen, 1978). Citing numerous studies, Berkley (1990) suggests "that ADHD arises out of sensitivity to consequences-reinforcement, punishment or both" (Berkley, 1990; Biniger, 1989; Haenlein & Carl, 1987; Quay, 1988; Sagvolden, Wultz, Moser & Morrid, 1989; Sergeant, 1988). Numerous studies have suggested that hyperactive children demonstrate distortions in their cognitive processing including greater than average ability to maintain attention to tasks (Douglas, 1983), especially where dull, or repetitive situations prevail (Lelich, Loney & Landau, 1982; Luck, 1985; Zentall, 1985). This may also explain the correlations found between bright ADHD children within special education and mainstream classes and oppositional or distracted behavior. They may be bored and demonstrating increased ADHD symptomology.

Early cognitive therapy programs designed to address ADHD have demonstrated limited and inconsistent effectiveness, with some studies demonstrating only minimal positive effects (Cameron & Robins, 1980). Others have demonstrated much more limited effects or no additive effective of cognitive therapy to medication. Follow-ups at nine months

also demonstrate limited effects when medication is discontinued, (Ialongo et al., 1983). This may in fact be due to the focus of therapy upon the child and the ADHD symptoms. By utilizing contingency management programs directed toward training and counseling, the parents rather than the child, significant improvement in the child's behavior were found (Pisterman, McGrath, Firestone & Goodman, 1980; Pollard, Ward & Barkley, 1983). Employing an 8-12 week program of information counseling, contingency management training and skill building, Anastopoulous & Barkley (1990) propose a 10-step parent training/counseling program. It incorporates education about etiology, opportunity for parents to express their concerns, opinions, family dynamics and expectations. It teaches the parents about their role in effect of positive and negative re-enforcement, time out, home token economy and how to handle future behaviors.

At present, medication appears to be the most effective treatment to reduce symptomology in the short term, however cognitive-behavioral family/parent training programs such as those proposed by Barkley (1990) fill many of the gaps left unaddressed by medication alone.

However, approaching a parent training program such as that presented above assumes that; parents entering the program are motivated, cognizant of their feelings and attitudes about the child; the family; ADHD and the future. Further, it appears to focus on predominantly logical or rational understanding of all of these factors. Often parent and/or child compliance with cognitive and behavioral interventions can be enhanced through the use of hypnotherapy (Burte & Araoz, 1987).

Utilizing an approach of medication (when applicable), cognitive therapy focused on parent training/counseling along the lines of the Attention Deficit Hyperactivity Disorder Clinic at the University of Massachusetts Medical Center (Barkley, 1987, 1990) and Ericksonian Hypnosis, a program designed to meet the inattention, impulsivity, hyperactivity and motivational needs of the child and family has been developed. The role of medication has been briefly reviewed earlier in this article and readers are referred into Barkley (1987, 1990) for detailed descriptions of the cognitive parent training program mentioned. The focus of this portion of the paper shall be upon the application of Ericksonian and New Hypnosis, hypnotic techniques in conjunction with and independent of medication and parent training/contingency management.

The program, while still in its early stages and not yet systematically evaluated, is discussed as theoretical orientation and application of techniques which have demonstrated effectiveness without our overall framework for working with ADHD.

From the outset, the ADHD problem is re-interpreted as a family problem Araoz and Negley-Parker (1988) suggest "six laws of when hypnosis is applicable to family therapy." In many cases, the ADHD families evidence many of the problems to which the "laws" apply. Briefly hypnosis is useful when 1) family communication needs improvement; 2) the family is ambivalent (fearful) of change; 3) the family is emotionally stuck; 4) there is a need to increase the family's expectations for success; 5)

the family needs a holistic emphasis; 6) the family needs to examine new possibilities or choices.

The program can be broken down into four main components:

1. **Pharmacotherapy (Optional), Evaluation Liaison**

Pharmacotherapy: Approximately 70% of the children are on pharmacotherapy, however, that is not a requirement of the program. For parents who are ambivalent about pharmacotherapy, the pros and cons are discussed and consultations are arranged with pediatricians or pediatric psychiatrists when appropriate.

Evaluation: Upon expressing interest in the program and (with parental consent) teachers are administered the Connors Parent Rating Scale and Connors Teacher Rating Scale, respectively. When deemed necessary, more complete batteries may be administered to rule out other disorders (i.e. learning disabilities, oppositional defiant disorders, intellectual impairments, depression and anxiety disorders). A plethora of diagnostic tools for evaluating these disorders is available to the trained diagnosticians. Additionally, further scales or questionnaires focused on the ADHD and/or family functioning may be administered. Upon completion of the evaluation, the families are enrolled in the program.

Liaison: We have found that liaison with school and medical personnel can play a vital role in mobilizing outside supports for gains made in therapy. Often teachers and school personnel have to be alerted to anticipate and reinforce small changes in the child's behavior. At best, weekly dialogue with teachers helps them know what to look for or how to utilize "key phrases" presented within the therapy program.

Reframing teacher's views of a child's daydreaming, inattentive, hyperactive or non-compliant behaviors into understanding it as boredom or lack of stimulation often helps teachers seek ways to increase the child's stimulation or motivation rather than punish the child. This may include new materials, changing materials, engaging the child more often, or utilizing the child's imagination. In addition, school personnel, especially teachers, often welcome the opportunity to offer feedback and /or merely vent their frustrations. Such times often offer excellent opportunities to help them reframe their perceptions of the child.. It offers the therapist an opportunity to let the teacher know that they are not alone, helping them possibly overcome some of their educational and social concerns about the child.

As professional child educators, the teachers and school personnel provide valuable information about the child's behaviors within a range of settings, (i.e., math versus recess), as well as a general view of their peer acceptance and relationships. Since most schools have by their very nature contingency management built into the educational curriculum, the child's behaviors as reported by the teachers often provide valuable insights into the child's capacities and reactions within that system.

Often teachers can provide an objective assessment of the child's capacities over time (taking into account the child's mood swings, reactions to vacations and changes in routine). In addition, they provide feedback as to how the child is progressing relative to his or her peers.

Active participation in treatment planning of children's Individual Education Plans where parallel contingency management programs can be overlapped creates situation consistency, important in new habit development. Therapeutic stories and metaphors have been utilized within the school setting for behavior problems (Benson, 1980; Callow & Benson; Mills & Crowley, 1986, 1990).

Liaison with the family pediatrician and/or pediatric psychiatrist helps the parent develop confidence in their decision and their actions. It helps the parents gain a fuller acceptance of the "biological" nature of the disorder and remove some of the emphasis on the behavioral aspects of the symptoms. In turn, it helps the parents turn from blaming the child, themselves or each other for the existence of the ADHD problem and create room for a more relaxed, accepting approach to change.

INTERVENTION

The program approaches the ADHD as a problem which exists within the family and it is therefore up to everyone to participate in helping to resolve the problem. To accomplish this, the second component of the program involves parent counseling/training consisting of education and contingency management training (Berkley, 1990).

While the parents are receiving training, the diagnosed child is entered into the children's socialization program (CSP), the third component. The CSP consists of children matched for age and behavioral dysfunction. The final component of the program involves family counseling with an emphasis on hypnotic intervention. The rational behind this is that such techniques will help remove getting to the "emotional states" of the family and circumvent some of the intellectualization and defenses which have accumulated over time. A somewhat deeper discussion of the remaining three components follows.

2. Parent Training/Counseling

Following the model of Barkley (1987), parent training consists of education parents as to the facts about ADHD, exploring expectations and teaching proper attending skills through structured exercises utilizing effective ways to communicate. Behavioral interventions also include the proper use of contingency management techniques such as home token economics, response cost and time out from reinforcement. Generalization outside the home and how to anticipate future changes in behaviors both positive and negative are reviewed and if necessary, rehearsed. The emphasis is on applying "motivational incentives" with specific situational contingency management rather than just addressing noncompliant behaviors.

In addition, hypnosis has been extremely helpful in helping parents to explore their feelings of anger, frustration and fear. Although most parents entering the program present with issue of frustration and anger, the fear component is by far the most overwhelming for them. Utilizing "somatic bridges" as suggested by Araoz (1985), parents are encouraged to let themselves listen to what they are telling themselves about the situation. Often, one or both parents are themselves troubled with ADHD, and were handled in much less sophisticated ways than are currently available. Their own feelings of lack of confidence in themselves or their parenting abilities come readily forward.

A spouse's anger or resentment at their partner for "passing on" this problem which they may not have discussed ahead of time also comes out. Through hypnotic techniques of reframing, parents are encouraged to see the child or situation differently. Often, much of the emotionality (which can interfere with contingency management) can be brought out and resolved during hypnotic session. Parents are resistant to hypnosis for fear of intrusion beyond their defenses of intellectualization or denial. They may be attempting to avoid or displace their feeling of anger, guilt, worry or fear. Hypnosis offers them an opportunity to vent those feelings in a constructive way where those energies can be dissipated or utilized. Often in asking parents to visualize their child, they vocalize that "I can see myself in him" or "he's just like his father." These become the inroads to both explore what that means to that parent and uncover new ways to experience the child "breaking out of limiting preconceptions and forming a broader understanding of human potential" (Erickson & Rossi, 1981).

Within the hypnotic session, suggestions for habit change on the parent's part can be developed including stress responses to chronic behavioral patterns. Relaxation techniques and stress reduction may also fall within the scope of using hypnosis to develop better skills with the situation.

Ericksonian "self-image thinking techniques" (Erickson & Rossi, 1981) have proven helpful with one of both parents. Finally, within the setting of the parental meeting, issues concerning the marital relationship can be explored further. Often parents divide their time with the ADHD child to "relieve" one another. This often results in little or no quality time for them as a couple. Sexual or communication problems are not unusual and may require intervention (Aroaz, 1982; Burte & Aroaz, 1994). Survival tactics such as avoiding all social occasions or family trips begin to become common while marital fatigue and financials stress are not uncommon. All of these issues are worked through utilizing hypnotic approaches designed to help parents develop new ways of reframing and expanding family, marital and individual experiences.

3. Social Skills Peer Relations Training Group

As the parent training is going on, the child has begun his individual or group social skills training program. Children are judged as to whether a proper fit can be achieved within a group setting or whether a few initial sessions of individual therapy to prepare the child for the group may be required. Whereas group hypnosis with ADHD children has not yet been successfully demonstrated, attempts to do individual sessions with ADHD children

have met with some success (Calhoun & Bolton, 1986). The somewhat limited success of the above authors may reflect the attempt to gain “relaxed focusing” and “traditional inductions” with minimal incentives. Utilizing relaxation techniques and re-attention to internal physiology both Denowski and Denowski (1984) and Raymer and Poppen (1985) achieved some success in reducing hyperactive behaviors.

The approach utilized with the social skills training group session reflects more the styles of Olness and Gardner (1981) and Lankton and Lankton (1983) in which activity and/or metaphor storytelling techniques (i.e. engaging the child in creative active imaging) are utilized. Although few published scripts are designed to be utilized with many of the behaviors or feelings associated with ADHD, including impulsiveness, patience, concentration, self-acceptance and self esteem (Bret, 1988; Bret, 1992; Havens & Walters, 1989; Lankton & Lankton, 1989).

Hypnosis is employed as part of the group program to reinforce pro-social skills taught during the group. Children during the group are taught through coaching and modeling specific pro-social skills ranging from impulse control to sharing. Attending to peers, offering feedback, acknowledging others, eye contact, waiting to take a turn, greeting and suppressing outbursts are a few of the specific skills covered within the social skills training component. This is accomplished by means of group play activities which the children find both interesting and fun. As such, the group overcomes the problem of boredom and lack of motivation. The opportunity to interact in an environment where they feel welcomed and where there is a built in system of positive reinforcing contingency management helps them develop self esteem and remain focused.

To increase motivation part of each session is spent in a visualization exercise or story time. During this time, children are led into experiencing themselves “getting the things they want” or getting to do the things they want to do” through pro-social means. They are taught how to “listen to their bodies” and how to “slow down and pay attention to their body and to get what they want.” Suggestions for the possibility of changes by direct and indirect suggestions are interwoven throughout the sessions.

While the children are given pre-arranged behavioral homework assignments, parents are taught contingent responses to these new behaviors and specifically how to respond when the child behaves in this way spontaneously.

In addition to skill acquisition, the second function of the group is to focus on the secondary problems presented by many ADHD children. These include enuresis, oppositional defiant disorders, depression, social isolation, mood swings, low self-esteem and a lack of self-confidence. Through the use of visualization techniques and “somatic bridges” at times in a one-to-one setting, metaphor and the OLD-C model proposed by Araoz (1985) are employed. The OLD-C model which “leads” the child into their own experiences through the therapist’s “observation” of behaviors and psycho semantics is especially useful in helping the child later develop the understanding to “discuss” their feelings. The therapist can then teach the child how to “check” how they feel in order to help guide in the direction of progress. The goal is to help children understand their

feelings and develop new understandings about their problems. In group support, children are taught how to lead each other through positive self-talk and dispute negative self-hypnotic images.

One such utilization may occur by having a child describe the feelings that occur when he feels himself about to act badly. He is asked to close his eyes and really see that part of him, to describe how it looks, what is it saying, how it feels. Continually focused inward, the child is to create a clear representation of that "part" of him, then to look for a "part" that "feels different," a part which feels "good" or "happy." Sometimes, children describe armies at war or individual characters in battle. The child is asked to "help the good part to win" and if possible, to explore those feelings.

At other times, we explain to the child that he and the therapist are going to work to help him teach his brain to think or feel or act differently and through a series of sessions with deepening relaxation (when possible) the child learns to become the "therapist or teacher of his brain." Teachers and parents are encouraged to reinforce this self-talk. Older children are encouraged to view the division as a conflict between the left side of the brain which is logical and the right side which is creative but bored. Using imagery of the child's creation, conflict resolution and communication between the different sides of the brain is developed. The eventual goal is re-acceptance of the newly trained, more focused brain.

Albeit simplistic, such techniques used under hypnotic imagery and suggestion do appear to be initially effective. Throughout the therapy process conventional hypnotherapeutic techniques are utilized on the full ranger of pediatric disorders presented as they might in any pediatric psychotherapy and hypnotherapy setting (Erickson, Rossi & Rossi, 1976). Of tantamount importance is the therapist's ability to reframe his or her own thoughts about stereotypical ADHD responses and develop a comfortable and creative approach to the utilization of the child's internal representation, perceptions and behaviors.

4. Family Counseling

In the next component of the program, family counseling, the family meets together whereupon a group induction is encouraged. Each family member is encouraged to express the images that come to mind as they focus on the family. The focus is on getting in touch with the "inner experiences" and shifting attention away from "talking about" the problems. Instead, they are encouraged to "feel" themselves in new ways (Araoz & Negley Parker, 1985). Also, they are encouraged to express, in positive terms, how they experience the ADHD child, focus on their strengths and create images and metaphors to describe those feelings. The emphasis is, as it should be, "primarily on the positive aspects of the family" (Haley, 1973).

The goal of family counseling is to develop positive family-esteem and to help the child integrated that into his or her own self esteem. In addition, they may rehearse positive interaction with each family member reinforcing the image. These are sometimes prescription situations offered by the therapist (i.e. in a few minutes as you leave the

office try to imagine how each of you can make this a really good time … (to child) what can you do to make leaving special (repeat this with each family member.) Move back inside now, how does that feel, look and sound. The goal is to make the experience as realistic as possible enabling the child to utilize as many sensory modalities as possible. Families are encouraged to practice their own preparatory situations as they come up (i.e. in 20 minutes we are going to grandma's house. Let's imagine how we can make the visit fun).

The family counseling sessions are scheduled to occur after both the parents and the child have had experience with hypnosis in their respective sessions (Lankton & Lankton, 1989). Damman (1982) offers a summary of Erickson's work in hypnosis in family therapy.

The complete program is designed to allow children to remain in the program until the goals set by the parent and the child have been reached. Goals are adjusted as the child progresses, however an average of six months is most common from enrollment to completion. Maintenance or review sessions are scheduled during the following six months on an as-needed basis. Occasionally a family crisis (i.e. severe illness or a parent) or a positive family life change (i.e. birth of a sibling) can necessitate reinstituting aspects of the treatment as family dynamics and situations change.

SUMMARY

Whereas pharmacotherapy is the most commonly prescribed treatment for ADHD with stimulants being the predominant form of medication administered, in 20-30% of cases, pharmacotherapy doesn't work or is contaminated.

In such cases, and/or in conjunction with pharmacotherapy cognitive behavioral contingency management programs have proven effective in helping ADHD children gain increased improvements in behavior-symptomology associated with impulsivity, inattention, hyperactivity and lack of motivation. However, cognitive behavioral programs alone may not fully provide for many of the secondary issues associated with ADHD. Low self-esteem, lack of confidence, negative self-image, low family esteem may benefit from hypnotherapy. It is hoped that the current program still under investigation and presented as an initial theoretical model, incorporating Ericksonian approaches into a cognitive contingency management program offers investigators and clinicians a general framework for future research.

This paper has offered the briefest of overviews of ADHD treatment, with an emphasis on the broad-based literature within the field rather than specific research articles. Clinicians who have not already done so are strongly encouraged to review Russell A. Barkley's book *Attention Deficit Hyperactivity Disorder: A Handbook of Diagnosis and Treatment* as well as his accompanying workbook *ADHD: A Clinical Workbook (1991),* and Lauren Braswell and Michael Bloomquist's book, *Cognitive Behavioral Therapy*

with ADHD Children: Child, Family and School Interventions (1991), is also an excellent addition to any ADHD library.

A plethora of materials ranging from clinical manuals to interactive workbooks and games for children are currently available from various manufacturers and distributors. Clinicians are encouraged to utilize these materials as children with ADHD appear to respond well to many of the stimulating creative and interesting approaches these materials offer. Finally, the ADHD child's needs for interesting stimuli can be well utilized through hypnotherapy. Many books are now available which offer hypnotherapeutic scripts and metaphors, instruct clinicians on how to create their own or present techniques for pediatric and family hypnotherapy.