This paper examines the danger of clinical hypnotherapists ignoring the patients' stated objectives in order to pursue their own prejudiced assumptions.

The author argues there is an orthodoxy which too easily can blind therapists to the most effective means of helping their patients. That there is a tendency to look for a cause which fits the therapist's personal perceptions and ignore the clearly stated views of the client.

The paper goes on to express the view that rather than follow 'standard' procedures, hypnotherapists must pay attention first and foremost to what their patients want.

This claim is illustrated by an anonymised case history in which the author admits his own early failure and the lasting value of the lesson it provided.

All at sea with Admiral Nelson and a phobic fallacy

By
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He arrived in the United Kingdom from Budapest following the 1956 Hungarian uprising.

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He has also developed a variety of motivational training programmes for major industrial corporations including stress, time management and sales training.

Case History

The year was 1977 and I had only recently started my career as a hypnotherapist when Janice – not her real name – whom I had never met, rang asking for an appointment as quickly as possible. She did not explain why – but she sounded desperate and arrangements were made for her to come the following day.

She was punctual, stylishly dressed, in her early-twenties and in every way appearing a picture of health.

She came straight to the point. “I have come to you as a last resort. I heard about you from a colleague whom you stopped smoking a few weeks ago. But I don’t want you to stop me smoking. I have a terrible problem, a phobia, but before I tell you what it is I want you to promise me something.”

"What is it?" I asked.

Slowly, stressing her words, she replied: “When I tell you about ... the problem ... when I tell you about me ... please promise you won’t laugh at me.”

I did so without hesitation; in the course of my training, and as a trainee practitioner, I had read about and heard many strange tales, and expected neither shock nor amusement at anything new.

Hesitantly Janice continued: “The sight of a certain thing ... when I think of it ... or just see a picture of it in a newspaper or on television ... I just collapse. I can’t stop myself.”

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Janice was becoming tense, sitting forward to the edge of her chair, her cheeks gathering colour.

"I feel physically sick and nauseous. I even throw up sometimes. I perspire all over, and shake as if I was running a temperature. My face flushes and my eyelids seem to swell up over my eyes as if I am going to be unable to see between them. I can't speak. I have to lie down for a while...It's awful!"

Even as she spoke, she began taking on the aspect of a person entering just such a crisis.

She explained her attacks had been occuring for more than two years. Carefully I began to investigate. "You said there is a particular 'thing' that starts off these attacks – something you see, and then ..."

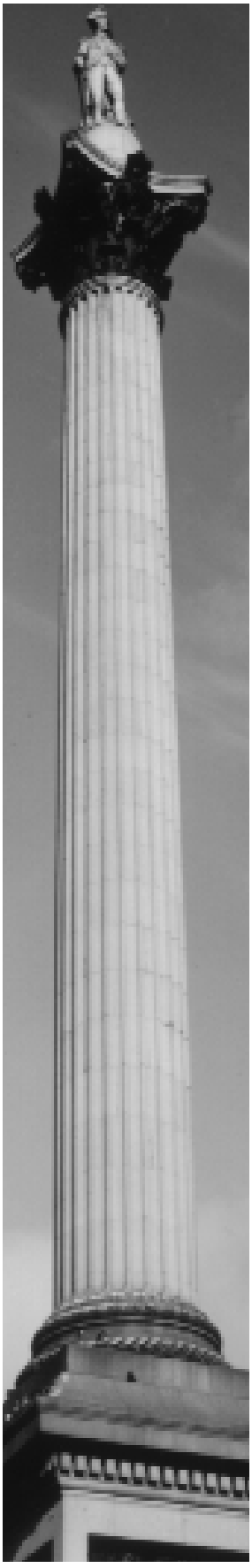
This produced another long pause, more tension. Then she said: "Nelson's Column."

"Nelson's Column …" I repeated in the best matter-of-fact voice I could manage. She watched me, apprehensively. It suggested her phobia, with its all too apparent Freudian connotations, had provoked insensitive mirth on previous occasions.

I began taking a thorough case history, the usual things – her general health, her life till that time. Then I moved on towards her personal relationships – within the family, with people of her own age, of her own and the opposite sex.

Suddenly she cut me short. "Look here. You are just asking the same old questions all over again, the same as everyone else I have seen."

Then she began to tell her story. Her doctor – quite properly – had sent her for tests. They produced nothing. She was put on tranquillisers – they didn't help. She was then referred to a psychologist by whom she was asked to fill out a number of questionnaires and her condition was duly diagnosed as a phobia.



After this an appointment with a psychiatrist resulted in her being referred to a psychoanalyst. She visited the psychoanalyst once a week for approximately thirteen months.

Eventually she discontinued her analysis because she was "fed up with talking about my childhood week after week while my problem got worse".

Choosing her words carefully she continued: "The truth is there was nothing wrong with my childhood. I loved my mother. I loved my father. I get on well with them now. I have a younger brother whom I just adore."

"What I mean is … everybody thinks that my problem has something to do with my sex life. It is simply not true! My sex life has always been what I wanted it to be."

"My problem is Nelson's Column. *Everybody thinks it's funny – but it's hell*. So please do what you like with me. Hypnotise me so that I'll never be frightened again."

I explained to Janice hypnotherapy did not quite work in that way, and before helping her I needed to find out a lot more about her.

She told me, somewhat abruptly and in her own words to 'mind my own business' about everything else in her private life and would I please do what she had asked me to do. She sounded very determined and arguing with her seemed counter productive. I agreed to hypnotise her, with the proviso that only a 'mild' form of hypnosis would be used and she would come back for another session next week. This was readily accepted, since I also promised her that I would do what I could to...'do what she asked me to do'.

In that first session I hypnotised Janice using a simple 'progressive

relaxation' technique and with a ten to one countdown as a deepener. The full 'ego-strengthening' (Hartland[1]) suggestions were then employed and I awakened her with some standard suggestions for well-being. This is an excellent method to conclude a first session of hypnosis when hypnotherapists are unsure of what course of action to follow. The time between the first and second sessions will give them time to think or seek advice and generally consider the patient's problem. The patient also benefits by experiencing the relaxation response, and will certainly be more ready to accept whatever therapy is suggested because of the powerful effects of the full 'ego-strengthening' suggestions.

After careful consideration I decided to use age regression in the second session, explaining to Janice that by going to the source of the problem we would have an excellent chance of resolving her difficulty once and for all. She readily accepted and I hypnotised her in exactly the same way as the previous week. After the deepener I installed an Ideo Motor Response (I.M.R.) using the right index finger as the signalling mechanism – this, of course, in itself deepens the trance.

I did not at this time believe that hers was a classic phobic response - 'one trial learning' - but suspected an unresolved sexual conflict of some kind. Therefore, a free-floating regression technique (Blythe[2]) was chosen that would allow her to explore a myriad of experiences in her past which might have played a crucial part in the development of her problem.

One trial learning?

Essentially, the suggestion was given that there would be a finger movement each time:

'... when something happened to you ... which not only affected you deeply at the time ... but has continued to affect you...and to play an important part in the problem you have been having ...'

It took only 30 seconds for her finger to lift, followed by a strong physical reaction. Her face blanched. She began to heave, thankfully without actually throwing up. Eventually the heaving subsided and she began to cry, followed by a smile that was to remain throughout the session. When the finger went down I waited approximately ten minutes for the finger to rise again but nothing happened and I concluded that the cause of her problem was probably a 'one trial learning' after all.

I re-orientated Janice to the present time and whilst she remained in the trance I asked her to describe to me what she had been feeling a few moments before. She declined to speak so I awakened her employing a short 'ego-strengthening' method that I was developing at the time (see Conclusion) and with the suggestions that:

'... no part of you remains in the past ...

Classic phobic response

every part of you will be back here with me in the present ...'

When she awoke she could recall the episode clearly, but with a complete sense of detachment. She saw herself on her way to work, travelling on the top deck of a number 159 London bus. Approaching Trafalgar Square – the location of Nelson's Column – she was overwhelmed by what she described as a 'nasty turn'. Indeed, she had temporarily re-experienced the same nauseous feelings while in the trance. However, she claimed to have no (conscious) recollection of this event.

I told her, that, somehow, Nelson's Column had become associated in her mind with the 'nasty turn' and since then the sight of Nelson's Column had inevitably triggered off an action replay of the nausea. Since nobody likes to feel sick, I explained, it was perfectly natural for her to avoid looking even at a picture of the column – a classic phobic response in fact.

Janice was happy with this explanation. She sounded overjoyed, even triumphant, as she told me: "I knew there was nothing wrong with me." When we finished congratulating each other I wished her luck and she was on her way. I never expected to see her again.

1 Hartland, J., 1966 Medical and Dental Hypnosis & its clinical applications. Second Edition, Bailliere Tindall, London

2 Blythe, P., 1976 Self Hypnotism, Arthur Barker, London 1976

At around 6 p.m. that evening however my phone rang, with a hysterical Janice at the other end of the line. On returning home she had turned on her television set. One of the news items was a demonstration around Trafalgar Square and when she saw Nelson's Column she immediately became violently sick again. I asked to see her again and an appointment was fixed for early next morning.

I decided to turn to the behavioural sciences, hoping *systematic desensitisation* (Wolpe[3]) would 'uncouple' the image of Nelson's Column from her feelings of nausea once and for all. A simple Subjective Unit of Disturbance (SUDS) scale was constructed and as Janice was an excellent hypnotic subject I felt that we could dispense with the preliminary deep muscle relaxation training usually recommended for this method. No formal hypnosis was employed at this time, but each time a low anxiety value scene was presented she was asked to 'remember how relaxed she felt when she was hypnotised'.

The whole process took less than an hour and when she had no adverse reaction to any of the images of Nelson's Column that I could conjure up for her I showed her the morning papers. She looked at the pictures of Trafalgar Square and the statue and in a matter of fact voice told me she was sure that she was free from the awful problem that had made life miserable for her these last two years. Janice was then discharged.

DISCUSSION

PART ONE.

A letter from her General Practitioner three weeks later – and subsequent telephone calls to the GP at three monthly intervals for the next 18 months and at six monthly intervals for the following two years – confirmed that she no longer suffered from those 'nasty turns'.

Janice's problem expressed itself in a very physical way. This is an excellent – if rather unusual – example of not only a classic phobic response but also of a psychosomatic disorder. Many people suffer physical symptoms for psychological reasons, but far too few get the treatment they really need. From the start, Janice didn't disguise the fact that she came to see me only as a last resort. She was, as it were, scraping the bottom of the barrel – fortunately the barrel was not entirely exhausted.

Janice came to win – not to play well!

She had seen her doctor, undergone psychological tests, tried psychoanalysis for more than a year, all to no avail. This, though, is not surprising – it is happening everywhere, countless times a day. This is not to argue that the medical practitioner, the psychologist or the psychoanalyst were all wrong – nor is it suggested hypnotherapists have special abilities in health care that other professionals cannot share. If hypnotherapy is not used as widely as it should be, that's almost certainly because too few doctors know enough about it – and too few patients ask for it.

The 'real' goal

The doctor sent Janice for 'tests'. In a way, one can hardly blame him; after all, the symptoms of collapse were real enough and it probably comforted them both to know that she was not suffering from disease of the heart or the digestive system. But what then? Tranquillisers were prescribed – and even the most enthusiastic physician would hardly expect these to *cure* anything. At best they might have afforded Janice temporary relief from anxiety; but Janice wanted something better than that. Frankly, who wouldn't?

As we know, the cause of the problem lay 'in the mind'; but neither the psychologist nor the analyst found out what it was. I think the simple reason was that these practitioners – perhaps quite properly – approached Janice with an interest in her health as a whole.

They failed to take seriously the fact that Janice was looking *only for relief from a disastrous phobia*. Her real 'goal' was the getting rid of a debilitating symptom. **Janice came to win – not to play well!**

Back in 1977 I had not yet realised that hypnotherapy – unlike medicine and psychiatry – was a *goal-orientated* pursuit. Patients come in search of something *in particular*, and I believe it is our duty to help them achieve it.

[3] *Wolpe, J., 1973 The Practice of Behavior Therapy, Second Edition, Pergamon Press, New York:*

In eighteen years of practice, I cannot recall one patient asking for *generally better health;* instead, like Janice, patients usually ask for freedom from a source of distress.

PART TWO

But what are the implications of this story from 1977 for the clinical practitioner of today?

Let me ask you a question. What were your immediate assumptions when you read how Janice, a healthy young woman, had explained that the object of her phobia was no less powerful a phallic symbol than Nelson's Column?

Almost everyone who has heard this story responded much as I did when Janice first explained her problem to me – and assumed it was a form of sexual fixation. There should be no surprise therefore that I carried my prejudices into the first two sessions. I was looking for a cause that would fit *my* perception of Janice's problem. Indeed, at first I did not even attempt to treat it as a phobia.

There has been a tendency for practitioners of clinical hypnotherapy to split into three main groups:

1 – Analytical

Those whose methodology is to regress patients to the source of their problems, irrespective of their presenting symptoms. They tend to believe that a cure can be affected only through the re-living and eventual understanding of a patient's traumatic experiences.

2 – Behavioural

Those who believe all behaviour is learned and can thus be unlearned (deconditioned).

3 – Eclectical

Those who are willing to employ any kind of therapy that will affect a beneficial change in their patients.

So, which is the right way? It is obvious to me that in the case of Janice regression wasn't really necessary, though it did provide her with a useful explanation. However, the fact remains that she continued to be frightened even after *understanding* her problem.

Regressionists may argue that the 'nasty turn' could have been *caused* by the sight of Nelson's Column triggering some traumatic memory in her past. But Janice had seen the offending statue – and such like objects – hundreds of times before and it never caused her any fear. Also, she responded readily to *systematic desensitisation* without recurrence – or transformation – of her symptoms.

This, of course, is just the kind of story that would to some behavioural psychologists *prove* that behavioural disorders and inadequacies are solely matters of stimulus-response sequences mediated by the nervous system. But this does not explain the poor results obtained by behavioural therapies in, say, hysterical conversions. Indeed, as in the case of 'war neurosis', the bringing of repressed experiences into consciousness and the consequent relieving of tensions (catharsis) is usually sufficient to bring about an effective cure.

Happily eclectic

Eclectics will be happy to employ both analytical and behavioural techniques. Eriksonian hypnosis, NLP, symptom transformation and amelioration, even symptom removal by direct suggestions, are natural tools for these practitioners and I must admit that I belong in this group.

However, the most important lesson I learned from Janice's story was this: **No matter what the presenting symptom, therapists who ignore the Pavlovian bell do so at their peril.**

Any symptom (response), whatever the cause, will always be preceeded (triggered off) by stimuli. In the case of Janice, repeated adverse reaction to the image of Nelson's Column has established a *conditioned reflex*, so she had no choice in her behaviour even after re-living and therefore intellectualising her 'traumatic experience'.

This can also be observed in bulimic patients who, after successful resolution of their psychological problems, still continue to binge.

Therefore, any maladaptive *conditioned reflex* must also be deconditioned or ameliorated.

CONCLUSION

So, what would I do if someone like Janice were to come to consult me today?

There are of course a range of options. Indirect Ericksonian approaches, NLP, plus a variety of dissociation methods developed by the research team at LCCH, would now provide greater scope to help Janice with her problem, probably in just one or two sessions.

For instance, I could use **Hypno-desensitisation**, a technique that relies on the formal induction of hypnosis and a post-hypnotic 'cue' – the word *NOWwww* – to stabilise, deepen, or re-introduce the relaxation response at any time during the session.

Step-by-step guide

It might be of assistance at this point to set down a few straightforward instructions describing the way in which hypno-desensitisation can be employed.

First: Construct your hierarchical 'scale' (SUDS)

It is important to obtain as thorough a case history as possible. A simple Subjective Unit of Disturbance (SUDS) scale should be constructed by a combination of interviewing the patient, interpreting the patient's history, prepared questionnaires and, most important of all, the therapist's intuitions.

It is not always possible to do all of the above. If, for instance, a patient has a fear of flying, and he or she is due to travel the next day, the therapist's intuitions should become the single most important factor in the construction of the SUDS scale.

Second: Induce as deep a trance state as possible

Third: Establish an 'instant' deepener

After deepening the trance the 'cue' word should now be installed.

"*In a few moments time ... you will hear me say the word ... NOWwww ... and ... whenever you hear me say the word ... NOWwww ... every muscle in your body ... from the top of your head to the tips of your toes ... will be relaxing ... all the unnecessary ... unimportant nervous tensions ... will be going out of your body ... and your body will continue to sink down ... more and more limp ... relaxed ... and comfortable too ... in fact ... your body is going to feel ... so pleasantly comfortable ... there may be times when ... you will not even be aware of your body ... won't be aware of your body at all ... in fact ... your body will feel as if it was weightless ... weightless ... so ready ... if you have any unnecessary nervous tension ... in any part of your body ... I want you to ... NOWwww ... let go of that unnecessary nervous tension ... allow every muscle of your body to relax ... a very pleasant ... slightly warm sensation ... may very soon ... begin to spread from your chest ... and shoulders ... and out over your whole body ... and I want you to ... NOWwww ... let this wonderful feeling of relaxation ... go all the way down ... down through your body ... down to your fingertips ... and down to your toes ... and ... NOWwww ...*"

Take a very deep breath before saying the word "... *NOWwww* ...". Use a deep tone of voice, slowly and quietly, concentrating on the outbreath rather than the voice itself. You should also insert the patient's name from time to time, thus making it more personal for them.

Fourth: Install I.M.R. (YES and NO fingers)

Fifth: Scene presentation

" *... and ... NOWwww ... I am going to ask you to imagine certain scenes ... and each time the scene is clear in your mind ... you will indicate this to me ... by a slight nod of your head ... I will then ask you how you feel ...if you feel comfortable ... safe and secure ... and at ease ... and if your answer is YES ... the unconscious part of your mind will ... signal this to me ... by lifting the first finger of your right hand ... the index finger ... and if the answer is NO ... if you don't feel comfortable ... safe and secure ... and at ease ...then ... your left index finger will lift ... but if your left index finger lifts ... I will ask you to imagine the same scene again ... so if you are ready ... I would like you to ... NOWwww...imagine that ...*"

Start from low scale level

Scene presentation should now begin with the lowest anxiety value on the SUDS scale (for example, Janice could be asked to imagine herself relaxing on a holiday in a far away country) then gradually guiding her nearer and nearer the object of her anxiety.

If you get a YES signal, proceed to the next low value scene on the hierarchical scale.

If you have a NO signal, you must re-present the same scene:

"*... that's fine ... let the finger go down ...*"

"*... and ... NOWwww ...*"

If still NO ...

"*you are feeling calm and relaxed ... and ... NOWwww ...*"

Or …

"*you are feeling safe and secure ... comfortable ... and ... NOWwww ...*

You may vary your suggestions for feelings of comfort, relaxation, safety and security, etc., (with *NOWwww* ...) for as long as it takes to get a YES signal.

If you get a persistent NO, present a lower anxiety value scene.

Sixth: 'Short Ego-strengthening' suggestions

Some form of 'ego-strengthening' suggestions should always be given before bringing the session to a close, whether the desensitisation process has been completed or not.

'And…before I wake you…I would like you to know that…as each day goes by…you are going to become…a little more mentally calm…a little more clear in your mind…each day…which means that…you are going to be able to…think more clearly…see things more clearly…so that nothing…and no one…will ever be able to worry you…or upset you in quite the same way…your mind becomes…more and more clear…crystal clear…allowing you to feel…physically more relaxed too…not only in your body…but you will feel more relaxed…about yourself…about the world around you…and as the days…and weeks…and months go by…and you become…ever more calm and clear in your mind…ever more relaxed in your body…it will be perfectly natural…that you are going to be able to cope better…with anything and anybody…and any situation you have to handle in your daily life…because you are coping more calmly…more relaxedly…and more confidently too…more confidently…because…you will have greater self-control…greater control over the way you think…greater control over the way you feel…and greater control over the way you do things…the way you behave…every day…you are going to experience…a greater feeling of well-being…physical…as well as mental feeling of well-being…a greater feeling of safety and security too…than you have experienced in a long…long while…altogether…you will feel as if a weight…a burden has been lifted off you…allowing you to live your life…in a way that will be so much more satisfying…'

Seventh: Awaken the patient

EPILOGUE

A last word about the original therapy for Janice. It was, of course, quite possible Nelson's Column was a *symbol* for her – certainly over the intervening years it became one for the author.

Attempting to devise therapy for a patient based upon what Nelson's Column so obviously appeared to represent is the type of error therapists can so easily make.

The memory of Janice's case has become a personal 'cue' for this practitioner whenever therapy with a patient fails to proceed as envisaged. For the author Nelson's Column has become as near as it can get to a conditioned reflex – an invaluable reminder of the dangers of seeing patients' problems from some preconceived therapeutic stance and the constant need to consider a range of possibilities.

It is hoped therefore that this article may remind others in the field of their own Nelson's Column.