LESSONS MY CLIENTS HAVE TAUGHT ME, AND OTHER STORIES

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Acknowledgements

As you will come to see, my clients were the main inspiration for this book, and I heartily thank them for their insights and lessons to inform my practice of applied psychology over the years.

I would like to thank my friend and former associate Dr. Arnie Slive for volunteering to edit this book. Arnie continues to edit collaboration books and is still on the editorial board of the Journal of Systemic Therapies. His comments have been quite helpful in shaping our work together as we have developed as professionals. I would also like to thank Don Efron M.S.W., the original founder and editor-in-chief of the pioneer Journal of Strategic and Systemic Therapies, where many of our founding editorial board members published some of our first original journal articles.

I also appreciate the support of my family and friends in steadily encouraging me to publish this book about my professional journey. Thanks also to all of you readers who keep me going forward with enthusiasm and passion.

Foreword

As a student of psychology and as a psychotherapist, I have been informed by many lessons my clients have taught me over the years of my career. Through the collaboration of therapeutic relationships, I have learned about life, relationships, meaning, and interventions that provide patterns of possibility for solutions that uniquely fit life dilemmas.

This book began very long ago, in 1981. In the early days of the Journal of Systemic Therapies, one of my first articles as a Founding Editorial Board member was the first chapter of a proposed quarterly column “Lessons My Clients Have Taught Me.” The first one was called “Teach Me Your Symptom.” This was a great deal of fun to write and was received very well by our readership. Then life

became increasingly busy for all of the editorial board as we reviewed and edited the many submissions of articles for publication in the Journal. Somehow, I never got back to writing stories about my cases, although I would occasionally talk about them in workshops and lectures that I gave. Perhaps I was intimidated by the formal requirements of publishing in a professionally-refereed journal.

After moving to Calgary, Alberta, in the early 1980s, I was invited to write a column on Mental Fitness for Impact Magazine, a western Canadian fitness publication with a circulation of over 35,000. The writing requirements were quite different, being very succinct, topical, and for a general audience. Now I could write in an informal manner similar to how I talk, engaging the audience or readership as if we were in a private conversation. Still, life seemed too busy in career, family life, judo, music, and other projects.

Now, as I settle in to semi-retirement, I have more time to focus on a more generative agenda, that of writing short stories and essays, assembling enough chapters and coherence to begin a few short books that are easy reading for the public.

This book is aimed towards those who are interested in coaching, counselling, and psychotherapy, and those outside these professions that are merely interested in human nature, and how therapy can work in transforming lives. It provides an inside view of what can happen in the therapy room, turning points in therapeutic conversations, and the brilliance and creativity of clients as they respond to the therapeutic alliance and collaborate for a successful and enduring outcome. It also at times reveals the strategies and structures involved in designing and delivering interventions, and the mind of the therapist in focusing on pivotal points. Some chapters outline metaphors and stories that are not provided by clients but are useful in reframing life dilemmas so that they become more solvable.

This book is supposed to be fun and easy to read, so I have largely dispensed with literary references giving proper credit for the origin of the idea. So, in an academic sense, I confess to the offense of plagiarism. There are so many ideas that have been repeated and quoted so many times that I have largely forgotten their origin. Like many Native cultures, most of these stories are passed on by the oral wisdom of the elders. My stories are best understood as merely historical fiction, although you may see yourself in them. I sincerely hope that you, the reader, have as much fun with these “Lessons” as we have had in developing them for your pleasure.

Preface

SQUIRRELS IN THE ATTIC

Sometimes I wonder why I am writing this book. Perhaps my main hope is that the reader will be entertained, fascinated, and maybe even enlightened by these stories. Others may get a better understanding of the elements of a solution-oriented model of psychotherapy, counselling, and coaching. Some may use the lessons as an approach for self-help and discovery of inner resources liberated by different ways of perceiving and describing a problem, thus making it more solvable. Some

consultants and life coaches might be intrigued by the novelty of some interventions. So I guess a major motivation for writing is attempting to be altruistic in helping others.

But mostly, this book is written in homage to the many clients who have informed my professional practice as a counsellor over the last three decades. Their creativity has inspired me to use my own ingenuity in collaboration with them in the therapeutic alliance.

However, perhaps the most selfish reason for writing is to get these stories out of my memory banks and out on disk or in print somewhere so that I don't have to keep them locked inside my mind. That reminds me of a story...

Around the time of my early professional psychology career, I lived in the upper level of a rented house in London, Ontario. Directly below us lived two prostitutes, but that's another story. Above us lived a family of grey squirrels in the attic. Despite our repeated requests, the landlord took no action to evict them, neither the prostitutes nor the squirrels, but it certainly made for rather noisy and distracting evenings. There seemed to be minimal sound insulation, especially between our ceiling and the wooden attic floor above us.

Each night, as we tried to sleep, the squirrels would carry on their evening ritual. There were many large oak trees around our house, so there was an abundance of acorns to be collected and stored. That's the official version. But I have it by good authority that there was something else going on. This squirrel family was running a bowling alley. Each night they would invite in the neighborhood squirrels for games where they would roll acorns from one end of the floor to strike the other nuts at the other end. You could hear the scratching of their toes, the rolling of the acorn, the scatter at the other end, accompanied by chattering that could only be interpreted as cheering and scoring by the teams gathered there. This would go on for about a half-hour, then would mercifully tail off. We would have a chuckle or two, then fall off to sleep ourselves. While we were mildly anxious about the remote possibility of an electrical fire caused by squirrels gnawing wires, we came to regard their antics as comical, rather than annoying. Still, their evening ritual somewhat disturbed our drowsy thoughts as we prepared for sleep. Staying up late to outlast them was not productive, nor was banging on the ceiling, which merely prolonged their games. Eventually, we solved the problem after a few months by buying and moving into our first home, and you can bet I sealed the attic in our new house thoroughly.

So, as you can now see, I write to get the story squirrels and their rolling thoughts out of my head so that I can be free and open to new ideas and inspirations. I hope in reading these chapters that you will find some of their acorns worthy of enjoyment and utilization.

PART ONE: PATTERN DISRUPTION INTERVENTIONS

Perhaps at this point you were expecting the next chapters would be about hypnosis. And if that is all you want, you can skip this section and go directly to the chapters on hypnotically-based interventions. In the meantime, I invite you to read the stories in this section to examine how a certain hypnotic principle can work to invite new patterns of possibility.

In a solution oriented approach (see www.solutionorientedcounselling.ca) one of the best ways to intervene in a problem situation is to disrupt the sequence of events in which the problem is imbedded, or disturb the usual consequences of the symptomatic behavior. Sometimes that is all that is required. New patterns can arise spontaneously in client repertoires that emerge as solutions to the presenting problem. Here are some examples.

1. TEACH ME YOUR SYMPTOM

Occasionally people ask me "Whatever got you interested in hypnosis in the first place?" I invariably break out in a wry smile and reflect back on how it all happened. The story reminds me that our client-teachers are often neither random nor passive as they collaborate in the therapeutic process to catapult our thinking to new levels of consciousness.

The prototype client-teacher in my mind is a young woman who propelled me into strategic hypnotherapy long before I heard of the utilization approaches of Milton Erickson or the problem-solving concepts that were later to evolve into a field known as strategic and systemic therapies.

Sue Doenimm[1] was a virtuoso in the lifescript role of failure. The scapegoat sib of a rather large German-Canadian family, this 17-year-old had learned an unusual way of coping with the binds and disqualifications that prevailed in her perfectionistic family communication. When exposed to untenable situations she would become quiet and rigid, unable to move or talk for hours and sometimes days. At those times she would seem to conform to the image of being a useless person, the total failure scripted by family and others in a loop of self-fulfilling prophecy.

What made Sue Doenimm outstanding, however, was her consummate hypnotic skills in unconsciously drawing others into her self-image of hopelessness. She contaminated all those who came in contact with her, including friends, family, former therapists, with her dread disease of failure. Even her boyfriend, a ballet dancer, could not escape this aura, and on one occasion lost his balance and fell down a staircase, breaking his leg in the process. Beyond her ability to distract and dissociate, Sue's autonomic control (and simultaneous denial of it) was impressive, almost like a fakir, the way she could raise welts and nearly blister her skin during anxious moments in her sessions. Most dramatic, however, was her ability to go into a rigid and almost catatonic trance for several hours to several days depending

[1] In case you have not figured this out already, Sue Doenimm is a pseudonym for her real-life name. In keeping with the tradition of writing case vignettes, the real names of all clients have been changed to protect their confidentiality.

on her stress level and the severity of the conflicts and binds she was facing. This symptom was her presenting problem, which had been unresponsive to several previous attempts at psychodynamic therapy and psychotropic medication. Her psychiatrist, in desperation, referred her to me. At that time I was an enthusiastic, if perhaps unseasoned, cognitive behavior therapist.

In the first several sessions I tried to use progressive relaxation training and everything else I could think of at the time in an effort to build her abilities and skills in coping with stress and distress. After ten sessions it was clear that her prophecy was about to come true: she would try hard and I would try hard and the result would, of course, be complete failure. After all, the symptom had been going on for years, and was completely involuntary, so how could it be otherwise? Finally, in exasperation I told her, “In this session I want you to teach me how to paralyze myself. I want you to paralyze me.”

She said, “I can’t do that! I don’t know how! I told you I have no control over it!” The fear and frustration were evident in her tone of voice at this sudden switch.

I said, in my best answer to her formidable rationalization, “Never mind. Do it anyway. I have to learn how you do this so I can figure out a way to help you, because right now I am incompetent to help you.”

The anxiety generated by this declaration and demand already had begun the process of her “freezing,” but she obediently began coaching me on how to hyperventilate and autosuggest as she went further into her paralysis. I became aware of stiffness in my entire body, including my face, so that I could barely talk. As I became more rigid and immobile she became slightly more relaxed and somewhat curious about the zombie-therapist she had produced over the last twenty minutes. I could just barely move my lips to tell her that her hour was nearly over. I implored her to get me out of my paralysis because another client was due to arrive in a few minutes.

Again she panicked, saying, “But I can’t! I can’t! I don’t know how to get you out!”

Now I too began to worry about my dilemma, as I tried unsuccessfully to move my limbs or talk. Through clenched teeth I could barely whisper, “Use some of the techniques I taught you to get me out of here!” So she did, and gradually with her coaching and feedback I was able to regain movement and bodily control. I then thanked her gratefully for returning me to my normal condition and providing me with a rather unique experience, and rapidly ended the session.

After Sue left the office in a somewhat confused but pleasant daze I began to come out of my dissociative fog. A new feeling of excitement swept over me, with the realization that I had just had my first experience of deep trance and hypnotic catalepsy. Now I really knew what it was like for her to be imprisoned in her own body. Of greater importance, I was also deeply confident that now the crucial corner had been turned in her therapy. After all, how could she really accept that such paralysis was involuntary and uncontrollable when somebody could be trained to both go into it and come out of it in less than an hour? And how could she continue to protest incompetence after successfully paralyzing and rescuing her therapist who had placed his trust in her abilities?

In subsequent sessions my client had no difficulty in voluntarily inducing and removing paralysis both in me and herself. She also began learning and using other coping mechanisms and assertive communication skills to deal with family and social situations and overcome her failure script with a tentative but positive self-image. Throughout her improvement I kept on cautioning her, “Remember, don’t lose this power to hypnotize yourself. You may want to use it some day, and there are people who would go out of their way to have unusual experiences and altered states like you brought me through.” However, she did not want any part of it, and was glad to see this pattern totally disappear from her responses to stress and distress. Her family and friends were quite amazed, but pleased and relieved that she was now progressing in school and other aspects of life.

About seven years later I met her again in a restaurant where she was working as a waitress and assistant manager. She told me that life was going well for her now. As for me, this lesson began the intense fascination and respect I have for hypnosis, utilization, and unusual strategies for dealing with perplexing cases as both a therapist and consultant.

One day I went back to the restaurant and asked if she still had the ability to paralyze herself. She told me that, although she had not done so since her therapy, she felt confident that she could if she had to. I asked her why she felt so sure about it. She calmly replied with a knowing smile, “Well, I taught you how to, didn’t I?”

2. TAMING A SQUIRREL

This is a short story, but it is a relatively easy and adaptable intervention. The exact details are scant, as I remember peering through the mists of time, but the most important details stand out. Once again, this happened when I was travelling throughout southwestern Ontario doing outreach mental health clinics as part of an interdisciplinary team. We were quite effective given our limited resources in a team of four who visited small communities once a week. As the saying goes, a good highway generates its own traffic, so soon our reputation exceeded our capacity, so we had to institute a waiting list. Sadly, we had to triage cases in terms of urgency, such that easier cases were sidelined by severe and acute cases. As all of you know, this becomes a crisis-generating system, where easy cases become difficult through chronic neglect. It is not a good way to deliver mental health from both the receiver and provider perspective. Nevertheless, it was all we could do given our limited time and clinical resources.

As part of the triage assessment procedure, we would interview prospective clients for ten minutes, assess their urgency, and place them on waiting lists. One woman I assessed was a 50-ish spinster who talked quickly, sharply, and incessantly, and moved her limbs and body frequently in almost sudden movements. She said that she found herself unable to relax and that her mind never stood still. I did a quick mental status exam and found out that she had no history of bi-polar or ADHD symptomology; it’s just that she was chronically a very frantic and nervous type of person, with no particular reason to be agitated, and relatively mild current stresses.

I told her that I likely would not be able to counsel her in the near future, but I could give her a homework assignment that might be helpful for her disorder. Given some motivational interviewing preparation, she became receptive and agreed to carry out the assignment. She was tasked to tame a squirrel while talking to it in soft and slow tones, rather than her rapid staccato usual way of talking. Taming would be indicated when a wild squirrel would willingly eat from her hand. Now, we all know that any loud noise or sudden movement of any sort would spook most animals, so I thought this discipline would constitute an ideal meditative focus activity for my client. She would have to be still, talk slowly, and access her internal sense of peace and quiet confidence in order for a wild animal to trust her.

During our ten-minute follow up interview a month later, she proudly proclaimed that she had tamed her first squirrel. As we mutually celebrated, I noticed that her breathing was slower and deeper and more confident, and her tone of voice was softer and friendlier. She also reported that she could now walk around her neighbourhood with less fear of dogs in back yards that used to bark at her. I commended her for her diligence in following through with the assignment and for her level of mastery in overcoming her fear of novel situations where the outcome is uncertain. I asked her to repeat the same homework for the following month to make sure the results were not merely a fluke, but rather evidence of a steady way to overcome her “nervousness and lack of confidence.”

As you likely anticipated, she reported in our next monthly ten-minute interview that all was going well. She had tamed two squirrels now, and she had made friends with almost all of the neighborhood dogs, so that they barely barked beyond a greeting “Woof!” She reported many other ways in which her life and relationships had improved, so I happily discharged her from my waiting list with mutual congratulations on our therapeutic alliance in helping her face and resolve her problems.

Taming a wild or frightened animal is a task that requires calmness, soft voicing, slow and rounded movement, rhythmic breathing, attention to your animal, and calm responsiveness to its non-verbal behavior, empathy, compassion, acceptance, and vast patience. In short, it is one simple pathway to a Zen sense of living in the Now.

3. FAVORITE DRESS

Upon moving in 1982 to Calgary, Alberta, I continued my beginning interest in treating eating disorders. Dr. Arnie Slive and I had begun to consult with each other about treating these cases in London, Ontario, in previous years, but we were continuing our fascination with the complexities of treating anorexia and bulimia nervosa. I was interested in them as an aberration of the search for excellence and over-control resulting, paradoxically, in the disorders controlling them.

In addition to some severe anorexic cases seen as inpatients in our mental health clinic in a general hospital, an increasing incidence of bulimia nervosa began appearing in our outpatient referrals. I seemed to be their therapist of choice, as I had an accident of competency in successfully treating several cases. They told their network of friends, and soon a flood of referrals emerged.

One such case involved a woman in her early twenties. She fit all the classical signs of an eating disorder, such as perfectionism, obsession around physical beauty and body image, dyscontrol of eating followed by purging in almost daily episodes, black-white thinking, almost incessant food-and-figure obsessions, etc. Nevertheless, she was otherwise quite functional in her career and social life, and had an absence of family or personal history trauma or communication pathology. The habit component had ascended to become the primary reason why she was unable to stop her compulsive ritual of overeating followed by purging through induced vomiting.

During our two assessment sessions, I asked her if she had a favourite dress. She responded that she did, a red cocktail dress in which she felt especially attractive. I asked her that, in the interest of her recovery, would she be willing to pack this dress in a gym equipment bag next to her workout clothes. She was curious about this question, wondering where it was leading.

After another session of motivational interviewing, we both came to the conclusion that she was ready to take direct action to end enslavement to her eating disorder. She just needed a compelling ritual to break free from it. I was by this time quite well-versed in pattern-disruption interventions during the several previous years where they had yielded good results in intractable cases. So, by the time my client was ready to do almost anything to break free from her disorder, she agreed to the following intervention:

My client could from now on indulge in purging as often as she wanted to, with one limiting condition: she would agree to vomit only while wearing her favourite dress. She was shocked but intrigued with this arrangement. It would imply a great deal of inconvenience and limited opportunity to practice her habit, especially at work and in social situations, which were some of her primary trigger contexts. Moreover, the idea of contaminating her favourite dress in the privacy of her apartment was also distasteful. Nevertheless, she had agreed to this intervention, and left the session perplexed as to how this would play out in the subsequent week.

Several times during that week she was triggered to purge, but was overwhelmed with the burden of difficulty and thought of contamination, so she did not complete her changing into her favourite dress. Predictably, as the urge passed, each time the compulsion became weaker. Within a week, no purging had occurred. The urges became less frequent and intense. Because purging was eliminated, overeating episodes also subsided. My client reverted to regular well-balanced eating patterns with minimal coaching and encouragement from me in the ensuing weeks. Thus, by five sessions the bulimia patterns had vanished, and we closed the case successfully. There had been no relapses at her six-month follow-up. However, by that time she had referred her friends and fellow-sufferers to me, which created a new problem for my practice in a public clinic. Client demand was now surpassing my capacity to treat. Perhaps the lesson was: watch out for success; it could trap you in a ghetto of restricted practice with a narrow population and an unwitting specialty.

4. THE REPLACEMENT RULE

As most of you know, bulimia nervosa is a complex disorder involving self-imposed food deprivation, followed by chronic intermittent episodes of disordered food intake, called bingeing, followed by some

type of purging or attempted undoing of the caloric intake. Purging behaviours can involve self-induced vomiting, laxative abuse, and several other patterns. Therapy for these disorders is often multidimensional, as is the disorder. We intervene at the biological, nutritional, psychological, familial, and social and cultural levels to address the many factors that drive this problem pattern. Among these, food intake requires moderation and structure; we cannot stop eating. On the other hand, purging can stop “cold turkey” with virtually no complications. So, you could stop purging totally while learning a moderation strategy for eating, if only there were an adequate intervention to accomplish this result. Thus, I developed this idea called the replacement rule.

This idea will not work unless the therapist has prepared the client with motivational interviewing. That is, the client must be fully motivated and ready to do whatever is required to end the misery of bulimia. The whole literature about Milton H. Erickson M.D. (Haley, 1976) is full of examples of how to conduct motivational interviews with restraints, scepticism, future pacing of scenarios of change versus non-change, and many other strategies to help the client come to a commitment to change no matter what. These devices are too elaborate to outline here. If you are a therapist, you likely know how to prepare the client for such an intervention.

The prescription goes like this: from now on you can purge just as much as you want to, provided you agree to end each purging episode by replacing the food you vomited in the episode. For example, if you ate 6 donuts before vomiting, you would have to end the incident by eating and digesting another 6 donuts. In other words, a bulimic episode would thus end with food being maintained rather than expelled.

This prescription worked exceptionally well with more than 40 clients over a period of four years. However, at least 10 clients wiped out when, despite their best intentions, they were so overwhelmed with anxiety and guilt and fear of weight gain that they could not follow through with the agreement. In several of these cases, the issue was to revisit readiness and bolster anxiety management strategies and peer support for persistence.

Overall, the replacement rule worked quite well when used in conjunction with a comprehensive therapy plan. Encouraged by success with pattern-disruption interventions in eating disorders, such as bulimia nervosa, I began to think in greater depth about why they were so powerful. Essentially, many pattern disruptions derive their effectiveness by stopping or reversing the usual reward or payoff that typically maintains the habit or disordered sequence of behaviour. That is, the client is encouraged or ordered to continue the symptom, but with some unusual twist of timing, place, order, sequence, or context that disrupts the integrity and symbolic payoff of the ritual itself. The replacement rule nullifies the reason for purging itself, so motivation for the behaviour unravels each time the rule is invoked. It is also powerful in that relapse prevention is built into the design of the intervention. That is, whenever a relapse occurs, your client now has a way of undoing the undoing of the relapse, by reaffirming the overall context of therapy.

There is also the added advantage that pattern interventions such as the replacement rule usually involve a symptom prescription. The client is often perplexed by the paradox that the therapist is

demanding that the client do a variant of the very behaviour they wish to eliminate. Often such interventions invoke a spirit of rebellion against the symptom itself.

However, it is likely the main reason why these prescriptions work is that the very integrity of the symptom complex is shattered or unravelled. When the core of integrity is removed, the parts of the pattern begin to fall apart, and the symptom problem dissolves almost by itself. The replacement rule has proven to be effective in eliminating the purging habit, thus disrupting a major component of the bulimic cycle.

5. QUIT SMOKING WITH CHAIN-8

Another example of the Replacement Rule is a method for ending cigarette smoking, called Chain-8. Once again, this rule can apply when proper motivation and other supports are in place. The procedure is to chain-smoke eight cigarettes in a row non-stop as your last experience with smoking. When you have finished the last cigarette, you rip up the remaining cigarettes and flush them down the toilet. You resolve that, from now on, every time you even have a drag or puff from someone else's cigarette, or have a cigarette or even a partial cigarette, the next thing you do is you buy a pack of cigarettes, chain-smoke eight of them, and destroy the rest. This commitment ensures that if you slip up on your record of being several hours, days or weeks being smoke-free, you have an instant ritual that will ensure the slip will be unlikely to happen again. How does it work?

When you first learned to smoke, you were overwhelmed with the bitter taste, the urge to cough, the dizziness and almost nausea as the poison of nicotine and the irritation of the smoke choked your throat. As your eyes watered, you wondered why anyone could ever feel this as a pleasant experience. Gradually, after many repeated exposures, you habituated to the drug, numbed your body's reaction to the poison, and became addicted. In the Chain-8 ritual, you override your body's adaptation to poison by overdosing on the substance. Your body now returns to the revulsion and disgust you had initially when you started smoking. Thus, in each instance, your last experience of smoking was a very negative one. This happens every time you have a slip backwards in your recovery. Usually, all it takes is one or two instances of relapse and chain-8, and you will never want to smoke again. Furthermore, the last negative experiences imprint so strongly, that positive memories and images of smoking are virtually erased. You are now smoke free, and never have to feel deprived of smoking again. Recovery from smoking also requires learning other behaviours and techniques for dealing with trigger situations, stressful events, and strong emotions. These need to be well-rehearsed prior to quitting smoking as part of your relapse prevention strategy. With the added structure of the Chain-8 commitment, you and your clients can break free from addiction to cigarette smoking.

Again, a pattern intervention based on prescribing the symptom can break up a highly compulsive addictive ritual.

6. COMPULSIVE HAND WASHING

In my therapeutic work, I have often used the ideas of Strategic Therapy. These are structural interventions based largely on Jay Haley's documentations of the pattern disruption strategies utilized by Milton H. Erickson, M.D., the most famous hypnotherapist of the 20th century (Haley, 1976).

One example earlier in my career was a woman in her early 30s who had a severe case of compulsive hand washing. She had been treated psychiatrically with a series of ineffective medications, some brief insight-oriented psychotherapy and brief hospitalizations in psychiatric wards in two general hospitals in our medium sized city of London, Ontario. Finally, she was admitted as an in-patient in a provincial psychiatric hospital, with a repeat of previous interventions, now augmented with group therapy on the ward over the past two months. Nothing worked. Her hands were raw, and she was actually losing patches of skin on her hands that were by now bandaged. She was agitated and distressed that nothing could stop her painful compulsion. She was going through several laundry hampers a day in washcloths and towels. In desperation, the staff referred her to me.

In our initial interview, she revealed that she had a severe dread that arose gradually in her early adulthood that her germs would infect others such that they would die. I asked her for her data that this was a reasonable fear. She said that no one had died or even got sick because of her diligent efforts to shower and wash her hands. Of course, she knew that that this logic was flawed, but that did not diminish her feelings of the certainty of doom if she were less than diligent. I told her that pattern reminded me of the story of another client.

This man came in rubbing his left temple continually every minute of two. I asked him why he did that. He replied, "to keep the tigers away!" I said, "but there are no tigers in our city." He continued rubbing his head, saying "pretty effective, eh?" My current client was hardly amused by this story, and that made me somewhat concerned, because a client who has lost her sense of humour often has lost the perspective to meta-observe and describe her predicament. The ability to create a space between you and your problem situation is a first step toward examining patterns of possibility for its resolution. However, my client did not have access to this resource.

She did, nevertheless, have one important factor that pointed towards solution: she was what I call "**suitably desperate**." In motivational interviewing, we set the stage by exploring the extent of influence the problem has in our client's life, previous attempts to solve it, and explore with the client the risks and benefits of a proposed therapeutic change. We then assess with them the stage of readiness they are at before beginning treatment (Weeks and L'Abate, 1996). As my client was ready to do almost anything to resolve her situation, I had her make a "pact with the devil." That is, she agreed to enact an intervention without full knowledge of its technical details, provided that it was legal, ethical, and did not require any more than her current level of physical pain. Upon securing her agreement, I outlined the treatment plan.

I told her that, beginning this minute, she could now wash her hands and body as much as she wanted, with the requirement that she would terminate every washing occasion with one simple behaviour: she would touch the tips of her fingers of each hand to her nostrils. At that moment, she had a brief look of

horror in her eyes, but she had agreed to the pact, so she swallowed hard and began to contemplate the dire consequences that she believed would happen. I assured her that I would teach her affective regulation strategies to deal with her anxiety, and would be on hand to help refer the victims of her contamination for further medical treatment as necessary. She was relieved that I was willing to unburden her responsibilities for the catastrophes that would ensue.

Within two days the bandages were off her hands. She had washed her hands several times at appropriate intervals. She had followed through with her closure assignment each time, had touched doorknobs and other common items on the ward. No one got sick or died (thank God!). In our second session I made a custom audiotape of the session and loaned her a tape player so that she could practice these relaxation strategies as often as necessary, but certainly once a day. Within a week, her compulsions had vanished, her obsessions were reduced to occasional thoughts totalling less than 20 minutes a day and steadily diminishing. She had no other problems or complications. Her level of confidence was boosted by her own self-efficacy and mastery of this problem pattern. At the end of the week she was discharged from the hospital, her hands fully healed, although still somewhat reddish from residual irritation.

I saw her weekly for three more sessions to ensure that the results were enduring. She had now returned to work productively. She still used her tape daily, and enjoyed the profound sense of relaxed trance it induced. Back in those days, hypnosis was not permitted in public hospitals, so I referred to our work as “guided imagery” and “relaxation training” which it basically was. She asked if I had used these relaxation techniques with other patients and clients, and of course I routinely did. She suggested that I make a commercial version of our tape, as she felt it would help many people beyond my caseload. As I frequently respect the advice of my clients, I eventually worked in a sound studio and wrote and produced the audiotape “Wave-Pattern Breathing: Meditations for stress management” which became a best-seller in the Mind State Management Audiotape and CD productions series. These products are now available as MP3 Downloads (www.solutionorientedcounselling.ca). I guess no program is complete without a commercial, so there you have it.

As an interesting epilogue to this case, I heard from my former client approximately 10 years later. She had many years symptom free, but now some of her obsessive thinking was returning in other forms such as checking stoves and locks several times. She did not want her symptoms to regain their former control over her thinking and behaviour, so would I please make another tape as she had long since worn the old one out. I was pleased to reply that, although I now lived in Calgary, Alberta, several thousand miles away, that I had followed her earlier advice, so that she could order her own copy of Wave-Pattern Breathing. She did so and resumed her daily practice to a level of five times a week. The obsessive symptoms reduced in severity and frequency almost immediately. Within three weeks they were virtually gone. She thanked me for this follow-up telephone contact. That was over 20 years ago. Pattern interventions can work dramatically well. Both the therapist and the client must be fully aligned for them to do their magic, and so it was in this case.

PART TWO: PARADOXICAL INTERVENTIONS

At times it is not sufficient to merely disrupt the symptom context or pattern. Sometimes it is best to prescribe the symptom itself, even without the modifying rules for how and where and when the symptom should occur. The basic premise still applies: you are asking the client to perform the symptomatic behavior, which is by definition not at the client's conscious control, again at the therapist's demand, supposedly at the therapist's control. Thus, once again the symptom becomes an integral part of the therapy, a beneficent paradox.

In these stories there is an added element of risk. The symptom must be prescribed with an acceptable rationale for the client. But more importantly, the therapist does so without the assured knowledge of how this might turn out. Intuition and previous experience might guide the therapist, and a sincere wish for no negative or harmful outcomes for the client. Still, as you will see, many of these prescriptions are counterintuitive. My experience with judo leads me to believe that one of the safest places is what we call "the eye of the tiger" or "the eye of the hurricane." This place is momentarily totally safe, but you need to jump into it with total commitment to be effective. As such it takes courage on the part of the prescribing therapist, and great motivational preparation for the client. You will see what I mean.

7. THE OLD MAN

This is one of my favourite stories. As you can imagine, in my career as a psychotherapist, I get a chance to see human nature at its worst, but more often, at its best. In this marriage therapy case, although I found the husband to be charming and loveable, it was the wife who was truly an inspiration about the essence of loving.

This story dates back to an era before cell phones. Around the late 1970s, there was a fad among long-haul truckers known as the CB (Citizen's Band) craze. There was even a popular culture of songs and movies around the ideas of truckers getting together by CB communication to inform each other and outwit speed traps and other roadside hazards, as well as rather mundane chatter, today's equivalent of Twitter and blogs. Back then, it was a relative novelty of remote communication. Part of the culture was to have a nickname, and one of these was "The Old Man." Now, for reasons of confidentiality, I have changed his handle for the purposes of our story, but it was something like that.

The Old Man drove an 18-wheeler semi through various cities and towns hauling freight on a long-distance highway. He was in his late-forties, with thinning black hair, a disarming boyish grin, and a pleasant way of instant engagement. As it turned out, he used these skills in flirting with truck stop waitresses, and had developed a reputation that had leaked back to his wife. She was in her late forties, rather attractive, and like her husband, mildly overweight. Now that the kids were grown and almost launched, she had resumed her career as an executive assistant in a small company in their hometown.

She had put up with her husband's shenanigans, and reputation as a flirt, as a necessary evil and an extension of his flamboyant personality. She didn't take it seriously, nor did the trucker friends on his main routes, until more persistent rumours circulated that he had special favourites that he almost bragged about without being specific in his CB blurbs. After her nagging suspicions, which he cavalierly denied as malicious rumours, he finally admitted he had been sexually intimate with Lark, a 28-year-old waitress. Perhaps, and who knows, there might have been other affairs in terms of one-night-stands, but The Old Man swore this was the only infidelity. His wife, who I will call The Old Lady in the vernacular of the day, guardedly accepted this version of reality. However, she needed a verdict about his commitment to his marriage to her. Did he really love her? She said in the initial marital interview she needed to know if the marriage was going forward. Other than facilitator, I was not guiding this interview. It merely unfolded before my eyes and ears.

The Old Lady stated boldly that she was the best woman for him, and that it was about time he knew it. Then she made a daring and unpredictable move: she challenged The Old Man to move out and live with his new fling! She said that there would be no animosity. She loved him with all her heart, but if he could find greater happiness with this younger woman, she would not stand in the way of his happiness. That would be the signature of her love for him. However, she also said that she was the best lover he could ever want, and she would await the verdict without judgment, and would accept him back if he returned from this experiment. She also said if the experiment went on for years, she could not guarantee that she would still be available.

I was awestruck as a therapist witnessing this interaction of love and permission. Mind you, I was relatively young in my career at that point. I had never encountered this form of love before. It was a combination of being fed up with nonsense and the genuine acceptance of the inner child within her 48-year-old spouse. I noted that here was no condemnation or criticism, just nurturance for an adult pup gone astray with chasing his own tail, in both meanings. And so it was that I was almost merely a witness to their new arrangement. At first The Old Man could not believe his ears. Did she really mean it? She said she was serious: both he and she needed to know that others could not match her genuine love for him, and that he could make a final and enduring commitment of monogamy with her. The now-liberated Old Man was free to pursue his new romance, but the stakes were also high. She also made the stipulation of no unprotected sex, so that the health of all would be safe during and after this experiment.

In the next several weeks by mutual agreement he moved in with this young waitress in a nearby city. As predicted, the sex was great in terms of novelty, as the Old Man was also in love with the state of being-in-love with Lark. Perhaps he fooled himself that he was in love with her, perhaps as an unconscious way to justify the affair. However, fairly soon this illusion was unravelling with each day they spent together, hanging out with her friends and activities. Her friends were into their own almost teenage way of talking, taste in music, shallow values, uninformed opinions, and casual involvement with alcohol and street drugs, almost daily. Her friends were also amused with Lark's relationship with a man old enough to be her father. However, they were respectful, if somewhat awkward, with the Old Man as he tagged along with them to nightclubs. The more he and Lark talked, the wider the generation gap became, both

finding out they had almost nothing in common. Furthermore, the Old Man began missing the comfortable and caring conversations with his wife. Most of all, he missed her gentle and kind sense of humour, as compared to the edgy and cutting jibes that Lark and her friends thought to be funny. After three weeks, the Old Man decided that he wanted to end the affair and return home. Lark also agreed that this decision would be the best for everyone. The novelty had worn off, and she was feeling increasingly uncomfortable in his presence. They knew that they did not fit in each other's lives. The breakup was not in any way an angry one. Lark still held some affection for him but was relieved that their awkward affair was over. It was just a fling, and Lark went on with her life without missing a beat. For the Old Man, the breakup had more impact. He was shocked at Lark's casual detached attitude and lack of grief. He became aware of how much he had projected his hopes and dreams into this fantasy, and how quickly it had dissolved into a cloud of smoke within weeks. He also felt ashamed of being so foolish in risking a great marriage in chasing this illusion in his own mind.

About a week after his return home, the couple came in for their next session. They had been having many heart-to-heart talks that week. The Old Lady was cheerful and felt validated that in many ways her husband was a changed man. He was far more humble and sincere, and appreciated her qualities more than he had in years. In our conjoint session, he repeated for me and his wife the life lessons of the last month, especially what he had learned about himself, the value of his marriage, and the profound respect and admiration he had for his wife. In this session they both displayed their care, affection, and love for each other. There even were a few comments about greater mutual passion in their sexual relations, a nice side benefit of their greater emotional closeness. There was surprisingly little processing to do, as all was by now forgiven and restored.

By a month later the couple had recalibrated their relationship to a new normal. Among his trucker friends, he was still The Old Man, but he had lost a lot of his swagger. He was no longer a big braggart. Those who did know about his escapade accepted it with a shrug and a smile, calling it an AFGO, code for Another F...ing Growth Opportunity. To them, he had merely embarrassed himself, as in the saying "There's no fool like an old fool." They still accepted him. He still occasionally flirted with waitresses at truck stops, but now it was more light banter, no longer loaded with innuendo. He never again wanted to have any of these women calling his bluff.

The marriage continued to solidify over the coming months, with the couple going on more trips and sharing activities together. In my follow-up call about a year later, they reported continuing marital happiness, and a warm relationship with their grown-up children.

As I look back on this case, I had virtually no work to do in our sessions. I merely had a privileged window into the inspirational workings of true love. Later in my career, I also saw other variations of sending your spouse away to find him-or-herself with an outside lover, or a dramatically different lifestyle and trial separation. In each case the gamble paid off; the marriage was reaffirmed. However, in all of these stories, none impressed me as much as the love of The Old Lady for her Old Man.

8. I JUST CAME BACK TO SAY GOODBYE

Judy was an attractive and intelligent 28-year-old executive assistant who had been living for more than a year with Giles, a 30-year-old used car salesman. All of Judy's friends warned her not to date Giles. Although he was charming and handsome, there was something about his glib manner and superficial values and attitudes that warned them that Judy would get hurt, but she was hopelessly in love with her man. They just didn't understand him, that's all. While Giles was somewhat successful as a salesman, in his spare time he enjoyed going to bars, drinking, and smoking marijuana occasionally. Judy had met him at one of those bars, and quickly liked the sensual way he danced and made her laugh with his goofy antics and juvenile humour.

In the year they lived together, their fit was becoming more ragged, as the very features of her original attraction were becoming tiresome. He resented her taking night courses towards her B. Comm. Degree, while he still hit the bars. On more than one occasion her friends had seen him flirt and dance with other women. He claimed it was all just innocent fun, but she began to be more suspicious as he stayed out later, made alibis about being out with his male friends, and became generally more defensive. Several times she had caught him out in lies, but in the face of his repeated denials she often forgave him, and allowed him a chance to build back trust, while he coped with her seemingly oversensitive undue jealousy and unfounded suspicions. After these arguments about his escapades the couple would settle into a honeymoon phase and another new start. There were other signs that Giles did not fit with Judy's goals and social circle of her student and faculty friends at university. He could not keep up with their conversations, and he would withdraw into alcohol and generally behave rather boorishly in her intellectual crowd. As the months went on, Giles would deny having affairs, but would finally be confronted with inconsistencies in his cover stories, erotic emails, and other telltale signs. When cornered Giles would try to lie, distract, counterattack by accusing Judy, but would finally admit he had an affair. At that point he would cry and say he truly loved only her, that these other dalliances were meaningless, and that he would reform. There were at least three of these discovered affairs in their year together. Each time, against the advice of her friends, Judy would take him back.

One night Giles came home more drunk than usual. He said he could not stand their relationship any longer. He was going to leave by the next day. Judy was shocked, but level headed enough to ask him where he was going to live. Giles then disclosed that he was going to move in to live with his mistress of the last month. At that point Judy lost it, screaming at Giles in her rage at yet another betrayal. All through the night she helped him pack all his belongings, apart from some shared furniture and larger items, and pushed him out the door that morning.

All of this story came from Judy in her first interview with me. She felt lonely and was grieving the breakup that occurred three weeks before her first session. Although I tried to reserve judgment about Giles, given that this was just one side of a story about relationship breakdown, it seemed to me he was a manipulating philanderer, in plain terms, a jerk. However, what was even more remarkable was Judy's huge attachment to this man. There was a strong element of co-dependency in her insistence that, given enough support, Giles would prove to be a diamond in the rough, a great guy. Coming as she did from a family where her father was an alcoholic and divorced her mother after many affairs, it was easy to see

how transference was clouding her judgement in her dedication and loyalty to a losing cause. Her personal history also explained why she had always been attracted to carefree and charming men and was bored by more stable and goal-oriented men. Furthermore, her teenage rebellious nature accounted for her former party lifestyle around alcohol and pot, previously dropping out of university to get a job to support her lifestyle. She also was continuing to rebel against her strict and controlling mother. Her younger sister had dealt with the struggles of life in this single-parent family by being passive and obedient towards her mother, quietly focusing on her studies. Now that Judy was more mature in the last year, she had graduated beyond the shallowness of her party lifestyle, focusing instead on her night school courses, while continuing to work dutifully during the day. Only two aspects remained of her delayed adolescence: attraction to charming goal-less men and refusing the sage advice of her friends. She had this "I'll show you" or "I'll live my life my way" insistence about her that was fiercely independent, and quite like the gender script of her father.

Given the strong transference issues in an adult child of an alcoholic family, our first sessions were devoted to healing the "Inner Child." We worked through on an emotional level the mystique about pursuing the absent father with the hopes of reforming him, a theme replicated in her relationship with Giles. They say that "love at first sight" is likely an instance of transference. And so it was with Judy and Giles. She instantly felt a sense of familiar comfort and kinship in this passionate and tumultuous relationship with this wild but wonderful man. Regardless of this insight, her longing for Giles persisted, and only he could unlock her heart, or so she felt. Lately she had heard that he had moved out from his new girlfriend's place and was living on his own in an apartment. She desperately wanted to reconnect with him. She asked my professional opinion on what to do. I kept throwing the decision back in her lap, going over potential scenarios of what could happen if she took him back, versus what could happen if she just pursued her studies, and left herself open for potential other relationships in the future. I think Judy must have detected my bias toward the latter path. Even though we worked on integrating parts of herself with empty chair techniques, she still had the resolve to get Giles back, no matter how irrational that path seemed.

Once more she asked for my professional opinion. I was in somewhat of a therapeutic quandary. To refuse to answer would be a breach of authenticity and our therapeutic relationship of support. So I told her that, as a registered psychologist, it might be unethical of me to recommend that she return to a psychologically abusive relationship. All reasonable signs indicated that to follow such a path would lead to further suffering and harm. On the other hand, I knew in my core consciousness that Judy was determined to return to Giles regardless of my cautions, as she had rejected her friends' and family counsel as well. I told her jokingly that "maturity is being able to follow your parents' advice, even if they are right." She pressed me further for a definitive opinion, so I told her, "I know, regardless of what I or others say, that you are going to return to Giles. All I ask is that you take full responsibility for your decisions and its consequences, keep your eyes open, and that you learn from your experience, no matter how it turns out." Judy thought this was sound advice. Within a month she had convinced Giles to move back in and give their relationship another try.

What followed was really an enlightening experience for me as an observer in their life. Judy was never a member of Al-Anon, although in retrospect I could have recommended it to her. She never went to a

meeting of ACOA (Adult Children of Alcoholics), even though it might have been helpful. Judy was one of those people who are caught in the Groucho Marx Paradox, namely, “I would never join a club who would accept me as a member.” She was staunchly independent. However, almost miraculously, she had internalized some key principles of these organizations. In contrast to her mother’s stance of over-controlling co-dependency, Judy no longer criticized Giles’ drinking and partying. She made no excuses for his behaviour in front of others when he made a fool of himself. She made his attendance at her social gatherings optional, and he gradually excluded himself. I don’t know exactly what their arrangement was regarding his potential infidelity, but I think the writing was on the wall: one more strike and you’re out. Giles seemed to accept those terms, and gradually his drinking and partying curtailed as he settled down.

I met Giles on three occasions. Twice in their early relationship of living back together, Judy dragged Giles in for a session or two to talk about their relationship. He was suitably distant and defensive, given that I had been Judy’s individual therapist in their time apart. However, he went beyond that stance into belligerent ridicule and derision of “shrinks,” most of them screw-ups anyway, and couples should be able to sort out their own stuff anyway, without anyone else snooping in.
Despite my best attempts to engage him, he was not interested in couple therapy. He struck me as not very intelligent, but also arrogantly self-opinionated. I regret not being objective, but that was my impression of him.

Over their months together in this new arrangement, the couple was gradually and peacefully drifting apart, on separate paths. I only saw Judy now on a monthly basis, as she felt satisfied that all was going in the direction she wanted. She had by now realized that the spell was broken: she was no longer in love with Giles. She still had a soft spot for him, but it was now like a distant smile for a rascal dog that she once knew. Of course, she eventually moved on to graduate with her B.Comm., moved up the career ladder to a much better executive position, met a great guy and got married.

The last time I saw Judy and Giles together was in the latter phase of their relationship. They were on the grass at a Folk Festival and called me over to talk with them. They still shared their original love of music, and liked being together for that purpose, but they told me that they had both outgrown each other. They were no longer in love, but still cherished memories of some of the good times they had together. It was bittersweet, but now they acknowledged the time to separate had come. They were making arrangements to live separately within that month. Judy assured me that she would be fine. Giles looked resigned but calm that Judy had grown beyond him, and the gap could never be filled. They were different people, and that was that. Judy contacted me by phone message two months later, saying she felt fine, and was moving on with her life as a single woman. I have not had any further contact with Giles, so I don’t know what he learned from the whole experience of their relationship, but I suspect he will conclude, “We weren’t meant for each other.” But my guess is that he will wistfully remember her as “the one that got away,” with a sense of remorse about how he misplayed that relationship. That is looking hopefully, that he learned from experience. Many like him grow old, but don’t grow up. I hope he has a better fate.

As for Judy, well, I think her reason for returning to Giles was based less on love and compassion, and perhaps more on ego. Perhaps she could not stand the narcissistic insult that this creep dumped her. As the song goes, “I just came back to say goodbye” might sum up her involvement to resume this hopeless relationship for the final triumph of rejecting him. Actually, it was not a real victory of rejection for either of them, just the realistic conclusion that their relationship was unworkable. Perhaps more charitably, we could say, she just needed more time with Giles to break the spell of her transference projections upon him, so that she could release her heart and mind for more suitable life partners.

9. THE BLUSHING CONTEST

In Toronto a while back I conducted an all-day workshop for about 30 realtors, called “The Psychology of Sales.” At the end there was some time left over for questions and concerns. One middle-aged woman rather tentatively held up her hand for a question. She said that she had a problem sometimes in sales presentations, especially in larger groups. As she talked and her colleagues watched, her face and neck glowed a crimson red in a noticeable blush. She asked if I could help with this problem, as it was quite embarrassing. I replied that solving this perhaps lifelong problem might require more than a half-hour of intensive group therapy. However, in a bold move I asked the audience if anyone else present had this problem. About ten heads turned toward another woman, who immediately flushed in embarrassment. I asked her if she would volunteer to help her colleague and herself to overcome this problem. She agreed, and I asked her to join her flush-faced client at the front of the room.

What happened next was a gamble on my part as a health coach. I asked the spectators to place side bets, not to exceed two dollars each, on which realtor could remain the reddest after I announced the start of the race. My women clients at the front of the room looked in astonishment as their fellow-realtors eagerly placed their bets in the service of light-hearted fun. When all bets were placed, I announced to my two blushing clients: “When I say, ‘Go!’ I want you to try to blush as darkly as you can. Got it? Okay, 1-2-3 Go!” At this moment they both turned as white as sheets! Actually, this is an exaggeration. The point is, both of my clients lost their blushes and returned to their normal flesh tones in their complexions. The audience was aghast and had a hard time in declaring the winner of the bet. Both of my contestants were dumbfounded at the disappearance of their mutual symptom of blushing. I asked them, the next time they felt warmth in their faces, to remember The Blushing Contest, and how they had both assisted each other in eliminating this shared individual problem by trying to make it worse, and in public, no less! This demonstration had a great impact on all concerned, and, in a six-month follow-up by their district sales manager, both the realtors no longer had problems of blushing in presentations.

My quick insight into an idea for a blushing contest was not a total leap of faith. I already knew that in many anxiety symptoms, as the saying goes, “you have nothing to fear but the fear itself.” In other words, if you go with the flow, rather than resisting it, the force dissolves itself when you abandon the struggle against it. This prescription is certainly counter-intuitive to people with anxiety symptoms, but from a mindfulness perspective, yielding to a symptom and allowing it to take charge beyond our

control often turns out to be an excellent strategy. The key is to allow surrender of control to be supplanted by an attitude of peace and acceptance, allowing the symptom pattern to overtake and flow through you without your resistance and attempted control. I have used this strategy of paradoxical surrender and acceptance in helping many clients overcome their anxiety and panic disorders over the years of my practice. Although surrender seems counter-intuitive to the anxiety-combatant client, it can be helpful tool to overcome anxiety dilemmas.

10. FAINTING IN CHURCH

Many years ago, I worked in rural mental health clinics in Southwestern Ontario. Each day of the week would serve a different community, so sometimes our team would not visit the same town more than once every two weeks. Accordingly, often there were wait lists, and our team would have to triage the cases according to urgency of care needed. Unfortunately, that kind of patient care often generates a crisis generating system, but it was the best we could do with limited public health care resources. Thus, as noted in Chapter 2, part of our mandate in these roving clinics was to do a brief 10-minute assessment of a case for triage purposes. This requirement meant that we clinicians would often need to assess situations astutely based on limited information and clinical intuition. Most of the time, this process worked rather well.

In one case a woman in her late thirties presented with the problem of being very frightened of "fainting in church." Actually, I am familiar with this problem. In my childhood I served as an altar boy on the sanctuary of our Roman Catholic Church. In some of the longer formal masses and ceremonies, for some undiagnosed reason I would become sick and dizzy, and either have to leave the altar area or faint on the spot, needing to be revived so that I could make my exit and other people would have to carry on in my place. Fortunately, these were rare incidents, but they certainly were embarrassing, and I sometimes had anticipatory anxiety that such incidents might reoccur at any given time in church.

As a cognitive behaviour therapist, I wanted to know the triggers, frequency, severity, and duration of this woman's fainting episodes. She told me rather embarrassedly that she could not tell me this information, as she had never quite fainted in church. She coped with a feared episode by merely staying in church, struggling through the service, and leaving greatly relieved, but still fearful that the dreaded event might happen next time. You might think that the fear would extinguish after so many repeated exposures without incident, but sometimes these anxiety problems seem to have a life of their own. A cognitive intervention of reframing her experience perhaps might have been enough, but in a mere 10 minutes I did not have a strong enough therapeutic alliance to attempt an intervention that could be seen as superficial or dismissive, given how strongly fearful she felt about the issue. She was not very afraid of physical harm, just the intense embarrassment of seeming weak and frail in her church community.

I told her that I had some potentially effective ideas about how she could be cured of this condition, but that I currently had no appointments available to treat her. Meanwhile she could do something to prepare for treatment: she could begin to collect data on the problem. She was highly

motivated to cooperate, so I asked her in the next month to go to as many church observances as possible with two of her friends, one on each side, to catch her whenever she faints, so that no damage would happen to her head or teeth. She agreed to do her homework assignment.

A month later she faithfully attended her five-minute reassessment interview. She told me she was not able to collect any concrete data, as she had been unsuccessful in generating a fainting spell in church. I told her in a spirit of mild consternation that I would be unable to treat her if she was not able to collect any baseline data. She would need to renew her efforts, trying as hard as she could to faint in church so that we could examine the problem she was dealing with. She agreed, with the modification that perhaps only one friend in attendance would be enough to safely catch her as needed. I agreed to this variance on the original assignment.

A month later this woman returned to announce that she still had no data to present about fainting in church; however, she had a new insight. She discovered that sometimes she **did not want** to go to church. This revelation was tantamount to blasphemy in this bible-belt community. Nevertheless, she now wondered if she didn't have to go to church if she didn't want to, and therefore could end her homework assignment. I replied that this would be unwise, as a phobia could return with even greater force if she started to avoid church to avoid the fear itself. No, she would have to face the fear directly by continuing to try to faint in church so that we could gather enough data so that we could treat her disorder. She bravely soldiered on with the assignment.

A month later she returned to announce that she was now **convinced that she could not faint in church!** I asked her if she was totally sure, and she repeated that she was. I said that I guess she didn't need to continue her homework any further. She was triumphantly relieved. I shrugged my shoulders and apologized for being unable to treat her. We shook hands and exchanged a knowing smile.

11. THE NEAR PERFECT LOANS OFFICER

Doris was a middle-aged loans officer in a bank. She was proficient, competent, knowledgeable, and had good customer relations skills. Nevertheless, she had been referred to me by her human resources department, as she was about to be fired if she did not change her pattern of persistent minor errors that were increasingly annoying to her new supervisor, a male assistant manager that had been transferred to her branch six months ago. The situation between them had become progressively worse over the months. As the case was a referral through her employee assistance program, I would have no mandate for organizational development intervention. I would not be able to interview the supervisor. All our sessions would be strictly confidential, with no reporting or contact with the bank other than a billing number. Whether her employment could be saved would be strictly up to her work performance.

In her first session with me, Doris presented as highly anxious, suspicious, somewhat irritable and annoyed that the situation had come to this critical point. She described her supervisor as old-school, somewhat sexist and disrespectful of her and other female employees in the branch. While she prided her work, he was unusually picky about small details, and increasingly critical of the loans applications

she submitted to him for his approval. What was really maddening for Doris was not only that her errors were becoming more frequent, but they were more serious. Sometimes, she would even do a sloppy credit check that would come back negative, in this industry a huge error of neglect and due diligence. She was so angry that these mistakes would give her smug boss the satisfaction of chastising her. You can see from reading this that on some subconscious level she was transferring some sadomasochistic drama from her past, perhaps with her father or a demanding teacher. However, a history probe revealed no previous enactment of this dynamic. Nevertheless, it represented a classic case of passive aggression, covert rebellion against arbitrary authority. What made it more impressive was that this mild but hyper-efficient woman had always followed the requirements of detailed precision in her job until now. Something in the imperious attitude of her boss was triggering this unconscious but self-destructive rebellion accompanied by self-embarrassment. It was so maddening for her to play directly into the hands of her adversary. Given these obvious psychodynamics, we explored them in her personal history, with negative results. Then it occurred to me: maybe she had never encountered in her sheltered and blessed history a genuine a..hole. Just to be sure, we did empty chairs and other role-play enactments with other bosses and authority figures in her life. Despite our best efforts, nothing seemed to be working. Her unconscious errors persisted. Then I had an inspiration from my work with self-handicapping athletes (see Chapter 33): I told her a story about Japanese pottery. It goes like this:

It is said that in many places in Japan there are centres of pottery where many artisans produce beautiful vases and other art pieces upon pottery wheels, shaping them with their fingers and other hand tools. At the end of their creation, the artisan typically looks at this wonder of symmetry and perfection that the artist has created, but just before firing in the kiln, the artist does a crucial but spiritual act. The artist deliberately puts a tiny indentation or nick in the work. This act is to deconstruct hubris, the attempt at man's ego to assume god-like proportions. To state a rule of discipline: every human act should be made into a state of close to absolute beauty, but one step short of perfection, as an acknowledgment of humble reality and the human condition in this changing and capricious world.

Based on this story, I gave my client a piece of homework that I have used with virtually all my perfectionist clients: you can do any act you feel you need to do, as long as you do it leaving one tiny element unfinished. This means that you can clean an entire carpet, but you need to leave one dust bunny by the corner unswept. You dust an entire plant but leave an entire leaf undusted. In other words, a perfectionist pattern cure prescription is to require your client to do everything they do to a standard that is imperfect, but not-catastrophic. In other words: your client is to perform every action in a minor but deliberately imperfect way. To give you an example, supposing you have to submit a report written in MSWord format, and you deliberately omit a space between the end of a word , and a comma as I did just did here. The green prompt tells you that you have made some formal, but likely not critical, violation of best English grammar.

So, as you might guess, I prescribed that my client should deliberately make a minor and not-crucial mistake on every document she made, especially loans applications and their investigation documentation. As you can imagine, she resisted this idea, but her job was on the line, so she resolved to make deliberate but annoyingly minor errors, such as writing the loans applicant's address entirely on one line rather than three, which was dictated by the form of the loans application document.

After her initial resistance to this intervention, she took surprising delight in vexing her supervisor with minor but non-crucial edits to her "typos." She stopped making unconscious errors, because her therapist demanded that she make conscious mistakes in a deliberate way in every report. After a while, she delighted in this assignment. It not only delivered from her state of paranoia and performance anxiety about evaluation, but also allowed her a sense of showing off to evaluative observers just how valuable she was to her bank. As an afterthought, her assistant branch manager moved on, and the problem resolved itself. Perhaps in his future promotion he met his fate. About him there are such clichés as: "all cream rises till it sours." My mother had an expression for this as well: "time wounds all heels." As often happens in organisations, by the time a terrible manager is found out, many key employees have lost the business to go elsewhere. In this case, my client outlasted this manager's transfer rotation and she got to keep her position.

What is most important in this story for me is that my client preserved her career by deliberate rather than unconscious errors. She made the covert obvious and thereby temporarily defused the attacks of her boss, who after awhile came to see her mistakes as silly but minor and moved on to other concerns. I know she never challenged and channelled her unconscious anger towards this officious male supervisor. That is an inequity that exists in office politics. I was not mandated to reverse office power structures, nor was Doris. The main thing was that she finally found a way of taking charge of her unconscious impulses, and hereby saved her career.

12. VALIDATING THE DECISION TO NOT CHANGE

Mike and Karen were a middle-aged couple with two young children. They originally presented with marital problems, and there were concerns about their children as well as family-of-origin issues. They were both likeable, and readily engaged in the process of couple therapy. Karen was very anxious and easily threatened. She had suffered lifelong psychophysiological disorders, aggravated by stress and sensitivity to perceived criticism. She coped with obsessive-compulsive and perfectionistic defenses to lower her worries and insecurities. Difficulties and conflicts tended to loom larger for her, and at the time of referral she felt depleted and exhausted by the complexities of raising young children at home.

Mike played the complement of Karen's amplifier position by being a conflict-avoidant stimulus reducer. His role was that of family provider and protector, trying to put out fires as fast as they ignited, and becoming quite agitated whenever Karen became upset, taking on her position in dealing with conflicts with teachers and other parents and children in the exclusive private school in which their children were enrolled. Mike also took on the role of family protector when Karen's parents would try to spoil the children with treats instead of the strict diet of healthy foods that Karen prepared. It was as if her parents were passive aggressive in undermining Mike and Karen's way of raising children. However, Karen was also critical at times when she thought that Mike overplayed his role, and he felt caught in between Karen and the perceived threats of the outside world. Mike was the eager Rescuer trying to soothe Karen whenever she became upset, but Karen often felt dismissed and invalidated when Mike would try to take an external position, himself trying not to worsen the distress of the couple. It was a

classic dance of gender issues contaminating the couple's mutual wish for domestic peace and emotional security, the systemic loop of a problem-amplifying solution. Predictably, the more Mike tried to play the role of over adequate protector, the more Karen would become the worrying damsel in distress. This loop had become worse, such that the escalations of her helplessness trumped his inadequate attempts to rescue. Both felt frustrated and powerless, while each of them had an unconscious investment in their respective roles. Despite these conflicts, Mike and Karen were a loving couple, eager to help each other and "do the right thing" in balancing the demands of modern family living.

The approach I employed to deal with this core issue was essentially couples emotion-focused therapy. I guided them through several enactments of their core struggles, addressing their attachment styles and their underlying wishes and dreams of how they could function beyond this negative spiral. I also used EMDR in helping Karen break out of the conflict arising from her identity fusion and enmeshment with her mother. After about ten sessions the couple were doing much better, and strife around schooling issues settled down with their calm but firm teamwork.

Nevertheless, there was one deep scar in their couple history that they could not heal. About four years earlier, at the time of birth of their second son William, Karen had a prolonged labour. The couple had poor sleep the night before as some contractions began increasing in frequency and then subsiding. Mike had worked in his computer consulting job during the day, taking Karen to the hospital in the early evening and remaining there with until about two o'clock in the morning. The waters had not yet broken, and Karen by this point was feeling something was very wrong. She felt pain and nausea, and was highly anxious. The doctors examined her but could not detect any abnormalities. Karen could not be consoled and wanted Mike to stay in her hospital room. Both were exhausted, and Mike was intensely drowsy from being awake for almost two days. The hospital staff told him that there was nothing he could do, so he should go home and get some rest. Mike took their advice and went home. Karen eventually fell asleep.

The next day William was delivered, and within two days Karen was discharged from hospital with their new son. Still, Karen did not feel well, but the medical staff thought she was just feeling discomfort recovering from the delivery. However, after a week of progressively worsening symptoms including excessive and severe abdominal bleeding, she was readmitted to hospital. It turns out she had an undiagnosed hematoma and had to have transfusions of blood and emergency surgery to correct her condition. She was then able to make a fairly rapid recovery, at least from a physical standpoint.

However, she found the whole sequence was very traumatic. She felt invalidated, abandoned, and betrayed by Mike for not staying by her side and not insisting that the doctors look harder and further for the cause of her distress. At that moment in the middle of the night she felt like she was dying and that nobody would listen, and her husband had abandoned the situation, perhaps leaving her to die. Bearing in mind that she had a history of high anxiety and hypochondriasis, it is understandable that this was a very important and terrifying moment in her life. She felt that, from that moment on, she could never again trust Mike to be there for her, regardless of their previous or subsequent history together. Although Mike continued to be the try-hard husband, and they were getting along much better than

before, Karen felt she could not forgive Mike for that incident of betrayal, and nothing could assuage her distrust and ultimate fears of abandonment. She would become upset, angry, and tearful at any mention of that night or related themes. Then something rather amazing happened.

Since Karen had already had a positive experience with EMDR in resolving feelings and issues with her relationship with her mother, I proposed that, if she wanted to get beyond the PTSD around the birth of William, we could use EMDR to process those emotions and thoughts. Suddenly at that point she dug in her heels and firmly but not angrily refused to work on resolving the issue. It was as if she was declaring a boundary, even though at some level she knew that her decision might perpetuate their underlying conflict and keep Mike in the role of perpetual offender. Both Mike and I were puzzled by her stance but admiring her courage and honesty in holding her position.

My response was also surprising, in that I felt okay about her decision. It certainly is a client's right as a consumer to refuse treatment, and I fully respected her calm but firm refusal to deal with the issue. Also, it was not a matter of dislike for the process of EMDR, nor even doubting its effectiveness. Karen merely wanted to stand firm and be validated for doing so. So I did.

Then I praised the couple for progressing as far as they had, and perhaps this was good enough, and they could leave therapy with the satisfaction of what they had achieved over our months together. At that point Mike said, "Wait a minute! How about we do EMDR with me? I was pretty upset about the whole thing, too. I want to work on resolving some of my feelings about it." Karen was surprised and curious, but we all thought it was a good idea. So there we were, me doing EMDR with Mike, with Karen silently observing in the corner seat of the office.

For those of you not familiar with Eye Movement Desensitization and Reprocessing (EMDR), you can go to www.emdr.com or any number of books and articles available from the Internet. Over the years I have found it to be a remarkably useful technique to assist people with post traumatic stress disorder (PTSD) and other cases of strong but unwanted emotional reactions to remnants of past situations and their echoes in current life.

In reviewing the key scenes of that night at the hospital, Mike's negative cognition or caption was "Whatever I do, it's never good enough." We worked together to come up with a positive cognition statement or caption of the scenes: "I am a loving person within the limits of my stamina and my understanding." Going back to the hospital scene, no one but Karen sensed that something was terribly wrong. As the doctor and nurses examined her and said that everything was normal, she became increasingly invalidated and agitated. She considered it a betrayal that Mike did not back her up and insist on a second medical opinion. (This was at 2 a.m. in the morning). Karen thought it a further betrayal and abandonment that Mike took the advice of the medical staff without much protest and went home to sleep.

Recalling this scene, Mike was now agitated to the level of 9 out of 10, feeling tension in his jaw, stomach, and Right shoulder, thinking "I should do something!" but feeling powerless and defeated, unable to help his distressed wife. As we went through several passes of bilateral stimulation in the EMDR protocol, he thought "Next time this happens, I will stop the nurse and refuse to leave Karen in

this state and fall asleep with her in her hospital room." This was his relearning of what he could have done. His subjective units of distress (his SUDs level) then dropped to 5, as tension began to drain from his body. In subsequent EMDR passes his SUDs level dropped to 1, or neutral, whereupon we infused the attribution "I forgive myself for being tired, confused, and helpless." I think this affirmation was more powerful than the previous phase, where he was still trying to perfect the role of superhero. Now he was acknowledging defeat of his superhero status, coming to terms with his own impotence and the futility of his ego role. This was a huge shift away from personal hubris toward humility and acceptance. More important still, it was a unilateral declaration of the end of his role of codependency, a role that Karen appreciated but resented because she unconsciously knew was unsustainable. We ended the session with Mike exhausted but relieved. Karen, observing this process, felt a little unsteady while strangely relieved. We agreed to meet for a follow-up session two months later.

Needless to say, I was intensely interested in what might happen with this couple. Would Mike's EMDR session shift their dynamics as a couple? Would his abandonment of superhero status lead Karen to her greater emergence as an emotionally stable person? It turned out that Mike continued with his changes from the day of our session. He announced to workmates that he would no longer be the Rescuer of the corporation; he would merely do his reasonable job, but others had to step up to fill the gaps of his long hours. He closed his office door more often, and let others find solutions to their problems. As he explained it, "I have less on my plate. It's only a saucer now, but I'm eating well." This assertive shift at work pleased Karen immensely, as Mike was far more emotionally present and attentive in family life and their relationship. Furthermore, he was far more likely now to push back when Karen tried to put the burden of problem-solving on his shoulders, tending to active listen rather than go into action mode on her behalf. Initially, this stance activated her abandonment issues, but increasingly she sensed the rise in her own power of self-efficacy in dealing with life issues as they arose, consulting with Mike as she needed, but often willing to carry the ball herself.

Well, with all these positive developments, I again congratulated the couple on their progress and resolution of key partnership issues. I was about to close their case as significantly improved, even in the first half-hour of our last session, when Karen made a surprise announcement. She had continued to be amazed at the steadfastness of Mike's abandonment of his superhero stance after the EMDR treatment, so now she wanted to complete her own work to put the hospital saga behind her. At this point, I was even more in admiration of this couple as Karen reached out for her need for closure.

In this EMDR session, all three of us were braced for a reactivation of all the emotions that happened many years ago at her horrible moment of abandonment and terror. However, I suppose that over the previous two months she had done a great deal of her own work in emotionally processing and cognitively reframing the scenes of that night. The EMDR passes worked smoothly and effectively to reduce the SUDS to a level of 1, with Karen's affirmation, "Even though Mike isn't perfect or hugely powerful, I can trust that he loves me." With this completion, we virtually ended their therapy, although once or twice a year we do follow-ups to consolidate their gains.

Looking back, I thought the most pivotal point in the therapy of this couple was our mutual decision to affirm Karen's refusal to change, despite the potentially limiting implications of this choice. What made

it especially beautiful is that Karen displayed the choice actively and responsibly, rather than the more passive-aggressive way of her persuading Mike to terminate couples therapy. Many couples avoid recalibrating their relationship by withdrawing from therapy at the threshold of potential realignment. To those couples the dictum is: better the devil you know, than the devil you don't know, the uncertainty of change. I applaud this couple for their courage and honesty, and the abiding love they continue to share.

So, there you have it: a superhero gratefully dethroned, and his damsel in distress arising to the call of her own personal power. Life is good.

13. "UNETHICAL" THERAPY?

Well, it's about time I wrote this chapter, actually, quite late in my career. It has to do with an earlier point in time, about four years ago. The story encapsulates several "pseudo-dilemmas." That is, upon reflection, every decision in this case seems so clear and obvious. But back to the story:

I was referred by Veterans Affairs Canada to treat a 74-year-old former soldier who was diagnosed by his social worker as "Major Depressive Disorder, with Suicidal Ideation."

When I first met Joe, he was formal and dignified in demeanor, but amazingly direct and open about his anguish about his situation. Joe wanted to know about the options available to eventually kill himself. While I admired his candor and directness, I wanted to know about the nature of his current distress.

Well, it turned out that no one in his personal circle wanted to talk about his anticipated death. His wife and family and friends were horrified at his obsession with death, although he was a war veteran suffering from pain syndromes and PTSD resulting from his many military deployments over the years of his army career. Even though his death was not immanent, he did not want to remain alive in a future time when he was no longer able to feed or toilet himself. He did not want to depend on others to deal with his indignities, especially if he became demented. He was already noticing some cognitive decline in recent memory and in the naming of objects. Of course, in that era there was no provision for medically assisted dying in Canada. In fact, there were only a few countries in the world where you could engage that service.

What disturbed Joe worst was that no one was willing to talk about suicide. He felt alone, isolated, and invalidated in his concerns. Other than the distress over this issue, Joe seemed to be coping rather well with his physical pain and progressive disabilities resulting from his military career.

Now that we had established the main presenting problem, I informed him that I had a professional ethical dilemma to ponder. As a registered clinical psychologist, I was not supposed to counsel clients about how to plan their suicide. To do so was outside our ethical code of conduct. However, I asked Joe if he would be willing to engage in **"unethical" therapy** with me. He quickly answered that he would like to explore that option. Encouraged by his assent, we spent the rest of the session talking about several jurisdictions in the world where he might travel to have a death with dignity when he felt the time was

right. His mood brightened with relief and even enthusiasm as the session went on. We even rehearsed how he would deal with other people who would try to shut down discussion about his plans, how he would calmly but assertively tell his family that this was a key issue for him.

Close to the end of the first session I told Joe that I had concerns about his diagnosis to address, so we went through the 21 questions in the Beck Depression Inventory. As expected, his answers confirmed that he was not depressed at all, just mildly unhappy with his life and frustrated with his family's stance on his key issue. I told joe that perhaps I was just lucky to catch him on a good bounce when he was thinking clearly and lucidly. He agreed to arrange a follow-up interview in one month to reassess how he was doing.

Not surprisingly, the validation and relief that Joe felt in our initial interview had spread to give him greater confidence and efficacy during the ensuing weeks. His family and friends shifted their stance to listen to his concerns and even validate his potential future plans. Armed with the confidence that he would have some control over his life and even death, his feelings of urgency greatly diminished. His disposition was cheerful and thankful that our first session was a turning point for him. We both celebrated his successful outcome. However, I told him about one final dilemma.

During that month between sessions I pondered about how I would write the final report about his therapy for the Department of Veteran Affairs. While accurately reporting Joe's progress in counselling, I wanted to avoid invalidating the social worker that had rendered such a severe diagnosis just two months previously. I sensed that Joe was not depressed in the first 15 minutes of that first session, and it turns out that my intuition was accurate. While It was true that he did indeed have suicidal ideation and was in fact wanting to discuss a suicidal plan, that didn't seem like a problem for either of us as we worked together. Still there remained the difficulty about the diagnosis. Then the answer occurred to me a few days before our follow-up session.

For a person with cancer, after treatment when the symptoms are gone and the X-ray pictures are clear, we don't say that the cancer is cured, only that it is "in remission." The diagnosis remains in effect, but with the qualifier that it seems to be inactive at the current time. Joe laughed out loud at this solution and heartedly endorsed it.

In the treatment report we concluded with the diagnosis: **Major Depressive Disorder with Suicidal Ideation, in Remission**.