LESSONS MY CLIENTS HAVE TAUGHT ME, AND OTHER STORIES

By Frank D. Young Ph.D., R. Psych.

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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 Dohnimm 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 Dohnimm 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 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 that 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 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 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 in a paradoxical consumption of control of these disorders over their willing hosts.

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. 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 undoubtedly you 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, 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 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 to assess with them at what 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, to agree 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.