LESSONS MY CLIENTS HAVE TAUGHT ME, AND OTHER STORIES

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

Here is a quick preview of my book, including the Table of Contents and introduction and two selected chapters. I hope you are curious to read more interesting stories about my clients and key moments in helping them over the years of my professional career.

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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. 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, 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, but 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.

Obviously, most problems are not resolved that easily, but I encourage you, the reader, to explore in this book some enjoyable alternatives to traditional therapeutic approaches in helping clients in their search for solutions to life's dilemmas.

FY.