Context-Enriched Conversation Analysis of Relational Hypnotherapy with a Client Diagnosed with a Phobia of Blood and Needles

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Context-Enriched Conversation Analysis of Relational Hypnotherapy with a Client
Diagnosed with a Phobia of Blood and Needles

By

Carlos Ramos

A Dissertation Presented to the
College of Arts, Humanities, and Social Sciences
In Partial Fulfillment of the Requirements for the
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This dissertation was submitted by Carlos Ramos under the direction of the chair of the dissertation committee listed below. It was submitted to the College of Arts, Humanities, and Social Sciences and approved in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the Program of Marriage and Family Therapy at Nova Southeastern University.

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### TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Acknowledgements</th>
<th>iii</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>viii</td>
</tr>
</tbody>
</table>

### CHAPTER I: INTRODUCTION
- Introduction to Fears and Phobias                                              | 1     |
- Individual Approaches to Understanding and Treating Phobias                      | 5     |
  - Psychoanalyses                                                                 | 6     |
  - Applied Behavior Analysis                                                      | 7     |
  - Cognitive-Behavioral Therapy                                                  | 9     |
  - Rational Emotive Behavior Therapy                                             | 10    |
  - Traditional Clinical Hypnosis                                                 | 11    |
- Systemic Approaches to Understanding and Treating Phobias                        | 12    |
  - Natural Systems Theory                                                         | 13    |
  - Structural Therapy                                                            | 14    |
  - Narrative Therapy                                                             | 16    |
  - Mental Research Institute (MRI)                                                | 17    |
- Solution-Focused Brief Therapy (SFBT)                                            | 20    |
- Ericksonian and Neo-Ericksonian Hypnosis: Bridging the Individual and the System | 22    |
  - Relational Hypnosis                                                           | 24    |
  - Overview of Chapters                                                           | 28    |

### CHAPTER II: REVIEW OF THE LITERATURE
- Introduction to Hypnosis                                                        | 33    |
- An Ericksonian Approach                                                          | 35    |
  - Conscious/Unconscious Relationship                                              | 37    |
  - Utilization                                                                    | 38    |
  - Indirect Suggestions                                                           | 40    |
  - Metaphors, Anecdotes, and Stories                                              | 41    |
- Gregory Bateson                                                                  | 42    |
  - The Map is not the Territory                                                   | 42    |
  - Thinking Systems                                                               | 44    |
  - Communication                                                                  | 45    |
  - Mind and Body Connection                                                       | 46    |
- Neo-Ericksonian Approaches                                                       | 47    |
  - Conventional Brief Therapy Approaches                                          | 47    |
  - Hypnotherapy Approaches                                                        | 53    |
- Relational Hypnosis                                                              | 57    |
  - Interpersonal                                                                  | 57    |
  - Hypnosis                                                                       | 61    |
- Research on Hypnotic/Brief Therapy Treatment of Anxiety/Fear/Phobias             | 65    |
  - Quantitative Research                                                          | 65    |
  - Qualitative Research                                                           | 68    |
  - Process Research                                                               | 71    |
Abstract

Although clinical hypnosis has been studied in a variety of ways, most of the research has focused on individual and evidence-based approaches; few have examined relational or systemic models. Influenced by Milton Erickson’s hypnosis methods and Gregory Bateson’s systemic concepts, relational hypnotherapists value the importance of both the intra- and interpersonal context in the treatment of problems, accentuating the significance of the mind and body connection (or relationship) in inviting non-volitional therapeutic change. The author of this research explored how Douglas Flemons, the developer of relational hypnosis, facilitated an enduring non-volitional shift with a client, “Grace,” who desired to have a baby but could not see or talk about blood, needles, or medical procedures without fainting. Using context-enriched conversation analysis (CECA), the author embraced his theoretical understanding of relational hypnosis as a guide to examine multiple sources of data, which included selected audio-recorded excerpts from Douglas and Grace’s hypnotherapeutic sessions; Grace’s descriptions of change in her email correspondence with Douglas; and Douglas’s case notes. Although there were a total of eight sessions, the author’s analysis revealed that the most influential and significant moments occurred during the first two sessions. Douglas’s initial interventions, or as he would say, intraventions, laid the foundation for a shift in Grace’s identity, which helped her embrace a variety of resourceful skills and attributes to overcome her problem. The author also discussed the clinical and research implications for relational hypnosis, brief and family therapy, and psychotherapy in general.

Keywords: relational hypnosis, NeoEricksonian hypnosis, conversation analysis, phobia, family therapy
CHAPTER I: INTRODUCTION

A recently married young heterosexual couple would like to start a family, but the wife, “Grace,” is afraid of needles. She is also afraid of doctors and medical procedures; afraid of hospitals; afraid of the sight of blood, whether her own or another person’s; afraid of photos or movies or television shows depicting blood; afraid, even, of *stories* of needles or doctors or medical procedures or hospitals or blood. When encountering any of these fear-provoking scenarios, Grace tends to faint. She and her husband, “Leo,” wonder how she will ever manage to have a baby. They decide to consult a psychotherapist.

If Grace and Leo were to decide not to just go to the first clinician they heard about but, rather, to systematically visit an array of therapists, each an expert in one of the many individual and systemic approaches currently dominant in the United States, they would learn diverse explanations of her symptoms, and they would encounter a dizzying variety of procedures and interventions intended to help her. Below, I survey this range of current theories and treatments, as it helps contextualize the particular approach I focused on for this study. But first I wish to establish the scope of my research interest and to articulate my research question.

Prior to engaging with postmodern philosophy, my theoretical understanding as a behavior analyst was to identify clients’ “abnormal” interactional patterns and to provide interventions that would extinguish or modify the targeted behaviors. The ultimate goal was to create the “appropriate” change that would allow individuals, primarily children, to better adapt to their environment. Rather than embracing their uniqueness or strengths,
my therapeutic intentions were primarily invested in molding them to match a particular criterion—one that was predominantly influenced by empirical research.

Over the course of my involvement in my Ph.D. program, I became more and more interested in systemic thinking, specifically in the ideas of Gregory Bateson. One of Bateson’s countless statements that truly challenged my behavioral epistemology was in regards to classical conditioning and the process of learning. He stated that “the animal who has had prolonged experience of Pavlovian contexts might never get around to the particular sort of trial-and-error behavior necessary to discover a correct instrumental response” (Bateson, 2000, p. 294). Bateson inferred that the Pavlovian approach, which is a fundamental component of behavior analysis (Skinner, 1990), inhibits the organism from engaging in the trial-and-error process that is essential for learning. Consistent exposure to a particular schedule of reinforcement or conditioning limits individuals from discovering something new, something different (Bateson, 2000).

I was intrigued by this notion of creating a therapeutic context that encourages trial-and-error learning (or trying something different); however, I was not clear about how this idea would translate in practical applications. I remained unclear until I was introduced to the clinical ideas of Milton Erickson, particularly his notion of utilization. A concept further explored below, Erickson’s (1980a) utilization technique shifted my understanding of therapy—the conceptualization and resolution of problems. The more I read, the more I discovered that problems are not “things” that can be objectively discovered and subsequently treated as something that can be extinguished. This foundational assumption led me to the therapeutic ideas of Douglas Flemons, who
embraces the idea of connecting with and inviting relational shifts to the problem, rather than engaging in or supporting efforts to vanquish it.

I thus decided to focus my research on Douglas Flemons’s relational brief therapy approach, which reflects the influence of Milton Erickson’s principles of hypnosis and Gregory Bateson’s notions of communication. I was particularly interested in how relational hypnotherapy works—how the hypnotic communications are structured and offered, and how the therapist endeavors to bring forth relevant change. In order to better understand and appreciate this process, Douglas and I enhanced the conventional traditions of a process-research approach known as conversation analysis (CA). Referred to as context-enriched conversation analysis (CECA) (Flemons, personal communication, March 13, 2018), I embraced my theoretical understanding of relational hypnosis and the conventions of CA to examine transcripts of actual therapy sessions, Grace and Douglas’s email correspondence, and Douglas’s case notes. The sessions were conducted with the clients mentioned above—Grace, and to a small extent Leo—over a three-year period, from 2014 to 2017, when Grace gave birth to a baby boy. Although the birth was medically complicated, requiring Grace, for example, to have a C-section and thus an IV, she went through the process feeling strong and without fainting. Prior to the birth, she was able to comfortably discuss all the procedures with the doctor. For the C-section itself, she stayed awake and engaged, and the anesthesiologist administered no anti-anxiety medication. Post-op, her nurses told her that she was requiring far fewer pain medications than is typical.

As is common in his practice, Dr. Flemons audio recorded the sessions (a total of eight). I listened to these archival recordings and selected relevant portions, mostly from
the initial sessions, for inclusion in my study. I obtained and read Douglas’s case notes and his email communications with Grace. A CECA helped me discover influential interventions in the initial sessions that were related to Grace’s email descriptions of her therapeutic changes.

As Gale (1996) noted, CA is a useful tool for exploring how identities develop as a result of conversations or language, a tool that is thus consistent with second-order cybernetics, an important influence on post-modern approaches to systemic therapy, including relational brief therapy. Second-order cybernetics is understood as a process that “jumps an order of recursion and places the observer as part of the observed system” (Keeney, 1983, p. 76); it underscores the role of interaction and communication in the configuration of experiences (Mead, 1968).

With hypnosis, moments of transformation can be conceptualized as non-volitional or non-voluntary experiences—“thoughts, feelings, and behaviors that are experienced as occurring automatically” (Kirsch & Lynn, 1999, p. 504). This characteristic of hypnosis is further explored in Chapter II. My overall goal was to discover what happens in the communication between a therapist and a client that makes it possible for someone with a fear of blood and needles to experience a non-volitional change in experience, such that she learns not to excessively fear or to faint and is thus able to pursue her goal of having a family. In other words, how does a relational hypnotherapist facilitate a non-volitional change in a client’s experience so that it becomes possible for her to do what she could not do before? How does a relational hypnotherapist achieve a shift in a client’s expectancy, and even identity, making possible a feeling of safety?
For the therapist’s work in this case to be thoroughly explicated, it needs to be understood within the context of its Batesonian and Ericksonian foundations, which is introduced below and explored in depth in Chapter II. First, though, I put the approach itself in context. I introduce various currently held conceptualizations of anxiety and phobias, and I discuss a range of individual and interactional approaches to treating them. I conclude the chapter with a brief exploration of relational brief therapy and how Flemons proposes making sense of and treating fears and phobias.

**Introduction to Fears and Phobias**

Anxiety disorders, which include phobias, are the most prevalent class of mental health disorders in the general population (Kessler et al., 2009). The American Psychiatric Association (2013) defined a specific phobia as an irrational fear of a particular object or situation. Conventional fears, or even extreme fears, are not classified as phobias. In order for a fear to be categorized as a phobia, it has to reach a level of irrationality, meaning the object of fear is perceived as life threatening although it does not pose harm to the individual. Although people suffering from such phobias understand the irrationality of their experience, the simple thought of the feared object can elicit severe panic or anxiety attacks.

Approximately seven to nine percent of Americans are hindered by a specific phobia (American Psychiatric Association, 2013), and women are twice as likely to experience phobias as men (McLean, Asnaani, Litz, Hofmann, 2011). Although there is a range of perspectives on the causes of phobias, it is believed that phobias are prevalent in families, indicating both genetic and environmental factors.
Whereas the mental health field is unable to agree on a definitive explanation for phobias, Sigmund Freud conceptualized the etiology of a phobia as a byproduct of a deeply rooted emotion, neurotic fear (Freud, 2014). Freud’s understanding and description of emotions and fear had a significant influence on several of the current individual and systemic approaches; many of these treatment modalities continue to exhibit traces of his psychoanalytic assumptions. Because of Freud’s widespread influence, I begin with a discussion of his conceptualization of emotions in relation to fear and phobias.

**Individual Approaches to Understanding and Treating Phobias**

In the following section, I have provided a range of current individual approaches to understanding and treating phobias, starting with Freud and psychoanalysis. Freud’s (1920) conceptualization of fears and phobias was guided by his understanding of emotions and the unconscious. He valued the importance of eliciting and processing unconscious experiences in the treatment of phobias. Similarly, cognitive-behavioral and rational emotive behavioral therapists acknowledge the importance of information processing to enhance reasoning and logic but also emphasize the necessity for behavioral adjustments in the treatment of phobias (Beck, 2005; Ellis, 1999). Cognitive-behavioral therapists use hypnosis as a tool to enhance clients’ receptiveness and suggestibility to behavioral interventions (Lynn, Kirsch, and Rhue, 1996). With an emphasis on behaviors, behavior analysts conceptualize phobias as maladaptive responses in specific locations; their treatment consists of modifying the environment (surrounding stimuli) to evoke change (Davey, 1992).
Psychoanalyses

Freud (1920) defined an emotion as “indefinite motor innervations or discharges” and definite sensations, which include the perception of motor activities and the sensations of pleasure and pain. These physiological fluctuations are the result of “a repetition of a certain significant experience” (p. 342), with its inception (or initial conditioning) being associated with the complexity and painful development of birth. Although Freud postulated that emotions (specifically fear) are inherited through countless generations, the repeated exposure to essential experiences such as birth and separation from one’s mother further ingrain these physiological (or automatic) responses.

According to Freud (1926), phobias are subjective and situational manifestations of a deeply rooted emotion, neurotic fear. He described a phobia as a form of fear that “is psychologically more circumscribed and bound up with certain objects or situations” (Freud, 2014, p. 347). Although he was aware of the variety of phobias, objects of fears, and circumstances, Freud believed there was a common underlying cause.

Freud (2014) postulated that neurotic fears, such as phobias, are “closely connected with certain processes in sexual life” (p. 350). Unfulfilled, and as a consequence repressed, sexual urges result in a reduction of “libidinous excitement . . . and anxiety takes its place in the form of expectant fear and in attacks and anxiety equivalents” (p. 350). In other words, according to Freud, phobias surface as a result of sexual restraints placed on individuals—by themselves, by others, and/or by their circumstances.

Freud (1909) provided the example of “Little Hans,” a five-year old boy whose
A genital curiosity regarding his and other “widdlers” (penises) was encountered with threatening statements of castration from his mother. During one instance, Hans’s mother “found him with his penis on his hands” (p. 245). His mother, horrified, responded by stating that she was going to send him to the doctor, so he can cut it off, leaving him without a widdler. Freud provided a second example of Hans’s mother scolding Hans for his widdler curiosity at the zoo. These experiences, along with several others, burdened Hans with guilt, which resulted in what Freud referred to as a castration complex.

According to Freud (1909), castration is the loss of what the male child considers an important part of his own body. Experiences of castration are first encountered at birth where the child is separated from his mother. The child continues to experience feelings of castration when he is removed from his mother’s breast after feeding. Although these are natural and universal experiences, the continued repetition of aversive castration experiences, especially those that inhibit sexual curiosity, can induce a neurotic fear or phobia of a particular object.

Hans’s repeated exposure to threats of castration resulted in repressed sexual urges, which surfaced to consciousness as a phobia of horses, or what Freud (1909) conceptualized as a fear of large animal penises. What was once a source of pleasure and curiosity for Hans transformed into a distressing neurotic fear. Freud advised the boy’s father to refrain from suppressing Hans’s sexual curiosity. Rather, he encouraged him to engage Hans in conversations that allowed his unconscious to express his sexual desires, whether through conversations, dreams, or metaphors. Freud (2014) noted that fears and phobias “vanish when the sexual misuse is abandoned” (p. 350).

In Grace’s case, a psychoanalyst would explore her phobia of blood and needles
with the intention of bringing to light any repressed sexual forces (Rudnick & Heru, 2017). As a female, Grace would not have experienced aversive castration experiences. However, Freud (1963) conceptualized neurotic fear in women as repressed sexual urges that resulted from a fear of engaging in heterosexual relationships because of the possibility of contracting syphilis and transmitting it to their children. With this understanding, Grace’s intimate relationships and sexual experiences would be explored, in order to provide her with a conscious understanding of her unconscious tendencies and how they relate to her fear of blood and needles. Only when the meaning of her fear was thoroughly understood would she be able to move beyond her dilemma (Jung & Hinkle, 1916).

**Applied Behavior Analysis**

Behavior analysis can be described as a process that applies tentative understandings of behavior to improve specific behaviors, while simultaneously evaluating whether improvements are adaptable to the relative circumstances (Baer, Wolf, & Risley, 1968). Environmental stimuli (or antecedents that trigger a behavior) and reinforcement contingencies (consequences that immediately follow a behavior) are the guiding principles of applied behavior analysis (Skinner, 1961). A behavior analyst is responsible for identifying the environmental stimuli that serve to elicit behaviors, as well as manipulating the current reinforcement schedules that are sustaining some, and hindering other, behavior patterns (Baer et al., 1968).

Clinicians are also responsible for observing, identifying, and operationally defining maladaptive behaviors and/or patterns (Carr, Coriaty, & Dozier, 2000; Iwata et al., 1994). Because they prioritize observer objectivity, they are not interested in the
client’s understanding or verbal description of the problem. Their perception of change is directly correlated with an observable behavioral change. They are interested in “what [individuals] can be brought to do rather than what they can be brought to say” (Baer et al., 1968, p. 93).

Behavior analysis conceptualizes phobias as unconditioned responses to surrounding stimuli or conditions (Davey, 1992). The acquisition of phobias are a byproduct of classical conditioning (or associative learning), where the individual has established relationships with certain stimuli that automatically elicit these unconditioned responses. The goal of a behavior analyst is to identify the triggering, aversive stimuli and devalue their influence on the individual’s response. If a behavior therapist were to treat Grace, he or she would thoroughly inquire about the location(s) of the incidents and would proceed to conduct therapy in those contexts with the hopes of diminishing the influence of the surrounding environment on Grace’s observable responses.

**Cognitive-Behavioral Therapy**

Like psychoanalysts, clinicians with a cognitive-behavioral therapy (CBT) perspective believe that information processing enhances reasoning and logic. Although CBT was originally invented to treat depression (Beck, 2005), it has been extended to treat excessive fears, including phobias (Otte, 2011). Beck (2005) postulates “that the processing of external events or internal stimuli is biased and therefore systematically distorts the individual’s construction of his or her experiences, leading to a variety of cognitive errors” (p. 953). This process is guided by underlying “dysfunctional beliefs incorporated into relatively enduring cognitive schemas or structures” (p. 954).

According to Beck, phobias are the result of a distinctive and dysfunctional core
belief (Beck et al., 2001) that predisposes individuals to focus their attention on potential risks, to display unnecessary safety behaviors, and to ascribe cataclysmic interpretations to ambiguous information (Beck, Emery, & Greenberg, 1985). This core belief, which is automatic and not under conscious control, is referred to as a “danger-oriented bias” and is inherent in all phobias (Beck & Clark, 1997).

CBT therapists focus on addressing current problems and analyzing available psychological information, rather than unraveling unconscious experiences and traumas (Beck, 2005). The overarching goal is to explore individuals’ inner worlds with the purpose of carefully identifying and modifying the cognitive content, including their underlying assumptions or dysfunctional core beliefs (Beck, 1976).

With Grace’s experience, a CBT therapist would treat her avoidance of medical settings and practitioners with a systematic desensitization procedure. It is a procedure guided by a habituation rationale in which the therapist would gradually expose Grace to the feared stimuli—either a hospital or possibly images of blood and/or needles. Through this experience, the therapist would aim to generate conversations that could modify Grace’s dysfunctional beliefs and thoughts regarding her phobia. Dudley, Dixon and Turkington (2005), for example, provided a case description of a man who had a phobia of dogs and was taken to a dog shelter to confront his fear and process his thoughts.

**Rational Emotive Behavior Therapy**

Similar to CBT therapists, practitioners from a rational emotive behavior therapy (REBT) perspective emphasize the importance of altering cognitions, but they recognize that a therapeutic shift is more likely to occur in conjunction with behavior modification (Ellis, 1962). In the early 1990s, postmodern therapists (Guidano, 1991; Mahoney, 1991)
questioned REBT’s assumption that it is possible to establish the objective truth of a “rational” idea. Influenced by these criticisms, Ellis (1999) realized that “we can have no absolute criterion of rationality. What is deemed rational by one person, group, or community can easily be considered irrational by others” (p. 154).

Although Ellis (1999) acknowledged the subjectivity and relativity of rationality, he speculated that all humans “have biological tendencies to construct rational wishes and preferences—such as the desire to be productive and achieving the desire to relate well to other people (p. 155). Problems surface when people choose to “raise their preferences to absolutistic, rigid demands” (p. 155), which result in irrational beliefs. Fears and phobias are a consequence of these existential choices and rigid belief systems.

Ellis (1999) acknowledged the biological (hormonal, neurochemical) and environmental (family, cultural) factors of phobias, but he insisted that humans have a freedom of choice or freewill. Their ability to think, “think about their thinking, and think about thinking about their thinking” (p. 156) provides the opportunity to reason about alternative choices, which opens the possibilities for the engagement in new behaviors. If Grace would seek out an REBT clinician, the therapist would likely encourage “vigorous verbal re-thinking” (Ellis, 1962, p. 205) to accomplish behavior change or would insist on “desensitizing and deconditioning actions” (p. 188) to achieve a shift in cognition. The goal would be to disrupt “irrational beliefs and provide [her] with experiences that [would] encourage [her] to think and act rationally and self-helpingly” (Ellis, 1999 p. 158).

Traditional Clinical Hypnosis

Kirsch (1994) defined clinical hypnosis as “a procedure during which a health
professional or researcher suggests that a client, patient, or subject experience changes in sensations, perceptions, thoughts, or behavior” (p. 142). Although hypnosis is not used as a stand-alone intervention, many of the aforementioned individual approaches incorporate hypnosis as an adjunct form of treatment. How hypnosis is employed is dependent on the model or the therapist’s theoretical orientation. For instance, CBT therapists use it to create an atmosphere that enhances clients’ suggestibility and receptiveness to therapeutic suggestions (Lynn et al., 1996).

CBT hypnotists present suggestions to elicit alterations in experiences, which include “relaxation, calmness, and well-being” (Kirsch, 1994, p. 142). In the treatment of phobias and fears, they utilize “a desensitization procedure that involves relaxation and imagery” (Lynn & Kirsch, 2006, p. 34) to “achieve initial fear reduction” (p. 34). A CBT hypnotherapist would also provide imagery exercises and would teach self-hypnosis skills that can be practiced and applied in real life settings. If Grace were to see a CBT hypnotist, that person would likely address her “catastrophic thinking” (p. 137) by presenting hypnotic suggestions for Grace to “imagine feared events and [to] detect feelings as they unfold” (p. 139). As the imagined situation unfolded, the hypnotist would continue to present suggestions intended for Grace to reinterpret her physiological responses to blood and needles.

**Systemic Approaches to Understanding and Treating Phobias**

In this section, I discuss the predominant current systemic approaches to understanding and treating phobias, including Bowenian, Structural, Narrative, Mental Research Institute (MRI), and Solution Focused Brief Therapy (SFBT). Influenced by Freud’s conceptualization of emotions and anxiety, Bowen (1978) extended Freud’s
principles by acknowledging the influence of the family (the emotional system) on the individual. Similarly, Structural therapists perceive the family as a natural system that consists of particular structures and interactional patterns; an individual’s well-being is in relation to his or her social context (Minuchin, 1974). Like Structural therapists, Narrative therapists are influenced by Bateson’s (2000) ideas about relations and pattern, but they extend their understanding to include the impact of culture on individuals and families (Friedman & Combs, 1996). The last two approaches I discuss are both brief therapy approaches. MRI therapists focus on the resolution of problems (Weakland, Fisch, Watzlawick, & Bodin, 2009), whereas SFBT clinicians emphasize the importance of developing solutions (de Shazer, 1985).

**Natural Systems Theory**

Although Natural Systems Theory emphasizes that humans share more similarities than differences with other species, it acknowledges that humans have an “elaborate cerebral cortex and complex psychology [that] contribute to making [them] unique in some respects” (Kerr & Bowen, 1988, p. 3). The development of the prefrontal cortex provides the capability of observing our internal states (emotional, feeling), and, as a result, “capable of some degree of choice about [the] influence of those states on [our] actions and inactions” (p. 37). With this understanding, the goal of a Bowenian therapist is to increase the client’s level of thoughtfulness, or what Bowen referred to as basic level of differentiation.

An increase in differentiation of self (DOF) is achieved in correlation with a reduction of anxiety (Kerr & Bowen, 1988). The authors distinguish between acute and chronic anxiety. Acute anxiety normally occurs in response to real threats, whereas
chronic anxiety “is a response to imagined threats and is not experienced as time-limited” (p. 113). Although acute anxiety is a driving force present in all organisms, a sufficient level of chronic anxiety “reduces an organism’s adaptiveness,” which manifests itself in physical, psychological, and social symptoms such as fears and phobias.

Fears or phobias are treated with a systemic understanding that acknowledges the influence of the immediate and extended family (or the emotional system) on the individual (Kerr & Bowen, 1988). From this perspective, chronic anxiety does not solely reside within the individual. Rather, it is a byproduct of previous generations, which is transmitted within the current emotional system. Fears and phobias are manifestations of the multigenerational and nuclear emotional system.

Bowen (1978) provided a case study of a family whose daughter had been hospitalized for psychosis on several occasions. As the therapist, Bowen correlated the daughter’s psychosis with the mother’s intense fear, which surfaced during pregnancy. The mother’s desire to fulfill her commitment as a woman evolved into “worries that [her] child would be defective or born dead” (p. 31). The mother’s intense fear ensued throughout the years, during which she “worried about the daughter’s development, her appearance, her dress, her hair, her complexion, her social life, and many other such items” (p. 31). As a result, the daughter was very attached to her mother and experienced difficulties relating with others, experiencing her first onset of psychosis while living away at college.

Bowen (1978) conceptualized both the mother’s intense fear and the daughter’s psychosis as symptoms of the family’s high level of chronic anxiety. The mother’s fear and overinvestment in her daughter’s life impeded the daughter’s ability to make her
own decisions, which resulted in psychotic episodes. Bowen intervened by encouraging the mother to provide her daughter a fair amount of autonomy. She was advised to treat the daughter as if she was not helpless. After several months of treatment, the mother “arrived at the conclusion that parents should let their children lead their own lives” (p. 41). As a result of this understanding, the mother’s fears regarding her daughter decreased. The lowering of the mother’s anxiety (or increase in DOF) provided the daughter with the opportunity to pursue the career and social life she desired.

If a Bowenian therapist were to work with Grace, he or she would likely accentuate the family’s anxiety transmission process in hopes of enhancing awareness of her family’s maladaptive interactional patterns. An increase of thoughtfulness, or an increase in her DOF, would be expected to result in a reduction of anxiety, which would subsequently lead to the alleviation of her fear of blood and needles.

**Structural Therapy**

Similar to Natural Systems Theory, Structural family therapists emphasize the importance of “approach[ing] the individual in his [or her] social context” (Minuchin, 1974, p. 2). Influenced by Bateson’s (2000) idea of mind and total circuits, Structural therapists value the family’s organization and interactional patterns as the source of therapeutic problems. Minuchin stated that a family is a “natural social group, which governs its members’ responses to inputs from within and without. Its organization and structure screen and qualify family members’ experience” (p. 7). Because of this understanding, a Structural therapist focuses on changing the organization of the family. Once the structural patterns of the family transform, “the positions of members in that group are altered accordingly” (p. 2). As a result, the family members’ experiences shift.
From this framework, a symptom, such as a fear or phobia, is perceived “as an expression of a contextual problem” (Minuchin, 1974, p. 152). A contextual problem can consist of unresolved conflict between parents, which can manifest itself as a phobia in either a child or other family member. A therapist working with an individual with a phobia would shift the family dynamics by influencing the members to assist the individual with the presenting symptom. The modifying of family structure might consist, say, of strengthening the relationship between the identified client and his or her father in order to diffuse the conflict between the parents.

Minuchin (1974) provided an example of a child who attended therapy for a dog phobia that was so severe that he was “confined to the house” (p. 153). The diagnosis was that the boy’s symptom was a byproduct of an “implicit, unresolved conflict between the spouses,” which resulted in an alliance between the mother and child (p. 153). Treatment consisted of utilizing the father’s experience as a mailman and dealing with dogs to “teach his son how to deal with strange dogs” (p. 153). This experience strengthened the child’s relationship with his father and diffused his relationship with his mother. As a result of this shift, the phobia disappeared. If a Structural therapist were to see Grace, he or she would approach her phobia of blood and needles in a similar fashion—altering family alliances to shift her experience with the symptom.

**Narrative Therapy**

Whereas Narrative Therapy is considered a systemic approach, Friedman and Combs (1996) stated that “the idea of ‘family systems’ . . . can limit our ability to think about the flow of ideas in our larger culture” (p. 2). The authors indicated that the prevalent family theories (General System and Family System) are approaches that limit
the field’s ability to acknowledge the impact of culture on individuals or families. With this understanding, family therapists such as Michael White and David Epston arranged their therapeutic approaches based on “the metaphors of narrative and social construction rather than the metaphor of systems” (p. 2).

Narrative therapy is an approach that focuses “on how people interact with one another to construct, modify and maintain what their society holds to be true, real, and meaningful” (Friedman & Combs, 1996, p. 27). It is based on the premise that reality is socially constructed; society’s customs, beliefs, traditions, morals, and rituals are the result of language and social interaction (Gergen, 1999). Narrative therapists utilize language to deconstruct cultural norms or conventions to develop identities that coincide with their clients’ preferred selves (White, 2007).

Parting from the Western notion of objectification of identity, White (2007) stated that “many of the problems that people consult therapists about are cultural in nature” (p. 25). He did not believe the problems people encountered, or presented in therapy, represented the “truth of their identity” (p. 25). He promoted the use of externalizing conversations to separate clients’ identity from the identity of their problems; this increases agency and provides a range of possibilities that can shift problematic relationships.

White (2007) provided a case study of a young boy (age 8), Martin, whose parents were concerned about a fearfulness “that had been a feature of Martin’s life since he was 4, and it was becoming increasingly pervasive in its effects” (p. 36). Martin’s fearfulness was associated with aversive physical symptoms, “including headaches and stomachaches, with profound insecurity in social contexts, with insomnia, and with a
range of highly preoccupying worries” (p. 36). His concerned parents had tried every possible solution in dire hopes of resolving Martin’s dilemma, but to no avail. They arrived at the conclusion that Martin was simply a “fearful boy” (p. 36).

White (2007) intervened by initiating an externalizing conversation where Martin was presented with the opportunity of “openly characterizing his worries” (p. 36). White encouraged Martin to name his worries and to provide a variety of other descriptions and explanations for them. Martin was able to provide his understanding of the worries and to clearly distinguish them from one another. The purpose of this intervention was to assist Martin in making the “intangible tangible” (p. 36)—creating “boundaries . . . to a problem that had an all-encompassing presence in Martin’s life” (p. 36).

Once the boundaries were established, and the worries were defined, White (2007) explored the relevance of culture in Martin’s experience. White discovered that Martin’s worries were related to major global events such as the “2004 tsunami, the AIDS epidemic in Africa” (p. 36), and other significant events that were consistently broadcasted across all media or news outlets. To the parents’ surprise, they learned that Martin would regularly watch the news.

As a result, Martin was able to interact with his parents in conversations that “validated his worries” (White, 2007, p. 36). His parents no longer perceived him as a fearful boy but, rather, would engage with him in these conversations and would also assist him in making plans to address his concerns. The physical symptoms were no longer an issue, as well as his insomnia and social insecurities. White’s decision to externalize Martin’s worries from his identity, in conjunction with the exploration of his cultural context, made it possible for the family to achieve an alternative understanding.
If a Narrative therapist were to see Grace, he or she would probably engage her in an externalizing conversation that would separate her from her phobia of blood and needles. The conversation would make it possible to explore Grace’s cultural context (the associated dominant discourse), and its influence on the negative perceptions Grace has about her identity in relation to the problem. The therapist would likely then engage in a reauthorizing conversation that would explore and utilize positive experiences associated with her phobia (unique outcomes) to co-construct a preferred self or identity.

**Mental Research Institute (MRI)**

With the introduction of a systemic orientation, “what were once called symptoms, or individual problems, began to be redefined as products of personal relationships” (Haley, 1973, p. 9). From a brief therapy understanding, clinical symptoms are conceptualized as a byproduct of intra- and interpersonal communication or an exchange of a “series of messages” (Watzlawick, Beavin, & Jackson, 1967, p. 50). Communication (or behaviors) that appear as cognitive impairment are not “the manifestation of a sick mind, but may be the only possible reaction to an absurd or untenable communication context” (p. 78).

With an emphasis on communication, MRI therapists “[a] focus] on observable behavioral interaction in the present and [(b) implement] deliberate intervention[s] to alter the ongoing system” (Weakland et al., 2009, p. 40). From this perspective, problems are simply manifestations of ordinary and current life struggles that are handled poorly. These struggles could include life transitions, such as child bearing, adolescence, marriage, and/or retirement. Or they could include common everyday difficulties, including issues at home, work, and/or school. Regardless of the issue, problems are
taken at face value, meaning they are “not merely the sign of some deeper and more fundamental disorder in the person or in the family” (Weakland, 2009, p. 154).

Whether intra- or interpersonal difficulties, problems are maintained and perpetuated by the individuals’ attempted solutions (Weakland et al., 2009). Attempted solutions are behaviors or on-going efforts designed to eliminate problems undertaken by the individual in distress and others with whom they interact. These ineffective efforts to solve the problem paradoxically sustain and intensify the difficulties, which heightens their relevance.

MRI therapists perceive fears and phobias as being exacerbated by these willful but ineffective efforts. With this in mind, an MRI therapist would approach a client with a fear or a phobia with the intention of assisting him or her in the abandonment of ineffective attempted solutions (Weakland, 2009). Because it can be difficult for someone to cease a specific behavior, Weakland suggested that the therapist “must promote the substitution of some different and incompatible behavior for the original ‘solution’ behavior” (p. 157).

Watzlawick, Weakland, and Fisch (1974) described a case study “of a phobic who [could not] enter a crowded, brightly lit department store for fear of fainting or suffocating” (pp. 87-88). After several aversive experiences, the individual managed the situation by avoiding department stores and by regularly consuming tranquilizers. Unfortunately, his attempted solutions further intensified his relationship with the problem.

The therapists intervened by presenting a counter-paradox. They instructed him to “walk as far into the store as he wanted, but to make sure to stop one yard short of the
point where his anxiety would overwhelm him” (p. 88). Although seemingly unconventional, the goal of the intervention was directed at changing his attempted solutions and providing a replacement behavior. If an MRI therapist were to work with Grace, he or she would gather information regarding Grace’s attempted solutions to dissolve her fear of blood and needles. Then he or she would likely provide an incompatible behavioral intervention that would simultaneously disrupt and replace these attempts.

**Solution-Focused Brief Therapy (SFBT)**

Similar to MRI therapists, SFBT therapists pay little attention to clients’ past events or experiences (de Shazer, 1985). If attention is focused on the past, it is primarily “focused almost exclusively on past successes” (p. xvi) or what de Shazer referred to as “exceptions to the rule” (p. 34). Berg and Steiner (2003) conceptualized exceptions as elements of solutions interwoven in the problem. They provided the example of a depressed individual who experiences short moments of relief from his or her oppressive depression.

Influenced by Erickson (1954), de Shazer believed therapeutic change is a result of clients trying something different. Although new or foreign behaviors could be helpful, SFBT therapists are primarily interested in actions that have been successful in the past, when the problem was not a problem. They believe that clients are more than likely to cooperate and try something different if they are familiar with the therapeutic suggestions and process. In other words, SFBT therapists encourage their clients to do more of what has worked or has shown to be helpful.
Unlike MRI therapists, SFBT therapists do not deem it “necessary to have detailed knowledge of the complaint” (de Shazer, 1985, p.7), nor are they interested in discovering what is maintaining the problem behavior. They operate under the perception that any behavior that is “really different in a problematic situation can be enough to prompt [a] solution and give the client the satisfaction he seeks from therapy” (p. 7). Thinking in terms of process, SFBT therapists facilitate solutions by assisting clients in the development of “a ‘vision’ or description of a more satisfactory future, which can then become salient to the present” (p. xvi). Once this vision is constructed as a prospective alternative, clients are more likely to “develop ‘spontaneous’ ways of solving the problem” (p. xvi).

de Shazer (1985) described a case study of a young female client who “came to therapy because her mother would no longer take her to the grocery store in order to protect her from panic attacks” (p. 84). The client’s onset of panic attacks surfaced three years after her divorce, and, as a result, she feared and avoided going places alone. Her fear of panic attacks was growing, and she was slowly isolating herself from her friends, as well as situations that entailed social engagement.

de Shazer (1985) intervened by utilizing hypnosis to create a vision where they co-constructed their expectations for the future. The vision consisted of the client watching others interact at a grocery store as if she were watching a movie scene unfold. As the client felt more comfortable with these interactions, de Shazer continued to add further descriptions. During the fifth session, the client experienced these visions as a possibility, and went to the grocery store unaccompanied the following week. She reported “that a panic was continually trying to develop but she did not let it” (p. 85). Six
weeks after, she reported two additional trips to the grocery store without noticing any fears.

In Grace’s case, an SFBT therapist would first inquire about exceptions of her fear of blood and needles. He or she would explore, as a starting point, situations where Grace feels the least amount of discomfort. Once that was established, the therapist would utilize these experiences to assist Grace in constructing a vision that included therapeutic expectations and a satisfactory future.

**Ericksonian and Neo-Ericksonian Hypnosis: Bridging the Individual and the System**

Similar to Freud, Erickson acknowledged and valued the role of the unconscious in therapeutic change (Erickson & Rossi, 1979). Both psychoanalyses and Ericksonian hypnotherapy are structured around discovering unconscious information and processes. But unlike Freud, Erickson believed that it was a theoretical and clinical misconception to make conscious the unconscious mind or to prioritize conscious awareness or recognition (Erickson, 1987).

Erickson devalued the importance or the role of the conscious mind in the resolution of problems. He perceived the conscious mind as being limited by habitual frames of reference or beliefs that created, sustained, and/or perpetuated problems (Erickson & Rossi, 1979). Conscious awareness was not necessarily an asset to dissolving problems or discovering solutions.

Because of his appreciation for the unconscious, Erickson (1987) deemed it necessary “to have a great deal of . . . knowledge at the unconscious level” (p. 75). This myriad of unconscious knowledge was embraced and utilized in the treatment of clinical
symptoms, specifically during the implementation of hypnosis.

Erickson and Rossi (1979) provided an example of an aspiring female professional harpist who presented several anxiety-related clinical issues, but one which specifically included an airplane phobia. While in trance, Erickson asked the client to think about her fear of airplanes and then to allow her unconscious mind to provide a causal explanation for her phobia. The client mentioned that her fear of airplanes was a manifestation of claustrophobia that was associated with a childhood experience. She stated that her brother hauled her into a closet with a cat inside. Because of that event, she avoided airplanes and experienced intense palm sweating at the thought of riding one.

Erickson responded to her unconscious understanding of her dilemma by providing a personal story about an uncomfortable plane trip (Erickson & Rossi, 1979). Although he did not provide the details of the story, his intention was to elicit her feared response within a context that embraced and utilized her unconscious understanding of the problem. Once the response was elicited, Erickson acknowledged her special ability to sweat and underscored that her unconscious mind could have other abilities—to have “dry handed and hot handed” (p. 229) experiences. Subsequently, the client mentioned that she had a “compelling need to run to the airport and catch the first plane out” (p. 229).

Erickson emphasized that hypnotherapy is a process that “help[s] people utilize their own mental associations, memories, and life potentials” (Erickson & Rossi, 1979, p. 1) or capabilities that already exist within a person. Hypnosis serves as a conduit in discovering and utilizing these individual and unique potentialities. In the example above, Erickson utilized trance to access the client’s unique unconscious ability to fluctuate the
temperature in her hands to develop a solution for her phobia.

Although Erickson focused on the individual in the treatment of problems, he, along with Neo-Ericksonian therapists, also acknowledged the influence of the interpersonal context on individual symptoms. Haley (1973) stated that “it is becoming more evident that families undergo a developmental process over time, and human distress and psychiatric symptoms appear when this process is disrupted” (p. 41). This conceptualization of symptoms extends its focus beyond the individual to a broader understanding of the social context. Erickson perceived traditional psychological or psychiatric concepts such as “identity,” “delusional formations,” “unconscious dynamics,” or “laws of perception” (p. 41) as being interrelated with the family life cycle. The nature (or well-being) of the individual is intertwined with his or her intimate social fabric and its associated life transitions.

Erickson perceived symptoms as a “signal that a family has difficulty getting past a stage in the life cycle” (Haley, 1973, p. 42). These developmental stages can range from the courtship period to child rearing, as well as transitioning from adolescence to young adulthood. Symptoms, such phobias or fears, surface when an individual or family experiences a crisis that impedes their ability to move to the next life stage.

With this understanding, “Erickson’s therapeutic strategy has as its larger goal the resolution of the problems of the family to get the cycle moving again” (Haley, 1973, p. 42). Haley provided an example of Erickson’s work with a young man who feared main roads and entering public buildings and would travel through back streets and alleys to avoid entering buildings. Although this situation could be conceptualized as a fear of
streets or public buildings, Erickson had a different understanding and approach to the situation. Influenced by his understanding of the family life cycle, Erickson conceptualized the client’s situation as a fear of women.

Erickson’s assumption regarding the client’s fear of women was influenced by the client’s relationship with his overbearing mother and his mediocre employment and deplorable living conditions. The client’s fear of women had impeded his ability to transition to the courtship period, which resulted in a lack of desire to improve his work situation and living arrangements. Although Erickson was aware of this information, he did not disclose these details to the client. As noted, Erickson was not fond of recognition therapy. Rather, he “showed an interest in [the client’s] physique and worked with him on what sort of apartment a man with his musculature and strength and brains should have” (Haley, 1973, p. 67).

As a result, the client moved into an apartment away from his mother, and his perception of himself, specifically his body image, improved. Erickson’s response to Haley regarding his decision to refrain from informing the client of his fear was the following: “Why should I ever tell him he was afraid of women? He isn’t any more. He’s married” (Haley, 1973, p. 67).

Erickson would likely treat Grace’s fear of blood and needles utilizing both individual and systemic assumptions. He would likely strive to gain a better understanding of Grace’s symptom within her family context and relationships. Depending on Grace’s relational circumstances, Erickson would likely incorporate hypnosis to elicit unconscious wisdom that could potentially provide potential solutions and/or resources for Grace’s fear within the realm of her family life cycle.
Relational Hypnosis

Influenced by Erickson’s ideas, Flemons’s (2002) relational approach values the importance of both the intra- and interpersonal context in the treatment of problems. Flemons (2004) acknowledges that we (humans) have “the ability to be conscious of ourselves being conscious, of perceiving ourselves perceiving, of thinking about the fact that we are thinking” (p. 18). This ability creates the misguided perception that our conscious awareness, which he refers to as our “mini-self” or “observing-i” (Flemons, 2002), “is separate not only from everything ‘out there,’ but also from the rest of the self” (Flemons, 2008, p. 18), which he refers to as the “observed-me.” From this vantage point, the observing-i is subject to judging, categorizing, labeling, admiring, and/or admonishing a variety of intrapersonal experiences that include thoughts, ideas, feelings, physical sensations, and emotions. We draw boundaries or distinctions that position our observing-i above and separate from our observed-me. In other words, we create a Cartesian split—the perception that the mind and body are two separate entities.

Similarly, our observing-i creates distinctions and boundaries that separates it from everything beyond the self (Flemons, 2004)—our environment, such as family members, friends, colleagues, and peers, and their associated thoughts, feelings, emotions, and other experiences. This gives us the impression that our experiences (whether cognitive or emotional) are isolated, and separate from, those with whom we are in relationship. But Flemons (2002) described this understanding as a fallacy: “You, like old Rene Descartes, think of the world as a bunch of discrete selves, solitary individuals, detached perspectives, and independent entities. But, in fact, nothing in your awareness exists in isolation” (p. 6).
Problems, including fears and phobias, are sustained and exacerbated when we distinguish ourselves from our experiences and, as a result, engage in “disjunctive solutions—where one tries to quickly destroy or banish or defeat a problem” (Flemons, 1991, p. 94). These efforts to control or eradicate the problem create a dissociative relationship, or what Flemons (2002) referred to as a separated connection—an unwanted and paradoxical connection that is a result of our conscious and willful efforts to negate the problem. “Attaching no to unwanted thoughts, feelings, memories, behaviors, and so on never eliminates them from your experience; rather, it ensures their continued presence and importance” (p. 11).

Flemons (2002) approaches the treatment of fears and phobias with this understanding. He perceives therapeutic change as “a movement toward freedom” (p. xvi) between clients and their problems. This is achieved by the inverse of a separated connection: a connected separation or “a relaxed letting go” (p. 30). Clients experience connected separations when the conscious boundaries or distinctions between themselves and their problems are blurred—when there is a “crossing over something” (p. 137). Flemons (2008) accentuated this phenomenon as the hallmark of hypnosis—“a shift in the boundaries that normally divide self from other (i.e., client from therapist) and divide consciousness (the presumed source of awareness and willpower) from the rest of the self” (p. 18).

Flemons (2002) described a case of a young boy, Robert, who was “terrified of encountering a prowler somewhere in his parents’ new two-story house” (pp. 197-198). He acquired this fear after learning that his friend’s house had been burglarized. Robert would avoid, at all costs, venturing into any part of his house alone. If his parents were
upstairs watching television, he would remain by their side and would not go downstairs. If his family was downstairs, he would refuse to go unaccompanied upstairs to his bedroom or family room. He felt “both frustrated and humiliated by his inability to negotiate the stairway on his own” (p. 198).

Providing live supervision for the case, Flemons (2002) instructed the therapists on his team to help Robert construct a picture of “the menacing, shadowy presence that was causing him such misery” (p. 198). With the assistance of the therapists, Robert was able to imagine an image of the individual with specific physical attributes (i.e., his height, as well as his hair and eye color). Once this was done, Robert was helped and encouraged by the therapist to give the individual a name. He quickly came up with “Richard.” At the end of the first session, the family was encouraged to “go home and sit on the stairs together while Robert drew a picture of Richard” (p. 198).

During the following session, the family disclosed that Robert was starting to feel comfortable with the stairs. At that point, the therapists decided to encourage Robert to give Richard a nickname; he settled on “Little Richard,” which the therapists then used exclusively, informed by the idea that it rendered the “potential intruder” still less menacing. The family was also encouraged to invite “Little Richard” to different family events and conversations, including the dinner table. Little Richard, or the experience of Little Richard, had become part of the family. Six months and a year after the last session, Robert’s parents reported Robert feeling fine and comfortable at home.

Robert and his parents were encouraged to connect to, rather than separate from, the object of Robert’s paralyzing fear. As a result of this relational shift, the distinction between Robert and his fear became irrelevant; the boundaries were blurred. Both Robert
and his parents experienced the relational freedom, or a relaxed letting go, of the fear that was troubling Robert. As Flemons (2002) stated, “when clients connect with whatever is troubling them, when they stop treating it as Other, they are freed from its stranglehold” (p. 30). The family was freed from the fear’s daunting grip and were able to move beyond this dilemma.

In introducing the ways other therapeutic models approach issues of fear, I speculated how clinicians working within those traditions might intervene with Grace. When it comes to Flemons’s relational approach, I depart from this pattern, as Chapter IV of this dissertation was devoted to exploring what Flemons actually did in his therapy with her.

**Overview of Chapters**

In this chapter, I introduced the case study, presented the research question and method of inquiry that guided my explorations, and described the variety of ways clinicians understand and treat phobias. In Chapter II, I delve further into Erickson’s therapeutic principles, and I discuss the influential ideas of Gregory Bateson. I then illuminate more of the brief therapy models informed by Erickson and Bateson’s work. I conclude the chapter with a review of the relevant research on brief therapy and the treatment of phobias. In Chapter III, I explain conversation analysis (CA) as a process-research method, and I explain how I used it to closely examine key sequences of interaction between Flemons and his client. I also discuss my decision to adopt a context-enriched conversation analysis (CECA) (Flemons, personal communication, March 13, 2018) in order to fully appreciate the special conditions of a therapeutic setting. I divided Chapter IV into two sections. The first section encompasses an exploration of relevant
contextual information about the researcher and the case. This included information about the researcher’s theoretical knowledge and the couple’s descriptions of change. In the second section, I describe the process by which Douglas facilitated an enduring non-volitional shift in Grace’s experience. In Chapter V, I discuss and illuminate the study’s findings in comparison to other approaches. I also review the study’s limitations and clinical and research implications.
CHAPTER II: REVIEW OF THE LITERATURE

To offer a full understanding of a relational approach to brief therapy and hypnosis, I must first explore its theoretical underpinnings. With this in mind, I first provide a brief introduction to hypnosis, before moving on to a discussion of the ideas and clinical assumptions of Milton Erickson. I then outline the systemic principles of Gregory Bateson to provide a context for, and understanding of, the three conventional brief-therapy approaches that subsequently be described. Following this, I explore the hypnotherapy approaches inspired by Erickson and Bateson’s ideas; this section includes a thorough description of relational therapy. Finally, I explore some relevant research on the brief treatment of phobias, as well as process research on hypnosis.

Introduction to Hypnosis

During the early 20th century, Freud’s (1910) understanding of the unconscious and psychopathology was influenced by Charcot’s (1888) hypnosis research. Charcot suggested that hysteria (or symptoms of psychological trauma) were a manifestation of unconscious processes that could be demonstrated through hypnotic suggestions beyond subjects’ conscious awareness. Although these understandings had an influence on Freud’s (1910) theory of a dynamic unconscious, he rejected hypnosis as a form of treatment, labeling it as a temporary cure (Kline, 1958).

Freud’s rejection of clinical hypnosis downgraded its use in both psychological and medical settings during the first half of the 20th century (Lynn & Kirsch, 2006), with the exception of Young (1926) and Hull’s (1933) experimental research. Hull’s (1952) first experience with clinical hypnosis was with one of his students, who asked him to get rid of a phobia. Although Hull was uncertain of the process, he utilized a crystal, as well
as instructions in a book, to both induce trance and to treat the phobia. Hull’s clinical success influenced his pursuit of experimental research on hypnosis, which inspired one of his early students at the University of Wisconsin, Milton Erickson (Erickson & Rossi, 1980a).

Born “with a number of congenital sensory-perceptual problems” (Erickson & Rossi, 1980, p. xi) and having been stricken by polio, Erickson realized at an early age “the relativity of our human frames of reference” (p. xi). Erickson’s efforts to understand and cope with his circumstances led him on a personal journey, which resulted in the “rediscovery of many classical hypnotic phenomena and how they could be utilized therapeutically” (p. xi).

These experiences shaped how Erickson conceptualized the nature of hypnosis, which at the time conflicted with dominant assumptions (Erickson & Rossi, 1980a). For instance, his mentor, Clark Hull, believed that the primary figure in the induction of trance was the hypnotist, or “operator.” He argued “that the operator, through what he said and did to the subject, was much more important than any inner behavioral processes of the subject” (Erickson, 1980a, p. 3). However, Erickson disagreed with Hull’s clinical assumptions and his standard technique to hypnosis by emphasizing the importance of the subject’s unique and individual experiences. Rossi attributed Erickson’s rejuvenation of the field to his “development of the nonauthoritarian, indirect approaches to suggestion wherein subjects learn how to experience hypnotic phenomenon and how to utilize their own potentials to solve problems in their own way” (Erickson & Rossi, 1980, p. xi).

In addition, Erickson challenged the presuppositions supporting the dichotomy between brief and long-term treatment (Fisch, 1982). At the time, long-term treatment
was considered “somehow fuller, more complete, more thorough, and therefore a more reliable way of handling human problems” (p. 156). Alternatively, short-term approaches were rendered only during instances of crisis, where there was a shortage of time and/or resources. Erickson revolutionized the field of psychotherapy by reformulating these basic assumptions. He advocated for the resolution of problems or completion of tasks. Once accomplished and change was realized, he would part company with his clients, “at least for a significant while” (p. 159). Rather than brevity or length of treatment, his focus was on efficiency.

Erickson’s innovative techniques inspired a variety of professions to implement hypnosis as a form of treatment (Lynn & Kirsch, 2006). Ranging from in-depth psychotherapy to brief problem-focused approaches, hypnotic methods are prevalent in the treatment for a wide spectrum of clinical issues. Although the treatment goals and assumptions may differ among those who employ clinical hypnosis, the practice itself is currently considered an effective modality of treatment. Most clinicians agree that hypnosis provides therapists the flexibility to expand the boundaries of how they interact with their clients (Yapko, 1993). They are able to communicate ideas and possibilities that elicit unique internal experiences, and clients are also more than likely to be receptive to these therapeutic suggestions.

**An Ericksonian Approach**

As noted in Chapter I, Erickson utilized both individual and systemic understandings in the treatment of problems. Although he engaged in a range of clinical procedures, he judged therapy by “whether it is efficient and effective in aiding people with their complaints or whether it wastes time” (Fisch, 1982, p. 157). Effectiveness and
efficiency were guiding principles supporting Erickson’s therapeutic approach. Unlike psychoanalysts, he was not invested in gathering “interpretable information or try[ing] to get his patients to gradually achieve insight” (p. 158). If insight was pursued, it was for the sole purpose of enhancing clients’ cooperation to complete a task.

Erickson also deviated from the common practice of engaging clients in detailed exploratory conversations about significant past events. As Haley (1967) described Erickson’s approach, “emphasis should be placed more on what the patient does in the present and will do in the future than on a mere understanding of why some long-past event occurred” (p. 406). Erickson approached clients with the understanding that change can happen at any moment, regardless of their past or current relational or situational difficulties.

Erickson’s expectation of change was not limited by the complexity or severity of clients’ issues (Fisch, 1982). Rather, he challenged those clinicians who organized their time and effort in accordance with the severity of the problem or the identified patient. He believed that “if one can cut out a great deal of work and still resolve problems, the implication is that the job to be done is not as difficult as was thought” (p. 158). Although Erickson was not invested in detailed information of clients’ past, he was interested in the idiosyncrasies of their symptoms. He strived to attain a comprehensive picture and understanding of clients’ struggles, as well as information about how others interacted with them.

Erickson perceived symptoms as resulting from limitations and restrictions of a social context, in which “a person is in an impossible situation and is trying to break out of it” (Haley, 1973, p. 44). Erickson and Rossi (1980b) referred to these impossible
situations as paradoxes or double binds, in which the individual’s efforts, and those of others they interacted with are detrimental and/or ineffective. Thinking in terms of paradox and interactions, Erickson acknowledged and emphasized the “degree to which a patient’s family and larger social contexts can help or hinder change” (Watzlawick, 1982, p. 147).

With a relational understanding, Erickson deviated from pathologizing, or objectively identifying problems within individuals, and structured his approach around intra- and interpersonal growth and learning (Haley, 1973). Rather than accentuating the negative, he fostered an environment that embraced clients’ strengths and expertise. He believed that the underscoring of the positive creates a therapeutic context that enhances collaboration, as well as increases the possibility for clients to discover something different, something new (O’Hanlon & Martin, 1992).

**Conscious/Unconscious Relationship**

Erickson’s focus on the importance of resourceful possibilities was influenced by his understanding of the conscious mind, and most importantly, his conceptualization of the unconscious, which he defined as “the deeper, wiser self” (O’Hanlon & Martin, 1992, p. 108). Erickson perceived the unconscious mind as having a wealth of knowledge that could be useful for clinical treatment (Erickson & Rossi, 1979). A facet of Ericksonian therapy, specifically hypnosis, is structured around utilizing unconscious processes in the resolution of problems, which he prioritized over simply focusing on enhancing conscious awareness (Erickson, 1987). Erickson and Rossi (1979) postulated that “hypnotherapy can be effective simply by providing patients with a period of therapeutic trance so their own unconscious resources can resolve the problem” (p. 165).
Erickson stated that in order for individuals to function or survive, the conscious and unconscious mind have to coexist (Erickson, 1987). He provided the example of shoestring tying, and the difficulty (or impossibility) associated with being consciously in tune with, and aware of, every step in the entire process. It is something that needs to be done “automatically, at an unconscious level” (p. 75). Clinically, he speculated that clinical problems do not require a conscious understanding to resolve.

Because Erickson perceived individuals as having the necessary resources for solving their problems, he accepted his patients’ understandings and behaviors, regardless of how seemingly unconventional (Erickson, 1980a). Erickson believed that his ready acceptance of clients’ attributes helped to facilitate the therapeutic and trance process. He conceptualized trance as an interpersonal phenomenon that entailed mutual cooperation (Erickson, 1985). Hypnotherapy is facilitated through a ready acceptance and cooperation from the hypnotist, rather than securing compliance from patients (Erickson, 1980a).

**Utilization**

Erickson’s initial therapeutic acceptance and cooperation was the foundation of his clinical orientation, which he termed as “Techniques of Utilization” (Erickson, 1959, p. 272). As Zeig (1994) stated, the implementation of utilization was “a central facet of all of Erickson’s interventions” (p. 298). It is understood as “utilizing what people bring to the situation, giving them permission for being whatever they are and then communicating to them that any response they give is okay” (O’Hanlon & Martin, 1992, p. 11). Erickson was interested in creating a safe and welcoming context that was amenable for trance and that would allow patients to express what they wanted without feeling restrained or hindered by the process (Erickson, 1980b). He emphasized that “any
attempt to ‘correct’ or alter [clients’] behavior, or to force them to do things they are not interested in, militates against trance induction and certainly against deep trances” (p. 156).

In addition, Erickson utilized his clients’ idiosyncrasies and personalities in the structuring and implementing of interventions (Erickson, 1980a). As he described, “techniques must be tailored to fit the individual needs and the needs of the specific situation” (p. 15). Erickson organized his approach around what the client presented, so his interventions were more “in accord with the subjects’ own capabilities” (p. 15).

Hypnotherapy is conceptualized as a procedure that “use[s] whatever the client brings to the hypnotic situation as part of the trance induction” (O’Hanlon & Martin, 1992, p. 6). Clients’ distinctive characteristics, thoughts, and/or behaviors are the primary sources for interventions that are utilized to induce trance and/or enhance treatment. As Erickson stated, “the presenting behavior of the patient becomes a definite aid and an actual part of inducing trance, rather than a possible hindrance” (Erickson, 1980c, p. 168).

An additional facet of utilization revolves around clients’ intentions and expectations of therapy. Unlike other therapies, in which the goals are established by the therapists (Baer et al., 1968; Beck, 2005; Freud, 1920; Kerr & Bowen, 1988), Erickson believed that therapy should be less dependent on the clinician’s wishes, focusing instead on the client’s aspirations and perception (Erickson & Rossi, 1979). He stated that hypnotherapy, “which is evaluated in terms of the experimenter’s plans, wishes, intentions, and understandings[,] is invalid unless communicated to the subjects’ understandings and so accepted” (p. 17). In other words, Erickson emphasized that
therapy should be a process that is co-constructed, including clients’ perceptions, hopes, and desires in the organization of goals and objectives. He reinforced this assumption by stating that therapists “should keep in mind that that common goal is a goal for the welfare of the patient wherein the patient is cooperating with you to achieve something that primarily is of benefit to him” (Erickson, 1980b, p. 166).

**Indirect Suggestions**

With the induction of trance or overall implementation of hypnotherapy, Erickson realized that direct and authoritative techniques were invasive and generally ineffective (Erickson, 1980a). They inhibited clients’ ability to embrace their creativity, as well as fully explore possibilities or potential solutions. Erickson, regarding his clinical and research experience, stated “that the simpler and more permissive and unobtrusive is the technique, the more effective it has proved to be . . . in the achievement of significant results” (p. 15).

The role of the hypnotherapist is simply that of a guide or catalyst, where he or she offers possibilities that have the potential to resonate with the client and hopefully elicit a therapeutic response (Erickson, 1980d). Because the hypnotic experience belongs to the client and not the therapist, the hypnotist’s primary function is to “proffer stimuli and suggestions that evoke responsive behavior based upon the [client’s] own experiential past” (p. 43). These stimuli or suggestions are, as noted above, simply methods of communicating ideas; “in themselves they are of no particular significance. It is only the responses and the behavior that they stimulate the subject to make that have any value” (Erickson, 1980e, p. 292).

Erickson and Rossi (1980c) emphasized that the communication of ideas or
hypnotic suggestions should be presented indirectly, “where the relation between the [therapist’s] suggestion and the [patient’s] response is less definite or obvious” (p. 452). Erickson believed that direct suggestions or instructions establish a hierarchy that limits unconscious processes, as well as hinders trance induction. Direct suggestions run the risk of being questioned and challenged by clients or consciously scrutinized. Indirect suggestions tend to bypass conscious criticism and elicit unconscious searches that permit clients’ unique life experiences and potentials to manifest. As the authors emphasized, “the most effective aspect of any suggestion is that which stirs the listener’s own associations and mental processes into automatic action” (p. 459).

**Metaphors, Anecdotes, and Stories**

Erickson (1980d) postulated that the sole implementation of hypnosis was not a cure; rather, “the cure is accomplished by a reassociation of the client’s experiential life” (p. 38). Erickson facilitated unconscious processes or reassociations through indirect suggestions in the form of metaphors, anecdotes, and/or stories. He believed that metaphors or anecdotal stories precluded conscious scrutiny, in which clients are able to experience trance without conscious effort that is normally elicited by instructions. The use of metaphors or stories assist clients in the search for valuable meanings that could reorganize or recontextualize their experience or perception of the problem.

Erickson assumed that clients knew more than what they thought they knew (Erickson & Rossi, 1979). The reason why clients were clients was “because the conscious mind does not know how to initiate desired psychological experiences and behavior changes to the degree one would like” (p. 18). Individuals do not lack the resources; rather, they lack the necessary associative links to elicit unconscious processes
that can assist in the resolution of their problems.

With this understanding, Erickson utilized metaphors and stories as a
communication of ideas to initiate unconscious searches (Erickson & Rossi, 1980c).
Influenced by Erickson’s clinical assumptions, Lankton and Lankton (1983) defined a
metaphor “as a figure of speech that makes implicit comparison between two unlike
entities” (p. 78). Erickson and Rossi (1980c) highlighted that metaphors met clients at
their model of the world while simultaneously providing them a new framework that
could elicit new meanings. The new framework allows new experiences to be entertained,
which would have been unlikely with the previous understanding.

**Gregory Bateson**

In addition to being influenced by Ericksonian principles and practices, relational
hypnotists are guided by Gregory Bateson’s (2000) ideas about difference, information,
pattern, communication, and his notion of Mind/mind. Bateson distinguished himself
from theorists who “borrow from the hard sciences to provide a conceptual frame upon
which they try to build theories about psychology and behavior” (pp. 458-459). The use
of energy theories or external governing forces to explain human behavior is the result,
said Bateson, of a confused epistemology or worldview. These understandings work well
in the physical sciences (or the world of the non-living) but not in a world defined by
distinctions or differences.

**The Map is not the Territory**

Bateson (2000) believed that the world of the living consists of ideas or
information, which is composed of differences, differences between differences, and
differences between these differences between differences. He defined an idea, “in its
most elementary sense, [as] synonymous with difference” (p. 459). But unlike causes identified in the physical sciences, differences do not physically impact objects, and they themselves are not “things”; rather, they are abstract (Bateson, 2000). Bateson quoted Korzybski’s phrase “the map is not the territory” to make the point that differences are the “stuff” of perception and mental process, meaning that the information that makes it on to an individual’s map is not an objective representation of “reality” or of the “territory.”

What makes it onto the individual’s map is guided by his or her selection of information, or how he or she categorizes an experience. Bateson (2000) stated “that the most elementary aesthetic act is the selection of a fact” (p. 459). The selection of a fact, or the punctuation of an experience, is a mapping process that influences how the individual perceives, interprets, and encounters a situation. The way in which the thing is named influences how the reality of the circumstance is experienced.

Bateson (2000) supported this understanding by providing an example presented by the philosopher Emmanuel Kant. In a piece of chalk, there are an infinite number of facts (or differences) around or within it—countless differences ranging from its molecular structure to its relational surroundings. But only a limited number of facts are selected and become information, which is then transformed by our neural pathways to provide an overall subjective understanding (or interpretation) of it. As Bateson emphasized, “all ‘phenomena’ are literally ‘appearances’” (p. 461).

Furthermore, Bateson (2000) would describe the naming or categorization of abstract “things,” such as emotions like love, fear, and/or hate, as an error in logical types. He asserted that “no class can in formal logical or mathematical discourse, be a
member of itself” (p. 280), “nor can one of the members be the class, since the term used for the class is of a different level of abstraction” (p. 202). With the example of fear, the physiological responses (i.e., increased heart rate, sweaty palms, and shortness of breath), or the members of the class, do not fully encapsulate fear as a whole. Fear is at a higher level of abstraction than its members, thus, cannot be equated with the arbitrary selection or experience of physical responses.

**Thinking Systems**

Within the realm of the non-living, physicists create equations to measure “effects . . . caused by rather concrete conditions or events—impacts, forces, and so forth” (Bateson, 2000, p. 458). These equations are based on a cause-and-effect principle that can be consistently replicated across individuals and contexts. It is a linear and causal explanation where the impact of one (or multiple) variable(s) can predict the effect(s) on another variable. Bateson talked about the impacting of billiard balls on a pool table to demonstrate this perspective: “Ball B moved in such and such a direction because billiard ball A hit it at such and such an angle” (p. 405). The movement of ball B can be accurately described and explained by ball A’s weight, size, force, speed, and trajectory.

In the world of mind or mental processes, effects are not the cause of external forces; they are elicited by difference (Bateson, 2000). Humans (and other living organisms) are surrounded by differences or information. In order to conceptualize the individual mind, one must consider internal processes, but just as important, the individual’s setting. As Bateson stated, “there are lots of message pathways outside the skin, and these and the messages which they carry must be included as part of the mental system whenever they are relevant” (p. 464). He provided the example of “a tree and a
man and an axe” (p. 464). In observing the man cutting the tree, we notice that the axe is directed towards the pre-existing cut in the side of the tree. To explain this phenomenon, one must be interested in both internal differences (differences in the retina of the man, nervous system, and muscles), and external differences, such “as the cut face of the tree . . . [and] differences in how the axe flies, to the differences which the axe then makes on the face of the tree” (p. 465). The explanation of this scenario “will go round and round that circuit” (p. 465). Therefore, the behavior under observation is not linear but rather in the form of a total or completed circuit, which Bateson described as an “elementary cybernetic thought” (p. 465). He also labeled this phenomenon as the simplest unit of mind, where the transformations of the messages within the circuit are considered elementary ideas. In other words, a unit that exemplifies “the characteristic of trial and error will be legitimately called a mental system” (p. 465).

**Communication**

Ruesch and Prestwood (1950) defined communication as a “process through which intentions, feelings, and thoughts of one person are transmitted to another,” (p. 413) or as any process that leads to an exchange of information. Bateson (1979) acknowledged human communication (verbal and nonverbal) as an exchange of information but also emphasized “the notion of *context, of pattern through time*” (p. 14). Without context, human communication (words or actions) has no meaning. He postulated that there are multiple components inherent in the idea of context. As individuals, we are filled with stories, “stories built into [our] very being” (p. 14). These stories are the result of experiential and interactional sequences that unfold over time, whether experiences with our parents, friends, and/or with others in our relational realm.
They are the fabric of our understanding in which we consciously and/or unconsciously utilize to interpret (attribute meaning) and respond (communicate) to internal or external information.

A second component of context is setting or geographical location, which Bateson (1979) described it as “a piece of the world of ideas” (p. 14). He presented the example of attending a therapy session with a Freudian psychoanalyst. The analyst and the structure and geography of the room are what Bateson referred to as context markers, that is, sources of information about the context—indicators that provide clues for how the patient is to make sense of the communication that is exchanged, influencing and guiding his or her responses and actions.

This becomes part of an interactional pattern, in which the patient’s (verbal and nonverbal) communication in turn influences the analyst’s actions, which then guide the individual’s response and so forth. Bateson (1979) described this process as a communication or feedback loop, which “is a universal characteristic of all interaction between persons” (pp. 14-15). This experience then becomes the context for future interactions. As Bateson emphasized, “the shape of what happened between you and me yesterday carries over to shape how we respond to each other today” (p. 15).

**Mind and Body Connection**

Bateson (2000) disagreed with theoretical perspectives that prioritize thinking over emotions, for example, those espoused by Ellis (1962), Freud (1920), and Kerr and Bowen (1988). He stated that the “attempt to separate intellect from emotion . . . is monstrous” (p. 470). Approaches that separate thought from emotions create metaphorical distinctions that position the mind in opposition to the body. Physiological
sensations are not valued and are perceived as inferior and separate from thoughts or awareness. Bateson (2000) argued that emotions “are central to the life of any mammal” (p. 470) and should not be discredited. With a systemic understanding, he perceived emotions to be matters of relationship. Emotions categorized as love, hate, fear, dependency, dominance, and so forth are the result of relational thinking; they are not isolable things that reside within individuals (Flemons, personal communication, August 30, 2016). Rather, emotions are our bodies’ way of thinking and communicating in relationship to others and/or the circumstances. Bateson quoted the English poet Blake to emphasize this view: “A tear is an intellectual thing” (p. 470). He further supported this notion by quoting the French poet Pascal: “The heart has its reasons of which the reason knows nothing” (p. 470).

**Neo-Ericksonian Approaches**

**Conventional Brief Therapy Approaches**

**Mental Research Institute (MRI).** Influenced by Bateson’s (2000) ideas about perception and reality, MRI therapists are not invested in discovering truths; rather, they are only interested in exploring clients’ worldviews (Fisch, Weakland, & Segal, 1982). As Fisch et al. emphasized, “views are all we have, or ever will have” (p. 10). Although some views might be more effective than others, it is not a question of reality but, rather, of perception. With the prioritizing of perception, MRI therapists deviate from explanatory behavioral and psychological theories and primarily focus on exploring the client’s understanding of the problem.

Unlike psychoanalysts (e.g., Freud, 1920), MRI therapists shift from what is behind (the past) and beneath (the unconscious) to the here and now or the present
(Watzalawick et al., 1974). For MRI therapists, a here-and-now orientation consists of attaining a detailed description of the problem—“what it is, in what way it is seen as a problem, and by whom” (Fisch et al., 1982, p. 12). Along with a description of the problem, MRI therapists pay close attention to clients’ efforts to resolve the problem. They believe that clients’ performance, or attempted solutions, perpetuate and even exacerbate their problems.

MRI therapists differentiate themselves from family therapists, for example, from Kerr and Bowen (1988) or Minuchin (1974), in that they do not believe that a family’s dysfunction has to be addressed to resolve the problem (Fisch et al., 1982). Problems from the MRI perspective originate from everyday difficulties, which then evolve into problems when ineffective solution attempts are implemented to deal with them. With this understanding, neither clients nor their family members are perceived as having individual or systemic deficits.

Although MRI therapists do not see families as dysfunctional, they agree with family therapists in thinking individuals are part of an interconnected system, and a change in one part of the system can influence the whole (Watzlawick et al., 1967). As the authors emphasized, “every part of a system is so related to its fellow parts that a change in one part will cause a change in all of them and in the total system” (p. 123). In other words, a shift in an individual’s behaviors or actions will more than likely influence those he or she is surrounded by.

Influenced by Bateson’s (2000) systemic ideas, MRI therapists consider all human behaviors or actions to be forms of communication (Watzlawick et al., 1967). Whether verbal or nonverbal initiations or responses, these actions are considered sources
of information that elicit responses from others. Communication (or the exchange of information) is what links an individual to his or her system—it is the relationship.

Given these assumptions, an MRI therapist “must be an active agent of change” (Fisch et al., 1982, p. 19). The goal of an MRI therapist is to resolve problems by encouraging clients to try something different, which consequently interrupts the vicious cycle of ineffective attempted solutions sustaining the problem. In their view, “if at first you don’t succeed, you might perhaps try a second time—but if you don’t succeed then, try something different” (p. 18). This leads to “the possibility that an initially small change in the vicious-cycle interaction . . . may initiate a beneficent circle” (p. 19). With this understanding, even severe and chronic problems can be resolved with brief and limited treatment.

MRI therapists also value the importance of clinical maneuverability (Fisch et al., 1982). Although therapy is conceptualized as brief, MRI therapists avoid prematurely offering clinical interventions. As the authors emphasized, a therapist initially knows little about the client’s values, principles, and priorities. Premature interventions run the risk of both hindering the therapist’s credibility and the client’s compliance or cooperation. Therefore, the logic of brief therapy does not infer that a solution must be immediately discovered. Timing and pacing are key elements utilized by MRI therapists. Fisch et al. stated that “it is better for a therapist to appear dull and slow than to feign understanding when matters are not really clear” (p. 72).

**Strategic Therapy.** Similar to MRI therapists, strategic therapists are active agents of change; they fully accept the responsibility of planning a strategy that can resolve the client’s problem (Haley, 1963). The goals are clear and directly related to
solving the problem, and the interventions are tailored to uniquely fit the client’s situation. The client’s interpersonal context is significantly considered during the construction of goals and interventions. Haley (1976) conceptualized problems as “a type of behavior that is part of a sequence of acts between several people” (p. 2). Like MRI therapists, strategic therapists acknowledge the influence of the relational context in the formulation of problems. But unlike MRI therapists, they emphasize that problems are the result of a hindrance in the family life cycle. Therefore, their goal is to assist clients in transitioning from a crisis to the next stage in family life.

Influenced by Erickson’s ideas about human idiosyncrasies, a hallmark of strategic therapy is acceptance and tolerance, meaning strategic therapists do not pathologize or label individuals, or their behaviors, as abnormal (Haley, 1976). The use of labels and diagnoses create problems that are essentially unsolvable. Haley emphasized, “if therapy is to end properly, it must begin properly. . . . The act of therapy begins with the way the problem is examined” (p. 9). That is, how therapists think about a problem will determine the strategies that are used. Rather than pathologizing, strategic therapists perceive clients as having natural and unique traits that can be useful in the resolution of problems (Madanes, 1991).

Strategic therapists present their interventions in a direct way, which are normally “about something that the family members are to do, both inside and outside of the interview” (Madanes, 1991, p. 396). The interventions are tailored to shift the way they relate to each other or with the therapist. They can be simple and individual suggestions or complex directives that can involve the whole family. If the approach is not successful in reaching the goals, an alternative strategy is implemented. Again, the emphasis is on
resolving the problem.

Strategic therapists subscribe to the notion of control and power dynamics. Aside from organic illnesses, they conceptualize all problems presented in therapy as voluntary, meaning they are under control of the individual or the family members (Madanes, 1991). Even if clients conceptualize their problems as involuntary, the first step is to redefine the problem as voluntary. The problem with an involuntary understanding from a strategic point of view is that it puts clients in a powerless or helplessness position, in which the situation is out of their control. Strategic therapists consider this a handicap that deprives clients of urgency and agency.

Within a family context, the “helpless” individual is part of an interactive cycle with his or her family members (Haley, 1976). The individual’s helplessness can be viewed as a source of power over his or her family members, whose lives are dominated by the needs of the individual (Madanes, 1991). Alternatively, his or her actions can be perceived as a result of victimization. This understanding or punctuation of power determines how a strategic therapist intervenes to encourage either the symptomatic individual and/or the family members can become agents of change. Regardless of the punctuation, the objective is to “redistribute power among family members and change how the power is used” (p. 404).

**Solution-Focused Brief Therapy (SFBT).** Influenced by their experiences and colleagues at Palo Alto, de Shazer and Berg developed SFBT after realizing that clients convey exceptions, times when the problem is not a problem, during their description of the problem (de Shazer et al., 1986). With this understanding, their approach shifted from acquiring thorough descriptions of the problem to details of exceptions—a shift from
problem resolution to solution development. Subsequently, the role of therapist in relation to the client evolved as well. Clients are perceived as experts of their own lives. The function of the therapist is to collaborate with clients in the construction of solutions (DeJong & Berg, 1998).

SFBT therapists maintain eight basic assumptions: change is continuous and inevitable; small changes lead to bigger changes; focus is on the future rather than the past; clients are experts of their own lives; every individual and situation is unique; we live in a world of relationships; all problems have at least one exception; and there are a variety of ways to change, not just through therapy (Simon & Berg, 1999).

Unlike MRI therapists, SFBT therapists do not structure their approach around a specific amount of time or sessions; time is not perceived as a motivator of progress (Simon & Campbell, 1996). Rather, SFBT therapists are primarily concerned with the accomplishment of collaboratively defined goals, regardless of the time frame. Therapy is considered complete once clients have reached their goals.

The development or selection of therapeutic goals is organized by multiple understandings (Berg & Miller, 1992). The goals have to be relevant to the client, and they must be small, specific, concrete, and observable. They should focus on initiating, rather than extinguishing, and, just as important, they need to be realistic and attainable: Therapists should always avoid constructing utopian goals.

A common intervention used by SFBT therapists is the miracle question (de Shazer, 1994). The intention of the miracle question is “to allow clients to describe what it is they want out of therapy without having to concern themselves with the problem and the traditional assumptions that the solution is somehow connected with understanding
and eliminating the problem” (p. 273). Influenced by Erickson’s (1980a) logic of hypnosis, SFBT therapists present the miracle question with careful pacing, ensuring that they stay connected with the client (Simon & Berg, 1999). It is designed to encourage the client to sit back, relax, and engage in a form of introspection that can initiate the solution development process.

**Hypnotherapy Approaches**

In addition to brief therapy models, several different hypnotherapy approaches have evolved as a result of Erickson’s (1959) clinical ideas (e.g., Gilligan, 1987; Lankton & Lankton, 1983; O’Hanlon & Martin, 1992; Zeig, 2008). Unlike certain researchers who link the ability to experience trance with neurophysiological attributes (e.g., Aikins & Ray, 2001; Crawford & Gruzelier, 1992; Jamieson & Woody, 2007), Neo-Ericksonian hypnotists believe that hypnosis can be done with just about anyone (Lankton & Lankton, 1983; O’Hanlon & Martin, 1992). They do not believe certain people are hypnotizable (or suggestible) because of their physiological qualities and others are deficient of these resources. Such an understanding infers that hypnosis is dependent on the recipient’s individual traits.

Rather, Lankton and Lankton (1983) stated that “trance is by its nature interpersonal” (p. 131). They perceive hypnosis as a social phenomenon, stating: “anyone that can be socialized can be hypnotized” (p. 131). With this understanding, hypnosis is conceptualized as a recursive process that entails a cooperative experience from both the therapist and the client. In other words, the client is not perceived as a passive recipient of hypnotic suggestions/interventions, but rather is engaged in co-constructing or developing of solutions.
Gilligan (1987) supported and extended Lankton and Lankton’s (1983) perception of the interpersonal nature of hypnosis. He inferred that therapists “typically find themselves in an externally oriented interpersonal trance” (p. 78) and used Carl Rogers’s (1980) description of empathy, and the unconscious, to understand this phenomenon. As Rogers explained, “to be with another in this way means that for the time being, you lay aside your own views and values in order to enter another’s world without prejudice” (p. 143). Similarly, Gilligan described interpersonal trance as entering clients’ private worlds without judgment or fear, being sensitive and understanding to clients’ views and mental processes.

When immersed in a client’s world, Rogers (1980) stated his “nonconscious intellect takes over. [He] know[s] much more than [his] conscious mind is aware of. [He does] not form [his] responses consciously, they simply arise in him” (p. 565). Gilligan (1987) conceptualized this experience as “a state of heightened responsiveness” (p. 79), meaning the restrictions placed by conscious awareness are depotentiated. The unconscious mind is “free to operate in an autonomous and creative fashion” (p. 82).

Solution-oriented hypnotherapists (O’Hanlon & Martin, 1992) embrace empathy by “utilizing what people bring to the situation, giving them permission for being whatever they are and then communicating to them that any response they give is okay” (p. 11). Utilization is a way of connecting with clients, as well as inducing trance. Rather than viewing clients as resistant, they “take whatever [clients are] showing . . . and include it, utilize it as part of the trance induction” (p. 8). The goal is to meet clients at their model of the world, and utilize their understandings, behaviors, and/or beliefs as conduits to trance.
In addition to the utilization of clients’ beliefs or behaviors, Gilligan (1987) values the utilization of the problem, its difficulties and discomfort, as a bridge to trance, as well as an opportunity for growth and learning. Influenced by Bateson’s (1979) ideas about context, Gilligan (1987) postulated that the way clients interpret or give meaning to their experiences is primarily guided by their settings and the ideas associated with their culture. He provided an example of two women who had similar experiences but with two completely different interpretations because of the perception and understanding of their community—one experience was understood as a spiritual journey; the other, a psychotic meltdown.

With this understanding, Gilligan (1988) argued that “symptom phenomenon are versions of classic hypnotic phenomena” (p. 327). He conceptualizes cognitive changes (sustained attention, inner absorption) and somatic fluctuations (sweaty palms, increased heart rate) experienced during symptoms as legitimate hypnotic expressions. The role of a hypnotherapist is to explore, utilize, and “recontextualize problematic processes so they can function as ‘value-able’ solutions in the developmental growth of the person” (Gilligan, 1987, p. xiv). In other words, the symptom is not the target of extinction; rather, it is experientially restructured as an opportunity for a meaningful therapeutic or hypnotic experience.

Like Erickson (1959), Neo-Ericksonian hypnotists do not try to implant their ideas in clients (O’Hanlon & Martin, 1992). Trance is conceptualized as an intense inner absorption, which essentially involves clients focusing on their “own thoughts, values, memories, and beliefs” (Lankton & Lankton, 1983, p. xvii). These intrapersonal experiences are elicited rather than imposed. As O’Hanlon and Martin (1992) stated,
hypnosis is the “evocation of involuntary experience” (p. 13).

Involuntary experiences have the feel of something “just happen[ing]” . . . The patient can suddenly realize that images just happen, memories just happen, that the passage of time is different, and so on” (Zeig, 2008, p. 106). Indirect suggestions such as stories, metaphors, and/or anecdotes can be used to elicit such involuntary experiences. Lankton and Lankton (1983) use metaphors, or embedded metaphors, to elicit non-volitional experiences, as well as to enhance or vivify clients’ concentration on their internal processes.

Once an involuntary experience develops, the hypnotherapist then guides and directs it towards achieving the client’s goals (O’Hanlon & Martin, 1992). With issues such as fears and phobias, an involuntary experience “may be built on therapeutically as a stepping stone to countering the negative dissociation inherent in symptoms” (Zeig, 2008, p. 108).

Although significantly influenced by Erickson’s (1959) ideas, solution-oriented therapists disagree with Erickson (and other state theorists) in considering hypnosis as an actual “thing” and trance as a different state of consciousness (O’Hanlon & Martin, 1992). O’Hanlon argued “that trance isn’t a thing at all. It’s a distinguished state in language” (O’Hanlon & Martin, p. 20). Zeig (2008) would concur: “Hypnosis is not a thing, but is a way that things happen in a social context” (p. 101). Hypnosis is a construct of convenience in which the label is used to describe mental and physical manifestations that unfold as a result of a particular conversation. These and similar experiences are associated with a trance state, which then presents the perception of hypnosis as a thing that can be identified.
However, Neo-Ericksonian therapists do subscribe to the legitimacy of the experience of trance (O’Hanlon & Martin, 1992; Zeig, 2008). O’Hanlon and Martin (1992) provided love as an example. Given that love cannot be physiologically measured, one can tell when he or she is in love, and others can notice as well. In essence, trance is similar. Hypnotherapists can identify when someone is in trance, and others that may be observing could notice the shift as well.

Although some Neo-Ericksonians approach trance with Erickson’s (1980b) understanding of the unconscious (Gilligan, 1987; Lankton & Lankton, 1983), others extended their perception of it (O’Hanlon & Martin, 1992; Zeig, 2008). O’Hanlon and Martin (1992) defined the unconscious as a “jukebox of learnings, that is, [a] jukebox of memories” (p. 108). It consists of sensory experiences that have accumulated over time but are not deliberately available to the conscious mind. In other words, “the stuff you have on automatic pilot” (p. 109) or “the things you do automatically” (p. 110). They provided the example of driving a car. Someone with driving experience does not have to think about how to use the brakes or how to change gears. “Once you learn it and your unconscious gets smart about it, you don’t have to think about it” (p. 110).

**Relational Hypnosis**

**Interpersonal**

Relational therapists are theoretically guided by the ideas of Eastern philosophy, specifically Taoism, in conjunction with Bateson’s (2000) understanding of mind and difference (Flemons, 1991). Flemons postulated, “any act of knowing, any knowing act, begins with the drawing of a distinction, with the noting of a difference” (p. 1). A distinction is a boundary that is drawn to separate a part from a whole or a part from
another part within a whole. For example, the differences between toe/foot, son/family, human/nature, or genes/environment are part/whole relationships; the differences between pinky/thumb, brother/sister, mind/body, and petal/stem are part/part relationships. All come into being or perception as a result of demarcations, of defining boundaries, which “constitute the ‘stuff’ of mind (p. 1).

Demarcations or distinctions are a manifestation of language (Flemons, 1991). The use of words to classify and describe certain elements, experiences, or phenomenon creates the illusion of the world being constituted of separate parts:

The discrete divisions within language—between subject and object, or between static noun and active verb—can seduce us into believing that such separations are not simply the stuff of description, but in fact inhere in the nature of the world. (Flemons, p. 25)

The classification of a noun as separate from a verb, or an observer separate from the observed, creates a boundary that “distinguishes this from that which it is not” (p. 25).

Flemons (1991) argued that the nature of language, or the drawing of distinctions, has the potential to lead to serious problems if we misconstrue how language operates. What Flemons referred to as “an epistemology of dichotomous separation” (p. 26) is a fundamental misunderstanding about the nature of language and the distinctions drawn within it. We continually create seeming oppositions when, in language, we distinguish something from what it is not (e.g., front from back, teacher from student, mind from body) and treat each as a distinct entity. Flemons used the philosopher Alan Watt’s (1957) criticism of Western society’s perception of humans as unique, and separate from, their environment to emphasize this erroneous logic. This division creates “an either/or
orientation to the world, a reflection of the assumption that we can control nature” (Flemons, 1991, p. 28).

Not only is the either/or orientation to nature or other phenomena deeply troubling, but also our efforts to adapt, or solve problems, within the realm of this logic are similarly destructive (Flemons, 1991). An either/or orientation, or an “us” versus “them” understanding, justifies efforts to control or extinguish what is labeled as different or other. As Flemons emphasized, “blindness to this simple realization characterizes not only our tragic relationships to each other and our world, but also our relationships to ourselves” (p. 29).

Similar to MRI therapists (Watzalawick et al., 1974), relational therapists recognize that ineffective solution attempts perpetuate unwanted life difficulties; however, they go further in characterizing what is in fact problematic about such attempted solutions: they are focused on eradication (Flemons, 1991). According to Flemons, “symptoms are haunting reminders that attempts to eradicate pieces of our lived experience, to banish parts of our minds, can unwittingly create and entrench the very problems we most dread” (p. 29). However, relational therapists conceptualize efforts to negate, or separate from, a problem as a manifestation of dichotomous thinking.

Although this orientation creates the perception of isolation (problem separate from individual), “the boundary that separates the two sides of the created distinction necessarily connects them” (Flemons, 1991, p. 2). In other words, an individual’s attempt to distinguish, or isolate from, a problem ultimately creates a relationship between the two sides. As Flemons emphasized, “each side exists by virtue of the difference that separates it from, and connects it to, its complement” (p. 22).
Like Bateson (2000), Flemons (1991) perceived these willful attempts to eradicate a problem as a result of conscious purpose. As Flemons stated, conscious purpose “tend[s] to self-reflexively split itself off from the balance of Mind, from the body and its social and biological contexts” (p. 89). Conscious knowing, or the Observing-I (Flemons, 2002), creates distinctions between self and other, body and mind, or self and problem, which then result in goal-directed or willful actions that undermine the total complexities of relationships or systems.

Conscious purpose is similar to a racehorse with blinders suffering from tunnel vision; it strives to get to its destination in the quickest and shortest way possible (Flemons, 1991). In other words, its limitations result in a particular action, or the focusing of one side of the distinction: “a desired ‘good’ is isolated and pursued as if it were an independent entity, as if there were no limit to it . . . and no recognition that there is always another side to the coin” (p. 90). For example, willful efforts to banish “irrational thoughts” or modify cognition creates a hierarchy between the mind and body. The mind is prioritized and perceived as isolated, or separate, from the body.

Predictably, clients pursue therapy with a similar orientation (Flemons, 1991): “Requests for therapeutic help almost always reflect a desire on the part of clients to have some ‘piece’ of themselves (or of other people) eradicated” (p. 109). With the assumption that problems can be objectively identified and isolated, clients hope their therapists will function as exterminators, using chemical-like interventions to remove unwanted pest-like problems. However, Flemons cautions “that any move on the part of the therapist to directly answer such [requests for the destruction of whatever is troubling the client] . . . will only help spin the vicious circles in which the person is caught that much faster and
tighter” (p. 91), further locking in place the client’s relationship with the problem.

**Hypnosis**

Relational hypnotherapists recognize “the problem-forming-and-escalating effects of personal othering” (Flemons, 2004, p. 43), or the consequences of trying to banish discomforting or aversive experiences. They acknowledge that these attempts to eradicate are the result of an internal battle between the Observing-I and the rest of self. The Observing-I, which perceives itself as the “knower and controller of our experiences” (p. 42), assumes the responsibility of labeling and classifying non-volitional experiences: bodily processes, emotions, thoughts, memories, or images. It interacts “with the rest-of-the-self as if from behind an invisible wall, monitoring and attempting to reign in or destroy out-of-control [experiences]” (p. 43).

Flemons (2004) conceptualizes hypnosis as the temporary dissolution of the boundary that divides the Observing-I from experience. He compares it to the flow-state phenomenon associated with meditation, writing poetry, playing sports, or listening to music, where one is immersed in, or absorbed by, the experience (Flemons, 2016). As Flemons (2004) described, “your fold-back knowing becomes ‘distributed knowing,’ with no Observing-I hanging back, claiming ownership of or responsibility for what’s happening” (p. 43). In other words, conscious awareness becomes irrelevant; it is no longer evaluating or classifying internal or external experiences.

Although Flemons (2016) relates trance to a flow experience, he does not conceptualize it as a special state of consciousness (Flemons, 2002). He agrees with O’Hanlon and Martin’s (1992) understanding of trance as a self-referential construct of convenience. As Flemons (2002) echoed, “the ‘state’ of hypnosis is used to explain the
existence of hypnotic phenomena, which, in turn, are used to define the hypnotic state” (p. xv). Rather, he perceives it “as the creation and maintenance of a special relationship, a relationship that bridges the mind-body division, altering, while it continues, the everyday boundaries of the conscious ‘self’” (p. xvi).

This special relationship consists of multiple components, one of which is the therapeutic relationship itself. To facilitate the client’s hypnotic experience and therapeutic change, the therapist must move from an outsider to an insider position (Flemons, 2002). Flemons accentuates the importance of therapists curiously engaging with clients rather than interacting from a distant or removed position. As he cautioned, “if, looking at a client, you see only a hopeless Other, therapy is out of the question” (p. 52). The act of keeping a client at arm’s length undermines the possibility of any therapeutic change.

Since a component of trance is conceptualized as a shift in therapeutic boundaries, relational hypnotherapists strive to achieve concordance or an empathic connection (Flemons, 2002). This is achieved when one “cross[es] not only the self-Other boundary—from outside to inside [clients’] culture—but also the self-other boundary, from outside to inside [clients’] heads and hearts” (p. 58). It is the action of immersing yourself in their world to gain a better understanding and appreciation of their experiences, without the need to judge or label.

Hypnotherapists typically enhance their connection with clients by speaking in rhythm with their breathing, with emphasis on certain words or phrases in concordance with clients’ exhalations (Flemons, 2016). Flemons noted, “this intimate conjoining serves to ambiguate the line of conscious differentiation that is normally invoked between
two people engaged in an everyday conversation” (p. 821). As the trance process unfolds, the therapist’s efforts interweave with the client’s sensations or experiences, resulting in what Flemons (2002) referred to as an experience of their being “of one mind.”

Given that the goal is to diffuse a distinction, relational hypnotherapists do not structure their approach with the intention of helping clients to isolate, control, or eliminate problems (Flemons, 2002). Flemons (2016) reasons, “a problem is not, in fact, an object existing independently of clients but is rather woven into the fabric of their experience []; thus[,] all efforts to manage it will necessarily and reflexively become part of the problem itself” (p. 822). Thus, instead, the therapist’s primary focus is on shifting relationships—“relationships between people, but also between people and various parts of their experience, whether a body part, physiological response, idea, emotion, memory, dream, or behavior” (Flemons, 2004, p. 50). This “facilitate[s] the associative development of a connected separation: a relationship with the problem that allows for a comfortable connection and/or a relaxed letting go” (Flemons, 2002, p. 178). This becomes possible when clients are encouraged to curiously engage with their problem. As Flemons emphasized, “curiosity helps clients reverse the way they orient to their problem, to connect with what they’ve been trying to keep separate” (Flemons, 2004, p. 50). This orientation allows clients to sit comfortably with the problem—keeping it close enough to potentially learn something different about it.

Flemons (2002) acknowledges that curiosity and learning become difficult if clients are recoiling from their experience—unwilling to take risks and go beyond their comfort zone. With this understanding, relational therapists contextualize therapy as a trial-and-error learning process, meaning both clients’ successes and failures are
encouraged and perceived as essential for change. Although improvements are valued, failures (or aversive changes in the symptom) are not frowned upon or discouraged; rather, they are embraced. As Flemons reinforced, “my clients and I conduct mini-experiments, allowing them to get as much or more from experiences that bomb as from those that go swimmingly. As a result, failures are always relative and necessary” (p. 189).

Curiosity or a comfortable connection can also be facilitated by what Flemons (2002) described as “intraventions,” or “suggestions from inside the concordance between . . . clients and [the therapist,] ideas designed to alter (not negate) the relationship between the clients and their symptoms” (p. 77). Suggestions that unfold as a result of an empathic connection are different from interventions, where the therapist assumes the responsibility of displaying his or her expertise and creativity, thereby inadvertently undermining the legitimacy and importance of the clients’ experiences. Rather, intraventions are conceptualized as a cooperative endeavor, in which the suggestions consist of an interweaving of the therapist’s knowledge and the client’s circumstances.

A clinician’s intraventions or insider suggestions are guided by a metaphoric orientation, which can surface in the form of ideas, stories, or images (Flemons, 2002). As noted, a metaphor makes an implicit association between two different entities (Lankton & Lankton, 1983). The metaphoric connection is not achieved through conscious awareness, nor is the boundary that separates the entities consciously scrutinized. Metaphoric thinking is employed with a similar logic; it can be understood as a “not-noticed relationship, [or] by definition, unconscious—not consciously discerned”
Intraventions organized by this orientation create a context where clients can experience non-volitional changes outside of, and free from, conscious recognition.

An alternative understanding of a non-volitional shift is “the special relationship people develop with themselves when the boundary between mind and body is crossed over—the boundary that, during times of normal conscious dissociation, separates the [Observing-I] from the rest of self” (Flemons, 2002, p. 137). In the treatment of phobias, the goal of a relational hypnotherapist is to establish a special relationship between the conscious self and the physiological sensations that have been othered. Body experiences such as difficulty breathing, profuse sweating, or an increase in heart rate become opportunities for curiosity and intravention. During hypnosis, the Observing-I is not standing behind an invisible wall, claiming ownership and passing judgment. With awareness and experience interlaced in the mind-body connection of hypnosis, the “self” becomes inclusive, rather than exclusive.

**Research on Hypnotic/Brief Therapy Treatment of Anxiety/Fear/Phobias**

**Quantitative Research**

In general, in-vivo exposure is the treatment of choice for specific phobias or fears (Bandelow et al., 2014; Nathan & Gorman, 2007). The logic of exposure therapy is to assist clients in confronting their objects or situations of fear, so a reconditioning (or reassociating) of their physiological, cognitive, and behavioral experiences can unfold (Delgado et al., 2006). Although there are a variety of exposure interventions (Oar et al., 2015; Wolff & Symons, 2013), approaches that guide clients through the process have been shown to be more effective than instructional, non-monitored treatment (Lang et al.,
2012).

Vögele et al. (2010) exposed 427 participants with agoraphobia and 98 participants with social phobias to high-density clinical treatment, in which patients confronted their feared situations for several hours a day. Participants were presented with a cognitive assessment before treatment, six weeks after treatment, and one year after treatment. The results indicated that both groups significantly improved between baseline and six weeks post-treatment. Clinical effects were maintained during the one-year follow up. Shiban, Schelhorn, Pauli, and Mühlberger (2015) investigated the effects of exposing 58 spider-phobic individuals to multiple contexts and different species of spiders. Although exposure to different settings was not shown to be significant, exposure to multiple kinds of spiders decreased fear responses, as well as reduced the chances of a relapse or return of fear.

Raes, Koster, Loeys, and De Raedt (2011) were interested in studying the influence of mediating variables in exposure therapy, which mechanisms are useful in explaining its success. They randomly assigned 31 spider phobic patients to either a behavioral exposure group or a cognitive-mediated exposure group. The behavioral exposure group solely focused on modifying behavior, whereas the cognitive behavioral group implemented cognitive restructuring. Both groups experienced significant improvement, indicating that even when cognition is not targeted, exposure to the feared stimuli resulted in a shift in cognition. Botella et al. (2014) also found that participants with a fear of flying experienced a shift in cognition, whether they were exposed to virtual reality with cognitive restructuring or one without it.

Although in-vivo exposure has been shown to be effective, clinicians rarely
implement this form of treatment (Deacon et al., 2013). A potential factor could be the level of stress associated with the process. Schumacher et al. (2015) reported that both therapists and clients experience high stress levels during flooding exposure interventions, in which clients are initially exposed to their most anxiety-eliciting stimulus or situation. Because of its ineffectiveness and hindrance on treatment, the authors recommended a gradual or progressive exposure approach and emphasized that therapists’ elevated stress levels should be addressed during clinical training.

Hypnosis has been used in conjunction with a variety of clinical approaches in the treatment of phobias (Kraft, 2013). Although most of the research on hypnosis and the treatment of phobias involve case studies, a few quantitative studies have been recently published. Spiegel, Maruffi, Frischholz, and Spiegel (2015) explored the effects of engaging 178 patients with a flying phobia to either a 45-minute hypnosis session or a relaxation/concentration training. The participants identified as hypnotizable were taught to induce self-hypnosis, which involved relaxation and imagery techniques. They were encouraged “to feel themselves floating with the plane, rather than to ignore, struggle with, or avoid the fear” (158). As a result, 52% of the participants experienced partial or complete mastery over the phobia. Hypnosis patients experienced a higher percentage of mastery over their problem than those who solely engaged in a relaxation/concentration training.

Wannemueller et al. (2011) evaluated the effect of multiple forms of treatment, which included individualized hypnosis, standard hypnosis (use of a generalized script), cognitive-behavioral therapy (CBT), and general anesthesia on 137 participants who suffered from dental phobia. The authors found CBT and individualized hypnosis to be
more successful than the other forms of treatment, with CBT being the most effective. The participants in the CBT and individualized hypnosis groups reported lower levels of anxiety before and after dental treatment.

**Qualitative Research**

**Case studies.** As noted, hypnosis has been used in combination with other modalities of therapy to treat fears and phobias (Kraft, 2013). Iglesias and Iglesias (2014a) reported that hypnosis in conjunction with systematic desensitization was more effective in treating phobias than systematic desensitization alone. In their case study with an individual with a highway phobia, they found that hypnosis allowed the individual to attain a higher level of relaxation and vivid visualization than through traditional body relaxation techniques. In a follow-up case study, Iglesias and Iglesias (2014b) explored the effect of hypnosis and fixed role therapy with a 32-year-old male with a social phobia. The participant was asked to identify the personality traits he desired, as well as to construct thorough and detailed descriptions of simple social interactions. Hypnosis was used to incorporate the personality traits and to play out the social interactions. After 10 office visits and 220-225 self-hypnosis sessions, the participant reported to have engaged in both simple and complex social encounters across a variety of settings.

In the treatment of flying phobias, limited access to an airport or airplane typically precludes in-vivo exposure. Instead, clinicians have incorporated virtual reality exposure therapy with hypnosis to address this issue. Hirsh (2012) investigated the effects of treating a 69 year-old male with a 50-year history of aviophobia. During the first few office visits, the author implemented hypnosis to create a flying experience. Imagery and
relaxation techniques were used to assist the patient through the process. The patient was then exposed to a variety of virtual boarding and flying simulations and encouraged to utilize his hypnotic experiences to cope with his anxiety. After multiple sessions, the author accompanied the patient on a shuttle flight from New York to Boston. Although the patient experienced sweaty palms, he reported low levels of anxiety.

The use of hypnosis for needle phobias has also been researched (Gow, 2006; Morgan, 2001). Weigold (2011) explored the influence of utilizing hypnosis within a cognitive therapy perspective with a 15-year-old girl who developed a fear of needles after three vaccinations. Treatment consisted of relaxation techniques, dissociation, and hypnotic suggestions. During trance, the author explained the cognitive structures the client was using to create and maintain her fear of needles, which included the theory behind the fight or flight response in relation to her “faulty alarm system” (p. 191). A week after treatment, the client reported she had confidently obtained her required vaccinations at school. She was able to decrease her anxiety through logic and self-talk, “telling herself that her fears were unfounded and were actually more detrimental than the vaccination itself” (p. 195).

Gow (2006) used hypnosis with a 31-year-old female, Jan, who developed a dental phobia after having an aversive needle experience in a hospital setting. Jan had required many needles during a difficult childbirth, during which she almost lost the baby. Since then, she had avoided all settings and treatments that involved needles.

At the time, Jan had excruciating tooth pain that needed immediate extraction, but she was hesitant to pursue a dental procedure due to her fear of needles. To alleviate Jan’s fear, Gow (2006) utilized hypnosis to desensitize her to the vision of a needle that
could be used for the anesthetic. This included both imagery techniques and visual exposure to an actual needle. Once she felt comfortable with the visual, she was gradually exposed to a series of injection procedures that would more than likely occur during her dental visit. Post hypnotic suggestions such as encouraging Jan to find the confidence to overcome her irrational fears were also used. After seven sessions, Jan was able to attend her dental appointment and have her tooth removed. She reported low levels of anxiety throughout the process.

Morgan (2001) explored the use of hypnosis with a 26-year-old pregnant client who was fearful of her childbirth experience. Paula attributed her fear to needles after having several fainting experiences at medical clinics during adolescence; she also had a tendency to faint at the sight of blood. The author’s use of hypnosis focused on imagery techniques, in which the client was instructed to imagine herself at a cinema. Through hypnotic suggestions, Paula was encouraged to imagine and watch a black and white film of her fainting in a blood pathology unit. During this experience, Morgan presented statements accentuating the difference between the film and her current response. The goal was to create a dissociation between Paula and the fainting experience.

The film was played in a variety of ways: it was played in color, as well as backwards, and during one showing, “Paula was invited to enter the frame and to participate in the film” (Morgan, 2001, p. 112). Although the author encouraged a follow-up session, Paula was unable to attend. During a follow-up phone call a few months after, Paula disclosed that she had had a pleasant childbirth experience. She requested an epidural at an early stage of the delivery and reported moderate levels of anxiety but not to the extent as before.
**Process Research**

One of the pioneers of process research, which focuses primarily on the unfolding of therapy sessions, was Carl Rogers, who listened to audio recordings of his therapy sessions to evaluate instances of the change process or “moments of movement” (Mahrer, 1985, p. 92). With the focus on processes or communication, a facet of process research (or discourse analysis) can be conceptualized as “a detailed examination of how the talk itself is a performative action that helps to both interpret and produce behaviors” (Gale, 1991, p. 3).

In the realm of family therapy, process-oriented researchers analyze change by exploring these performative actions or communication patterns between therapists and clients (Greenberg & Pinsof, 1986). One way of examining how interactive sequences result in a therapeutic shift is through a detailed and discovery-oriented transcript analysis (Gale, 1991), which can be interpreted as a transcript-grounded exploration (Flemons, personal communication, December 7, 2017).

Two transcript-grounded explorations of hypnotherapy sessions stand out as exemplary uses of a process-research qualitative approach to understanding how hypnosis contributes to bringing about therapeutic change. The first entailed multiple analyses by different researchers and clinicians of a transcribed hypnotherapy session conducted by Stephen Lankton (Lankton & Erickson, 1994) with a client suffering from anxiety. The second, conducted by Flemons (2002), involved his use of Conversation Analysis (CA) to analyze transcripts of five hypnotherapy sessions with a female client with agonizing pain.
Lankton (1994) conducted a single session with a 37-year-old woman “with anxiety attacks and deep despair” (p. 81). Joan was a single mother of one son but lived alone. Her mother died when she was young, so she lived with her grandmother until the age of 11. In her late teens, Joan eloped from her father’s house and entered an abusive relationship that lasted for about a year. She married her ex-husband in her early 20s and had a son at age 25. The marriage ended in a divorce five years after, and Joan lost custody of her son due to allegations of drug abuse and sexual promiscuity. Because of the allegations, she only saw her son for a couple of weeks in the summer. Although she had a boyfriend, it was a long distant relationship, and she continued to live alone.

According to Joan, her feelings of anxiety and deep despair were perpetuated by her son’s visits; she felt guilty for losing custody, which inhibited her ability to provide and care for him. Lankton (1994) used hypnotherapy as a form of treatment to assist Joan with her intra- and interpersonal difficulties. After several follow-up phone calls with Joan, Lankton was able to report that she was consistently feeling “secure, uplifted, confident, and ‘reempowered’” (p. 82). Lankton’s interventions were guided by Ericksonian practices and principles. The following researchers explored and analyzed the transcript of the session to provide a detailed explanation of these interventions, as well as their perception of what they considered to be influential.

Matthews (1994) accentuated Lankton’s use of Ericksonian interventions, such as an emphasis on the positive and Joan’s strengths; a focus on the family life cycle; engaging in a solution-focused/future oriented approach rather than gathering thorough information about her past; and “employing indirect and direct suggestions, utilizing client presentation, and creating a useful spilt between conscious and unconscious ways
of knowing” (p. 109). Matthews also highlighted Lankton’s disclosure of personal information to normalize Joan’s difficulties with not having any memories of her mother. Lankton divulged that he recently lost his mother and that he had a “troubling picture of her” (p. 110). In paraphrasing Erickson, Matthews stated that “Erickson believed that nothing can happen in therapy in the absence of the therapeutic relationship” (p. 110). Thus, Matthews considered Lankton’s normalizing statements to have created a context for change.

Fisch (1994) inferred that most of Lankton’s normalizing comments were implicit. One example was about Joan’s inability to show any pictures of her son because her purse was recently stolen. In response, Lankton stated that he threw away his wallet in an Ace Hardware bag with pictures of his family. In addition to normalizing, Fisch believed that Lankton’s comments were also examples of Lankton’s taking a “one-down position” (p. 134). This stance implies that “the therapist is not an all-powerful, all-knowing authority (p. 132).

Johnson (1994) also underscored Lankton’s non-expert clinical posture. She conceptualized Lankton’s initial “stumbles” and inarticulate forms of communication as efforts to create a relationship in which the therapist is not perceived as fully competent and able. Influenced by Ericksonian practices, she maintained that “obvious competence allows or invites the patient to be less involved, to be too passive and uninvolved” (p. 142). Thus, Lankton’s initial blunders (or confused style) enhanced Joan’s desire and efforts to engage in the process.

Like Matthews (1994), other researchers acknowledged Lankton’s emphasis on Joan’s strengths and resources. Schwarz (1994) commented on Lankton’s decision to
highlight Joan’s statement about her self-confidence while choosing to ignore her self-criticism. Fisch (1994) indicated that Lankton’s focus on the positive unfolded as the result of reframes. For instance, Lankton reframed Joan’s negative expectations about her son’s visit as something most mothers experience and so she was not any different from the rest.

Keeney and Eichenfield (1994) focused on the instances of change or as they referred to them, “trance-formational moments” (p. 139). They invited a diverse group of therapists to examine the transcript in search of these experiences or turning points in the session. The authors’ preliminary findings suggested that “different clinicians, even with varying backgrounds, more often than not [recognized] the same moments of transformation in a session” (p. 140). The first example of a major transformational moment was initiated by Lankton’s suggestion for Joan “to make internalized pictures of her son, beginning with when he was three years old and moving toward his present age” (p. 140). In the creation of these images, Lankton asked Joan to “notice the feelings of pride and happiness associated with a mother’s watching the development of her child” (p. 140).

Keeney and Eichenfield (1994) inferred that Lankton’s suggestions elicited resourceful and positive responses such as smiling, laughter, and feelings of tenderness, which were then classified as “the pride of a mother” (p. 140). Joan was then asked to hold onto these experiences and to imagine herself growing up from age three while juxtaposing the previous images of her son: “she was instructed to hold onto the good feelings associated with being a mother” (p. 140). Subsequently, Lankton shifted Joan’s attention to her body, “noting the difference between relaxation and tension” (p. 140).
Relaxation is accentuated and associated with the feelings of being a proud mother. Lankton then moved back to having Joan imagine herself as a three-year-old while experiencing the positive feelings of being a nurturing mother, which was associated with relaxation. Keeney and Eichenfield considered this to be the most significant transformational moment, “when communication is suggested between the woman’s image of herself as a three-year-old and the image of herself as a grown-up in a way that is resourceful to both the child and the grown-up” (p. 140).

The next important transformational moment was Lankton’s reframe of Joan’s anxiety “as a vibration that could be associated with ‘giggling’” (Keeney & Eichenfield, 1994, p. 140). Lankton presented the idea that the vibrations of her current anxiety could be replaced with the vibrations of her inner child’s giggling, feelings that can “just echo and vibrate through [her] bones” (Lankton & Erickson, 1994, p. 99). Lankton then extended this intervention by indicating that Joan could continue to use her inner child experiences as resources for a wide range of adult difficulties.

The “final transformational moment involved the masterful mention of the presence of her mother’s spirit” (Keeney & Eichenfield, 1994, p. 141). Lankton vivified the idea of her mother’s presence by providing a story about a client, who as a child, saw an image of his late grandfather. The client’s father lost his father (the grandfather) at the age of three but like his son, at times, felt his presence. Keeney and Eichenfield suggested that this story “helped to underscore the existentially real presence of her mother’s absence” (p. 141). Lankton presented this suggestion with the intention of encouraging Joan to value her mother’s presence by shifting focus from her complaints to engaging in conduct that is resourceful to her own development.
As noted above, the second transcript-grounded exploration involved Flemons’s (2002) work with “Anna,” who for several years had struggled with pain in her joints that prevented her from gripping anything. Similar to Lankton (1994), Flemons presented transcriptions of the sessions; however, he used CA conventions to guide his detailed inquiry of meaningful, therapeutic interactions with his client. He noted pauses in the talk, which were strategically used to shift the pacing of his words with Anna’s breathing; highlighted the rate of speech and fluctuation in voice (e.g., tone, pitch, and volume) to demonstrate emphasis on certain words or phrases; and acknowledged the pronunciation or faltering of words to offer double meanings.

With this background on the variety of modalities and research in the treatment of phobias, I am now able to proceed to the next chapter, where I demonstrate how I analyzed my research question: How does a relational hypnotherapist facilitate an enduring non-volitional change with a woman suffering from a fear of blood and needles.
CHAPTER III: METHODOLOGY

Using conversation analysis (CA), this study seeks to explore the talk-in-interaction between a therapist and client. As Psathas (1995) stated, CA can be conceptualized as interaction analysis “because all aspects of interaction, nonverbal and nonvocal, are also amenable to study” (p. 2). This study explored how hypnotic communications can result in the kind of therapeutic experiential shifts that make it possible for a person to do what previously felt impossible. The following research question guided the specifics of the inquiry: How does a relational hypnotherapist facilitate an enduring non-volitional change with a woman suffering from a fear of blood and needles? To answer this question, I studied selected conversations and hypnotic communications that unfolded between Douglas Flemons and a client, Grace, over the course of her therapy. However, my analysis primarily focused on the first two sessions. In addition, I examined Douglas’s case notes and his email correspondence with Grace, in which she described a variety of therapeutic changes.

In the courses he teaches and the practicum he supervises, Flemons often expresses concerns about the common use of the title “Doctor” to establish the authority of therapists and professors in relationship to their clients and students. Recognizing that such context markers can implicitly delegitimize or undermine the resourcefulness of clients and students, Flemons typically encourages his students and clients to call him by his first name (Flemons, personal communication, January 10, 2018). He distinguishes between reverence, which an official title encourages clients and students to experience, and respect, which is earned by the therapist and/or professor and thus requires no title (Flemons, personal communication, March 14, 2018). In keeping with Flemons’s position
on titles and names, I, throughout the dissertation, refer to him mostly by his first name, Douglas, particularly when mentioning him in the context of his work with his clients.

**Qualitative Inquiry**

Creswell (2007) advocated for the use of qualitative research when there is a need for a “detailed understanding of [an] issue” (p. 40) when quantitative methods are not the appropriate fit. “Wide-angle lenses,” such of those provided by quantitative inquiries, are too distant and thus are limited in their ability to provide answers to specifically defined problems. As Ragin (1987) emphasized, quantitative research deals with many cases and few variables, whereas qualitative inquiries focus on a few cases but with many variables. Thus, a qualitative endeavor provides the researcher the opportunity to engage in a detailed exploration of the topic of interest (Creswell, 2007).

Creswell (2007) recommends choosing a qualitative approach “in order to study individuals in their natural setting” (p. 17), which includes gaining access to data such as video and/or audio materials. Similarly, Denzin and Lincoln (1994) described qualitative research as the “study [of] things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them” (p. 2). Unlike most empirical studies, qualitative analysis does not require participants to be removed from their natural environments; they do not need to be researched in contrived settings such as laboratories (Creswell, 2007). As Gale (1991) cautioned, “a major concern of family therapy process researchers is to avoid stripping events from their context through a reductionistic approach” (p. 22).

As discussed in the previous chapter, most of the current research focuses on individual approaches to the treatment of fears and phobias (Bandelow et al., 2014;
Nathan & Gorman, 2007). There is little to no research on systemic approaches to treating phobias, particularly of phobias related to blood and needles, and only one study has been conducted (Roscoe, 1996) on the means by which a relational hypnotist facilitates therapeutic shifts. As Strauss and Corbin (1990) accentuated, qualitative inquiries should be used when little is known about a phenomenon of interest. In keeping with this recommendation, this research endeavor aimed to explore, describe, and provide a thorough understanding of relational hypnotherapy in the treatment of a phobia of blood and needles in a clinical setting.

**Conversation Analysis**

The development of ethnomethodology and conversation analysis (CA) was the result of methodological debates in sociology in the 1960s (ten Have, 2012). Garfinkel (1967) highlighted the importance of studying social activities within their natural settings free from pre-elaborated theories. Rather than taking an external top-down approach, Garfinkel believed that “members of society should not be treated as ‘dopes’ whose task it was to act according to some theories but rather as actually capable of ‘doing social life’, which can be investigated ‘from within actual settings’” (p. 68). Thus, Garfinkel was interested in studying how people analyze, engage, and make sense of their interactions in specific contexts.

Ethnomethodologists also distinguish themselves from other qualitative researchers. Rather than gaining knowledge from participant interviews, they strive “to discover the interpretive practices through which interactants produce, recognize, and interpret their own and others’ actions (Pomerantz, 1988, as cited in Gale, 1991, p. 2). In order to analyze and discover these performative actions, Garfinkel underscored the
importance of researchers fully immersing themselves in the topic of interest, if not physically, then mentally (ten Have, 2012). He emphasized the importance of acquiring “membership knowledge to become what [he] has elsewhere called ‘vulgarly competent’ in the setting” (p. 104). If physical immersion is not possible, then other forms of natural data should be used, which often include video or audio recordings (ten Have, 2012).

Founded by Harvey Sacks and his colleagues, “CA can be seen as a specialized form of EM, originally focusing on verbal interaction and later also considering nonvocal aspects” (ten Have, 2012, p. 103). As Wooffitt (2005) stated, CA “is one of the key methodological approaches to the study of verbal interaction” (p. 1). A basic position of CA, or the study of talk-in-interaction, “is that social actions are meaningful for those who produce them and they have a natural organization that can be discovered and analyzed by close examination” (Psathas, 1995, p. 2). This normally includes social actions involved in everyday interaction, as well as “in the sayings/tellings/doings of members of society” (p. 2). Conversation analysts work under the assumption that the rules and structures (the orderliness) of a group are produced by their interactions.

An early example of the use of CA was conducted by Harvey Sacks during employment at the Suicide Research Center (Psathas, 1995). After examining the audio recordings of several phone calls, he realized “certain recurrent phenomena that appeared in sequences of talk (p. 13). One of the issues at the center was obtaining callers’ names; most individuals were resistant to provide their names when directly asked. Alternatively, when callers were indirectly asked for their names, for example, when employees disclosed their names during the initial introduction, then callers were more than likely to provide their names. With this discovery, Sacks concluded “that what speakers do in their
next turns is related to what prior speakers do in the immediate prior turn” (p. 13). That is, utterances are best understood in the context of what precedes and follows them. Sacks referred to these sequences as pairs and acknowledged them as units, which can be “examined as phenomena in their own right, to see how they were organized and to learn what they accomplished” (p. 14).

Although Sacks identified patterns of interaction, he did not suggest that a specific greeting (e.g., when employees initially disclosed their names) always resulted in a particular response (callers providing their names), nor was he suggesting that these patterns can be generalized across different settings (Wooffitt, 2005). As Wooffitt commented, Sacks was “simply noting that it was possible to analy[ze] how, in this instance, this particular utterance performed this particular activity in this particular slot, or place in the interaction” (p. 6). Thus, the goal with CA is not to achieve “empirical generalizations,” but, rather, to provide “analyses that meet the criteria of ‘unique adequacy’” (Psathas, 1995, p. 50).

Given that the goal is not to produce empirical generalizations (Psathas, 1995), CA is concerned with empirical evidence, meaning it “is strongly data-driven, guided by the phenomenon which appear in the data interaction” (Gale, 1991, p. 21). Bateson and Ruesch (1987) highlighted the need for empirical studies to analyze communication patterns in specific contexts, such as therapy sessions, which coincides with the intention of family process researchers—to study events within their settings (Gale, 1991). With CA, this means that sequences of actions are a major part of what we mean by context, that the meaning of an action is heavily shaped by the sequence of previous actions from
which it emerges, and that social context is a dynamically created thing that is expressed in and through the sequential organization of interaction. (Heritage, 2005, p. 223)

In other words, the back-and-forth interactions between individuals is what shapes, or essentially is, the context, which establishes a foundation for future interactions; this co-constructed production and projection process results in a context-specific structure or organization. Thus, “the emphasis is on working directly with the participants’ language and the participants’ own understanding of their social context” (Gale, 1991, p. 27).

Sacks, Schegloff, and Jefferson (1974) also discovered that the sequences of actions that produce context are context sensitive, meaning the conversations that unfold between individuals are influenced by their settings. The researchers acknowledged that the context had a set of restraints that organized the patterns of interactions. Pomerantz (1978) supported this discovery in her research about the acceptance or rejection of compliments. Although there are various ways of responding to compliments, her research indicated that there are systemic features (or constraints) that seem to structure and limit these responses.

Researchers from this perspective strive to discover the rules and structures that create and establish the orderliness of these discursive practices (Psathas, 1995). It is their task to analyze and provide a description of the natural organization of social actions. Similar to ethnomethodologists, conversation analysts examine these phenomena with a preclusion of theoretical presuppositions: “All such constructive analytic interpretations are set aside, because they interfere with the direct examination of the phenomenon themselves” (p. 47).
Theories that spawn from sociology or other sciences are referred to as “‘practical reasonings’, whose very character might need to be studied rather than accepted as explanatory schemas” (Psathas, 1995, pp. 7-8). With this in mind, conversation analysts approach the data with “an open-mindedness and willingness to be led by the phenomena of study” (p. 2). In other words, the analyst does not have a fixed theoretical agenda; he or she approaches the context of interest with the understanding that the orderliness or organization produced by those involved is subject to discovery, rather than the result of pre-formulated assumptions (Heritage, 1984). Thus, CA is structured “to discover previously unnoticed phenomenon” (ten Have, 2012, p. 107). In relation to therapy, “this would lead to an understanding of how the therapist and the clients, together, create and maintain the institutionalized structure called a ‘therapy session’”(Gale, 1991, p. 27).

In addition to discovering unnoticed phenomena, a goal of CA is “to extend and refine what is known” (ten, Have, 2012, p. 109). As Ten Have argues, this process of evolving what is known is achieved by the analyst’s understanding of the phenomenon of interest. Although conversation analysts approach the data with an open-minded agenda, this does not signify that they must fully discard their theoretical knowledge and wisdom. Conversation analysts utilize their theoretical sophistication in their selection and identification of segments (Gale, 2010). For example, in his analysis of Bill O’Hanlon’s session, Gale (1991) utilized his understanding of solution-oriented therapy to identify key interventions that resulted in therapeutic shifts.

**Conversation Analysis and the Study of Hypnosis**

Although all interactions involve some type of turn-taking structure (Sacks et al., 1974), conversation analysts first have to consider whether their interaction of interest
“involves the use of a special turn-taking organization” (Heritage, 2005, p. 225). These kinds of interactions are different from ordinary conversations, in which little of what we say or do is determined in advance, meaning interactions are unpredictable (Sacks et al., 1974). With special turn-taking organizations, “the topics, contributions, and order of speakership are organized from the outset in an explicit and predictable way” (Heritage, 2005, p. 226). Examples of special turn-taking organizations include classroom and court settings, in which there is an explicit Q-A structure; teachers and judges/lawyers are expected to ask the questions, and students and defendants/witnesses are expected to answer. Given that in a therapeutic setting clinicians are more than likely the ones asking questions, this form of interaction does not constitute a special turn-taking organization: “Interactions organized by this kind of Q-A organization are distinct from those, like many professional-client interactions, in which one party tends to do most of the question asking and the other does most of the answering” (p. 226). Although hypnotherapists do most of the asking (and more than likely most of the talking), they do not sanction or restrain their clients from inquiring or asking questions (Flemons, 2002).

However, hypnotherapeutic conversations can be conceptualized as interactional asymmetries because hypnotists are perceived as “institutional representatives” (professionals such as doctors, teachers, and social workers), who “take and retain the initiatives in these interactions” (Heritage, 2005, p. 236). As Heritage mentioned, ordinary conversations are not bound by “any particular set of social roles, identities, or tasks” (p. 237). In contrast, with hypnosis, therapists are considered agents of change who determine “when a topic is satisfactorily concluded, what the next topic will be, and through the design of their questions, how that new topic will be shaped” (p. 237).
Institutional representatives can often guide conversations in ways that are different from regular interactions.

Because context is understood as “generated within the talk of participants and, indeed, as something created in and through that talk” (Heritage, 2005, p. 283), CA is an appropriate fit for the study of relational hypnosis, which acknowledges communication in the construction of context (Flemons, 2002). As reviewed by Gale (1991), CA, as a discovery-oriented approach, is a methodology that is “sensitive to discern patterns consistent with a systemic epistemology” (p. 3): “It is sensitive to observing events from a cybernetic orientation in that it notes the sequences of talk as they are recursively . . . or reflexively connected within the context of the conversation” (p. 23). Furthermore, CA can assist in the discovering “of patterns of the institutional talk of family therapy” (p. 3), which can offer therapists “new ideas and skills toward the advancement of family therapy as a new paradigm” (p. 3).

In addition, Gale (1996) emphasized that “CA can examine how clinicians actually perform a particular therapeutic model” (p. 120). For example, Gale (1991) analyzed Bill O’Hanlon’s solution-oriented approach during a demonstration session with a couple in their late twenties experiencing marital conflict. Different from most individual therapists (Beck, 1962; Freud, 1920), solution-oriented therapists perceive “language . . . as an interactive, constructive process as opposed to a system that represents what is ‘really’ happening inside the person” (Gale, 1991, p. 34), which is consistent with an ethnomethodological orientation (Potter & Wetherell, 1987). Thus, Gale (1991) used “conversation analysis to investigate the sequential and linguistic features of the therapeutic process” (p. 34). He was interested in discovering how change
was achieved from a solution-oriented perspective—to “describe how patterns of change are constructed in the therapy session” (Gale, 1991, p. 32).

Gale (1991) illuminated and described nine categories of interventions that O’Hanlon used in his pursuit to elicit solution-oriented responses from the couple. The procedures consisted of pursuing a response over many turns; offering clients answers to elicit a particular response; overlapping his talk with the wife’s talk in order to get his turn; reformulating the wife’s associations of the problem to co-construct new meaning; clarifying unclear references; modifying assertions until he elicited the desired response; posing rhetorical questions in which he provided the answer; and strategically using humor to shift the focus of the conversation.

Gale’s (1991) use of conversation analysis allowed him to demonstrate how O’Hanlon’s initiations and responses were connected and influenced by his continuous interactions with the couple. However, because of the nature of hypnosis, the conversations that unfold during trance are different from those of a “conventional” session. Although the hypnotist’s responses (or interventions) are guided and shaped by the client’s communication, often times he or she will offer stories, anecdotes, or metaphors (Flemons, 2002) that may not on the surface appear to be related to immediately prior comments or sequences. Nevertheless, Schenkein (1978) revealed that stories are also sequentially structured and in relation to particular interactions. Through CA, he noted that stories are initiated by what was said in the conversation, even if when they did not seem to be topically coherent. Schenkein discovered that during the introduction of stories, individuals used “disjunct markers,” such as “oh,” “incidentally, or “by the way,” which signaled a departure from the talk in progress. A second example
is the use of “embedded repetitions,” in which some part of the previous talk is presented, for example, the storyteller might say, “in speaking of John,” where John is the repeated element. As Psathas (1995) echoed, “these methods serve to show that the story is not disconnected from the ongoing talk, but is in some ways continuous with it” (p. 22).

In addition to studying the structure of interactional sequences, CA “examines the paralinguistic features of the talk” (Gale, 1991, p. 21); it was developed with the intention “to examine talk-in-interaction at the microscopic level of social interaction” (Gale, 2010, p. 10). Sacks (2000) considered paralinguistic features, such as pauses, inhalations/exhalations, over-lap of talk, etc., as part of the sequence of interaction, as well as influential in the developing talk. As Gale (1996) emphasized, “every action both shapes the context and is constrained by the context. . . . Therefore, all interactional features of the context are relevant to the analyst” (p. 109). An example of this form of analysis was presented in Chapter II, in which Flemons (2002) identified specific details, such as pauses and voice fluctuation, to examine their therapeutic influence.

Rather than approaching the data with theoretical assumptions tailored to explain “why” things happen, conversation analysts are interested in the “what” and “how:” “‘What are the participants doing here?, ‘How’ are they accomplishing that?, and ‘How’ do they display the orderliness of the talk for each other?” (Hutchby & Wooffitt, 2008, p. 133). In order to answer these questions, the researcher directly examines “‘what happened before’ and ‘what follows next’, taking into account the manner in which participants themselves display that they make sense (meaning) of what occurs” (Psathas, 1995, p. 48). These understandings guided me in examining the data to answer my research question, which was to explore and describe how a relational hypnotherapist
facilitates an enduring non-volitional change with a woman with a fear of blood and needles.

An enduring non-volitional change can be conceptualized as what Safran, Greenberg, and Rice (1988) referred to therapeutically as an “ultimate outcome” (p. 5). The authors noted that an ultimate outcome is connected to a chain of suboutcomes that unfold during the process of therapy. Safran et al. understood suboutcomes as shifts in the client’s psychological state that set the context for the therapist’s next interventions. That is, statements made by clients that indicated progress or movement shaped how the therapist responded. Gale (1991) makes the case that these suboutcomes are similar to what Rogers (1942) referred to as “moments of movement,” which can be found through intensive empirical examination. CA, as a discovery-oriented, microanalysis of naturally occurring talk, is useful for identifying these key therapeutic moments, or what the authors referred to as “good and very good moments” (Mahrer et al., 1987, p. 9). Hence, CA presents itself as an appropriate methodology for discovering and describing the process (suboutcomes or key moments) involved in how a relational hypnotherapist accomplishes an enduring non-volitional shift. The identification and description of influential therapeutic communication provided a better understanding of the component patterns that gave rise to the ultimate outcome, an enduring non-volitional shift.

Procedure

Case Selection

Ethnomethodology tends to use two kinds of data-gathering methods, which include intensive ethnography or recordings. With CA, “the use of recordings is absolutely required” (ten Have, 2012, p. 108). As the author emphasized, “it is only
through the observation of the details of interaction that CA can be convincingly done” (p. 108). Although I did not have visual data, I had access to audio recordings of Douglas and Grace’s therapy sessions and their email correspondence, which remains consistent with this method of analysis. The audio recordings and email correspondence consisted of naturally occurring talk in which my role (or presence) as a researcher was absent. It is important to note that Douglas’s email correspondence with Grace was encrypted to protect sensitive information from being read by anyone other than Douglas.

In addition, in order to fully appreciate the special conditions of a therapeutic setting, I included Douglas’s clinical case notes as part of the analysis. Although the case notes are not considered talk-in-interaction, they provided a context for the conversations that unfolded between Douglas and Grace. Adopting a context-enriched conversation analysis (Flemons, personal communication, March 13, 2018) allowed me to thoroughly capture the context of change by examining Douglas’s descriptions of Grace’s trance experience, specifically during the second session. The case notes provided descriptions of Douglas’s clinical expertise (interventions or methods) and of what transpired throughout the course of therapy. As Gale (2010) emphasized, a researcher’s theoretical understanding can be useful in the identification of key moments or sequences. Indeed, Douglas’s case notes and email correspondence with Grace were helpful in recognizing and highlighting Douglas’s interventions that resulted in these “moments of movement” or therapeutic changes. Thus, I examined transcriptions of portions of the therapy and the therapist’s and the client’s descriptions of or thoughts about these conversations.

Douglas Flemons’s case with Grace was selected for multiple reasons. First, Douglas is the founder of relational therapy, which makes him the expert in the
implementation of this form of treatment. He has published several books and articles demonstrating the use and effectiveness of relational hypnosis with a variety of clinical issues (Flemons, 1999; Flemons, 2002; Flemons, 2004; Flemons, 2007; Flemons, 2008).

Second, Grace’s case was selected because of my interest in exploring relational hypnosis in the treatment of phobias. Third, Douglas has audio recordings of the eight sessions that he conducted with Grace, along with case notes and copies of their email correspondence. These recordings, case notes, and email correspondence allowed me to analyze in great detail how Douglas accomplished a variety of therapeutic changes that were steps toward the ultimate outcome of an enduring non-volitional shift in Grace’s relationship with needles, blood, and medical procedures.

Prior to the final selection of the case, I spoke to Douglas about the possibility of examining one of his cases, specifically one about anxiety. In our subsequent discussions, we came to the conclusion that the topic (or understanding) of anxiety is overly broad; I needed to be more specific in my research of interest. Douglas then presented the option of examining a hypnotherapy case with a client who had a fear of blood, needles, and medical procedures. Furthermore, Douglas stated that he had permission from the client to both audio record and to use the recordings, case notes, and email correspondence for research purposes. With this opportunity available to me, I examined this specific case. Prior to listening to the recordings, reading the case notes, and their email correspondence, and transcribing portions of them, I received research approval from Nova Southeastern University’s Institutional Review Board to conduct my analysis.
**Transcription Process**

With conversation analysis, there are foundational elements that the researcher should consider during the transcription process. ten Have (2012) emphasized the importance of the “the analyst first [trying] to understand what the interactants are doing organizationally when they speak as they do” (p. 109). The attempt to understand by repeatedly listening to the recordings is also a crucial element. As Hopper and Koch (1986) suggested, “new insights frequently emerge during multiple listenings” (p. 12).

Given that CA is a discovery-oriented approach, it also takes into account the researcher’s “membership knowledge,” which influences how he or she constructs an understanding of the phenomenon of interest (ten, Have, 2012). In this case, my membership knowledge was conceptualized as my theoretical grasp of hypnotherapy and therapeutic change. As Gale (1991) demonstrated, his theoretical understanding of solution-oriented therapy assisted him in the selection of significant interventions and methods in the session. “The theoretical perspectives presented are to orient the researching therapist’s gaze for analyzing discourse and not as an ideology for adopting any particular theory or model of therapy” (Gale, 2010, p. 13). Thus, I employed a similar strategy, utilizing my knowledge of Ericksonian and Neo-Ericksonian concepts in the identification and transcription process.

Gale (1991) noted that the transcription process “is more than simply putting words down on paper” (p. 34). It is a “constructive and conventional activity [in which] the transcriber is struggling to make clear decisions about what exactly is said, and then to represent those words in a conventional orthographic system” (Potter & Wetherell 1987, as cited in Gale, 1991, p. 35).
In addition to listening to and reading the data, Gale (2010) emphasized that the transcription process “is a significant element of analysis and practice for developing a critical and non-judgmental attitude” (p. 17). The data must be meticulously transcribed with the inclusion “of each word, rhythm, and emphasis, pauses, interruptions, overlaps, repetitions, [and/or] breath intakes/exhales” (p. 17). As Gale further mentions, “repeating this many, many times immerses you in the talk-in-interaction” (p. 17). With my analysis, I repeatedly and carefully listened to the audio recordings using headphones in my private office, where I also read Douglas and Grace’s email correspondence and Douglas’s case notes. I transcribed the sections I considered relevant to my research question on a Microsoft Word document on my password-protected computer.

The recordings were transcribed verbatim using a system of commonly used transcription symbols. Because CA is a detailed-oriented and empirical form of analysis, it is pertinent that the researcher use a common notation system in order to enhance communication among other researchers, rather than create confusion (Psathas, 1995): “Most researchers [settle] on the transcription notations developed originally by Gail Jefferson” (p. 12). Furthermore, I collaborated with my chair in listening to and transcribing the recordings to improve the overall quality of this process.

**Data Selection and Analysis**

Although a myriad of relevant and useful information can be analyzed, my intention was to examine information related to my research question: How does a relational hypnotherapist facilitate an enduring non-volitional change with a woman with a fear of blood, needles, and medical procedures? This inquiry guided my selection of audio segments, case notes, and email correspondence that I considered relevant to my
research interest. As Gale (2010) stated, “while any segment of clinical talk-in-interaction can demonstrate how meaning is constructed, it can be useful to purposefully select a segment” (p. 16). The intentional selection of a section allows the researcher to fully immerse him or herself in the inquiry of interest.

With the selection of audio segments, Gale (2010) recommends including “five or more minutes of talk-in-interaction on either side of the segment” (p. 17). Gale mentioned that it is not uncommon for the phenomenon of interest to have occurred earlier during the conversation than when first acknowledged and “that some sequences extend longer than first realized” (p. 17). Furthermore, analyzing extended segments allows the researcher to “notice patterns that repeat or cover multiple turns” (p. 17), which may shift the way the researcher approaches the rest of the session or lead to an intentional selection of different segments.

The intentional selection of audio, case notes, and email segments (or purposive sampling) were guided by the Ericksonian and Neo-Ericksonian ideas offered in Chapter II. I highlighted segments that demonstrated the interventions Erickson and Neo-Ericksonians are noted for doing (e.g., utilization, use of metaphors, stories, indirect suggestions, etc.). In addition, I looked carefully for potential indicators of successful suboutcomes (mainly described in the emails), which were useful for identifying (backtracking) related and relevant segments. Suboutcomes or indicators of suboutcomes present themselves in the form of non-volitional shifts, which are conceptualized as “thoughts, feelings, and behaviors that are experienced as occurring automatically” (Kirsch, 1999, p. 504). However, the inclusion criteria only served as a guide for my
analysis. I remained receptive to other instances of suboutcomes or moments of movements that were not considered non-volitional but were related to the end result.

The process I undertook in choosing exemplars from the hypnotherapy sessions was guided by the information presented in the emails. Grace described a variety of changes in her email correspondence with Douglas throughout the course of therapy. These descriptions oriented how I approached the data; they influenced my selection of Douglas’s intraventions, which I considered to be connected to Grace’s enduring non-volitional shift. However, during my analysis of the audio segments, I discovered new and relevant information that I had not considered (or noticed) during my analysis of the emails. With this information, I revisited and reexamined the emails, which then revealed further insight. This continuous back and forth (or recursive process) between the email correspondence and the audio segments was an essential component in my analysis. In consultation with my chair, we interactively decided that the foundation for Grace’s therapeutic experiences were paved during the first two sessions, meaning that the most influential intraventions unfolded during their initial conversations. Although other sessions were explored and discussed, my analysis primarily focused on the first two sessions, each of which was approximately two and a half hours long.

Adhering to Gale’s (2010) suggestions, I limited the duration of the audio segments to between 10-15 minutes. I transcribed these segments with as much detail as possible in order to gain insight and to describe the process of facilitating non-volitional shifts. I transcribed these segments using the transcription conventions used by Gale (1991), which is “a slightly modified version of Jefferson’s notation system” (p. 35). Please refer to Appendix A for a description of this convention.
In keeping with recommendations of Gale and Newfield (1992), my first step following the transcription process was “to find patterns of particular features of the talk and then to find deviant examples of those features” (p. 158). The process is referred to as a falsification process, in which there is a “testing [of] descriptions against the details of each new instance” (Hopper, 1988, p. 56). These features were examined using Glaser and Strauss’s (1967) constant comparative method, which involves “simultaneously coding and analyzing the data in order to develop concepts” (Gale & Newfield, 1992, p. 157). The continuous and repeated comparison of the features (specific incidents) resulted in a refinement or rejection of the concepts, as well as assisted in establishing relationships.

Gale and Newfield (1992) propose an analytic induction that adheres to the following steps:

- (a) developing a hypothesis (or category);
- (b) studying the fit of the phenomenon with the hypothesis;
- (c) reformulating the hypothesis if it does not provide a good description;
- (d) looking for negative cases to disprove the hypothesis; and
- (e) when negative cases are found, reformulating the hypothesis or redefining the phenomenon. (p. 157)

Through this form of analysis, I was able to formulate a hypothesis of how a relational hypnotherapist facilitated an enduring non-volitional change. The ultimate hypothesis was the result of an ongoing endeavor, which was constructed and re-constructed through the discovery and comparison of categories in the text. The comparison task consisted of both finding concepts that supported the working hypothesis and searching for examples that disproved it. The results of this effort presented a core group of categories and
subcategories that demonstrated how a relational therapist achieved an enduring non-volitional shift. The concepts discovered were based on direct quotes (exemplars) from the text, which aid the reader in deciding whether my observations/analysis are reliable and valid.

**Quality Control**

Gale (1991) underscored that conversation analysis adheres to scientific validity because “it follows a rigorous procedure of repeated listening to recordings towards developing the transcription of the conversation” (p. 29). This process allows researchers to fully immerse themselves in the data and provide minute details that would be observed in naturally occurring talk—“to describe what is universally the case” (p. 29). Gale (1996) describes this effort as maximizing the integrity of the data, its credibility, applicability, and dependability. In addition, validity is also addressed through the constant comparative method, or falsification process, “by tracking how the participants themselves make sense of their talk and comparing exemplars against other exemplars” (Gale, 1991, p. 30). Reliability and generalization are achieved “through comparing exemplars from one context . . . with exemplars from other conversational contexts” (p. 30). These recommended techniques were implemented during this research study.

Gale (2010) emphasized the importance of the researcher developing a critical and non-judgmental attitude. This means that the researcher should avoid making practical judgments by focusing instead on engaging with the data with a “self-conscious suspension of normative beliefs about ‘therapy’” (Stancombe & White, 1997, p. 26). My role as a researcher was different from that of a therapist, who embraces certain clinical assumptions. Although there is “no neutral or contextually independent position” (Gale,
2010, p. 12), the researcher should strive to curiously approach the data with an open mind. Gale refers to this endeavor as analyzing the data with a “mindfulness indifference” (p. 13), a notion influenced by Garfinkel and Sack’s notion of ethnomethodological indifference.

Conceptualizing CA as a mindfulness practice, Gale (2010) recommends that researchers remain attentive to the emotions that could be evoked by this form of microanalysis—“as any word, utterance, statement or interaction one hears can spark the analyst’s own personal emotional and storied significance” (p. 18). Keeping this in mind, I embraced my meditation and mindfulness understandings during the analysis of the data. This effort consisted of a non-judgmental orientation towards emotions, feelings, thoughts, and/or sensations. Fortunately, during this procedure, I did not encounter a discomforting or hindering emotion, but if I would have, I could have consulted or processed this experience with my dissertation chair, Douglas Flemons, or committee members, who are all trained and seasoned therapists.

Furthermore, Gale (2010) noted that the skills used during daily interactions, whether speaking or listening, are different from those of conversation analysis. As he accentuated, “it is important to critically and non-judgmentally consider how the participants achieve particular meanings and accountabilities of one another’s actions” (p. 13). Thus, all conversations that unfold were mindfully scrutinized: “As the micro-aspects of talk-in-interaction pass so quickly[,] they often go unnoticed and the routine attributing meaning and normative valuing is taken for granted and viewed as an intrinsically natural understanding” (p. 13).
However, this form of rigorous and discovery-oriented analysis does not mean that concepts can be objectively found. As Potter and Wetherell (1987) noted, the examining is done by the researcher, who struggles with the transcription process and with decisions about the selection and linking of incidents. As Edwards (1991) described, it is “not just a way of seeing, but a way of constructing seeing” (p. 523). This implies that the developed concepts (or patterns) were constructs that I perceived to be relevant and related to the ultimate outcome. In addition to approaching the data with a mindfulness indifference (Gale, 2010), I consulted with my chair to discuss my observations and interpretations. Gale suggested that “when analyzing one’s own work that the analyst work with a team to refine the analysis through the support of multiple perspectives, critiques[,] and conversations” (p. 16).

One benefit of conversation analysis is that the data are available for the readers to make their own decisions—to make their own sense of what unfolded. Acknowledged by Gale (1991), “exemplars of the transcript are also provided in the research report so that the reader can assess the data and conclusions for him/herself” (p. 30). The researcher also has the option of replicating or repudiating “the findings through seeking different exemplars” (p. 30). However, Douglas’s work with Grace consisted of eight sessions rich with confidential information that is strictly limited by the IRB to the research team. Thus, for confidentiality, ethical, and legal purposes, a copy of the transcripts is not included in an appendix.

**Dual Relationship**

It is important to note that I analyzed Douglas Flemons’s therapeutic work. As both the therapist, whose work is being researched, and my dissertation chair, Douglas
acknowledged his role as a researcher, whose primary purpose was to guide and not dictate my analysis. Thus, Douglas provided me the freedom to explore and analyze the segments in his recordings that I considered useful. He allowed me to determine the interventions I considered to have been most effective with his work with the couple. Additionally, Shelley Green, who is both a committee member and married to Douglas, provided me with the same support and range of freedom.

There were no concerns or repercussions for my research decisions; thus, I did not have to seek outside consultation from my third committee member.

**Confidentiality and Protection of Data**

Adhering to Nova’s Institutional Review Board’s (IRB) research policies and procedures, I undertook the following steps: I confirmed with Douglas that both Grace and her husband have signed a consent form acknowledging the release of audio segments, case notes, and their email correspondence for research purposes. Douglas transferred the consent form from his private, password-protected computer to my password-protected computer. Upon receipt, I submitted a research protocol with the inclusion of the clients’ signed consent form to the IRB for approval. Once the research project was approved, Douglas transferred the audio recordings, saved as MP3 files, as well as his email correspondence with Grace (saved in a Microsoft Word file) and his case notes (scanned and saved as a PDF file), to my password-protected computer. I read the emails and Douglas’s case notes, and listened to the recordings using headphones, in my private office, where I also conducted the entire transcription process. Douglas and I were the only ones who had access to the data.
Summary

In this chapter, I revisited the research question and described the necessary conditions for the use of a qualitative inquiry. I provided a detailed explanation of the objectives and requisites of process-research, specifically conversation analysis (CA). I then provided a brief history of CA and examined its use with hypnotherapy. I concluded the chapter with an explanation of the criteria and processes involved in data selection and analyses, as well as my proposed procedures for ensuring quality control and human-subjects safeguards.
CHAPTER IV: FINDINGS

Upon completing the data analysis process, I categorized this chapter into two sections to illuminate how Douglas facilitated an enduring non-volitional response with his client, Grace, who suffered from a fear of blood, needles, and medical procedures. Although the total course of therapy consisted of eight sessions, between one to three hours each, my primary focus was on the first two sessions. After listening to all of the audio recordings and reading the emails, I arrived at the conclusion that the most influential and significant moments occurred during the first two sessions. I discovered that Grace’s significant changes—described in her ongoing email correspondence with Douglas, as well as what she said in the final session and in a follow-up email, after the birth of her son—reflected, or were interconnected with, Douglas’s initial interventions.

This study consisted of a two-fold analysis. The first section of this chapter encompasses an exploration of relevant contextual information about the researcher and the case. This includes information about the researcher’s theoretical knowledge and understanding, which entails a distillation of key principles associated with relational hypnotherapy. It also focuses on the descriptions of Grace’s problems, and the significant changes described in the emails and the last session. In the second half of the first section, I explore the shifts in Grace and Leo’s descriptions of their experiences, both during the first two sessions and in subsequent emails. I conclude the section by suggesting ways to account for the significant changes previously examined.

In the second section, I describe the process by which Douglas facilitated an enduring non-volitional shift in Grace’s experience. This includes descriptions of his interweaving of outside information in the development and enhancement of trance and
the therapeutic process. It also includes illuminations of how he identified and utilized Grace’s resourceful identities and skills, including an exploration of her symptomatic identities (and associated symptoms), and the discovery of the resourcefulness of these identities and symptoms. The last part of this section investigates how Douglas implemented his interventions. In other words, it demonstrates the variety of ways he was able to communicate his therapeutic intentions in order to encourage Grace to engage in, and experiment with, new behaviors. All of my claims in both sections are supported by direct quotes from the sessions or the email correspondence. All quotes are accompanied by citations from my transcription of the recordings of the sessions. For example, a quote extracted from the beginning of the first session is cited as follows: “(1, p. 3).” This refers to page three of the transcription of the first session.

**Contextual Information for Process Analysis**

**Theoretical Background**

Having studied and practiced relational hypnosis, I used my knowledge of its underlying key principles and techniques as a guide in accentuating certain facets of Douglas’s communication that I believe prompted Grace’s changes. As noted in Chapter II, relational therapists are influenced “by the hypnotherapeutic innovations of Milton H. Erickson (Flemons, 2002, p. xiii), found, for example, in Erickson’s (1959) “Techniques of Utilization” (p. 272), in which he explains that the therapist endeavors to accept, cooperate, and utilize his clients’ idiosyncrasies and personalities in the structuring and implementing of interventions.

Relational therapists are also oriented by Erickson’s understanding of the role of the unconscious in the resolution of problems. Erickson (1987) believed that the
unconscious mind has a wealth of knowledge, and that therapy, specifically hypnosis, should embrace, and be structured to elicit, these unconscious resources. A second noteworthy technique was Erickson’s use of indirect suggestions (Erickson, 1980a). Erickson believed that direct suggestions or instructions limited unconscious processes; they run the risk of being consciously challenged and scrutinized by clients. Thus, he often structured his interventions in the form of stories, anecdotes, and metaphors designed to bypass conscious criticism and evoke unconscious processes or the clients’ experiential learnings.

In addition to Ericksonian techniques, relational hypnotherapy encompasses Bateson’s (2000) ideas about difference, information, pattern, communication, the mind/body connection, and context. Although I have discussed these ideas in Chapter II, I revisit those I found useful in my analysis. The first idea I want to discuss is Bateson’s understanding of abstract concepts, including emotions, such as fear, love, and/or hate. He described the naming of these “things” as an error in logical types. In other words, with the example of fear, the physical responses associated with a fear or a phobia (i.e., increased heart rate, sweaty palms, and shortness of breath) reside at a different logical type. Fear is at a higher level of abstraction than its members; thus, it cannot be equated with the physical responses that comprise it.

A second important idea was Bateson’s (2000) description of communication, pattern, and context. Bateson inferred that “all actions are parts of organized interaction” (Keeney, 1983, p. 39). Bateson (2000) acknowledged these actions as communication, in which the responses (whether verbal or non-verbal) of one person influence the other, which then guide the first individual’s response, and so forth. Bateson (1979) described
this process as a communication or feedback loop. A potential way for someone, say a therapist or researcher, to recognize the systemic nature of these interactions is by adhering to Bateson’s (1979) both/and logic, or as he referred to it, “double description” (p. 69). As Keeney (1983) explained, it is a way of achieving a “higher order view through an epistemology in which bits of simple action and interaction are connected to more encompassing patterns” (p. 154). This epistemology provides the researcher or therapist a pair of lenses that allows him or her to see the interconnections between simple actions (communication) and larger, more encompassing patterns.

Relational therapists are also influenced by Bateson’s understanding of the intellect and emotions, in other words, the mind/body connection. Bateson (2000) argued that emotions should be acknowledged and valued, not discredited. Emotions are central to all humans, as they are our bodies’ way of thinking and communicating in relationship to others and/or about our circumstances. Bateson believed that therapeutic interventions, such as those put forward by therapists informed by CBT and Natural Systems Theory, that attempt to separate intellect from emotions are disastrous, causing more harm than good.

Like Bateson, Flemons’s (2002) acknowledgement of the ineffectiveness (or harm) of taking an either/or orientation to thoughts, emotions, and/or experiences was a noteworthy relational assumption that guided my analysis. This orientation creates a hierarchy and fundamental separation between the Observing-I (the presumed source of awareness) and what it experiences, whether from inside (e.g., a thought, emotion, or sensation) or outside (e.g., communication from another person, such as a spouse or relative). Rather than further entrenching a dichotomous epistemology that suggests it is
possible to effectively *counter* troubling experiences, relational therapists strive to assist their clients to *encounter* their problems. They invite clients to *connect* with their problems with a different orientation, perhaps with a sense of casualness, curiosity, and/or humor. This form of connection to, or relationship with, the problem, allows clients to comfortably engage and potentially discover an effortless and “relaxed letting go” (p. 30).

The therapeutic goal of *encountering* uncomfortable experiences is routinely employed in relational hypnosis. Relational hypnotherapists conceptualize trance as a temporary dissolution of the boundary that divides the Observing-I from the rest of self (Flemons, 2004). Flemons (2016) compares it to the flow-state phenomenon associated with meditation, writing poetry, playing sports, or listening to music, in which one is immersed in, or absorbed by, the experience. He also perceives hypnosis as the “creation and maintenance of a special relationship” (p. xvi), an empathic connection that begins with the therapeutic relationship itself. This serves as a foundation for establishing a mind/body connection for the clients, characterized by a dissolution of the boundary between their Observing-I and their experience, including the elements of their problem.

**Problem Descriptions**

Grace and Leo were a white middle-class couple in their early thirties. Grace was a math teacher and Leo was an architect. They had been married for a couple of months but had been together for several years. They sought Douglas’s hypnotherapeutic services in the hopes that Douglas could treat Grace’s fear of blood, needles, and medical procedures, including contact with doctors and/or hospitals. Grace had a tendency to faint at the sight of these stimuli, whether through direct or indirect exposure, for example,
when she would see depictions on television or other digital media outlets (Facebook, etc.), or during conversations with Leo, her colleagues at work, or family members.

Friends and family had consistently encouraged Grace to overcome her fears. Grace had managed her fears primarily through strategies of avoidance, trying to ensure she would not see images or hear topics that made her afraid. For example, she had neglected for several years to stay current on recommended inoculations. However, Grace and Leo had concluded that Grace needed to overcome her fears if they were going to start a family. Thus, it was the prospect of potential childbirth that was the driving factor in their decision to see Douglas. The couple arranged to meet with him in March of 2014, flying in for their first two sessions, which were held on consecutive days. Douglas included both Grace and Leo in the first session, and saw only Grace in the second. Each appointment lasted approximately two and a half hours.

**First session.** During the first session, Leo described one specific incident in which Grace “kept focusing on” and “thinking about” (1, p. 6) a particular topic of conversation. She “got herself going and worked up and more worked up” (1, p. 6), to the point that she fainted. He mentioned that he tried to “get her to think about something else” (1, p. 6) but his efforts were ineffective.

The topic of over-focusing also surfaced in other circumstances, and Leo perceived the behavior to be problematic. He mentioned that Grace had difficulties with answering her phone—she did not like to answer calls in the presence of others. Grace confirmed Leo’s understanding and mentioned that she preferred to respond via texts because this form of communication gave her sufficient time to “think about what she was going to say,” providing her enough time to “have a game plan” (1, p. 28). The
problem with phone calls was that she would get “too focused on them hearing me and think about my responses” (1, p. 28). Grace also mentioned that phone calls made her feel “anxy,” meaning she experienced a “faster heart rate” (1, p. 25).

Grace informed Douglas that a psychiatrist had diagnosed her inability to pick up the phone as “social anxiety” (1, p. 40). and presumed that it was connected to her phobia of blood and needles. She also said that the psychiatrist understood her social anxiety and fainting incidents to be some kind of “mood disorder” (1, p. 39).

Grace’s preference to “have a game plan” (1, p. 28) or to spend hours on a particular task was also something Leo had trouble understanding. He could not fathom why Grace would spend so much time on her lesson plans. She would spend, he said, “three hours” on “notes” and would only have “like a sentence [completed], and you’re like, ‘!my paper would be done by now. And I wouldn’t care half as much’. She tries hard” (1, p. 29). Leo, trying to be helpful, would tell her, “Don’t spend so much time; you’re way too prepared” (1, p. 32).

Grace’s eating pattern was also a slight concern for Leo, although he mentioned that she was “kinda adapting” (1, p. 51). He said that at first, “she only liked a particular” restaurant, and she “didn’t eat any meat” (1, p. 51). With time and encouragement, Grace was “starting to eat white meat, like turkey and chicken. No red meat, but, but she open[ed] up new horizons for us to cook” (1, p. 51). Grace mentioned that she had been a “vegetarian for 15 years” and would only eat at “one or two restaurants,” which made Leo “really upset” (1, p. 51). She modified her diet once she realized that he “was right” (1, p. 51) about her strict eating patterns. Regarding certain restaurants, Grace mentioned
that she tried not “to think about it” but tried to go “when he suggests going somewhere else,” although “sometimes I’ll be like, ‘No, I don’t want to go there’” (1, p. 51).

Grace was exploring new restaurants, but she had difficulties consuming particular foods, such as “white flour,” because she was “obsessed” with her “body image” (1, p. 54). She would “look at [herself] in the mirror all the time” (1, p. 56) thinking that she was overweight. Although Grace stated that this “obsession” was a daily struggle and that she “would like to be normal,” she said, “if I eat what I think is okay, I’ll feel fine that day” (1, p. 56). Her difficulties were with Leo’s insistence that she eat foods made with white flour: “He’s, like, ‘No, come on, have, like, the white flour. I’m like, ‘I don’t want the white flour. . . . Like, white flour is bad’ or whatever. So I feel like, if I put that in my body that I just destroyed myself” (1, p. 56).

The last problem description in the first session focused on Leo’s perception of Grace’s relationship with pain and fainting: “Well, you got the social thing with anxiety and the doctors. I guess, you know, it’s the pain too. I just want to let you know [said to Douglas], it’s not just, like, uh, phobia of needles. It’s a little of, it’s pain, too” (1, p. 53). In addition to Grace’s diagnosis of social anxiety and a needle phobia, she suffered, Leo believed, from a fear of pain. He provided an example. Grace once “hit her funny bone” on the trunk of her car and “she kept focusing on it and thinking about it” until she “ended up passing out” (1, p. 53). Leo concluded, “that’s the only thing I would just add to [the description] is the, um, there is the doctors and stuff, but it’s the pain too” (1, p. 53).

**Second session.** Although Grace provided some insight regarding her uncomfortable experiences in the first session, she elaborated on them in the second. She
described her initial experience of “passing out” (2, p. 2) in a doctor’s office during a medical procedure. She had been 15 or 16 and had broken a toe. A trip to the doctor was necessary. During the examination, he “moved the toe around” (2, p. 1) while asking pain-related questions. Grace said that the pain was unbearable, and she eventually “passed out” (2, p. 2). She continued to pass out during subsequent checkup visits to the doctor. Her mother assumed something was wrong with her and had her get blood work done. Although Grace wore headphones to deal with the situation, the procedure was “really uncomfortable” (2, p. 2). The headphones were no longer helpful after a couple of visits, and, thus, her fainting experience became progressively worse. Grace stated that she was required to consistently get shots for her job, and it resulted in her “passing out once every three rounds,” which subsequently “got worse and worse” (2, p. 2).

Grace went on to explain how her situation had evolved. She described an incident in which her sister was getting a medical procedure and her “dad started to talk about it at home” (2, p. 2). This conversation resulted in Grace fainting and being transported to the hospital. More recently, she had fainted outside of a relative’s house after observing her cousin’s scar, who had recently been discharged from the hospital. Grace said her family “find it hard to understand” (2, p. 2) her situation; they constantly question her. After a couple more fainting incidents, they decided to avoid talking about medical procedures when she was present, ultimately withholding information related to important family health issues.

**Emails.** Although most of Grace’s emails to Douglas, dating from April of 2014 to August of 2017, primarily focus on positive changes, there was one in which she mentioned some problematic incidents that occurred after she began seeing him. In
February of 2016, Grace emailed Douglas to inform him of “multiple setbacks,” disclosing two incidents that resulted in her “passing out.” One occurred while driving back from vacation, during which Leo received “medical news.” Grace “felt trapped in the vehicle and the surprise of the news led [her] to pass out.” The other was triggered by Leo’s suggestion that Grace needed “stitches” for an “intense cut” on her finger that was caused by “shattered glass.” Although she “thought [she] was fine,” Leo’s mention of stitches evoked her fainting response.

Grace went on to describe further setbacks:

I am finding that since the last two rounds of syncope, . . . I am afraid to watch movies and I am afraid to hear or see anything medical. For instance[.] I panicked recently when Leo called to tell me that he had pneumonia.

Grace said, “I was able to pull myself through” certain incidents, but she felt “that the fear [was] taking over.” Things appeared to her to be getting worse, not better: “I feel as if anything can set me off now, whereas in the past[,] my episodes were mainly due to shots.”

Resolution Descriptions

Emails. In this section, I discuss experiences that Grace described as successes. These include mentions she made of non-volitional changes (or surprises), of changes recognized by herself and others, and/or of changes she specifically attributed to the hypnotherapy or to Douglas’s efforts.

Grace sent Douglas a follow-up email two weeks after the initial sessions. She said she had noticed that she was “more welcoming to the discussion of hospital situations and the observance of needles (on television).” In addition, she mentioned that
during a discussion with her colleagues about surgery, “everyone looked at me, aware of my phobia, to see a reaction.” However, “they observed that my face turned red rather than the usual white,” which Grace found to be “a neat experience.” She “was able to laugh it off and feel fine.” Grace concluded the email by attributing her changes to Douglas’s involvement: “The fact that I’m not instantly freaking out when surgeries get brought up or IVs appear on TV, I know that your work helped.”

Grace then emailed Douglas in August of 2014 to describe further changes in her experience. During her “yearly female physical,” Grace’s doctor “brought to my attention that my tetanus shot was four years overdue—all four years I would refuse the treatment, always with an excuse of fear of passing out.” Although she initially “began to back out of the shot,” she then “had the sudden urge to tackle this challenge and put our work to the test!” She mentioned that she was “excited, eager, and somewhat fearful all at once.” However, she did not “want to leave the doctor’s backing out of the shot.” She wanted to “surprise Leo and [her] family with her bravery.”

Grace elaborated: “Another phenomenon took place” during the “shot administration.” She “felt most comfortable sitting up for the shot” and “afterwards . . . felt fine and accomplished!” She “was so excited to share the unexpected news that [she] skipped out of the office forgetting to check out :).” She continued: “I later on began to have thoughts as to if I felt this proud after a tetanus shot, imagine the joy that I would bring to myself when it comes time to have blood work done.” Grace concluded the email by saying that “this was a huge deal for me and my family. My mother-in-law even cried.”
In October of 2014, Grace scheduled to meet with Douglas for two hypnotherapy sessions. Approximately three weeks after, Grace emailed Douglas, notifying him that “I had my lab work this AM and I DID NOT pass out :).” The afternoon before the procedure, Grace “experienced a lot of anxiety.” However, after lunch, she “noticed a switch,” in which she felt “eager” and “excited” to complete the process. She also mentioned that in “preparation,” she ate “extra veggies” during the week, prior to the procedure. Grace said that she “absolutely loved the person who drew the blood[.] She is perfect for me.” Overall, Grace classified the experience as being “so positive.”

Describing other interesting moments, Grace disclosed that she “dreamt of a picture that I was using in our session,” a picture of her one year-old niece. In the dream, she accompanied the image with a song, which she used to get through the appointment. The morning before the appointment she “woke up in a sweat” after having dreamt of an unknown man standing over her saying, “it was all learned,” which she understood as “interesting stuff.” Grace concluded the email by saying that she and her family “are all so happy and each one wants to thank you tremendously.” She said she leaves the hypnotherapy sessions “feeling inspired and willing to take on my biggest fear. I know that I have all of our work to thank for all of this.”

Grace met with Douglas in April of 2016 for two sessions. In August of 2016, Grace emailed Douglas to update him on her progress and recent health-related events. The “first notable change was my refocus from the thoughts ‘I’m going to pass out’ or ‘this will make me pass out.’” Instead, “I find myself to be more inquisitive within conversations and sometimes find myself engaged by things happening on television.”
Grace said that she had had two “blood-draw” appointments since they last met. The first was one of the “quickest blood draws to date,” and she had walked “away within minutes.” She discovered that “thoughts of passing out” were not in the “foreground”; instead, she was able to “focus on small items or noises in the room.” She stated that Leo and her mother were in “shock” and “amazed by what they witnessed during these past couple of weeks.”

In February of 2017, Grace emailed Douglas to inform him that she was five months pregnant and that she wanted to meet with him to prepare for childbirth. Grace met with Douglas for their final two sessions in April, 2017. Three days after the second meeting, Douglas emailed Grace an MP3 recording of their final hypnotherapy session as a preparation resource for childbirth or other medical procedures.

In July of 2017, Douglas emailed Grace inquiring about her preparations for birth. Grace responded a couple of days after, informing Douglas of the events that had transpired since they last met. She mentioned that she had a “small scare” at week 26 of the pregnancy, in which she was “put on modified best rest” that required her getting two shots. However, she stated that “shots are no longer an issue for me really.”

In addition, Grace mentioned that she was more than likely going to have a C-Section, which was giving her “anxiety.” She “tried self hypnosis during some peak episodes” and “during some more relaxing periods.” Although anxious, she did not experience “breathing difficulties,” nor did she faint. As Grace underscored, she had “not passed out once this pregnancy[,] which is a huge accomplishment for me.” Leo also recognized her improvement, saying she was doing “tremendously better with conversations and watching tv with any gore.”
Grace concluded the email by expressing her thoughts about the C-section process. She stated that in the past, her preference would have been “to be 100% knocked out during the procedure.” But now, she wanted “to meet our son when everyone else does.” Although not absolutely sure, Grace wanted to take her time to prepare but noted that she was proud of her ability to consider it, which, as she mentioned, signified “strength.”

Douglas responded to this news, using the word “liberation” in ratifying her progress. A week later, Grace responded, zeroing in on “the mention of my liberation.” She disclosed that she “was able to freely converse with a doctor regarding a C-section, spinals, and IVs.” It was, she said, “indeed liberating to not find my mind trying to escape this conversation :).”

The last email correspondence was in August of 2017, which consisted of Grace contacting Douglas shortly after the childbirth experience. Grace said that she had prepared for the childbirth process by having the MP3 of the hypnotherapy recording “on repeat,” spending most nights listening to it. She also prepared for the C-section by focusing and listening to the recording during her “pre-op blood work, which was 5 vials.” Grace stated that the “blood draw” process was “perfect.” Her exposure to the needle in the morning “made [her] completely comfortable with the IV” in the afternoon.

Grace explained that her “water unexpectedly broke” two days before her C-section appointment. Although she found this “stressful,” she was able to listen to the MP3 of the “last session as much as they allowed” and excitedly claimed she was able to “make it!” Even though the anesthesiologist did not administer any “[anti-]anxiety meds,” she “at one point was calm and assumed it was happy drugs!” that were making
her feel that way. It wasn’t—she was accomplishing it on her own. Grace concluded her final email by saying, “I tackled my biggest fear, thank you so much for freeing my mind! My family is so happy, the best thing I ever did for myself :).”

**Last session.** During her last session with Douglas, in April, 2017, Grace provided further insight regarding some of the positive changes that had unfolded to date. Grace noticed that she has been more “in tune” with visuals that sporadically surface either on “Facebook” or on “TV.” Instead of “staring away from [them],” she said, she “kinda felt, like, I was pulled into it.” (8, p. 1). For instance, she saw “advertising” on Facebook that involved actress and musician “Selena Gomez” and a “couple of cast members” from the Netflix show “13 Reasons Why.” The actress was getting “a tattoo about depression.” The advertisement “actually showed a picture with a needle on her skin,” and Grace was able to “look at that,” rather than responding as she would have in the past, saying “like, ahhh!” Grace perceived this experience as being “kinda neat” (8, p. 1). She was also able to “visualize” her “C-section,” which she perceived as a “troublesome” procedure “as opposed to [a] natural” birth (8, p. 2). Although it was uncomfortable, she was able to imagine herself going through the process.

Something that Grace identified as a “big change” was that she was able to get her “lab work” (8, p. 2) done in a different place by a different person. She mentioned that she used to go to the “same place” and “ask for this girl that I was always doing well with.” Unfortunately, she “stopped working there,” so Grace was told she had “to go to a lab.” Grace “didn’t fight it. I said ‘alright’” (8, p. 2). She was willing to give it a try.

Although she saw the lab as sterile, as “nothing personal at all,” Grace reminded herself, “I can do it,” which she did. She noticed that the needle at the new lab “pricks a
little more” and that is “what usually sends me over” (8, p. 2). Normally when she feels the prick, she said, she will “usually say I want someone who does it better ((laughs))).” However, this time she did not ask for a different phlebotomist, and she was able to “handle” the pricking sensation. Rather than letting the sensation of the “prick . . . linger on and on,” she noted that it lasted “just for a second” and then it was “gone” (8, p. 3).

Grace also described how her family had been responding to how she had changed. They all, including her in-laws, were “excited about it,” perceiving it as a “big deal” (8, p. 3). After completing medical procedures, Grace would “send out texts,” informing everyone of her accomplishments, and they would “celebrate” and send her “gifts” (8, p. 3). Grace’s mother pointed out that she never expected Grace to even talk “about this stuff,” (8, p. 3) let alone engage in these procedures. Grace noted that she and her family “could never have full conversations in the past. . . . They would withhold information from me.” Their efforts were focused on “protecting me by not telling me,” and “now they don’t have to.” Grace’s mother noted that “whatever [Grace] was doing is working” (8, p. 5).

**Subtle Shifts in Grace and Leo’s Language**

In this section, I track the subtle shifts in Grace and Leo’s language, or choice of words, used to describe their experiences and understandings. These shifts, apparent in both the recordings of the first two sessions and in Grace’s subsequent emails, indicate the degree to which the couple were unconsciously responding to and accepting Douglas’s therapeutic framings. As such, they provide tangible, albeit subtle, evidence of a reorientation to the problem, thereby setting the context for Grace’s subsequent changes
in experience. The second half of this chapter focuses on what Douglas was doing to facilitate these shifts and changes.

**First Two Sessions.** The first shift surfaced 15 minutes into the first session. Leo described how he would urge Grace to try hard to think about something different, reasoning that purposefully distracting herself would hopefully prevent her from fainting. In response, Douglas emphasized that such conscious “effort doesn’t help,” that what Grace wanted was to “have something that happens automatically” (1, p. 6).

Grace had previously mentioned that her psychiatrist recommended CBT therapy, but he underscored that this type of therapy “can take a long time” (1, p. 1). Douglas utilized that information to describe the differences between CBT and hypnosis to elaborate his response to Leo’s ineffective efforts. Douglas mentioned that CBT could take a while because it’s a two-fold process; the therapist first has to “get your conscious awareness to change and then convince your unconscious” to change, “and the reason it takes a while is that, that process can be complicated” (1, p. 7). Douglas then described hypnosis as a “way of your unconscious learning something new, easily, comfortably, and then with that new learning, being able to then respond automatically, differently, to whatever it is that you’re” (1, p. 7) afraid of. Leo interrupted, saying, “unconsciously, almost, yeah, right.” (1, p. 7). Leo’s statement indicated that he was receptive, or at least understood, the importance of unconscious learning, rather than challenging Douglas’s explanation of change. Thus, this seemed to be both a shift in Leo’s perception of change and his language used to conceptualize it, which was interconnected to Douglas’s communication.
The second example relates to Grace’s description of how she would solve math problems. Douglas was curious about how she, as a mathematician, approached math problems: How did she “work through a problem?” Did she “have a feel for what the next step would be?” How did she “work it out step-by-step?” “How do you, how do you go into the problem solving mode?” (1, p. 15). Grace answered, “it kinda flows,” (1, p. 15) a description on which she elaborated later in the session: “Like once I got a flow going or whatever I know what I’m doing, and it’s fine” (1, p. 30).

Prior to Grace using the word “flow,” (1, p. 15) Douglas had said it five times in a variety of ways. I present two examples. The first mention of “flow” was in response to Grace’s wondering whether Douglas had worked “with people that pass out from fears” (1, p. 5). Douglas replied that he had not “worked with anybody who fainted” but had “worked with people who have had other automatic blood flow changes that they wanted to change,” for instance, “people who blush when they don’t want to” (1, pp. 5-6). Douglas explained that “some stimulus causes blood flow to rise up into their, uh, often chest and faces. And then they become self-conscious about that and that causes more [blushing]” (1, p. 6).

**Emails.** The third shift in Grace’s description of her experience occurred in an email she sent to Douglas five months after the first two sessions. Grace mentioned that during her “yearly female physical,” she decided to get a long-overdue tetanus shot. Grace noted that she “felt most comfortable sitting up for the shot,” in contrast to her “typical procedure,” which was “to lie down.” This experience is further explored below, in the section regarding associational suggestions.
Throughout the first two sessions, Douglas presented the possibility of Grace feeling “comfortable” during “uncomfortable” (2, p. 11) experiences in a variety of ways. He also presented stories of previous clients discovering “comfort” (1, p. 5) in situations they considered uncomfortable. In the first session, Douglas mentioned “comfortable” or “comfortably” 33 times, and in the second session, 45 times. I highlight five in the first session and five in the second.

The first example occurred a couple of minutes into the first session, with Douglas asking Grace, “So if you found yourself more comfortable around doctors and hospitals and all that kind of stuff, then the prospect of having a child, it would feel different for you” (1, p. 1)?

The second example occurred during a story Douglas told about a previous client who had had a fear of lizards “for years” (1, p. 5). This client’s usual reaction had been to panic at the sight of lizards, but, Douglas told Grace, her experience during hypnosis made it possible for her to feel “comfortable” around them, and “she stayed comfortable” (1, p. 5).

The third example took place in response to Grace talking about her difficulties answering her phone because she felt uncomfortable talking in front of others. Douglas asked, “If you could have it the way you want it? Are you comfortable having the phone where you, it doesn’t ring on you? . . . Or do you want to be able to be comfortable answering it?” (1, p. 26).

At a different point in the first session, Douglas asked Grace, “Have there been experiences where you were in a flow state and you, so you, were feeling very comfortable and in that flow state you encountered some challenging situation and you
found yourself feeling confident in it” (1, p. 40). And at the end of the first session, Grace mentioned that during the trance experience she had just had, she felt “relaxed or couldn’t move or something” (1, p. 70). Douglas responded by asking, “too heavy to move or too comfortable to move” (1, p. 70)?

Douglas continued to accentuate comfort in the second session. For example, he explored the possibility of Grace learning how to “comfortably stay safe, comfortably” (2, p. 11). This was something that she had learned as a teacher, he said, “the importance of (long pause) responding efficiently and early (long pause) to any divergence from what feels comfortable and respectful” (2, p. 11). He also explored with Grace how she could “feel comfortable in the privacy of your own body” (2, p. 12); how she “could always be moving, comfortably moving on the inside”; and how she could always “comfortably wonder what the next [step] will be” (2, p. 15).

The final shift in language I am going to explore relates to Grace’s mention of “bravery” in her August of 2014 email to describe her experience as she got her tetanus shot. Grace said she “did not want to leave the doctor’s office [having backed] out of the shot. I wanted to surprise Leo and my family with my bravery, regardless if I passed out or not.” Grace’s description of her bravery marked a change from her initial descriptions of her sense of self in the first session. Grace had initially referred to herself as someone who gets “anxious” (1, p. 39) or “scared” (1, p. 2) during difficult situations.

Throughout the first two sessions, Douglas underscored Grace’s courage as a teacher, having to deal with inappropriate and misbehaved students. After Grace explained that she had dealt with difficult students for two years, Douglas responded, “That took a lot of courage to be going in everyday to deal with that kind of stuff” (1, p.
38). He went on to emphasize and ask, “Oh, wow, how did you muster the courage to go back everyday?” (1, p. 38). During the latter part of the first session, Douglas revisited Grace’s teaching experience to reemphasize this ability she seemed to be unaware of: “I know that you have incredible courage because ((Grace laughs)) for you to endure a whole year of challenge and abuse and then not only endure but to learn from it” (1, p. 52).

In the second session, Douglas utilized trance to elaborate on Grace’s courage. For instance, he underscored that Grace’s other skills, such as confidence, were “constructed from [her] courage” (2, p. 11). He went on: The “courage you exhibited to demonstrate so many experiences, so many circumstances, quiet courage, subtle courage. The courage to move forward into any old, any old, uncertainty (short pause) with the certainty that you can access your learning modality” (2, p. 11). He shortly after stated that “proceeding with the courage that (short pause) that you could consciously question but unconsciously recognize is an essential part of so many adventures you’ve embarked upon” (2, p. 12).

The last mention of courage was similar to the ones listed above. Douglas accentuated Grace’s additional skills alongside courage. However, in this example, he emphasized that she could use those skills, specifically courage, in other situations: “That in any situation you can articulate any curiosity with the sophistication a woman of your courage; a woman of your intelligence, to bring that courage and confidence and sophistication with you into any old conversation, regardless of who’s there” (2, p. 16).
Inferred Changes that Resulted in Moments of Movements

The purpose of this section is to give the reader a contextual understanding of the changes Douglas facilitated to assist Grace in resolving her fear. As mentioned above, the second half of the chapter examines how he undertook this facilitation—the process involved.

Over the course of the therapy, Grace came to embrace five attributes or abilities that she saw as contributing to her therapeutic changes. The first, mentioned in the emails, was Grace’s “bravery,” which made it possible for her to proactively request a tetanus shot. The second was her commitment to preparation. For example, Grace said that she “prepared” for her first “lab exam” by having “extra veggies” throughout the week. She also “prepared” for the procedure by “making an enjoyable breakfast” and by taking “juice” with her. Most importantly, she prepared for her C-section by listening to the MP3 recording of her last hypnotic conversation with Douglas, both during her “pre-op blood work, which was 5 vials,” and the night before the procedure itself.

Grace’s third notable ability concerned her skill in focusing and shifting her focus. For instance, during conversations about blood, needles, or medical procedures, she was able to “refocus from the thoughts, ‘I’m going to pass out’ or ‘this will make me pass out’, to “find[ing] myself to be more inquisitive within conversations.” In addition, during one of her lab appointments, her “focus[ing] on small items or noises in the room” prevented her “thoughts of passing out” from being in the “foreground” of her experience. In the last hypnotherapy session, Grace told Douglas that she had been visualizing or imagining the birthing process. These experiences helped her to “think
about just being there,” and “focus on whatever” (8, p. 4) was unfolding during the visualization.

The fourth attribute Grace identified was “strength.” She originally thought she would want “to be 100% knocked out during the [C-section].” However, she ended up deciding that she wanted to be conscious so that she could meet her son immediately upon his birth. Grace acknowledged this change of mind as a significant moment that “signified” her “strength.”

The fifth attribute was Grace’s developed ability to, as Douglas put it, “call the shots,” (3, p. 5) that is, to choose or make her own decisions regarding her medical appointments and other health-related choices. In several instances, Grace showcased a sense of autonomy or independence that helped her achieve her therapeutic goals.

Douglas introduced the punning phrase “calling the shots” in the third session to underscore that Grace could take matters into her own hands. In the October 2014 email, Grace described the lab appointment and said that Douglas would be “glad to hear that I did call the shots!” She drove herself to the lab; didn’t take “drugs” before the procedure; and chose “to have music accompany” her. She also told a “newcomer” who came into the lab to assist the technician “to leave.” Although Grace later felt bad about this, she said, “I coached myself to get over this because this was my day.”

Another description of Grace “calling the shots” can be found in the August 2016 email. She said, “the most astounding step in my progression followed th[e blood] draw.” Her OBGYN considered her fasting glucose at 106mg/dl to be concerning, a possible indicator of diabetes. As “a runner and clean eater,” Grace believed that her sugar levels were fine and tried to explain to her doctor that the influx of glucose was the result of her
“phobia and adrenaline.” Regardless, the doctor wanted Grace to take a “3-hour glucose test to rule out diabetes,” which included an “infamous orange drink.” Strongly opposed to this artificial and unhealthy concoction, Grace “preferred to take matters in [her] own hands” and ordered a “glucometer,” which required daily needle sticks for at least two weeks. She “poked [herself] over 15 times” to make sure that she did not have diabetes. She described the procedure as being “so much fun” that she even “tested Leo as well.” Grace was excited to show her doctors the accurate glucose levels to “prove” she “was right.” Unfortunately, she was not. In the July, 2017 email, Grace said that she had been diagnosed with gestational diabetes after all, which required her to track her blood sugar at home. As part of the monitoring process, Grace once again chose and “embraced” self-injections, rather than taking a daily pill as a form of therapy for her diabetes.

These instances of Grace “calling the shots” suggest a shift in identity, from a person afraid of shots to a person comfortable with receiving, and even self-administering, shots.

**Context-Informed Process Analysis**

This section explores what Douglas did to facilitate the shifts in Grace’s experiences in the first two sessions. All of Douglas’s interventions can be understood as an application of the principle of utilization, so this analysis can be understood as an explication of this implementation. Flemons (in press) defined utilization as being predicated on the relational idea that problems are best dealt with by encounter[ing] them—by approaching and engaging them. Typically, clients, and those who fail to help them, attempt to solve problems via negation, . . . substitution, . . . or symmetrical battle. . . . In contrast, utilization-informed
therapists invite therapeutic change via acceptance, . . . inclusion, . . . and complementary (circular) engagement.

Douglas’s implementation of utilization consisted of two components: 1) the identification of resourceful information and experiences, and 2) the inclusion (or interweaving) of this information throughout the course of therapy.

The first example of utilization I focus on is Douglas’s identification and inclusion or interweaving of outside information, such as sounds, voices, and/or noises, in the development and enhancement of trance and, more importantly, the recognition and application of Grace’s resourceful skills during uncomfortable moments. Grace mentioned that she endeavored at all costs to avoid “distractions” while preparing for lesson plans or answering phone calls. She “tried to eliminate” them by isolating herself in her room or “like an office,” if in a work setting (1, p. 27).

**Utilization of Outside Information**

In the second session, Douglas invited Grace into trance approximately 25 minutes into the session. During its development, Douglas incorporated an outside sound to both enhance the trance process and to accentuate Grace’s unconscious wisdom.

Douglas: Because your unconscious mind is very wise. :It’s really a matter of :accessing it. (Long pause) And so you create, !that’s right, .the position, the situation, the opportunity to be able to begin to drift (short pause) .down. ((loud truck driving by)) ?And that anything that is occurring on the outside, whatever is going by, can !just go on its way. (short pause) You can devote a breath (short pause) to anything that (short pause) ?interrupts the flow, to acknowledging that it’s there. (short pause) (2, p. 8)
Midway through Douglas’s assertion of Grace’s unconscious ability, a loud truck drove by. What potentially could have been a distraction, Douglas utilized to underscore that Grace could simply acknowledge and “devote a breath (short pause) to anything that (short pause) ?interrupts the flow” (2, p. 8). Douglas also emphasized the word “flow” to highlight this skill as well.

Approximately an hour and twenty minutes into the second session, Douglas underscored Grace’s courage as a teacher. In the process, inaudible chatter sporadically surfaced outside of Douglas’s office.

Douglas: Proceeding with the courage that (short pause) you could ?consciously question but unconsciously recognize is an essential part of so many adventures you’ve embarked upon. And you continue to offer yourself opportunities to explore. (long pause) And to find your balance, ((outside chatter)) regardless of what’s going on, on the outside. You know how to move ?inside to regroup (long pause). !Why not discover that you can both be inside and outside simultaneously (long pause). (2, p.12)

In this example, Douglas utilized the “outside chatter” to communicate to Grace that she can “find her balance” or can “move to the inside to regroup,” regardless “of what’s going on, on the outside.” Grace could “discover that [she] can both be inside and outside.” Douglas’s case note of the second session indicated that she “kept her eyes open throughout the whole trance. She never closed her eyes longer than a few seconds.” However, “she seldom blinked, and her pupils became dilated,” indicating a trance state. Thus, Douglas’s mention of the outside chatter in relation to Grace’s ability to “both be inside and outside simultaneously” coincided with her trance experience.
The last example of incorporating outside information surfaced approximately two hours into the second session, in the midst of Douglas’s suggestion for Grace to “have another medical encounter, physician assistant, or a doctor, or a nurse, all three” (2, 15). Previously, Douglas explored Grace’s initial steps as a toddler. He mentioned that Grace “learned by the third or the fourth step how to recognize the beginning of the movement from doing balance to being unbalanced, and how to accommodate that movement in such a way to maintain your balance” (2, pp. 11-12). Douglas encouraged Grace to use her past experiences (skills) as a child to encounter future medical procedures. He utilized outside voices to enhance this experience.

Douglas: How you found to maintain your balance by moving forward and move forward? All the way to the future with your unconscious mind. (short pause) You could see; you could smell. ((chatter in the background)) You could hear all the signals that suggest needles and blood and (procedures). (2, p. 15)

While Douglas highlighted that Grace could move forward with the balance into the future, outside voices surfaced. Douglas interwove and associated this information with “signals that suggests needles and blood and (procedures)” that Grace could “hear” during upcoming medical visits.

**Identifying Resourceful Identities and Associated Skills/Attributes**

In this section, I discuss how Douglas identified resourceful identities, each with associated skills and attributes that could be useful in the resolution of Grace’s problems. It is important to note that there is some overlap between some of Grace’s resourceful identities and their skills and attributes. For example, Grace’s experience as a teacher and
as a mathematician are closely linked. However, there are certain attributes that Douglas emphasized that are unique to each identity.

**Mathematician.** Grace first mentioned that she was a “teacher” approximately 27 minutes into the first session; Douglas’s followed up with a question about her specialty: “What were you trained to teach?” Grace responded, “Math” (1, p. 13). Douglas wondered whether she had “always been good at math” and had “always enjoyed it.” Grace responded “Yeah” (1, p. 14) to both questions. She mentioned that she “remember[ed] being good at it” in “high school,” so she decided to pursue a degree in “engineering,” but she realized that she did not like the field, “just the math.” She “like[d] high school” math and liked solving “proofs,” despite not being as “good as many math people” at “computations.” Still, she “liked learning it,” or, as Douglas described it, “figuring it out” (1, pp. 14-15).

Douglas established that Grace’s “figuring out” or “problem solving” (1, p. 15) abilities were simply associated with her identity as a mathematician. In the following segment, which occurred 29 minutes into the first session, he enhanced or vivified the fact of these abilities by exploring the details of her computation (problem-solving) process.

Douglas: ?So how do you, how do you do your, when you’re figuring it out, uh=

Grace: ?What’s the computation?

Douglas: Proofs.

Grace: Or a ?proof?

Douglas: ?Either. What’s your process?
Grace: Um, I’m trying to think. I don’t know really. It’s, a lot of it’s just out of a book and spells it out for you. So I’ll just go through it quick, once, and then I just try to do it on my own. (1, p. 15)

Douglas responded with an interpretation of, and further questions about, Grace’s ability to derive a principle for problem solving from one situation and apply it to another.

Douglas: So you learned, the, the logic of it over here.

Grace: Uh-huh.

Douglas: And then you can take that and apply it to whatever problem [Grace: Yeah, then I’ll apply to other ones] to other problems. When you’re working through a problem, do you see the next step? Do you just have a feel for what the next step would be? Do you work it out step by step? Like, how do you, how do you go into problem-solving mode? (1, p. 15)

Grace confirms Douglas’s underscoring that she had “learned” how to “take” the “logic” of solving a problem from one area and apply it in addressing “other problems.” They are ostensibly talking about math, but the generality of the descriptors makes them much more broadly applicable. Going into “problem-solving mode” is an unconscious skill that could be employed in dealing with problems having nothing to do with math.

Shortly after, Douglas accentuated Grace’s problem-solving ability by presenting a story about his daughter and math experience.

Douglas: I know that from watching my daughter do her problems, of course there’s a whole bunch of them she does. She’s, she’s taking a particular, um, area and trying to apply it. And each of the problems come[s] at [it in] a little bit different way, so that she’s taking this, this idea, taking this principle, and being
able to, regardless of the unique particularities of the problem, she’s able to apply the same principle. (1, p. 16)

Through a story about his daughter, Douglas was able to indirectly underscore how Grace’s ability to learn a principle in one area could be useful in a variety of others, “regardless of the unique particularities of the problem” (1, p. 16).

A second skill or attribute Douglas associated with Grace’s being a mathematician was her ability to access a flow state. When Douglas inquired about Grace’s “problem-solving mode,” she responded, “It kinda !flows” (1, p. 15). As she mentioned, math problems “can be repetitive” and because she has “seen so many,” she “just know[s] how to do it” (1, p. 15). Later in the session, Douglas underscored Grace’s experience of flow with information about a book describing the concept. This helped him demystify the experience of hypnosis by connecting it to what she already knew from doing math.

Douglas: Did you ever read the book, Flow?
Grace: No.

Douglas: It’s [by] a guy, a psychologist by the name of ?Csikszentmihalyi, and he’s written a couple of books on flow. And, uh, ?there’s a lot of similarities between hypnosis and flow ’cuz you’re ?absorbed in something that, in that, if you’re in ?absorbed in a very useful way, it !feels good. So you can get, you can get absorbed and get into a ?flow state while you’re doing math. (1, p. 30)

Early in the session, Grace stated that she was “really scared” (1, p. 2) of the trance process. Douglas embraced Grace’s experience with math and flow to shift her perception of hypnosis by underscoring the similarities. First, he used the book, which he
underscored was written by a psychologist, to associate the experience of hypnosis with flow. Then, he indicated that Grace could enjoy the experience and usefulness of hypnosis in the same way she would experience flow while doing math.

Douglas continued to highlight Grace’s ability to experience flow by providing the difficulties his daughter experienced while doing math problems.

Douglas: ?Well, as I was saying, what, what my daughter finds math to be, it shakes her .confidence. ?But you, which is certainly not common among women, you are comfortable with math. ?So, and you get into a ?flow state doing what other [Grace: Yeah] women would find !really nerve-wracking. (1, p. 40)

Grace presented herself as someone that was often “scared” and “anxious” (1, p. 39). However, Douglas presented a different understanding or a counter narrative to Grace’s perception of herself. He used his daughter as an example to accentuate that Grace is able to “get into a flow state” and find “comfort” in an area that most women “would find really nerve-wracking.”

Douglas detailed a third skill/attribute related to Grace’s identity as a mathematician: a dedication to preparation. As noted earlier, there is some overlap between Grace’s experiences and skills as a mathematician and those as a teacher; “dedication to preparation” (1, p. 29) is one such example. Here, I introduce how Grace prepared as a mathematician, and then I elaborate on this ability in the next section.

During the first session, Douglas asked Grace how she “learn[ed] new domains of math” in college. Grace mentioned that “for new stuff,” she would have to read her textbooks “over and over again” and solve math problems “over and over again” (1, p. 16). Leo then informed Douglas that Grace does “a lot of studying.” Grace agreed, saying
that she “spends hours, literally hours and hours, reading through texts and notes and stuff” (1, p. 17).

Grace mentioned that she took a similar approach to answering work-related phone calls, for example, when she had to speak to a parent of one her students. She liked to first have “a game plan of what [she was] going to say” so that she had time to “think or whatever” (1, p. 28). The following segment demonstrates how Douglas connected this information with her experiences as a mathematician.

Douglas: Yeah. So if you, it sounds, like, a little bit like the way you would prepare in math—that you would work very hard in advance, to be able to accomplish whatever task that you wanted to do. And that part of your ability to do well is preparation; your ability to prepare= (1, p.29)

Douglas discovered that Grace approached phone calls in the same way she solved math problems, in which he categorized and reframed as an “ability to prepare.” He also associated Grace’s ability to “work hard in advance” or prepare as a steppingstone to her being able to “accomplish whatever task that [she] wanted to do.” Thus, Douglas’s statement indirectly communicated that Grace’s ability to prepare could be helpful in solving her fear of blood, needles, and medical procedures.

**Teacher.** Although she was not currently employed as a teacher, Grace defined herself, approximately 27 minutes into the first session, as a “teacher,” saying “that everything that I am geared at doing is teaching” (1, pp. 14-15). She earned a “Master’s in Education” (1, p. 19) and taught math for two years at a high school. Grace liked math, but she did not “like teaching” because she did not “come across as stern or anything, so the students would “walk all over me” (1, p. 19). Leo confirmed that she would “spend
hours” working on her “lesson plans” (1, p. 29). Douglas characterized this experience as
Grace “lik[ing] to be prepared.” Grace agreed and mentioned that she endeavored “to
make sure every little minute [of class], uh, is accounted for” (1, p. 29).

Immediately after, Leo asked Douglas if Grace’s efforts to prepare were
“separate, probably, from the doctors and the blood phobia” or if they were
“interconnected.” The question offered two possible answers, both of which risked
further establishing Grace as someone with deep-seated problems. Douglas responded by
describing Grace as someone devoted to being prepared, and that this was part of her
“learning style”:

Douglas: !Um, uh, I think they’re interconnected in a useful way. Clearly, it, it, is
different that if the sight of blood can cause you to lose consciousness for a
minute. But ((coughs)), but, (short pause) but, your devotion to being prepared for
what you’re going to face (short pause) um, and that being really part of your
?learning style, also seems like part of your communication style. (1, p. 29)
A “devotion to being prepared” for whatever Grace was “going to face” meant it could be
applicable and helpful, whether the situation entailed math problems, phone calls, and/or
lesson plans. The foundation was also being laid for this later to be applicable and helpful
for her needle and blood problems.

A second resourceful quality Douglas identified was courage, which he noted that
Grace displayed during her difficult experiences as a teacher. In the first session, Grace
described students, primarily males, who would “screw” with, and, in her second year at
the school, “poke fun at,” her because she was a “female” (1, p. 37). She believed that the
students perceived her as “inferior or whatever” (1, p. 37). She added that one specific
Douglas established the fact of Grace’s courage in the face of these challenges.

Douglas: That took a lot of courage to be going in everyday to deal with that kind of stuff=

Leo: And she was there by herself there in Illinois. (1, p. 38)

Leo supported the view of Grace as courageous by emphasizing that she was able to manage being “there in Illinois” by herself. With her courage accepted as a given, Douglas could further concretize it by questioning how it was accessed.

Douglas: Oh, wow, how did you muster the courage to go back everyday?

Grace: I don’t know. I had to, (short pause) it’s tough. I thought after that first year it would all be better. (1, pp. 38-39)

Approximately halfway through the first session, Grace and Leo informed Douglas of their eating patterns and diet. Grace mentioned that although she’s a “vegetarian,” she was willing to “try different” (1, p. 51) restaurants in support of Leo.

Douglas took advantage of this interchange to circle back and reinforce an understanding of her as courageous.

Douglas: So when you try, what’s the spirit which you do that trying? I know that you have incredible courage because ((Grace laughs)) for you to endure a whole year of, uh, challenge and abuse and then not only endure but to learn from it. So that when summer school comes and you’re doing something different, that speaks of perseverance. (1, p. 52)

In addition to reinforcing Grace’s courage, he expanded on it. He identified Grace’s courage as consisting of endurance, perseverance, and just as importantly, as a capacity to
learn from previous experiences and to use these learnings when presented with similar circumstances. These statements continued to build on Douglas’s assumption that Grace’s courage could be useful and applicable to her fear of blood and needles.

**Runner.** In the first session, after determining that Grace could experience a “flow state while . . . doing math,” (1, p. 30) Douglas asked Grace, “What else do you do that gets you into a flow state?” Grace responded, “I run a lot” (1, p. 30). Douglas investigated: “How far” did she run? Was it on a “treadmill?” Grace said that she ran “five, six miles” on “average” on an “in-door track.” She added that she was practicing for “a half marathon” (1, p. 30).

Douglas: Um, ?so you’ll run 5 or 6 miles at .a time? And do you get in the zone doing that, .I guess?

Grace: ?Yeah, ’cuz it’s kind of neat, ’cuz at some point, I’m like, !wow, I don’t even remember the past [Douglas: Yeah] ((Grace laughs)) .3 miles and its .been, so= (1, p. 31)

Douglas responded by comparing Grace’s experience as a runner, in which she “[doesn’t] even remember the past,” to the process of hypnosis.

Douglas: So you might ?find something similar with the hypnosis, just as you do, you can sort of lose track at ?3 miles while you’re running. You might lose track of stuff that .we’re doing. ?Obviously, you’re ?still there in some way because you keep running and you .find your way. But you allow your unconscious mind to do the guiding. (1, p. 31)

Douglas used the word “track” to associate Grace’s experiences as a runner with the possibilities that could unfold with hypnosis. In other words, he permissively
communicated that she could approach hypnosis in the same way that she did running; she did not have to be consciously in-tune with every step of the trance process. Grace’s ability to find flow, or as Douglas reframed, her “unconscious mind,” could do the “guiding.”

Identifying Symptoms Associated with Symptomatic Identities

Grace and Leo’s initial descriptions of her symptomatic experiences attributed her problems to her symptomatic identities—a view shared not only by the couple, but also by family members on both sides. They all agreed that Grace had “a lot of issues” that were the result of her “way of being” (1, p. 22).

Anxious/Fearful. Grace perceived herself as someone who was “anxious” or fearful, or, as the psychiatrist had indicated, as someone suffering from a “mood disorder” (1, p. 39). Thus, in keeping with Grace’s perception and the psychiatrist’s diagnosis, the couple attributed Grace’s fainting at the sight or mention of needles, blood, and/or medical procedures to her anxiety or “mood disorder” (1, p. 39).

From the couple’s perspective, Grace’s anxiety expressed itself in many ways. For instance, Leo associated Grace’s fainting response to her “anxiously overthinking” during situations that were “not just . . . phobias of needles” (1, p. 53). Leo mentioned, as illustration, that Grace was “afraid” of “pain.” He described a time when the “trunk of the car hit” her “funny bone,” and because she was “so focused on it,” she “ended up passing out.” As Leo underscored, “she passed herself out” (1, p. 53). He understood her overthinking as the cause of her fainting.

Another apparent expression of Grace’s anxiety was her decision to “screen” phone calls before answering them. Grace mentioned that she did not like “to talk” on the
phone “in front of people,” that she preferred to “text.” Whenever she would pick up the phone with others around, she felt “antsy” (1, p. 25). This was something that “frustrated” Leo, who attributed it to her “social anxiety” (1, p. 25).

Contending with her history of fainting and the resulting anticipation of future occurrences, Grace would try “to talk [herself]” out of thinking she was “going to pass out,” consciously reassuring herself that she was going to be “fine” (2, p. 2). For instance, Grace would tell herself, “you got !your music, and you ate a big !breakfast. . . You have this” (2, p. 3). She also had the support of her “mom” and “sister,” who would “come” (2, p. 3) with her to her appointments. However, recently, Grace’s self-talk had evolved from reassuring herself that she “wasn’t going to pass out” to constantly thinking, “I’m going to pass out.” She said she had made a “switch” from “positive thinking” to “fear” (2, p. 3). However, both kinds of self-talk continually put fainting in the forefront of her mind.

The last example is Grace’s perception of herself as a teacher. Because of her negative experiences with students, she felt as if she was “always in fight-or-flight mode” (1, p. 39). Grace stated that she would “be fine” with “just presenting” the class lectures “if no one misbehaved” (1, p. 40). The teaching component, the preparation and presentation of lectures, was not the issue. However, because of her “fight or flight” (1, p. 39) response, Grace would, perhaps, get too anxious to deal with difficult students and continue teaching.

**Resistant/Stubborn.** Grace’s family members and in-laws perceived her as someone who was rigid, resistant, and/or stubborn. In the first session, Grace described Leo’s frustrations with her food-related behavior, which initially involved her only eating
at “one or two restaurants” (1, p. 51). She agreed with Leo that this was “not fair to [him],” and she believed that Leo “was right” about her rigidity, so she decided to “try something different,” or, as Leo put it, “she’s adapting” (1, p. 51). Although she was trying different restaurants, Grace was adamant about not consuming “white flour,” which was “upsetting” for Leo because it was their “main” cooking “ingredient.” Grace noted that when she did eat it, she “satisfied” Leo but “upset [herself]” (1, p. 55).

Similarly, in the second session, Grace mentioned that her father was also concerned about her eating patterns, as he believed that her fainting experiences were related to her diet. She mentioned that her father’s typical reaction to hearing about a fainting experience was to advise her that “she needs more protein” because “she’s too small.” Grace said that her father “doesn’t believe in the whole mental aspect.” Rather, he assumed that Grace was “doing it to herself” (2, p. 5) as a result of her rigid diet.

In the second session, Grace described her most “recent” fainting experience—at her in-laws’ house during a family visit. The purpose of the visit was to provide comfort and support for one of Leo’s cousins, who had “had surgery” (2, p. 2) and recently returned home from the hospital. When she heard of Leo’s intention to visit, Grace had insisted, “I can’t go,” but Leo and his family told her, “You have to” (2, p. 2). Grace recognized that because Leo’s family is “very, very close” and this “was a family thing,” she really had no choice. She knew she “had to go,” but she warned them that if she did, she was “going to pass out.” But because “they don’t understand,” they asked her, “How can you pass out just from being around someone” (2, p. 2)?

Soon after in the session, Grace expressed her frustrations with everyone’s demands and their effect on her. She perceived “life” or “everything” as “a chore” (2, p.
Leo consistently reminded her, she said, “how I don’t clean my stuff;” and he, along with everyone else, continually emphasized, “You gotta do this. You gotta do that. You gotta do that.” She said, “there’s no, like, freedom to explore and relax, anything like that” (2, p. 7).

**Discovering Resourceful Skills and Identities within Symptoms**

The couple initiated therapy with the intentions of finding a solution for Grace’s “phobia of blood,” “needles,” and “doctors” (1, p. 1), and more specifically, her fainting response, which they associated with a “mood disorder” (1, p. 39). They hoped that Douglas’s hypnotherapeutic efforts would accomplish what their a psychiatrist recommended—to assist Grace in getting “rid of” (1. p. 1) her phobias and fainting response.

**Fainting.** The couple viewed Grace’s fainting as a result of her over focusing and over thinking. However, Douglas described it as an *ability*—an example of her biological *superiority*. He did not present this perspective immediately, however; he built up to it. He started by asking Grace if “the doctors [had] explained to [her]” that she “faint[s] because of a drop in blood pressure.” She confirmed that they had. He went on: This “drop in blood” pressure is the result of a “thought or the sight of anything medical .to do with blood” (1, p. 6). This “idea or image” then “causes a change in, in the way your body’s pumping blood and that loss of blood pressure means that you then !faint.” Douglas underscored that this is “something that happens automatically” without “conscious effort” (1, p. 6).

Later in the session, Douglas informed Grace that her “unconscious [was] really good at dropping her blood pressure” and that “there’s an evolutionary reason some
people think” she’s had this “reaction” to “blood” (1, p. 9). After Leo asked, “Is it like playing dead, almost,” (1, p. 9), Douglas presented his explanation.

Douglas: Oh, well, that is one of them. The other ?one is that, um, if your blood pressure drops, you bleed less. And there’s some thought that we evolved, those of us that are ?most evolved, like you, so that if you see blood, and your blood pressure drops, it means that if it’s ?your blood that you’re seeing, you will bleed less. And you’re less likely to bleed out if you were to have some kind of injury.

So you’ve evolved ahead of the .rest of us. (1, p. 9)

As noted, the couple initiated therapy with the intention of finding a solution for Grace’s deficiencies. At this point, the couple had the mutual understanding that Grace was the identified client. Leo’s role in the process was to provide Douglas information about Grace’s struggles and difficulties. However, Douglas provided an alternative understanding of Grace’s experience. Rather than perceiving Grace as deficient, Douglas described her as someone who is more evolved. Douglas’s redefinition of Grace’s fainting experience was intended to shift the couple’s assumptions of rationality and incompetence.

Douglas proceeded to explain the physiological components associated with fainting. He asked Grace if “anyone” had “explained to [her] about adrenalin.” No one had. He said that her drop in blood pressure “gets prompted by the release of adrenalin” and “some other stress hormones.” Although these physical experiences “can wear [her] out,” he said that Grace had a “really finely-tuned mind/body connection—that an idea can produce a bodily response—and not everybody has that” (1, p. 10). Grace’s ability to automatically drop her blood pressure is, he said, an uncommon “finely-tuned mind/body
connection” (1, p. 10). Later in the session, he described Grace’s physical reactions as a “built in ability” that allowed her to function “like a finely-tuned efficient machine” (1, p. 68).

Anxiously Anticipating/Overthinking. The second symptom Douglas identified as a resourceful skill was Grace’s anxious anticipation and/or overthinking during uncomfortable moments. As earlier noted, Grace anxiously prepared for her lectures by making sure that “every minute” of class time was “accounted for” (1, p. 29). In addition to underscoring Grace’s commitment to preparation, Douglas described these efforts in the first session as Grace having a “singularity of focus” (1, p. 29). While working on her “lesson plans” or on a “proof,” she had the ability to “maintain that focus for a length of time” (1, p. 29).

Grace’s ability to focus also surfaced during times when she had incessant thoughts about fainting. During the second half of the first session, Douglas responded to Leo’s comments about Grace “getting worked up” and “pass[ing] herself out” by emphasizing that Grace “wasn’t doing it on purpose.” He mentioned that Grace had “an ability to focus, and it was an automatic thing” (1, p. 53). Douglas continued to underscore that the ability to focus “works incredibly well when you’re having to learn a new skill, such as a new math, a new math theorem or whatever” (1, p. 54).

In addition, Douglas determined that Grace experienced “flow” (1, p. 66) during math, during which she did not have to consciously reassure herself about, or overthink, the process. For example, in the beginning of the second session, he mentioned that Grace had “a great deal of reassurance” with math because she knew that she had
“always been good at [it].” Grace did not “have to question” the process because she just “knew it” (2, p. 5).

Later in the second session, Douglas also underscored that Grace had had a similar experience during her first-session hypnotic trance. Grace mentioned that trance was a “different” experience for her. It was “different because [she was] not used to, uh, relaxing and staying still” (2, p. 7). She was under the impression that she did not often attain these qualities because she was “usually on the go, or [she was] always thinking about stuff” (2, p. 7). Grace described her trance experience as “?kind of a moment of ((chuckles)) freedom” (2, p. 7)—a different kind of focus.

**Avoidance/Resistance.** As noted earlier, Douglas in the third session identified Grace’s ability to “call the shots” (3, p. 5). Here, I explore how Douglas, during the first and second session, laid the foundations for later identifying and naming this ability.

According to Leo and Grace’s psychiatrist, Grace’s avoidance of answering phone calls was due to her “social anxiety” (1, p. 40). Douglas, in contrast, identified this behavior as Grace wanting “to secure some nice alone time, on, uh, a conversation on the phone” (1, p. 29). The following exemplar demonstrates how Douglas reconceptualized “avoidance” as a beneficial preference for “alone time,” (1, p. 28) which helped her feel more confident.

Douglas: !What else does that aloneness allow you to do that makes it more difficult .when people are around?  
Grace: Ehh, more ?confidence, I guess.  
Douglas: More confidence in figuring out how to respond to .what’s going on?  
Grace: Uh-huh.
Douglas: How, do you feel the confidence? How do you notice it= (1, p. 28)

By presenting and then exploring the legitimacy of “aloneness,” Douglas was able to discover and highlight a skill: Grace’s ability to have “more confidence in figuring out how to respond to what’s going on.” Thus, what Leo understood as instances of anxiety or avoidance, Douglas identified as moments of confidence that were helpful for Grace during difficult situations.

Further in the session, Douglas discovered how Grace used this confidence to set boundaries with her students during her second year of teaching. She provided an example of a “kid” in summer school who “made a joke,” and Grace “sternly said, you know, that’s not, that’s not okay;” and “that was that” (1, p. 42). Douglas inquired further.

Douglas: Okay, so how did you find the idea of what to say and how to say?

And to be able to do it in the moment? How did you do that=

Grace: I just learned, from that last one, I didn’t want to go there. (1, p. 42)

As earlier noted, Grace had difficulties responding to situations that deviated from her lesson plans: she “spent hours” on her lesson plans “to make sure every little minute. . . [was] accounted for” (1, p. 29). Thus, Douglas was interested in how Grace was able to appropriately, but more importantly, naturally respond to an unexpected situation; a situation that was not accounted for in her lesson plans.

Grace mentioned that if she let “small things . . . go, it just got bigger and bigger” (1, p. 42). Douglas then underscored that Grace “learned” that if she took “care of them
when they’re small, they don’t get big.” He identified this ability as “a source of confidence—to be able to take care of something when it’s small” (1, p. 42).

In addition to noting Grace’s confidence, Douglas accentuated Grace’s ability to “learn” (1, p. 42) from previous mistakes. As noted, Grace’s difficulty with teaching was related in part to her inability to figure out how to address inappropriate students. Grace assumed that she was not capable of teaching because she was a “soft” spoken “female” (1, p. 37). However, Douglas discovered an instance in which Grace used her past experiences as a learning opportunity for coping with a similar situation.

**Utilizing**

This section illustrates how Douglas facilitated his utilization techniques. I examine the variety of ways Douglas, in both the first and second session, communicated his intraventions to facilitate non-volitional shifts.

**Humor.** Douglas utilized humor to alter Grace’s perceptions of events or experiences as “scary” or “uncomfortable” (1, p. 2). For example, after Grace mentioned that she was “really scared” (1, p. 2) of hypnosis in the beginning of the first session, Douglas informed her about the process and then presented a story about a previous client who was “very afraid” (1, p. 3) of lizards. Although this client’s usual reaction was to panic at the sight of lizards, he told Grace, her experience during trance made possible an enjoyable and “comfortable” (1, p. 5) non-volitional shift. Douglas mentioned that his client “was very good at visualization,” and during trance, “she started to see a little, um, lizard.” She envisioned a lizard “with a top hat” and a “cane” (1, p. 4) playing the piano. This description elicited laughter from both Grace and Leo. Douglas then went on to
mention, “and this [was] before the Geico commercials” (1, p. 4), which ignited further laughter from the couple.

Douglas continued to interweave humor throughout the session. Shortly after the story, Douglas asked Grace if she had any other questions “about hypnosis or of [him]?” Grace mentioned that she was “afraid [she was] going to pass out ((chuckles)), like, talking about stuff” (1, p. 8). Douglas responded to Grace’s concern and nervous chuckle by saying, “So the nice thing about this couch is ((Grace laughs)), !it’s very comfortable ((laughter from couple))” (1, p. 8)! Although Grace had expressed her fear of fainting, both Grace and Leo laughed at Douglas’s comment about the possibility of Grace fainting on a “very comfortable” couch.

Douglas also used humor in the telling of a story about a previous client who was “afraid of shots.” At the time, this client was in the “tenth or eleventh grade” and “had to get a bunch of shots” or “immunizations” (1, p. 47). He was “afraid” that when the “nurse” approached him “with the needle,” he was going to “hurt her.” He said that he would not do it “on purpose,” but out of “panic” he might possibly “hit her and push her ((Grace laughs)) out of the way” as he ran. “And [he anticipated that he wouldn’t] stop running for many, many blocks” (1, p. 47). Although the story was about a topic or situation Grace found uncomfortable, Douglas’s use of humor helped Grace respond or relate to the story in a new way.

**Speaking casually.** Along with humor, Douglas casually communicated relevant and sometimes unsettling information without underscoring its importance or significance. For example, he casually presented a variety of stories and explanations that
were embedded with information about the feared stimuli, making it seem secondary to the direction or purpose of the story or explanation.

For example, as noted earlier, in the first session, Douglas informed the couple of the “evolutionary reason” why humans experience “a drop in blood pressure.” Embedded in this explanation, he casually mentioned the possibility of Grace seeing her “blood” (1, p. 9).

Douglas: And there’s some thought that we evolved, those of us that are ?most evolved, like you, so that if you see blood, and your blood pressure drops, it means that if it’s ?your blood that you’re seeing, you will bleed less. (1, p. 9)

The focus of this explanation was on the evolutionary process and the purpose of “a drop in blood pressure” (1, p. 6). However, along the way, Douglas slipped in two statements of Grace seeing blood—the very thing she had been avoiding at all costs—the first involving seeing blood in general, and the second, Grace seeing her own blood.

A second example involves a story about “a demonstration of a guy doing hypnosis” (1, p. 13). Initially, the hypnotist used a “blood pressure cuff” to read the participant’s “blood pressure,” and it “read normal.” Then the hypnotist had “him lose all the blood in his arm, and so, he did that and then took [the guy’s] blood pressure and it was zero” (1, p. 13). Douglas had already mentioned “blood” four times by this point. By the time he finishes the story, in the next sentence, he has referenced it three more times, along with the casual mention of “needle” (1, p. 13).

Douglas: There was no blood in his arm, ?so then they took the ?back of his ?hand and then they put a needle through (Grace: !baaah)) and ?there was no
blood ((Grace makes cringing sound)) because there was no !blood ((Grace laughs)). (1, p. 13)

When Grace communicated her distress—“!baaah”—Douglas could have changed the topic or stopped and directly addressed her reaction. Instead, he just casually completed the story, which elicited laughter from Grace.

A third example, explored above, had to do with the teenager who was afraid he was going to hurt the nurse. Prior to the story, Grace had said she did not want to get a “tetanus shot” that was “two, three years overdue” (1, p. 47). Douglas casually discussed his previous client’s experience with medical procedures, which involved a nurse administering “a bunch of shots” or “immunizations” (1, p. 47).

**Offering physiological reframes.** Douglas frequently utilized physiological reframes to recontextualize and normalize Grace’s fainting experience and other uncomfortable moments. In the beginning of the first session, Grace asked Douglas if he had “worked with people that pass out from fears” (1, p. 5). Douglas said that he had “never worked with people who fainted,” but he had “worked with people who have had other ?automatic blood flow changes that they wanted to change” (1, p. 5). Douglas said that he had “worked with several people who ?blush, um, when they [didn’t] want to” (1, p. 5). Rather than acknowledging Grace’s fainting experience as a consequence of “fear,” he reframed it as a result of “automatic blood flow changes” (1, p. 5).

Shortly after, Douglas explained “what happen[ed] with people who blush when they don’t want to.” He stated that “some stimulus causes blood flow to rise up into their, uh, often chest and faces,” and “they become self-conscious about that and that causes more” (1, p. 6). Douglas then explained that “what happens with the fainting is very
similar. The drop in blood pressure contributes to [an additional] drop in blood pressure, so it, it escalates,” (1, p. 6) causing Grace to faint. This explanation shifted the cause of Grace’s “passing out” from fear to a “drop in blood pressure” (1, p. 6).

Similarly, later in the session, Douglas said her fainting was “prompted by the release of adrenalin” and the “effects of other stress hormones.” Although this experience “can wear you out,” it is “normal” (1, p. 10).

Still further in the session, Grace stated that when put “on the spot,” she was not capable of solving “computations” (1, p. 35). As a math teacher, she preferred to have reviewed the computations before class or “up in advance” because of the concern of computing them “wrong or something” in class (1, p. 35). The following segment shows how Douglas connected the reframe of “adrenalin” release to this experience.

Douglas: When you’re put on the spot. (short pause) If you have too much adrenalin, what it does, it shuts down your prefrontal cortex and so, uh, and it does it for a good reason. You have adrenalin in your body so that you’ll go and do what you do very well, which is to run. And we’ve evolved so that we would run rather than sit down and think, !hmm, I wonder what I should do here. We just run like a bat out of hell. And, so, what tends to happen is, it, too much adrenalin and ?you’re jazzed in order to move, not in order to ponder. And, so, thinking becomes, ?it’s interesting because a little bit of adrenalin, you actually think better. (short pause) And your body is an expert at delivering adrenalin. (1, p. 35)

Rather than Grace suffering from fear or anxiety, Douglas conceptualized Grace’s “put on the spot” experiences as a manifestation of “too much adrenalin.” He reinforced this
idea by referencing Grace’s ability to run, which was the result of the same adrenalin that she was experiencing as a teacher. Hence, Grace was struggling with unique physiological responses that were useful for her in other areas and that could potentially be useful for her as a teacher.

Douglas continued to emphasize Grace’s ability to produce adrenalin. He said that “once [her] body [knew] how to regulate it,” she might “get inspired by the adrenalin, rather than it shutting [her] down” (1, p. 35). She had the potential to “turn into a computational wizard.” He concluded that it was “just a matter of just having enough, not having to have more than you need” (1, p. 36).

**Associational suggestions.** Douglas offered multiple suggestions for how Grace could find herself utilizing her resourceful skills as a mathematician, teacher, and runner during future uncomfortable interactions or situations. Douglas communicated these associations in a variety of ways, including both direct and and indirect interventions, such as metaphors, stories, and word play. Douglas communicated most, if not all, of these associations during trance experiences. Thus, a facet of his communication consisted of his speaking hypnotically, which entailed the use of rhythmic speech (or fluctuation of voice and pace of words) and interspersal of key ideas. The first set of resourceful skills I discuss are related to Grace’s experiences as a teacher.

As previously noted, Douglas identified Grace’s courage, confidence, and ability to learn from past mistakes. Approximately an hour into the second session, Douglas underscored Grace’s experience as a “new teacher.”

Douglas: You learned as a new teacher the importance of (long pause) responding efficiently and (long pause) early (long pause) to any divergence
.from (short pause) what feels comfortable and respectful. !Some learnings are difficult to go through but then what you learn from (short pause) the process can be carried forth to make subsequent interactions so much easier (long pause). (2, p. 8)

Douglas illuminated Grace’s teaching experience, her ability to learn and adapt, as a segue to convey that she could also use her previous experiences (or learnings) with blood, needles, and/or medical procedures to encounter subsequent, yet similar, interactions.

Shortly after, Douglas acknowledged Grace’s ability to use her skills as a teacher in the future.

Douglas: Why not !enjoy the (short pause) certainty that (inaudible). Certainty that you have, that ?you do have the skills and experience, and the knowledge, history necessary to move into the future with confidence and .your ability to learn with that confidence that’s constructed from your courage (short pause) goes throughout your body. Courage you exhibited to demonstrate in so many experiences, ?so many circumstances. (2, p. 11)

As earlier noted, Grace struggled with the uncertainty of class lectures and phone calls—an uncertainty she associated with anxiety and her identity as someone fearful. However, Douglas recontextualized those experiences to develop a new identity. He illuminated that Grace had gained a great deal of certainty during instances of uncertainty, and rather than approaching situations with uncertainty, she could encounter medical procedures with the confidence and courage she developed as a teacher.
In the following example, Douglas indirectly communicates how Grace could use her courage during upcoming medical procedures. Approximately two hours into the session, Douglas presented a story about his son. He mentioned that his “son used to be afraid of needles. “He worried for 5 years between one set of inoculations and the next, worried about going in [and] having another series of shots” (2, p. 14).

During the inoculations, Douglas’s son would “always recoil” from the nurses’ “touch.” However, Douglas suggested that the “next time he went in,” he “talk to the nurse and present her his arm” (2, p. 14). So the next “time he went in,” he “chatted with her and then he took his arm and he moved it forward, rather than back. He looked her in the eye and just smiled and said, let’s see how good you are” (2, p. 14). Douglas did not directly mention “courage”; instead, he indirectly presented an example of it within the story.

Skills and attributes that Douglas identified as part of Grace’s experience as a mathematician included her ability to experience flow and to problem solve by applying a “principle from one area to another” (1, p. 41). At the end of the first session, during the trance portion, Douglas mentioned that Grace “learned through repetition” until she felt “comfortable” (1, p. 68). Once she was comfortable with the “principle,” or once it was “absorbed in her bones,” she “could apply it to any old problem that comes [her] way” (1, p. 68). Douglas then described this style of “learning” as “developing a flow state” that she can “apply” to “any old problem” or “any new encounter of the challenge” (1, p. 68).

Approximately one hour and 20 minutes into the second session, Douglas categorized this experience of “learning” and applicability as a “theorem,” a mathematical term Grace was familiar with:
Douglas: Your eyes can be opened and closed at the same time, (short pause) like proving a theorem. You could hold the theorem ((outside chatter)) (short pause) (car passing) conduct the proofs, the proofs illustrating and confirming the theorem (short pause), just makes sense that conducting the proofs is the way to provide reassurance of the truth of that theorem. (long pause) (2, p. 12)

Like the examples above, Douglas continued to suggest that Grace could use her knowledge and wisdom to solve problems, however, here he does it more indirectly. Douglas’s intention was to reorient Grace’s approach and relationship with her problems, and he does it here by embracing her expertise and identity as a mathematician. He implicitly associates her fear of blood, needles, and medical procedures math problems (or proofs)—problems that she enjoyed, and was accustomed to, solving. With this reconceptualization, he then suggests that Grace approach her problems using her skills (or learnings) as mathematician.

Later in the session, Douglas revisited Grace’s ability to “hold a theorem” and to use it “to conduct the proofs.” However, in this instance, he associated Grace’s ability “to hold a theorem” as being “in the past.” And he mentioned that she could use her “theorem,” or past learnings, in “conducting the proofs” (2, p. 16) in present and future experiences.

Douglas also made reference to Grace’s resourceful identity as a runner, specifically her ability to experience “flow” or not to have “to consciously think” of every step. In the example below, Douglas associates Grace’s fainting response as a “loss of balance” and then offers an alternative. He begins at the beginning, with the first steps Grace took as a toddler, and goes on to indirectly communicate to Grace how she could
use her skills and knowledge as a runner to unconsciously relate differently to her fainting experiences.

Douglas: How many *steps* have you taken (short pause) *since* that very first? You learned by *the* third or the fourth step how to (short pause) *recognize* the beginning of the movement from *being balanced* to *being unbalanced*, and how to *accommodate* that movement in such a way [so] as to *maintain* your *balance*. When it was still just a small, small *diversion* from being balanced, so *that* now you can run *mile* (short pause) *after mile*, maintain your *balance* (short pause) throughout, without having to *consciously* think at all [of] the complex and *delightful* ways that you’re adjusting your trajectory. (2, p. 10)

As a runner, Grace was not consciously scrutinizing every step; she discovered “flow” by allowing her mind/body to go through the motions. Douglas used this experience to indirectly communicate that Grace could approach her goal (trajectory), which was to overcome her fear of blood, needles, and medical procedures in order to have a child, without having to consciously recognize (or think about) how she was changing in relationship to her problem. Grace could allow her unconscious wisdom to take the necessary steps to solve her issue.

**Encouraging New Behaviors**

**Experimentation.** In both the first and second sessions, Douglas employed a variety of hypnotic methods to encourage new learning and new behaviors. The first occurred during the first session, after Grace said that she was “afraid [she] was going to pass out. . . talking about stuff” (1, p. 8). In addition to Douglas stating that the couch was “very comfortable,” he informed her that it would actually be “very helpful” if she “were
to pass out.” Because if they did “end up having a child,” they were going to “watch their baby learn how to walk” (1, p. 8).

Douglas: And what you’re gonna see happening again and again is that he’s going to get up, and he’s going to fall down. He’s going to get up and going to fall down. And he’s going to take a step. And he’s going to learn how to walk by falling. And so, if you could manage to faint a couple of times while we’re doing this today=

Grace: ((laughs)) !I don’t know.

Douglas: Because you don’t have to worry about getting hurt. (1, p. 9)

Douglas was not only accepting of the possibility of Grace fainting, but also actively encouraging it as a potent source of new learning. To support this idea, Douglas described what she could learn from watching their future child’s first walking experiences. This allowed him to encourage learning through failure, but also to talk about their future child as a tangible reality. As he was directly talking about her learning from her future child’s learning, he was indirectly communicating the implicit assumption that she would, indeed, resolve her problems and start a family.

This was not the only time Douglas projected Grace’s attention into the future. Approximately an hour and forty-seven minutes into the second session, he suggested that Grace “go now into the future, conduct some proofs” (2, p. 13). He said she could “realize” that she did not “have to consciously reassure herself” but could “rely on [her] confidence of [her] unconscious mind’s learning” (2, p. 13). With this understanding, Douglas suggested that Grace “allow [her]self to be in a doctor’s office and to recognize that in the past, this wouldn’t have been for the ?faint at heart” (2, p. 14). He then
suggested that Grace could “go ahead and discover” how she could encounter this unpredictable situation with the “predictability of your learning style” (2, p. 14). Douglas encouraged Grace to “use all of the learnings” that she had and “use them now to go into the future to do some proofs and discover yourself there with the doctor, in the doctor’s office” (2, p. 14). He was suggesting that her skills as a mathematician (along with her courage) could help her encounter differently what she had feared in the past. Notice the word play he used to make indirect mention of her courage—he described the situation as one not for the “‘faint of heart.”

Shortly after, Douglas elaborated on his suggestion by mentioning the following:
Douglas: ?You can ?have a nurse in there with the !doctor. The ?nurse can, the nurse can have a needle. !And go ahead and notice that on the inside. (short pause) You can notice their faces. You can ?notice the needle. You can notice color of the ?walls. You can notice sounds outside your ?room. (2, p. 14)

Douglas asks Grace to notice the nurse’s needle “on the inside” (i.e., to track the effect of seeing it on her internal experience) and then he directs her attention to other items of interest—faces, wall color, and sounds, but also, again, the needle. Rather than trying to distract her attention away from the needle, he encourages her awareness of it, but it just becomes one of many sources of possible interest, thereby draining it of its usual overwhelming significance.

Later in the session, Douglas continued to encourage this type of imagining. He suggested that Grace “go ahead and now have another medical encounter, [with a] physician assistant, or a doctor, or a nurse, [or] all three” (2, .15). He suggested that she could “‘hear all the signals that suggest needles and blood and procedures.” And Grace
could “allow herself to be curious” about the people in the room. For example, she could “look the doctor in the eyes” and “become absorbed [by] how interesting they are as people” (2, p. 15). This suggestion involves not only noticing details other than the needle, but also becoming absorbed and interested in them.

Douglas encouraged new behaviors and experiences during trance, but also, near the end of the second session, he encouraged her to discover changes after she returned home.

Douglas: ?I would be very interested if you were to, um, contact me after you have the opportunity to have some kind of situation, where in the past, you would’ve fainted and you don’t. (2, p. 18)

Throughout the two sessions, Douglas was interested in Grace’s ability to learn from previous failures or experiences. Here, he encourages Grace to do something similar. Instead of having Grace focus on the outcome (whether she fainted or not), Douglas encourages her to focus on the experience and to contact him with details or information about the process.

**Making choices.** In the second half of the first session, Douglas emphasized Grace’s ability to set boundaries or make her own decisions. In the following excerpt he refers to Grace’s diet. Rather than pathologizing her eating patterns, Douglas encouraged her to use her wisdom to make her own nutritional decisions.

Douglas: ?And you can learn to listen to all of you so that you not only listen to your husband saying, “I want you to have a bite of this.” ?If you listen, you can acknowledge that he is saying it and you can acknowledge that it’s coming from a place of love. ?And you can then listen to your body and decide, “!Man he’s right
Douglas provides Grace with the opportunity of listening to “all” of her. This opportunity frees her up from thinking that she has to take an either/or approach, meaning that she has to choose between either listening to Leo or listening to herself. This orientation would consequently put her in opposition with her husband and/or herself. However, Douglas presented Grace with a different way of conceptualizing boundaries and choices. He framed Leo’s intentions as being positively motivated, but then he suggested that that alone did not necessarily mean she would have to agree with him. Grace could acknowledge his perspective and then proactively decide on her own to agree, or not, with what he was promoting.

During trance in the second session, Douglas presented an anecdote to indirectly communicate the possibility of Grace shifting how she related to others and make her own decisions. Douglas told her that his “students all want to call me Dr. Flemons, and I told them . . . this is a problem” because it “made them too deferential” to “authority” (2, p. 13). Douglas said that he wanted his students to “realize their own learning, to be able to fully embrace their own ability to learn.” He stated that “part of their matur[ity] . . . was to be able to recognize their own courage; their own strengths.” As he stated, “the best way for that to happen was to lose their deferential way of relating to someone like me in authority” (2, p. 13).

Grace’s comments regarding the exhaustive demands of others implied that her ability to make decisions was limited. Douglas indirectly communicated through his anecdote that she could relate differently to the authority figures in her life. And what this
meant was that Grace could “respect a person without losing respect for” (2, p. 13) herself.

**Preparing.** Douglas encouraged Grace to take her ability to thoroughly prepare and apply it to new areas in her life. For instance, towards the end of the first session, he asked Grace if she had ever “meditated.” She said, “Not really.” Douglas then provided a story about one of his students, who was a “teacher,” and “every morning, with her students, they start the day with 20 minutes of meditation” (1, p. 63). This activity was “part of their everyday practice.” Douglas mentioned that “this is something [Grace could] do.” If she were to do it on a “daily basis,” this would be “another way” for her to “maintain balance.” Meditation, he told her, was what kept he, himself, “sane” (1, p. 63).

Douglas stated that his students had discovered a way to use their meditation practice to prepare for “big standardized exams.” If Grace wanted to and “found it helpful,” she could “take the “skill” he was going to “teach” her and “could do it anytime, everyday.” She could use it when “preparing to see a doctor” or in a “doctor’s office,” or when she was “in the hospital about to give birth” (1, p. 63). Douglas mentioned that she could use this meditation practice to gain “access to [her] flow experience,” and she could “use that in a way to encounter whatever it is that you’re facing with access to all of you; access to all of your skill” (1, p. 64). For Douglas, the line between meditation and self-hypnosis is mostly not relevant. Elsewhere in their work together, he also encouraged and facilitated Grace practicing “self-hypnosis.” But here, at the end of the first session, he taught her a method of meditating that she could practice and use in her preparations for what lay ahead.
Summary

I divided this chapter into two main sections. In the first section, I provided the context for the couple’s presenting problem—their descriptions of Grace’s experiences with blood, needles, and medical procedures and other uncomfortable situations. This section also included both the subtle and significant changes described in the sessions and email correspondence.

In the second section, I discussed what Douglas did in the first two sessions to facilitate these changes. All of Douglas’s interventions can be understood as an application of the principle of utilization. For instance, the first session primarily focused on the identification of resourceful information and experiences. Grace initially described and perceived herself as someone predominantly anxious, rigid, and afraid. However, Douglas identified resourceful narratives and identities embedded in Grace’s descriptions, such as her expertise as a teacher, mathematician, and runner. Douglas also identified a variety of skills associated with each resourceful identity, for example, Grace’s ability to prepare and to experience flow as a runner and mathematician.

In addition, Douglas identified strengths within the couple’s descriptions of Grace’s symptoms. Douglas redefined Grace’s fainting response as an evolutionary advantage, which implied that she was biologically superior. Douglas also recontextualized Grace and Leo’s description of her anxious overthinking as a “singularity of focus” (1, p. 29), and he reframed her consistent resistance to others’ demands as an ability to make choices or “call the shots” (3, p. 5).

Douglas interwove and suggested how Grace could make use of this information in the first two sessions. However, it was more prominent in the second session during
trance. Douglas used a variety of ways to communicate these suggestions. For instance, he made direct and indirect associations, through the use of anecdotes, metaphors, and stories. Douglas also used other methods of communication to encourage Grace to experiment with new learnings and new behaviors. He casually spoke about Grace’s experience with her fears and used humor to encourage her to comfortably engage with them.

Overall, Douglas’s initial interventions facilitated a variety of both short and long-term changes. Shortly after the second session, Grace emailed Douglas informing him how she was able to find humor in a conversation about medical procedures. In August of 2014, Grace informed Douglas that she was able to find the courage to get a tetanus shot. In October of 2014, after their third and fourth session, Grace emailed Douglas describing her “lab work” experience and how her ability to prepare was useful. She also mentioned that she was able to “call the shots” by choosing to drive herself to the procedure, not taking “any drugs” before, and by having “music accompany” her.

Following their fifth and sixth session, in August of 2016, Grace informed Douglas of how her ability to focus and shift focus was helpful during two “blood-draw” appointments. She also continued to “call the shots” by choosing to use a “glucometer” over having to consume an “orange drink” to assess for diabetes. The glucometer required daily needle sticks for at least two weeks. In February of 2017, Grace informed Douglas she was pregnant and wanted to meet for two additional sessions.

Douglas met with Grace in April of 2017 for their last two sessions, during which Grace underscored further changes. She mentioned that she felt comfortable with the sporadic visuals of blood, needles, and medicals that surfaced on either “Facebook” or
“on TV” (8, p. 1). Grace had also become comfortable visualizing her “C-section,” which was something she found “troublesome” (8, p. 2). In July of 2017, Grace reported that she more than likely was going to have a C-section and was using self-hypnosis to cope with her “anxiety.” However, she was, at the moment, considering not being “100% knocked out during the procedure.” Grace wanted to meet her son “when everyone else does” and this consideration signified her “strength.”

The last email correspondence was in August of 2017, which consisted of Grace contacting Douglas shortly after the childbirth experience. Grace described how the MP3 recording of their last hypnotherapy session was helpful with her “pre-op blood work” and other medical procedures. She reported that she did not take the anti-anxiety medication and at one point felt “calm” during the process. She concluded the email by saying that she had “tackled [her] biggest fear” and then by expressing her gratitude for Douglas. She also proclaimed that “this was the best thing she ever did for [herself] :).”

In the next chapter, I focus on the implications of this analysis and findings. I discuss the relevance of Douglas’s intraventions in comparison to other therapeutic approaches in the treatment of phobias. I also explore the research implications of process research and personal reflections of conversation analysis (CA) on understanding hypnosis and therapy.
CHAPTER V: DISCUSSION

The purpose of this study was to explore and better understand how a relational hypnotherapist approaches the treatment of a phobia of blood, needles, and medical procedures. This study examined how one specific relational therapist, Douglas Flemons, facilitated an enduring non-volitional shift with a woman who was afraid of blood and needles. In this chapter, I begin with a discussion of the limitations of my study, and I offer future directions for researchers, and psychotherapists, hypnotherapists. I move on to present the results of the therapy and to apply my findings to an understanding of relational hypnosis and relational psychotherapy, contrasting it with other approaches. I then discuss the study’s implications for clinicians and researchers. This includes clinical implications for brief therapists, family therapists, and hypnotherapists and implications for researchers interested in conversation analysis. I conclude by examining the study’s implications for teachers and supervisors and by reflecting on relational hypnosis.

Limitations and Implications for Future Studies

Before I discuss the implications of my findings, it is important to first acknowledge the limitations of my study. Although there were a total of eight sessions, my analysis primarily focused on the first two sessions, a facet of the last session, and Douglas’s email correspondence with Grace. My analysis indicated that the changes Grace described in her emails (and last session) were interconnected with Douglas’s initial intraventions. Ultimately, I concluded that the most influential and significant moments occurred during the first two sessions. However, there were five additional sessions rich with information, which I did not discuss but could have indeed been relevant to Grace’s therapeutic experience. Thus, future researchers interested in
relational hypnosis in the treatment of a fear or a phobia could conduct an expanded analysis of a case study, potentially exploring all of the sessions. This approach may reveal information that was not considered in my analysis, which may enrich our understanding of the process of relational hypnosis.

In addition, because I only had access to audio recordings, I was unable to analyze every feature of Douglas and the couple’s interactions, such as their non-verbal communication or body language. As Sacks (1984) recognized, audio recordings contain a “good enough record of what . . . happen[s]” (p. 26); however, “other things to be sure, happen.” For instance, I was unable to analyze Grace’s hypnotic (non-volitional) responses to Douglas’s communication. I had to refer to Douglas’s case notes for a description of this process.

O’Hanlon and Martin (1992) stressed the importance of the hypnotherapist’s ability to observe his or her client’s non-verbal behavior. As they mentioned, the purpose of hypnosis is “to build up this sense of responsiveness[,] and you’ll only know what they are responding to if you observe it” (p. 13). Hence, future researchers interested in expanding their knowledge of relational hypnosis (or hypnosis in general) may collect and analyze visual data in order to have access to information (or communication) that is unavailable with audio recordings.

Given that the researcher is the instrument of study in conversation analysis (Gale, 1991), the claims that I have made are based on my interpretation of Douglas’s work. I used my theoretical and therapeutic understanding of relational hypnosis to identify and underscore patterns of communication I considered interconnected to Grace’s enduring non-volitional shift. Ochs (1979) discussed how researchers are
affected by their theoretical understandings (and interests) as they attend to and represent their data. To address this dilemma, I consulted with my dissertation chair, Douglas Flemons, who consistently encouraged me to be more reflective in my selection of exemplars and in my interpretation of the study process.

An additional way I addressed this limitation was by providing the readers examples from the transcripts associated with each of my claims. One benefit of conversation analysis is that the data are available for the readers to make their own decisions—to make their own sense of what unfolded (Gale, 1991). As Gale noted, readers use their own epistemology to organize and “make sense of what is written” (p. xi).

Although this study provides rich information about relational hypnosis in the treatment of a phobia, it only focused on one middle-class, white female’s experience and on the treatment of one specific phobia, a fear of blood and needles. It also only featured the work of one relational hypnotherapist, Douglas Flemons. Thus, my findings could be limited in their applicability to different populations (e.g., cultures, ages, genders), to other fears or phobias, and, indeed, to other relational therapists. Thus, researchers interested in extending our understanding of relational hypnosis could focus on the treatment of other presenting problems and examine how other relational hypnotherapists approach similar or different problems.

**Discussion of Findings**

**Utilization**

Chapter IV demonstrated how Douglas utilized (Erickson, 1980a) Grace’s resourceful identities, along with the associated skills that could be applied to the
resolution of the problem. For example, Grace’s devotion to preparation and courage as a teacher and her ability to focus proved to be useful during her childbirth experience. According to Erickson (Erickson & Rossi, 1980b), the therapist “must accept and utilize the behavior that develops, and be able to create opportunities and situations favorable for adequate functioning of the subject” (p. 167). Douglas’s interventions accepted and accentuated Grace’s experiential understandings and learnings. However, as presented in Chapter IV, there were a variety of elements in his use of utilization that proved to be effective in his work with Grace.

**Resourceful skills.** Douglas explored Grace’s identities as a mathematician, teacher, and runner with the intentions of eliciting or identifying skills Grace could use in different contexts, for example, during medical procedures or other experiences she found uncomfortable. Douglas’s ability to distill these qualities from areas that on the surface would appear to be irrelevant to the problem illuminates an innovative approach to utilization. Although Gilligan (1987) referred to utilization as an associational process, his emphasis was on acknowledging and utilizing the non-volitional responses that were elicited during trance. As he noted, “a person’s life history may be represented as a complex network of different interrelated associational complexes bounded by shared stimulus cues and higher-order gestalts (e.g., abstracted meanings)” (p. 211). Thus, the goal from this perspective is to disclose information (stimuli) that elicits non-volitional responses that can be either utilized to resolve the problem or recontextualized. In other words, “the utilization approach emphasizes hypnotic communications based on the naturalistic use of a person’s associational values” (p. 211).
Although Douglas’s hypnotherapy intentions were to elicit and utilize non-volitional responses, his purpose in utilization also included identifying, underscoring, and transferring skills developed in one area to another, seemingly unrelated, one. This form of utilization could be understood as a form of what de Bono (1970) referred to as “lateral thinking.” De Bono described the generativity of this mode of thought: “With lateral thinking[,] one does not move in order to follow a direction but in order to generate one” (p. 40). Different from CBT and behavior approaches that subscribe to predetermined treatment plans (Rachman, 2009), Douglas’s use of utilization demonstrated that he did not have a defined outcome procedure. In other words, his therapeutic course was not predetermined; rather, it was guided by the conversations and events that naturally unfolded throughout his interactions with Grace and Leo.

Lateral thinking could also be conceptualized as a process Bateson (1979) referred to as abduction, that is, “finding other relevant phenomenon and arguing that these, too, are cases under our rule and can be mapped onto the same tautology” (p. 84). Douglas was interested in finding, connecting, and highlighting a pattern of resourceful skills that Grace could use to solve her problem. These were skills that Grace, Leo, and their family did not acknowledge. They were also attributes that other clinicians would have more than likely considered irrelevant.

**Discovering resourceful skills within symptoms.** In addition to discovering resourceful skills, Douglas identified positive attributes within experiences or characteristics that a wide range of individuals perceived as symptoms. This included Grace’s psychiatrist, who shared a similar perspective with her family members in thinking that there was something pathologically wrong with her, hence the diagnosis of a
mood disorder. However, as described in Chapter IV, Douglas redefined Grace’s fainting experience as a unique “finely-tuned body” (1, p. 10) skill, which was the result of “adrenalin (1, p. 35) and “blood flow” (1, p. 5). A second example was his reconceptualization of what Leo and Grace’s family members interpreted as avoidance and resistance. Douglas embraced and labeled these characteristics as “calling the shots” (3, p. 5).

It is important to note that Douglas did not impose these characteristics. Although influenced by brief therapy principles, this approach is slightly different from an MRI approach, in which a reframe is normally presented at the end of a session to recontextualize clients’ experiences (Watzlawick et al., 1974). As shown in Chapter IV, the discovering of these positive qualities or redefinitions of what Grace understood as symptoms naturally unfolded during the course of the conversation. The way in which Douglas formulated a question resulted in a particular response by either Grace or Leo, which then served as a stepping-stone for Douglas’s follow-up statements or intraventions. For example, Douglas’s question to Grace about “what aloneness allows you [to do]” resulted in Grace using the word “confidence” (1, p. 28) to describe her experience. The notion of confidence then became a building block that unlocked the possibility of identifying other positive skills, including Grace’s ability to “call the shots” (3, p. 5).

In addition, Douglas’s follow-up questions demonstrated his curiosity about Grace’s experience of confidence, but, just as importantly, they helped to elicit further information regarding how Grace related to, and embraced, confidence by her willingness and ability to “call the shots” (3, p. 5). As Flemons (2002) stated, “when your clients
describe a change, inquire, if you can, about the implication it brings. The more detailed information you have, the better you can help vivify their experience” (p. 171).

As an Ericksonian hypnotherapist, Gilligan (1988) views symptoms as “a person immersed in a naturalistic, albeit self-devaluing, trance” (p. 328). In other words, he considers symptoms as having hypnotic qualities that can be useful in the resolution of the problem. The goal of the hypnotherapist is to “join the hypnotic processes in the problematic expression and to cooperate in ways that allows their transformation into self-valuing solutions” (p. 328). Similarly, Douglas identified the hypnotic qualities in Grace’s uncomfortable experiences, such as her devotion to preparation and her “singularity of focus” (1, p. 29) during instances of fainting, and he then utilized these skills in solving Grace’s dilemma.

**Facilitation.** Douglas communicated his interventions in several different ways—by casually describing ideas and possibilities; by using humor; by redefining Grace’s experiences; by proceeding in stepping-stone fashion; and by speaking hypnotically during the trance process. These facets of communication or (interventions) were not empirically based procedures. In other words, Douglas’s approach to helping Grace shift her relationship with her fears was not guided by the current research on the treatment of phobias. For instance, behavior analysts structure their approach or behavior plans dependent on evidence-based interventions that have been consistently suggested to work with a particular population or problem (Villamar, Donahue, & Allen 2008). Since most of the research focuses on exposure therapy in the treatment of phobias (Bandelow et al., 2014; Nathan & Gorman, 2007), they, and other evidence-based clinicians, are limited to this form of treatment.
In contrast, Douglas’s interventions were shaped by his theoretical understandings of how problems are formulated and maintained. Flemons (1991) underscored that efforts to eradicate a problem only heighten its significance. As referenced in Chapter IV, Leo’s attempts to help Grace during difficult moments were counterproductive. As Leo mentioned, his goal was to get Grace “to try to think about something else” in order to stop her from getting too “worked up” (1, p. 53). However, these attempts were ineffective because they forced Grace into a “me” versus “it” position. As Flemons (2002) acknowledged, “effort[s] to manhandle our body responses will create a separated connection between the i—the Napoleonic part of the self trying to call the shots—and the rogue emotion” (p. 185). In other words, “you won’t accomplish [change] by directing [clients] to think, emote, or act differently” (p. 179).

For instance, rather than directly exposing Grace to anxiety-provoking stimuli and having her cognitively process it, Douglas allowed descriptions of the feared stimuli to casually find their way into the conversation. Through the use of stories, metaphors, anecdotes, and puns, Douglas gradually conveyed information that essentially shifted Grace’s relationship with blood, needles, and medical procedures. Different from clients treated with CBT and other awareness-driven approaches, Grace was not encouraged to think differently about her situation. She could experience change without having to make a conscious effort to resolve her problems by trying to control or eliminate her emotions, thoughts, and/or behaviors. Thus, Douglas endorsed an effortless (or non-volitional) endeavor, in which Grace was not consciously confronted (or cornered) with expectations of how she should change.
Findings and Previous Studies

Encountering Rather than Countering

From the start, Douglas accepted or encountered all of Grace’s fears pertaining to both her phobia of blood, needles, and medical procedures and her concerns regarding the trance process. Carl Rogers (1980) described empathy as “temporarily living in the other’s life, moving about in it delicately without making judgments” (p. 142). Douglas empathized with Grace’s concerns by providing a variety of explanations and stories intentioned to help Grace feel comfortable with the trance process and her current dilemma. Douglas also exhibited the same acceptance and cooperation approach with all of Grace and Leo’s responses, regardless of the topic. This included all communication in the sessions and email correspondence.

Douglas created a context in which there were no “right” or “wrong” answers. During instances in which either Leo or Grace did not understand or have an answer to a question, Douglas was welcoming, attentive to, and respectful of their responses. Flemons (2002) described this as “offering [his] sincere interest” (p. 189)—an interest and curiosity that remains constant, regardless of the clients’ response.

Douglas also encountered Grace’s usual reaction to the feared stimuli. As noted in Chapter IV, Douglas was not only receptive to Grace’s fear of trance and concern with “passing out” (1, p. 5), but he also encouraged and embraced it. This is different from CBT hypnotherapy approaches in the treatment of individuals with phobias, in which therapists endeavor to suppress irrational thoughts in order to change the problem behavior(s) (Beck, 2005). From this perspective, clients are perceived as having malfunctioning cognitive processes that impede their ability to socially function. Instead,
Douglas formulated an environment that advocated for “trial-and-error learning” (Flemons, 2002, p. 189). He believes that responses that clients identify as uncomfortable or aversive can contribute to “creative transformations” (p. 189) or therapeutic change.

**Resourceful Rather than Resistant**

With CBT, the identification and modification of irrational thoughts and/or rigid belief systems is commonly processed through exposure-based therapies (Alpers, 2010). They are considered the empirically validated treatment of choice. However, not all individuals with phobias are willing to engage in this process. Marks and Sullivan (1998) found that up to 25% of patients refuse this form of treatment because of excessive fear of the procedures. CBT therapists label individuals who do not initiate or complete the process as “resistant” or “non-compliant” (Spiegel, 2014). One way CBT therapist address this issue is by assessing their clients’ “readiness for treatment” (p. 391) during their initial consultation. Another way CBT therapists circumvent what they label “resistance,” “unwillingness to participate,” and “premature dropout” is through the use of hypnosis (Leahy, 2010). According to Lynn and Kirsch (2006), clients are more receptive to therapeutic suggestions during hypnosis.

However, as a Neo-Ericksonian hypnotherapist, Douglas does not view clients as resistant, but rather as reluctant and resourceful (Flemons, 2002). He “think[s] of clients’ reluctance as their struggle to accept one or more aspects of the therapeutic process, as their way of saying no to what doesn’t fit for them” (p. 92). He goes on: “Many therapists interpret clients’ reluctance as resistance, as their neurotic inability to trust the therapeutic relationship, as their stubborn unwillingness to change.” (p. 92). However, he “take[s] a different tack” (p. 92). Douglas displayed this “tack” by allowing Grace to repeatedly
express her fear of the trance process without passing judgment or defining Grace’s actions as an unwillingness to participate. In addition, during the trances in the first two sessions, Grace opted to keep her eyes open throughout the entire process, despite the fact that Douglas suggested she could close them at any time. Rather than considering this an instance of non-compliance, Douglas offered anecdotes or stories that embraced Grace’s decision to keep her eyes open. Furthermore, Douglas utilized Grace’s reluctance by giving it a label, “calling the shots” (3, p. 5). What Grace’s previous psychiatrist identified as a “mood disorder,” Douglas perceived as a strength or a “special ability.”

**Mind/Body Connection**

My CA revealed that Douglas’s conscious emphasis on unconscious (or non-volitional) learning is a form of multi-level communication, which includes both a conscious component to treatment as well as an unconscious requisite to change. This notion of embracing both levels of consciousness in therapeutic change stems from Ericksonian (1980a) practices, but just as importantly, Bateson and Ruesch’s (1987) understanding of communication. Bateson and Ruesch stated that all communication has a dual component: “Every message in transit has two sorts of ‘meaning.’ On the one hand, the message is a statement or report about events at a previous moment, and on the other hand it is a command—a cause or stimulus for events at a later moment” (p. 179). As was richly explored in Chapter IV and is further discussed below, Douglas’s relational approach embraces this double element of communication, which acknowledges the mind/body connection (or conscious and unconscious relationship) without attempting to suppress or prioritize one over the other.
The doubleness of Douglas’s way of intravening should not be confused with what he refers to as dichotomous epistemologies (Flemons, 1991). Rather than engaging in an either/or orientation, as displayed by most individual approaches (Baer et al., 1968; Beck, 2005; Ellis, 1999), Douglas embraced Bateson’s (2000) both/and logic, which diffuses the metaphorical boundaries created by language and connects both sides of a distinction. In other words, “the focus of attention and involvement [was] not on the level of the particular but on the relations between them, on the context” (Flemons, 1991). This form of both/and inclusion is consistent among Douglas’s intraventions, some of which are discussed below.

**Physiological reframes.** The couple initially attributed Grace’s fainting response to Grace’s anxiety, which was a result of her “over thinking” (1, p. 6). Their perception of Grace’s problem was also reinforced by their psychiatrist, who attributed Grace’s fainting response to anxiety and recommended that she take “medication” and/or see a “cognitive behavior” therapist. Although this may seem like an anecdotal perception, this type of understanding, which associates a specific pattern of thinking to anxiety disorders, is quite common. For instance, the Self-Regulatory Executive Function Model (S-REF) (Wells, 2000) suggests that the cause of anxiety disorders is correlated with an activation of a particular pattern of thinking referred to as cognitive attentional syndrome (CAS), which consists of repetitive thinking, constant rumination, and excessive focus on thoughts and feelings.

However, Douglas provided the couple a different perspective. He acknowledged Grace’s thinking patterns during fainting incidents but also underscored the physical processes associated with fainting. Douglas presented the couple with physiological
explanations (or reframes) that accentuated Grace’s unique abilities. For example, Douglas redefined Grace’s “passing out” experiences as an ability to have “automatic blood flow changes” (1, p. 5), which was the result of her being more “evolved” (1, p. 9).

Thus, Douglas’s attention to the physical factors associated with fainting demonstrates his recognition of, and emphasis on, Grace’s mind/body connection.

Few studies have focused on underscoring (or embracing) the physical components associated with fears and phobias. If these factors are acknowledged, they are labeled as symptoms, as sensations that are the result of thinking, and, thus, should be extinguished (Ruiz, & Odriozola-González, 2017). For instance, Ruiz and Odriozola-Gonzalez explored the effects of metacognitive therapy and Acceptance and Commitment Therapy (ACT) on anxiety disorders. They broadly classified physical sensations as anxious and stressful feelings or unwanted emotions that result from dysfunctional beliefs, experiential avoidance, and/or cognitive fusion. Thus, their research focused on how cognition (thoughts) or metacognition (beliefs) shifted as a result of therapy. There was no interest in their participants’ physical responses. Nowakowski et al. (2016) associated social anxiety disorder and panic disorder with anxiety sensitivity—a list of undesired physical symptoms such as an increased heart and difficulty breathing. The authors also labeled these physical sensations as panic symptoms and, thus, were interested in how CBT therapy decreased these aversive physical experiences. Although they focused on the symptoms or physiological sensations, their goal was similar to other CBT therapists—to extinguish uncomfortable sensations rather than embrace them.
Clinical Implications

Clinicians treating individuals with fears or phobias may deem the findings in this study significant in several ways. Douglas offered a unique perspective of how to engage with a client struggling with a fear or a phobia. Guided by Erickson’s (1959) “Techniques of Utilization” (p. 272), Douglas accepted and embraced all of the couple’s experiences and responses, which proved to be useful in the resolution of Grace’s problem. Thus, practitioners working with clients with similar circumstances may be inspired to perceive them as having the necessary skills and experiences to solve their problems, including opportunities for learning following times of “failure” or “setbacks.” Douglas demonstrated that Grace acquired unique skills, such as “confidence” and “courage,” during moments of difficulty or what she understood as “disappointments.” Therefore, clinicians may be encouraged to conceptualize instances of “failure” as useful occasions for learning.

For Hypnosis and Hypnotherapy

With traditional hypnosis, CBT hypnotherapists give great value to the client’s individual characteristics (Lynn, Laurence, & Kirsch, 2015). For instance, the authors underscore the importance of the client’s “attitudes and beliefs”; their “motivation to respond to the hypnotist and his or her suggestions”; and “their interpretation of how to respond to suggestions and willingness and ability to imagine experiences consistent with the requirements of diverse suggestions” (p. 315). They consider these factors to be essential in the client’s ability to experience and benefit from hypnosis. Similarly, relational hypnotherapists value the importance of clients’ beliefs, attitudes, and motivation, along with their idiosyncratic responses to suggestions. However, they do not
prioritize particular characteristics as prerequisites for trance or hypnosis (Flemons, 2002). As Douglas demonstrated, he was interested in exploring, embracing, and utilizing Grace’s responses and experiences to both enhance the trance process and to develop solutions for Grace’s problem. He organized his intraventions around her unique capabilities and understandings. These findings support the Ericksonian idea that treatment is best inspired and guided by client qualities.

Additionally, Douglas acknowledged his role in the hypnotherapeutic process. He understood the systemic quality in his intraventions, meaning that he was aware of how his communication shaped Grace’s responses, which, in turn, influenced how he responded. Flemons (2002) identifies this recursive process as an essential component of hypnosis.

He perceives hypnosis as the “creation and maintenance of a special relationship” (p. xvi), which is facilitated through the communication that transpires in therapy. Thus, my findings may inspire individual therapists to acknowledge the interpersonal nature of hypnosis, to recognize the influence of their communication on the hypnosis process and the clients’ hypnotherapeutic experiences.

**For Brief and Family Therapy**

Clinicians who identify as brief therapists may benefit from the findings of this study in several ways. As Flemons (2002) stated, “the logic of hypnosis lies at the heart of therapy” (p. xviii). As thoroughly discussed in Chapter I and II, most (if not all) brief therapy approaches were influenced by Erickson’s (1959) ideas of hypnosis and therapy. As Fisch (1982) underscored, Erickson’s ideas did not only contribute to the field of family therapy, they were “revolutionary in its implications” (p. 155). One of the major
contributions was his interest in clients’ symptoms, rather than a lengthy understanding of their psychological history. Erickson spent “considerable effort in obtaining rather a detailed picture of the symptom, problem, or complaint and how it was performed, as well as how it was performed in conjunction with others involved in the problem” (p. 158).

My study revealed that Douglas took a similar stance in the treatment of a phobia. He was interested in the idiosyncrasies of Grace’s fainting experience. Douglas was also interested in the relational context—how Leo and her family members (including in-laws) had an influence on her symptoms. However, he was not invested in gathering a wealth of information about Grace’s past experiences. If this information was presented, Douglas explored these events and experiences with the intentions of utilization. For example, Grace’s negative experiences as a teacher proved useful in the development of resourceful skills. Thus, the findings invite brief therapists to consider exploring the particularities of the symptoms associated with fears or phobias and how they are interconnected with their relational context.

Although Douglas was interested in the Grace’s symptoms, he was not oriented by the category of a “phobia” or “fear.” Bateson’s (2002) asserted that “no class can in formal logical or mathematical discourse, be a member of itself” (p. 280). In keeping with this idea, Douglas conceptualized Grace’s physiological responses as different from the label (or labels) the couple used to encapsulate Grace’s physiological experiences. This was evident in Douglas’s use of physiological reframes, which were intentioned to redefine the physical sensations Grace experienced during instances of fainting. Douglas’s focus on the physical particularities of Grace’s symptoms presents a unique
understanding of an emotion such as fear. Brief therapists may be inspired to focus on and invite change in the physiological changes that clients and other professionals classify or categorize as a “fear” or a “phobia,” rather than engaging in efforts to modify the class as a reified entity.

Like Erickson (Fisch, 1982), Douglas structured his approach to reflect efficiency and effectiveness. As described in Chapter IV, he discovered and underscored a variety of Grace’s resources and skills that proved to be useful in the first session. Douglas then interwove this information in the second session during trance. Shortly after their initial meetings, Grace informed Douglas of a variety of changes in her experience. This, along with other descriptions noted in Chapter IV, indicated the effectiveness of Douglas’s initial interventions. As Howard, Moras, Brill, Martinovich, and Lutz (1996) noted, clients are more than likely going to experience most change earlier, rather than later in the treatment. Thus, brief and family therapists are invited to value their initial encounters with clients and to consider the immediate effects of treatment regardless of the complexity of the presenting problem.

Family therapists may be inspired to embrace (or further embrace) Erickson’s (1959) techniques of utilization in the treatment of a fear or phobia. A key tenet in postmodern approaches, specifically SFBT, is that clients “have the resources necessary to help themselves; they are the experts” (Simon & Berg, 1999, p. 2). This conceptualization of clients and resources originated from Erickson’s notion of utilization (de Shazer, 1988). With Grace, Douglas demonstrated the usefulness of her conscious and unconscious expertise or skills in the resolution of her problem. For instance, Douglas accentuated that Grace could exhibit a conscious effort by “calling the shots” (3,
p. 5) and could also embrace her non-volitional skills, such as her ability to discover “flow” (1, p. 30) and experience “automatic blood flow changes” (1, p. 5). Thus, my findings may inspire practitioners with postmodern sensibilities to embrace interventions that utilize both their clients’ conscious and unconscious attributes in the treatment of a fear or a phobia.

**Research Implications**

The way in which I conceptualize process research was shaped by both my academic and therapeutic experiences. Most of the research I encountered in both my graduate and undergraduate experiences focused on outcomes studies, in which the research is “aimed at determining if a treatment is effective, or how its effectiveness may compare to an alternative treatment” (Williams, Patterson, & Edwards, 2014, p. 264). In other words, it is a type of research that focuses on the overall outcome or effectiveness of a particular model of treatment or intervention(s)—did it work?

This emphasis on effectiveness or outcome oriented how I approached this analysis. As noted, I adopted a context-enriched conversation analysis (Flemons, personal communication, March 13, 2018) to include Douglas’s case notes to thoroughly capture the context of change. However, I also used Grace’s descriptions of change in her email correspondence with Douglas as contextual parameters, which guided my selection of data (or interventions) that I could consider related or interconnected to Grace’s changes. With the parameters set, I then focused on the process of hypnotherapy. It is important to note that this approach is different from traditional conversation analysis, in which “information is not discarded by the conversation analyst[,] as the investigator does not
know early in the project which details are important” (Gale, 1991, p. 29). As Hopper (1988) stated, “conversation-analytic data reductions occur late in the inquiry” (p. 57).

I found the conventions associated with conversation analysis (CA) to be a useful research tool for exploring and understanding the communication that transpired in the hypnotherapy. As Gale (1991) noted, CA is useful for “investigat[ing] the sequential and linguistic features of the therapeutic process” (p. 34). I was able to discover and describe how a relational hypnotherapist achieved change with a client suffering from a fear of blood and needles. This included the process by which Douglas facilitated the development of alternative identity descriptors for Grace that allowed her to relate differently to her problem. As Gale (1996) stated, CA is a useful tool for exploring how identities develop as a result of conversations or language.

CA conventions were also helpful in identifying the paralinguistic features of Douglas’s hypnotic communication (e.g., emphasis on words) and other subtle, yet relevant sources of information, such as outside sounds and noises, which proved useful in Grace’s therapeutic experience. As Gale (2010) mentioned, CA was developed with the intention “to examine talk-in-interaction at the microscopic level of social interaction” (p. 10).

A limitation of most outcome research is that researchers do not consider the role of the therapist or the therapeutic relationship in the change process (Williams et al., 2014). Again, the focus is on the effectiveness of a particular treatment—an interest in cause-and-effect. However, CA was designed to explore “the sequences of talk as they are recursively . . . or reflexively connected within the context of the conversation” (Gale, 1991, p. 23). This simply means that researchers using CA to examine therapeutic
conversations value the recursive nature of communication, in which both the therapist and the client influence, and are influenced by, the process (or context). My findings suggested that Douglas’s intraventions had an influence on Grace’s experience. However, his communication was also shaped by Grace’s ongoing responses. Thus, researchers who are interested in exploring the role of the clinician in the therapeutic process may be inspired to use CA as a method of analysis. As Gale (1991) highlighted, CA is a methodology that is “sensitive to discern patterns consistent with a systemic epistemology” (p. 3).

CA was originally designed to examine “naturally occurring interactions” (Pomerantz & Atkinson, 1984, p. 287), for example, how individuals respond to compliments (Pomerantz, 1978). However, my analysis consisted of a therapeutic interaction, in which Douglas used his expertise to guide and shape the conversations. As Anderson and Goolishian (1988) underscored, “the therapist is a master conversational artist, an architect of dialogue whose expertise is creating and maintaining a dialogical conversation” (p. 9). Douglas and Grace’s interactions are contextually different from the interactions that would unfold in a natural setting. I valued Douglas’s expertise by including his case notes as additional information about the sessions.

I also valued my expertise of relational hypnosis in the selection and interpretation of data. With conventional CA, researchers approach the data “without advance knowledge” (Gale, 1991, p. 29) and discover patterns through “repeated exposure to recordings and transcriptions” (Hopper, 1988, p. 54). Given that I repeatedly listened to the recordings, I embraced my understanding of relational hypnosis as an additional guide for my analysis. I used my expertise to examine and connect the
intraventions that I considered to be relevant and related to Grace’s overall outcome. Researchers with clinical expertise may be influenced by my approach to embrace a context-enriched conversation analysis as a method of accepting and utilizing their knowledge and expertise when examining a treatment modality with which they are familiar.

**Implications for Supervision**

Supervisors who practice from an Ericksonian or Neo-Ericksonian perspective could be informed by the findings of this study in several ways. Zeig (1994) stated that the implementation of utilization was “a central facet of all of Erickson’s interventions” (p. 298). As demonstrated, most (if not all) of Douglas intraventions reflected this Ericksonian principle. Inspired by how this was done, supervisors could invite and guide their supervisees to embrace utilization as an organizing principle, in which guides the way they interact with clients and, just as importantly, approach the treatment of a fear or phobia (or any problem).

The findings of this study may also inspire supervisors to encourage their supervisees to experiment with unique and creative ways to embrace utilization. Erickson highlighted the uniqueness of each individual and “was concerned that his approach might be codified and reified” (O’Hanlon, 1987, p. x). Erickson appealed to the idiosyncratic qualities of all therapists: “Develop your own technique[;] . . . just discover your own. Be your own natural self” (p. x). As explored in Chapter IV, Douglas demonstrated his natural self in the way he communicated with the couple. For example, he casually interlaced his intraventions with humor. In addition, his use of associational suggestions appears to be unique to relational hypnosis. Thus, supervisors could be
inspired to create a supervision context that provides supervisees the freedom to explore and discuss their natural abilities and resources that they consider useful as therapists.

**Implications for Teaching Relational Therapy and Hypnosis**

Douglas created a therapeutic atmosphere that allowed the couple to freely express themselves, free from judgment and discouragement. This was evident in how he empathically responded to Grace’s frequent concern about hypnosis. Rather than criticizing her nervousness, he became curious about it. As Flemons (2002) stated, “curiosity is a wonderful antidote for estrangement, for it pulls you across any self-Other boundaries you’ve imposed” (p. 47). Furthermore, he stressed that concordance (or an empathic relationship) is achieved “in the service of allowing [clients] to be themselves” (p. 77). This is different from approaches that consider thoughts and beliefs to be irrational and/or dysfunctional (Beck, 2005; Ellis, 1999). Douglas’s perception of Grace (and clients in general) has implications for teaching relational therapy in both a classroom and supervision settings. Those teaching or supervising from a relational standpoint can create environments that inspire students, too, to be themselves—an atmosphere that encourages curiosity, learning, acceptance, and creative collaboration.

The findings described in this study could also be helpful in teaching hypnosis. Although the evidence supports the effectiveness of clinical hypnosis (Lynn, Kirsch, Barabasz, Cardeña, & Patterson, 2000), there is limited emphasis on the details of the process. Most of the qualitative research consists of clinical case studies that provide only stories and/or limited descriptions of what transpired in therapy (Hirsh, 2012; Iglesias and Iglesias, 2014a; Weigold, 2011). Highly specific illustrations and explanations of hypnotherapy can enhance students’ recognition and understanding of the process of
effecting therapeutic change.

**Personal Reflections**

The process and findings of this study have enhanced my knowledge of relational hypnosis, and, more specifically, my understanding of utilization. CA was a useful tool for discovering the recursive and evolutionary nature of utilization. I learned that it is more than just a set of techniques; rather, it is an orientation to treatment, guiding the perception of and interaction with clients.

This therapeutic orientation is a significant departure from how I practiced as a certified behavior analyst. Back then, my decisions about what to do and my interactions with clients were primarily shaped by empirical research. From a behaviorist’s perspective, clients are not considered to have the necessary strengths or wisdom to solve their problems and, as a result, are provided with minimal autonomy in the treatment process. Thus, they have to mostly depend on the therapist for his or her expertise.

The notion of utilization has profoundly transformed the way in which I perceive and interact with clients. I have learned to appreciate their unique experiences and to value their inner and relational resources in the resolution of problems. This study has enhanced my understanding of how this approach can be facilitated with more severe problems and with individuals who are considered or labeled by others as having minimal strengths or resources.

This conceptualization of utilization also gave me a better appreciation of the unique and interpersonal nature of hypnosis. Bill O’Hanlon said it well: “An Ericksonian approach says that you can do trance with just about everybody. Everybody is
hypnotizable. You’ve just got to find the ways in which they’re responsive and hypnotizable” (O’Hanlon & Martin, 1992, p. 3).
References


A. Austin & J. E. Carr (Eds.), *Handbook of applied behavior analysis* (pp. 91–112). Reno, NV: Context Press.


New York, NY: Brunner/Mazel.


Appendix A

Transcript Notation

(short pause) A pause five seconds or under.

(long pause) A pause over five seconds.

= There is no discernable pause between the end of a speaker’s utterance and
the start of the next utterance.

: One or more colons indicate an extension of the preceding vowel sound.

Under Underlining indicates words that were uttered with added emphasis.

CAPITAL Words in capitals are uttered louder than the surrounding talk.

(.hhh) Exhale of breath.

(hhh) Inhale of breath.

( ) Material in parentheses are inaudible or there is doubt of accuracy.

[ ] Overlap of talk.

(( )) Material in parentheses indicate clarificatory information, e.g.,

((laughter)).

? Indicates a rising inflection.

! Indicates an animated tone.

. Indicates a stopping fall in tone.

* * Talk between * * is quieter than surrounding talk.

> < Talk between > < is said quicker than surrounding talk.

(Gale, 1991, p. 105)