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Heating Up to Cool Down: An *En*countering Approach to Ericksonian Hypnotherapy and Brief Therapy

Douglas Flemons

Edgy and exhausted from continually failing to control his body's stress response, Azran—"Az"—was referred to me by a therapist who'd tried unsuccessfully to help him with hypnosis-infused relaxation training. Any time Az had to deal with someone he deemed an "authority figure"—a teacher, coach, supervisor, cop, doctor—he would become hyper-alert and self-conscious, which was soon followed by intense anxiety. The same sensitivity would arise whenever he felt another person's eyes staring at him. Unfortunately, this was not an infrequent occurrence, as he had the face of a movie star and the powerful build of a professional athlete. An accomplished tennis player and gifted graduate student, he moved gracefully and spoke eloquently.

Az's shift to a heightened, reflexive focus was triggered by either the social status or lingering scrutiny of others, but it was jet-fueled by his anticipation and dread of what people would think of him once they noticed what typically happened next. Beads of sweat would form on his forehead, and then, when he failed to calm his pounding heart or contain his mounting panic, his thoughts would race and his whole body would heat up. He could, he said, "soak through a shirt in two minutes flat." His previous therapist had offered hypnotic imagery of cool locations and breezes to counteract this automatic response. When he could picture such conditions during their sessions, it helped him feel more comfortable, he said, but it didn't make a difference outside the office.

Az and his family had immigrated to the U.S. eight years earlier, when the political situation in his home country had become untenable. Eighteen months prior to their leaving, back when Az was 16, his older brother, driving alone, was detained at a military checkpoint. A search of his car was initiated. A scuffle ensued. A severe beating followed, and then imprisonment. Some months later, while still in custody, long before any trial, Az's brother died.

A few months after the funeral, Az was in a car with some friends when they were pulled over for speeding. As the policeman approached the driver-side window, Az, sitting in the backseat, started trembling. Somehow he managed not to draw the officer's attention, but by the time his friend had offered a sufficient bribe and they'd been waved back into traffic, Az felt spent and his clothes were drenched.

Now, nine years later, Az, living in the States, wasn't sure he could continue pursuing his graduate studies. He believed his current struggles traced back to what happened to his brother, but his symptoms involved more than the trembling and sweating he experienced that day in the backseat of his friend's car, and they could be set off by virtually anyone—authority figures, sure, but also family, friends, neighbors, fellow students, and both tennis opponents and tennis partners. The person didn't even have to be in his presence; he'd sometimes start having a panic attack and get tongue-tied while talking on the phone. He felt so impossibly caught and interpersonally shut down, he'd been thinking about suicide. His mother, recognizing his struggle and self-doubt, was afraid for him; his father was just disappointed and critical. He told Az that he needed to "get control" of himself.

The previous therapist's strategy of offering hypnosis-induced relaxation training was well-meaning and no doubt skillfully delivered. But the logic informing the approach was in keeping with what Az had already been frantically doing on his own—trying to tamp down or

counteract his symptoms. Relaxation necessarily involves a softening, a letting go. But when it is raised as a shield to protect against frantic, visceral sensations, or when it is thrust as a sword to smite unrelenting anxious thoughts, it freezes into something hard and brittle, rendering it useless—nothing more than an experiential oxymoron. So rather than signing on to help Az *counter* his thoughts and visceral symptoms, I committed to helping him *en*counter them instead. I didn't explain this, didn't say it directly; rather, my commitment was implicit in what I asked, described, invited, and suggested. The organizing principle of my engagement was what Milton Erickson (1980) called *utilization.* I approached Az's sweating, ricocheting thoughts, and fast-beating heart as *abilities* that, if effectively applied, refined, or tweaked could themselves serve as pathways to the amelioration of his suffering. Ericksonian hypnosis and the logic informing it are ideally suited for inviting such alterations.

Az and I met for three sessions, each 90 minutes long. Our time together was interlaced with hypnotic interactions, though I seldom labelled them as such. Az hadn't been demonstrably helped by his previous experience of hypnotherapy, so I wanted to mark what we were doing as somehow different. I thus offered no formal hypnotic inductions (e.g., "As I count backwards from 10 to 1, you can feel yourself moving deeper and deeper into trance"), and I never suggested that he close his eyes and relax. His finely-tuned, non-volitional mind-body connection was very much in evidence in his hair-trigger visceral responses to challenging circumstances. It only made (Ericksonian) sense, then, to utilize these easily evoked reactions as efficient segues into mini therapeutic trances. Az could never quite put his finger on what was happening to his body as we worked together, and, as you'll see below, he was never quite comfortable with the process, but he could tell that something significant was shifting—something he was unable, but also didn't need, to control.

Early on in the first session, I told Az a story of an initiate who went to Nepal to study with a Buddhist teacher. The monk literally lived in a cave in the mountains, so he recognized the urgent necessity of his new student's learning to use meditation to raise his body temperature. The young man would need to master the skill in order to survive the fast-approaching winter. "Isn't it interesting?" I mused, "What you already know how to do automatically, the student had to travel all the way to Nepal to learn." He laughed nervously and said, "Let's go the other way. Let's cool me down."

Az's worried appeal for "going the other way" was predicated on the rational idea that problems are best dealt with by counteracting or avoiding them. However, a utilization approach is predicated on the *relational* idea that problems are best dealt with by *en*counteracting them—by approaching and engaging them. Typically, clients, and those who fail to help them, attempt to solve problems via negation (e.g., in this case, *preventing* or *stopping* heating up), substitution (e.g., *going in pursuit* of cooling down *as opposed to* heating up) or symmetrical battle (e.g., *pitting* cooling down *against* heating up). In contrast, utilization-informed therapists invite therapeutic change via acceptance (e.g., *allowing* heating up), inclusion (e.g., *embracing* both cooling down *and* heating up as legitimate), and complementary (circular) engagement (e.g., *arriving* at cooling down *by way of* heating up).

Over my three sessions with Az, I used anecdotes and experiments to invite shifts toward acceptance, inclusion, and circularity. The first experiment, designed for him to fail, helped him reconsider his, and his father's, assumption that what he needed was more control over his body.

Douglas: Would you like to do an experiment?

Azran: Okay.

Douglas: Okay, can you purposefully raise the temperature of your forehead right now? Not by imagining something, just by you consciously making it happen, by saying to your forehead, "Okay, temperature, up you go."

Azran: *[After some time spent trying]* No.

Douglas: Try harder. Use more willpower. Demand it.

Azran: *[After several seconds]* I can't do it.

Douglas: Gives you a sense of why that meditation student had to head to Nepal. Okay, can you purposefully speed up your heart?

Azran: *[After several seconds]* Can't do that either.

Douglas: No. You've been thinking something was wrong because you can't, on cue, cool your forehead or slow your pulse. But you can't heat or speed up your body, either. Not on purpose…You can't police your body.

Azran: As hard as I try.

Douglas: Right! Your body isn't going to let anyone mess with it—not your dad, not even you.

Rather than try to protect Az from his symptoms by helping him arm himself against them, I invited his panicky thoughts and body reactions into our sessions, both directly and indirectly, so he could practice relating to them differently—relating to them resourcefully rather than fearfully. Az dated the beginning of his problem to the time the police officer was walking toward the car he was riding in as a teenager, and of course this followed the death of his brother at the hands of the military. With this in mind, I evoked the presence of such authorities through my metaphoric language choices ("you can't police your body"), and I made sure to sip my tea out of a cup that had the initials *FBI* prominently displayed on the side. Near the end of the first

session, I asked him, “So, is it okay for your conscious mind to take off the badge?” He said it was.

Paying attention to such contextual details is integral to relational sensitivity and a relational sensibility, one that accounts for and utilizes details of both the inter- and intra-personal relationships composing the client’s experience. I heard in Az’s voice the anger and frustration he felt in response to his father’s dismissive belief that Az wasn’t strong or determined enough to get his symptoms under control.

Azran: He thinks I should just buck up.

Douglas: He thinks if you only try harder, you’ll be able to beat it.

Azran: Yes.

Douglas: Your body understands that bucking up, fighting back, doesn’t help—it actually makes it worse.

Azran: My father doesn’t.

Douglas: Your father doesn’t understand that, no.

What better, more satisfying, way for a young man to come into his own, to find his confidence, his bearing, than in contradistinction to an overly critical father, a father that didn’t, and probably could never, understand? What better way to launch into trusting, rather than fighting against, his body?

The naming of conditions of suffering—e.g., “anxiety,” “panic attacks,” “depression,” and such—facilitates short-hand communication and understanding among clinicians, as well as between them and their clients or patients. On the surface, this seems sensible, nothing more than an efficient summing-up. But such naming concretizes classes of symptoms as stand-alone entities, prepackaged with a set of cultural and personal preconceptions and expectancies about

the frustrating irrationality and intractability of them. Considered formidable, uncontrollable opponents, such entities—categories of mental illness—are therefore commonly assumed (by clients and clinicians alike) to require powerful counteracting interventions to wrestle them into submission. No wonder brain-altering, side-effect-inducing medications seem so alluring.

Implicit, and therefore invisible, in such characterizations is the assumption that the process of addressing mental-health problems entails doing something *to* them. I choose instead to do something *with* them. This is, after all, the essential therapeutic shift in orientation inherent in Ericksonian utilization. But I don't take the classified whole of the problem as a given. That is, I don't attempt to do something with such entities as "anxiety" or "panic attacks." Instead, I work with (more, *play* with) the contextualizing definitions of problems, as well as the non-volitional *composing strands of experience* that get clustered into such categories. I'm interested in the details, the blood-and-guts descriptions of visceral, tangible, identifiable thoughts, actions, sensations, feelings, emotions, and images. I am thus curious about instances of, for example, pain, temper, despair, fainting, desire, urges, disgust, crying, flashbacks, sweating, nightmares, cramping, nausea, dizziness, temperature shifts, heart-quickening, humiliation, hyperventilating, perseverating thoughts, and/or hallucinated voices and images. It is important to underscore that none of these experiential strands can themselves be considered as stand-alone "things"; they are all noted and articulated in the interactive, self-fulfilling swirl of expectation, perception, interpretation, and response that recursively defines intrapersonal communication, conscious awareness, and interpersonal conversation. This is why they are all amenable to change, to therapeutic alteration—they aren't isolable *entities*, they are *patterns* of intra- and interpersonal interaction. Introduce a difference somewhere in the unfolding of such patterns, and it, and the

difference it makes, can ramify. That's how therapeutic change typically happens—it starts small and extends out of the office and into a life.

Having experientially discovered that he couldn't purposefully lower *or raise* his temperature or heart rate, Az was amenable to experimenting with a different approach.

Douglas: Like other elite athletes, you have a highly refined mind-body connection. When you're on the tennis court, your conscious mind doesn't issue orders to your feet and your shoulders and your arms and your grip. You rely on a virtually instantaneous, integrated coordination between different parts of your body—right hand and left foot, left eye and right hand, right hip and left shoulder—and between all of these parts and your awareness. When you're in the zone, it's all effortless.

Azran: Yes. Very much.

Douglas: Being in the zone, being in sync with your mind-body coordination, is an excellent way to learn. Hypnosis is just a means for getting in the zone without having to be on a tennis court.

Azran: Okay.

Anecdotes and stories allow ideas to be offered and considered analogically, rather than analytically. The fabric of them, the pattern organizing them, implicitly communicates a shift in orientation, a shift in relationship between the person and his or her experience (Flemons, 2002). The following story and the experiments that evolved out of it illustrate the process:

Douglas: I once directed a clinic that developed an air-conditioning problem. Actually, the AC in most of the building was just fine. But the largest room, the one where we met for staff meetings and group supervision, it got to where it was way too cold all the time. Anyone who was going to be in there for any length of time made sure to

bring a sweater; otherwise, it was unbearable. Over the course of a year, we probably had the AC guy come out half a dozen times, and every time he told us the same thing in the same irritated, authoritative voice: “Nothing is broken: the condenser checks out, the air handler is fine, and the thermostat isn’t stuck.” But my staff and I were still miserable, so I asked the office manager to call yet again. I guess the usual guy was away, or maybe he was sick of dealing with us. Anyway, a new technician comes out, and he does the usual equipment check, and then he does something the other guy didn’t. He comes and stands with me in the cold room. Doesn’t say anything, just stands there, feeling the temperature, looking around the room. And then he asks, “How long has that floor lamp been there in the corner, next to the thermostat?” I think for a while. “Oh, I don’t know, I guess about the same amount of time that we’ve been freezing our asses off.”

Azran: *[laughs and continues looking at me]*

Douglas: The heat from the lamp was perpetually warming the air right next to the thermostat, so from the thermostat’s perspective, the room was never cold enough to trigger it to send a signal turning off the AC. Once we moved the lamp, the AC would cool down the room *and* the thermostat, and when that lower-level threshold on the thermostat was reached, it tripped a switch and the AC would turn off, just like it was supposed to. This would allow the room to start warming up, and when the thermostat registered that the roomed had warmed sufficiently, when the upper-level threshold had been reached, it sent a signal that fired up the AC, and the room started cooling down again. Just like it was designed to do. The room had to cool down enough for the thermostat to know it was time for it to begin warming up, and

it had to warm up to the necessary threshold before the thermostat could send the signal to start the cooling process. For the thermostat, it's all just a circle: you cool down *so* you can heat up, and you heat up *so* you can cool down.

Let's facilitate your body remembering, or learning perhaps for the first time in a long time, how to heat up till you reach that threshold where your metabolism, your internal thermostat, triggers an automatic cooling down. Instead of trying to make it happen, you can just allow your body to activate the balance of that circular process.

Azran: Okay.

Douglas: So you can just become aware of my eyes looking at you.

This was my invitation to Az to go into trance; nothing more was needed.

Azran: *[nervously laughs]* Oh, I just knew you were going to do something twisted.

Douglas: *[laughs]* Is that okay? Are you okay registering the fact that I, in my twisted way, am looking at you?

Notice my use of the word "registering," which I'd used when talking about the thermostat.

Azran: Yeah, it's okay.

Douglas: You're comfortable with feeling uncomfortable?

Azran: *[laughs]* Yeah, well, no, but okay.

Douglas: Great, so as you notice my eyes, even focusing on them, what else are you registering?

Azran: My heart is beating faster.

Douglas: Yes! Excellent! What else?

Azran: I'm heating up…

Douglas: Yes, your heart and your temperature can work together that way. Faster and hotter, hand in hand, heart and head, faster and hotter.

Azran: I can feel your eyes on me. That's what's killing me.

Douglas: Good.

Azran: Oh boy, *[laughing]* this is rough. Ahhh.

Douglas: What's happening?

Azran: Oh, it's still going.

Douglas: Oh, it is.

Azran: Yeah, 'cause I can feel like your eyes on it and I can't stop it.

Douglas: Terrific, so go ahead and look at me.

Azran: *[laughs]* I don't want to look at you.

Douglas: I know you don't.

Azran: *[laughs]*

Douglas: Just allow it to continue until the upper-level threshold is reached and your internal thermostat sends the signal to automatically initiate the cooling and the slowing process. Keep heating up till you reach that threshold. I don't know if the signal will first be from your heart, registering that it got fast enough to trigger the slowing down… Or whether your heart will get the message second-hand from your forehead, or from somewhere else in your body, that the upper-temperature threshold has been reached and the cooling down process has been triggered. In which case the slowing of the heart can be fast on the heels of the cooling down.

Azran: That's crazy.

Douglas: What's crazy?

Azran: I got cool.

Douglas: Cool. So, what happened?

Azran: I felt your eyes on me, and I just started heating up.

Douglas: Terrific. And what happened then?

Azran: I don't know, I just relaxed.

Douglas: Ah-ha.

Azran: I don't know. I can't explain it.

Douglas: You can't explain it consciously, but your body understands it.

Azran: It's happening again right now, but it's not as bad.

Douglas: Great. Keep looking at me, then. Allow your body to recycle this learning again and again. With more practice, it just becomes second nature. Just like in tennis. It's one thing to understand this intellectually. Now you've shifted to knowing it in your body, viscerally. You've shifted to unconsciously employing it. A kind of tennis knowing. I don't know if your conscious mind will ever figure out what your body already knows.

Azran: Oh, it just happened again.

In that first 90-minute session, Az later said he had a "double-digit number of panic attacks," that is, times when his heart and his temperature rocketed up. And each time, he'd reach an upper-limit threshold that triggered a slowing of his heart and a cooling of his body. It got so that by the end of the appointment, the cooling would start before he broke a sweat. He left gratified but also troubled. In the second session, he explained why.

Azran: I really didn't want to come here. But this is helping.

Douglas: Talk to me about the not wanting to come.

Azran: I still don't understand it, but the attacks are so fast from hot to cold, it's awesome.

Douglas: Yeah…

Azran: But double-edged.

Douglas: What is double-edged about it?

Azran: I don't understand why it starts in the first place.

Douglas: And if you understood it?

Azran: I'd stop it.

Az hated not knowing why he heated up, and he hated not understanding how his body was able to automatically cool down. We devoted much of the session to running more hypnotic experiments so that at least his body could "get the hang of it."

During the third and last appointment, we had the following conversation:

Azran: I don't know what you did to me *[laughs],* but it's good.

Douglas: Well, I don't know that I did anything *to* you. I think your body has figured out a different way of getting comfortable.

Azran: I'm amazed. But I'm not cured.

Douglas: What does that mean?

Azran: I'll still feel the heat. But it goes away. So. And the fact that I have no voluntary control of stopping. I hate that.

I reiterated my view that striving for voluntary control isn't necessary or helpful.

Azran: *[laughs]* Yeah.

Douglas: Last time you found it disconcerting that you couldn't understand how it was happening. So, can you be comfortable going into the future, saying "that was some weird shit [we did]?"

Azran: *[laughs!]* Yes, I can, I can.

Douglas: All right. You're an academic, so of course you want an intellectual understanding. But you can forgo that?

Azran: Yes.

Douglas: You're sure? You can be comfortable with your body figuring it out?

Azran: Yes, because it happens so fast. It's amazing.

Douglas: Sounds like your body has discovered the wisdom of circles.

Az described his mother as "elated" at the changes she had seen. She was "glowing" at seeing his life back on track. His father, predictably, was not effusive. But Az could meet the gaze of other people, his words weren't getting tangled when talking to his professors or classmates, and his body reliably knew how to heat up to cool down.

Six months after our last appointment, I was leaving a store, walking to my car, when I heard someone calling my name. I turned and saw Azran, waving and then striding across the parking lot towards me. We shook hands. Smiling, he said, "I guess you can tell by how dry my grip is how well I'm doing."

Clinical theorists sometimes construe successful counterintuitive interventions as paradoxical, postulating that there is something inherently helpful or healing about "paradoxing" clients (e.g., Selvini-Palazzoli, Boscolo, Cechin, & Prata, 1978; Watzlawick, Weakland, & Fisch, 1974). I take a different view. To my mind, the stories and experiments in this case were *en*counterintuitive—that is, they fit a way of approaching therapeutic change that privileges

acceptance and inclusion of, and complementary engagement with, clients and the idiosyncratic patterns of their problematic experiences. What transpired only appears paradoxical if viewed from the outside perspective of conventional rationality. From the inside perspective of therapeutic *relation*ality, my client and I extemporaneously and collaboratively explored and discovered what can happen when symptoms are embraced as vehicles for, rather than shunned as roadblocks to, resolution and change.

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