BY STEVE ANDREAS

From Certainty to Uncertainty

Using NLP to Help a Panicked Client

"People don't come to therapy for explanations; they come for experience."
FRIEDA FROMM-REICHMANN

WE'VE ALL SEEN CLIENTS who suffer from debilitating and obstructive feelings of uncertainty: "I don't know what to do with my life," "I don't know whether to stay or go," "I can't motivate myself." But sometimes the problem is that people are so certain of a particularly paralyzing perception of themselves or the world—"I can't make it on my own," "No one else will ever love me," "My life is over"—that they can't take productive action to improve the quality of their life. In such cases, reducing certainty can be an essential first step in working effectively with a presenting problem, or even defusing it completely.

I view certainty, like all our feelings, as an internal experience composed of images, sounds, feelings, and thoughts. The principal element in creating certainty is the vividness and clarity of that internal experience. An experience that's remembered as a large, close, colorful, panoramic image with intense sound will feel much more certain than one that's remembered as a small, distant, colorless, flat picture with no sound. The link between the intensity of the emotional and visual imagery and the resulting certainty is true of both lasting traumatic memories and positive imprints—those special life-changing memories that sustain us through difficult times.

If you've ever tried to change someone's mind when they're certain about something, you've probably discovered how futile that can be, even when they're consciously agreeing with you. Someone who's phobic of water may agree with you that the water in a bathtub isn't dangerous, but her vivid memory of a near-drowning experience reinforces her fear, and all your logic won't change that. A phobic client must be able to change her image of nearly drowning into something less intense and scary to lose her certainty that water is dangerous.

One way to accomplish this is, literally, to move the image to a location far behind her, as reflected in the common advice, "Just put it behind you," which most people think of as a metaphoric suggestion. Another way is to change the client's point of view from being inside the traumatic memory—as if it were really happening again—to seeing it as a more distant image on a movie screen, so that it looks as if it's happening to someone else.

Another key component of certainty is the number of examples that support it. Since I've driven many different cars and trucks over a long period of time, on a variety of roads and in almost all weather, I have hundreds of thousands of memories that demonstrate to me that I can do this. When someone has numerous experiences of failing at something or being disappointed, he's likely to have the same degree of certainty about that. Decreasing the number of problematic examples, and/or adding positive counterexamples can be another useful way to weaken the certainty of a limiting belief or generalization.

A third important factor in certainty is the authority behind the information. When the source is a parent, expert, or other authority figure, we're usually more certain about the information. If the source appears to have little knowledge or expertise, we're less certain about the information presented.

In the session reported below, my primary task was to reduce the certainty of a client's fear ►

ILLUSTRATION BY SALLY WERN COMPORT

response resulting from an experience of receiving bad news. Rather than work directly with her memory of the images and emotions related to the experience, I tracked changes in them as a way of evaluating the effectiveness of our work together.

Bad News

Sarah, a 72-year-old therapist in private practice, whom I've known for many years, called and asked if she could have a session with me to discuss a "health issue."

She was tense and hesitant as she settled into her chair and began to tell me about her situation. Two years before, she'd felt some discomfort in her abdomen, and as part of the medical testing for this, she'd had a CAT scan of her lower torso and the lower section of her lungs.

In the follow-up appointment, her doctor, after telling her the scan had revealed no problems in her abdomen, showed her the image of her lungs and said in a distant, nonchalant tone of voice—"as if it wasn't a big deal"—that she did have lung disease and had "two months to six years to live." Sarah said she'd taken this as a "death sentence," even though she hadn't had any breathing problems other than a slight cough. Since then, she'd experienced intense fear about her health and a lot of anger at her doctor for his offhand, insensitive attitude; however, instead of trying to learn more about her ailment or its possible treatment, she'd tried to blot from her mind the entire experience of receiving the bad news—without much success.

Whenever someone is afraid—especially without an external stimulus—the fear is coming from their own internal images, along with the feelings, sounds, and thoughts that accompany them. To determine how Sarah created her fear, I asked her, "What do you see when you think about the doctor telling you about your lungs?"

As she described her memory of the CAT-scan image, she gestured with both hands directly in front of her face, about two feet away, outlining an area about a foot square. This image of her diseased lungs was literally "in her face," where she couldn't ignore it. Seeing the image of her diseased lungs right in front of her was the main reason that the unpleasant content of this picture made her so afraid. However, her memory of the original CAT-scan image had spontaneously changed in an interesting way from what she'd seen in the doctor's office. She said that each lung now looked like "the big hoops with paper that clowns jump through at the circus, and afterward, you can see the torn edges of the paper where the clown broke through." Since this torn image showed only parts of the image of her lungs, it wasn't quite as disturbing as the original CAT scan had been, but it still bothered her.

Then Sarah reached into her purse and took out a small scrap of torn paper, folded in half. She handed it to me as if it were a poisonous snake that she wanted to let go of as fast as possible, saying in a tense voice, "This is what the doctor said I have. I don't want to say or see the words." As she handed me the paper, her upper body moved away from her outstretched hand. When I opened the paper, I saw that she'd written "interstitial lung disease." The word *disease* was crossed out, and under it was written "condition."

Seeing that Sarah barely wanted to touch the piece of paper, I respected her need to avoid the words on it for the time being. So as soon as I'd looked at the note, I refolded it, put it on the arm of my chair, and covered it completely with my hand, so that it was out of sight and wouldn't bother her. When I did this, she relaxed slightly and moved back toward me a little. Because of this response, I kept my hand over the paper throughout most of the rest of the session, which lasted an hour and forty-five minutes.

Sarah was aware of her feelings of fear, but like most of us, she was only partly aware of how she created these feelings. Although many therapists would probably have asked her to say more about the feelings, I didn't believe that would be useful. I could ask her to describe her feelings all day long, but the feelings themselves would remain unchanged, unless we could change the certainty that elicited the feelings.

One of the first things I did was to focus on weakening Sarah's certainty about the negativity of this experience by questioning the authority of the doctor's grim statement, and thus her acceptance of it. I laughed and said, "Doctors and their predictions! Do you know what I do when a doctor makes a prediction like that?" I paused briefly until she shook her head to be sure she was engaged. "I look around at all the diplomas on the wall —I elaborately pantomimed craning my neck to look around at all the walls of my office—and then I look at the doctor and ask, 'Do you have a fortune-telling license?'" As I acted this out, I looked into Sarah's eyes to bring the "story" into the immediate present and elicit a strong response.

She laughed, and then told me that her sister had had juvenile diabetes as a child, and the doctors had said she wouldn't live past 40, but she lived to be 75. When her sister was in her sixties, Sarah had asked her what she'd thought when the doctors had told her that she'd die young. Her sister had replied in an offhand way, "Oh, I just thought they were talking about all those *other* people out there, not about me." As Sarah said this last sentence, I noticed that she gestured with her left hand in a broad, sweeping motion away from her body, from the front to the side and back.

This story about her sister, which was a great example of how doctors often make predictions inappropriately, offered Sarah an alternative behavioral choice of simply dismissing the doctor's pronouncement. The fact that she'd recounted it told me that she understood me perfectly, and that I was on the right track. Since I wanted her to distance herself from the experience of fear induced by her doctor's statement, I said, "Great, I want you to do the same thing that your sister did. Think of what your doctor said to you, and in the same casual tone of voice as your sister, say, 'He was talking about all those *other*

people out there, not about me.' As you say this, use that same broad, sweeping gesture with your left hand." When Sarah reenacted exactly what her sister had done—both verbally and nonverbally—she took on her sister's attitude, mentally and physically, consciously and unconsciously. Of course if I'd asked her to do this and she'd had some objection or discomfort with it, that wouldn't have happened.

After Sarah had spoken her sister's words and used her gestures, she smiled and pointed toward her upper chest, saying, "That helps me breathe easier." This spontaneous change in breathing was a good indication that change was occurring unconsciously as well as consciously, and it confirmed that what I was doing was useful to her. As John Grinder, a founder of Neuro-Linguistic Programming, used to say, "Any verbalization that is not accompanied by congruent nonverbal behavior should be treated as unverified rumor."

At this point, some people might think that I was imposing my strategies on Sarah without consulting her; however, at every step of the way, I was using her nonverbal feedback to guide me. If she'd objected at any point, I'd have immediately adjusted what I was doing in response.

The Limits of Predictions

I went on to say, "It's one thing for a doctor to be honest with you and give you whatever statistical information he has about a medical problem, but it's quite another thing to make a prediction about a particular person." Then I told her about a small parotid tumor that I've had under my right ear for about five years. The surgeons predicted that it would grow larger, and they wanted to take it out—which would require a four-and-a-half hour operation, because the main facial nerve goes right through the middle of it. I gathered information on the Internet and decided to wait and monitor it. In the last four years, the tumor hasn't changed in size or been a problem. This gave Sarah another vivid personal example of a doctor's incorrect prediction, further weakening her certainty about the validity of the "death sentence."

To reduce her certainty about the doctor's statement even more, I asked Sarah to close her eyes and return in her imagination to the doctor's office and tell him how angry she was with him, and anything else that she wanted to tell him, both what she'd felt at the time, and anything she'd thought of later. This was to help her move from feeling like a passive victim of events to taking charge of them—what's often called being "empowered." When she was done, she said, "Oh, that felt gooood," and again said that her breathing felt easier—yet another unconscious response that confirmed that I was on the right track.

Then she said she was still angry that the lung problem had been discovered by accident when the abdominal scan had been done. "If they hadn't done that, I never would have known about it, and I wouldn't be afraid." In response to this, I told her of a story I'd read recently about a man who was in a similar situation. The tumor they discovered accidentally was still very small, and he felt very *grateful* and *lucky* to find out about it early, so that it could be removed before it spread, resulting in a complete cure. This story invited her to feel lucky and grateful (instead of angry) to have found out about her lungs—in contrast to not knowing there was a problem and being unable to do anything about it.

Next I said, "For two years now, you've been trying to avoid this experience, but it's continued to terrorize you. I'd like you to be able to think about it differently, without fear—just as *information.* Does that sound useful to you?" Sarah considered this thoughtfully, but her expression wasn't enthusiastic.

"Let me tell you my reasons for this," I continued. "First, fear can be useful to get you out of a dangerous situation, but chronic fear isn't good for your body, and interferes with health and healing.

"Second, when you don't know about something, it's much scarier than when you do know about it. For instance, you don't know what's in that closet (pointing to the closet in my office). If you were to worry about it, you could think of all sorts of horrible things that might be in there. But if you opened the closet, you'd see some clothes on hangers, some boxes on the floor, and other stuff that would be much less scary than your images.

"Third, even if you did find something dangerous in there, knowing what it is would give you information that you could use to protect yourself. If you don't know about something, there's no way to make informed choices and decide what to do. The more information you have, the more choices you have about what to do to make your life better."

I mentioned how some women who discover that they have a dangerous breast cancer gene have decided to have their breasts removed, because they'd rather be alive without breasts than dead with them. This might seem like a somewhat grim example, but it was a good match for Sarah's thinking about her lung condition as a "death sentence," and it illustrated how accurate information is a basis for being able to make choices. Sarah pondered this and didn't disagree, but her expression didn't change much.

I'd like to point out that I was using both my words *and* my nonverbal behavior to create experiences to elicit alternative, new, unconscious *responses* in Sarah. Even when I offered her broad generalizations about fear, knowledge, and choices, I was tracking how she responded and using this feedback to adjust what I did next. Those generalizations were useful in creating a frame of understanding, but it was the experiences that I helped her have—through stories and the actions she took in response to my suggestions—that elicited new, more useful responses.

Playing with Words

Because Sarah had responded so strongly to the slip of paper and how I'd handled it, I thought it might be useful to work directly with that at this stage as another way of reducing her fear. "Now I'd like you to play with ►

the words that you wrote on that piece of paper. Just now, in your mind, you were able to 'diss' that doctor with ease. So you do indeed have 'diss' ease."

As Sarah smiled broadly at this reframe, I went on to say, "I'd like you to do something similar with that longer word; find some other meaning in it, perhaps by saying it with a foreign accent, dividing the word up, or some play on words." Sarah laughed and said, "I don't know where this came from, but I came up with the word *intercourse!*" This was yet another nice contribution from her unconscious—later she said that, to her, intercourse meant conception and life, the opposite of the "death sentence." It really didn't matter what alternate meaning she came up with for the word *interstitial.* Any response would give her something else to think of automatically and unconsciously—an alternative response to the same stimulus.

This new response provided an experiential basis for choice, because now she could think of the old meaning, the new meaning, or both. Since the new meaning is much more enjoyable, Sarah was more likely to choose it, and this would dilute or diffuse the word's threatening meaning. The fact that she came up with something that made her laugh was a bonus, because, as brain science has shown, a pleasant feeling adds emotional charge and makes it easier to remember what elicited the feeling.

Then I returned to the theme of learning more about her lung condition so she could use whatever information she found. I asked her to close her eyes and imagine going online to search for more information. I had two reasons for making this suggestion: I knew that the more information she had, the less fearful she'd feel, and I wanted her to have the information so she could take whatever actions might be indicated to preserve her health. This is an example of the importance of sequence when working with a problem. Sarah had been too afraid to think about finding out more about her health problem for two years. By taking the time in our session to reduce the fear by diminishing the certainty sustaining it, it became something we didn't need to struggle over. Once the fear was reduced, we could begin to talk about searching for more information.

Knowing that curiosity is the opposite of fear as well as the best impetus for research and learning, I asked her to think of situations in which she'd felt curious, and gave her an example of my own. Some time ago, I'd wondered how the interior rearview mirrors in cars work when you flip them down to reduce headlight glare at night. I told her that after puzzling about those mirrors for a few months, I finally took one apart so I could understand it. Sarah found it amusing that I'd done that, both because it wasn't something she'd have done, and because she was fascinated by how other people figure things out.

Some might think that the important aspect of my stories is that they're personal disclosures used to build relationship; however, I think of them differently: I choose stories that I hope will elicit a spontaneous and memorable unconscious understanding. Making the stories personal adds to their reality, and I choose stories that I can act out, so they become part of the present moment, not a musty tale of what happened in a distant time and place.

For instance, when talking about the car mirror, I imagined being in the driver's seat, and I reached out with my right hand to adjust the mirror, and I later gestured differently when I talked about taking it apart. When I use stories that aren't personal, I still bring them into the moment by identifying with the protagonist and putting myself into the situation described, so that my natural nonverbal actions amplify the story's impact.

By this point in our conversation, Sarah clearly had experienced a number of changes in her reaction to the "death sentence"; however, I didn't know whether she could feel comfortable about researching information related to the lung disease. So, using the piece of paper and the words it contained as test stimuli to determine whether her fear had decreased sufficiently, I held up the paper, still folded, and asked Sarah if she was ready to take a look at the writing inside. She seemed hesitant, though no longer terrified, and said she wasn't ready for that yet—which told me we needed to do more work.

I then reviewed some of the themes that I'd already mentioned, and amplified them with additional examples of the value of getting as much information as possible to make informed choices, so she could cope with the lung disease or whatever other difficulties life might present. I also reviewed the value of curiosity in searching for information and alleviating fear.

After a while, Sarah said, in a voice that was calm and bit surprised, "Oh, that's interesting. That image of my lungs is down here now," and she gestured about waist level and three feet to her right. Both her tone of voice and the change in location of the image of her lungs were spontaneous unconscious changes that indicated that she now had a significantly different response to the threat posed by the image: it was no longer "in her face."

A little later she said, "You know, those words are just letters of the alphabet"—and I chimed in, "and out of order, too, just squiggles on paper." When she said in a relaxed and grounded tone of voice, "I'm ready to look at those words now," I handed her the note to read. She read it, and then folded the paper and tore it into small pieces. I said it was fine to tear up the paper, as long as she was committed to searching for information about the words on it and what they really meant. She calmly said that she was willing to do that, and her nonverbal expression was congruent with her statement. The note, the image of her lungs, and all they referred to no longer terrified her. Her condition was now only something that she needed to learn more about, so we ended the session.

Follow-Up

A month later, Sarah e-mailed me, "That was one heck of a session! I've looked up the condition and it seems

so small to me. I think of it only occasionally. In the articles I read on the web, it became boring."

Three months later, she e-mailed me again, "I've since found out that a medication I take for high blood pressure has a side effect of a slight dry cough! I think of that experience only on occasion now, and sort of shrug my shoulders."

After our session I looked up interstitial lung disease and found that it's a general term for *any* kind of scarring of lung tissue, with a wide variety of causes and outcomes. Little is known about it, and there's no known cure, other than the palliative treatment of symptoms. Since Sarah is symptom-free, there's no useful action she can take in regard to the disease, so her thinking of it as small and boring and "shrugging it off" is completely appropriate. After she read the final version of this article, she said, "It all looks great to me," and added that now the image of her lungs is "down by my right knee"—further confirmation that the changes we made together continue to be useful.

CASE COMMENTARY

By Dan Short

In 1692, the missionary explorer Girolamo Merolla da Sorrento entered into his diary the following story. A young boy, native to the Congo, went to spend the night with an older boy. The teen host played a trick on his unsuspecting guest by preparing a breakfast of wild hen, a food strictly forbidden by tribal custom and tradition. A few years later, when the two met again, the older man asked the younger whether he'd eat a wild hen. The younger replied that he'd been solemnly charged by the witch doctor not to eat that food. Thereupon the host began to laugh and asked why he refused it now after having eaten it at his table before. On hearing the news, the younger man began to tremble, absolutely possessed by fear. In less than 24 hours, he was dead.

In 1942, Harvard physiologist Walter Cannon, documented similar instances of psychogenic or psychosomatic death, which he termed "'Voodoo' Death." This phenomenon is believed to be the result of strong emotional shock, most often fear paired with a specific suggestion of impending death. Similarly, in a 1992 journal article, titled, "Hex Death: Voodoo Death or Persuasion," a researcher outlined the case of a man diagnosed with cancer who, along with his physicians and family, believed the cancer would soon kill him. However, after his death, the autopsy revealed that cancer wasn't the cause of death. The author suggests that the man's belief in his imminent demise was the actual cause of death. This type of premature death seems most likely to occur if there's an authority figure involved, with privileged knowledge of the body, who activates a state of emotional shock using the "vision-to-fear pathway" or the "auditory-to-fear pathway."

I say all of this to highlight the importance of the work done by therapists in cases such as the one described by Steve Andreas. While I wouldn't go so far as to say that the medical doctor was trying to kill his patient with Voodoo Death, I think it's fair to say that his lack of psychological sophistication created some serious problems for the patient. When the doctor used the CAT-scan to accompany his verbal suggestion of impending death, he imprinted a terrifying image that wouldn't easily leave her mind. In other words, he simultaneously activated the vision-to-fear pathway and the auditory-to-fear pathway, thereby increasing the strength of his suggestion for her demise. Briefly speaking, I think this woman was not only in a state of extreme emotional distress, but also in real physical danger.

My guess is that Andreas fully understands the power of suggestion, and that's why his first action was to nullify the doctor's semihypnotic suggestion. He accomplished this by attacking the physician's authority and humorously accusing him of fortune-telling without a license. Although the use of humor may not seem like a hypnotic technique, it's interesting to note that recent studies using functional magnetic resonance imaging (fMRI) indicate that humor is one of the few forms of communication that simultaneously activates left and right hemispherical functioning. In other words, humor is a useful method for accessing multiple levels of conscious awareness.

Next, the doctor's grim prediction of death is replaced as Andreas weaves together a series of images from Sarah's own memory and stories from his life experiences suggesting the possibility of happy productive living, even as imperfections continue to exist within the body. Andreas describes his client's shift in posture and breathing as evidence that changes were occurring at an unconscious level. Using the language of neuropsychology, we could speculate that these physiological changes signaled a shift in the sympathetic nervous system, from a state of chronic hyperarousal to a state of rest and repair, or parasympathetic activation. As already mentioned, there's a growing body of research that suggests the presence of unconscious reasoning and its responsiveness to certain types of verbal communication, such as the use of story, metaphor, and imagery—all of which Andreas employed, in some instances with the client having her eyes closed.

Whether we should call Andreas's intervention Neuro-Linguistic Programming, hypnosis, mindfulness, cognitive therapy, or something else really depends on the professional lexicon a person is most comfortable with and which aspects of the treatment one wishes to emphasize. For now, I'd like to point out an important fact revealed within the first sentence of the case description. Andreas wrote, "Sarah . . . whom I've known for many years." Right away, we know that a meaningful relationship exists between these individuals. My guess is that Sarah came to Andreas as someone she trusts and respects. In this case, as in all others, I believe that a strong relationship is the most important ingredient for emotional healing. Decades of study in psychotherapy outcomes supports the idea that technique contributes only a small portion to the change that occurs within the sessions, while the strength of the therapeutic relationship accounts for the lion's share.

The background of this case is a medical authority's careless communica- ►

tion that heightens a client's fears to the point of immobilizing her. She comes to Andreas as an authority on healing, and the way he manages the relationship with her is crucial to the outcome of this case. Initially he gives her specific tasks, such as gesturing with her arm, closing her eyes to visualize past experiences, and dealing directly with the piece of paper that had become a focal point for her fears. She responds to his instructions with cooperative compliance, thereby formalizing the alliance and deepening her involvement in the suggestive therapeutics. Because of Andreas's encouragement to find and utilize inner resources, combined with his implicit confidence in her ability to overcome this challenge, Sarah's felt sense of impending death is replaced with a healthier expectation that good things can come from a desire to learn and a will to live.

The last point to address would be my criticisms of this case. Unfortunately, I have none to offer. Successful therapy is a psychological endeavor measured by the client's subjective satisfaction with what's occurred. According to Andreas, Sarah was very pleased with her visit to him, and continued to be pleased with the outcome when this article was written. Because the client is the ultimate judge of whether the therapist has succeeded in reducing his or her suffering, all that I can say is that it seems to have been a job well done. ■

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