

***Cognitive
Behavior
Management
#29***

Fast Phobia Technique

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I am not able to acknowledge the materials used to develop this technique. Normally, I document thoroughly and keep hard copies even of materials found on the internet. Unfortunately, I have apparently not done so in this case. If the author or authors recognize their words in the following materials, I would be happy to include such recognition.

Technique #29 - ***Fast Phobia Technique***

Clinical Prompt

- Step 1: ***Establish Rapport*** with the client in order to gather information.
- Step 2: ***Evolve the Client*** from his/her present state to their desired state.
- Step 3: Integrate the desired state of experience into the client's ongoing behavior with ***Future Pacing***.

Forms & Charts

None

Technique #29 - *Fast Phobia Technique*

Introduction

A. BACKGROUND

1. Variously called 'Fast Phobia Cure', 'Rewind Technique', and 'Double Dis-association method'
2. Developed by the developers of Neurolinguistic Programming (NLP) by Richard Bandler and John Grinder (1975, 1976)
 - a. Studied highly effective therapists (Satir, Perls, Erickson)
 - b. Combined discoveries with own knowledge of linguistics and computers
 - c. 'Neuro' (derived from the Greek 'neuron' for nerve): Behavior = neurological processes.
 - d. 'Linguistic' (derived from the Latin 'lingua' for language)
 - f. 'Programming' is the process of organizing the components into a sensory system to achieve specific outcomes.
3. Highly recommended and effective with any anxiety disorder

B. THEORETICAL PRINCIPALS

1. Clinical observations compete with the client's observations.
2. Sensory information is vital to understanding the client's subjective experiences.
3. Focus is on client's sensory observations rather than abstract 'conditions'

4. Everything affects everything else (non-linear).
5. Emphasis is on changing the client's internal frames of reference, which in turn changes, the structure of the experience.

C. **BASIC CONCEPTS**

1. Representational Systems. A client's frame of reference is determined by the way s/he constructs experience in his/her mind.
2. Synesthesia/Strategies: The ordered sequences of internal representations are called strategies.
 - a. Important to a person's memory is the order in which the sights, sounds, feelings, smells, and taste (internal representations) occur.
 - b. They are learned thinking patterns.
 - c. A Synesthesia occurs when two representations are linked.
3. Sub-modalities.
 - a. In any given experience, there is a difference in sub-modality that makes a difference in a client's experience.
 - b. That is, a change in the right sub-modality will result in a different response.
 - c. The clinician's role is to instruct the client to change the sub-modalities.
 - d. S/he can help make them less bright or dark, turning down the sound, and so on, with the goal of changing the client's internal experience and, thus, the client's external behavior.
 - e. Sub-modalities are the building blocks of the senses/representations.
 - f. They explain how each picture, sound, or feeling is

- composed.
- g. During a dissociated memory, the client looks at the memory image from a point of view other than from his or her own eyes.
 - h. The client might see it as if s/he were looking down from an airplane, or the client might see it as if s/he were someone else watching a movie of himself or herself in that situation.
 - i. **Unfortunately**, The client may re-experience any sounds of the memory.
 - j. However, in a dissociated state, the client does not relive the emotions, tastes, or smells.
4. Anchoring Resources: Anchoring refers to the learned association between an external stimulus and an internal response, or between one response and another.
- a. A traumatic experience becomes encoded in memory either immediately (as in the case of a phobia) or over time (as in the case of repeated exposure to dangerous environments).
 - b. There is a deliberate association, or anchor, between stimulus and a specific experience.
 - c. The resources for change lie in a client's personal history.
 - d. Once an association has taken place, the experience can be triggered at will by representational and linguistic cues.
 - e. An anchor is a trigger or stimulus that elicits a memory as well as a response and behavior.
 - f. An anchor works, in essence, the same way that language does. If a clinician asks a client to remember a time when s/he felt very confident, the clinician's words send the client on a search through his/her past experiences and allows him or her to access various memories congruent with being confident.

D. THE MODEL

1. Approach in a Nutshell: the clinician can desensitize the client from the distressing memory by:
 - a. Identifying what internal representation (internal picture, word, feeling) triggers the traumatic or phobic response.
 - b. Then isolate what has to happen in the environment or in the person's mind to produce that particular internal representation.
 - c. This for the purpose of getting the client to have a different internal representation in response to the stimulus so he or she has a choice of ways to respond.
 - d. The new representation might be of the same category (visualization to visualization), or it might be one of a different category (visualization to auditory).
 - f. In either case, if the old trauma, or phobic response-producing representation, is obliterated by another representation of comparable intensity, the trauma, or phobic response, will not be activated (i.e., desensitization).
 - g. The cure of the trauma or phobia demonstrates that the tiniest change on the level of internal representation can often change an entire frame of reference.

E. CLINICIAN'S ROLE AND PROCEDURE

Step: ***Establish Rapport*** with the client in order to gather information.

- a. One method of establishing verbal rapport with a client is to match the sensory-based words a client uses.
- b. Other ways of establishing rapport with a client verbally

- is to match the client's voice tone and tempo.
- c. To establish rapport non-verbally, the clinician can match the head tilt, body posture, breathing rate, and gestures of a client.

Step: ***Evolve the Client*** from his/her present state to their desired state.

While maintaining rapport the clinician gathers information about the traumatized person.

- a. What was the person's life like before the trauma occurred?
- b. What kinds of losses have been experienced as a result of the trauma?
- c. Is there any secondary gain from keeping the trauma?
- d. What will things be like for the person when he or she no longer is experiencing the symptoms of this traumatic experience?
- e. Ask about the present state (why are you here for help, not what it was like at the time of the trauma) and desired state of the client (target thoughts, feelings, emotions, sensations).
 - (1) The outcome should be stated in positive terms.
 - (2) It must be testable and demonstrable in sensory experiences; it must be initiated and maintained by the client;
 - (3) It must explicitly and appropriately fit the context in which the change is needed.
 - (4) It must preserve any positive by-products of the present state; and
- f. It must be ecologically sound, that is, creating no further problems when the client gets his or her outcome.

- Step: Integrate the desired state of experience into the client's ongoing behavior, a process called ***Future Pacing***.
- a. Ask the subject to imagine (in an associated perspective) the next time that they would be expected to have the fear or anxiety and observe his or her new, changed response.

Now if you start doing experiments with human subjects where you change people, you run into a very obvious ethical problem. But what if, instead of doing the usual sort of university psychology experiments, you work with people who are actually seeking to be changed? Thus, the first process in any intervention is to help the client decide what s/he wants to change - to define his/her personal goals, and to identify the barriers to attainment of those goals. This is relatively easy when talking about phobia - the client is there because they want it to STOP!

So in helping them stop, you must find a way to help them disassociate with the experience. This is a re-learning process. A reordering, if you will, of the internal representations to come to a better result.

Symptom Effectiveness

No matter how well-done, rigorous and conclusive a study is, it will not meet the above criteria unless it is 'published'. Unfortunately the psychological journals and academic press have been notoriously hostile to certain topics, and studies supporting NLP techniques.

For instance: In 1992 a study of the NLP 'fast phobia cure' was completed. The study took a population of 'simple' phobics, and

divided them into three groups. Group A was given the NLP process and then was interviewed each week for six weeks about their phobic experiences. Group B was given accelerated progressive-desensitization treatment and the interviews, and group C was given just the interviews. The subjects were re-evaluated at 6 months, one year, and 5 years and grouped by the level of returning symptoms: none, few, many, all. At the end of the 5 years, the results showed that the NLP group fell 90%+ into the 'none' category, the p-d group was about 35% 'none', 33% 'few' and the rest 'many' or 'all', and the control group was 90%+ 'all'.

The results were written up in proper fashion and submitted to three journals. The first two returned them almost immediately with notes saying that they fell outside the subject areas which they publish. The other actually sent the article to the reviewers, who declined to review it on the grounds that NLP was 'pseudoscience' and not worth their time and effort.

The simple fact is that lack of publication doesn't necessarily equal lack of evidence. Since the process is benign, it offers an opportunity to test the efficacy with and individual client without inflicting trauma.

Time for Mastery

The technique usually takes from one-half [1/2] to three [3] hours.

Instructions

A STEP BY STEP EXPLANATION OF THE INTERVENTION

Background

1. Clinician instructs the client in how to erase the traumatic feelings associated with past events so that a different perspective can be achieved.
2. Specifically, it assists the client in "dis-associating" from the remembered event, thus creating a perceptual shift to allow new input.
3. Changing the sub-modalities of the internal memory by altering visualization develops this shift and auditory components to needed resources.
4. Thus a revised stimulus-response pattern is created that promotes resolution of the problem.

Specific procedures:

1. ***Establish the safe place (bailout) anchor by saying:***

Clinician: "Now think about a safe place. Imagine your being at that place and tell me what you see, what you hear and what you feel in a sensate way."

Client: [answers]

Clinician: "Is it okay if I touch your hand? Ok, Now when I touch you on your hand, right here, I want you to think about that safe place again with all of your senses. Nod your head when you can do this."

2. ***Setting the Stage.***

Clinician: "Please imagine yourself on the screen of a cinema, in a

still, frozen image of moments before the trauma, when the feelings were still neutral or when you were experiencing a sense of comfort.

Client: [signals that they have done so]

Clinician: "Now please imagine floating out from your body to watch yourself watching the screen (double dissociation)."

[Instruct the client to allow as much distance as is needed to keep from being captured by the event. This includes, for example, having the client float back to the projection booth and behind the little window or even outside the door of the projection booth - wherever the client feels safe but can make out the image on the screen.]

Client: [does so and may give off signals about how s/he is feeling and should say where s/he has located him/herself in this imagined exercise]

Clinician: "Now, do you see yourself on the screen and also yourself watching yourself on the screen?"

3. ***Run the Movie.***

Clinician: Now run this movie in black and white and at a point when the immediate danger was past, and you felt safe again.

Client: [The client will be seeing this in a double dissociated state, watching herself watching a younger self go through the experience on the screen. Thus, you are able to help them maintain the necessary emotional

distance.]

This form of exposure allows the client to set the dosage to a point where it is tolerable but yet s/he is able to take in the details of the experience without being 'associated' enough to re-experience it. If, at any time, the client begins to associate then suggest ways to withdraw (i.e., make the scene move fast forward, rewind) the association to once again dis-associate.

Clinician: "Now start the movie again and notice yourself watching the movie. That person may be scared and may miss some of the lessons you might discover from watching it from a safe distance. You will learn what that person on the screen didn't know at the time of the event. Later, I will ask you to tell your self what you have learned."

Client: [continues to run the movie and may say what is happening and how s/he might be adjusting the way s/he is watching the movie or manipulating the theater or the pace of the film to make it more tolerable]

Clinician: "That's right, let the scene just go by and while you do, notice how your younger self is watching the screen, perhaps frightened and uncomfortable and even putting his/her hands over his/her face, which is okay. You can tell him/her what you have learned later." [Clinician needs to keep the client dis-associated at all times. If the client falls back into the feelings, come back to the here and now, reestablish the comfort anchor and start again.] If this happens, reassure the client as you proceed by saying something like: "You are safe, here, pretending to watch a movie."

Continue to run the movie as often as needed until the client is completely desensitized (i.e., reached an end point).

4. ***After the Movie***

Clinician: "Way to go! You were very brave and you did it! You were able to watch and remember without the old traumatic feelings! Now I want you to move your seat right next to your self. As you watched that younger you from that safe distance, what did you learn about that time that you didn't know then." Have the client pretend by having a vacant chair next to him/her to talk to his/her younger self.

Client: (possible statement) "I learned that I did not need to be afraid anymore. I notice that during the scariest part I kept my cool. I survived. I did the best I could under the circumstances. I can survive again if I need to again, but I will be much smarter this time."

Clinician. "Now I would like you to imagine stepping into the screen to give your younger self that information and any needed nurturing, support and encouragement."

Client: [The client can reassure his/her younger self by saying, "I am from the future, you survived, it's OK. You never have to go through it again."

5. ***Integration***

Clinician: [When the younger person understands] say: "Now I would like you to bring the younger self back from the screen into your body, and allow some quiet time to recover and integrate the profound changes that will

have taken place.”

Client: [responds as requested]

6. ***Future Pace***

Clinician: “Now, I would like you to imagine (from an associated perspective) any events that previously caused the unpleasant or unwanted reactions (thoughts, feelings, emotions, sensations) triggered by the memories you just reviewed on the movie screen.”

7. ***Follow-Up***

- a. Sometimes two sessions are necessary if the client later remembers more details.
- b. If so, follow the same procedure.
- c. Also, the client may wish to focus on and become desensitized to other bad memories.