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Therapy

Psychovisual Therapy

When a miracle is needed!

Stephen Bray

The use of psychovisual therapy in the treatment of anxiety and stress. A case example.

When Linus (not his real name), aged 52 years moved into his new home with his wife and teenagers life seemed perfect; yet within a week everything was to change. Linus had built a business as an wholesaler (not his real career) but as his 50th year approached he recognised that he wanted to experience more from life than the relentless grind of the 14 hour days so common in self employment. As a result he sold his chain of businesses and bought a comfortable property in a quiet village in the south of England. He had visualised making some alterations to the listed property and perhaps even moving on to renovate other houses in the future. His wife seemed enthusiastic about his plan and the children liked the idea of their father spending more time at home.

It was not to be for the day after the move a heavy lorry bulldozed into the property demolishing much of the ground floor and rendering the house uninhabitable.A lengthy period followed in which the family lived in hotels and whatever houses they could rent whilst their 'dream' fell victim to wrangles between insurance assessors, heritage and building agencies. Linus' nerves began to unravel and as they did so his wife sought comfort outside of the marriage and left taking the children with her.

Three years later Linus consulted with me because he had developed the habit of sleepwalking and occasionally this was accompanied by the embarrassing habit of urinating in the wardrobe or corners of a room. He had remarried by this time but both he and his new bride were in high pressure jobs. His partner was almost as disturbed as

Linus was by his sleepwalking and so he had sought my professional help.

One of the problems in treating patients such as Linus who have a history of being let down by those whom they have loved and trusted is that there is a tendency for them to be unable to fully trust again. Hypnotherapy like most medical practices however relies on a degree of trust in the practitioner if it is to be effective. Furthermore the very term hypnotherapy raises expectations within patients about the nature of trance. An internal debate may be generated within a patient about whether or not they are 'truly' in a trance. Sometimes this becomes communicated into the session and indeed for some practitioners the whole issue becomes one of "Can the therapist induce a trance within me?" (Erickson 1959).

Throughout the consultation Linus sat uncomfortably as he recounted his story and details of his embarrassing symptom. I concluded that whilst undoubtedly he wanted and needed help, it was also essential that he regain a sense of independent judgement and effective influence. In his case, I decided, these two conflicting needs would make it unlikely that he would respond to a conventional hypnotherapeutic intervention. Indeed my experience has taught me that we could have ended up in a lengthy series of gambits in which I sought to induce a trance acceptable to his expectations.

Accordingly I decided to distance myself from hypnosis, and also his treatment reasoning that if I was 'less responsible' for his 'cure' then Linus would be more likely to trust me and any debate about the efficacy of the treatment could directed at the option offered rather than at me as his therapist.

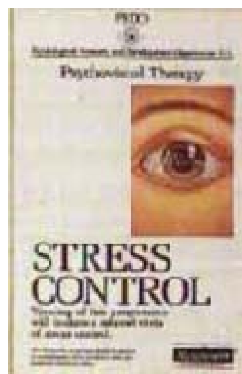
"You must understand", I said, "I am a psychotherapist who sometimes uses hypnosis when it is appropriate. In your case I would first like you to try something else first".

The words 'try' and 'first' implied that the treatment offered would be likely to fail (Chomsky 1972). I reasoned however that as Linus was reluctant to trust an other's judgement and needed to perceive himself as independent far from diminishing the possibility of his taking against psychovisual therapy, the words would make it much more likely to be a successful treatment.

I explained that many patients had found all the help they needed by watching therapeutic video tapes because they could "take what they needed from all the information given on the tape". I explained that much of the information would seem irrelevant and that watching the tape may "seem like a waste of time" adding as an aside

that "it can be a powerful treatment for those people for whom it is designed to help".

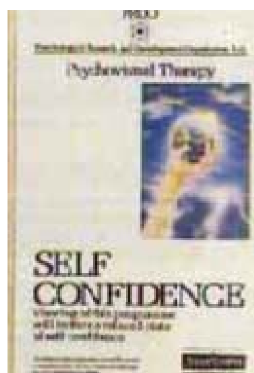
Psychovisual tapes are distributed on the basis that they are sold to patients; they should not be loaned or rented out. To charge Linus for the tape up front however seemed to risk the precarious balance of my intervention. I decided therefore to charge solely for the consultation on this first meeting making it clear that he would pay for the tape "only if it was effective". This approach seems to extend a possibility of the patient and the tape disappearing for ever, but in my experience this has never happened. In Lunus' case I was confident that the tape would serve its purpose and as I expected when he returned for a follow up having used 'Stress Control' for the week he reported dramatic improvements.



The first indicator that the choice of treatment had been correct was the abatement of Linus' habit of sleepwalking with a concurrent cessation of his problem of involuntary urination. Unlike lengthy psychodynamic therapies my experience of psychovisual therapy has shown consistently that where patients are motivated to change and therefore apply themselves to watching the videos; then the psychovisual programme will rapidly affect the presenting problem.

The second indicator of the efficacy of this treatment was that Linus has developed a strategy in his mind of what he needed to do in order to address a number of work related issues. He was now able to discuss these with me in some detail, a further indication in itself that he had started to develop the capacity to trust others once again. It was clear however, that the changes he had in mind would require a degree of confidence which although present in the past, had been badly shaken since his marriage had collapsed. When Linus left his second meeting he not only had purchased his copy

of Stress Control but also had taken Self Confidence.



I did not see Linus for about three weeks as during this period he and his new wife had decided to take some time out to enjoy a holiday in abroad. On his return he eagerly reported that his outlook had completely changed. He was more ready to delegate responsibility and his relationship with his current wife which had shown signs of becoming strained had now recovered. She too had watched the tapes with Linus and reported learning from both of them. His sleepwalking had stopped completely.

A follow up at six months confirmed that all the improvements cited had lasted. Subsequent reviews have not been possible as the couple emigrated shortly thereafter. I am satisfied on the basis of my clinical experience that the results obtained with psychovisual therapy cannot be attributed solely to the placebo phenomena. The tapes with their powerful combination of chromatherapy (relaxing light) and alpha wave patterns are packed with educational and subliminal information (Knight and Carr-Jones 1992) enabling an individuals psyche to adjust itself to the world at large. When psychovisual therapy is introduced with sensitivity to the patient's internal and social systems the likelihood of the patient benefitting from the powerful ingredients of psychovisual therapy will be maximised.

This study illustrates the utilisation and importance of linguistic patterns (Erickson op.cit., Chomsky op.cit., Sinclair and Bray 1998), when preparing a patient to make use of psychovisual therapy. It is however not always necessary to go to the lengths suggested here for not all potential beneficiaries of psychovisual therapy will be polarity thinkers.

References:

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The Psychovisual Video Range can be ordered from: Michael CarrJones@AOL.COM

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