The Level 1 Intake Form

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These questions will give a greater insight into the clients presenting difficulty than you might otherwise discover from their description. It will not be needed for every client; it's a complex and lengthy document which can take an entire session to complete, so could be counter-productive for some of the more straightforward of presenting issues.

The client's presenting difficulty will fall into one of three catogories:

- **Direct:** Phobias or fears about spiders, crane flies, 'creepy crawlies' and the like
- **Indirect:** Anxiety or fear that could be hidden 'behind' the apparent presenting difficulty
- **Compound:** Usually presenting as G.A.D. or multiple issues of two or three components, i.e. fear of driving in front of a police car, anxiety where people are getting drunk and behaving noisily, anxiety about talking to a stranger in front of other people, etc.

Direct
You will not usually need this questionnaire for the first category, the ***Direct*** *anxiety, fear or phobia. This sort of issue generally responds perfectly to the simplest of approaches: the explanation of 'brainwork' to the client followed by the implementation of the process. As long as the client has fixated on the 'worst' memory and created a suitable replacement response, then the 'freeze' followed by an intensity of delivery will ensure the rapid, single session resolution that BWRT® is so capable of when working at the correct trigger.*

Once in a while, the result is incomplete and the client still experiences some residual anxiety. It is when that situation is sustained after a week or so that you could usefully employ this questionnaire. Preparation of the client is important but simple enough: *"Okay, it looks as if something else might be holding on to* <problem> *in some way, so let's get my investigative kit working."* It's vital that you say nothing about this to the client at the very beginning, or you'll be inviting a 'fail'!

Indirect
The **Indirect** fear/anxiety is one which *could* be hiding something else. For instance, fear of flying might well be just a straightforward situation that will respond to the same simple approach as for the **Direct** fear. But it can also easily be any of: *Claustrophobia, Emetophobia, Fear of heights, Social phobia, Fear of stairs, Fear of alcohol, Fear of public toilets, Shy bladder syndrome, Anxiety about eating in public, Fear of strangers, Misophonia, Aversion to body odour* apart from the obvious fear of crashing. All the client recognises, though, is that they *really do not want* to get on an aeroplane and so translates it as a fear of flying.

There are many indirect anxieties, including driving, motorway driving, career issues, or fear of: lifts (elevators), escalators, strangers, restaurants (or eating in one), shopping malls, busy roads, crowded places… you get the idea.

One of the easiest ways to determine if a presenting situation is **Direct** or **Indirect** is to consider whether or not other people are likely to be involved. If they are *not* then it is in all probability a Direct fear or anxiety; if they *are* then it is likely to be an indirect situation that needs at least some investigation even if not necessarily the full questionnaire that is being presented here. Most of the time, you will gain all the information you need from

a simple enquiry: *"What are you frightened might happen if you do* <situation>?" The answer to that question will more often than not tell you what *really* needs working on. Taking flying fear for example, you might get one of:

- *Somebody throwing up/being sick*
- *People getting drunk* (this response is sometimes emetophobia)
- *I might get airsick*
- *I might need the toilet and not be able to get in*
- *I can't eat in front of other people*
- *The food might make me ill*
- *I feel too conspicuous*

The first two can be indirect, since they involve other people; the rest are all asscociated directly with the individual, they are all "I" responses and are therefore direct fears and you can then continue as for the Direct anxiety. Sometimes, though, the client will say something like: *"Everything about it – the whole thing!"; "I don't know – I just can't do it."; "I'll be completely out of control," and so on.*

It's when you get answers of that sort, or when it becomes evident that your client has presented with a **Compound** issue (which sometimes shows up when you ask the *"What are you frightened might happen?"* question) that the questionnaire here comes into its own. The major problem with compound disorders is that the client tends to be frightened of every facet and every nuance, half-convinced that they are in some way mad or at least that they are beyond help because they are 'such a mess'. They might well not even realise what part of it all is creating the major part of the problem, and will focus their attention onto something they've been told by a well-meaning (maybe!) friend or something they've read on the internet.

Hence the questionnaire goes into great detail in an attempt to help the client explore the psyche in a more structured manner, looking at elements of their difficulty that in all lielihood have never occurred to them before. As with all all questionnaires of this sort, it should not be rushed, which brings us back to something mentioned at the beginning. It won't always be necessary to use it – it can take up an entire session to complete and in the case of the direct anxiety, which can usually be resolved in a single session, it covers far more detail than will normally be needed.

There's been no attempt to 'marry' this with the earlier 'Pre-Questions' and this could be viewed as a possibly superior replacement.

The questionnaire itself starts on the next page and assumes that:

- Your client's personal details (age, gender, married/single, sexual preference, date of birth, contact details, etc.) have already been noted
- You have already asked the *"What are you frightened might happen if you do* <situation>?" question and the answer has indicated a compound or multi-faceted issue
- If applicable, ensure that your client has seen their GP or that you have already sent an 'opt out' lesson.

Level One Intake Form
There are two columns of questions: those in the right column are conditional upon the answers to those in the left. We do not attempt to elicit the PAL at this stage.

Begin:
I'm going to ask you quite a lot of questions now and though they might not always seem to be connected with your difficulty they are important. If there's something you really don't want to tell me about though, that's fine. Is that all okay? Wait for a 'yes' but if doubt is shown enter into more discussion about why the questions are necessary.

1: *Tell me what* <problem> *actually feels like to you.* Getting the client to describe their symptoms as fully as possibly will often provide a good pointer to the later therapeutic work. Obviously, you need a little more than *'Horrid!"* and you should keep digging to get a clear description. If there are multiple symptoms, list everything as for the G.A.D. protocol.	
2: *Tell me all about the earliest time you can remember that.* Just getting the time-scale of the issue. You need to establish when, what was happening at the time, how long it lasted, what the client felt/believed it meant.	
3: *Have you had those feelings at any other time?* The answer here can provide clues to other events/situations that might need working on if you are to get the result the client needs.	
↓ No Yes ➔	3.1: *When was that?* If it was before (2, above) it might be of more importance than the client recognises. 3.2: *Why do you think it happened that time?* Sometimes, the client will make a useful connection at this point, revealing that the presenting problem actually goes further back than they thought. If that is the case continue with: 3.3: *What do you think that might mean?*

	This is an 'invitation' to the client to explore the likelihood that the problem is older than the might have originally. believed
4: *Have you tried to deal with this before?* We might not be the first therapist the client has seen for the same issue – when they have seen several therapists without a good result it can increase resistance.	←
↓ No Yes →	4.1: *What was it you tried?* This is really just for information and reference if needed. 4.2: *How effective was it?* If it wasn't, go to **Q5**, otherwise 4.3: *And how long did that result last?* You should seek to discover if the return of symptoms was triggered in some way or if it 'just wore off'. Both situations indicate the possible existence of an ISE. If it was triggered, work at the trigger. Otherwise, suspect an agenda.
5: *What can you tell me about the precise moment you decided to seek my help?* This can reveal one or more triggers that the client might not have otherwise mentioned and that can, again, provide information about what really needs working on.	←
6: *Are there, or have there been, worse things in your life than what brought you to see me?* Sometimes, there is material in the client's psyche that they don't recognise has been the precursor, or possibly even a direct trigger, to their current problem.	
↓ No Yes →	6.1: *Okay, thank you. Tell me about that in as much detail as you can.* If the client declines, go to **Q7** otherwise get as much information as you can; there is a definite possibility of abreaction here, in which case work through it and the therapy is in all likelihood complete. Alternatively, this might reveal that there

	is a different situation to work on – grief is a common example of what might show up at this point. 6.2: *Does it seem as if that is in any way connected to what you've come to me with?* Explore the client's answer either way.
7: *Does anybody you know have the same or a similar issue?*	←
↓ No Yes →	7.1: *Tell me about that* This can reveal an agenda, where the client is seeking the same attention that somebody else is getting (or that somebody is seeking the same attention as the client). Also can indicate a learned or acquired response. 7.2: *How do you feel about that?* 'Irritated' or similar hints at an agenda and there is a need to explore; 'comforted' or similar might indicate underlying undeclared anxiety and there is a need to explore; 'indiiferent' or similar is self-focussed and healthy.
8: *Now, because of the way the brain works, even something we consciously don't like will be there for a purpose. So what do you think it might be trying to do here?* The reason for this question is obvious – the important thing here is to explore thoroughly and ensure the client is ready to let go of any recognised agenda. If they are unable to think of anything, move on.	←
9: *If there was just one part of you that you had to protect from change, what would that be?* Use your therapist's skills and knowledge to decide whether BWRT would be likely to create a change in that area and be sure to discuss this with the client. Usually, any change will be positive.	
10: *Now the opposite – if you were able to change just one thing, other than what*	

brought you here in the first place, what would that be? What you are looking for here is the presence of anything that might inhibit the success of therapy. Some issues might be: **controlling, judgmental, critical, reistant to change, flaky, don't stick at anything…** (if you've studied 'WSN', negative Warrior and Nomad attributes). Discuss as necessary.	
11: *What do you believe others will think of you when your therapy is successful?* This is just another version of the 'Who might try to stop you?' and 'Who will be rooting for you?' questions. Be sure to get a full answer and don't accept a 'Don't know' response. If necessary, say: *"Okay – make it up then."*	
12: *How would/do you feel about that?* Sometimes, the perception that others might not appreciate the change can greatly inhibit therapy. Discuss as needed.	
13: *On a scale of 1 – 10 with '10' high, how good will your life be when therapy has been totally successful?*	
🡻 Eight or higher Seven or Lower 🡺	13.1: *What would have to happen for it to be higher than that?* This can reveal issues that the client might have perceived as unchangeable. If that is the case, point out that you might be ab le to change the way the client feels about the situation concerned. 13.2: *Is that something you would like to work at?* If 'No' go to **Q14** 13.3: *Shall we mark that down for later then?* If 'yes' go to **Q14** If the client decides they want to work on it now: 13.4: *Okay – but if you were going to fix only **one** of these issues, which would it be?*

	This is to ensure that the client has not simply encountered resistance.
14: *Most people have a secret, or even several secrets, and would be horrified if the whole world were to know about it. Now, if you have such a secret, I'll never ask you to tell me about it but it helps the therapy greatly if I know there's something there. So, is there anything that you really want to keep absolutely to yourself?*	←
↓ No Yes →	14.1*: Okay, thank you, And can you now tell me how bad that would feel on a scale of 1 – 10 if everybody knew about it? Make it really vivid in your mind.* We need the highest possible PAL here. If < 6 we can probably ignore it. 14.2: *Good, thank you. Now can you tell me if this is (a) about the way you are, so that you didn't choose it; or (b) it's about something you did; or (c) it's about something you still do. You can tell me it's any of those, all of those, or just 'a' and 'c', for instance.* This covers every eventuality and we need to know in order to allocate the best replacement response. 14.3: *Okay – now, sometimes, anxious secrets of that sort can get in the way of the best results for therapy. It's possible to take the anxiety out of it while we're working if you want to so we can get the best result for you. You won't need to say even one word about it but I'll only work at it if you agree. We can still do some good work, though, if you don't want to. So, yes or no?* Yes [ ]; No [ ] a b c choice/combination:
15: *Okay – thank you. We're almost done with the questions now but is there anything you think I might have missed or that you think would help to make the therapy even better?*	←

At this stage, anything that comes up is evidence of resistance – either previously, or now, because therapy is about to start. Explore.	

Guilty Secret Work
This might already be familiar to you, but just in case…

The therapy we are going to do might well make changes for the future, but in order to get the best out of it, we have to disable the guilt process in the psyche at least for a while. Get agreement on this point before continuing.

You will be using prefabricated replacement responses dependent upon which of the (a), (b), or (c) responses your client has given.

(a): *You didn't choose it, so it's not your fault*

(b): *You've been punished enough now*

(c): *You'll change that when it's right to do so, now, tomorrow, or some other time*

Any combination of 2 or 3 of a, b and c: *You're making changes today*

(This last option is almost universal enough to be applied to all circumstances but the first three are more 'targeted' and might be better with specific circumstances.)

- We avoid the PAL here – we need to deal with this issue and close it in one session
- Hold some representation of the secret in thoughts, then Zoom and freeze
- Fade to pale colours - this is like NLP but we avoid fading to black and white so there is still a connection with reality but greatly diminished
- Now the Replacement Response but handled like suggestion therapy: *"Now I want you to create an image in your mind that means* <whichever of the above is valid> *and drag it in front of that frozen image so that it become such apart of that frozen image that you can really **feel** it, and just nod once when you have it."*
- Continue as the standard protocol (6 loops) but without testing the PAL

*NB: If we test the PAL in this routine the client might be fearful that the therapy won't work if the PAL isn't reduced enough. We **can** enquire as to how much (not 'if'!) less uncomfortable the secret feels now we've worked at it, confirming that it's good when it's reduced. If it's the same, we can say that this proves it to be static and therefore not affecting anything. If it's more uncomfortable, we can say this shows it to be active and there's a need to desensitise it – and the client now has two choices:*

1. *Go through the above again working harder with the replacement response.*
2. *Tell you what the secret is so that you can help them disarm it.*

Example 1:
The client has agreed there is a guilty secret and wants to work on it. They've said that it was about something they did (Q 1.2, option (a)) and it's something they still do (Q1.2, option (b)). So here, the replacement response in the loops will be for any combination

of options: *"Now I want you to create an image in your mind that means **You're making changes today** and drag it in front of that frozen image so that it become such apart of that frozen image that you can really **feel** it, and just nod once when you have it."*

Example 2:
This time, the client has chosen only option (a) in Q1.2, so here the replacement response in the loops would be: *"Now I want you to create an image in your mind that means **You didn't choose it so it's not your fault** and drag it in front of that frozen image so that it become such apart of that frozen image that you can really **feel** it, and just nod once when you have it."*