When All Else Fails

Some New and Old Tools for Doing Brief Therapy

Rubin Battino, MS

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Foreword

Michael F. Hoyt, Ph.D.

I first heard Rubin Battino teach a brief therapy workshop, then met him through several of his books—*Metaphoria, Expectation, Ericksonian Approaches,* and *Healing Language*. We became acquainted as colleagues at conferences, and more recently, I have had the pleasure of spending friendly time with him and his lovely wife, including a long lunch and a walk through our local Marin County national monument, the beautiful Muir Woods. It is thus with multilayered pleasure that I welcome his latest book, *When All Else Fails: Some New and Some Old Tools for Doing Brief Therapy,* which, dear reader, you hold in hand.

All that is new is not true, and all that is true is not new. There is much in this fine volume to commend it, including reviews on hypnosis and ideomotor signaling, NLP, bioenergetics, psychodrama, Gestalt Therapy, and other approaches that are often overlooked today. What I like the most, however, is the emphasis on what is too frequently given quick lip service in much current therapy training: the importance of the alliance, the role of expectations, and the conscious and skillful use of language. There is plenty of useful technical information here—some from older approaches, some *au courant*—but what matters most is the human relationship. Clients don't care what you know until they know that you care, and the therapeutic alliance is the soil in which therapy techniques may (or may not) take root. Please, take heed.

Rubin is a seasoned and wise clinician. He provides a thoughtful, personal guide that can enhance the effectiveness of your work with clients, regardless of your theoretical orientation. There are

lots of ideas and methods in this fine book that will be of interest. I enjoyed it, and expect that you will too!

—Mill Valley, CA

Part I

Ideas, Approaches, and Concerns

Chapter One

Introduction

1.1 How This Began

For a number of years now I have been doing workshops of various lengths on topics such as an introduction to hypnosis, very brief therapy, and guided imagery. The attendees have been relatively young, mostly under forty, with a significant number still in graduate school. My style of presentation involves an outline of the workshop which is generally completely covered, and random thoughts about related subjects that pop into my head as I go along. I also tell stories. From time to time my thoughts stray from the regular material to discussing other forms of therapy than the one I am presenting. The "very brief therapy" workshop does include discussions of many methods and approaches. What I have invariably found is that a large proportion of those attending have never heard of many of the things I talk about. Of course, lots of approaches have gone "out of fashion," so to speak. Yet, I believe it is important for modern day therapists to know about how therapy has changed and developed over time. Is psychodrama an anachronism or even, perhaps, an artifact? How many therapists know about Gestalt Therapy and use it in their practice? Cognitive Behavioral Therapy (CBT) seems to have won out over many other approaches since it has the blessing of presumably being "evidence-based." It is almost as if the experiential evidence of effectiveness of those who have studied and participated in psychodrama, for example, no longer counts!

At the present time counselors, social workers, and psychologists do face-to-face talk therapy. Psychiatrists appear to be stuck in the medical model wherein finding the right drug to match a particular

diagnosis is the norm. For them, with less than ten minutes face time with each patient talk therapy is not possible, and is just a thing from the past. Michael D. Yapko is a recognized international authority on chronic depression. He uses hypnosis in ten to twelve sessions for chronic depression, and in his experience this results in "cures" in the sense that his clients are no longer chronically depressed. The medical model approach has clients on anti-depressive drugs forever, or seemingly forever. Hypnosis has no side effects. The drugs usually take one or two months to have an effect. Also, anti-depressive drugs are typically changed and adjusted in dosage over the time the patient sees a psychiatrist. That is, finding the right drug and dosage for a particular patient appears to be almost a hit-and-miss approach. Yet I suspect that these drugs (and other psychotropic medicines) are popular, since all the patient has to do is pop a pill, rather than visit a talk therapist over a period of several months. Initially, popping pills appears easier, even if it is not more effective!

Please note that I am not against medication when used appropriately in some time-limited fashion (or long term if needed). Medications certainly appear to help many people on a short term basis, and are frequently useful in emergency situations. The medical model works for medical difficulties. For mental health concerns talk therapy is still the best bet as far as I am concerned. I could cite difficulties with the usefulness and accuracy of the Diagnostic and Statistical Manual, 2013 (DSM), but have already done so in an earlier book (Battino, 2006). In that book I also cited studies on the effectiveness of using psychoactive drugs. Double-blind studies on those drugs always show that placebos have a high degree of effectiveness. To my mind, unless a drug is *significantly* better than a placebo it is questionable as to whether it should be prescribed. After all, placebos have no side effects! As a last comment here it should be noted that in many of these double-blind studies the test subjects were able to distinguish between whether they were taking placebos or the test drug. One outcome of these studies is that it is now sometimes the case that placebos are adjusted to give some discernible side effects!

My friend and colleague Luciano L'Abate has published a great deal (see Chapter 9) about the demise of face-to-face (f2f) talk therapy, and its being replaced by distance learning and workbooks. We disagree about this, and my main argument is that the approach he is proposing invariably includes some f2f sessions. A person can

download workbooks on particular areas (such as depression) online, and then carry out the instructions. Writing about one's personal difficulties has long been a useful modality; workbooks and medications and f2f all have a place in helping people in distress. A principle of cybernetics (requisite variety) states, "In any complex system, the component with the most variability controls." For the two-person interaction between a therapist and a client to be effective the therapist must have more variability in the interaction than the client. That is, in the immediacy of the interaction the therapist needs to have many choices of response at their disposal, and be flexible in this. A therapist who only knows CBT, for example, is at a disadvantage.

1.2 Rapport Building

The so-called "therapeutic alliance" has been well studied (Wampold, 2001). What is meant by therapeutic alliance is that there is something in the way the therapist and client interact that gives the client the feeling that the therapist is on their side—a companion, friend, ally, helper—working through the client's concerns to outcomes that the client wants. This ally is with them in their struggle to becoming comfortable with themselves, and in becoming capable of taking care of themselves. That is, the client is not isolated or alone with a technician who provides some sort of mechanical or verbal fix.

In the old days of psychotherapy the therapist was endowed with almost magical powers to help/fix the client. The therapist knew best and was the "operator" while the client was the "subject." (This aura of operator/subject still exists in many medical interactions where the medical doctor is imbued with esoteric special knowledge and skills. This is realistic in many ways, and I certainly trusted the knowledge and skills of my orthopedic surgeon and his staff when he gave me an artificial knee several years ago.) When working with mental health concerns, in addition to being knowledgeable and skillful, the therapist also has to be a real person in her interactions with a client. Within the isolated four walls of a consulting room two individuals meet, and the therapist is privileged to share in the life and world of the client. That meeting of two human beings can be enhanced by the knowledge, practice and skill of rapport building.

In almost all of my books relating to psychotherapy there is a chapter on rapport building. This was done deliberately as it is always important for you and your client to fit into the world in similar ways, i.e. your personal and human connection. It is done deliberately here because in my workshops I have discovered that many of the attendees have been "exposed" to this in their training, but not to the depth and degree that is needed in my judgment. So, in this section I am going to go over the basics of establishing rapport once again.

My colleague, Thomas L. South, Ph.D., believes the essence of establishing rapport is in *pacing and leading.* That is, when you are in rapport with someone you are pacing their five-dimensional existence in the world in some way. In addition to the XYZ coordinates of space there are time and the emotional/physical or mind/body coordinate or parameter. Once you have paced them, then you can lead them into useful ideas and feelings.

There are two basic ways of establishing rapport: verbal and postural. In *verbal pacing* you match your client's speech patterns in some manner. We all have unique ways of speaking. Some characteristics of speech are: speed, tempo, accent, rhythm, and loudness or softness. If your client speaks rapidly, you increase your rate of speech just enough for them to know that you are speaking faster. You need to match only *one* of the patterns of speech for them to have a sense that you are speaking in the same manner. If a client has a regional speech pattern (like from the South or West or Bostonian), you need to *subtly* match their speech. If you mimic them exactly, they will know that you are doing this. So, with a Southerner you can add some musicality or rhythm to your speech without going overboard. The pacing has to effectively be subliminal to work. Practice this by sub-vocalizing when in the presence of others.

People tend to describe the world they live in using primarily visual, auditory, or kinesthetic (physical) words. In the field of Neurolinguistic Programming (NLP) this is called *representational systems*. That is, people see things clearly, hear them soundly, or feel them physically. Listen for how people describe the world around them, and talk back to them in their preferred representational system. There are also neutral words that are not in one of these systems, like sense, believe, and process. Since the meaning of any communication is the response that you get and not your intent, you need to be sensitive to how your clients react and respond to what you say. Pay attention to them and not your own internal states. Intuition may be fed by awareness, but close observation is safer. When

Rubin Battino has been presenting workshops on the art of very brief therapy for years. In *When All Else Fails* he addresses both new and old ways of doing brief therapy. Some of the new ways include: expectation; the power of pauses; chatting as therapy; poetry; healing language; touch and laughter. Some of the old ways include: Gestalt therapy; bioenergetic analysis; neurolinguistic programming (NLP); encounter groups and group therapy; ideomotor signalling; psychodrama; narrative therapy, provocative therapy and hypnosis. The last is an important part, both directly or indirectly, of all the methods discussed. Whenever a client 'goes inside' during a session, they are effectively in a trance state.

A therapist who can choose between a variety of brief therapy techniques is more likely to be in greater command of the therapeutic process as he or she will be able to choose exactly those techniques that fit their client's situation and their personality. This book offers the professional myriad options that are open to him or her for creating a better, more well-rounded practice.

"I read everything Rubin Battino writes. He is one of the most profound teachers and practitioners of Ericksonian psychotherapy that I know. In this volume, Rubin reveals how many ways there are to establish intimate, soulful connections with clients in brief therapeutic encounters. This book will magnify your healing power, and inspire your patients to create new endings to their old stories."

Carl Hammerschlag MD, author of *The Dancing Healers* and *Kindling Spirit*

"Another excellent and sometimes provocative book from Rubin Battino that refreshingly embraces the current move towards pluralism in therapy. Exploring the modern requirement for very brief therapy, *When All Else Fails* delves into a cornucopia of techniques, unashamedly giving new relevance to old approaches that have, as a result of unwarranted bias towards more populist approaches, fallen out of favour."

Peter Mabbutt FBSCH, Director of Studies, London College of Clinical Hypnosis,
Vice President, British Society of Clinical Hypnosis

"Rubin Battino is a scientist, but he is also a trickster. His poetic "chatting" and his aesthetic approach to life and therapy permeate this book. The title could suggest that this book is a last resort. I say it is a first resort, a wonderfully human place for anyone, however experienced, to begin."

Dr. Rob McNeilly, former student of Milton H. Erickson

Rubin Battino MS, has a private practice in Yellow Springs, Ohio. He is Adjunct Professor for the Department of Human Services at Wright State University. He is President of the Milton H. Erickson Society of Dayton and was co-chair of an ad hoc committee to establish certification standards for training in Ericksonian hypnotherapy. He is the author of eight professional books.

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