INTRODUCTION

WHAT IS VERY BRIEF THERAPY?

A number of years ago I did a library search on the subject of brief therapy and found a book by that title. It was written by an analyst and he wrote about the advantages of doing brief therapy which he defined as only taking one year of fifty sessions! Most modern day therapists would consider brief therapy to be ten or fewer sessions. My private practice consists of doing very brief therapy which I define as one or two sessions. That is, I treat every session as if it were the last one.

I heard the late Steve deShazer once talk about some research done at the Brief Family Therapy Center of Milwaukee. They are located in the inner city, and their clients can be difficult. The receptionist read the completed intake form and informed the client, ‘Oh, it usually takes ten sessions to help people with these concerns’. The next client would be told, ‘For what you have written here it usually takes our staff five sessions to help people’. The staff did not know what their clients were told. On follow-up about one year later there was about an 85% satisfaction rate by the clients in the study. Those who were told ten sessions started doing significant work around the eighth or ninth session; the five session people did this around the fourth session. The only difference was the expectation of the client.

My reasoning at this point was that if ‘expectation’ could effectively reduce the number of sessions from ten to five, why not use this idea to reduce effective change work to one or two sessions? So, I now tell all of my clients that I rarely see people more than once or twice, but I will see them for as many times as they find seeing me helpful. I should also add that I am retired with a good pension, and that there is thus no economic incentive for me to prolong therapy. I work for myself on a cash only basis (no insurance accepted). And, my sessions are always open-ended with no given time limit.

Does this work? I, indeed, see most of my clients for one session. Although encouraged to keep in touch, I generally get feedback erratically, and up to years later. If you are into instant gratification, do not do work in this manner. I do get referrals from former clients – sometimes years later!

MOSHE TALMON’S STUDY

The Israeli psychologist Moshe Talmon wrote a seminal book (1990) on single-session therapy (SST). He worked for a large health maintenance organization in California, and studied how many sessions psychotherapy clients attended. He found three rather surprising things in his study: (1) the modal, or most frequent length of therapy, for every one of the therapists was a single session; (2) 30% of all patients chose to come for only one
session in a period of one year; and (3) there was essentially no correlation in a follow-up study between what the client stated helped him/her, and what the therapist thought was helpful in that single session. Quoting Talmon (1990: 111), ‘in most of the SST cases where patients reported particularly successful outcomes, the therapist appeared to have conducted a rather simple, almost dull session. In fact, in many successful SSTs, it is the patient who appears in control and sets the pace for change.’ There was about an 85% satisfaction rate among these clients. Also, the therapeutic orientation of the therapist was not correlated with client satisfaction. Amazing!

In his introductory chapter Talmon makes the interesting observation that the ‘founder’ of single-session therapy was probably Sigmund Freud who treated a number of his patients in one session, the most famous being curing Gustav Mahler of his impotence during a single long walk in the woods!

**Principles relating to the power of expectation**

Expectation is central to the power of the *placebo effect*. There are literally thousands of papers on this subject, and many good books. Double-blind studies are done on new pharmaceuticals and treatments to separate the effect of the active agent from that of a placebo. With respect to pain control it is well known that placebos are about 55% as effective as the medication – placebo morphine is considerably more effective than placebo Darvon, which in turn is more effective than placebo aspirin. Placebo injections are more effective than placebo pills. The colour of a placebo can influence its effectiveness. When administered without information about whether they are stimulants or depressives, blue placebo pills produce depressant effects, whereas red placebos induce stimulant effects. Patients report falling asleep more quickly after taking a blue capsule than after taking an orange capsule.

It is worth quoting at this point Kay Thompson’s statement in response to a rhetorical question about expectation (Kane and Olness, 2004: 293):

> Question: How much of my success rate do I attribute to my non specific expectation that people can do these things? Thompson: Ninety-nine percent. My expectation has a great deal to do with it and they tell me that. I have worked with people who have failed to learn with other people. They say, ‘The difference is I know you believe.’ That may be corny. That’s where Milton Erickson taught me to come from. This nonsense about remaining objective; remaining objective does not mean that you do not care. There are those people who can remain objective and still be compassionate. And I think that’s important.

If you do not expect that what you are doing is going to help your client, why should they expect anything?

My philosophy with respect to my clients, and in my volunteer work with people who have life-challenging diseases is, ‘I always have hope, and I believe in miracles’. What is wrong with hope? And, do not the mind/body changes in the placebo effect smack of the miraculous? Kay Thompson has also said (Kane and Olness, 2004: 321), ‘It is my belief that the placebo is effective, because it frees your body to do the things your body knows how to do, without the interference with having to worry.’

There is a large literature on the subject of expectation (which I will not cite here). The consensus appears to be, ‘Expect and ye shall receive; doubt and ye shall be empty.’

If I had to recommend one book as must reading for every therapist it would be *Change* by Watzlawick, Weakland and Fisch (1974). They discuss that change is of two
types. First-order change is characterized by doing more of the same, that is, working within the system. Second-order change is external to, or meta to, or outside the existing system. It therefore appears to be paradoxical, illogical, unexpected, puzzling and strange. Effective therapy is second-order, and its most common manifestation is reframing. If you analyse therapy sessions and/or demonstrations of the masters, you will find that reframing is central to their work.

Clients come to you because they are stuck: they either have one response to a given stimulus, or one interpretation of that stimulus. Your job is to provide them with choices (plural!) with respect to response and interpretation. That is, help them to discover different perspectives – reframing is a change of perspective.

Before leaving background material, let me just cite three interesting observations from the you-should-read book by Duncan, Miller and Sparks (2004: 9):

Data from over forty years of increasingly sophisticated research shows little support for:

- The utility of psychiatric diagnosis in either selecting the course or predicting the outcome of therapy (the myth of diagnosis);
- The superiority of any therapeutic approach over any other (the myth of the silver-bullet cure);
- The superiority of pharmacological treatment for emotional complaints (the myth of the magic pill).

Varieties of very brief therapy: an overview

In this section I will briefly present a variety of ways that I have found to be effective in the very brief therapy mode. There are more details in my book (Battino, 2006a). However, that book is also a brief introduction to the many ways you can work, and you should consult the sources therein, and seek training in the many methods described. Since I am essentially an Ericksonian hypnotist and therapist, hypnosis is part of almost all of my sessions. Clients are curious about hypnosis, and it is usual to end a session with a hypnotic segment to consolidate what has preceded and to provide more choice. Although I have been trained in many approaches, I find that I am not an ‘interventionist’ wheeling out specific tactics. Rather, we chat a great deal – rapport is, after all, central – and parts of the following ways of doing therapy just flow into the conversation. If you are stuck in some name-brand therapy and are restricted to working in that fashion, then expect ‘resistant’ clients. If what I am doing does not appear to be working, I do something else. As a therapist you need to be more flexible than your client! Enough preaching . . .

As-if and the miracle question

Expectation has to do with the future – anticipation of what it is that is going to happen soon. There are long-range expectations, but I suspect that most are short-range. Why would a client make an appointment with a therapist without an expectation of being helped? They may feel helpless, but the act of visiting you contains a measure of hope – perhaps even something miraculous will occur! Research by Weiner-Davis et al. (1987) showed that when clients were asked about beneficial or useful changes that had occurred between the time they made their appointment and the appointment itself, most clients reported useful changes. The therapist’s task is then simply to elicit these changes by
as-if is magical. It is the fantasy play of children (and adults); it is theatre and play-acting, and it has the power of converting imagination into reality. If you will, as-if-ing involves faith and belief and hope and expectation. It is the essence of the placebo effect in the sense that as the person believes in the efficacy of the particular treatment or drug, the placebo-taker acts as-if the placebo were the ‘real’ curative with all of its potency and power. Thus, there are mind/body interactions involved with as-if, and there are mind/mind interactions as well. Acting as if the relationship with your spouse has significantly improved will change that relationship. Acting as if your life has taken a turn for the better and that you are happy affects how you think, feel and act. Acting as if the cancer in your body is part of you rather than apart from you makes it more accessible to your immune system having an effect on it. Acting as if the chemotherapy you are receiving is a ‘golden gift from God’ to heal you is healing (the converse is its being a poison administered by unfeeling technicians which exacerbates side effects).

Tests that have been run on actors and actresses who act as if they are depressed, anxious, tense, happy, elated, nervous, phobic, angry, etc., and people who are/or can be described with one of those labels show that there are no essential differences in the biological and mental test markers for those states between those acting and those being in those states. This is remarkable, and a therapist needs to be aware of these effects. Much of the material described separately below is based on the power of as-if.

Nardone and Portelli (2005: 73) have developed an interesting as-if instruction for using with any client concern: ‘During the following weeks, I’d like you to ask yourself this question. Every day, in the morning, question yourself: “What would I do differently today as if I no longer had my problem, or as if I had recovered from my problem?”’ Among all the things that come to your mind, choose the smallest, most minimal but concrete thing and put it into practice. Every day, choose a small but concrete thing as if you had already overcome your problem, and voluntarily put it into practice. Every day choose something different.’ Note that there are three as-if’s in this formulation. Also note that the client is to choose the smallest concrete thing – both instructions are important.

Insoo Kim Berg has told about how she learned about the ‘miracle question’ from a client who wondered what would happen in her life if a miracle occurred. After you have carefully listened to your client (and taken notes to show that you are actually listening), you can pose the miracle question: ‘Suppose that tonight while you are asleep a miracle occurs, and the miracle is that what prompted you to come to talk with me today is solved. This is a miracle. When you wake up tomorrow morning, what will have changed in your life? What will be different? How will you know that the miracle has occurred?’ (Notice the italicized words.) For the next fifteen to thirty minutes lead the client through as much detail as you can about how their life has (already) been changed by the miracle. For example, ‘What would your spouse / children / parents / coworkers / boss / relatives / friends notice in your actions, behaviour and demeanor that would let them know that you have changed?’ ‘If you were able to observe yourself somehow from outside, what would you notice that is different in the way you walk, stand, talk, behave after the miracle?’ At the next session find out how much of the miracle the client has experienced post-miracle. This validates the miracle question. Note that the client supplies the details...
about how their life has changed. This is a kind of reframing since the information they give you has changed the perspective from which they perceive themselves and, once they think of themselves in those different ways, it is effectively impossible to go back to the old ways, the old frame.

**Ambiguous Function Assignments (AFA)**

Erickson was probably the originator of ambiguous function assignments, and used them to the great advantage of his clients. Lankton and Lankton (1986: 136–52) have systematized their use. An ambiguous function assignment (or ambiguous task) is really a second-order change technique that gets the client to carry out a task in a particularly intriguing and open-ended manner – the therapist implies, directly usually, that the client will learn something of special importance from carrying out the ambiguous activity. In part, this is a confusion technique – how can doing this strange thing help me? In part it is metaphorical, since the client is actually living and experiencing in a new way, thus changing the story of their life. With regard to doing very brief therapy, an AFA is a shortcut for rapid change. What the client discovers can also be considered to be a reframe via changing perspective about a particular aspect of life.

It is generally useful to have the AFA involve a physical component of some kind since this ‘anchors’ the experience kinesthetically. You ask the client to wonder how carrying out the activity will help them or provide useful insights or new choices. The AFAs have to be safe to the client and others. After completion, the client reports back about what they have learned. Some AFAs follow:

- Climb a hill or peak where there will be significant physical exertion. The client may be instructed to carry something with them, find something to bring back, or leave something at the top or along the way.
- Be very observant during a walk in the woods, a mall, around their neighbourhood.
- Engage in random reading – open a Bible, encyclopedia, or dictionary and discover something of significance on that page.
- Visit a museum, zoo, botanical garden or circus with expectation for discovering.

**Ordeal therapy**

Definition: anything used to test character or endurance; any severe trial; a trying experience. Again, Erickson was a master at this. Haley (1984) wrote the definitive book on this subject. Ordeals have the following characteristics. They must

1) be more severe than the problem;
2) generally be related in some way to the symptom;
3) usually involve something good or beneficial like exercise;
4) be do-able by the client;
5) not harm the client or others;
6) be open to repetition;
7) linked to occurrence of the symptom.

Clients need to be ‘hooked’ into doing the ordeal by telling them things like, ‘I am not sure you will be willing to do this, or are even ready to attempt it, but I have something in mind that really works.’ The ordeal is selected by the therapist in collaboration with the client since it needs to realistically fit their lifestyle. Also, you need to elicit information about things that the client puts off and tends to drag their feet about.
Some ordeals that can be used when the symptom appears during the day involve getting up in the middle of the night using an alarm clock:

1) exercise – the exercise needs to be sufficiently active so it can be felt in the muscles the next day;
2) catch up on reading or filing or postponed writing or balancing the cheque book or paying bills;
3) carry out various household chores like cleaning out cupboards, waxing floors, polishing furniture, etc.

If there are two symptoms, then one can be required each time the other one occurs. In essence, the ordeal extinguishes the symptom/behaviour.

**Bill O’Hanlon’s inclusive therapy**

O’Hanlon’s inclusive therapy is described in some detail in his book (2003). The basic idea is that clients and therapists tend to think either/or rather than both/and. People think of and describe their behaviour in terms of polarities – they are either depressed or happy, anxious or calm, smart or stupid, successful or a failure. Clients can be released from this bifurcation by making oxymoronic suggestions: they can be sadly happy or happily sad, depressingly energetic or energetically depressed, calmly tense or tensely calm, angrily loving or lovingly angry, stupidly smart or intelligently stupid, successfully failing or a failing success. Other formulations are: you can feel angry, and you don’t have to feel angry; you can forgive and not forgive at the same time; that was either a terrible thing or it wasn’t.

Thinking oxymoronically is stepping outside the box, it is second-order change, and it breaks up fixed patterns. Typically, clients respond to these inclusivity statements with puzzlement, and then a refreshing acceptance: ‘Oh, I didn’t know that. Interesting.’ There are now more choices.

**Metaphorical approaches**

Everyone loves to listen to stories. The power of stories is that they are a direct route to the unconscious mind – we get ‘entranced’ while we listen, and create within our own minds the images, sensations and emotions suggested by the story. Erickson was a master storyteller. My book on metaphor (Battino, 2002) provides background information, references to the extensive literature on the subject and many practical ideas. When I was about halfway through writing that book I came upon R.R. Kopp’s *Metaphor Therapy* (1995). The general way that therapists used metaphor was to listen to the client, and then construct or adapt a story from their own repertoire that was in some way(s) isomorphic to the client’s concerns. That is, this was a therapist-generated story. Kopp did a 180° paradigmatic shift in promulgating client-generated metaphors as being more appropriate and effective. If you work within the client’s own metaphoric imagination, then you are closer to their internal being. Both Kopp and Battino describe ways of developing and using client-generated metaphors.

The language used in delivering a metaphor is essentially hypnotic language. It is most effective when you precisely and consciously choose vague language. (Erickson was said to be a master of the precise use of vague language.) The more specific you are, the fewer chances the client has to individualize embedded suggestions. The vaguer the language (as in much good poetry), the greater the likelihood of the client selecting suggestions that realistically match their uniqueness. Compare ‘As you relax further, you...”
can drift off to a beach by the ocean and listen to the waves breaking, and feel the warmth of the sun’ with ‘as you continue to relax even more, you can drift off within your own mind to your own special, safe, healing/learning/changing place’. The beach may be where you relax, but your client may have suffered severe sunburn or nearly drowned in the surf. Give them the choice.

There are many basic themes that you can use or adapt for apt metaphors. Your client’s metaphors can also be fit into the framework of one of these themes. Here are some: visit to a guru or wise person; a hero’s journey (generally involving challenges along the way); construction of a building; weaving; baking; sailing; and growing plants. Let your clients know that you are a storyteller. Once upon a time . . .

Guided metaphor
I developed this approach (Battino, 2002: 177–90) based on many disciplines. Basically, everyone has and is a story that they tell themselves and others. Meet a stranger on an airplane and you share life stories. Since our memories are malleable and are influenced by our life experiences to date, then our life story as we believe it and tell it to others is only partially rooted in reality. For example, both traumatic and joyous events change our memories. Our life story is what we believe it to be, and as such can be modified for our benefit. The guided metaphor approach works well for ‘global’ changes in a person’s life. A brief description of the process follows.

After explaining to the client about the nature of our life stories, I ask them to tell me their old life story as if it were a brief biography (like on a jacket blurb). I copy down as much of this old story as I can verbatim. Then, I ask the client to summarize their old life story in a sentence, and to distill it into a word or two, or a phrase. I then suggest that the client has the power to rewrite and change their old life story (much as an editor can) to a new life story that is as they would wish it to be. They tell me this new life story, summarize it into a sentence, and distill it into a word or two. Next, I ask them to tell me how their new life story has already changed their future – what will be different? Finally, using hypnotic language, I tell them back their old life story, the new one, and about their changed future. Typically, the old story is about twice as long as the new one, but in the re-telling I spend twice as much time on the new story as the old one, adding much detail. This, again, is an ‘as-if’ or miracle question approach, and the more realistic you make the new story and its implications, the more the client has reframed their life.

Rossi’s ‘Moving Hands’
Ernest L. Rossi has developed a basic four-step approach to doing therapy. The four steps are: (1) establish that the client is ready to work; (2) have the client do an inner search of all material relevant to their concern(s); (3) review all possible realistic options for resolving those concerns; and (4) ratify with an ideomotor signal that the client will choose one or more options. This is implemented via a kinesthetic anchoring with ‘moving hands’: (1) Hold your hands out in front of you about 6 to 8 inches apart, imagining that there is some kind of force field between them. Will you find those hands moving together somehow all by themselves to show that you are ready to work on what troubles you? (2) Now, will you find one of those hands moving down all by itself as you carry out an inner review of all relevant material? (3) [When that hand stops moving] As your other hand moves slowly downward all by itself you can consider many different realistic ways of resolving what it is that bothers you. (4) [When that hand has ceased moving] Please nod your head ‘yes’ to indicate that you are willing and going to use one or more of those new ways of taking care of yourself.
The entire process takes 15 to 20 minutes, and has been used with PTSD (post-traumatic stress disorder) clients. The basic four-step model can be adapted to other approaches.

**Neurolinguistic programming (NLP) approaches**

NLP practitioners have been prolific in developing methods of rapid change. A few of these are: the ‘swish’ method with submodalities; time-line therapy; V-K dissociation for phobias; six-step reframing; changing personal history; and meta-model language usage. Proper training and experience are necessary for the effective use of these methods.

**Hypnosis**

My clients all know that I do hypnosis and expect that this will be part of any session with me. I prefer conversational inductions to the more formal styles. Generally, this is done towards the end of the session as a way of consolidating what has come before. That is, the useful themes and ideas developed during the session are built into a hypnotic experience. We know that people are more susceptible to suggestions when they are in a trance state. They also have an expectation that something special is going to happen at this time. I always build in the suggestion that the client will be able to re-experience whatever happened in the hypnosis session by finding a quiet place for themselves, closing their eyes, breathing softly and easily, and just letting their mind drift back to whatever it was that was important for them to know and experience and learn. Their change work can and will continue after they leave. Of course, they will revise what it is they recalled to meet their current needs. Although I operate out of an Ericksonian perspective in preferring indirect rather than direct suggestions, direct (even forceful) suggestions are part of my repertoire. Following Erickson’s idea of utilization, each session and client are unique without forcing some standard model onto them. (Readers may wish to consult Battino and South, 2005, for a text on Ericksonian methods.)

**When all else fails**

Beware! There are ‘therapist killers’ out there and clients who are particularly difficult to work with. You can refer them out or use some of the following ideas.

**Really listen**

Ostensibly we are paid in large part to *listen* to our clients, and really *hear* what it is they are telling us. If you are too busy taking notes or thinking about what clever thing you are going to do/say next, then you may miss important information. So, listen up, hear!

When working with people who have life-challenging diseases it is particularly important to listen rather than witness or give advice. You are there for them and not vice versa.

**Ask the client**

Sometimes when I am stuck, I simply ask the client what to do next. ‘You know, I’m stuck now as to what to say or do. You are the expert on you. What do you think/feel/sense will be of the most help to you now?’ Surprisingly, they will frequently tell you!

**Minimalism**

Ernest L. Rossi is the master of this approach. He is expert at reading body language, too. If you can, obtain one of his videotaped demonstrations and note how he uses
minimal expectational suggestions with lots of pauses to move a client along. ‘Yes. Some more of that. Stay with that for a moment. Notice where that moves in your body. So I can help you further, let me know by a few words what is going on now. Just sense that a bit more strongly, and notice what happens.’ The client does all the work, Rossi is the guide, and his expectation that interesting and useful things will happen is tangible.

Let me emphasize here the importance of pauses in therapeutic work. If you talk continually, then the client will have to fit in their responses and ideas wherever they can. Give them time to process on their own, wherever it takes them. Then ask for feedback verbally or in their body language. The novice therapist talks too much!

**Switch roles**
A variant on asking the client is to switch roles and seats with them. ‘I’m a bit stuck here. Would it be okay if we switched chairs and I played you and you played me? I’ll be you to the best of my ability, and your job is to figure out to help me out of this impasse. After all, you are the expert on you, and I can only work from my experience and from what you have told me. Okay?’ This is a bit scary the first time you try it.

**Look at yourself from . . .**
‘To see ourselves as others see us . . .’ It is frequently useful to get the client to imagine that they are viewing you or their spouse from over their own shoulder, or to see themselves from over your shoulder or their spouse’s/boss’s/child’s/parent’s shoulder. This is another kind of reframing.

**Provocative therapy**
Frank Farrelly (Farrelly and Brandsma, 1974) developed the approach known as ‘provocative therapy’. The client is confronted forcefully and vigorously with their own behaviour and appearance. This is also done humorously and mostly in monologue. ‘You really are a big fat slob. I’m not sure that even a mother could love you.’ ‘You are so depressing that you even depress me. How sorry for such a sorry person can you be? It’s no wonder that you have attempted suicide. You are so far slumped down in that chair that it would take a crane to lift you.’ The provocative therapist may be the only person who tells the client honestly what they observe, and what they have heard. Rather than turn the client off, they know that this person is the first one who really knows what it is like to be them. CAUTION: You need training and experience to use this approach.

**Pseudo-orientation in time**
Erickson named this approach, which has also been called the ‘crystal ball’ approach. Basically, the client is asked to project forward into the future to a time when what it is that has been troubling them has been completely resolved realistically (always need to posit reality). They are then asked to look back through intervening time to the present to discover what it is that they did (perhaps with the help of the therapist) to bring about these changes. They can look into a crystal ball to discover how change occurred, or a series of crystal balls at different steps along the way. As-if . . .

**Universal very brief therapy intervention (UVBTI)**
The UVBTI builds on pseudo-orientation in time for a quick intervention that can be adapted to many circumstances. This was recently done as a group induction at the Brief Therapy Conference of 2006, and the entire one and a half hour workshop on the subject of this paper is available (Battino, 2006b). Feel free to adapt the following:
Sitting there comfortably now, please close your eyes (or leave them softly unfocused), and take a few relaxing breaths. Simply breathing easily and simply and naturally. And, as you continue to relax, something comes into your mind about concerns that you have or a pattern of behavior or habit that you wish to change. While you think about this, notice that somewhere out in front of you a blackboard or a whiteboard appears. There is some writing on this board, which you cannot read as yet. Firming up in your mind what it is you wish to change, please take a short time – knowing just how fast the mind can work – to carry out an internal review of all of the relevant factors related to this particular concern. That’s right, just a quick internal review. And, now, noticing that still fuzzy writing on the board, carry out another internal exploration of possible realistic ways of resolving what it is that has been troubling you. Take your time, in some quick fashion. For, this is your time now, a time to solve and resolve and find interesting solutions. When you have several, probably new, ways of taking care of yourself and these concerns look again at that board. On it is written a day and a month and a year and a time. And you know already, do you not, that this particular date and time are the ones by which you will have already completely resolved and taken care of what it was that had been troubling you, or which you wished to have changed. I do not know what surprising or interesting things you will have done by that date and time, but you do. The writing is now bold and bright and clear. This is your private date and time – please keep it for yourself. Your change and changes. Somehow, somehow, this has already happened, and you know this internally, in some deep way . . . yes . . . Yes . . . YES. Thank you. Please take a few moments now to consolidate what it is that you have done for yourself. And, when you are ready, you can take a deep breath or two, blink your eyes, and come back to this room. . . . Thank you. [Please put in plenty of pauses.]

**Summing up**

It is the expectation of the therapist that therapy can be both very brief and effective that is the essence of working in the very brief therapy mode.

**References**


Address for correspondence:
Rubin Battino
440 Fairfield Pike
Yellow Springs
OH 45387
Email: rubin.battino@wright.edu
Website: www.rubinbattino.com
Copyright of Contemporary Hypnosis is the property of John Wiley & Sons, Inc. and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.