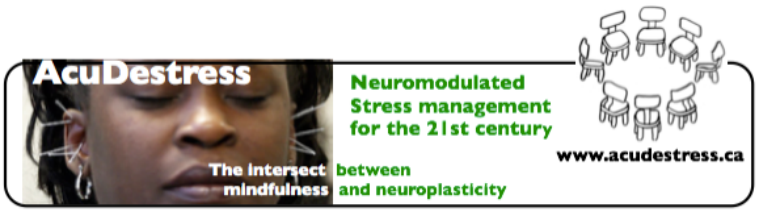


The Territory Beyond Talk Therapy

by Brian C. Bailey M.D.

A MANUAL FOR PRACTITIONERS OF ACUDESTRESS

Chapter 3; Presuppositions and Making the Transition To What Works

When I journeyed to Boston in the mid-80s to attend psychiatrist **Bob Blake**'s two-week-long *Mastery of Psychotherapy*, the lead-in reading material was a hilarious tongue-in-cheek article by Transactional Analyst, **Eric Berne** - ***Away from a theory of the impact of interpersonal interaction on non-verbal participation*.**

Blake's thesis, similar to the enigmatic Berne, who founded *Transactional Analysis* and had written *The Games People Play* was that psychotherapist were of two ilks, those who succeeded with patients by looking deeply at their own operating presuppositions, and those who spent their time talking at case conferences about how the patient's resistance made their therapy not work. The therapists in the audience came from all of the major and minor schools of therapy in play at the time. Then there were about 7 or 8. Now there are 450 schools. So there's lots of history afoot of therapists innovating on the basis of what they were doing not working. But, of course, we'd rather not admit to that. Just because we're psychotherapists doesn't mean that we don't have an ego like everyone else.

Eric Berne was ahead of the curve, suggesting that when psychotherapy doesn't work, the fault lies with the therapist (whom he frankly and outrageously called a "loser") - and not the treatment resistant patient. Resistance, in other words, isn't something that has to defeat us. It can even be something that spurs us on to greatness.

SECTION I: FEATURE ARTICLE

AWAY FROM A THEORY OF THE IMPACT OF INTERPERSONAL INTERACTION ON NON-VERBAL PARTICIPATION*

ERIC BERNE, M.D.

ERIC BERNE (c. 1969)

OK, today I'm going to talk very seriously; this is sort of a "give them hell" speech. At the time that I thought out the title two years ago, I had some idea of what I was going to say but I've forgotten so I'll just talk and say whatever comes into my head.

The problem is that in spite of everything there are still half a million or possibly a million patients in state hospitals, so there has been a great demand for psychiatry resulting in one million vegetables walking around taking phenothiazines, and estimates are that there are a hundred and twenty million people who need psychotherapy. So the problem is how are we going to cure patients, which is what I want to talk about. And I have some questions like: How many cured patients do you know? Have you ever cured a juvenile delinquent by psychotherapy? How many? Have you ever cured a schizophrenic and if not, why not?

The basic thing I'm going to talk about is that psychotherapists, like poker players, are winners and losers. If you have permission to be a winner from your parents you can cure patients, in which case you might not be in psychiatry, you might be a surgeon or a real doctor of some kind. Maybe the reason that people go into psychiatry is that they're not required to do very much except to have staff conferences to explain why they can't do very much. The analogy with poker is that you can tell, in about three hands, who's a winner and who's a loser by the way players react to what happens. And I think patients can tell in about three hours which therapist is a winner and which is a loser. And since most patients don't really want to get well they're very likely to stay with the losers, but if they do want to get well they may find a winner.

I'm going to try to talk about how people make themselves into losers, particularly in the social sciences where there

*Complete text of the keynote address delivered at the yearly conference of the Golden Gate Group Psychotherapy Society on June 20, 1970. Minor corrections to improve readability made by C. Steiner.

Berne famously said, *"A loser doesn't know what he'll do if he loses, but talks about what he'll do if he wins, and a* winner doesn't talk about what he'll do if he wins, but knows what he'll do if he loses." Wise words indeed. Too many people ... shy away from risk to their ultimate detriment by playing not to lose.

Blake pounded away unmercifully at the theme of therapist ineptitude, based on the failure to examine one's underlying *presuppositions*, which, when examined deeply, often reveal a losing mentality, a set of excuses for not getting the results one wants. He was able to get away with saying this, by not just talking about it, but engaging us in exercises which proved his point. So, first he told us what a *presupposition* was.

presupposition *noun* [C or U] UK /ˌpriː.sʌp.əˈzɪʃ.ən/ US /ˌpriː.sʌp.əˈzɪʃ.ən/
something that you believe is true without having any proof:
Your actions are based on some false presuppositions.
This is all presupposition - we must wait until we have some hard evidence.

He then went on to say that because we were all from different branches of the therapeutic tree, he'd chosen a *presupposition* that applies to all schools of therapy. He stated that most therapists have an unexamined assumption about how much time it takes to get a therapeutic result. A canvas of the room showed that most people, across therapeutic school lines, felt that an hour was needed and that anything less would fail. So then Blake said that we were going to examine our own *presuppositions* by every second day carrying out a psychotherapy session with half the time as the previous one - an hour, then 30 minutes, then 15 minutes, then 7 1/2 minutes, than four minutes and finally two minutes. There was a loud guffaw from the room. "Impossible!" everyone thought. And then we got down to business. Sure enough we found that when we were given increasingly shorter periods of time, we were still able to get results - sometimes even better results. When I got to the 2-minute therapy, I actually had 30 seconds left over. This was not me being brilliant. It was me and everyone else challenging the *presupposition* of how much time we needed.

I know I'll have to say a lot more about this below, but here I want to address how examining *presuppositions* allows us to move beyond *talk therapy* with patients who have shown themselves to be "stuck" outside therapeutic success, not just with psychotherapy, but often with medications as well. When this is seen, it is tempting to assume, if we have learned to do therapy in the *Cognitive Behavioural Therapy* world (as I did), or in the other offshoots of this form of therapy, that it is because the patient has an inaccurate and overly self-defeating notion of who he is, and that if properly directed he can talk himself out of it - or else I can. Seeing patient after patient benefit from reassessing their faulty operating assumptions, our assumption is that we just have to try harder, and that we will get there. But if the patient's fundamental problem is an addiction, an instance of Doidge's plastic paradox, we can use *talk therapy* till the cows come home and things won't get any better. They may worsen. And this is so in up to 40% of our clients.

AcuDetox discoverer Dr. Michael O. Smith & AcuDestress founder Dr. Brian C. Bailey

My assumption that I could talk my patients out of their mistaken negative notions about themselves, and that one could then have a successful conversation about solving life's problems by one feeling better about oneself, worked pretty well for the first 15 years of my practice. That was because the people who had really serious problems either went elsewhere, soldiered on themselves, or I sent them on to psychiatrists who had varying levels of success with them, leading me to assume, simply, that if the psychiatrist succeeded, he or she simply knew more about doing *talk therapy* than I did. Then there was the social worker therapist under whom I first trained, who seemed to get results with everyone, who often threw in outrageous comments and suggestions which blew to smithereens the patient's presuppositions, and resulted in amazing therapeutic results. I knew that he was a follower of Eric Berne the oft-iconoclastic critic of techniques which simply challenged thinking. But I would not have labelled him a *transpersonal therapist* until my own therapy training.

Dr. H. L. Wen

I met psychiatrist, **Dr. Michael O. Smith** in 1990 when he was brought to the *University of Toronto* by the *Ontario Alcohol and Drug Research Foundation.* Smith had created a stir in New York City's *Lincoln Hospital* when he replaced methadone in the hospitals heroin treatment clinic with ear acupuncture, whose efficacy was discovered by Hong Kong neurosurgeon, **Dr. H.L. Wen.** Smith was getting results in high numbers in seemingly impossibly substance-addicted patients, while forbidding his students and co-practitioners to use any form of psychotherapy. He had also found that comorbid personality problems were yielding to his treatment as well, to 15 ear acupuncture sessions within a month. In a1979 *Miami Drug Court* study, crime recidivism dropped from 44% to 3%, leading to the inclusion of Smith's AcuDetox protocol in many prisons.

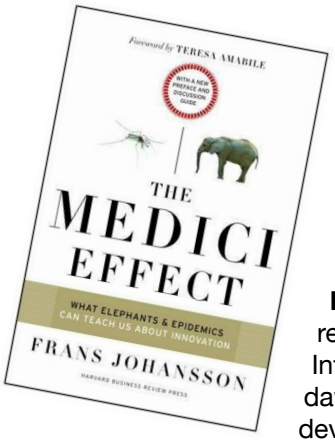
It's very hard to convince a psychotherapist (like me) that not doing psychotherapy helps. We are often led to it kicking and screaming. We think we know better, because psychotherapy does work. But it's not doing *talk therapy* that works with those who are addicted. This doesn't mean that we can't talk, though sometimes this helps, but it means, more broadly, that if we can get patients to experiment hands-on with exercises that prove to them that the limitations they perceive are addictive brain changes which can be transcended, this will happen, alexithymia will melt and PTSD will burn itself out. Disbelief stopped me in my tracks for 5 years. Now when I train others, if they have a *talk therapy* background, they often feel that it is *harsh treatment* of patients not to encourage them to voice their troubles. So it helps immeasurably to have a *neuromodulator* like ketamine, or MDMA or Smith's 5-point ear acupuncture or EMDR. Convincing conventional therapists and patients who have had a *harsh* early life background, however, seems *harsh* to them but is actually *soft.* Training is fraught with difficulty, until they can re-examine their presuppositions. I may have to endure being seen in that *harsh* light until the lights go on for patients and therapists alike. They do get better, but it takes one trial-and-error step at a time. By learning this, not only do they get better, but they keep getting better.

Talk Therapy vs. Non-talk therapy

The difference between *talk therapy* and alternatives to talk therapy is not the presence or absence of talk. Nor is it (usually) the difference between verbal communication and nonverbal communication. *Talk therapy,* as invented by **Aaron Beck**, presupposes that help comes either from the outside or from existing mental/emotional resources while non-talk therapy assumes that help comes from *inner evolution* - a bubbling-up of enriched latent skills.

Talk therapy therefore lends itself to more acute and immediate dilemmas, which, for differing reasons can be reasoned away - solving overwhelm, inexperience, stubbornness, activation of coping mechanisms, low self-esteem, mistaken ideas of the self - using logic. *Non-talk therapy* trends away from logical reasoning (i.e. using and improving on cortical resources which already exist) in favour of inductive thinking (relying on help from the right brain." Not making *talk therapy* wrong, *non-talk-therapy* realizes that if the brain is "badly wired," talking one out of this state almost always fails. By training the brain to alter its trauma-created performance patterns, childhood abuse or neglect, addiction, personality disorders and other entities assumed to be brain "wiring" malfunction on account of faulty programming, it works by stimulating *neuroplasticity*.

As I've related above, my own "vested interest" in my accomplishments during 20 years of talk therapy handcuffed me from actioning it for 5 years after I saw it work powerfully in 1990 at a presentation at the *University of Toronto* in the hands of the New York City psychiatrist, who was to become my mentor. I'm not alone, though.



Prior to the patronage of **Cosimo d'Medici** in Florence in the early 1400's, art was compartmentalized by papal patronage which also dictated what could be painted, sculpted or built. Art gas stood still for centuries. Perspective had not entered painting. Art was largely two dimensional. D'Medici uniquely hired artists to do what they wanted, and it released a reined-in creativity as the lines of demarkation between artists' talents melted away. The melding of one specialized art form with another spurred immense creativity, which became ***the Renaissance***. One if the beneficiaries of *the Renaissance*, **Michelangelo,** for instance, did his amazing sculpture, but was also the architect who designed to dome of St. Peter's in Rome. It was a d'Medici family pope who saw that this took place.

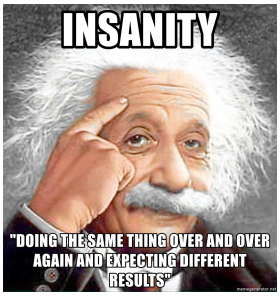
Frans Johansson *(The Medici Effect)* noted that several singular streams of expertise have reached the same potential melding point un the late 209th and early 21st centuries. Intersects between diverse aspects if science have sprung up. A new renaissance has dawned. But when someone sees the potential of the intersect, those who have been developing the component parts defend what they have "purely" developed to the bitter end. This is what we see as "vested interests" - and my "vested interest" was the fact that I had worked hard to accomplish what I could already do. I'd already become good at acupuncture over 15 years and I was already good at psychotherapy over 20, but I hadn't until Dr. Smith seen the intersect.

It's a major leap for psychotherapists to shift from familiar *Talk Therapy* to *Non-Talk Therapy*. It requires a shift of (limiting) presuppositions linked to beliefs about what's possible. *"Vested interests"* (explained more fully in The Medici Effect) instead, tend to defend *"the way things are done around here."* I might have had it easier than some, as I'd already had to question my medical school presuppositions of how the body/mind works when I was learning acupuncture. Otherwise I might never have tried it out, which was the only way to discover that it worked and how it worked. I was told that acupuncturists only become expert after 25 years. This may pertain to **Malcolm Gladwell**'s Outliers notion that 10,000 repetitions are the way true expertise develops. If these repetitions are ways of allowing us to see that things are not always the way we first see them, can we call what ensues *intuition or insight*?

So, How Do We Get There? (More Importantly, How Do We Manage NOT To Get There?)

Psychotherapists, whether *talk therapists* or *non-talk therapists*, succeed by continually examining their *presuppositions* so as to adapt to unworkability and ”stuckness.” Unexamined *presuppositions* inclines the brain to rationalize avoidance of discomfort, limitations, blaming ourselves and others. Eric Berne reminds us that lack of resilience kills many good ideas and that therapeutic failure is usually (erroneously) blamed on the patient, while, actually, while often the change-generating impetus sits outside of the therapist’s (and patient’s) *presuppositions.* Admittedly, *non-talk therapists* are more likely to change-horses-in-midstream, simply because we already have *talk therapy* in our bag of tricks from having used it previously, but aren’t wedded to it, and, in this way are introduced to *associative barriers*[6]*.*

A striking example of *associative barriers*, seen in Robert Blake’s *Mastery of Psychotherapy* course, is the unexamined *presupposition* which overarches different schools off therapeutic thought, that a certain minimum time is required for a psychotherapist-induced intervention to occur. After explaining this to us, Blake had us undertake therapy sessions, first an hour long, then, two days later, sessions of half an hour, then 15 minutes, then 7 1/2 minutes, then 3 3/4 minutes, and finally of two minutes. Astonished participants found that they could adapt to the time changes and accomplish the same results in two minutes that they usually accomplished in 60 minutes. This overcomes out “vested interests.” Seeing us believing. This wouldn’t have happened unless we’d discovered it ourselves, hands-on, willingly obeying instructions. And the result must be “striking” for it to catch. We must be able to remember it like it happened yesterday. The overarching *presupposition* of *talk therapies* like *Cognitive Behaviour Therapy* is that the competent therapist’s rational skill (or the patient’s, after some practice) will overcome the his/her mental resistance. Examining one’s presuppositions engenders a certain bravado which is healthy if it’s determination mixed with listening to one’s intuition, and unhealthy if it lacks the ability for creatively “not knowing” in the course of coming to know. Mastery thus supports your intuition by supporting mine.



While one’s notions of what’s so may be accurate (often they’re not if the patient remains unmoved by them), and while self-confidence and an open mind lends itself to learning how to do good *talk therapy*, or even to coming by talking skills naturally, it totally falls apart if a patient is not susceptible to *talk therapy* (and usually not susceptible to medications either.) This suggests that an addiction is in play rather than a mistaken thought/feeling process. Is it the patient who’s addicted or the therapist? And how often do I react to being commanded to *“think outside the box”* with self-protective anger towards whomever asked me to do so. How often do we need to hear that insanity is doing the same (erroneous) thing over and over with the same results, with the expectation that something different will happen this time? We must be careful with this Einstein misquote, If we’re doing the right thing, practicing it over and over can lead to mastery!

Treatment of PTSD with Non-Talk Therapy - What Works and What Doesn’t?

Briefly, PTSD is the *dissociation (or hiving off)* of a memory which the subject cannot bear remembering. In this way, *dissociation* is seen as a primitive, non-logical, limbic brain defence. The traumatic memory flees conscious memory channels, at a primitive sub-cortical level, activating one’s sympathetic nervous system fight-or-flight mechanism, only to re-emerge erratically when triggered by one of its original components, at times as subtle as the breeze blowing at the time, if the traumatizing event was singular. But now we’re seeing more PTSD, once it was discovered that multiple small early life traumas can do much the same thing. Such cases are often inapparent until *mindfulness* opens channels which reverse dissociation. *EMDR* and *neurobiofeedback* can then be joined by *neuroplasticity* as channel-openers.

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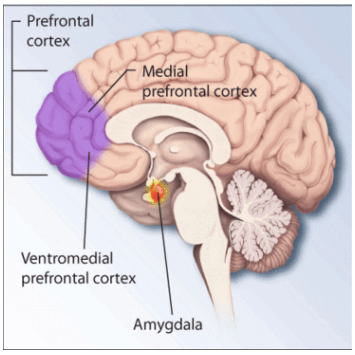
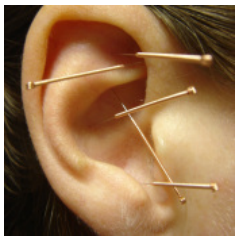
[6] "*The Associative Basis of the Creative Process,*" Psychological Review 69, no. 3 (1962): 220-232.

PTSD is never a case of false reasoning. Thus one cannot be talked out of it, only trained out of it. And even at that, the training must impinge on the limbic brain, where the problem is. This is a delicate time The patient has a "vested interest" in thinking that things can be solved by talking them out. But not when they're limbic brain problems. Sometimes this happens by the psychotherapist expanding his/her *associative barriers*, doing something different, as happens in Blake's two-minute-therapy experiment.



But therapists unaccustomed to doing so, can persist at trying (and failing) to persuade patients to behave differently. They fail because they don't deftly *expand their own associative thinking* for their patient to mirror them, and often they just can't do so. As Nobel laureate **Ilya Prigogine** discovered, the healthy *associative expansion* that stress can stimulate can be feared or resisted, and one's favourite resistance is often to blame someone else. When one dissociates from a traumatic memory, one loses one's ability to deeply fathom one's own feelings, understand others' feelings or bring about creative solutions. Repeated, this is then experienced as *alexithymia*, resembling the unworkable impersonality of the narcissistic personality disorders. Alexithymia, which keeps the subject at a (amygdala) limbic level of coping, deprives him of a (prefrontal brain) self with which he'll know how to act to break the addictive shell in which he's wrapped.

PTSD patients have decreased brain activity in the dorsal and rostral anterior cingulate cortices and the ventromedial prefrontal cortex, areas linked to the experience and regulation of emotion.The amygdala is strongly involved in forming emotional memories, especially fear-related memories. During high stress, the hippocampus, which is associated with placing memories in the correct context of space and time and memory recall, is suppressed. According to one theory this suppression may be the cause of the flashbacks that can affect people with PTSD. When someone with PTSD undergoes stimuli similar to the traumatic event, the body perceives the event as occurring again because the memory was never properly recorded in the person's memory.



The amygdalocentric model of PTSD proposes that the amygdala is very much aroused and insufficiently controlled by the medial prefrontal cortex (VmPFC) and the hippocampus, in particular during extinction. This is consistent with an interpretation of PTSD as a syndrome of deficient extinction ability. As it happens, the training approach to PTSD often benefits greatly from stimulation applied from the outside to lower amygdala activity or enhance VmPFC function or both. MDMA-assisted transpersonal therapy, now increasingly used for PTSD joins EMDR (Eye Movement Desensitization and Reprocessing) as the only forms of therapy seen to make actual structural changes measurable by fMRI or PET scanning - or EEG monitoring. Smith's 5-point ear acupuncture is another, which offers certain advantages. The treatment-related advantages, which I'll elaborate on in Chapter 4 below relate to the fact of there being three variations on PTSD - called *Externalizing, Internalizing and no Pathology.* The mechanism of PTSD is an either/or mechanism where flashbacks, if they occur, are amygdala-dominated, and the freedom-from-PTSD re-evaluative side is brought back online by restoring VmPFC or dlPFC activity or both. I use **Smith's *5-point ear acupuncture*** as a **neuromodulator** - which, without any other intervention on my part, at least at this juncture, both down-regulates the amygdala and up-regulates the VmPFC, while training the recipient to retain it, until it's happened long and often enough for it to "catch." But, as will be seen in Chapter 4, correcting the three variations differs greatly.

Studies substantiate the three varieties of PTSD based on personality studies. DSM-5 now describes dissociative and non-dissociative PTSD[7]. Again, with some (significant) variations of adjunct treatment much like those proposed by **Cloitre et al**[8] **Smith's 5-point ear acupuncture** works for each variation.

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[7] Armour C, et al The co-occurrence of PTSD and dissociation: differentiating severe PTSD from dissociative-PTSD.

[8] Cloitre M. : An examination of the influence of a sequential treatment on the course and impact of dissociation among women with PTSD related to childhood abuse.

The adjuncts suggested by **Cloitre et al** - ***Skills Training in Affective and Interpersonal Regulation*** (STAIR) followed by ***Narrative Story Telling*** (NST) are not *talk therapy* even though they involve words. They are *sine qua non* training exercises. They do make a difference, it's apparent, but that difference is both deepened and sped up by **neuromodulators**, much as is seen with brief treatments with *ketamine* for refractory depression and *MDMA (ecstasy)* for refractory PTSD - but without the downsides of using possible street drugs in therapy. Once acupuncture catches on, some time between 1 and 28 days, it will stick. During this opportune time, which reads like a period of grace, if the subject is *alexithymic,* the relief from stress provided renders the patient much more susceptible to training the amygdala to switch over to parasympathetic functioning at will, in as little as five days of biofeedback training, taming the unregulated amygdala with *HeartMath's emWave2* heart-lung coherence biofeedback device via the vagus nerve.

Our way, it becomes apparent, is not the only way to proceed. One can go the VmPFC route with **Michael Mithoefer**'s use of the *neuromodulator* MDMA linked to *transpersonal psychotherapy.* With this potent, rapid-acting **neuromodulator** enhancement, "phenomena" which are transient activations of the VmPFC are seen to occur, briefly. One is alerted that change is immanent. If one fails to see this is happening or if it is imperceptible, one can err by falling back into *talk therapy,* if one is used to using it in a crisis. This means people not trained in *talk therapy* are easier to train. It also means that people who are good at *talk therapy* may not be good at training-oriented therapy, and are prone to blame their trainers for it.

Michael Mithoefer says: "While the specific mechanisms involved are not completely understood, MDMA is known to significantly decrease activity in the left amygdala. Studies in healthy volunteers suggest that MDMA alters recognition of and responses to expressions of facial emotion in ways that foster greater rapport, such as making facial expressions of positive emotion easier to recognize and negative emotions harder to detect. This action is compatible with reported effects of MDMA such as reduction in fear or defensiveness and it contrasts with the stimulation of the amygdala observed in animal models of conditioned fear, a state similar to PTSD. Current studies of MDMA-assisted psychotherapy suggest that this reduction in stress-induced activation of the amygdala may be enhanced by interaction with the therapists during and after the MDMA experience."

As **Mithoefer** says, the *transpersonal psychotherapist* acts by seeing when a breakthrough is immanent, supporting it, nudging it forward, knowing that an unsupported subject all too easily regresses to primitive defences like projection, or dissociation, which being limbic, defy treatment. The attuned therapist holds the space of *associative expansion* so that the briefly freed subject can mirror it (and, in short order, learn it.) This demonstrates over and over that there is a tipping-point where a therapist's right action is crucial.

Helen Palmer[9] taught me, by having me serve briefly on one of her exemplar personality panels that I could make use of this profitably in my own therapy - that I could enhance breakthroughs in doing so by building panels of people who had already had good results from previous iteration of any group training process, on hand at the time, that the patients were "ready to pop." This exposure, later in therapy, spawns *integration*.

But we haven't talk about this yet, really. I've told you only that when I started, I used no words at all. it was the only way I could remain true to Smith's dictum not to use talk therapy. But that was before I learned about *neuroplasticity* and saw that not was already happening in any patients - and could be augmented. It can. Conversely though, if I have students in my therapy room who are *talk therapy trained*, or who regress to *talk therapy* which narrows *associative focus* rather than expanding it, when the air becomes thin with change, they will often get worried about what I am doing or jump in with something they fashion to protect the patient against what they fear are attacks. I'm anything but attacking. Left to my own devices I will gently nudge the patient in an expansive direction. But when I do so, *talk therapists* can miscast me as *harsh*. I'm being strategically *harsh*, never *harsh* to the person but to their limitations. This is a teaching moment for new therapists who are learning, demonstrating that what's needed at first seems illogical. On to **Chapter 4.**

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[9] Palmer, Helen: *Our Intuitive Capacity for Spiritual Wisdom:* https://www.scienceandnonduality.com/our-intuitive-capacity-for-spiritual-wisdom-helen-palmer/