A Seasoned Style:

An Interview with Joseph Barber, Ph.D.

Charles Holton, LCSW

CH: Before we narrow the conversation to talk about hypnosis, I'd like to ask you how your thinking about psychotherapy in general has grown and changed over the last few years.

JB: When I was a young psychologist, just starting out, I often was mindful of the fact that I was too young to be doing this. And I felt a little embarrassed, and thought it was silly somehow that psychologists could be so young. And now that I'm not so young, I'm even more convinced of that perception. I look back and think of myself in my twenties and I'm grateful that I didn't do more harm than I did. I'm grateful for the subsequent life experience I've had, because it makes clinical work a little bit easier. I don't think the principles of good therapy change over time, but how we apply them, the art part of the scientist practitioner model, is something that really does get better and easier with time. For one thing, you see someone and you realize you've seen this kind of person, this kind of situation before. It's another example, I suppose, of the capacity to conceptualize., which is vital to intellectual growth. So I often have a simpler, sometimes faster response than I might have had earlier in my career. And I also try to recognize that just because I think I've seen this person or this situation before, I need to be equally mindful of whatever differences there might be.

CH: Well, as we age we've seen more of the arc of life, and that's a lot of experience to draw on.

JB: One thing that my experience has done for me, for good or ill, is I'm much less optimistic, as a clinician and as a person. When I was much younger, I really did believe, I'm embarrassed to admit, that I could help anybody who came to see me. And the advantage of that kind of optimism is that it really does support you with a lot of energy and a lot of enthusiasm to gain the experience that you're going to need over the years.

But now, some of the people that I see are people I realize I'm not going to be able to help. Or at least certainly not in the way that I once thought I would, not in the way that they're hoping that I can.

CH: A more realistic sense of what's possible.

JB: I believe that that might be the biggest change that came with experience, becoming more realistic about what's possible. And I'm also aware that younger practitioners can't see it this way, and that my students, in fact, see me as, among many other things, as an unrealistically pessimistic guy.

CH: You're a curmudgeon!

JB: Yeah, I'm a curmudgeon. And when I do supervision, for instance, and I am trying to focus someone on being realistic about possibilities, I can see their disinterest in being realistic about it –I mean, they think they are being realistic – and I can really see myself thirty years ago in them.

CH: I like how you see the pros and cons to both positions, how the enthusiasm and the energy are helpful, as well as the realism and experience.

JB: I really believe that the impossible-to-treat patients ought to be seen by young, unrealistically optimistic clinicians. And it may even be that when I was younger and unrealistically optimistic I did help some people that a more realistic practitioner, including me now, wouldn't.

CH: Well, the odds are there, that it may be a small percentage of people who are going to be helped by that level of intervention, but since so many wouldn't, you're less willing as an older therapist to engage, and predictably fail nine times out of ten. But the one success out of ten may be just enough juice to keep the young practitioner going.

JB: That's certainly how I feel.

CH: Well, given what you're saying, I don't imagine there are any new techniques or approaches in psychotherapy that have exactly piqued your interest.

JB: I quite honestly am not aware of anything new. I know there are new names given to things, but to the best of my knowledge there is nothing known now about psychotherapy that wasn't known when I did my training over thirty-something years ago.

CH: I wish I could remember the primary reference, but I do recall a study of the systems of categorizing temperament which concluded that there had been no improvement over the ancient Greek system of sanguine, melancholic, phlegmatic and choleric. I guess it's an arguable point that humans really haven't changed that much since then. It's just a matter of paying attention.

JB: That's a very interesting point you make, which is the value of paying attention. Careful, intelligent observers have known a lot for a long time. I used to say there wasn't much taught in psychology classes that my grandmother didn't already know. And that's not literally true, but it is true that experienced, intelligent, thoughtful observers know a lot.

CH: It reminds me of the resurgence in interest in mindfulness, which almost has a kind of faddish quality as these waves of therapeutic fashion rise and fall. I've really found it a useful practice myself, and in thinking about your psychodynamic orientation, it's struck me how they're almost different names for the same thing.

JB: Mindfulness is a current fad name for something that reflects a process many thousands of years old.

CH: And it's about tolerating difficult emotional states, and being present with your experience, which is really what all therapy is asking, and hopefully teaching, people to do.

JB: I guess that's true.. I'm reminded by your comment of the tremendous popularity of CBT. On the one hand, this reflects an appropriate respect for a set of ideas and practices which can be validated and taught with replicable results. On the other hand, in my view, CBT reflects a diminution of appreciation of the human condition. We—and the people whom we treat—are more than behaviors, thoughts and emotions. One of the reasons it is helpful for clinicians to learn hypnotic techniques is that, in doing so, we are faced with the complexity of human experience. More, we are faced with processes which are not conscious and which, nonetheless, have significant effect on our conscious experience. The current emphasis on CBT contributes, I believe, to the growing denial of that effect.

CH: And I see Ericksonian threads in Seligman's positive psychology movement: the focus on practical, functional, strength-based outcomes, the emphasis on strong family and community relationships, personal accountability and a sense of contributing something valuable. Different packaging for the same ideas.

JB: And Erickson himself was offering different packaging for ideas that people had talked about earlier than he. Erickson didn't invent practical, functional, strength-based outcomes.

CH: I remember how surprised I was when I discovered that family therapy was the dominant style of therapy before Freud. And the cycle continues to turn …

JB: Right.

CH: So how has the integration of hypnosis in your practice developed?

JB: Well, I'm not sure that it has changed very much over the years. I think it was relatively easy for me to see hypnosis as a set of interventions that could be integrated along with all the other interventions we learned in training. So I never saw myself as a hypnotherapist, since I never saw hypnosis as something isolated from the rest of it. I was always interested in understanding how hypnotic phenomena were an integral part of the larger psychological landscape.

The other day I was trying to see if I could identify for myself how I thought about hypnosis when I first learned about it. When I was an undergraduate and was first reading about hypnosis, particularly Erickson's papers, I saw hypnosis as magical. And the literature at that time certainly contributed to the perception of hypnosis as magic. But what I read told me that hypnosis could make miraculous changes in most people for

most problems. I don't think that's really the case, but as a result of that I remember saying, "Why doesn't everybody do hypnosis?"

My question would be a different one now: Why isn't hypnotic theory and technique a part of contemporary clinical training? But to answer your question, I don't think my integration of hypnosis has changed very much over the years. Early on I had a sense of when hypnosis might be helpful and when it might not be. Learning hypnotic methods isn't that difficult or complicated, really. Learning how to assess the appropriateness of those methods and then judging how to integrate them into a particular treatment plan—that can be more difficult.

CH: Well, it always seemed in the cases that you would write about that the hypnotic interventions came as an organic response from knowing the person well. Not only the focus for interventions, but the way you would intervene and the kind of hypnotic responses you were looking to elicit came from both what the problem was calling for and the resources of the person. I don't remember you ever coming out with a "Hey, I've got these interesting things to do to you and let's see if it helps" kind of attitude. There was always a sense of very careful, thorough understanding of the dynamics of the person and their life, and from that the hypnotic intervention was a very natural outgrowth. The word "integration" is more important than the word "hypnosis" in that sense.

JB: Well, I think you have a charitable sense of that work. Here's an example. Just recently a woman sought treatment of very severe osteoarthritic pain. Because of other medical problems she is unable to be offered pharmacologic treatment. She can't even take aspirin. And she can't have a surgical intervention, so she's really stuck. Unfortunately, she is one of those people for whom hypnosis is going to be a very difficult experience. She is very practically oriented, very practically-minded. She's very unimaginative. And so it's going to be very hard for her. So after two hypnotic interventions during which she had no response that I could detect, I told her that I thought the better solution for her was a trial of acupuncture. Now I'd be perfectly happy to continue trying to help her, but my sense is that even though hypnotic intervention is a very good one for the kind of pain she has, it's not a very good one for the kind of person she is.

I'm confident that over time she might obtain benefit. But just thinking of it as a practical matter, she can get a pretty good benefit from acupuncture sooner.

CH: And that intervention doesn't call for strengths she doesn't have. I find myself wondering how you would describe what psychotherapy has to offer as you think about it now, when you've stripped away the unrealistic, magical thinking and the heroic grandiosity.

JB: Well, first, I doubt that my view of this is any different than anybody else who has clinical experience, but, that having been said, I think that psychotherapy has two kinds of things to offer. On the one hand, it has a relatively circumscribed, practical relief to offer people who have relatively circumscribed problems, let's say behavioral problems

in which cognitive-behavioral treatment might be all that is needed, let's say a phobia or a habit. Or maybe hypnotic treatment for the same kind of problem. For people who have more complex problems that originate in personality features, let's say, someone who has a vulnerability to anxiety, or depression, or impulsiveness, CBT has only limited help for someone like that. And what I see as the benefit of psychotherapy in a broader sense, and which for me implies a psychodynamic model, is for someone to learn to understand themselves. To be able to come to know, to identify, those qualities which tend to get them in trouble. It's not likely that they'll be able to change those qualities, we can't readily change inheritable features, but we can come to understand them.

I sometimes offer this example. If we discover, for instance, that we have a limp that can't be fixed, we're less likely to trip if we accommodate to that limp, and learn to walk with the limp. Similarly, if we have a vulnerability to anxiety, we can learn certain cognitive ways of managing it. We can learn to thought-stop, we can learn to relax and so on. But even so, we are going to continue to be plagued by the impulse to be anxious. But we can learn to use regulatory methods more effectively, and, we can be less likely to create secondary anxiety. They're going to be less troubled by their anxiousness. Same thing with someone who's depressed, you know, or any of the experiences that are arise from natural human difficulties.

CH: Back to those Greek temperaments, huh?

JB: Yeah, exactly.

CH: One of the advances I see in Linehan's DBT model is seeing overarousal as the primary problem, a given not caused by faulty thinking or even bad behavior, but rather a physiological starting point to be managed when it occurs rather than blamed on the patient. It really avoids the kind of invalidating the patient's experience that leads to therapy being ineffective and even damaging.

Joseph, would you talk a little about what you plan to teach at the Fall Conference?

JB: We'll focus on how to determine which patients and which problems are likely to benefit from a hypnotic intervention, to be able to evaluate for appropriateness. And we'll discover how to integrate hypnotic methods into a larger practice. So we willexplore methods for changing behaviors , and we will explore how to use hypnotic methods for enhancing non-hypnotic psychotherapy. I think one of the real under-used, under-acknowledged benefits of hypnotic intervention is when psychotherapy has become less effective, has become stale, and the patient doesn't have anything of value to report—particularly when that's how they *think* of it, when a patient says, "Well, I don't have much to report this week," as if therapy is about reporting what happened during the week rather than describing internal experience. Hypnotic methods are valuable for enhancing a person's awareness of internal experience. They can be used to help a person be better able to describe primary process experience, and , sometimes, to get psychotherapy back on track if it has become less effective. And the third application I see for hypnosis in psychotherapy is for using the hypnotic experience to heighten, to

amplify the therapeutic relationship. That's going to happen whether you intend it or not, of course, but for some patients it's a very useful intervention. Some patients have a primary difficulty in benefiting from therapy because they're unable to connect in a healthy way with the therapist, and the hypnotic experience can really make this easier.

So my intention in this workshop is to describe, and then to explore with the group, these methods of using hypnosis to make therapy more effective, and also faster. Particularly in these days of managed care, knowing how to accelerate therapy can be a usefulskill.

I have repeatedly heard experts say that hypnosis isn't dangerous. However, this hasn't been my experience. So, in this workshop, we will discuss the unintentional consequences of hypnotic treatment—rare, but occasionally undesirable side effects. I'll relate some of my own more unsettling clinical experiences and what I have learned from them.

CH: What do you find is the most important thing you want to convey to clinicians in your teaching?

JB: We're not so very different from our patients. And that may seem like a fatuous thing to say, but what I mean by it is, it's very easy for us as psychotherapists to become over-identified with a patient and to lose clinical objectivity, and to lose judgment, to blur boundaries. But it's equally easy to maintain an inappropriate distance from the patient, thinking that the patient is very different from us. You could even think of it as a reaction formation: We are so frightened of the fact that we do see ourselves like the patient that we unconsciously push ourselves away, saying that they're very different from us. But either one of those reactions is a mistake, a distortion of what's real. I think it's important for us to be able to acknowledge whatever is similar as well as whatever is different between us and patients. And there again, in a certain respect it harkens back to what you said earlier about mindfulness. The more we know about ourselves the more mindful we can be about our own nature, the better we are going to be able to help our patients without getting in their way.

CH: What do see as the biggest strength in the clinicians you train?

JB: (Chuckles) Their hopefulness, their irrational optimism.

CH: (Laughs) Well, I guess it's a double-edged sword.

JB: I guess I would say the same thing was true for me. The biggest disadvantage of a young clinician is inexperience, and the biggest advantage is the optimism that comes from lack of experience.

CH: And the biggest advantage of experience is realism, but the disadvantage is that you give up too soon. It's all about balance, isn't it?

JB: Exactly so.

CH: So these days, what's the biggest thrill for you in teaching?

JB: Several things come to mind. One is, being able to have some of the youthful exuberance of my students rub off on me, and to be able to be charmed and delighted by their hopefulness. And then over time to watch as they become effective clinicians. It's really a pleasure to do supervision and see young, inexperienced clinicians doing very good work.

CH: Any other thoughts on clinical practice you want to share?

JB: One of the things I've learned that was more important than I realized initially and that I think is greatly undervalued and undertaught in current training is initial evaluation. I think personality evaluation is rarely taught anymore, it's thought of as a superstitious concept. I give MMPIs to almost all of my patients very early on, and it's valuable to my understanding of a patient's strengths and vulnerabilities. Sometimes I discover people are more fragile than I would have thought, so I need to be more cautious with them or, even, torefer them to someone better qualified to treat them. Other times I see just the opposite. I'm thinking of a woman who presented as very disturbed, and I remember when I first saw her thinking, "How am I going to treat her? I need to refer her out." And on about the third visit, she had done her MMPI, and to my amazement, the MMPI showed her to be much, much healthier, but to be someone who exaggerated her pathology in order to be taken seriously. So that gave me the confidence to treat her as if she was healthier. And she became healthier. She wasn't at all the crazy borderline that she presented herself to be. And, of course, some people present healthier than they really are, and without the testing I would make the mistake of expecting too much of them.

When I was young and knew everything I would take everybody on. Now, when I see a new patient, I make it clear that we're going to have an evaluation period during which I will determine what I think is best for them, and it may not be me.

CH: It's nice to have that understood from the beginning, so it's not a rejection of the patient. Joseph, thanks so much for your time, I can't wait to see you at the Fall Conference.

JB: Thanks very much.

Pull quotes:

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