Sleight Of Mouth Patterns (SOMPs)

Five recommendations for a better relationship

by Ed Redard, M.D.

ISo what are these wonderful things we call SOMPs? SOMPs are a delightful way to loosen the boundaries that individuals have built up around their "problems". What do I mean by that? Frequently I'll have a person come to me with a statement such as, "I can't lose weight because I don't have willpower." This is a dramatic statement and demonstrates a great deal about their map of weight loss. On their reality map, the city of Weight loss has a boundary, or wall, built that won't allow in willpower. It also implies that if willpower were able to penetrate the city walls of weight loss, then losing weight would be possible. This is the map of their belief. Is it "true"? They certainly seem to be behaving as though it were true. And what is a belief anyway? A belief is a feeling of CERTAINTY about something, that you KNOW where the line between problem and non-problem is, and it is exactly that feeling of certainty is what gives us such conviction about our beliefs. And so in service to the client (with ecology in mind of course), the first step in moving to a more resourceful belief is to shake the feeling of certainty they have about the old one. This is where the meta-model comes in and allows us, through the process of questioning, to discovery the quality and type of boundaries that are present. By the way, have you ever noticed that when you are questioning the client about their problem, it sometimes just disappears or lessens. Or have you ever questioned a client until they get to a juicy point that is near the core of their belief and all you get from them is blank stare (I like to call this the "null point")? What happens at that instant is that the boundaries between problem and "non-problem have opened and a new map was considered or redrawn. So, you may be asking, what does this have to do with SOMPs? SOMPs are a fun way to loosen the frame around a belief. It is NOT intended to be a way to change a belief in itself, however, that can frequently happen. As you deliver your Somps and the client goes off on their Transderivational Search (TDS) or experiences a state change as demonstrated by a change in skin color, breathing pattern, or other aspects of physiology, you will know that the boundaries are at least being examined, a great place start a generative change process.

Before we get on to SOMPS, one more pleasing way of defining and loosening boundaries is to use the questions derived from Cartesian Logic. There are four questions to consider and they take the client through all the possible outcomes of their present belief. The questions are as follows:

Client: I can't lose weight.

Cartesian Questions

1. What would happen if you did?
2. What would happen if you didn't?
3. What wouldn't happen if you did?
4. What wouldn't happen if you didn't?

Client: I can't lose weight because I don't have willpower.

Possible Cartesian Question:

1. What would happen if you lost weight without willpower?
2. What would happen if you remain the same weight even with willpower?
3. What would happen if you lost weight with willpower?
4. What would happen if you remain the same weight without willpower?
5. . What wouldn't happen if you lost weight without willpower?
6. What wouldn't happen if you remain the same weight even with willpower?

The purpose of these question are not only to notice what answers the client gives you, it is also to begin to loosen up their model of the world as they begin to examine the limits of their boundaries.

Now On To:

Sleight of Mouth Patterns

Redefine
I. What other meaning could the equation have?
2. A # B, A = C, and that's D
Consequence
What will happen to them if they continue to think this way?

Intention
I. Why are they saying this?
2. What is the secondary gain?
3. What are they trying to get?

Chunk Down
I. What specifically?
2. What are examples of this?
3. What are parts of this?

Chunk Up
I. For what purpose?
2. What's important about this?
3. Exaggerate.

Counter Example
1. Invert the belief
2. Make into a universal statement or question.
3. Was there ever a time when A # B?
4. A causes B, not B causes not A.

Another Outcome
What is another outcome you could shift to?

Metaphor/Analogy
What story will relate to their belief?
Tell a metaphor or story about the solution.

Apply to Self
Don't think about it; just use the word back on itself.

Hierarchy of Criteria (Values)
1. What are higher criteria (values)? .
2. Apply current criterion (value) to current sentence.

Change Frame Size
1. Something (larger or smaller) they haven't noticed.
2. Different frame, same behavior
3. Chunk up to Universal Quantifier

Meta Frame
How is it possible they could believe that?

Model of the World
1. Switch Referential Index
2. Is this true in everyone's Model of the World?

Reality Strategy
1. How do they represent that belief?
2. How do they/you know if it's not true?
3. Apply current criterion (value) to current sentence.

I hope you enjoy using these as much as I do. I wonder if you are not already more proficient in using Somps that you know you are? Nevertheless, I don't know what gets you as much results as practicing does. So remember, as long as you're going to practice, HAVE FUN!

Until next time!

Ed Redard, M.D.

Sleight Of Mouth Patterns" and Communication Patterns in Psychiatric Settings.

The term 'chaos' has countless colloquial meanings, but is very specific and precise in its scientific usage. It refers to the behaviour of a system - biological, physical, or mathematical - with extreme sensitivity to small (and even infitesimal) changes in the initial condition of the system. An example of such a system is a leaf floating down a swiftly-moving stream - where the slightest displacement of the original position of the leaf (a breath of wind) will lead to dramatic changes in it's final trajectory. Such systems become unpredictable very quickly, and move deeper and deeper into the unpredictability of chaos. (A clock pendulum, by contrast, is stable and non-chaotic; any small disturbance in the pendulum will be rapidly lost.) In classical mechanics, it seemed that if the state of a system at a given time were known with sufficient accuracy, one could forecast its future with perfect accuracy and certainty; but this is precisely what one cannot do if a system is chaotic.

Oliver Sacks, "Awakenings" p355.

Robert Dilts' Sleight of Mouth Patterns came from modeling the language patterns such notables as Socrates, Gandhi, Erickson and Bandler amongst others.

Click here for off-site article: When Bandler Played The Blame Game.

Dilts has written several excellent books on "Sleight Of Mouth" and belief change patterns which are well worth adding to your reading list. I present these patterns here not as a 'cure' for schizophrenia (I don't know if such a thing exists yet), but as a working guide for those working with schizophrenics on a regular basis (ie in a community care unit) or for those seeking a better understanding of the patterns used in psychiatric environments.

I begin with the various patterns a schizophrenic might deploy in order to psychotically answer the statement, "People with schizophrenia can learn to control their neurology" spoken by a non-schizophrenic. This translates at the surface as the belief/complex equivalence that "schizophrenia is equal to an uncontrolled neurology"

"People with schizophrenia can learn to control their neurology."

Pattern #1 - Redefine: "You don't understand what it is like to have this illness."

Pattern #2 - Consequence: "You just want people like us under mind control."

Pattern #3 - Intention: "You want us under mind control because you don't care about us."

Pattern #4 - Chunk Down: "That might help other people, but it won't help me."

Pattern #5 - Chunk Up: "So you think you can cure all schizophrenics?"

Pattern #6 - Counter-Example: "The drugs are supposed to help with that and they don't work either."

Pattern #7 - Another Outcome: "Maybe people with schizophrenia need better drugs. "

Pattern #8 - Analogy: "That's like teaching a pig to sing - it not only doesn't work, but upsets the pig."

Pattern #9 - Apply To Self: "That kooky idea makes you sound like a schizophrenic too."

Pattern #10 - Hierarchy of Criteria: "?"

Pattern #11 - Change Frame Size: "Maybe everyone should learn to control their neurology then I wouldn't have to."

Pattern #12 - Meta-Frame: "?"

Pattern #13 - Model of The World: "."

Pattern #14 - Reality Strategy: "How do you know?"

The difficulty for the operator when hit with these reframes is knowing which reframe he is buying into. For example, the operator replies to Pattern #3 - Intention: "What do you mean by that?" by explaining what he means, ie "it's a beautiful day" will rapidly find himself being pulled down into the psychotic pathway of reasoning that he may find it very hard to deal with.

Visitor: "Good afternoon, I have an appointment with Dr. H. My name is Watzlawick" [VAHT-sla-vick]

Receptionist: "I did not say it was."

Visitor: (taken aback and somewhat annoyed): But I am telling you it is."

Receptionist: (bewildered): Why did you say it wasn't?

Visitor: "But I said it was!"

At this point the visitor was "certain" that he was being made the object of some incomprehensible but disrespectful joke, while, as it turned out, the receptionist had by then decided that the visitor must be a new psychotic patient of Dr. H. Eventually it became clear that instead of "My name is Watzlawick" the receptionist had understood "My name is not Slavic," which indeed she had never said it was. It is interesting to see how even this brief interchange due to a verbal misunderstanding, immediately led to mutual assumptions of badness and madness.

"Pragmatics" page 95.

Now, let's look at the patterns from the reverse perspective. A patient who is asked to carry out a task X,Y or Z denies responsibility/capability by stating, "I haven't got a head." I have experienced a patient that maintained this line for several years. The standard response from the staff was a simpering effort of, "Well, that is just how you feel, why don't you go and sit down." Because she was labeled as "ill", this statement was permitted as a statement of feeling and thus supported and inadvertently legitimized by the staff. Through experience, the staff had soon learned on arriving in the department that for themselves, this was the line of least resistance. Questioning this patient too closely could prove to be a very frustrating affair where invariably the patient would still get her own way.

Statement: "[I cannot do X,Y,Z because] I haven't got a head."

Pattern #1 - Redefine: "Many of us don't have the right head on at times."

Pattern #2 - Consequence: "And what happens when you haven't got a head?"

Pattern #3 - Intention: "I admire your intention of not having to worry about your hairstyle."

Pattern #4 - Chunk Down: "So how can you talk without a head?
"
Pattern #5 - Chunk Up: "

Pattern #6 - Counter-Example: "How is it that you are able to talk then?"

Pattern #7 - Another Outcome: "The issue isn't whether you have a head or not, the issue is whether or not you want breakfast!"

Pattern #8 - Analogy: " I wish I could be like that today, I have such a hangover!"

Pattern #9 - Apply To Self: "So the head that you haven't got thinks that?"

Pattern #10 - Hierarchy of Criteria: "Isn't it more important that you get along with me rather than worrying about some small defect like that?"

Pattern #11 - Change Frame Size: "Oh right, so if we all used that excuse, nothing would ever get done."

Pattern #12 - Meta-Frame: "You only say that because you like to confuse the staff about how you feel."

Pattern #13 - Model of The World: "In my opinion, you are saying that as a metaphor for something else, are you not?"

Pattern #14 - Reality Strategy: "How do you know that not having a head stops you from doing X,Y,Z?"

This approach of "Frame setting" rather than "Frame responding" means that the operator can directionalise the transderivation of the client, rather than finding himself being directed into the psychotic reality of the client.

I was called to see a patient held under a compulsory detention order who told me that he was a secret agent, placed there to evaluate the professionalism of the staff. He had been maintaining this apparent "delusion" for several weeks and no one, nor any drugs, had appeared to relieve it. My impression of this guy was that he didn't really believe it for one single second, but his ability to maintain the conversational postulates of it outdid that ability of the staff to argue with him.

My conversation with him went something like this:

John: "I'm a secret agent here, don't argue with me or I'll report this back to my superiors."

Andrew: "Bullshit - wanna bet?"

John: "Bet on what?"

Andrew: "That you are not really ill, you are just behaving like a dickhead." (presupposition, double bind, change of frame)

John: "But I'm not ill!"

Andrew: "Exactly my point, you are just being a dickhead." (change of frame, closure of bind)

John: "Well, that's your opinion."

Andrew: "How much are you getting paid to assess the staff?" (shift of frame, Chunk Down)

John: "Not much."

Andrew: (Picks up telephone and starts dialing) "I'll check with the hospital administrator to ask for a pay rise for you." (Chunk Down, implied threat of consequence - the administrator sits on the appeal panel when a patient challenges the compulsory treatment order - I was due to represent this client in 2 days time).

John: "Don't do that."

Andrew: (stands up, speaking in mock aggression, southparks style) "Ok, I'll tell you what, if you are a secret agent, you get to kick me in the nuts, if you are just a dickhead I get to kick you in the nuts. Stand up." (Consequence)

John: (Looks anxious) "You can't kick a patient here."

Andrew: (Laughing) "No, but I can kick a secret agent, right? It's part of the risk you guys take." (reverse of reframe, double-bind, Consequence)

John: (Laughing) "Ok, ok, maybe I really am ill, I can't help it..."

Naturally, I immediately denied he was "ill" and we did another round, then another and another, until exhausted and exasperated he flopped down on his bed crying, "Enough, enough! You are insane!!"

As RB puts it, it's a matter of breaking through the schizophrenia to reach the person behind it.

Observing the staff-patient interaction on this "Show-Case" department, a department that has one of the best reputations in the UK (well, the carpets look nice), observing the staff's communication demonstrated that they were entirely supportive of the psychotic communications of the patients. It led me to wonder what would happen if all the staff there were trained in the meta-model, reframing and sleight of mouth patterns, and were encouraged to use them on all the inappropriate communication by their patients - how different would their results be? However, in our culture this is not always acceptable behaviour, since it appears to deny empathy and sympathy that ids all too often demanded in these settings - the apparent foundation of any therapeutic relationship, as taught in mental health training.

Many total institutions, most of the time, seem to function merely as storage dumps for inmates, but, as previously suggested, they usually present themselves to the public as rational organizations designed consciously, through and through, as effective machines for producing a few officially avowed and officially approved ends. It was also suggested that one frequent official objective is the reformation of inmates in the direction of some ideal standard. This contradiction, between what the institution does and what its officials must say it does, forms the basic context of the staff's daily activities.

Erving Goffman, "Asylums" p73.

R.D Laing illustrated another paradox whereby everybody's behaviour on a ward would shift whenever a person of importance entered the ward:

"No doctor ever entered the locked door without the telephone ringing from another ward the telephone ringing from another ward to say that he was on his way…and everyone would take up their appropriate positions and start up their usual numbers. What the doctor then saw (and presumably, the doctor who had been the superintendent of that hospital and who wrote one of the most commonly taught textbooks of psychiatry) bore little resemblance to what otherwise went on in that place." "The Facts of Life" P114.

The difficulty with creating a shift in the behaviour of the staff of these institutions is to be able to do it without detriment to their clientele. Many of the procedures that exist in psychiatric practice were initially put into place to protect the patients from the staff. This rather extraordinary state of affairs is easily demonstrated by examining any of the psychiatric patient's bill of rights. Whilst most psychiatric staff offer to act in their patients' best interests (to the limit of both their ability and scope of permissible practice), I have regularly encountered staff who act only to serve their own interests - mostly to reinforce their power status over other human beings. However, there is a fine line here - all too often, I have encountered staff that were more afraid of their patients symptoms than their patients were, and this didn't appear to me to be a very good start.

The catastrophic consequences of such scenarios are eloquently described by Oliver Sacks in "Awakenings",

"When I returned, indeed, I found the ward in chaos - it was not just Miss D., it was everybody in trouble. I had left a fairly calm and healthy ward in August, but when I went back to it in September, a horrifying site met my eyes. Some of the patients were shaking and grossly Parkinsonian, others had returned to statuesque catatonia, many were ticking, some were verbigerating, and a dozen or more were plunged back in oculgyric crisis. My own first thought, when I saw all of this, was that there had been some colossal, terrible mix-up in the pharmacy, that every patient had been given the wrong medication or the wrong dose. My next thought (when a glance at the charts showed their medications to be in order) was that they all had the flu, and possibly a high fever (which I knew could drive such patients into exacerbated pathology). But this was not the case either.

What had happened, then, in the brief months I was away? It took me several days to piece this together. There had been, I found, a drastic, even draconian, change in the hospital administration, with the appointment of a new director; the patient community had been abruptly disbanded, visiting hours had been sharply curtailed, and day passes to leave the hospital had been cancelled without recourse or warning. The protests of patients had been completely ignored - they suddenly found they were denied any say in their own affairs. It was this - their sense of grievance, shock, and impotent rage - which had been given a physiological form, and 'converted' into Parkinsonian, crises [and] tics…

And indeed, later that autumn, as the patient community was reestablished, and visiting privileges and passes became available again, a dramatic physiological improvement occurred, and many of these 'side effects of L-DOPA' (so-called) suddenly dwindled or disappeared, though a certain sense of insecurity, all too understandably, persisted."
Page 53.

Whilst employed in the "Community Care" mental health units, I observed dramatic alterations in the overall behaviour of the "residents" according to the organization of the staff duty-rota. In one particular unit, it was the manager who managed to observe the most psychotic behaviours - mostly generated in response to her appalling communication skills. She viewed residents/patients as broken people who should be protected from both themselves and from other people and as people who needed drugs immediately that their behaviours deviated from her own [variable according to mood] criteria. Unfortunately, this belief manifested itself as condescension and patronization and could be quite disturbing to observe. What was missed from her feedback loop was that much of the manifest behaviour in any one resident was not necessarily a manifestation of a diagnosable illness, but was more likely a manifestation of a detained resident's difficulties in coping with her communication. It was only a matter of time before she was at the receiving end of my psychotic type of behaviour during which time this normally nervous and twitchy human being transformed into a calm, rational being who clearly felt more comfortable dealing with crisis that dealing with "normal" people.

This is nothing new, in 1969, Laing posited the following in "The Politics of The Family":

…to what extent does 'schizophrenia' 'cause' his subsequent behaviour? If you like: to what extent is the behaviour most typically regarded as hard-core schizophrenia, iatrogenic?

Hypothesis: this set of ascriptions to a person, and this induction into the role of schizophrenic, themselves generate much of the behaviour that is classified as 'symptomology' of schizophrenia.

Experiment: Take a group of normal persons, group N (by agreed criteria) - treat them as schizophrenic.
Take a group of 'early' schizophrenics, group X (by agreed criteria) - treat them as normal.

Prediction: Many of N will begin to display the agreed criteria of schizophrenia.
Many of X will begin to display the agreed criteria of normality.

Experiment: Take a group of 'early' schizophrenics.
(i) treat them in role as crazy.
(ii) Treat them like oneself as sane.

Prediction: In (i) the symptomatology of schizophrenia will be very much greater. In (ii) the symptomatology of schizophrenia will be greatly diminished.

Frank Farrelly innovated what he termed "Provocative Therapy" and wrote a fantastic book of the same title. What is outstanding in Farrelly's approach is the recognition of the absurdity of the psychiatric environment that cuts straight through the paradox outlined by Goffman. Reading Farrelly's book reminded me of my senior school math teacher. I started this particular school with the highest grades in most of my year classes. Within two years, much to everyone's expressed disappointment, I had been demoted to the 'dummies classes' for most subjects. The teacher for remedial math was a man who both thrilled and terrified us. On our first day with him he made it clear that we would be learning our math from him and not from the course books - he told us that we were never to open our course books in his lessons. He told us stories and metaphors, he told jokes and would often rant and rage about the state of modern schooling methods - he was a very angry and a very powerful and fearless man that demonstrated an utter and total benevolence to every child in his lessons. He mocked and shouted at our misunderstandings in such a way that made us all giggle and was nearly always unpredictable whenever asked a question. Best of all, he was the scarey man that was on our side and not the side of the educational establishment. We all loved him and we all passed our math exams.

I'm not going to debase the book by attempting to summarize Farrelly's style - *buy the book* - but I quote here at length from pages 26-27:

I had been essentially communicating three basic ideas to him: 1. You are worthwhile and of value; 2. you cabn change and 3. Your whole life can be different. He, in turn, has been persistently communicating back to me three complementary responses: 1. I am worthless; 2. I'm hopeless and can never change; and 3. My life will always be one long psychotic episode and hospitalization. It was becoming increasingly clear that empathic understanding, feedback, warm caring, and genuine congruence were simply not enough and were getting us nowhere. At this point I "gave up" and said to him, "Okay, I agree. You're hopeless. Now let's try this for 91 interviews. Lets try agreeing with you about yourself from here on out."

Almost immediately…he began to protest that he was not that bad, nor that hopeless…He became less over-controlled and showed humour, embarrassment, irritation, and far more spontaneity. In a very embarrassed tone, he spoke about his "regressing" (a favorite, central term in his emotional lexicon) but felt that I had been of great help to him. I replied, "Help? Hell, I started seeing you a year and a half ago on a locked ward, then you moved out to an open ward, then you got discharged from the hospital, and now here you are, back again on a closed, locked ward. Well, if I've been of any help to you and you're showing any kind of progress, you're moving with all the speed of a turtle encased in concrete."

He became red in the face and stated that I shouldn't expect too much from him: "It'll probably take me two or three years of resting up here before I get out of the hospital." My heart sank down to my liver, but I disregarded my affective response and blandly replied, "Yeah, I can see you now, as we go on and on towards the second 91st interview. You'll probably 'regress' more and more as you keep saying, until I'll be feeding you your Pablum like a tiny baby." Then in a coaxing voice I added, "Come on Billy, take your Pablum." He blushed beet red and burst out laughing. I continued, "Then you'll probably lose control over your bowels and bladder (he again blushed furiously and laughed explosively), and I'll have to change your diapers, which we'll have to make up out of bedsheets because you've got such a fat ass, until finally by the time we reach the next 91st interview you will have made medical history. The patient looked puzzled and asked cautiously, "What do you mean?" I answered, "Well, hell, Bill, if you can continue this 'regression' like you keep saying, by that time you''ll be the first neonate on record with pubic hair!