

**Abstracts**  
**of the 2° Conference on**  
**Brief Strategic and Systemic Therapy**

Abstracts presented  
at the 2° European Conference  
of Brief Strategic and Systemic Therapy

“EUROPEAN WAYS OF BRIEF THERAPY”  
*“best practice best teaching”*

November 9th-10th-11th-12th-13th 2005

Arezzo, Italy

## **Strategic Treatment of Epileptic Phobia**

Avigdor Bonchek

A 41 year old married male who has suffered from Epilepsy since age 10 was treated for recently developed phobic fear related his epileptic attacks. He takes medication for his attacks. His phobic reactions, including difficulty traveling on buses and being in crowded public places, developed about a year before he entered therapy. At first session he was given the paradoxical prescription of having an attack in the office "so I could see what it looks like." His failure to have one, lead to the prescription of bringing it on at work. His panic about being "discovered " as an epileptic lead to the prescription of revealing his "secret" to selected individuals. He did this at work and at home with his children. His fears abated significantly. And number of attacks were reduced but not eliminated completely.

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## **Strategic Treatment OCD scrupulosity in prayers**

Avigdor Bonchek

An 18 year religious student with intense difficulties saying his daily prayers (he would get "stuck" and repeat words over and over). His problem began at age 11. His prayers were inordinately long and very stressfull for him. He had been on SSRI medications and "behavioral" treatment for over a year with little progress. He stopped all medication before our treatment. The treatment prescription of repeating the words he compulsively repeated another ten times lead to dramatic results. I have an audio tape of his progress from initial treatment, mid-treatment and end of treatment. Follow up 6 months later shows gains maintained. It is a truly striking case.

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## **The usefulness of stigmata: a case of severe depression with learning problems**

Dezsoe Birkas

The author presents a case report of a 23 year old, intelligent law student with a medical history of recurrent depression and learning problems. The patient was already treated with antidepressants because of an episode of depressed mood, hopelessness, symptoms of anxiety. He was on the medication for 6 months and „was only able to take exams because of that.”

At the first contact (09.17.2004) the patients complained about depressed mood, aimless agitation, suicidal thoughts, diarrhoea, tremor and ambivalence about future work, his being unable to complete studies. He intended to quit his study of law (it was his last semester and he had very good achievements) and tried to obtain an admission to the police academy. For that purpose, he already asked for the admission sheet at the secretary. He refused to eat, because he „does not deserve food”. The patient and his overconcerned mother pushed for inpatient treatment and imminent medication. Contrary to psychiatric advice, they decided to postpone his exams by only two weeks, to give it another try under the „doping effect” of antidepressants.

Family background: Parents divorced because of alcohol problems of the father, mother is a lawyer. The child is pampered, overprotected. His mother always tried to make up for matrimonial conflicts of the past.

During pharmacotherapy his condition worsened, he complained day by day, that medication does not work. Despite all efforts, care, attentiveness, and empathy, his condition worsened. Finally he declared his case is hopeless, and asked permission to leave the hospital.

On the first out-patient contact the patient’s condition remained unchanged. This made it necessary to plan a strategic intervention (and winning his mother for our plans), which we did. We declared to him in a benevolent and gentle manner, his poor condition wasn’t his fault, neither the medications’. His depression was a certain constitutional sign of his mental limits, as a response to stressful situation of having to take exams, a sign of his mental disability to learn any longer, so he won’t be able to fight his symptoms because depression evoked by this stressful situation caused an alteration of his learning processes. Marking a growing anger in his glance we continued with our explanation: It is useless to try, he could be the most brilliant police officer in the country but only a mediocre lawyer at most, even if he could obtain his

law degree. It's better to give up in time, we encouraged him to break up his studies. His mother would also consent (which she did) since it was the more important for her to have a carefree son without misgivings, than a successful but anxious and depressed lawyer. She was openly encouraged not to set hopes too high, to be realistic and discourage him, and not to get involved in any act of help. As an answer to that he asked for permission to leave, which we gave him. By the 15th November he completed two exams. The last one was taken in May 2005. Now he wants to become a public prosecutor- as a result of his anger?

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## **There is nothing like the efficacy of placebo caused by a nothing like placebo**

Dezsöe Birkas

Gianfranco Cecchin said „therapy is a trick without a trickster”. Placebo is „objectively without specific activity for the condition being treated” although the „placebo effect” encloses all nonspecific changes in the patients condition during therapy. To state it paradoxically: There is nothing like the efficacy of placebo caused by a nothing like placebo. „Placebo effect” is a semantically wrong word formation, since it is not caused by placebo. It is as if labeling traffic a „vehicle effect”. „Placebo” is a functional, not a structural notion.

Treatments of unknown action, unpredictable by their outcome; environmental, material, personality - and time dependent nonspecific factors causing unpredictability are referred to as "placebo". Using the placebo concept in an erroneous, structural sense leads to its simplified definition of „inert substance”.

Placebo's contextual everpresence forces us to reassess therapies from an instrumental, functional viewpoint. To state it irreverently: Placebo is the scandal for classical neuropsychiatry, that Marcel Duchamp's „Fountain” (i.e. the exhibition of the urinal) was for aesthetics / arts.

It has always been the aim of neurosciences to provide valid, predictable treatments. Placebo has been used in „randomised, double blind” clinical trials

in order to filter out „methodological noise”, guided by efforts to measure „real, specific changes” caused by (psychotropic) drugs only. Attempts to „filter out” placebo’s everpresence and nonspecificity are comparable to the task of observing environmental effects caused by a rivers undulation, by measuring only those changes caused by regular, predictable waves.

Understanding placebo as an „inert substance” and using a double blind technique, has severe consequences on therapy.

(1) The presence of nontrivial, unpredictable phenomena leads to an annoying occurrence of the „ghost in the machine”, causing significant standard deviations in statistics of outcome studies.

(2) Placebo’s instrumental function becomes eliminated. Nonspecific variables like „trust” disappear by the trick of objectivity. Self fulfilling prophecies like trust’s effect on healing are rejected. The consequence:

(3) Alterations of „placebo response rates” are led back to disturbances at the structural, organic level only. Lower „placebo response rates” in cases of recurrent depression for example are explained with increasing abnormalities of the patients brain, without taking into account the negative effect of the patients’ and the physicians’ growing mistrust in therapy.

(4) Long and extensive research for specifics of a problem gardually leads to the „truth” that the problem is unchangeable. Trust- truth are reciprocal concepts.

The presentation attempts to throw light upon nonspecific effects of self-fulfilling prophecies on the therapeutic process, in the course of pharmacotherapy for different diagnostic entities listed in the DSM IV-R and the ICD 10.

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## **An introduction to Transformation through Symbolic Modelling\***

Justina Claudatus

Symbolic Modelling is a new psychotherapeutic approach based on David Grove's Clean language, cognitive linguistics, self-organising systems theory and Neuro-Linguistic Programming. This method facilitates individuals to become familiar with the symbolic domain of their experience so that they discover new ways of perceiving themselves and their world. With this model we find out how the human mind concentrates personal experience into metaphors which condition everyday thinking, feeling and behaviour modalities. In fact, from the moment we are born we create mental models of how the world works, depositing this experience into metaphors. Thus, metaphors are both prescriptive and descriptive and therefore can be *a tool for creativity or a self-imposed prison*. Once into the process the idiosyncratic bi-dimensional metaphors become four-dimensional allowing the individual to move within their own personal world and reorganize their symbolic perceptions, permitting change to occur.

During this short course the following topics will be covered:

- Definition of metaphors and Symbols
- Fundaments of Clean Language
- Practical application

\*The approach is based upon the psychotherapeutic process proposed by James Lawley and Penny Tomkins in *Metaphors in Mind* -The Developing Company Press -2000

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## **Beyond blame – Towards an integrated systemic approach to working with young people who have committed sexual abuse**

Declan Coogan

Within the field of intervention and therapy with young people who have committed sexual abuse there is an emerging consensus that dominant practices can fail to explore the multi systemic patterns of behaviour and relationships within which the individual is embedded. Sexual abuse can have a restrictive and oppressive impact on the lives and relationships of the young people who have committed sexual abuse, families and the children and young people who have been sexually abused. Working with young people who have committed sexual abuse, the therapist may also become vulnerable to allowing personal fears and values confine the scope of conversations in therapy. Using case examples, this workshop will explore the liberating routes to conversations about the correlates of sexually abusive behaviour and the alternative patterns of meaning and behaviour that can be found through systemic therapy practices. Participants in the workshop will become familiar with systemic practices that take place at an out-patient inter-agency service for young people who have committed sexual abuse and their families. The workshop will raise questions about the possibilities of an integrated perspective that brings together systemic, feminist and cognitive behavioural approaches in a complimentary relationship at the service of the families with whom therapists work. The workshop presenter will include sometime for discussion during which the presenter would hope to hear about the opinions and experiences of participants in the workshop.

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## **Technical principles & main techniques in brief systemic strategic therapy with couples**

Teresa García

Practicing and training people to do brief strategic psychotherapy has led me to realize that there are a series of clear cut principles that consciously direct senior master practitioners. Making these principles explicit can permit us to evaluate our practice, to teach and to train our students. These principles can also be useful in defining what is brief strategic psychotherapy and in letting us distinguish between different styles of work. I also use these principles to supervise sessions through group supervision and to let students give feedback to one another.

This conference will be double-focused: defining only those principles most used in couple's therapy and choosing only those principles most related to strategy and techniques.

Examples with couples will help further illustrate basic couples therapy techniques.

Closing with: What's technique without a language and a relationship?

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## **Technical principles & main techniques in brief systemic strategic therapy with couples**

Stéphan Hendrick

*Objectives:* there is still a lack of evidence that brief systemic therapy are efficient (Dunn & Schwebel, 1995 ; Shadish, Ragsdale, Glaser & Montgomery, 1995 ; Gingerich & Eisengart, 2000 ; Sexton, Alexander & Mease, 2003 ; Bergin & Garfield 2003; Inserm, 2004). IBST (Integrated Brief Systemic Therapy) is an original model that integrates problem focused therapy (Fish, Weakland & Segal, 1986), solution focused therapy (Isebaert & Cabie, 1999 ; De Shazer, 1996, 1999a, 1999b, 2002), Elkaim's concept of resonance (Elkaim, 1989), some hypnosis techniques and other features (Budman, & Gurman, 1988). IBST is a flexible manual-based treatment so that therapy is tailored to the client's needs (Hendrick, 2003).

*Design and Method:* we used Pinsof & Wynne (1995, 1996, 2000) methodological recommendations. An experimental group of 30 subjects with high distress level participated in 3 to 10 IBST sessions. The clients have been assessed with three self-reports before and right after the therapy (Family functioning, quality of life, symptoms). Two control groups (no treatment) have also been assessed, one group with high distress level (N=29) and one group with low distress level (N=30). Quantitative (MANOVA, effect size, RCI, etc) and qualitative analysis have been carried out.

*Results:* the clients improved significantly on the three self-reports. Moreover, results show that improvement are partially connected with some specificity of the model. However, results show that the dosage (10 sessions) is lightly insufficient. Results are discussed and we confronted our results with those one of the litterature.

*Conclusion:* the IBST model proved to be effecient. Results suggest that 15 sessions could be an average correct dosage. Up till now, it is one of the few

studies to test the effectiveness of the systemic brief therapies with a rigorous scientific approach. The assessment method is reliable and easy to implement. The present study has some limitations that are discussed. Some improvements are proposed. A new study is presently on the way.

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## **Sources of the Therapeutic Alliance in Systemic Therapy**

Adam O. Horvath

The therapeutic relationship in general and the concept of the therapeutic alliance in particular have been the topic of considerable theoretical discussion as well as empirical research for the past four decades (Horvath, 1994; Horvath & Bedi, 2002; Martin *et al.*, 2000). Much of this research has focused medium to long term individual treatments. In this presentation we will summarize the theoretical discourse on the role of the relationship in systemic therapy and report on our own theoretical and empirical research which focuses on the role of the alliance on time-limited systemic couples therapy.

We have provided time-limited (6 session) couples treatment to 42 couples in a clinical setting using experienced therapist. In this presentation we will draw on participant based data and a Systemic Functional Linguistics (FSL) of the therapy discourse to provide an evidence based theoretical framework for the role of the alliance in brief systemic couples therapy. The model presented likely have implications for individual as well as multiple client startegic/sytemic therapies.

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## **Investigation of energy expenditure:**

## **a dimension of perceived in rheumatoid arthritis**

Supalak Khemthong, Tanya L. Packer, Satvinder S. Dhaliwal

*Introduction:* fatigue as experienced by people with Rheumatoid Arthritis (RA) has many definitions. RA fatigue is commonly defined as a feeling of tiredness, increased pain, and a lack of energy whilst performing daily activities. Energy expenditure is an interesting variable; the physiological dimension of fatigue. Understanding fatigue and energy expenditure in terms of pattern and variability over time is poor in this population. This pilot study aimed to determine the pattern and variability of RA fatigue, to investigate the pattern and variability of energy expenditure and to examine the correlation between the two parameters. The aim was also to test measurement tools to see if they could measure pattern and variability over time.

*Methods:* four volunteers with chronic RA participated in the study by reporting their feeling of fatigue via the Activity Record, and their energy expenditure via the Actigraph over four consecutive weekdays. Raw data of both variables were first plotted and then calculated into the percent of waking time spent at each level (fatigue score or activity count intensity) by days. The percentage data were weighted and then averaged over one, two, three or four days. Mean and standard deviation (SD) of the weighted fatigue and activity count indicated the variability within subject. The measurement error was confirmed by examining the difference between the 4-day mean and the 2 and 3-day means. Spearman Rank Correlation was used to analyse the relationship between fatigue and energy expenditure.

*Results:* there was no obvious daily pattern in either parameter when individual data was examined. Mean and SD of the daily weighted fatigue score was similar over two, three, and four days. For example, the variability of the mean weighted 2-day average across subjects was within a range of  $\pm 0.5$ . This indicates that the variability over time is less than 25% of the 4-point likert scale. There was little difference for 3-day and 4-day mean weighted daily score. The weighted activity count showed no variability due to the very low intensity of activity in all subjects: the Actigraph appears to lack needed sensitivity for this group. No significant relationships between fatigue and energy expenditure were found.

*Discussion and conclusion:* people with RA appear to have no set pattern of fatigue or energy expenditure across weekdays. Weighted over a full day of

activity averages is the best way to measure subjective fatigue. RA fatigue can be accurately measured with the Activity Record using a 2-day weighted average. Energy expenditure detected by the Actigraph does not appear to be a sensitive measure in this population.

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## **Therapeutic alliance: helping adolescents to leave home**

Afrodite Nathanail

Working therapeutically with adolescents and their families requires more special skills and experience than working only with their parents.

It needs development of therapeutic alliance with a flexible way of communicating through therapy.

Specified tasks have to be accomplished in order to minimize chances of possible therapeutic failure.

The presentation concerns two clinical cases of a girl, fifteen and a boy, seventeen years old who both had problems in the relationship with their parents. They also exhibited self-destructive behaviors.

Working with Haley's strategic ideas the parents allowed the adolescents to grow up without any disturbed behaviors.

### **References**

Haley, J. (1980). *Leaving Home: The Therapy of Disturbed Young People*. McGraw-Hill Book Company. New York ect.

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## **Evaluating the clinical effectiveness**

## **of brief counselling interventions used by UK based employees**

Adriana Summers

An increase in UK employee sickness absence figures has been attributed to employee stress and medically diagnosed examples of psychological ill-health, such as, anxiety and depression. This concern has increased because, contrary to the lay person's assumptions that, people just need to 'pull themselves together' and they will become well again, clinical evidence shows that untreated anxiety and depression (sometimes identified as 'stress') gets worse (Reynolds 1997) and can lead to significant periods of sickness absence. Concerns were further identified when organisations responding to the Confederation of British Industry's (CBI) Absence and Labour Turnover Surveys from 1999-2003 identified that psychological illness caused the second highest level of sickness absence in the UK. The statistical data by Government bodies and other groups, has led to a review of the impact of sickness absence on both, the individual employee (who experiences symptoms of psychological ill-health) and the financial and other losses to employers whose employees become unwell. The concerns raised have led to the UK's Health and Safety Executive (HSE) publishing The Stress Management Standards (2004). The standards are a guide for organisations to help them audit and implement good practice systems that reduce levels of work stress reported by employees.

The last ten years have shown that some employees have been successful in their legal claim, that their employer had caused them to suffer significant levels of psychological ill health. This led to an appeal court ruling in 2002, which suggested that access to workplace counselling services provided by employers can be one tool to help employers support their staff. This in turn, has led to an increase in the purchasing and delivery of employee counselling services and by the end of 2002 the CBI reported that over 40% of employers in the UK, offered some sort of workplace counselling. However while there are a number of reported client satisfaction studies available in the UK and there is a reduction in the number of days lost due to stress in some industry sectors, we do not actually know if, or how the process of undergoing counselling changes the severity of self reported symptoms of anxiety or depression.

This study aimed to measure whether short focussed employee counselling interventions are clinically effective as a mechanism to reduce clinical symptoms of depression and or anxiety. It also asked the question, if the intervention is effective, is the effect more pronounced amongst employees in particular working roles and do employees who present with a cluster of concerns the same benefit from a short focussed intervention as other colleagues identify and focus on one issue?

The assessment tool used by employees to describe their symptoms was Goldberg's General Health Questionnaire – 28(GHQ-28) (1971). This has been tested for its validity and is internationally recognised for its reliability. The initial study was conducted over eight months and included 288 clients who accessed the service. 50% (144 clients) completed GHQ-28 at both the initial counselling and final counselling sessions.

Using a cut off point of <5 the results showed that 83% of clients showed symptoms of psychiatric 'caseness', at their initial counselling session.. This figure corresponds with Arthur's (2002) research which identified that 86.6% of employees attending an initial workplace counselling session showed symptoms of psychiatric 'caseness' unfortunately he did not proceed to ask the question how do we test the effectiveness of the counselling provided. This paper addresses this omission.

This research paper shows that, by the end of a six session model of counselling only 30% of employees self-reported symptoms above the normal level. This group of 30% also identified between two and four issues that they believed were impacting on their well-being. Even though two thirds of this remaining group were still above the 'normal' symptom level cut off point their scores nevertheless, showed a reduction in the severity of their symptoms and a further six sessions of counselling brought this group back into the 'normal' symptom range.. This left 10% of the original employees, who showed psychological symptoms requiring referrals to medical services. This final 10% figure contrasts well with the symptom rate within the UK adult population which is between 10 - 17%.

Following the outcome of these results the study was continued for a further year. The results of data combined over a twenty month period used data from 352 employees who returned both of the pre and post counselling GHQ-28, this represented 54% of all clients who accessed counselling. The larger group showed similar results to the earlier work, ie 81% of clients reported symptoms of psychological distress or 'caseness' on the pre-counselling GHQ-28. The post counselling GHQ-28 improvement rates also reflected the improvement rates found in the smaller client numbers. The employees who

used the counselling service and returned completed the pre and post GHQ-28 came from three main occupational roles, clerical/administrators; professionals and managers. The largest sub groups of presenting problems identified when accessing counselling were: personal relationships; psychological; occupational and stress. Counselling was shown to reduce self reported clinical anxiety symptoms and somatisation, to a greater extent than those of clinical depression. Counselling appeared most successful in reducing reported symptoms amongst employees who held management roles and a discussion about why that may have happened will be considered in the light of research that reviews how role autonomy impacts on general well-being at work.

This study lends evidence to support the view that a limited session model of counselling positively impacts on employee psychological well-being. It also suggests that where employees experience multiple issues they are likely to need longer interventions to help them reduce their symptoms.

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