Therapy in research,
research in therapy

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Abstract

Within the Brief Strategic Approach the therapeutic activity is strictly related to the research. In particular this model makes use of the principles of the Action-Research. This circular logic has allowed, over these years, to develop specific models based on the systematic study of the function of specific disorders.

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Background

Brief strategic model (BSM) has evolved in the last years. Especially the logic of interventions has changed. A real turning point took place, BSM has switched from a *manipulatory* to a *self-deception* logic. From its very origins until 1995, the therapist's style was very directive and the topmost moment of the session coincided with the final prescriptions. While giving out the prescriptions, the therapist made use of highly hypnotic and impressive language in order to capture the patients' attention (Nardone, 1991).

Since 1996 Brief Strategic, sessions started to be based on a self-deception logic characterized by a funnel-shaped sequence of *strategic questions* about the symptom. These questions help the therapist to define the problem and simoultaneously to give the patient the sensation of being in front of an expert. The questions are followed by *interrogative paraphrases* of the patient's answers, which confirm the therapist's hypothesis but above all this the continuous request for confirmation, leads the patient to think that he is conducting the session. This structure leads the patient to an immediate change of perspective regarding his problem.

Evolution and Research

The Model's evolution has taken place thanks to the research that in the brief strategic frame is always fast binded to clinical activity (Nardone, 1997).

In particular, research is defined by *Action Research* principles. Action research is a brainchild of Kurt Lewin (1951) that in early'50s, developed the first applications in social studies. The most common definition of action research is *a compared analysis of conditions and effects of social actions, that promotes social action itself.* This implies, to change a condition in the moment we try to know it. This is the link between action research and the BSM, in which there is the need to know and change simoultaneously a phenomenon that in the specific case of psychotherapy is a disorder.

This simoultaneity logic is included in the BSM (Figure 1). While working with a symptom, observation is not enough; it is necessary to act to understand the underlying logic of a disorder, following the *Learning by Doing* principle.
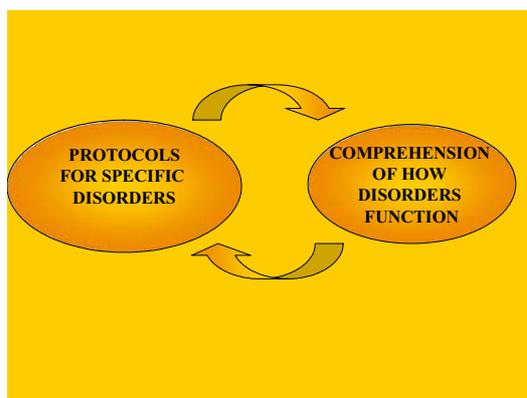

Figure 1 - Simoultaneity principle in the Brief Strategic Model

When a Brief Strategic researcher overhaul a specific therapeutic treatment for a specific disorder, he is actually verifying its functioning. *Vice versa* when we are able to understand the logic of a disorder we are able to define a treatment also. We don't know where the process begins or where it ends, but we actually don't need to know it. Being inside the system means to oscillate from one style to the other, giving new oxygen to the BSM.

It is important to underline that this circular logic belongs to two different levels of the model: the first is a *micro-level* that corresponds to single sessions in which the therapist generates this change and cognitive process, and a *macro-level* that regards the general theoretical model. An example of what we are discussing concerns the treatment protocol for an specific eating disorder: *vomiting* (Nardone, Verbitz, & Milanese, 1999). Treatments for anorexia and bulimia were not effective in some cases. This lack of effectiveness has defined a stand-alone disorder, vomiting, for which an *ad hoc* protocol has been designed and verified. This example regards both levels of the process because therapist looks for a single patient solution (micro-level), and this new observation defined a new protocol, which is now included in the Brief Strategic Model (macro-level).

Principles

There are four main principles that link research to therapy and therapy to research. The first principle, as we have already cited, is *simoultaneity*: while attempting to understand a phenomenon we induce a change. For example the strategic questions followed by interrogative paraphrases in the first session, elicit an hypothesis in the therapist and, simultaneously, change the patient's perspective regarding the symptom.

The second principle is *field change*: it suggests that the aim of the research is change. Especially in psychotherapy. Moreover the evolved model characteristics induce an early change in the patient.

The third principle is that of *coincidence* or indeed the interaction that, in research, is built between observer and observed. In the specific context of psychotherapy, it concerns the importance of the relationship between the therapist and the patient, that is enables the promotion or disclaimation of the therapeutical strategy effect.

The fourth principle regards the capability of *reproduction*: the researcher does not teach something new but finds functional solutions to problems together with the other persons involved, so that they will be able to reproduce it independently. In psychotherapy, the *emotional corrective experience*, formulated by Alexander, induced by prescriptions and the subsequent explanation always given by the therapist, promotes the acquisition of new functional solutions by the patient. He will be able to reproduce them outside the session. But he can only acquire new solutions by experiencing them directly, guided by the therapist.

Steps

There are mainly five steps in the therapy research process, concerning both levels: the single sessions and the general model. These describe the brief strategic therapist approach during a specific session and the brief strategic researcher approach in the model. The first moment is the *problem detection* and the *aim definition* in order to foresee therapy

direction, because when aims are missing, no effective strategy can be effective. The second moment of the process is the *hypothesis formulation* in order to change or the choice of the most fitting strategy to modify the phenomenon. The third phase concerns *hypothesis application* in order to bring about change: it's the moment in which, for example, in a first session the therapist chooses the specific strategic questions followed by specific paraphrases . Another example can be the selection of the fitting prescriptions made on the information emerged through out the previous phases. The fourth phase concerns the obtained *effects evaluation*. The fifth phase is the *theoretical organization* of the obtained effects. When the therapist recognizes a proper effect to the adopted strategy, it is necessary to make it a theoretical aspect in the model.

The role of evaluation

One of the most powerful phases is the evaluation of effects. It is the critical point between clinical practice and the setting of a new treatment protocol within the model. We can distinguish two kinds of evaluation at least (Zani & Palmonari, 1996): *formative evaluation* is done when the process is currently carried out. It's function is, above all, to verify whether the obtained effects fit with the aim, within and between each single phase discussed above. In psychotherapy, this concerns the checking of effects of the prescriptions given, in order to settle eventual changes. So this permits us to verify the effectiveness of strategies and to bring proper modifications, thus assuring flexibility to the model.

The second form is the *summative evaluation*. It is performed at the end of the process and its clear function is that of verifying results. In the specific context of psychotherapy, it may concern the final evaluation made together by the therapist and the patient, regarding the achievement of the therapy's aims. This kind of evaluation allow us to measure results in respect to the specific case and to the general model.

Finally, both evaluations can be *objective* or *subjective*. Some Authors call *realistic* evaluation the former and *constructivist* evaluation the latter (Leone & Prezza, 1999). The first one allows to examine the trend of some important variables respect to an external criterion; for example, efficacy studies in psychotherapy use the number of sessions as a criterion for the evaluation. The second kind of evaluation is based on stable and important (for the persons involved in the process) characteristics. An example can be the therapist's and the patient's evaluation of the therapeutic path based on the criterion of the achievement of the therapeutic aims.

It's now clear that evaluation is a complex concept that creeps into every aspect of the process and that allows modification in every step. So it's easy to understand that it's a different concept from the static logic of *control* and that it follows the circular logic within the model (Figure 2).
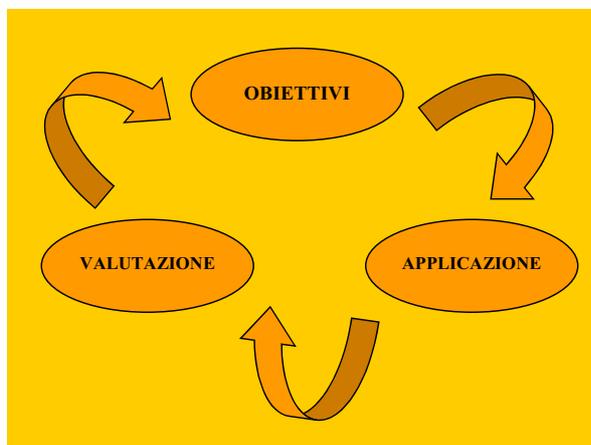
Figure 2 – Circular logic within the Brief Strategic Model

Also evaluation has the double function of bringing knowledge and change. Let's see this concept using an example: Problem Assessment- panic attack. Hypothesis in order to change- distractive strategy from the symptom. Application- *log prescription* (Nardone, 1991). Evaluation of effects- in the second session the patient brings his log filled-in with detailed descriptions. This might mean that we have misunderstood the problem and assigned an inappropriate strategy. Probably we are in front of an obsessive perceptive-reactive system, instead of a phobic system. In this case we have to step back in the process and make a new definition of the problem to assess the proper strategy.

For this reason a mistake in the process is not considered a therapeutic failure but a working information about the disorder solution. So the matter is not that the brief strategic therapist doesn't make mistakes; he actually can miss the target but thanks to the evaluation and to the model's flexibility, it is possible to correct the strategy and to avoid repetition of mistakes within the model (Lewin, 1948; Amerio, 2000).

What we have learned through practicing therapy and research, that a disorder is not a static phenomenon; it evolves in time and a therapeutic model must be able to follow its changes. And the only way to make it happen is to always link clinical practice to research, as in the BSM.

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