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**BRIEF PSYCHOTHERAPY FOR MANAGEMENT OF
PRIMARY HEADACHES: A CLINICAL GROUNDED
APPROACH**

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requirements of the University of Sunderland for the
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ABSTRACT

This research explores the potentialities of psychotherapy for the management of chronic pain. The model used is brief therapy of systemic orientation and the chronic pain managed is primary headaches (namely, migraines and tension-type headaches). In order to produce clinically relevant material, this research is carried out within an alternative research paradigm. The raw data are the audio-recordings of two cases: one with a man suffering from migraines; the other with a woman suffering from chronic tension-type headaches (aggravated by migraine episodes). These were selected from a pool of cases because they illustrate the phenomena under study and both completed a follow-up which confirmed an acceptable headache management outcome. The recordings were transcribed in order to be studied using discourse analysis of social constructionist orientation (DA hereafter). The research questions explored are: How were the headache problems, the therapeutic aims and the resources for managing them constructed during therapy? What did the participants do with these constructions? How was this particular type of talk interaction helpful in changing the way these two people managed their primary headaches?

DA reveals that: (1) the headache problems are entangled in many vicious cycles, Catch-22 situations and even double-binds, and that these patterns have the tendency to perpetuate the problems; (2) the meaning of the headaches vary from one patient to the other, being greatly influenced by their personal experiences, family histories and interaction with health professionals; (3) these meanings influence the co-construction of the therapeutic aims, with management (rather than a cure) emerging as a more achievable goal, with additional auxiliary aims also becoming very important; (4) specific interventions for managing the headaches and for achieving the auxiliary aims lead to concrete changes; (5) these changes are sometimes generalized for other situations, and therapy is seen as a useful resource.

Thus, this study shows some of the potentialities of brief therapy of systemic orientation to manage primary headaches, producing concrete suggestions that can be applied in clinical work.

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0. INTRODUCTION

The starting point of this inquiry was a reflection upon psychotherapy. While doing my Major in Psychology, I was introduced to this area. It was very interesting to learn that psychotherapy appeared at the end of the 1800s when some physicians, trying to help people with problems such as hysteria, started to develop different treatment methods using words as the main instrument of healing (Ellenberger, 1970; Feixas & Miró, 1993). As I continued to study psychotherapy through a Ph.D., I decided to explore a particular phenomenon that still puzzles and challenges the medical professional today: pain, specifically in its recurrent and chronic form. Historically, psychotherapy has been shown to be a resource to manage this type of pain, and yet we still do not know how it works (Malone & Strube, 1988; Norton, Asmundson, Norton, & Craig, 1999; B. H. Smith, Hopton, & Chambers, 1999). Bearing this in mind, I decided to research this area in a discovery oriented way that could lead to clinically relevant knowledge. In order to achieved this, I had to focus the inquiry. Thus, I chose to explore a specific kind of psychotherapy – brief therapy of systemic orientation – and a particular kind of pain – primary headaches (specifically tension-type headaches and migraines) by doing a discourse analysis of two clinical cases.

For this report, I will start by describing an initial phase of circumspection and survey¹ from my early professional experiences and from an initial research proposal to a literature review of psychotherapy, pain and research methodology. From there, a second phase of pre-emptive focusing is reported. Within it, space is dedicated to explain the specific therapeutic approach used (brief therapy of systemic orientation), the particular problem to be managed (migraines and tension-type headaches), and the methodology employed (discourse analysis). Then, a third phase is presented where the choices made are materialised into a discourse analysis of two clinical cases (one case of a man suffering from migraine; the other case of a woman suffering from chronic tension-type headache). After the discussion and conclusions, validity issues are considered as well as implications and applications of the present research to the clinical world of psychotherapy. To finish, some space is dedicated to seed ideas for future research.

¹ This and the following phases are inspired on George A. Kelly's Creativity and C-P-C Cycles (Banister, Burman, Parker, Taylor, & Tindall, 1994; Kelly, 1955/2001).

1. PHASE ONE: CIRCUMSPECTION & SURVEY

It involves the use of a wide focus lens to gather all thoughts, issues and materials of potential relevance. The issues we are open to in this highly creative phase are inevitably bounded by personal experience and frameworks (we all have our insights and blind spots) and by the literature search (Banister et al., 1994, p. 144).

My earlier professional experiences influenced the general research proposal that was the starting point of the present inquiry. For this reason, I will briefly describe these experiences before presenting the initial research plan. Afterwards, I will summarise the literature review on psychotherapy, pain and research methodology.

1.1. EARLIER PROFESSIONAL EXPERIENCE AND INITIAL RESEARCH PROPOSAL

Before starting this project and while finishing my B.Sc. (Major Psychology) at the University of Sunderland, I had some basic training in counselling (by the Sunderland Centre for Counselling Services) and in hypnosis (by the British Society of Medical and Dental Hypnosis). During that time I also did a literature review about pain and how psychotherapy could help people to manage it (namely through the use of hypnosis). This work, titled “Pain, Psychotherapy and Hypnosis,” was presented in 1996 at an Erasmus Intensive Course held at the University of Jyväskylä, Finland. After finishing my B.Sc., I decided to follow my studies with the present post-graduation program at the University of Sunderland. Since I had interest in pursuing training in psychotherapy and had curiosity in exploring pain management approaches, I decided to develop a research project in

the area of psychotherapies for chronic pain. Therefore, I presented the following research proposal²:

Chronic pain is a problem which affects a significant amount of the population (about 10%). These people suffer from pain over several months affecting their lives at all levels. Their self-image, occupation, family dynamics, social relationships and so on can go through radical changes which most of the time results in a deteriorating of their quality of life.

Traditionally it is the physicians with their medical knowledge that try to help these people. However, even with the development of new theories and therapies when facing the complexity of pain phenomenon, soon these professionals realise that they need more than an organic perspective. Theories such as the Gate-Control Theory, give a physiological support to psychological and cultural factors that influence pain, recognising the importance and significance of these factors.

In my research I propose to explore the role of psychological therapies to help chronic pain sufferers. I would like to focus my research on what is usually called psychogenic pain. These pain situations challenge our physiological knowledge, limiting the chances of pain relief to the sufferers. Drugs and neurological interventions usually fail to succeed in these cases. Psychotherapies have shown some potentialities. My aim is to explore these potentialities.

1.2. EXPLORING POSSIBILITIES

During this first phase, I carried out a literature survey on psychotherapy, pain theories and research methodologies. Let us look at each one of these individually.

² With this proposal, I received a fellowship to sponsor my post-graduation (Programme Praxis XXI, co-sponsored by the European Social Fund).

1.2.1. Psychotherapy

The word *psychotherapy* became fashionable at the end of the nineteenth century (Ellenberger, 1970). Some authors credit the Nancy School for that designation (Ellenberger, 1970; Geary, 1992; Shorter, 1997), while others refer to Walter Cooper Dendy as the one who, in 1853, introduced the name in his paper “Psychotherapeia, or the Remedial Influence of Mind” (Dendy, 1853; Portocarrero, 2000). Regardless of who named it first, it is known that Hippolyte Bernheim, a member of the Nancy School, used the term to describe the application of suggestion in the waking stage (Feixas & Miró, 1993; Thuillier, 1996). Furthermore, it is reported that Frederik Van Eeden, a Dutch psychiatrist who studied in the Nancy School, opened (with Van Renterghem) a clinic called Psycho-therapeutic, and that in 1889 during *The International Congress on Hypnotism*, they described it to the public (Ellenberger, 1970). Three years later, during *The Second International Congress on Psychology*, Van Eeden defined “Psycho-Therapy” as “the cure of the body by the mind, aided by the impulse of one mind to another” (Ellenberger, 1970, p. 765).

Nevertheless, the roots of psychotherapy go deep in time to the primitive healing methods of prehistory. It is beyond the scope of this

work to explore these roots³, however it is essential to realise that before modern science started to take shape around the sixteenth and the seventeenth century (Gribbin, 2002; Santos, 1999), health problems were understood from a different perspective. As Alexander and Selesnick (1966) put it: “When psychic and physical suffering were not distinguished one from the other, the precursor of the psychiatrist [psychotherapist] was any man who tended another in pain” (p. 17). For instance, while considering primitive healing methods, it can not be forgotten that they came about in a world of mystic-magic-religious beliefs (Reverte, 1981). In this world, there was not a clear division between mind and body. It was only with the classical civilizations that dualism started to emerge (e.g. Plato) and a clear division between mental and physical phenomena started to appear. This determined the beginning of two separate paths for healing: the healing of the body and the healing of the soul. The latter remained under the domain of religion for more than a millennium. The former became the responsibility of the physicians, who progressively improved their skills. After the seventeenth century, under the influenced of Cartesian dualism, empirical science bloomed and its theories started to affect all domains of knowledge, including the one about healing (Ackerknecht, 1968/1982; Shorter, 1997).

³ Henri F. Ellenberger, in his classic book *The Discovery of the Unconscious* (1970), presented a good account of it.

When we arrive to the nineteenth century, medicine already had achieved great progress. Nevertheless, there was a particular group of ailments that challenged medical doctors since they could not discern an organic causality for them – they name them functional illness. Hysteria and other neurosis are examples. Physicians such as Jean-Martin Charcot (1825-1893), Auguste Ambroise Liébeault (1823-1904), Hippolyte Bernheim (1840-1919), Pierre Janet (1859-1947), Josef Breuer (1842-1925) and Sigmund Freud (1856-1939) dedicated their careers to help people suffering from these ailments.

It was within this context that psychotherapy came forward. At its beginnings several models were proposed, such as the Psychological Analysis of Pierre Janet and the Cathartic Model of Breuer and Freud (Ellenberger, 1970). Even so, the first model to be widely acknowledge was Psychoanalysis. From this model, founded by Sigmund Freud, various other views emerged through his followers and dissidents which marked the field with diversity. Alfred Adler (1870-1937) with his Individual Psychology, and Carl Gustav Jung with his Analytical Psychology are just two examples of the dissenters. Others further developed Freud's psychoanalytic model, contributing to what is know as Ego Psychology. Anna Freud (1895-1982) belongs to this group. And others went on to emphasise human relationships and learning, creating different trends – the Object Relations, Self-Psychology and Interpersonal Models. Karen Horney (1885-1953) and

Harry Stack Sullivan (1892-1949) are representatives of these latter theories. All these models can by and large be categorised within the psychodynamic⁴ approach, which dominated the field of psychotherapy during the first half of the 20th century.

After World War II other approaches started to appear in the psychotherapeutic arena. Some psychologists, unsatisfied with both psychoanalytic and behaviouristic perspectives, proposed an alternative: the humanistic psychology movement. The theories of this third force had rapid therapeutic applications and as early as the 1940s the famous American psychologist Carl R. Rogers (1902-1987) proposed a therapeutic model, which was called Client-Centred Therapy. Around the same time others, influence by the existential movement, proposed new ways of understanding and doing psychotherapy. *Daseinanalyse* (i.e., existential analysis) of Ludwig Binswanger (1881-1966) is one of the first representatives of this development. These last two trends are considered today united as the humanistic-existential approach. This approach embraces a wide range of diverse models, such as: Perls' Gestalt Therapy, Berne's

⁴ The term dynamic, as Ellenberger (1970, p. 289-291) pointed out, became commonly used among doctors at the end of the 19th century. There was not a consensus about its meaning and thus, for some dynamic was the opposite of static, for others it expressed the notion of functional (in contrast to organic), for even others it had the connotation of conflict, and so on. Nonetheless more than a century later, dynamic is the term added to psycho- to name most of the psychotherapeutic models that appeared in the first decades of the 20th century. They have in common the characteristics of giving a special importance to unconscious processing and personality development (Zeig & Munion, 1990).

Transitional Analysis, Frankl's Logotherapy and Laing's Radical Therapy.

In the 1950s, the theories of behaviourism started to be enthusiastically applied to therapy. It is interesting to note that these behaviour therapies appeared independently in three research centres (Fishman & Franks, 1997, p. 143):

- I. In the United States within the group lead by Burrhus Frederic Skinner (1904-1990);
- II. In the United Kingdom, at the University of London Institute of Psychiatry, within the group of Hans Jürgen Eysenck (1915-1997); and
- III. In South Africa with the work of Joseph Wolpe (1915-1997).

From there, many others developed this trend which is called the behaviouristic approach.

Subsequently, some health professionals started to develop a different way of helping people based on the contents of the "black box" ignored by radical behaviourism, and in the 1960s the cognitive approach came forward. One of the first models of cognitive therapy to appear was the Rational-Emotive Therapy (RET) of Albert Ellis (b. 1913). Another model that is emblematic of this approach is the Cognitive Therapy developed by Aaron Temkin Beck (b. 1921) and his collaborators (A. T. Beck, 1963, 1964; A. T. Beck, Rush, Shaw, & Emery, 1979). In the psychotherapeutic arena this movement was

seen as a natural development of behaviourism, and marked the passage from behaviouristic to behavioural, cognitive and cognitive-behavioural models – denominations difficult to differentiate (Fishman & Franks, 1997).

Simultaneously in the 1950s and 60s, a different approach emerged – the systemic one. This approach was the offspring of developments in several areas such as the practice of family therapy, cybernetics and systems theory, and communication theory. The systemic thinking soon started to show its potential as a conceptual model to understand psychological problems with direct therapeutic implications. The research team directed by Gregory Bateson (1904-1980) made important contributions to this approach. Afterwards its members belonged to important centres that developed several important therapeutic models, which influenced other models and research groups. Examples of models from the systemic approach are: the MRI Brief Therapy (Fisch, Weakland, & Segal, 1982; Watzlawick, Weakland, & Fisch, 1974), the Structural Family Therapy (Minuchin, 1974; Minuchin & Fishman, 1981), the Strategic Family Therapy (Haley, 1963, 1976), Solution-Focused Therapy (de Shazer, 1985) and the model of Milan (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980).

Additionally, in recent decades due to the influence of post-modernism, new epistemological paradigms emerged that influenced

the psychotherapy arena. For instance, as an alternative to an objectivistic perspective of the human being, a constructivistic view started to appear proposing the contemplation of cognitive, emotional and behavioural phenomena as expressions of a constructive process (Capafóns, 1997). Social constructionism also left its mark by emphasising the commonality between the constructed realities of a group within a particular linguistic and cultural context.

With all these and other developments we arrived at the beginning of the 21st century with hundreds of different models of psychotherapy – some authors say that there are more than 400 (Ford & Urban, 1998; Garfield & Bergin, 1994). Due to this fragmentation, it is impossible for an individual psychotherapist to be acquainted with them all. One possible solution is to become familiar with the major approaches under (and in between) which most of these models can be grouped, such as the psychodynamic, humanistic-existential, behaviourist, cognitive and systemic approaches. In order to do so, it is important to have a comprehensive framework that allows a better understanding of specific approaches and models, and provides a standpoint of comparison between them.

1.2.1.1. Levels of analysis

With the aim of having this comprehensive framework, I developed a generic model with several levels of analysis for summarising and comparing different structured approach to healing. This generic model (condensed in Table 4, p. 36) is the result of my reflection on this topic and had as a starting point several publications of José Navarro Góngora (1986; 1992; 1995) and collaborative work with another psychotherapist, Ana Ovalle (Almeida & Ovalle, 1998).

While I was undergoing training in psychotherapy at the University of Salamanca (in preparation for the clinical part of the present study), I worked in a project aimed to create a computerised database for psychotherapy cases. The initial aims of this project were:

- I. To create guidelines on how to summarise psychotherapy sessions, in a way that could be useful for:
 - a. The psychotherapist;
 - b. The therapeutic team that worked with the therapist (including members in training), and;
 - c. Facilitating the follow-ups.

- II. To have the cases organised in a computerized database in such a way that it allowed searches using different parameters (names, dates, types, therapists, key words, etc.)
- III. To have the cases summarised and organised in such a way that they could become material for clinical research (such as the one I was planning to undertake).

In order to achieve these aims some time was dedicated to reflect about the general structure of the psychotherapeutic models. At that time (1998), we considered that we could analyse any model within three levels:

- I. Theoretical level (theories about the problem, change, etc.);
- II. Strategic level (general plans of action), and;
- III. Technical level (aims and intervention techniques).

We also noted as important the scientific paradigm from which the model comes from, as well as the socio-cultural context.

After finishing this project that had as an outcome a software database⁵, I went on reading more about other possible ways to conceptualise the different psychotherapy models. Along the way I

⁵ This project was important in my Ph.D. preparation because it allowed me to consider all these subjects and to develop an instrument (the database) that became very useful during my own clinical research.

found different ideas and I kept refining my own until I arrived to the present levels of analysis.

1.2.1.1.1. Philosophical level

While reading about constructivism, it became very clear how different epistemologies frame the way we perceive the world around us. For example, someone from the objectivism perspective considers knowledge as a direct representation of the real world, whereas, someone from a constructivism viewpoint sees knowledge as a construction of our experiences (Feixas Viaplana & Villegas Besora, 2000). These epistemologies are influenced by different ontological assumptions, that is, what we consider as the fundamental nature of things (Ford & Urban, 1998; Misiak, 1961; Santamaría, 2001). To clarify, ontology can be defined as the study of conceptions of reality and existence, and epistemology as theories of knowledge (the study of what can be known, what knowledge is, how it can be obtained and so on). The cosmological theories are also important to be taken into account since they explain how everything is organised.

All these philosophical assumptions have in common the characteristic that they form a set of core beliefs that can not be

proved or disproved by empirical means. We can offer better or worse rationales to accept one belief over another. We can argue that a specific core belief is more coherent with a specific theory and set of empirical data, yet we cannot go much further than that.

How do these ontological, cosmological and epistemological assumptions affect different psychotherapy models? We can say that any structured approach to healing has in its core a set of beliefs that determine how we see human beings, their problems and possible solutions (O'Donohue, 1989). These core beliefs reflect some of these assumptions.

Let us consider some ontological assumptions about the mind and body (see Table 1). In our Western culture, greatly influenced by Cartesian dualism, the commonsense view considers the existence of two separate substances, one account for the material world, the other for the immaterial world (Ford & Urban, 1998). For this reason, it is not strange that many psychotherapeutic models are also influenced by this assumption. Yet, an important question arises: if we consider the existence of two different principles, mind and body, do they influence each other? If not, as in psychophysical parallelism proposed by some philosophers (e.g., Leibniz), how can an intervention through words (immaterial) influence an ailment in the body (material) such as a pain? Under this perspective there is no

place for psychological treatment of functional diseases. However, under dualism it can be considered that mind and body are different and separated but they influence each other (e.g., Descartes) – psychophysical interactionism. In this case, talk therapy makes more sense.

The latter is the broad assumption taken by the psychodynamic approach in general and Freud's psychoanalysis in particular (Alexander & Selesnick, 1966; Ellenberger, 1970; Feixas & Miró, 1993; Ford & Urban, 1998; Freud, 1940/1949; Wolitzky & Eagle, 1997). Freud and his colleagues were trying to help people whose complaints were in general of a physical nature (tics, paralysis, bleedings, etc.), yet they proposed a psychological origin to these maladies. They believed in a psychological apparatus (defined by Freud as having three mental agencies: id, ego and superego) that interacted with the physiological apparatuses, which in certain circumstances could cause functional illness.

Nevertheless, there are other possibilities for the mind-body problem. It can be considered that there is only one principle in the human being, this is called monism. Thus, the question is which: mind or body? Some philosophers considered only the existence of the material world, so only the body really exists (e.g., Democritus, Hobbes) – materialism. In a certain way this is the assumption that

underpinned the behaviouristic approach. This approach considered only the observable behaviours, that is, what the body does, eliminating the psychological phenomena (Fishman & Franks, 1997). Therefore, the therapist must concentrate on the behaviours, how the problems manifest at this level and how they can be changed to adapt to the present circumstances. Some can concede the existence of phenomena such as feelings, but only as epiphenomena of the bodily functions, that is, all mental phenomena are considered as non-influential by-products of body functioning (i.e., reducible to the matter).

On the other hand, if we considered that only the mind really exists (e.g., Berkeley) – idealism – our perspective totally changes. Now the focus is on the psychological phenomena, such as cognitions, feelings, and concepts as meaning, intention and choice. These can be considered as more influential than the exterior circumstances of the person. It is in this perspective that the cognitive approach and many humanistic-existential models can be regarded as having idealist assumptions.

Nonetheless, another possibility must be considered. The human is one principle that manifests two different aspects. This solution to the mind and body problem has many variants in philosophy from the hylomorphism of Aristotle, the double aspect of Spinoza and the

neutral monism of Lewes (Misiak, 1961; Santamaría, 2001). Despite the fact that this perspective did not influence directly the major historical approaches, it is a very fruitful assumption in our contemporary science.

MIND-BODY PROBLEM			
DUALISM There are two different principles in human beings		MONISM There is only one principle in human beings	
Do these two principles influence each other?		If there is only one principle, which is it?	
YES	NO	MIND	BODY
e.g. PSYCHOPHYSICAL INTERACTIONISM Mind and body are different and separated, but influence each other.	e.g. PSYCHOPHYSICAL PARALLELISM Mind and body are distinct and separated and they do not influence each other, but bodily and mental activities are perfectly correlated.	e.g. IDEALISM Everything is of a mental nature.	e.g. MATERIALISM EPIPHENOMENALISM The only thing that truly exists is matter.
		NEITHER	
		e.g. HYLOMORPHISM DOUBLE ASPECT NEUTRAL MONISM	

TABLE 1: Ontological assumptions – Mind and Body Problem

At the level of cosmological assumptions (i.e., how things are organised) it can be said that one of the biggest questions is the problem of causality (see Table 2). Modern science was founded on a mechanistic model. From the Italian Galileo Galilei (1564-1642) to the Englishman Isaac Newton (1642-1727) there was the belief that the

universe could be compared to a complex machine – Clockwork Universe – and that the role of science was to study in detail the bits and pieces of this big machine, discovering laws that govern it and add them together to explain everything. This mechanistic view implies reductionism and determinism. It implies that it is essential to study an isolated phenomenon and find the causes that lead to the results observed (the linear sequence of cause and effect) in a regular way. These principles influenced all emergent sciences, yet their fruitful results were always more visible in the natural sciences than in the so-called social sciences. Nonetheless, many of the psychotherapeutic models that dominate the 20th century are influenced by these cosmological assumptions. For example, Freud's model of libido that considers a limited amount of energy that if blocked at a point has to find release at another point (the hydraulic model) is based on the mechanistic assumptions of Hermann von Helmholtz's principle of the conservation of energy (Hunt, 1993). Moreover, his belief that “the child is psychologically father of the man” (Freud, 1940/1949, p. 87) also reflects a deterministic view of human nature. Even more evident is the mechanistic and deterministic underpinning of the behaviouristic approach, which bases most of its learning theories on linear causality (i.e., cause and effect), the paradigmatic example being stimulus-response studies. The cognitive models introduced more complexity in the equation, yet they still had

as a base the belief in linear causality. Otherwise how can one justify ideas such as the ABC theory of Ellis' Rational-Emotive Therapy: "Activating Events (A's) in people's lives are intermingled with their Beliefs (B's) about those A's, and largely because of the B's the result is Consequences (C's) – emotional and behavioural disturbances" (Hunt, 1993, p. 582).

As could be expected, there are other models to explain causality, such as contextual, organismic and self-organizing open systems models (Ford & Urban, 1998). The first underlines the importance of the ever-changing context where the event is happening. This perspective is particularly relevant to psychotherapy in the sense that the person that came asking for help is not living in a vacuum, and seeing the person-in-context can be very advantageous. The systemic approach tries to see the identified patient in context (of the family system, of the medical system, etc.), and considers that the systems that the person is part of are more than the sum of their parts (anti-reductionistic view). Moreover, the systemic approach proposes the circular causality as an alternative to the mechanistic linearity. The organismic model, inspired by many biological theories, defends that there is a natural development from simple to complex and that the organism develops towards a organised whole. The development is seen as a tendency to mature. This is very similar to the concept of self-actualization of humanistic psychology and

therefore it is not strange that this is a perspective taken by many models inside the humanistic-existential approach. The latter, the self-organizing open systems, is a more recent model influenced by the cutting edge quantum theories, nonlinear thermodynamics, chaos theories and so on. It embraces complexity and sees humans as:

(...) open systems whose existence and development require continual exchanges with their contexts of material/energy and information/meaning forms; and both stability and change result from the organization producing dynamics internal to the entity itself as it deals with perturbations of its existing states that result from its own functioning and transaction with its contexts. (Ford & Urban, 1998, p. 22)

This view considers more complex concepts of causality as mutual causality or the casual field. New models in the systemic approach (second cybernetics) and models influenced by some constructivistic theories are embracing these assumptions (Maturana & Varela, 1990; Varela, Maturana, & Uribe, 1974).

THE CAUSALITY PROBLEM			
MECHANISTIC MODEL Reduction Determinism	OTHER MODELS		
	CONTEXTUAL Context	ORGANISMIC Finality	SELF-ORGANIZING OPEN SYSTEMS Complexity

TABLE 2: Cosmological assumptions – The Causality Problem

In relation to the epistemological assumptions (see Table 3), traditionally two theories are considered, the empiricism and the

rationalism. Both theories try to explain how knowledge can be obtained. On the one hand, the empiricism, as defended by Locke and Hume, argues that knowledge is obtained through sensory perception (i.e., experience). On the other hand, the rationalism, as defended by Descartes, stresses the role of reasoning in the justification of knowledge. Accordingly, the former defends the role of induction and the latter the role of deduction. Another important point is that both epistemologies believed that the knowledge obtained is an objective representation of reality – realism. In the eighteenth century, Immanuel Kant proposed a synthesis between empiricism and rationalism and argued about the limits of knowledge (phenomenal and noumenal world). The exploration of these limits was intensively undertaken by the constructivism movement and serious doubts were raised about the possibility of true objectivity. The constructivism perspective argues that we can only know a representation of reality, that we can know the map but not the territory (some go even further doubting the existence of the territory). It is important to note that the constructivism movement encompasses different epistemological perspectives such as radical constructivism that emphasises the individual as the author of the maps, and social constructionism that rebuffs the notion of an isolated knower emphasising the role of context and language in the construction of common maps within a social group (Raskin, 2002).

		How knowledge can be obtained?		
		Through experience EMPIRICISM Induction	Through reasoning RATIONALISM Deduction	Through BOTH Deduction & Induction
What can be know?	Objectivism REALISM We can know the territory.	e.g. Empiricism as defended by Locke and Hume.	e.g. Rationalism as defended by Descartes	e.g. Synthesis proposed by Kant
	Subjectivism CONSTRUCTIVISM We can know the map.	e.g. Constructivism		

TABLE 3: Epistemological assumptions – Theories of Knowledge

It is difficult to pigeonhole the different therapeutic approaches to this grid because usually they fall in between categories. The behaviouristic approach is maybe one of the more clearly defined since its authors defended an empiricist and realist epistemology. The psychodynamic approach is more difficult to delimit. If we think about psychoanalysis, we can argue that it is based also on empiricism principles (importance given to the patient’s statements and the case study as a tool to develop the psychoanalytic theories), and that it has realist assumptions (otherwise how to explain some of its dogmas). The systematic approach (mainly the models influenced by the second cybernetics) is greatly influenced by constructivism. Many of its authors are important contributors to this epistemological trend.

With regards to the humanistic-existential approach, it is very difficult to catalogue. For instance, the client-centre model proposes that the person's own feelings and awareness of the events are more relevant than the events themselves. Thus, it can be said that it has a subjectivist bias with rationalism connotations. Yet Rogers argued for an empiricism epistemology for researching his own model.

This is a good illustration of the difficulty of categorising. Even within the ontological and cosmological assumptions other possibilities could have been proposed, as we can check in the literature (cf. Ford & Urban, 1998). The ideas proposed by these different approaches and models are complex, usually offering more than one possibility of interpretation and are not as coherent as philosophers would like them to be. Moreover, these assumptions are usually inferred since the authors of these models seldom wrote explicitly about them. Even so, for me the aim was never to achieve the perfect system of categorization. What was important, in this intellectual pursuit, was to reflect about all these concepts and to explore the psychotherapeutic approaches from different perspectives. By doing this I could achieve a better understanding of these approaches and contextualise some of their core beliefs. And this is important since these assumptions affect the remaining levels of analysis.

1.2.1.1.2. Theoretical level

Another important level of analysis is the theoretical one. This level is composed of organised sets of implicit or explicit conceptualisations about the problem, the treatment and other theoretical aspects.

Usually when a person comes to psychotherapy, they bring a difficulty or problem. The way that this problem is seen by the psychotherapists depends on their theoretical perspective (Navarro Góngora, 1986). An orthodox psychoanalyst would see a problem as result of a pathologic compromise formation of intra-psychical conflicts. For instance, from a psychoanalytic point of view, neuroses are considered disorders of the ego that usually have their prelude in early childhood. This often leads in adulthood to symptoms that are maintained through the ego defences mechanisms (which work at an unconscious level). From another perspective, a client-centred therapist could see the same problem as the result of a learning pattern that reflects an acute incongruence between self-concept and experience. This incongruence creates severe anxiety that the individual tries to avoid through two types of defence: denial to awareness and distortion in awareness. These defences have the

consequence of narrowing the person's world. To a behaviouristic therapist a neurosis is seen as a persistent, learned, unadaptive set of behaviours that are maintained through repetition and reinforcements. A different approach can be taken by a cognitive therapist that sees a problem as a set of dysfunctional emotions, behaviours and cognitions, the latter having an important role in maintaining the problems. On the other hand, a systemic therapist could see the problem as the result of a vicious cycle within a system that the identified patient is part of, and maintained by the system feedback loops. In sum, different models define a problem in their own way, explain its genesis differently, as well as the reasons why the problem persists.

All these concepts condition the treatment to be proposed, from the therapy aims, ways to reach them, through which specific interventions, done in which particular way, and so on. For instance, to the psychoanalyst the overall aim is to make the unconscious conscious in order to, on one hand, decrease the pressures on the ego, and on the other hand, to strengthen it. To achieve this aim it is necessary to overcome the unconscious ego defence mechanisms. Simultaneously the analyst has to deal with the phenomenon of transference and has to overcome the resistances against the progress of the therapeutic work. For all these to be successful a good therapeutic alliance has to be established with the client. At the

end of the process the patient must be more conscious of his psychodynamic processes, as well as to develop a stronger ego able to deal with the id and the superego in a more healthy and productive way in a given reality. To the client-centred therapist the specific goals of therapy are chosen by the client. However, there are several general purposes that guide the therapeutic process, such as to help clients to free themselves from their faulty learnings, allowing themselves to become more congruent and able to continue with their lives without therapeutic aid. To achieve the therapeutic goals and engage in the therapeutic process, the therapist has to communicate to the client empathy, unconditional positive regard and genuineness (the therapeutic core conditions). It is the client that decides when it is the right time to terminate treatment. To the behaviourist therapist the therapeutic aim is the extinction of the neurotic learned behaviour (i.e., unlearn it) as it appears at the present. This can be achieved, for instance, through reciprocal inhibition: the association of the events – stimuli – that elicit the neurotic response (e.g., anxiety) to an antagonistic response (e.g., relaxation) – since a person cannot simultaneously be anxious and relaxed. To the cognitive therapist the general aim is to relieve the emotional distress and other symptoms by changing the dysfunctional cognitive concepts. To achieve this, an appropriate therapeutic relationship must be created allowing a therapeutic collaboration. Within this context the therapist can explain

to the patient the rationale for cognitive therapy and the typical therapeutic process. Then he can proceed in a shared task of identifying and evaluating cognitions, and developing and testing hypotheses. Homework assignments are used as a therapeutic tool. From a different perspective, a systemic therapist of the MRI school could consider the problem as vicious cycles of attempted solutions that the system is trying with no success. Therefore the aim of this therapy would be to stop the attempted solutions by producing a second order change. This is achieved within a therapeutic process that lasts a maximum of 10 sessions, in which the therapist introduces the treatment set-up, collects data to define the problem, assesses which attempted solutions are being used, sets the therapeutic goals with the clients, applies a select plan of interventions, assesses their success and then decides when to terminate treatment.

Nonetheless, there are other important theoretical concepts that are not about the problem or the treatment. The relation of power between therapist and client is one example of these. For instance, in psychoanalysis, behaviouristic therapy and even cognitive therapy the authority is put on the therapist. He is the expert that must lead the therapeutic process and knows best about the problem. Yet, in client-centred therapy and some systemic models this question is more polemic. Many authors insist on the necessity of giving more

authority to the client. This debate is very interesting and maybe the best outcome is a compromise solution. On the one hand, it is important to recognise the therapists as the experts acknowledged by society who are paid for their expertise, and on the other hand, it is essential to recognise the clients as idiosyncratic individuals that have information and resources crucial to therapeutic success. That is to say, the therapist is an expert of a model or set of models, while the client is the expert in his or her own life.

1.2.1.1.3. Technical level

If we consider that one of the aims of psychotherapy theories is to orient the clinicians in their practical world, the theories about problems and treatments have to have a translation into concrete measures of action, that is, psychotherapeutic techniques. On the one hand we can think about techniques designed to assess the problems, their origin and/or maintenance, and on the other hand we can consider intervention techniques that allow the definition of the therapeutic aims and the ways to reach them. Examples of the assessment techniques could be the free-association and analysis of dreams in psychoanalysis, and the use of methodical inquiry and

written questionnaires in behaviouristic and cognitive therapies. With regards to intervention techniques, examples could be the interpretation in psychoanalysis, the teaching of different behaviour patterns in behaviouristic therapy, the cognitive rehearsal in cognitive therapy and so on. Nonetheless, this division falls short when we reflect about systemic therapies since within this approach the assessment is intentionally designed to also be an intervention, making it difficult to differentiate one from the other. Another difficulty arises when thinking about the client-centred model and many others inside the humanistic-existential approach because their authors have the tendency to understate the doing (i.e., specific techniques) and to emphasise the being (such as, being empathic, genuine, etc.). Moreover, there are other equally important technical aspects that can not be regarded as related to assessment or have the explicit intentionality of intervention, such as the frequency, pacing and number of sessions, position of the chairs in the therapy room and so on.

This technical level is many times the focus of professional workshops, and when looking to raw data of a particular therapy session either in video, audio or in transcript format it is one of the elements that can more easily be picked. Nevertheless, the applications of specific techniques can be better understood taking in consideration their theoretical underpinnings, as well as the specific

circumstance that the client presents. This is even more visible in the next level of analysis.

1.2.1.1.4. Practical level

In the clinical world, therapists have a client that comes to them asking for help. Despite all the theories that the therapists may have, all the technical skills they be proficient at, when facing a particular client they have to decide what to do in that concrete case. This is the practical level. This level is very important since it is the real thing, it is when words become actions and have consequences. As the saying goes: “The proof is in the pudding”.

An important point to underline at this level is that we know through word of mouth and research data that eclecticism dominates the practice of psychotherapy (Bechtoldt, Norcross, Wyckoff, Pokrywa, & Campbell, 2001; Beitman, Goldfreid, & Norcross, 1989; Mahoney, 1995). Probably due to the complexity of the human being, soon after more puristic training, psychotherapists feel like they are one of the blind men touching the elephant. To compensate for this reality, at a theoretical level in the last decades, there has been a tendency to propose integrative models (Norcross & Goldfried, 2005).

This is a good illustration of how a more specific level of analysis can influence the more general ones.

1.2.1.1.5. Strategic level

A cross level of analysis can also be added – the strategic one, which can be defined as plans of action for managing the therapeutic process by the articulation of theories, techniques and practice. In other words, it can be argued that the theoretical level predetermines a set of general principles that give generic rules or guidelines for reaching the aims of therapy from short to long term. These guidelines inform therapists of what they should or should not do within the general clinical situation. Nevertheless, in practice the professionals must carefully observe the client, who provides them with verbal and non-verbal clues as to which specific techniques they must use in order to implement the plan of action (Navarro Góngora, 1995). For example, if there is the theoretical assumption that a good relationship can positively influence the result of the therapy, then the guideline for the creation of a therapeutic alliance can be established. For achieving this aim therapists have to listen carefully to what the person is saying, check if they are understanding the client, and

implement whatever is useful to therapeutically bond with that particular individual.

To conclude the presentation of the levels of analysis, I recognise that the elements in them are not original, but I consider this model as my useful everyday recipe that I elaborate on using old ingredients in a simple way and with a personal touch. There are other frameworks that can be used to understand and compare different psychotherapeutic models and approaches (Corsini & Wedding, 2005; Ford & Urban, 1998; Navarro Góngora, 1986), yet I considered this one as a simple and useful compass that has been very helpful in keeping me afloat in the sometimes chaotic sea of diverse psychotherapy models. Besides, it provided me with a clear structure to describe the psychotherapeutic model that I chose to study during my Ph.D. (as can be seen in the description of Phase Two).

1. PHILOSOPHICAL LEVEL

It consists of the ontological, cosmological and epistemological assumptions underpinning the core beliefs of a model or approach.

2. THEORETICAL LEVEL

It is composed of organised sets of conceptualisations (implicit or explicit) about:

- 2.1. The problem (e.g., what the problem is, how it originated and/or how it is maintained).
- 2.2. The treatment (what the aims of therapy are, how they can be achieved, what kind of interventions can be used, what are the steps of those interventions, etc.).
- 2.3. Other aspects that do not fit into the above categories.

3. TECHNICAL LEVEL

It can be defined as the operational definition of the theories with respect to specific techniques, that is, the translation of the theory's concepts into concrete measures of action. Bearing in mind what was said in the theoretical level, the techniques can be grouped as follows:

- 3.1. Assessment techniques (concrete ways of arriving to the definition of the problem, its origins and maintenance).
- 3.2. Intervention techniques (sets of actions that allow a clear definition of the therapeutic aims, concrete ways of reaching them, etc.).
- 3.3. Other techniques that do not fit the above categories.

4. PRACTICAL LEVEL

It consists of the techniques' application in concrete cases.

5. STRATEGIC LEVEL

A cross level of analysis, which can be defined as plans of action for managing the therapeutic process by the articulation of theories, techniques and practice. In other words, the theoretical level predetermines a set of general principles that give generic rules for reaching the aims of therapy from short to long term. These guidelines inform therapists of what they should or should not do within the general clinical situation. Nevertheless, in practice the professionals must carefully observe the client, who provides them with verbal and non-verbal clues as to which specific techniques they must use in order to implement the plan of action.

TABLE 4: Levels of analysis to summarise specific models.

1.2.1.2. Some general considerations

As we saw in the previous pages, psychotherapy is an area marked by complexity, diversity, fragmentation and continuous developments. It is interesting to note several tendencies that are marking the contemporary development of psychotherapy. In parallel with the proliferation of new models, a tendency for integration is also gaining impetus. In addition, as already mentioned, the new post-modernistic epistemologies of the constructivism movement are affecting the theoretical and practical development of many models across the different approaches. Last but not least, there has been a tendency to shorten treatment, and without doubt the brief therapies are the fashion nowadays. Let us look into this tendency.

The expression “brief therapy”, so commonly used today, is the outcome of psychotherapy’s theoretical developments, reinforced by certain historical, economical and political conditions. When psychoanalysis became the orthodox dominant model, it was generally accepted that for a therapy to be efficient it was necessary to be long (i.e., 3 to 5 weekly sessions of 45 to 55 minutes over several years). The justifying argument was that psychotherapy had to go in depth into the patient’s mind to be efficient and this was only attainable through frequent sessions during a long period of time; otherwise, if therapy was shorter, that meant that it was superficial and that the

changes, if existing, were just temporary ones (Budman & Gurman, 1988). These beliefs made psychotherapy mostly suitable to a small group of people who had the time and the money to spend on so demanding a process.

Nevertheless, after the Second World War, important changes occurred. On one hand, there was a sudden increase in demand for psychotherapy (due to many cases of war neuroses and battle fatigue) and not enough psychotherapists prepared to provide help. On the other hand, more people started to demand the right to psychotherapy, and it could no longer be reserved only for the elite. Within this background, some voices started to rise defending new possibilities for doing therapy. Inside the dominant dynamic approach, some authors started to propose briefer therapeutic alternatives (Budman & Gurman, 1988; Fenichel, 1944/54), and outside it new models were emerging. For instance, Carl R. Rogers developed his client-centred therapy that could be shorter or longer depending on the cases (since it was the clients who decided when to terminate therapy), providing a more rapid training of psychotherapists (when compared to the psychoanalysts who before seeing patients had to go through analysis for several years themselves), and opening the door to other professionals besides physicians to be trained as psychotherapists (i.e., claiming that right for psychologists). In the case of the first behaviourist applications to therapy, such as Wolpe's

reciprocal inhibition, some treatments could last more than 100 sessions (being in today's standards long therapy), yet many others would last less than 40 and others even less than 25 (Wolpe, 1958).

Nevertheless, it was only during the 1960s and 70s that the short-term and time-limited therapy models started to become predominant. For example, in Beck, Rush, Shaw and Emery's *Cognitive Therapy of Depression* (1979) they stated that around 20 sessions were needed to treat a person with moderate to severe depression. Within the systemic models this trend went even further. In the case of the MRI model they set a maximum of 10 sessions and other models such as the Solution Focused Therapy claimed results in less than that. These systemic models can be called brief therapy by design because from the beginning the therapist and patient agree on a planned time-limited framework for treatment. This contrasts to others models where the treatment lasts even less, for instance, 25 sessions, but this is not planned beforehand – brief therapy by default (Budman & Gurman, 1988).

In addition to these theoretical developments, the appearance in the United States of the Managed Care Organizations (MCOs) directed that brief therapy become the rule (since time-limited is cost-limited). Moreover, the advances in psychopharmacology, namely the commercialization of more efficient anti-anxiety and anti-depressant drugs with lesser side effects, have launched a tough challenge to

psychotherapy, motivating further development of brief therapies and demanding research to demonstrate their potentialities (Wachtel & Messer, 1997).

It is within this context that the present research was carried out, justifying the narrowing of focus described in Phase Two (Pre-emptive focusing). Yet before going to that point it is important to reflect upon the problem chosen to be treated through psychotherapy.

1.2.2. Pain

Pain can be a private experience difficult to express. This is particularly evident when no external agent or specific body damage is identified. As Scarry (1988) said, “To have pain is to have certainty, to hear about pain is to have doubt” (p. 13). At this point pain is an individual phenomenon. Nonetheless, pain goes beyond the individual, as for instance, when help is needed to control it. Consequently, it involves of two or more people. In this quest for help usually a health professional is involved, and at times different practitioners have distinct perspectives on how to understand and treat pain depending on their professional background. Furthermore, even colleagues in the same profession can have different views about pain. For this reason, in this section I will describe several perspectives for understanding pain, namely from the point of view of physicians, psychologists and psychotherapists.

1.2.2.1. Physicians’ perspectives

Physicians have different perspectives for understanding pain based on multiple biological theories. The first prevailing biological theory that came forward was the Specificity Theory (ST). This theory

proposed the existence of a specific pain system that carried the information of a noxious stimulus detected by pain receptors, through a pain pathway, to a pain centre in the brain. It defended the existence of a straightforward biological system that supported a direct and fixed relationship between stimulus and the sensation of pain. The modern origins of this theory go back to Descartes (Melzack & Wall, 1988) and reflect a typical linear causality of mechanistic models. Through research, it has been possible to confirm the existence of physiological receptors specialised in the detection of painful stimuli (e.g., nociceptors), yet a pain centre in the brain was never found. Moreover, this theory can not explain why, in many cases, there is not a direct and fixed relationship between stimulus and pain's sensation (as shown in many clinical cases and cultural studies) or why pain can exist without a detected injury or an injury can exist without pain. Despite the fact that this theory reflects the commonsense view of how to understand pain, any physician who has to deal with patients in pain soon realises its limitations and the need of a better theory.

In 1965 a psychologist, Ronald Melzack, and a physiologist, Patrick Wall, proposed a more comprehensive alternative to the ST. They accepted that pain is influenced by learning and culture and tried to develop a biological theory that would incorporate these dimensions. Taking into account the neurobiological information

available at the time as well as the complexity of the pain phenomenon, they jointly proposed the Gate-Control Theory (GCT) (Melzack & Wall, 1965). This theory proposes that the incoming information from the stimuli is modulated before it reaches the brain. Consequently, they postulated the existence of a neural *gate* that can be opened and closed, controlling the flow of information. The location of this *gate* was proposed to be in the substantia gelatinosa (SG) of the spinal cord's dorsal horns. In a simplified way it can be said that a conscious pain experience occurs when the output of the central transmission cells (the T-cells) reaches or exceeds a critical level. The activation of these T-cells is modulated by the gate-control system (if the gate is opened there is an increase in the activation, if the gate is closed there is a decrease in the activation). The gate-control system depends on the balance between the impulses from the large-diameter afferent nervous fibres (e.g., A-beta), and from the impulses of the small-diameter afferent nervous fibres (i.e., the nociceptors, which are the small myelinated A-delta fibres and the unmyelinated C fibres), as well as the interpretation of these impulses by the brain (i.e., descending pathways). Consequently, the pain can no longer be explained as a straightforward result from peripheral factors (e.g., sensory stimuli). According to this theory, the central nervous system plays an important role in the pain experience. For instance, the spinal cord (through the gate mechanism) is able to

modulate the input that later is sent to the brain; moreover the brain is an active agent that besides selecting and interpreting the information that arrives from the spinal cord (through ascending pathways) can send impulses that modulate the action of the neural gate (through descending pathways). The influence of the nociceptors' activity comprises the valid data of the ST. The interference of the activity of other peripheral fibres (e.g., A-beta) justifies many of the manual therapies (e.g., massage). The descending pathways account for a biological base for the psychological, social and cultural influences on pain phenomena (Melzack & Wall, 1988).

When the Gate-Control Theory was formulated it was a huge speculative leap that generated much controversy, interest and research within the medical profession. Until today the developments of the physiology of the nervous system have not denied the basis of this theory. However, in spite of the Gate-Control mechanism explaining transient and acute pain quite well, chronic and recurrent pain remains a challenge. The GCT cannot explain why the pain persists after the tissue is healed, when there is no more direct stimulation of the nociceptors and the chemical medium returns to normal.

To try to explain chronic and recurrent pain, physicians are forced to reach to theories about nerve damage and more cutting-edge

theories about the role of the brain in all these processes, an example of which is the neuromatrix theory. This theory tries to understand the workings of the brain in relation to the pain experience (Melzack, 1993, 1999). As it is known, the brain starts at the brainstem that receives ascending messages from the spinal cord and inputs from the viscera, eyes, ears, mouth, face and head. Above the brainstem appears the forebrain that contains (between other structures) the thalamus, and the cortex. The thalamus, responsible for most of sensory processing and movement control, is surrounded by a group of structures (hypothalamus, hippocampus, the amygdala, etc.) that constitute the limbic system (sometimes referred to as the “emotional brain”). The cerebral cortex wraps around all these structures and, with billions of neurons receiving and sending information everywhere, has multiple functions such as thought, voluntary movement, language, reasoning and perception (Chandler, 2004; Melzack & Wall, 1988; Wall, 2000). Being that pain is a multiple-faceted experience (coloured by several sensations, perceptions, emotions, affects, thoughts, cognitions, behaviours, etc.), it necessarily involves an orchestrated activity of various areas of the brain (such as the ones referred to above). Using Melzack’s words (1993):

The areas of the brain involved in pain experience and behaviour are extensive. They must include somatosensory projections as well as the limbic system. Furthermore, because our body perceptions include visual

and vestibular mechanisms as well as cognitive processes, widespread areas of the brain must be involved in pain. (p. 620)

In this theory, pain is the outcome of a complex and widely distributed neural network activity pattern, activated by multiple influences (one of them can be, of course, the sensory input). This theory also argues that during the pain experience the brain incorporates sensory, affective, cognitive and motoric processing units. This is confirmed by functional imaging studies of pain that show activation of at least three major neural circuits in the brain: (1) the classical sensory pathway; (2) pathways through the brainstem to the limbic system; and (3) parietal association regions (Derbyshire, 2000; Petrovic & Ingvar, 2002).

1.2.2.2. Psychologists' Perspectives

Psychologists try to understand the pain phenomena from a different angle. To them, pain besides being a complex biological phenomena also involves many psychological factors that play an essential role in the overall experience. From a psychological perspective, it is important to take into account how much the pain hurts (i.e., perceived intensity of the sensation), how much the pain bothers (i.e., affective and cognitive components), the behaviours associated with it, as well as the systemic context where the pain happens (e.g., family, society, culture, etc.).

The first aspect, the felt intensity of the pain, depends greatly on a physiological apparatus but also on psychological components. When we have an injury we usually perceive pain. Yet there are occasions when an injury happens and there is no pain or the pain is only felt when the person becomes aware of the injury. This situation is well illustrated by the following passages (Livingston, 1953):

A fisherman is sitting in one of a line of boats stretching from one sand spit to another at the mouth of a river. He suddenly feels a smashing strike, and as he lunges back to set the hook, a large salmon breaks out of the water, shaking the hook in its mouth. He realizes that his best chance for landing the salmon lies in getting ashore before his line runs out or becomes entangled with the lines of other fishermen in the neighboring boats. Fighting the salmon as he goes, he starts crossing from boat to boat to reach the spit. Once there, he runs far out on the beach and after a hard struggle lands his salmon. As he winds up his line, he looks down and sees that the wet sand under his right shoe is reddening. Then he notices a long rent in his trousers and is surprised to discover a deep cut in his leg. By the time he has improvised a dressing for this wound he has found other injuries: skin scraped off three knuckles, a friction burn on his right thumb and two massive bruises on his left thigh. He realizes that

these injuries must have been sustained while he was crossing the line of boats. Yet he cannot recall having felt the slightest pain at the time. (p. 59)

If the person's attention is focused on something that is very important at that moment, an injury can be unnoticed and pain not reported at least until the person becomes aware of it. A parallel occurrence is observed in animals, as in the case when a mouse is attacked by a cat. First it runs to escape its predator and then only afterwards, when in a safe place, does it start to lick its wounds. There is an inherent survival value in this flight or fleeing reaction that justifies a biology evolution to allow this.

The second aspect, the affective and cognitive components, greatly influences the way potentially painful experience is perceived and tolerated. For instance, a pain that is the outcome of a successful surgery is usually more easily managed than the pain caused by a cancer. The meaning of the pain in these two situations is completely different and this determines how pain is felt and endured (Barber, 1996; Ferrell & Dean, 1995; W. B. Smith, Gracely, & Safer, 1998). For a large number of cancer patients pain has a negative meaning, from a symptom that disables the life of the patient, to an alarming sign that cancer is progressing and that death is around the corner. To no one's surprise, anxiety and depression are usually psychiatric co-morbidities of cancer pain and many other types of chronic pain (Barber, 1996; Dersh, Polatin, & Gatchel, 2002; Lipchik & Penzie, 2004; Vingoe,

1994). Cognitive processes such as beliefs, appraisals and expectations also play an important role on how much the pain bothers a particular individual. As it was referred to above, the person's beliefs about the meaning of a specific pain greatly influence the pain experience. At this level, automatic thoughts can mediate how a particular type of pain is interpreted. For instance, if the pain is appraised in a catastrophic way (e.g., as an indication of terrible disease) this will affect mood, coping strategies and the degree of pain control. Moreover, if the patient's expectations are negative (e.g., "there is nothing we can do about it", "if I move, it is going to hurt more") the prognostic of recovery is dim. Of course, the reverse is equally valid: if the person believes that he or she has the resources to deal with the pain, interprets the situations in optimistic terms and has positive expectations, all these elements will increased the probabilities of a better treatment response. It is important to remember that similar cognitive processes affect the professionals to whom the patient asks for help. The health-care providers' beliefs, appraisals and expectations are also very important contributors for the success (or failure) of pain management interventions (Turk, 2004).

A third aspect is also important to consider. When people experience pain they can express overtly through their behaviours that they are suffering. These conducts are usually called pain

behaviours (Turk & Flor, 1987). They range from verbal complaints, gestures such as placing a hand on the pain site and immobility to efforts in asking for help to reduce the pain. These behaviours are influenced by classic and operant conditioning in adaptive or maladaptive ways. Let us look to examples of the latter. For instance, if a child goes to a dentist (initial neutral stimulus) and has a painful experience (unconditional stimulus) that leads to the activation of the sympathetic system creating an anxiety state (unconditional response), probably the next time that the child has to go to the dentist he or she will show signs of anxiety (classic conditioned response). Or, for example, if a person suffers from low back pain that hurts more with movement, this person can start avoiding certain physical routines (behaviours). If this systematically leads to receiving more attention from a spouse, avoiding undesirable household chores, and so on (contingent reinforcements), these would be positive operant reinforcements of undesirable pain behaviours such as lack of exercise with the consequent weakening of the muscles that help sustain a more healthy back position. It is also interesting to note that early learning experiences have a great influence on pain behaviours. This is clearly illustrated by the experiment referred to by Melzack and Wall (1988):

Melzack and Scott (1957) raised Scottish terriers in isolation cages from infancy to maturity so that they were deprived of normal environmental stimuli, including the bodily knocks and scrapes that young animals get in the course of growing up. They were surprised to find that

these dogs, at maturity, failed to respond normally to a variety of noxious stimuli. Many of them poked their noses repeatedly into a flaming match, and endured pinpricks with little evidence of pain. They invariably withdrew reflexively from the flame or pinprick and oriented to the stimuli, but few of them showed strong emotional arousal or behavioural withdrawal. In contrast, the litter-mates of these dogs that had been reared in normal environment recognized potential harm so quickly that the experimenters were usually unable to touch them with the flame or pin more than once. (p. 20)

Last but not least, it is important to consider the systemic context where the pain happens (e.g., family, society, culture, etc.). When looking to the role of the family on sickness it becomes clear that it influences perceptions, beliefs, attitudes, expectations and behaviour regarding pain. All these factors greatly affects infant and child patients and, to a lesser or higher degree, patients throughout their lifespan (Skevington, 1995). There are also social and cultural differences that influence the way a particular individual lives his or her pain experience. As Skevington (1995) noted:

Cultural differences in levels of stoicism demonstrate that learning plays an important role in the predisposition to report pain. As a result of tradition, norms and imitation, societies set their own rules and expectation about whether and when it is appropriate to express pain, and the acceptable style for doing this. (p. 28)

There are many interesting studies about the pain experience and ethnicity that show differentiations and complex relations sometimes difficult to clarify (Abercrombie, 1960; C. L. Edwards, Fillingim, & Keefe, 2001; Green et al., 2003; Greenwald, 1991; J. A. Lipton & Marbach, 1984; Moore & Brødsgaard, 1999; Ng, Dimsdale, Rollnik, & Shapiro, 1996; Riley et al., 2002; Rollman, 2005). In order to see

more clear differences, we can resort to many anthropologic studies that illustrate the influence of culture for an experience to be named as painful. For instance, Melzack and Wall (1988) described the hook-swinging ritual practiced in remote Indian villages. During this ceremony a person, who is honoured by being chosen to be the celebrant, is lifted in a special cart by two hooks thrust in his back, then hanging only by the ropes connected to the hooks he goes from village to village swinging free in the air blessing children and crops. Everybody lives the situation as a happy festivity and the celebrant does not shows signals of pain. Another interesting example is the Anastenaria, a religious ritual still practiced in northern Greece that involves walking on fire. Danforth (1989) described this ceremony as lasting several days during which some people dance holding religious icons through the village street and houses at the sound of liras and drums. The emotional climax is reached when some of the participants dance barefoot over a large oval bed of hot coals in front of the community, which watches with astonishment. The participants believe that during the dances and the firewalking they are possessed by the spirit of saints who guide and protect them. Of course, there are people who offer scientific explanations of this phenomenon, referring to the low thermal conductivity of the wood coals, the short time of contact and so on (Latura, n.d.; Leikind & McCarthy, 1991). Nevertheless, as happens with studies with fakirs (Larbig et al.,

1982), even when scientific explanations are provided, the fact remains that for an outsider just to think about these situations evokes the expectation of pain. As Ken Cadigan said, “even if scientists do explain the firewalk someday, fire will still be fire, and people will still be people” (as cited in Danforth, 1989, p. 222). In other words, those experiences are interpreted as painful even when participants report no discomfort, since within our Western culture the belief prevails that potentially dangerous stimuli will cause pain.

Another interesting cultural factor is the lack of words to describe many dimensions of pain experiences. As Hardcastle (1999) put it:

The language we have for expressing our propositions concerning pain sensations is very crude. Unlike words for hue or pitch, we have few words that speak directly about the qualitative aspects of pain itself. Instead, pain is “described by illustration.” The adjectives we do use (e.g., cutting, dull, hot) are metaphorical. In addition, we give short shrift to the emotional side of pain. Ronald Melzack comments that “the affective dimension [of pain] is difficult to express – words such as exhausting, sickening, terrifying, cruel, vicious, and killing come close but are often inadequate descriptions.” We simply cannot express in a clear and unambiguous fashion how pain, in all its complexity, feels. (p. 151)

Moreover, in cross-cultural studies this problem is aggravated by the difficulty of translating pain-describing terms from one language to another (Skevington, 1995, p. 77).

1.2.2.3. Psychotherapists' Perspectives

As described previously, there are many different models of psychotherapy. Most of them can be grouped under or in between the following approaches: psychodynamic, humanistic-existential, behaviourist, cognitive and systemic. Below I will describe briefly how these approaches (and representative models) see chronic pain and its treatment.

For a psychotherapist within the psychodynamic approach, chronic pain is often seen as psychogenic, that is, as a somatisation of unconscious conflicts. Consequently, the therapeutic aim is going to be to work through these conflicts with the intend of arriving to a resolution and in this way relieving the symptom. For instance, to the psychoanalytic model chronic pain can be understood as a psychosomatic problem that has its roots in a primary interpersonal conflict (typically between the patient as a child and the parental figures)⁶. This early emotional conflict can block the development of the person's symbolic capacity. Therefore, their thinking can be too concrete and in adulthood when facing conflicts their anxieties can be lived through the body, as physical symptoms (Adroer Tasis, 1988)⁷.

⁶ Other causes attributed to chronic pain are repressed hostility, guilt, resentment and so on (Gamsa, 1994).

⁷ For an interesting paper on the psychodynamic oriented view of headache by Freud see Karwautz, Wöber-Bingöl, and Wöber (1996).

Regarding the humanistic-existential perspective it is difficult to present a concise general outline of this approach because it clusters many heterogeneous models that typically do not focus their interventions in particular problems. Yet, many themes explored by the humanistic and existential approaches are critical to help somebody suffering from chronic pain. The importance of awareness, meaning, and anxiety are just a few examples (Cain & Seeman, 2001; Yalom, 1980). Concrete models such as supportive counselling (Llorca Ramón, Villoria Medina, García Carretero, & Díez Sánchez, 1989) and transitional analysis as used by Sternbach and his colleagues (Turk, Meichenbaum, & Genest, 1983) can be cited as illustrations of how this approach deals with chronic pain management.

Within the behaviouristic perspective, chronic pain is often seen associated with non-adjusted behaviours that were acquired through learning processes, such as classic and operant conditioning (as it was referred to when describing the pain behaviours). For instance, if a behaviourist therapist is helping a patient who suffers from chronic pain, he or she is going to observe carefully the behavioural patterns that anticipate and follow the patient's pain episodes. This can be done through direct observation, through an interview of the person and related people (e.g., the spouse). Other instruments such as questionnaires, scales and diaries can also be used. After identifying the behaviours that help to perpetuate the condition (e.g., pain's

contingent reinforcements), the therapist can then draw a plan in order to change them and to promote “well behaviours” (for example, create reinforcements for a physical therapy program). This approach shows better results in helping people with chronic benign pain than those with chronic malign pain (Sarafino, 1997), probably because it discounts the importance of other variables of the person’s life that go beyond the behaviourist model (Gamsa, 1994; Hardcastle, 1999, pp. 178-179).

Within another approach – the cognitive one – there is the core belief that our thoughts influence our perception and feelings, as well as the subjective experience of pain. Therefore the cognitive models try to find out what people think about their pain experience, what kind of beliefs surround the pain and so on. For instance, in Beck’s cognitive therapy model, the treatment of a chronic pain patient has the aim of identifying the inadequate thoughts that anticipate and escort the pain. After demonstrating the irrationality of the cognitions, the therapist usually teaches the person helpful strategies to manage their pain (e.g., creative imagery). Other factors that are usually also taken into consideration are capacity of personal control, attention, problem solving, coping, imagery and so on (Gamsa, 1994).

It is important to underline that nowadays it is difficult to find behaviouristic therapy in its original isolated form. Most present models are cognitive-behavioural ones. Good examples of these are

the stress inoculation model (Turk et al., 1983) and acceptance and commitment therapy (McCracken, Vowles, & Eccleston, 2005) applied to chronic pain management.

Within the systemic approach chronic pain is seen as affecting the person, as well as all the systems that she or he is part of (e.g., family, work, medical services, etc.). In the systemic perspective, all these dimensions have to be taken in consideration in order to mitigate the problem. Usually the broad social context is not taken in direct consideration by the other models; nevertheless for the systemic approach, evaluation and intervention has to go through all these levels (from the individual to the institutional one). To achieve its aims different techniques are used that integrate cognitive and behavioural aspects too.

1.2.2.4. Some general considerations

With the aim of bringing some light to the pain phenomenon, three complementary perspectives were briefly described. As we have seen within the medical perspective, there was an evolution of biological theories to explain pain. From seeing pain as a straightforward sensory signal, advances occurred that now allow physicians to understand pain as a complex experience involving different dimensions that go beyond biology. These developments permit a logical integration of the psychological perspective that explores the role of psycho-social factors in the pain experience. It is important to understand how much the pain hurts and bothers a particular individual, as well as the behaviours associated with it and the conditions where it happens. All this knowledge informs the psychotherapies for pain management in general, while particular models underline the importance of certain factors over others. Psychodynamic models stress the significance of emotional conflicts. Humanistic-existential models underline the importance of meaning and awareness. Behaviourist models focus on pain behaviours, and cognitive models focus on thoughts, beliefs and expectations. The systemic approach explores the role that pain plays in different systems that the person is part of.

When reflecting on all the above, it cannot be forgotten that all

these theories are formulated within our Western culture which is dominated by dualistic principles. Our commonsense view still sees pain as a biomedical puzzle waiting to be solved (Morris, 1992); that is, if a person has pain there must exist a physical cause and a possible medical treatment. This view is very reductionistic and is underpinned by the Cartesian mind-body split (Bendelow & Williams, 1995). Consequently, if pain is considered organic, the physician must be the one to deal with it. When no organic cause can be found, pain is usually considered (by an elimination of possibilities) as psychogenic, thus within the frontiers of psychiatric and psychological care. This tendency stigmatises patients and is not scientifically justified (Hardcastle, 1999). The complexity of the pain phenomenon has taught health scientists and clinicians that this dichotomy limits the understanding of pain. Hence, trying to get around this dualism is very useful. Taking a double aspect monistic perspective gives health professionals a more comprehensive background where multidisciplinary treatments emerge as a principle for pain management.

1.2.3. Research Methodologies

Psychotherapy emerged at the end of the nineteenth century as a scientific enterprise aimed to help people with mental health issues. Since its beginnings there were efforts to investigate this area of theoretical and practical knowledge. Different research methodologies were proposed and used, influenced to a large degree by the dominant contemporary epistemologies, and to a lesser extent by the particular core beliefs of the psychotherapeutic approach under study. In this section, I am going to present a brief historical overview of psychotherapy research, followed by a reflection on the orthodox and alternative paradigms of research.

1.2.3.1. A brief summary of psychotherapy research

We can consider that psychotherapy research as a whole went through several phases (adapted from Orlinsky & Russell, 1994):

- I. An initial phase that lasted until the 1950s dominated by the psychodynamic movement;
- II. A second phase, from the 1940s to 1970s, which tried to provide research evidence more widely accepted by following the positivistic research methodology;

- III. A third phase, from the 1970s to today, that expanded, differentiated and organised the empirical knowledge obtained to the point of proposing empirically supported treatments;
- IV. A fourth phase that started in the 1980s that, dissatisfied with the limitations of the orthodox research paradigm and the increasing gap between research and practice, tries to reformulate the research methodology.

Lets us look at each of these individually.

During the first half of the twentieth century an initial generation of researchers established the field of psychotherapy research. These pioneers were psychotherapists of dynamic orientation who made important efforts to justify and develop their therapeutic theories and practice.

Clinical studies were one of the first methodologies used. For example, in the *Studies on Hysteria* (1895/2000) Breuer and Freud write with detail about several case histories, ending them with some theoretical inferences and psychotherapeutic implications. It was from these clinical cases (among others) that Freud developed psychoanalysis. His method for gathering and analysing the psyche became, besides a therapeutic procedure, also a tool for discovery and confirmation of his theories. Many criticisms were made of Freud's

research methods from over-generalization to pathologization of the normal (Ferreira da Silva, 1982), and Karl Popper even uses psychoanalysis as an example of pseudoscience, since according to him psychoanalytic theories are not refutable (Popper, 1963/2002). Nonetheless, many counter-criticisms were also made (Grant & Harari, 2005; Neuro-Psa, 2006; Solms, 2006) and as early as the 1930s outcome studies started to appear to research the effectiveness of the psychodynamic approach. For instance, Otto Fenichel compiled the therapeutic results of 592 cases treated at the Berlin Psychoanalytic Institute between 1920 and 1930; in 1936 Ernest Jones wrote the decennial report of the London Clinic of Psychoanalysis covering the outcomes of 74 cases; and in 1937, Franz Alexander did a report of the outcomes of 157 cases of the Chicago Institute for Psychoanalysis. In 1941 all these and other studies were summarised by Robert Knight in an article titled “Evaluation of the Results of Psychoanalytic Therapy”. There a total of 952 cases were tabulated by diagnosis and therapeutic results ending up with the conclusion “that psychoanalysis must be adjudged an effective therapy for the psychoneuroses, sexual disorders and organ neuroses, and a therapy of some promise in the more difficult field of addictions and psychoses” (Knight, 1941, p. 446). Nevertheless, this judgement of success was not widely accepted and in 1952 H. J.

Eysenck re-analysed these and others studies⁸, questioning the outcomes of psychotherapy as no better than spontaneous recovery.

In his own words (Eysenck, 1952, p. 322):

In general, certain conclusions are possible from these data. They fail to prove that psychotherapy, Freudian or otherwise, facilitates the recovery of neurotic patients. They show that roughly two-thirds of a group of neurotic patients will recover or improve to a marked extent within about two years of the onset of their illness, whether they are treated by means of psychotherapy or not.

Not surprisingly, many voices were raised contesting Eysenck's methods and conclusions (Luborsky, 1954; Rosenzweig, 1954). However, the great influence of this paper challenged the psychotherapists to prove that their models worked by doing more research.

Around the 1940s-50s, a second phase of psychotherapy research started to materialise producing interesting developments. For instance, within the humanistic-existential approach, Carl R. Rogers and his associates started audio-recording therapeutic sessions for posterior systematic analysis (i.e., process research)⁹. In this way they developed a different type of case study that through the recordings and transcripts of the sessions could be intensively analysed and even

⁸ 24 article on treatment outcomes, 5 of psychoanalytic model and 19 of eclectic methods.

⁹ In the book *Counseling and Psychotherapy*, Rogers (1942) published for the first time a transcription of all sessions of a case (the case of Herbert Bryan that lasted 8 sessions).

critically reanalysed afterwards from different perspectives. Rogers' group also published an important book on research: *Psychotherapy and Personality Change*. In this book they presented the initial findings of a very interesting research program. Using their own words (Rogers & Dymond, 1954):

This is the story of what happened to a group of people who came to the Counseling Center of the University of Chicago for help with personal problems. It is the first study to provide scientific evidence, based on adequate methods and controls, that people *do* change as a result of psychotherapy. As such it is a highly significant contribution to the whole field of personality theory as well as to psychotherapy and counseling.

The clients in the study came to the center for an average of thirty interviews each. The counsellors who worked with them were client-centered in their orientation. The clients were given an extensive battery of tests before and after therapy, and again after a follow-up period, to discover what changes, if any, had occurred. Then, in order to determine whether or not the changes were due to the therapy as such, the client group was compared with a matched control group and with an own-control group (clients themselves during a preceding period of no therapy). (...) Thirteen studies are reported, each investigating a different hypothesis as to change. Each presents the objective evidence, and several include extensive excerpts from recorded interviews.

The data are analyzed to reveal changes in the clients' self-perception, in their attitudes, their behaviors, and their basic personality structure. Also investigated are the reasons for failure in therapy, the influence of age, sex, seriousness of disturbance, rigidity, and other factors on the likelihood of change, and the degree of change in those who wish help when no therapy is given. (from front and back flap)

Even so, it was within the behavioural movement that research became more fully recognised. Behavioural therapy emerged from research on learning done within a positivist paradigm, such as Thorndike's trial-and-error experiments, Pavlov's famous conditional reflexes experiments, Watson's studies and proposals, and Skinner's operant conditioning works. The case of reciprocal inhibition is a good illustration of this. Wolpe, based on studies of animal's experimental

neuroses, proposed a therapeutic method to help people with phobias (Wolpe, 1952, 1958). Following the same scientific framework, soon afterwards several research studies started to appear about the efficacy of these emergent behaviour methods. Since these procedures were usually easily standardised (manualised), it was possible to create research designs such as random clinical trials (RCT) and the like that still today are considering the golden standard of research in psychotherapy. Even with the evolution of the behavioural movement that recognised the significance of other human expressions (e.g., thoughts and feelings) that were more difficult to encompass within this type of research, they maintained the positivistic paradigm anyway. For instance, in the often referenced *Handbook of Psychotherapy and Behaviour Change* (4th edition) Alan E. Kazdin (1994, p. 66) wrote: “The methods discussed fall within the quantitative and positivistic research paradigm that dominates contemporary psychotherapy research. Familiar concepts within this approach are operational definitions, standardized assessment, hypothesis testing, and quantitative methods of evaluation.”

From the 1970s onwards an off-spring of phase two can be identified. This third phase is characterised by the expansion, differentiation and organisation of the empirical knowledge of psychotherapy. A model that flourished within this phase was

cognitive therapy. It is worth noting how this model came about. Aaron T. Beck, a psychoanalyst by training, started to study patients' dreams with the aim of testing the psychoanalytic concept of inverted hostility in depression (A. T. Beck & Hurvich, 1959; A. T. Beck & Ward, 1961). After some initial hesitation, he started to realise that a better explanation for the high incidence of dreams with unpleasant content in depressed people (e.g. rejection, disappointment, humiliation, etc.) could be given through concepts of cognitive distortions (A. T. Beck, 1963, 1964; Rosner, 2002). From there Beck and his collaborators went on to develop the cognitive therapy for depression that progressively expanded to treat many diverse psychopathologies (A. T. Beck et al., 1979; Padesky, 2004). Along the way there was a continuing emphasis on empirical research following the positivistic paradigm at its best. Today, it can be said that cognitive therapy is one of the better empirically supported psychological treatments. It even can claim, in treating depression, to be superior at follow-up than pharmacological treatments (A. T. Beck, 2005).

Within this wave of success in 1995 the Society of Clinical Psychology – Division 12 of the American Psychological Association – proposed a set of Empirically Validated Treatments (EVTs), later renamed Empirically Supported Treatments (ESTs) (Beutler, 1998). Since one of the criterion for a treatment to be classified as well-

established is that experiments must be conducted with treatment manuals, it is not surprising that the majority of the treatments listed are behavioural and cognitive models. Many voices emerged criticising these efforts. For instance, Silverman (1996) express his views by saying: “In many respects, the Division 12 Task Force Report can be called Eysenck II in that, like its predecessor, Eysenck I, it makes irresponsible generalizations and stimulates emotional responses.” (p. 208)

On the other hand, with the rapid multiplication of psychotherapy models (or “brands”), it is increasingly difficult to sustain the Dodo bird verdict “everybody has won and so all must have prizes” (Luborsky, Singer, & Luborsky, 1975). Yet, more fruitful roads for a consensus can be taken. An interesting possibility is the pan-theoretical view that notes the common factors shared by many psychotherapy models that contribute to a successful therapeutic outcome. Examples of these are: client factors and extra-therapeutic events; relationship factors; expectancy and placebo effects; and technique/model factors (Hubble, Duncan, & Miller, 1999; Miller, Duncan, & Hubble, 1997).

To sum up, the biggest achievements of this third phase is the accumulation of enough research evidence to state that (Asay & Lambert, 1999; Lambert, n.d.; Lambert & Ogles, 2004):

- I. Psychotherapy is effective and its effects are more powerful than informal support systems and placebo controls;
- II. The outcomes of psychotherapy are substantial and tend to be maintained;
- III. Psychotherapy is relatively efficient – a good portion of patients improve after 10 sessions, yet a significant number need more sessions (in some cases more than 50 sessions are needed).
- IV. Psychotherapy by and large helps the patients who enter it, and yet for some patients therapy can have a negative impact.

Nevertheless, some researchers dissatisfied with the limitations of the orthodox research paradigm proposed radical changes in research methodology. These researchers represent the fourth phase that started in the 1980s. Even so, the roots of this dissatisfaction go back several decades. Already in the 1950s within the existential approach some voices had proposed more coherent methodology with their core beliefs. As Rollo May (1958) wrote :

Binswanger and others were convinced that the traditional scientific methods not only did not do justice to the data but actually tended to hide rather than reveal what was going on in the patient. The existential analysis movement is a protest against the tendency to see the patient in forms tailored to our own preconceptions or to make him over into the image of our own predilections. In this respect it stands squarely within the scientific tradition in its widest sense. But it broadens its knowledge of man by historical perspective and scholarly depth, by accepting the facts that human beings reveal themselves in art and literature and philosophy, and

by profiting from the insights of the particular culture movements which express the anxiety and conflicts of contemporary man. (p. 8)

Moreover, within the systemic approach important challenges were made to the positivistic paradigm of research. By arguing that many situations can be better understood using circular causality (A is not cause by B, or B by A, they are cause and effect at the same time), how can we study them using the linear thinking of orthodox research (A causes B)? It is like putting a square peg into a round hole – it simply does not fit. Furthermore, the systemic thinking continued increasing in complexity. Initially a therapeutic team, working with a one-way mirror, observed the relationship patterns and communication games of a family in interaction. Taking advantage of the one-way mirror (and video recordings of the sessions), some teams started to research how these interventions worked (see for instance, Weakland, Fisch, Watzlawick, & Bodin, 1974). From here, some groups started to explore the possibility of studying the entire therapeutic system (i.e., therapeutic team and the family) using systemic thinking: the observers (therapeutic team) became part of the observation (therapeutic system). This characterises the second-order cybernetics that sees therapy from a semantic to a constructionist perspective. That is, how different elements of the system make sense of a situation, how meanings can change through conversation, and how different perspectives can construct different

discourses about a situation, and so on (Elkaïm, 1998; Wahlström, 1997a).

This increase in complexity was a direct challenge to the orthodox research methodology. There was a need to depart from the traditional research methods based on a positivistic worldview and introduce methods that fit better with the post-modern perspectives (Burck, 2005; Laitila, Aaltonen, Wahlstrom, & Angus, 2005; Wahlström, 1997b). During the 1980s, with some hesitation this started to happen and spread, leading to a wider recognition of process research (Greenberg & Pinsof, 1986; Orlinsky, Rønnestad, & Willutzki, 2004; Rice & Greenberg, 1984) and of qualitative methodologies in general. From there, some researchers proposed even more radical shifts through alternative research paradigms that, respecting the complexity of psychotherapy, avoided some of the pitfalls of orthodox positivism paradigm (e.g., Reason & Rowan, 1981). It is to this research paradigm shift that the next section is going to be dedicated.

1.2.3.2. Orthodox and alternative research paradigms

Kuhn (1970) defined paradigm as what members of a scientific community share: from similar educations and professional initiations to common exemplars (that is, concrete problem-solutions that they learn and practice throughout their careers). From this perspective, in the scientific community of psychologists the orthodox paradigm can be characterised by: an educational system that values the positivistic view of science; in some cases the need to undergo a Ph.D. in order to become a clinician; and the veneration of problem-solutions such as randomised clinical trials. This paradigm reflects ontological beliefs that human beings can be studied as any other object of the physical world; cosmological beliefs that this object can be understood through mechanistic models of causality; and by epistemological beliefs that it is possible to know the human being through positivistic methodologies (reduction, quantification, etc.) and by the hypothetical-deductive method (the base of experimental and quasi-experimental designs).

The following paragraphs taken from a textbook on psychological research methodology illustrates this paradigm (Christensen, 1997):

“The best method for acquiring knowledge is the scientific method, because the information it yields is based as much as possible on reality. Through the scientific method investigators attempt to acquire information that is devoid of personal beliefs, perceptions, biases, values, attitudes, and emotions. This is accomplished by empirically testing ideas and beliefs according to a specific testing procedure that is open to public inspection.

The knowledge attained is dependable because it is ultimately based on objectively observed evidence.” (pp. 13-14)

Likewise the research given as evidence for the Empirical Supported Treatments (ESTs) is also a good case of these orthodox puzzle-solving exemplars that still dominate psychology. According to this model, to consider a treatment as well-established the following criteria must be met (Chambless et al., 1998):

- I. At least two good between group designs experiments demonstrating efficacy in one or more of the following ways:
 - A. Superior (statistically significantly so) to pill or psychological placebo or to another treatment;
 - B. Equivalent to an already established treatment in experiments with adequate sample size.

Or,

- II. A large series of single case designs experiments ($n > 9$) demonstrating efficacy. These experiments must have:
 - A. Used good experimental designs and
 - B. Compared the intervention to another treatment as in IA.

Further criteria for both I and II:

- III. Experiments must be conducted with treatment manuals.

IV. Characteristics of the client samples must be clearly specified.

V. Effects must have been demonstrated by at least two different investigators or investigating teams.

As referred to in the historical overview of psychotherapy research, these criteria lead to the overwhelming representations of behavioural-cognitive models within ESTs and consequently to the wider recognition and acceptance of these models in the academic and clinical world.

The knowledge produced within this paradigm, on the one hand, had the advantage of having psychological treatments recognised on the same grounds as pharmacological ones (Beutler, 1998), but on the other hand lead the field to a dangerous road of generalizations and paint-by-number models (W. H. Silverman, 1996). Moreover the gap between research and practice endures (Barkham, 1990; Howard, 1986; Krumboltz, 2002; Morrow Bradely & Elliot, 1986; Wilson & Barkham, 1994). Most of the research done is carried out in conditions that vary widely from real world clinical settings and thus its results bare little relevance to the practitioners. The difficulties in bridging this gap are aggravated by the metaphysical underpinnings of the orthodox paradigm that leads to the study of psychotherapy as a physical object. It assumes that the outcome of kicking a stone is similar to the outcome of kicking a dog. It neglects that even if in the

first case the result depends on the input, in the second situation it goes beyond that (Bateson, 2000). Imagine if biologists had not developed specific methodologies to study biological phenomena, which have a relation to the physical phenomena, but yet are different enough to justify a distinct science.

The incongruence between methodology of inquiry and object of study in psychology is easier to identify than to solve. The objective-subjective, primary qualities-secondary qualities, and quantification-qualification dichotomies are complex and difficult to transcend. Modern science has emerged by focusing on a selected object and by studying it through quantification of its primary qualities and ignoring as much as possible its secondary qualities. This worked well in the beginning for physics and other so called hard sciences. Psychology tried to mimic their success by copying their methods. This is exemplified at the end of the nineteenth century by the psycho-physics studies of Fechner and the first psychology laboratory in Leipzig directed by Wundt. Still, soon after these initial steps, psychology had to deal with the criticism that one of its methods – introspection – was too subjective to produce scientific knowledge. But how could we study mental processes without asking the subject about them? A solution was to substitute the object of study, focusing only on observable behaviours (Watson, 1913). (It was in this way that psychology temporally lost its mind.)

Psychology was not the only emerging science that applied the methodology developed in the natural sciences to its particular object of study. For instance, in sociology there was also an emphasis on positivistic methodologies that aimed to test hypothesis in order to arrive to general laws and explanations. Slowly during the 1960s several authors underlined the importance of discovery oriented methods that explore the induction processes as a way to achieve knowledge. Grounded Theory as proposed by its founders is a good example of this (Glaser & Strauss, 1967). Yet, most of these proposals were still in many ways within the orthodox paradigm (Annells, 1996).

A radical solution had already been presented at the end of the 1800s by philosophers such as Dilthey (1883/1988): the methodologies employed to study human and social sciences should be different from the ones used to study natural sciences. However, only one century later a significant number of psychologists arrived at a similar conclusion, proposing alternative research paradigms. The representatives of these new paradigms got their inspiration from problem-solution alternatives such as clinical methods, action research, phenomenology, existentialism, hermeneutics and other methodologies already developed within the social sciences. They also started to shift their ontological beliefs towards a perspective that considered psychological phenomena as specific and different from

physical and biological phenomena and to cosmological possibilities different from the linear mechanic model. With regards to the epistemological beliefs, they fall in a continuum from realism to constructivism, agreeing on the recognition that interpretation plays an essential role in research. They also started to more frequently use qualitative methods and develop them in order to better answer their research questions.

At this point it is important to differentiate methodology from method. The former can be defined as a theoretical framework that informs how the research should proceed, the latter is a set of research practices (Harding, 1987). For instance, observation and interviewing can be considered qualitative methods for data collection, and hermeneutics and phenomenology as methodologies that can use the referred methods with specific intentions.

Let us look briefly to these two research traditions – hermeneutics and phenomenology – that in many ways frame the development of the new alternative research paradigms (McLeod, 2001). On the one hand, we have hermeneutics that has its roots in medieval theological reflections on the possible interpretations of the Bible's sacred texts. The word itself comes from the Greek mythological god Hermes who had the mission of carrying and interpreting the messages of the gods. In contemporary social sciences, hermeneutics can be defined as an interpretative approach

that aims to uncover historical, social and cultural contexts of meanings of publicly accessible data. On the other hand, we have phenomenology that has more recent roots in philosophy. Edmund Husserl (1859-1938) is considered by many as the father of this approach that has as its aim to describe exhaustively the essence of a phenomenon. This is traditionally done by an individual through the bracketing of all his assumptions and careful and exhaustive description of the “thing in itself” (in order to arrive to the essence of the phenomenon). In sum, hermeneutics focuses on meanings contextualised by history and culture and phenomenology focuses on the meanings of the “thing itself”. They focus on opposite poles of the possibilities of knowing, the former on the context and the latter on the essence. Before proceeding, it is important to note that the roots of these methodological traditions are tinted by realistic epistemological assumptions. Initially, in theological hermeneutics there was the belief that it was possible to arrive to the true interpretation of the text, and in phenomenology there was the belief that we could arrive to the true essence of a phenomenon (i.e., the fundamental nature of it). Nevertheless, with the influence of postmodernism, hermeneutics opened-up its possibilities of interpretations without forgetting the influences of the context (sharing common ground with social constructionism), and phenomenology began to accept the risk of never being sure of the

universality of the essences and so opening the door to concepts such as personal constructions of a phenomenon (sharing some common ground with radical constructivism).

In psychotherapy research these methodologies have been applied in different ways (McLeod, 2001). One of the best exemplars that uses the hermeneutic methodology is the work of Philip Cushman (1995). In this work he explores several questions such as, “What are psychotherapy’s sociopolitical functions? What part does psychotherapy play in the complicated cultural landscape of the late twentieth-century America? How does psychotherapy either add to or challenge the status quo ?” (p. 1). He does this by critically interpreting many secondary sources (published and thus public texts) placing them within a historical, social and cultural context. Within the phenomenology tradition, exemplars of the application of this methodology to psychotherapy research can be found in the works of the Duquesne school (e.g., Fessler, 1983; Fischer, Eckenrod, Embree, & Jarzynka, 2001), and in more recent works such as Bachelor (1995) and Worthen & McNeil (1996).

Furthermore, there are other methodologies that can be situated in between these two traditions and that offer many alternative exemplars on possible ways of doing research in psychotherapy. Methodologies such as ethnography, grounded theory, interpretative phenomenological analysis, conversation analysis and discourse

analysis are good examples of these. To have a gist of these methodological possibilities I am going to outline them in terms of their general aims and typical procedures.

For instance, ethnography (with its roots in anthropology) aims to understand how a group of people constructs a way of life, by studying these people's actions (e.g., rituals, social practices) typically through fieldwork and participant observation methods. Examples of the application of ethnography to psychotherapy research are sparse (McLeod, 2001), yet it is possible to find good illustrations of this methodology in the works of Bloor, McKeganey and Fonkert (1988) on therapeutic communities, and of Gubrium (1992) on two centres of family therapy.

In the case of grounded theory that emerged within sociology in the 1960's, its aim is to construct theories grounded in evidence through an inductive process (Annells, 1996; Glaser & Strauss, 1967; Strauss & Corbin, 1990). This process is discovery oriented and it is systematically organised from data collection (usually through interviews that are transcribed) to data analysis (coding, constant comparative method, etc.) until the saturation of information allows a good conceptual ordering of the data and ideally the construction of a theory. Examples in psychotherapy research are the works of Frontman and Kunkel (1994), Rennie (1994), Rhodes and colleagues (1994), Bolger (1999) and Shaw (2004).

Interpretative phenomenological analysis (IPA) aims to explore how people make sense of their experiences (as in phenomenology) without forgetting that the researchers are interpreters of those experiences (i.e., interpretative activity). Typically the collection of data is done through semi-structured interviews of one or several people. These interviews are recorded and subsequently transcribed and then intensively and qualitatively analysed by the researcher in order to generate, connect and consolidate themes (J. A. Smith & Osborn, 2003). This more recent methodology has its origin within psychology and some examples of its application to psychotherapy research are Macran, Stiles and Smith (1999), Macleod, Craufurd and Booth (2002), and Schoenberg and Shiloh (2002).

With regards to conversation analysis (CA), its origins lie in ethnomethodology and it aims to understand micro-social processes that happen in naturalistic settings through the analysis of talk interactions (i.e., talk amounts to action). The data are usually recorded conversations that are transcribed with great attention to details (including overlaps, interruptions, emphases, pauses, paralinguistic cues and so on). From these texts, excerpts are selected for intensive analysis. The analytic process goes on through constant comparison between segments searching for similarities and differences having in mind some general structures of conversation such as turn-taking, sequential patterns, lexical choice and

interactional symmetries and asymmetries (Drew, 2003; McLeod, 2001). Good exemplars of CA in psychotherapy research are the works of Gale (1991), Silverman and Peräkylä (Peräkylä, 1995; Peräkylä & Silverman, 1991; D. Silverman, 1997), Edwards (1995), and Madill and colleagues (Madill, Widdicombe, & Barkham, 2001).

Under the name discourse analysis (DA) we can identify at least two trends: discursive analysis from a social constructionist perspective and Foucaultian discourse analysis. Both methodology approaches focus on how language is used to construct reality taking into account the social context within which this discursive activity happens. Nevertheless, the latter emphasises the role of discourse as a cultural facilitator and constrainer of social actions (social-institutional perspective), and the former focuses on more specific interpersonal communication interactions (social-individual perspective). Within the DA of social constructionist nature, the data is usually drawn from naturally occurring situations such as conversations that are recorded and carefully transcribed. These data are analysed by focusing on the internal organization of discourse in order to uncover what the language is doing. The researcher reads and re-reads the transcripts, selects extracts relevant to the research question and then carefully analyses these by exploring context, variability and construction of the discourse. Finally to clarify the analysis, the researcher writes-up a clear and coherent report. Within

the Foucaultian discourse analysis any symbolic system can be taken as data and the analysis undergoes several complex stages from selection of a text, identification of discursive constructions, examination of power relations and so on (Willig, 2003). We can find exemplars of the Foucaultian DA in the works of Parker (1998; 1999b), and of the social constructionist version of DA in works of Madill and Barkham (1997) and Avdi (2005).

It is important to note that there are other possible alternative methodological approaches to psychotherapy research (e.g., narrative analysis, personal construct approach, cooperative inquiry) as well as many hybrid models (e.g., comprehensive process analysis – CPA). Yet for the present survey, the above seems sufficient since the methodologies outlined provide a good illustration of what characterises the alternative paradigms, namely a post-modernistic view of the world in general and science in particular and the acceptance of diversity as a quality that can enrich our scientific knowledge.

1.2.3.3. Some general considerations

When reflecting upon the history of psychotherapy research, I can not help thinking about the old Sufi story of a man looking under the lamp post. According to this tale there was a man crawling and looking for his keys at night. A neighbour, seeing this, approached him and offered some help. After looking unsuccessfully for a long time the neighbour asked the man, “Are you sure that you lost your keys here?”, the man replied “No. I lost my keys over there.” Astonished, the neighbour exclaimed “If you lost your keys over there, why are we looking from them here?” The answer of the man was “Because there is more light here”¹⁰. In many ways psychologists and psychotherapists are carefully researching themes that fall under the light of the already established methodologies, even if this means leaving out aspects that are essential to a good understanding of their clinical work. I think that it is more useful (in spite of being recognisably more difficult) to try to devise new methodologies to explore the dark areas relevant to psychotherapy. The new alternative paradigms of research are representatives of these explorations, and in many ways we can say that they offer many good flashlights.

¹⁰ For other versions of this story see Epstein (2001).

Nevertheless, it is important to end this section by noting three important considerations:

I. The conundrum of the general and the unique in psychotherapy. Already Allport (1962) had called our attention for this dilemma in psychology. He stated that psychologists must be deeply concerned with the human personality (in general) as well as with Bill's personality (in particular). The question is: how can we develop knowledge to explain psychotherapy in general (through abstract theories) as well as knowledge to understand the particular therapeutic process with the particular person in front of us (concrete know-how). Without denying the importance of nomothetic knowledge in certain contexts, for the practitioner it is essential to have idiographic knowledge. For instance, nomothetic research shows us that cognitive therapy is effective for a significant percentage of people with depression, yet the question remains how to help a particular individual that can very well belong to the small (but also significant) percentage of people for whom cognitive therapy does not work.

II. We can see psychotherapy as a social event that involves people in interaction. Thus it makes sense to use methodologies inspired from social sciences to do psychotherapy research. On the other hand (keeping within a double aspect monistic perspective), we can not deny the importance of some theories developed by natural

science that bear great relevance to psychotherapy (e.g. neurosciences).

III. Diversity is a characteristic of post-modernity. Within it the pertinent question is not which methodology is the best one, but rather which can be more useful to explore a particular research question and how it can be complemented by other approaches. However, the same diversity leads to less consensus between colleagues and many times to difficulty in defining a general criteria to assess the validity of a particular research project.

2. PHASE TWO: PRE-EMPTIVE FOCUSING

The range of emergent issues from phase one are thoroughly explored and evaluated by the researcher, often with volunteer and/or colleague involvement, with the aim of focusing on those issues considered crucial. This process of progressive focusing, checking out the pertinence and appropriateness of issues, continues throughout (Banister et al., 1994, p. 144).

2.1. OVERVIEW

When I began this project my initial research proposal was to explore the potentialities of psychotherapy for chronic pain management. Soon after I started reviewing the literature about psychotherapy, pain and research methodologies, I felt the need to focus the aim of this project. Which psychotherapy model should I use? Should I concentrate on a particular type of chronic pain? What would be the best methodology to apply?

From an early stage, I decided to do research that was relevant from a clinical perspective. I did not want to just do another study that could be used as an example of the gap between research and practice. Thus I asked myself, “If you were a clinician doing psychotherapy to manage chronic pain, what should be interesting for you to study?” From that perspective this project started to materialise. If I wanted to study the real thing, that is, psychotherapy in action, I had to find a psychotherapist willing to participate in this demanding project (without the possibility of offering any economical rewards). So I was left with myself as the only psychotherapist available with enough motivation to carry out the study. I already had some basic training in counselling, but I did not feel prepared to undergo the project without further training. Therefore I decided to look for a place where I could get that training. But which model of

psychotherapy should I get training in? As we previously noted, research has shown that in general all psychotherapy models are effective (Asay & Lambert, 1999; Lambert, n.d.; Lambert & Ogles, 2004). Likewise, the Dodo bird verdict “everybody has won and all must have prizes” (Luborsky et al., 1975) remains valid. After decades of sophisticated research there is not a model that can be named as better than any other, and furthermore most research supports that different models work equally well (Lambert & Bergin, 1994; Lambert & Ogles, 2004; Miller et al., 1997). So does this mean that any model goes? Research does not deny or support this claim either. When looking to research on the common curative factors, it can be stated that the role of specific models and techniques has been hyper-valued. Yet the same research shows that focus and structure (given by models and techniques) are essential for a good therapeutic outcome (Miller et al., 1997). Moreover, if we look to specific research about psychotherapy for managing chronic pain, the same conclusions apply. Most of this research supports that psychotherapy is effective to manage chronic pain and that there is no significant differences between models (Malone & Strube, 1988). Sure enough there are already empirical supported treatments (ESTs) to manage chronic pain (Chambless et al., 1998; Woody & Sanderson, 1998). Yet this just means that these models were studied following defined criteria that includes research done within the orthodox

paradigm and using manualised treatments. Nevertheless these studies do not support that other models are not equally effective, and more importantly they do not reveal why or how psychotherapy works and how it can be improved. Bearing all this in mind, it seemed appealing to explore a less studied model that was more difficult to manualise in a discovery oriented way. It was within this context that I started making contacts with the University of Salamanca and the possibility of getting advanced training there in brief therapy of systemic orientation came forward. After some considerations it seemed a good option since:

- I. At a philosophical level, the core assumptions of this model are coherent with the core beliefs of the clinician/researcher.
- II. At a theoretical and technical level (as can be seen in point 2.2.):
 - a. This model offers a concrete structure and the possibility of applying a wide range of different techniques within an interesting framework;
 - b. It is possible to describe this model in a concrete way without resorting to the typical treatment manual format (cf. Kiesler, 1994);
 - c. When looking into research on brief therapy, there was no prior research found on the application of this model

to the management of chronic pain¹¹. Thus it seemed probable that the present study could be a distinct contribution to psychotherapy research;

III. At a pragmatic level:

- a. Because this model is brief by design, it facilitates the planning of a research study within the time limits of a PhD project;
- b. There was the opportunity of getting good training on this model.

IV. Furthermore, this model illustrates an important trend of today's psychotherapy.

Thus I made the pre-emptive decision to study this model of psychotherapy.

The next question was: should I also focus the study on a specific type of chronic pain? As the survey in Phase One showed us, chronic pain is a complex experience that still challenges health professionals. Moreover, it was concluded that the monistic perspective of seeing mind and body as double aspects of the person gives a useful comprehensive framework that invites a multidisciplinary approach to pain management. Consequently, it is important for any health professional to have some knowledge about the other disciplines involved in helping people suffering from chronic pain. Thus, the

¹¹ By searching in the PsycINFO Database.

psychotherapist has to have enough understanding and familiarity with the medical perspective to be able to communicate with doctors and with people who have typically been patients in the medical system for a long time. Within this framework it seemed a good idea to narrow the focus of the present study on a particular type of chronic pain. Then the next decision was which type of chronic pain to chose. After contact with the University Hospital of Salamanca and checking the viability of collaboration with a neurologist there, primary headaches emerged as a good topic. Following more readings and specific training in primary headaches, it was decided to focus the study even further on migraine and tension-type headache. This focusing seemed adequate since:

- I. Migraine and tension-type headache (being primary headaches) are considered diseases in themselves and not a symptom of other medical conditions (as in the case of secondary headaches).
- II. They are the two more common type of primary headaches and while many people who suffer from them can manage these headaches without professional help, there are some that even after undergoing treatment with their GPs and specialised physicians do not find a suitable solution for managing their chronic pain (Mohl, 1998; Rasmussen, 1995).

III. There were enough patients suffering from primary headaches at the outpatient neurological unit at the University Hospital of Salamanca to get volunteers for the present study. This was not surprising considering the literature (Gracia Naya, Marta, Usón, & Carod, 1996; Gracia Naya & Usón Martín, 1997).

Then a question still remained: which methodology should be used to study the potentialities of brief therapy of systemic orientation in the management of primary headaches, namely migraine and tension-type headache? After the survey already done on the different research methodologies, the alternative research paradigms emerged as a natural choice to this study since:

- I. They accept that psychotherapy is a complex socio-psychological phenomena.
- II. They recognise that interpretation plays an essential role in any research endeavour.
- III. They are discovery oriented by nature and suitable for intensive research of a small number of cases, such as clinical ones.

However, from the alternative research paradigms, which methodology should be chosen? From a post-modernistic perspective it cannot be argued that one approach is absolutely better than the other. Each different methodology allows a different insight into the

area to be studied. Thus, maybe it would be better to consider: which methodology would be suitable for exploring the potentialities of psychotherapy in dealing with a particular problem by using as its main data the therapeutic sessions? Traditionally, hermeneutic methodology is used to research publicly accessible texts, which is not the case with psychotherapy's transcripts. Phenomenology usually zooms in on a particular phenomena in order to explore its essence, yet it does not give a strong emphasis to the interactional aspects that can be interesting to study in the present project. Ethnography studies people's actions through fieldwork, but still its participant observation methods are conventionally not so active interventionally as a brief psychotherapist usually is. Grounded theory typically aims to construct a theory, which is too ambitious a project for the present study. Interpretative phenomenological analysis (IPA) could be an interesting option since it aims to explore how people make sense of their experiences without forgetting the interpretative role of the researcher. However (as the traditional phenomenology) IPA does not naturally lend itself to the exploration of interaction patterns. This latter aspect is highly considered by the conversation analysis (CA) that focuses on talk interactions such as the ones that happen in psychotherapy. Nevertheless, this type of research usually demands a transcription of the conversation in an almost microscopic way that becomes daunting when the original data of the psychotherapy is in

Spanish and the analysis has to be reported in English. Moreover, CA usually concentrates on the analysis of turn-taking patterns within very specific situations (e.g., opening and exit of telephone conversations). This characteristic constrains a more holistic analysis of the texts. Finally (and progressively), social constructionist discourse analysis (DA) emerges as a very interesting and viable option since:

- I. It focuses on how language is used to construct a given reality taking into account the social context, which very well suits the research on psychotherapy in action.
- II. It can study specific interpersonal communication interactions that can be drawn from transcripts of recorded therapy sessions.
- III. There is previous research that give exemplars on how this methodology can be applied in the study of psychotherapy in action (e.g., Avdi, 2005; Madill & Barkham, 1997).

Considering these points, the discourse analysis was the methodology chosen to undertake this study.

With the aim of clarifying these pre-emptive focusing decisions, the text is going to turn to a detailed description of: (1) the psychotherapy model chosen (brief therapy of systemic orientation), (2) the chronic pain selected to be studied (primary headaches,

namely migraine and tension-type headache), and (3) the methodology decided on (alternative paradigm – discourse analysis).

2.2. BRIEF PSYCHOTHERAPY OF SYSTEMIC ORIENTATION

“Professional responsibility and client welfare require all psychotherapists to make their guiding models, assumptions, or beliefs as clear and explicit as possible – at least to themselves – because only then can they evaluate, modify, and improve them. Growing demands from society for accountability will increasingly require this.” (Ford & Urban, 1998, p. 11)

Brief therapy of systemic orientation was the model chosen to be studied in its application to the management of a specific type of chronic pain, primary headaches, such as migraine and tension-type headaches. Before proceeding, it is important to clarify the designation chosen: “Brief therapy of systemic orientation”. As it was referred to in point 1.2.1.2., the expression “brief therapy” is in fashion nowadays and embraces a wide range of models of different orientations. Therefore, it was decided to add the qualification “systemic orientation” to identify the present model as belonging to a specific sub-group of brief therapies. Under the influence of the systemic approach, this model is designed to be brief since from the start the therapist and the client agree on a planned time-limited framework for the psychotherapy. Moreover, this model has as guidance many assumptions and principles of the systemic approach.

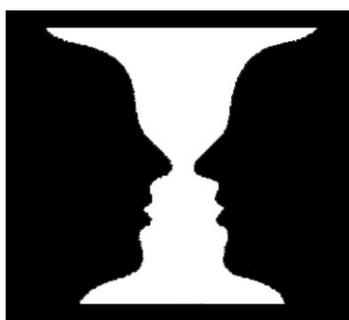
However, it was also decided not to refer to it as “brief systemic therapy” since this would have locked the model too much within the systemic school, limiting the integration of useful principles from other approaches. Consequently, a compromise was reached with the words “systemic orientation”. For the remainder of this section, this model’s characteristics are going to be explicitly stated while describing it using the previously proposed levels of analysis (see Phase One point 1.2.1.1.).

2.2.1. Philosophical level

At a philosophical level, this model has the following assumptions:

I. Ontological assumptions: The human being is a holistic entity that can be seen as manifesting two different aspects, the mental and the physical. In other words, the dualistic perspective which defends the existence of two different and separate principles (mind and body) is rejected. Instead, a monistic perspective which considers that mind and body are double aspects of the same entity is accepted (Misiak, 1961; Santamaría, 2001). Using Laing’s (1960) words:

Lets us consider an equivocal or ambiguous figure:



In this figure, there is one thing on the paper which can be seen as a vase or as two faces turned towards each other. There are not two things on the paper: there is one thing there, but, depending on how it strikes us, we can see two different objects. The relation of the parts to the whole in the one object is quite different from the relation of the parts to the whole in the other. If we describe one of the faces seen we would describe, from top to bottom, a forehead, a nose, an upper lip, a mouth, a chin, and a neck. Although we have described the same line, which, if seen differently, can be one side of a vase, we have not described the side of the vase but the line of a face.

Now, if you are setting opposite me, I can see you as another person like myself; without *you* changing or doing anything different, I can now see you as a complex physical-chemical system, perhaps with its own idiosyncrasies but chemical none the less for that; seen in this way, you are no longer a person but a organism. Expressed in the language of existential phenomenology, the other, as seen as a person or as seen as an organism, is the object of different intentional acts. There is no dualism in the sense of co-existence of two different essences or substances there in the object, psyche and soma; there are two different experiential Gestalts: person and organism. (p. 20-21)

This assumption is fundamental when exploring the potentialities of a psychotherapeutic procedure to help people suffering from pain. Dualistic beliefs limit our understanding of how psychological treatments (done mainly through words) can help physiological problems (that can be explained somatically). If we look in the past, within primitive healing methods the dualism versus monism question did not arise since they did not differentiate clearly between mind and body, and so their treatment procedures were holistic. Only starting with the Greeks and even more clearly after Descartes did dualism became a common view within Western culture. Psychology as a

science and psychotherapy as a scientific procedure emerged within this split.

When describing psychotherapy models, these ontological beliefs are usually not stated explicitly. Still, as noted in Phase One, many approaches have dualistic assumptions (e.g., psychoanalysis), while others have monistic assumptions that strongly emphasize either materialism (e.g., behaviourism) or idealism (e.g. cognitive therapy and many humanistic-existential models). Within the systemic approach there is a shift in the perspective of seeing the human being. As Wahlström (1997a) put it, most psychotherapeutic models see human beings as carrots (i.e., as individual entities with their essence under the surface), yet within the systemic approach people are seen as mushrooms (i.e., there is an individual structure above the surface, still each individual is connected to the others in a network). Thus, the emphasis is placed on the system – how different elements interact with each other (through talk and behaviours), and how these interactions affect its parts. Even when dealing with medical diseases (such as cancer) the attention is placed on how these diseases shape the system (e.g. the family of the patient).

In my view, the monistic assumptions of the present model are coherent with the systemic approach, since human beings are seen not in isolation but as part of a system where they interact with other

human beings. This interaction aspect glides us to the next set of assumptions.

II. Cosmological assumptions: Human beings are seen within a context of interactions, without forgetting that they are also self-organizing open systems. These assumptions are at the core of the systemic approach and are also a historically differentiating characteristic. Likewise the systemic approach openly rejects the linear model of causality, proposing as an alternative the circular causality model. Moreover, the development of the systemic approach (namely through the second cybernetics) embraces even more complex models of causality and sees the individuals and systems that they are part of as self-organised open systems (i.e., sets of organised entities that display emergent properties and are in continual exchanges with other systems).

III. Epistemological assumptions: It is possible to construct and develop scientific theories on psychotherapy that can help to improve its practice, and to research practitioners' works in order to advance theories. This continuous cycling back and forth between theory and practice facilitates the refinement of sound therapeutic models that respect the complexity of human phenomena. The hiatus between research and practice has been recognised in the psychotherapeutic arena for a long time (Wilson & Barkham, 1994). One of the reasons that leads to this situation is the emphasis put on extensive analysis

research (i.e., studies about the performance of groups) based on the orthodox paradigm. This environment discourages intensive analysis research that continuously has to justify its own existence (Safran, Greenberg, & Rice, 1988). However as Allport (1962) said:

Instead of growing impatient with the single case and hastening on to generalization, why should we not grow impatient with our generalizations and hasten to the internal pattern? For one thing we should ask, are our generalizations really relevant to the case we are studying? If so, do they need modification? And in what ways is this individual the asymptote of all our general laws? (p. 407)

Moreover, as it was referred to in Phase One, maybe it is more useful to adopt alternative paradigms that recognise the role of interpretation in any research endeavour. Additionally, if we considered the influence of the systemic approach, we have to hold epistemological assumptions influenced by the constructivism movement, namely by the social constructionism perspective.

IV. Some other core beliefs are: humans are idiosyncratic proactive beings; they are in a continuous process of development; they have more resources than they usually are aware of (unconscious resources); their behaviours manifest different experiential levels (neuro-physiologic, sensitive and intellective) that can be referred to from a cognitive and/or affective perspective (Santos, 1999); and therapy is a relatively small element within the person's life (Budman & Gurman, 1988). These assumptions are not specific of the systemic approach, but do not contradict its core beliefs either. Moreover they

are critical for the psychotherapist undertaking this study and therefore it is important to state them.

2.2.2. Theoretical level

On a theoretical level, the present model has the following conceptualizations regarding:

I. The problem to be treated – chronic pain as in primary headaches such as migraine and tension-type headache. As it was shown in Phase One, pain is a complex experience that can be seen from different complementary perspectives (within a double aspect monism). In the case of chronic or recurrent pain, it becomes a problem that potentially affects individuals in many dimensions of their lives and commonly interferes with their interaction with others. Moreover, chronic pain and all its consequences are often maintained by several vicious cycles. (A more detail description of the particular problem of primary headaches is going to be done in point 2.3.)

II. The treatment – brief psychotherapy of systemic orientation. The present model aims to help people manage their chronic pain by improving their functioning at different levels and by identifying and stopping vicious cycles that aggravate the condition. This can be achieved within a limited number of sessions (less than 10) by

following specific guidelines (as described in 2.2.4.). The overall therapeutic process can be seen as going through several stages:

- a. Definition of therapeutic context;
- b. Creation and maintenance of the therapeutic relationship;
- c. Definition of problems;
- d. Definition of goals;
- e. Specific interventions and homework assignments;
- f. Evaluation and amplification of changes;
- g. Follow-up.

It is important to note that this process is not so linear as the above list might suggest, and to give a more accurate illustration of it please refer to Figure 1.

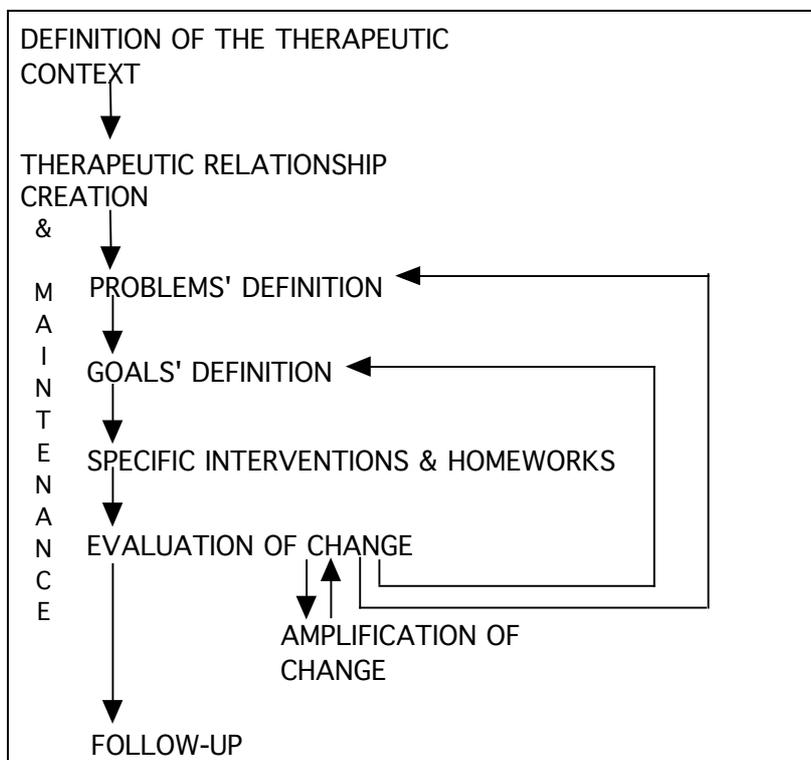


FIGURE 1: Stages of the therapeutic process.

III. Other theoretical aspects: Influenced by some assumptions of the humanistic approach in general and the work of Milton H. Erickson in particular, humans are seen as idiosyncratic proactive beings that should not be forced into fitting into a predefined treatment model (or manual). As Milton H. Erickson said: “Each person is a unique individual. Hence, psychotherapy should be formulated to meet the uniqueness of the individual's needs, rather than tailoring the person to fit the Procrustean bed of a hypothetical theory of human behavior” (Zeig, 1982). This principle which demands the individualization and tailoring of treatment to a specific client renders itself incompatible with a manualised approach that defends the application of the same treatment to a wide range of individuals (usually within a given diagnosis). Moreover the same respect for the idiosyncrasy of a person also contraindicates an assessment based on criteria such as the Diagnosis and Statistical Manual of Mental Disorders (DSM-IV) of the American Psychiatric Association (2000). This point is also clearly taken by the systemic approach that criticises this type of diagnosis because it creates a negative label that can make changing more difficult (Ackerman, 1971; Strong, 1993; Tomm, 1990). These points differentiate this model (of systemic orientation) from other models more influenced by behavioural and cognitive

approaches since they lend themselves to manualisation and accept as a given the DSM diagnosis¹² (e.g., J. S. Beck, 1995).

Furthermore, following the advice of Miller, Duncan and Hubble (1997), the therapist should never forget the four common curative factors found in most psychotherapeutic processes:

- a. Extra-therapeutic factors (i.e., clients and their environment, including chance events, which contribute to 40% of change in therapy);
- b. Therapeutic relationship factors (that contribute to 30% of the variance in psychotherapy outcomes);
- c. Expectancy, hope, and placebo factors (responsible for 15% of the variance in treatment results);
- d. Model and techniques factors (with 15% of the overall impact of psychotherapy).

¹² These are two reasons that make them suitable to the orthodox research that is the base for the ESTs.

2.2.3. Technical level

At a technical level, this model follows the systemic principle that any technique is an intervention, inclusive when its primary aim is assessing. Moreover, it is possible to integrate techniques of different orientations with the condition that their application be within the theoretical and philosophical assumptions previously mentioned. Bearing this in mind, the following examples can be given regarding:

I. Assessment techniques: Questionnaires, scales and diaries can be used to help to define the problem, assess its history and vicious circles of maintenance. Additionally other techniques such as observation, questioning, and summaries can also be used.

II. Intervention techniques: An integration of behavioural (e.g., relaxation exercises), cognitive (e.g., redefinition, reframing, positive connotation) and dynamic techniques (e.g., ego strengthening) can be used, as well as hypnosis when considered appropriate.

III. Other techniques that do not aim primarily either to assess or to intervene are also used. Examples are to be assertive and empathic through clarity of the information given, moderate rhythm of speech, visual contact, para-verbal confirmation signs, empathic gestures, etc.

It is important to remember here that following the Ericksonian influence, therapists must carefully observe the client in order to

collect information that allows them to tailor techniques to suite the specific person in front of them. The respect for the idiosyncrasy of the client is paramount.

2.2.4. Strategic level

The strategic level was defined as a cross level that gives therapists guidelines for managing the therapeutic process through the articulation of theories and techniques into practice. Within this framework it is possible to develop general plans of action for each stage of the therapeutic process. Following the model used by the Navarro Góngora team at the University of Salamanca (Navarro Góngora & Sánchez de Miguel, 1996a, 1996b, 1997), several tables were developed which summarise some of the basic strategies of this model of brief psychotherapy of systemic orientation (see tables 5 to 9).

GOALS	SUB-GOALS	SKILLS	FEEDBACK
<p>To define the therapeutic context</p> <p><u>Elements of the TC:</u></p> <ul style="list-style-type: none"> - Introductions. - Team work. - One-way mirror. - Microphones. - Intercom. - Video. - 1 hour, 2 breaks - Max. 10 interviews. - Fees. - Follow-up - Contracts 	1. To explain the therapeutic context and work conditions.	Be assertive and empathic, through:	1. To ask the client if he/she has understood the conditions of therapy.
	2. To motivate the client to collaborate in therapy.	<ul style="list-style-type: none"> - Clarity of the information given; - Firm and warm voice; - Moderate rhythm of speech; 	2. To solve doubts/problems about the therapeutic context.
	3. To manage the agreement on the conditions of the therapeutic settings.	<ul style="list-style-type: none"> - Eye contact. 	3. To ask explicitly (Yes...) if the client agrees with the therapeutic context.
	4. To evaluate the degree of cooperation of the client.	To observe client's reactions.	4. To observe how the client answers the inquiry about the agreement of the therapeutic context.

TABLE 5: Definition of the therapeutic context.

GOALS	SUB-GOALS	SKILLS		FEEDBACK
		Verbal	No-verbal	
To create and maintain a working relationship (where both the client and the therapist collaborate)	1. Relationship as care/attention: "Listen to the client"	- Questions.	- Visual contact; - Confirmation signs (head movements, sounds such as aha, m-hm...); - Empathic gestures.	Did the client have enough time to explain him/herself and his/her problem and to answer the therapist's questions? Did the client make an explicit comment that he/she told everything important about his/her problems? The therapist can ask if the client has something else to add which he/she thinks is important for the therapist to know about him/her or his/her problem.
	2. Relationship as understanding: "Show concern"	- Questions; - Summaries; - Mirror answers; - Answer completion; - Understanding statements		The therapist must ask or be told explicitly that he/she has understood adequately the client's problems. The therapist must ask the client if he/she understood specific details of his/her problems.
	3. Relationship as positive consideration: "The client has resources"	- Feelings' validation; - Redefinition; - Positive connotation; - Compliments.		The client accepts an idea, assignment or proposition that implies change.

TABLE 6: Creation and maintenance of the therapeutic relationship.

GOALS	SUB-GOALS	SKILLS	FEEDBACK
1. To define the problems.	1. To identify the problems to make them manageable.	Covert: - Generalise or specify. Verbal: - Questions. - Confirmations. - Summarisations.	1. The client confirms that the problems were identified.
	2. To define each problem in concrete terms (to define the base line).	Verbal: • Questions, such as: - How often does it happen? - How intense is it? - When does it happen? - Where does it happen? - In which situations...? - Associate with which behaviours, emotions, and thoughts... - Scales. • Summarise the answers.	2. 1. The client manages to define the problem in concrete terms. 2.2. The client confirms that the summary is correct.
	3. To rank the problems by priorities.	Verbal: - Questions. - Negotiation.	3. To establish a rank of priorities to start working with.
	4. To redefine the problems to make them solvable.	Covert: - To recognise inadequate labels. Verbal: - To ascribe the problem to a changeable cause. - To ascribe the problem to a external element.	4. The client does not reject the redefinitions and he /she can accept them verbally.

TABLE 7: Definition of the problems.

GOALS	SUB-GOALS	SKILLS	FEEDBACK
1. To define the goals.	a. To define the final line (the end-goals of therapy). b. To define minimal change.	Verbal: • Ask about goals: - How could you see that the goal was reached in behaviours, emotions, and thoughts... - In which situation do you realise that you are getting better? - Where... - When... - How often... - How intense... - Scales.	The client gives a clear image of the final goals (in term of behaviours, frequency, intensity, etc.)
	To identify the client's successful strategies.	Verbal: • Questions: - What happens when the problem vanishes or is less intense? • Summarise, stressing the importance of such strategies.	The therapist identifies clearly the successful strategies of the client. The client accepts this summary.
	To get a compromise for change.	Verbal: - In a dilemma: "Do you want to continue living with this prob. or do you wish to fight to overcome it?" - Ask about the client's willingness to do anything to solve the problem.	The client answers affirmatively his/her wish to work through to the solution of the problem.

TABLE 8: Definition of goals.

GOALS	SUB-GOALS	SKILLS	FEEDBACK
1. To evaluate the change.	1.1. To define the actual situation of the problem(s).	Verbal: <ul style="list-style-type: none"> • Questions, such as: - How often does it happen? - How intense is it? - When does it happen? - Where does it happen? - In which situations...? - Associate with which behaviours, emotions, thoughts... - Scales. • Summarise the answers. 	The client manages to define the actual situation in concrete terms.
	1.2. To compare the actual situation with the base-line and the goals.		The client confirms that the summary is correct.
2. To amplify the changes.	2.1. To identify the client's new successful strategies.	Verbal: <ul style="list-style-type: none"> • Questions: - What happens now when the problem vanishes or is less intense? • Summarise, stressing the importance of such strategies. 	The therapist identifies clearly the new successful strategies of the client.
	2.2. To recognize the resources of the client.	Verbal: <ul style="list-style-type: none"> - Feelings' validation; - Redefinition; - Positive connotation; - Compliments. 	The client accepts this summary.
			The client accepts an idea, assignment or proposition that implies change.

TABLE 9: Evaluation and amplification of changes.

2.3. PRIMARY HEADACHES – MIGRAINE AND TENSION HEADACHE

The specific type of chronic pain chosen to be managed through psychotherapy was primary headaches, specifically the two more prevalent types: migraines and tension-type headaches (R. B. Lipton, 1994; Rasmussen, 1995).

If we look back in time we can say that headaches are a type of pain that have affected people since pre-historical times. Some authors speculate that the genus *Homo* became susceptible to headaches because of the upright posture's development (Lance & Goadsby, 1993, p. 1). Others argue that one of the possible reasons for the trepanning operation – found in skulls since the Stone Age – was the attempt to treat headaches (Frommeyer, 1973, p. 341). In ancient Greece, Hippocrates wrote about headaches (Isler & Rose, 2000) and in the Roman world, Galen introduced the term “hemicrania” to describe unilateral headaches (Lance & Goadsby, 1993). Nevertheless, we had to wait until the 19th and 20th centuries for headaches to be considered an important medical problem that attracted many researchers and clinicians with the consequent proliferation of theories and pharmacological treatments (Isler, 1993; Isler & Rose, 2000; Lance & Goadsby, 1993). One of the names that stands out is Harold George Wolff (1898-1962), the American MD who initiated modern research in headaches. He wrote the book that

become a classic, *Headache and other Head Pains* (first published in 1948, 2nd enlarged edition in 1963), and also contributed to the creation one of the first modern classifications of headaches (Blau, 2004; Isler, 1993). Nonetheless it was only in 1988 that an international classification of headaches was published by the International Headache Society (IHS), founded 7 years earlier with the aim of promoting research into causes, mechanism, diagnosis, treatment and other aspects of headaches, as well as to disseminate useful results (International Headache Society, 2002). This diagnostic criteria follows the traditional distinction between primary and secondary headaches. The latter are considered symptoms of other medical conditions (from infections to tumours); the former represent around 90% of all headaches and are considered not secondary headache syndromes but rather independent diseases, as in the case of migraines and tension-type headache (Göbel, 2001) (see Appendix 1 for more details).

The development of this classification was very important since within the medical model, doing a correct diagnosis is seen as essential for prescribing the appropriate treatment and thus for the first time an operational diagnostic criteria for headache disorders was defined where all requirements were quantitatively specified. This system of diagnosis followed the model developed by the American Psychiatric Association in its Diagnostic and Statistical Manual of

Mental Disorders – DSM-IV (American Psychiatric Association, 2000). This fact gives food for thought. The DSM is a diagnostic criteria based on the implicit assumption that a cluster of symptoms reflects an identical somatic pathology that shares a similar aetiology (Bentall, 2003). In other words, just as a pneumonia identified by a clusters of symptoms reflects an inflammation of the lung tissue usually caused by bacteria, a mental disorder such as schizophrenia can also be identified by a specific set of symptoms that reflect a specific pathology and aetiology. Yet in the case of most mental disorders there are no definitive medical test or laboratory findings that can be used to confirm the diagnosis. Furthermore, there is little agreement about pathological mechanisms and even less agreement about aetiology. Therefore a set of symptoms is what is agreed on to identify a mental disorder. A parallel situation happens with primary headache: after a medical examination which excludes a secondary headache disorder, the doctors have to rely on the symptoms of the headache itself to classify it. This type of diagnosis based on symptoms is an agreement by consensus between professionals (since the mechanisms behind the disorders are still being explored in the hope of arriving at a better understanding and treatments).

After understanding why the International Classification of Headache Disorders (ICHD) got its inspiration from the DSM, the

question is: should the criticisms done to the DSM be translated to the ICHD? For instance:

- I. The DSM has been criticised for establishing arbitrary exclusion rules in order to differentiate between categories of disorders (preventing co-morbidities). This criteria goes against much clinical evidence (Bentall, 2003). In the case of the ICHD, it is possible for a person to be diagnosed with more than one headache disorder (e.g., 1.1 Migraine without aura and 2.1 Episodic tension-type headache). Yet there are difficulties in embracing some clinical evidence, such as in the cases of daily headaches since they are a mixture of symptoms from migraine and tension-type headaches – diagnosis categories that the ICHD tries to differentiate (Bigal, Sheftell, Rapoport, Lipton, & Tepper, 2002; Nappi, Granella, Sandrini, & Manzoni, 1999; Olesen, 2000a; Silberstein, Lipton, Solomon, & Mathew, 1994) .
- II. The DSM has been criticised because, even being a criteria established by consensus between mental health professionals, it is many times interpreted as an unequivocal representation of scientific evidence (Gaines, 1992; Tomm, 1990). The same critique can apply to the ICHD when this classification is not seen as a set of

possible working definitions and instead is seen as a perfect nosography: “The Headache’s Bible”.

- III. From edition to edition the DSM (now in its fourth revised edition) has been increasing the number of major diagnostic categories at a scary rate: DSM-I has 94, DSM-II has 137, DSM-III has 163, DSM-III-R has 174 and finally the DSM-V has 201. Are people going crazier? (Bentall, 2003; Kutchins & Kirk, 1997) The 2nd edition of the International Classification of Headache Disorders (ICHD-II) also increased the number of diagnosis categories. This trend should be watched critically.
- IV. The DSM represents a medicalisation of mental health and, by consequence, it props up the use of medication for the treatment of these disorders. This tendency reflects the mind-body split of our Western culture with its actual emphasis on the body. In the case of the ICHD, it is clearly a medical classification that also falls within this same cultural trend. A good illustration of this is the new category added to the ICHD-II: Headache attributed to psychiatric disorders, which has as its diagnosis criteria that it cannot be attributed to another cause and it fulfils a DSM-IV criteria (somatisation or psychotic disorder).

It is important to keep all these points in mind for the remainder of this section where the two more common type of primary headaches are going to be briefly described.

2.3.1. Migraine

Migraine is a primary headache with significant prevalence among the general population and with high socio-economic costs. In adults of Western countries the lifetime prevalence is calculated around 14% and the 1-year prevalence between 10% and 12%, with women being more affected than men (1:2 to 1:3 the ratio of prevalence male:female) (Rasmussen, 1995; Rasmussen & Stewart, 2000). Additionally, the socioeconomic impact of headaches is great in direct costs (i.e., costs sustained by the health care system); indirect costs (i.e., costs due to absenteeism, reduced productivity, etc.); and intangible costs (e.g., pain, suffering, reduction of quality of life), being ranked by the WHO as 19th among diseases causing disability (Michel, 2000; Steiner, 2004).

In 1962, the Ad Hoc Committee on Classification of Headache described migraine as “recurrent attacks of headache, widely varied in intensity, frequency, and duration. The attacks are commonly unilateral in onset; are usually associated with anorexia, and

sometimes with nausea and vomiting; and some are preceded by, or associated with, conspicuous sensory, motor and mood disturbances; and are often familial” (Ad Hoc Committee on Classification of Headache, 1962, p. 717). In 1988 the International Headache Society proposed that migraine disorder should be divided into 7 types (that were reduced to 6 in the second edition published in 2004¹³, see Table 10).

1988	2004
1.1 Migraine without aura	1.1 Migraine without aura
1.2 Migraine with aura	1.2 Migraine with aura
1.3 Ophthalmoplegic migraine	13.17 Ophthalmoplegic ‘migraine’
1.4 Retinal migraine	1.4 Retinal migraine
1.5 Childhood periodic syndromes ...	1.3 Childhood periodic syndromes...
1.6 Complications of migraine	1.5 Complications of migraine
1.7 Migrainous disorder not fulfilling above criteria	1.6 Probable migraine

TABLE 10: Reclassification of migraine disorders
(Headache Classification Subcommittee of the International Headache Society, 2004)

In their classifications they considered the first two types as the more important:

¹³ The *1.3 Ophthalmoplegic migraine* was reclassified as *13.17 Ophthalmoplegic ‘migraine’* because there are new data that suggests that the condition is a recurrent demyelinating neuropathy (Headache Classification Subcommittee of the International Headache Society, 2004).

Another change was the introduction of a new category diagnostic in *Complications of migraine*, *1.5.1 Chronic migraine*, which describes migraines without aura that occurs on more than 15 days per month for more than 3 months (in the absence of medication overuse). It is interesting to note the use of the term chronic in this context. In pain terminology chronic usually is used to describe pain that persists for more than 3 months and not pain that recurs often (≥ 15 d/mo) over more than 3 months as in the present case.

1.1 Migraine without aura (previously known as common migraine) is described as a recurring primary headache disorder lasting 4 to 72 hours per attack, having at least two of the following characteristics: (1) unilateral location, (2) pulsating quality, (3) moderate to severe in pain intensity, (4) aggravated by physical activity (e.g., walking or climbing stairs). Furthermore, it has to be associated with at least one of the following: (1) nausea and/or vomiting, (2) photophobia and phonophobia.

1.2 Migraine with aura (previously known as classic/classical migraine) is described as a recurring primary disorder manifesting itself in attacks of reversible focal neurological symptoms that usually develop gradually over 5 to 20 minutes and lasting less than 1 hour. These aura symptoms are usually of a visual nature such as diffused flickering spots, scintillations, fortifications and scotomas. Yet they can also be sensorial (e.g., paresthesias), motor (e.g., paresis) and speech related (e.g., aphasia) (Olesen & Cutrer, 2000). Typically after the aura there follows a headache with the features of migraine without aura.

The diagnostic category *1.2 Migraine with aura* has been divided into several sub-types depending on the type of aura, headache characteristics and so on. It is important to note that aura is different from premonitory symptoms. The latter are symptoms such as fatigue and irritability that can occur before a migraine attack with or without

aura. The former is a complex of neurological symptoms that has fascinated neurologists for quite some time and it is the main characteristic of the diagnostic 1.2.

For a long time, scientists have tried to explain the pathophysiology of migraine and its many different symptoms (such as premonitory symptoms, aura symptoms, headache, etc.). Nowadays, there is some agreement about its possible mechanisms. It is accepted that both genetic¹⁴ and environmental factors play a role in the predisposition to have migraine, which in conjunction with one or more precipitating factors¹⁵ can produce a specific migraine attack (Olesen & Goadsby, 2000). The premonitory symptoms that can precede the migraine headache by hours to as long as 2 days – such as hyperactivity, irritability, craving for certain foods, feeling tired or cold – are considered as having a hypothalamic origin (Lance, 1993; Zagami & Rasmussen, 2000). The transient neurological symptoms that characterise the migraine with aura are seen as the result of a cortical spreading depression (CSD) (Olesen & Cutrer, 2000). In relation to the migraine headache, a great significance was traditionally given to its vascular aspects (i.e., pulsating quality of the pain, etc.). For instance, Wolff considered that the head pain was the

¹⁴ The genetic predisposition is stronger in the rare sub-type of migraine with aura *familial hemiplegic migraine* that is autosomal dominant (Lance & Goadsby, 1993).

¹⁵ These precipitating factors can be endogenous (e.g., biochemical changes, female hormones, etc.) and exogenous (e.g., psychosocial stress, certain foods and alcoholic drinks, etc.).

outcome of extra-cranial vasodilatation – a theory that lasted until the 1980s (Blau, 2004). Nowadays, migraine headache is seen as the result of a complex pathophysiology where both neural and vascular elements play a role – neurovascular hypothesis (Lance & Goadsby, 1993)¹⁶.

Regarding possible treatments there are several possibilities from pharmacotherapy to non-pharmaceutical therapies. The latter consists mainly of psychological approaches such as psychotherapy; specific procedures, such as relaxation, biofeedback, meditation and hypnosis; and other treatments such as nutritional plans. Regarding pharmacotherapy, it can be either aimed to deal with acute attacks or to be of a prophylactic nature. For a long time analgesics such as acetylsalicylic acid (aspirin) and other NSAIDs (non-steroid anti-inflammatory drugs) have been used to abort migraine attacks, as well as other agents such as lignocaine (lidocaine) and opioids (narcotics). Ergotamine tartrate has been used as a specific anti-migraine drug for more than half a century (since it acts as an agonist of 5-HT receptors). Another ergot derivative, the dihydroergotamine (DHE) has also been commonly used. In recent decades more advanced anti-migraine drugs have appeared – the triptans – showing very positive results with lesser secondary effects (e.g. Sumatriptan, Naratriptan,

¹⁶ See also Burstein (2001).

Zolmitriptan, Rizatriptan, all specific 5-HT₁ agonists). In the preventative arena, drugs such as beta-blockers, tricyclic antidepressants and monoamine oxidase (MAO) inhibitors are used to reduce the frequency and severity of future attacks. When migraine in women is associated with the menstrual cycle, hormonal methods can also be utilised (Lance & Goadsby, 1993).

It is important to note that this synopsis of possible treatments is not exhaustive¹⁷ and in a clinical setting health professionals have to consider the individual patient to decide which are the best treatment strategies (Tfelt-Hasen & Welch, 2000). Usually an interdisciplinary approach (where at least medical and psychological perspectives are taken into account) is the most useful way to help migraine sufferers (Holroyd, 2002).

2.3.2. Tension-Type Headache

Tension-type headache is a group of primary headaches even more prevalent in the general population than migraine. As Olesen (2000b) said: “Tension-type headache is so prevalent that one can say, with some truth, that is more normal to have it than not to have

¹⁷ For a more complete review see Olesen, Tfelt-Hasen, and Welch (2000).

it” (p. 543). It was previously known as tension headache, muscle contraction headache, stress headache and psychogenic headache. Its lifetime prevalence is calculated above 50% and the 1-year prevalence ranges from about 30% to 80% (depending on the studies), affecting women more than men (1:1.3 ration male:female) (Rasmussen, 1995; Rasmussen & Lipton, 2000). Its socio-economic impact is high and yet very difficult to determine due to its high prevalence and the wide range of situations that it encompasses (from a sporadic headache that goes away by itself to a chronic headache that needs specialised care).

In 1988 the International Headache Society described tension-type headache as being typically pressing or tightening in quality, of mild to moderate intensity, bilateral in location and not worsening with routine physical activity. They also suggested that it could be more precisely classified into several types (see Table 11) depending mainly on its frequency. This factor is very important since a tension-type headache that occurs less than once a month can be considered a sporadic hassle that does not need medical attention (being classified by the ICHD-II as: *2.1. Infrequent episodic tension-type headache*). However, if it strikes more often it starts to be a health problem that when occurring 15 or more days per month can be called chronic – becoming a condition very difficult to treat (chronic tension-type headache).

1988	2004
2.1 Episodic tension-type headache	2.1 Infrequent episodic tension-type headache
2.2 Chronic tension-type headache	2.2 Frequent episodic tension-type headache
2.3 Headache of the tension-type not fulfilling above criteria	2.3 Chronic tension-type headache
	2.4 Probable tension-type headache

TABLE 11: Reclassification of tension-type headache
(Headache Classification Subcommittee of the International Headache Society, 2004)

There are many factors involved in the emergence of a tension-type headache, from psychological to physiological ones. Regarding the psychological factors, they were traditionally thought as pathogenic and for that reason tension-type headache was previously known as stress or psychogenic headache. This happened since in clinical practice it is usual to see patients with tension-type headache also showing signs of anxiety, depression and sometimes also hypochondriasis, suppressed anger and feelings of inadequacy (Lance & Goadsby, 1993). Without doubt they are comorbidities, yet it is not known if they coexist because: (1) they share the same risk factors; or (2) one condition causes the other; or (3) by random co-occurrence of different disorders (Merikangas & Rasmussen, 2000). It is also accepted that stress plays a role in tension-type headache, but what role remains the question. Andrasik and Passchier (2000) summarise the psychological mechanisms of tension-type headache as follows:

Accumulating evidence suggests that individuals with tension-type headache report experiencing more everyday mild stressors, judge these daily stressors to have high impact, and may use less successful strategies for coping with daily stressors. Furthermore, when experiencing pain or discomfort, individuals with tension-type headache reveal greater pain sensitivity, reduced pain threshold, increased muscle tenderness, and increased overall arousal. When compared with nonheadache controls, individuals with tension-type headache reveal higher elevations on various psychological dimensions, and these differences are most pronounced for samples drawn from clinic settings. However, direction of causality is uncertain. (p. 602)

Before proceeding, it is important to underline the problems with the term “psychogenic”, which so many times is used as an escape-goat diagnosis, leading to a false dichotomy between mind and body and to the stigmatisation of patients (cf. monism vs. dualism).

In relation to the physiological factors involved in the tension-type headache, probably they are related both to muscular and neurological mechanisms. In relation to the former, tension-type headache was also known as muscle contraction headache due to the tenderness of the muscles that can be observed in a significant percentage of its sufferers. For instance, in a study of a random sample population in Denmark, Jensen and Rasmussen (1996) found that 87% of subjects with chronic tension-type headache and 66% with episodic tension-type headache had present muscular disorder of the pericranial muscle (i.e., increased tenderness) that indicated excessive muscle contraction. Even so, it is difficult to know if it is the muscle contraction that causes the headache, or vice versa (Olesen & Schoenen, 2000). Moreover, it cannot be forgotten that there are

cases not associated with pericranial tenderness (see third digit classification of 2. *Tension-type headache*, in Appendix 1). Therefore, other factors must also be working in the pathophysiology of tension-type headache.

Olesen and Schoenen (2000) proposed a model of tension headache where they try to encompass the dynamic of interactions between different neurological structures and muscular tissue. In their own words:

An acute episode of tension-type headache usually occurs in a perfectly normal person. Thus, the attack may be viewed as a deflection of the normal mechanisms of nociception and central modulation of nociception from myofascial tissues or increased afferent nociceptive input from the tissues. Headache may be brought on by physical stress, such as riding a racing bicycle for the first time, or an nonphysiologic working position. In such cases, increased nociception from strained muscle seems to be the primary cause of the attack. Lack of rest and sleep may also cause headache by similar mechanisms. Increased input in C fibers and in sensitized mechanoreceptive A δ fibers (pain impulses) may cause an increased sensitivity of neurons of the trigeminal tract, and pain then may propagate itself to some extent. Under normal circumstances, such increased nociceptive activation is counteracted by descending antinociceptive systems. The tension-type headache is favored by inadequate activation of the pain-controlling pathways, possibly because of stress, anxiety, and emotional disturbances. The latter may increase muscle tension through the limbic system of muscle control and input from nociceptive muscle afferents. Possibly, these mechanisms also activate the so-called *on cells*, which facilitate nociception in the brainstem (...)

Chronic tension-type headache usually evolves from the episodic form. Prolonged painful input from the periphery may cause central sensitization in the trigeminal system (...) Myofascial factors are thus likely to contribute to the chronification of pain. When the central sensitization becomes sufficiently strong and widespread, the pain becomes chronic as a result of self-perpetuating disturbances in pain perception. A vicious circle may be initiated, and incoming peripheral stimuli may produce an abnormal reaction and probably maintain it long after the primary causative stimulus or stressor has stopped.

Initiating and chronifying mechanism are less clear in tension-type headache unassociated with muscular disorders (2.1.2 and 2.2.2). In these rare patients, the central dysfunction might be the only abnormality. (p. 617)

In relation to possible treatments, as in the case of migraines, there are several possibilities from pharmaceutical to non-pharmaceutical therapies. If a person suffers from sporadic episodic tension-type headache, probably they never go to a doctor regarding their headaches and solve the individual attacks by taking over-the-counter (OTC) medication (e.g., aspirin, paracetamol, etc.). If the headache starts to be more frequent, overuse of the OTC medication might occur, which can aggravate the headache problem – analgesic rebound headache (Peatfield & Edmeads, 2000).

Both episodic and chronic tension-type headache can benefit from non-pharmacological treatments such as psychological management (e.g., psychotherapy), physiological interventions (e.g., relaxation, EMG biofeedback, cervical traction or manipulation) and other procedures such as hypnosis, acupuncture, dental treatments and so on (Carlsson & Jensen, 2000; Graff-Radford & Forssell, 2000; Holroyd & Martin, 2000; Lance & Goadsby, 1993). Nevertheless, it is usual that only in more serious cases, people find the motivations to go through these potentially helpful procedures. Regarding the pharmacological options, there are drugs aimed at aborting individual attacks, while others attempt to reduce the frequency of future attacks. The acute pharmacotherapy of tension-type headache is based mainly in simple analgesics and non-steroid anti-inflammatory drugs (NSAIDs), such as acetylsalicylic acid (aspirin), acetaminophen

(paracetamol), ibuprofen, naproxen sodium, ketoprofen and so on. These analgesics and NSAIDs can be also found in combination with other drugs to enhance their effects and reduce their side effects (Mathew & Schoenen, 2000). Nevertheless, because most of these drugs are sold over-the-counter, many tension-type headache sufferers do not take an adequate dosage (thus not getting their headache relieved) or overusing them (which can lead to gastrointestinal problems and even to more frequent headaches). Therefore, medical advice should be taken, principally when the headaches becomes more frequent.

If a person suffers from chronic tension-type headache, prophylactic pharmacotherapy can be prescribed. Doctors can choose between tricyclic antidepressants (e.g., amitriptyline), muscle relaxants (e.g., tizanidine) and miscellaneous agents. Amitriptyline is usually the first choice, since it has been widely studied showing good analgesic effect (that is independent of its antidepressant action). Nevertheless, some people have problems with their side effects (dry mouth, drowsiness, dizziness, weight gain, etc.), or have contraindications to take them (e.g., heart block, arrhythmias, etc.). It is usually recommended that the prophylactic agents should be gradually discontinued after 6 months of treatment. After withdrawal some patients maintain improvement while others relapse.

Chronic tension-type headache is a disorder that is very difficult to treat, and to improve the chances of success a combination of pharmacotherapy and non-pharmacological treatments is the best approach (Mathew & Bendtsen, 2000).

2.3.3. Some General Considerations

As we can see, headaches are generally seen from the medical perspective. Yet, in spite of great advances in the neuro-physiological understanding of headaches and new drug treatments, there are still many people that cannot find relief (Mohl, 1998). Many of these suffer from migraine and tension-type headache in their more frequent and/or severe forms. Furthermore, there are cases of patients who do not want to use medical drugs to manage their headaches, or who have unpleasant side effects from the drugs, or even who cannot take the drugs due to contra-indications (e.g., pregnancy). For all these and other reasons, health professionals recognise that more treatment options are needed and that a multidisciplinary approach can be very useful. This context justifies the pertinence of research on the potentialities of brief psychotherapy for the managing of primary headaches.

2.4. ALTERNATIVE RESEARCH PARADIGM - DISCOURSE ANALYSIS

As was referred to previously, discourse analysis (DA hereafter) is a term used to designate several methodological trends. In Phase One, two of these were briefly described: DA from a social constructionist perspective and Foucaultian DA. Others could have been identified, such as: (1) linguistic DA which focuses on the relationship between components of spoken discourse (e.g., Brown & Yule, 1983; Coulthard, 1977), (2) cognitive psychology DA which focuses on mental scripts and cognitive schemas of discourse (e.g., Van Dijk, 1985; Van Dijk & Kintch, 1983), and (3) critical DA which can be defined as a deconstructive reading and interpretation of a problem or text (e.g., Fairclough, 1995, 2005). Some authors also use the designation historical DA to refer to Foucaultian DA (e.g., Peräkylä, 2005). Others argue that there is considerable overlap between several DA trends (Wetherell, 1998). And, to complicate the picture, sometimes the expression “discourse analysis” is used as an inclusive designation of several approaches that analyse talk or text (Potter, 2004; Wooffitt, 2005). This panorama can be confusing, yet it is a good example of the fragmentation of post-modernity that at times can go on *ad nauseam*.

Keeping this diversity in mind and in order to avoid misunderstandings, it is important to state that the approach chosen

for the present research is DA from a social constructionist perspective as in the work of Potter and Wetherell (1987). This approach is also known as discursive psychology (DP) in order to differentiate it from the other trends (Potter, 2004; Willig, 2003).

2.4.1. Social Constructionist Discourse Analysis

During the 20th century, language started to be looked at with different eyes. Progressively distinct approaches began to study how people used language to accomplish certain tasks within a given social context. This turn to discourse has important foundations in semiology, speech act theory and ethnomethodology (Potter & Wetherell, 1987). Semiology emerged in linguistics with Ferdinand de Saussure (1857-1913) as the study of signs and symbols in human communication. In this discipline, Saussure considered it essential to differentiate between signifier (a sign such as a word or phrase uttered) and signified (a concept, etc.). More importantly, he recognised the arbitrariness of their association. For example, the word “headache” can be considered the signifier of a set of symptoms that form a concept, yet this signified (set of symptoms) can be linked to another signifier, such as “dolor de cabeza”. The signifier and the signified are not intrinsically linked, but are in many ways a social

construction. The speech act theory was developed by John L. Austin (1975) within the philosophy of language. According to this theory, language is seen as a human practice which simultaneously describes and does things. This latter dimension of words as actions (that had been undervalued for a long time in philosophy) is an essential concept. Moreover, Austin also calls our attention to how social context influences language uses. These dimensions are further explored in sociology by the ethnomethodology approach founded by Harold Garfinkel (1967). This approach studies how people make sense of their social worlds, and one of its focuses is on how language is used in everyday situations. Within this framework, quotidian discourses are seen as social actions that deserve to be researched. These types of situations are further explored by one of the offspring of ethnomethodology – conversation analysis, developed initially by Harvey Sacks (1992).

These foundations lay the grounds for social constructionist DA. However, before proceeding to describe some of the typical stages of the application of this methodology, it is important to summarise several important assumptions of social constructionism.

As was referred to in Phase One, during the 20th century there was an epistemological movement that reflected on the limits of knowledge and started to raised doubts about the possibility of true objectivism as defended by realism. From this movement two parallel

offspring emerged: constructivism and social constructionism. Both can be characterised as postmodern epistemologies that call our attention to the construction processes involved in knowledge. Yet, constructivism emphasises the role of the individual subject in these processes, while social constructionism stresses the role of a group of people (who share a cultural, discursive and linguistic context) in their interactional constructions of knowledge. Within this contextualization it is possible to identify seven assumptions that characterise social constructionism (Burr, 2003):

- I. Anti-essentialism – there are no true essences inside things or people that can be uncovered to explain them.
- II. Questioning realism – knowledge is seen as a social construction, thus it cannot be taken as a set of objective facts.
- III. Historical and cultural specificity of knowledge – knowledge is not a static achievement, but rather is a dynamic endeavour framed by a particular time in history and a specific culture.
- IV. Language as a pre-condition for thought – the ways people think and understand the world are acquired and developed through language interactions.
- V. Language as a form of social action – people construct their worlds through language.

- VI. A focus on interaction and social practices – social practices and interactions between people are essential to understand how people live their lives and understand their world.
- VII. A focus on process – to understand how certain phenomena or knowledge are achieved by people, attention must be placed more on processes than on structures. Knowledge is something that people do together.

These assumptions of social constructionism have influenced social psychology, psychology and psychotherapy. For instance: in social psychology, they allow psychologists to go beyond the framework of attitudes and behaviours (Potter & Wetherell, 1987); in psychology, they gave arguments for criticising cognitivism (Willig, 2003), they support the development of critical psychology (Parker, 1999a) and the emergence of discourse psychology (Harré, 1995); and in the case of psychotherapy, they frame the developments of the systemic approach (Wahlström, 1997a) and the raising of models such as narrative therapies (White & Epsom, 1990). Nevertheless for the present work, it is important to underline that the above assumptions greatly influenced the particular research methodology in consideration here – social constructivism DA. Bearing this in mind, let us proceed to the description of the typical stepping stones of the

application of this methodology. These steps, as presented here, are based on the description of DA by several authors (Billig, 1997; Harper, 2006; Potter & Wetherell, 1987; Willig, 2003):

Step One – Decide on a topic of research: A research project usually starts with the decision to study a specific topic. From there a literature review is undertaken on the topic chosen and on the methodology to be used (in the present case DA).

Step Two – Research questions: The typical research questions in DA are about discourse construction and function (e.g., how are accounts constructed? What are people doing with their constructions?). It is important to note that DA (as with other qualitative methodologies) starts by exploring the topic of research with open-ended questions rather than with clearly structured hypotheses (as it is common in orthodox research paradigm). These research questions mature and become more focussed with the development of the research project, particularly within the stages of data analysis.

Step Three – Decide on the type of data to study: Once the topic to be researched is chosen and general DA questions emerge, researchers have to decide on the type of data that can be used to proceed with their inquiry. Typically DA explores naturally occurring talk recorded from a variety of situations, yet other materials, such as printed texts, TV programs and so on, can also be used.

Step Four – Data collection: Since DA gives preference to naturalistic settings, practical considerations are always present when collecting the discourse to be analysed. It is also important to note that because DA is an intensive research methodology, usually only a small number of talk interactions or written texts are needed.

Step Five – Transcription of the recordings: If the data is initially recorded material (audio or video), it has to go through this step. For obtaining a good transcription, it is important to listen to the recordings carefully several times, to transcribe them following a specific set of rules (that can vary in detail depending on the research aims) and to check the produced written texts against the original recordings. This process is very time consuming but it is an important step that allows researchers to immerse themselves in the data.

Step Six – Read and re-read data and start to select extracts: After having the transcriptions (or other written material), the researcher should read the material several times and start to develop inductive and tentative themes that allow the selection and indexation of discourse extracts to be intensively analysed.

Step Seven – Intensive analysis of the extract selected: The discourse extracts selected must be carefully analysed by exploring contexts, variability, construction and functions. The tentative themes are explored against the data and further elaborated or re-conceptualised.

Step Eight – Writing and re-writing a clear and coherent report: The writing of the report is seen as an opportunity for checking the analysis and to give directions to further analysis and therefore to the re-writing of the report. This phase is a circular process that involves continued writing and re-writing, reading and re-reading, analysing and reanalysing the data until a version of the report is produced that does not dissatisfy the researchers and their peers.

Step Nine – Validations: The validity of the research conclusions can be supported by checking: (1) the coherence of the report produced, (2) the generation of further research ideas, and (3) the fruitfulness of the conclusions achieved. This leads to the final step.

Step Ten – Implications and Applications: What are the implications of the conclusions for the area researched? Are there practical applications of the specific DA undertaken? This step is very important in psychotherapy research, since it forces researchers to bring their conclusions and conceptualizations back to the clinical world, bridging the gap between research and practice.

It is important to finish this description by noting that many times these steps work as dance steps (we have to go back and forth following the music that keeps changing). Another image could also be used which compares these steps to road signs that help travellers proceed to their destinations. In the case of the present research project, they fulfilled both these functions.

2.4.2. Some General Considerations

Before proceeding, it is important to note that the DA approach selected is coherent with some important assumptions of the therapy model to be studied. For instance, the system orientation of the model of brief therapy chosen emphasises how people interact with each other through talk and behaviour, how it is important to question the linear realistic thinking, and how it is central to recognise the role of interpretation in knowledge. As we have seen above, identical assumptions are taken by the DA trend described. This is a helpful consequence of both the therapeutic model and the research methodology being influenced by the social constructivism movement.

3. PHASE THREE: CHOICE

The work is brought into sharper focus. The research questions are chosen by either hypothesizing or proposing issues or questions that can be explored. The whole process is one of clarification, of ensuring that the material gathered is grounded in participants' experience, not merely in theoretical background (Banister et al., 1994, p. 144).

At the beginning of this project, I had the general aim of exploring the potentialities of psychotherapy for managing chronic pain. Soon, I realised that I needed to focus on a specific psychotherapy model and on a particular type of chronic pain. As it was explained in Phase Two, I took the pre-emptive decision of choosing brief psychotherapy of systemic orientation as the model to be studied, and primary headaches (namely migraine and tension-type headache) as the chronic pain to be managed. Furthermore, because I wanted to do this research from a clinical perspective, I decided to have clinical cases as the raw data. These cases could be audio recorded and their sessions transcribed for posterior analysis. With regards to the research methodology, social constructionist discourse analysis (DA hereafter) emerged as a good candidate for the job. Within this context, the initial research aim of exploring the potentialities of psychotherapy for managing chronic pain evolved to the more focused aim of exploring the potentialities of brief psychotherapy of systemic orientation for managing the two more prevalent types of primary headache (migraine and tension-type headache) through the discourse analysis of the transcripts of clinical cases. After these decisions were made, the project materialised into the particular study here before you.

3.1. SELECTION OF CASES

As I explained in Phase Two, several reasons led to the decision of getting training in brief psychotherapy of systemic orientation at the University of Salamanca, Spain. This training in psychotherapy had three components¹⁸:

- I. A broad theoretical instruction based on participation in several psychotherapy courses given by the University of Salamanca and the European Institute of Psychotherapy.
- II. A personal psychotherapeutic experience based on personal development courses (mainly in group format).
- III. A practical dimension achieved through participation (as a therapeutic team member) in live psychotherapy sessions; the review of recorded sessions of systemic brief therapy; and afterwards, the direct instruction and supervision (using a one-way mirror room) of individual therapy cases.

Afterwards and under the local supervision of José Navarro Góngora, PhD, and the continuous guidance of the director of studies, Peter J. Hawkins, PhD, I started to see clients suffering from primary headaches for the present study. These cases were referred to us by

¹⁸ It is important to note that this training follows the general guidelines of the European Association for Psychotherapy (see <http://www.europsyche.org/eap>).

a neurologist at the University of Salamanca Hospital (Dr. Jesus Cacho, MD). This neurologist, when seeing adult patients¹⁹ (at the outpatient neurology unit) complaining about chronic primary headaches, informed them about the present study. In a first phase (with the consent of the patients) I saw their medical files and I contacted them by phone (four people were referred to me and contacted). In a second phase, the neurologist gave the patients a card with my name and phone number. The patients, then, contacted me to make an appointment (twelve people were referred to me and ten contacted me). In the first phone conversation, I informed them that since the therapy was part of a research program the sessions were free of charge.

During the first phase I saw four cases:

CASE 1 (Male, 56 years old, construction worker, single): He was referred to me with a long history of common migraine (*1.1 Migraine without aura*). The psychotherapy lasted 4 sessions. After the last session, two phone follow-ups were made that confirmed improvement.

CASE 2 (Female, 41 years old, housewife, married with two children): She was referred to me with strange tingling sensations on the skin, perceived as pins and needles.

¹⁹ 18 years or older.

The psychotherapy lasted 7 sessions with modest improvement.

CASE 3 (Female, 53 years old, housewife, married): She was referred to me with tension headaches and came only to the first session.

CASE 4 (Female, 29 years old, waitress, married): She was referred to me with tension headaches. The psychotherapy lasted 3 sessions. Afterwards she was referred to marital therapy (at her request).

As it can be noted, one of the people referred to me (Case 2) did not have a primary headache, yet she was accepted into psychotherapy. This decision was taken in order to avoid one of the pitfalls of randomised clinical trials, which is the tendency to treat people as objects (i.e., if subjects do not fit a given characteristic, they can be easily discharged). In the present project, I decided that from the moment that the neurologist gave hope to the patient that psychotherapy could help and referred the patient to me, I had the ethical commitment to try to help that person (by either being their therapist or by referring them to another specialist – as it happened in Case 4). From the beginning, I realised that I was going to see cases which could not be used as data for the present research project – the aim was to have enough cases to be able to select from.

Consequently, in order to have more potential cases for this study, during the second phase a baseline interview was introduced where the headache problem was explored to confirm that the person suffered from migraine and/or tension-type headache for more than one year and that this was the main problem that the person wished to manage through therapy. When these criteria were not fulfilled, the person was referred to the therapy that better fit his or her needs. So, from the ten people that contacted me by phone in the second phase, nine came to the baseline interview:

CASE 5 (Female, 72 years old, housewife, widow): She was referred to me with tension headache and vertigo. During the baseline interview it became apparent that the main problem for the client was not the headaches but rather bereavement issues. Therefore this client was guided to appropriate psychotherapy.

CASE 6 (Female, 40 years old, housewife, married): She was referred to me with tension headache. During the baseline interview the diagnosis of *2.2 Chronic tension-type headache* (2.3 in the ICHD-II) was confirmed. She suffered from this type of headache for more than 10 years, having some periods better than others. She came to 8 psychotherapy sessions. However, she did not come to the follow-up interview.

CASE 7 (Female 40 years old, phone operator, married): She was referred with tension headache. During the baseline interview it became apparent that the main problem for the client was not the headaches but rather a buzzing in her ear and generalised anxiety. Therefore this client was guided to appropriate psychotherapy.

CASE 8 (Female, 28 years old, housewife, married): She was referred to me with tension headache. During the baseline interview it became apparent that there were other major problems for the client besides the headaches (e.g., stress of being the main care-giver of a close relative). Therefore this client was guided to appropriate psychotherapy.

CASE 9 (Female, 44 years old, housewife, married): She was referred to me with tension headache and during the baseline interview the diagnosis of *2. Tension-type headache* was confirmed. Nevertheless, it also became apparent that the main problem for the client was not the headaches but rather insomnia and anxiety. Therefore this client was referred to psychotherapy to help her directly with these problems.

CASE 10 (Male, 22 years old, student, single): He was referred to me with tension headache. During the baseline

interview the diagnosis of *2. Tension-type headache* was confirmed. He suffered from this type of headache for more than 1 year. He went through 4 sessions of psychotherapy, during which another type of primary headache – *3. Cluster headache* – was discerned. These headaches were considered by the client much more disturbing than the tension-type headaches.

CASE 11 (Male, 39 years old, businessman, married): He was referred to me with possible tension headache. During the baseline interview it was difficult to confirm any diagnosis since in the previous three months he did not have any headaches. He only came to one psychotherapy session.

CASE 12 (Female, 37 years old, housewife, married): She was referred to me with tension headache. During the baseline interview enough data emerged to confirm the diagnosis of *2.2 Chronic tension-type headache*, as well as the occurrence of also *1. Migraine without aura*. She suffered from these headaches for more than 7 years. She completed 6 psychotherapeutic sessions and a follow-up interview.

CASE 13 (Female, 31 years old, baby-sitter, single): She was referred to me with common migraine. During the

baseline interview it was found that she had only had three migraine attacks which first started 6 month ago. Thus, even though her headache characteristics lead to the diagnosis of *1.1 Migraine without aura*, it was too soon to classify her headache as chronic. Nevertheless, she did three psychotherapy sessions for helping with possible future migraine attacks.

From this pool of cases, two were selected for intensive study: Case 1 and 12. Case 1 was selected because this was a person suffering from migraine (*1.1 Migraine without aura*) who came to four sessions of psychotherapy and participated in the follow-ups, showing some improvement. Case 12 was selected because this was a person suffering from tension-type headache (complicated by migraine without aura) who went through 6 sessions of psychotherapy and a follow-up interview that revealed significant improvement. To have the gist of these cases, I am going to summarise them around the headache diagnosis²⁰ and the several stages of the therapeutic process as outlined in Phase Two (see Fig. 1).

²⁰ It is important to note that the present research used the 1988 ICHD (see Appendix 1) because this clinical work was done previous to the publication of the second edition (ICHD-II).

3.1.1. Description of the Cases Selected

In order to preserve the confidentiality of the clients' identity, their names were replaced by two very common ones in Spain: Pepe and Carmen.

3.1.1.1. Pepe's Case

Pepe was a single 56 year old male, who was a construction worker. He had a history of more than 40 years of headache attacks, where the headaches lasted several days, were usually unilateral in location (left side), described as strong in intensity (aggravated by physical effort) and as having a pulsating quality. During the headaches he usually felt like vomiting. The headache onset was unexpected, without any warning signs. If he drank alcohol or was in a place full of cigarette smoke he often developed an attack. His mother also suffered from headaches. The neurological examinations did not suggest any other disorder, thus the diagnosis of *1.1 Migraine without aura* (previously called common migraine) was confirmed.

Pepe's psychotherapy lasted 4 sessions during a 3 month period²¹. In relation to the stages of the therapeutic process the following can be said:

A. Definition of therapeutic context (see Table 5): The first session started with the definition of the therapeutic context, explaining some general work conditions such as:

- Length of the therapy: it would have a ceiling of ten sessions, yet if the therapeutic aims were reached before that or if either client (or therapeutic team) found it convenient, it would not be necessary to complete all ten sessions.
- Recording of the sessions: the client was informed about and authorised these recordings and their utilisation for research purposes (with the condition of anonymity).
- Follow-up: the client was asked to commit to be available for a follow-up after finishing the therapy.

The client explicitly accepted these conditions.

B. Creation and maintenance of the therapeutic relationship (see Table 6): With the aim of creating a working relationship starting with the first session, the therapist on a no-verbal level maintained eye contact, gave confirmation signs by head movements, sounds as "aha", "m-hm" and empathic gestures such as smiles when the client

²¹ For a more detailed description of the sessions see Appendix 2.

did so. On the verbal level during most of the first session, the therapist asked about the problem that brought the client to therapy. The therapist also explored other related problems that affected the client's life. From time to time the therapist summarised what was said by the client in order to check her understanding of the problem and its details. The therapist also gave some mirror answers (e.g., C: The headaches goes away, little by little; T: goes away slowly) and completion of answers (e.g., C: I feel like a tras, tras, tras; T: As if your heart was beating there inside your head) with the aim of showing understanding. The therapist also asked about the client's spontaneous strategies to solve his problems, inquired about his hobbies and validated them. In retrospect in the first session, the client had enough time to explain himself and his problems and to answer the therapist's questions. Yet, the therapist did not explicitly ask if the client had something more to add (which he thought was important about his problem); neither did the client say explicitly that everything important about his problem was told. In the following sessions the same strategies were used to maintain a good therapeutic relationship, which can be argued was obtained since the client agreed with the exercises proposed and did the homework assignments as requested.

C. Definition of problems (see Table 7): From the first session the therapist asked questions (from general ones to specific ones) in

order to have a precise idea of the problem to be treated (e.g., the migraine history and characteristics were detailed in both the first and second sessions). A pain scale from 0 to 10 (0 no pain, 10 unbearable pain) was used to determine the intensity of the migraine headache episodes (in the first session, the client said that his migraine headache was not a ten, but very high). Since the client could not remember with certainty the last time he had a migraine headache, an agreement was made for him to register the attacks. Other problems also emerged during the therapy, namely the client's nervousness as a factor that could magnify his headaches, his stomach problems that made the intake of analgesics problematic and his cervical pain aggravated by his job as a construction worker.

D. Definition of goals (see Table 8): The general therapeutic goal of helping the client to manage his headaches was present since the introduction of the therapy. During the second session the therapist and the client agreed that progress would be made if a reduction in the headache frequency, intensity and duration happened. Additionally this reduction had to be enough to allow the client to have his normal daily activities and to be maintained through time. In the first session the client said that he would feel able to have his normal life if the pain was around 3 or 4 (in the 0 to 10 scale of pain intensity).

E. Specific interventions and homework assignments: The therapist and client agreed on the type of techniques to be tried first

(since the client did not feel comfortable with the use of clinical hypnosis). During the first session, the therapist introduced to the client an imagination exercise to be used to manage his migraine attacks (named as “the fist exercise”). In the second session a relaxation exercise based on Jacobson’s progressive relaxation technique was practiced. This exercise was given as a homework assignment to be done daily in order to manage the client’s nervousness and tension (that aggravated the migraine episodes).

F. Evaluation and amplification of change (see Table 9): The second, third and fourth sessions started with the therapist asking the client about what had happened since the last meeting. The changes that were reported in the third and fourth sessions were explored in order to identify successful strategies. In the last session the client placed his migraine headache around a 2 or 3 on the pain intensity scale and said that he felt satisfied with therapy if the situation was maintained as it was.

G. Follow-up: Two short and unstructured follow-ups were done by telephone, confirming the maintenance of the improvements.

It can be argued that this particular psychotherapeutic process followed the general guidelines that were supposed to orient it, which makes this case a good example of how brief psychotherapy of systemic orientation can be used for managing primary headaches. More specifically, this psychotherapy (through the use of specific

exercises) helped the client to manage his migraine to a certain extent (e.g., the client clearly said that doing the fist exercise helped him to manage his migraine headache). Nevertheless, other factors such as changing jobs also played an important role in the outcome of the therapy (this extra-therapeutic factor was integrated and used during the therapeutic process as advocated by the general model).

3.1.1.2. Carmen's Case

Carmen was a married 37 year old woman, mother of two boys, who went to a baseline interview, had 6 sessions of brief psychotherapy²² (in less than 3 months) and participated in a follow-up interview. She entered psychotherapy complaining of having daily headaches that could be mild to severe. On most days the headaches were mild, worsening through the day. She also felt her neck area usually very tense with a sensation of weight and pressure. Her headaches fitted the description of the diagnosis of *2.2. Chronic tension-type headache* (see Appendix 1), since:

- A. In the past 6 months she had had these headaches almost everyday.

²² For a detailed description of the sessions see Appendix 3.

B. These headaches were described as:

1. Pressing in quality;
2. Mild to moderate in intensity; and
3. Bilateral in location.

C. With these mild to moderate headaches no vomit episodes occurred, yet when they intensified nausea was usually present.

D. The history, physical and neurological examination did not suggest other disorders that could justify the above symptoms.

On the other hand, the more severe headache crises had different characteristics that corresponded to the description of *1.1 Migraine without aura*, since:

A. The client had more than 5 of these type of headache episodes;

B. These headaches typically lasted for several days;

C. The headaches within these crises:

1. Sometimes started unilaterally;
3. Were severe in intensity; and
4. Aggravated by routine physical activity.

D. With these headaches, the client suffered severe nausea and sometimes had vomiting episodes.

E. Her history and her physical and neurological examinations did not suggest other disorders that could justify the above symptoms.

She said that her headache problems started 7 years previously, having several bad periods, relieved by some headache free periods (see Figure 2). The last bad period started 6 months before the first psychotherapy session.

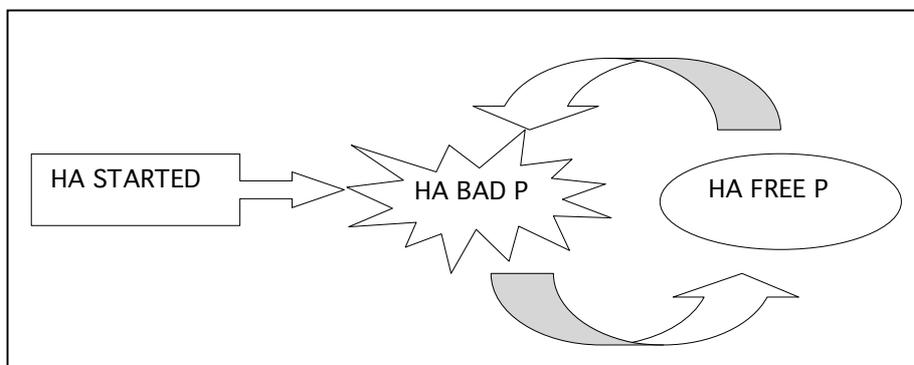


FIGURE 2: Graphic representation of Carmen's headache history (HA: Headaches; HA BAD P: Headache bad period; HA FREE P: Headache free period).

She was also undergoing pharmacotherapy: a daily dose at night time of 12.5 mg of Amitriptyline – a tricyclic antidepressant that can be used as a prophylactic agent in chronic tension-type headache (see Phase Two); and 5 mg of Medazepam – an anxiolytic.

In relation to the stages of the therapeutic process the following can be said:

A. Definition of the therapeutic context (see Table 5): The first session started with the therapist explaining the therapeutic context and the general work conditions. The client explicitly accepted these

conditions and authorised the recording of the sessions for research purposes.

B. Creation and maintenance of the therapeutic relationship (see Table 6): With the aim of creating a good working relationship, from the first session the therapist on a non-verbal level maintained eye contact, gave confirmation signals by head movements; on a para-verbal level the therapist used confirmation sounds such as m-hm and a-ha; and on a verbal level the therapist expressed care, concern and whenever possible underlined the clients resources. During the length of the therapy the client had time to express herself, and several times asked for clarifications and confirmed the therapist's summaries, as well as accepted ideas and propositions that implied change.

C. Definition of the problems (see Table 7): During the first sessions the therapist tried to identify the main problems that were affecting the client. The headache problem was the object of intensive questioning in order to confirm the information gathered during the baseline interview and to have a more clear picture of it. Other problems also started to emerge, such as the client's desperation with her headaches, her low self-esteem in general, the paralysis of her mother due to a stroke and a sense of loss of control. The definition of the problems continued to be a significant part of the next two sessions, where new problems emerged (e.g., her insomnia, high

anxiety, fear, a feeling of unfulfilment) and the problems previously identified were explored further. These problems were defined in concrete terms as much as possible, and a tentative hierarchy of the main ones was established (for instance, it became evident that a useful first step would be to help the client to manage her anxiety). Nevertheless, looking in retrospect, a more clear and explicit negotiation of the problems' ranking could have been done.

D. Definition of goals (see Table 8): Headache management was the implicit main aim of the psychotherapy and from the start, ways to achieve this general goal were proposed and rehearsed. In the first half of the therapy, the client gave a clear image of what would be considered as a successful headache management: She would consider it a significant improvement if she could control her nausea and the more severe headaches (even if she remained having frequent mild headaches). The importance of being able to relax, to have more self-control of her emotions and thoughts, to see life situations from a different (more positive) perspective and to recover her vitality also emerged as desired aims and important steps towards an overall change. The client also demonstrated motivation by following the therapeutic indications, yet she also showed disappointment for not having immediate results. During the therapy, successful strategies were identified and accepted as important changes by the client.

Nevertheless, it is important to note that there was a back and forth between definition of problems and definition of aims. This is a typical happening in therapy but in the present case (and in retrospect) could have been managed better by the therapist.

E. Specific interventions and homework assignments: Since the first session, the therapist looked for exceptions in the client's life (where or when the headache was not a problem), identified the client's resources, used rationalisations and analogies in a psycho-educative way and utilised redefinitions and reframings. To achieve the specific goal of managing the headaches, several relaxation exercises were rehearsed in the sessions and given as homework to practice (including muscular relaxation exercises, creative imagination exercises and biofeedback exercise using a skin electro-conductivity apparatus). Other activities such as taking a break after lunch, enjoying hot showers or massages and practicing yoga, were also encouraged. With the aim of increasing self-awareness, controlling the cognitive anxiety and changing perspective, a log of thinking patterns was suggested as an assignment.

F. Evaluation and amplification of change (see Table 9): From the second session onwards the therapist started the sessions by evaluating how the problems were and explored the changes that were identified. During sessions 4 and 5 a special emphasis was put on

improvements achieved, such as the application of new successful strategies and the recognition of the client's resources.

G. Follow-up: One month after the last session a phone follow-up was done. The client reported she was feeling better, her neck was less tense and she had no nausea lately, even though she felt moderate headaches sometimes. Four months afterwards a semi-structured interview was carried out. During this interview the client said she was feeling much better in relation to her headaches (they were still present but less frequent and lasting around one day). The client also reported that the psychotherapy helped her in different ways. She said that her mood improved and that she was seeing things from a different perspective. She followed using some of the relaxation exercises learned. Moreover, she acknowledged the importance of having had a place to speak freely about her headache problem. She was still doing the same pharmacotherapy (a daily dose at night time of 12.5 mg of Amitriptyline – a tricyclic antidepressant – and 5 mg of Medazepam – an anxiolytic).

Regarding the therapeutic process of this case, it can be argued that it followed the general plan outlined in Phase Two, yet in a less linear way than had happened with Pepe's case. Nevertheless, the general strategies of brief psychotherapy were followed to be able to consider this case as an illustration of this model. Looking at the description of the sessions (see Appendix 3) there were important

improvements achieved, though at the sixth and final session not enough headache management was considered yet reached to call the therapy a success, and even some of the improvements previously recognised were not considered as solid enough to last. Nevertheless the follow-up phone calls and the follow-up interview revealed that important improvements had occurred. Based on the report of the client, the psychotherapy was helpful and the client stated that she was still using some of what she had learned during therapy.

This case revealed itself as a very interesting one, since the client suffered from a complicated type of headache that continues to puzzle health professionals who still have few resources to help these clients. Some authors even defend a specific diagnostic category for these headache constellations under the name of chronic daily headache (Nappi et al., 1999; Silberstein et al., 1994).

These two cases illustrate the phenomena under study: brief psychotherapy of systemic orientation for the management of primary headaches (migraine and tension-type headache); and the recordings of their sessions provided sufficient raw material for DA. Yet, these data have to be transformed from audio into text.

3.2. FROM AUDIO TO TEXT: THE TRANSCRIPTION PROCESS

Typically, DA focuses on the language in use, in its spoken or written form. When the discourse to be analysed is spoken language, it is necessary first to record it and afterwards to transcribed it in order to have a written text that can be intensively analysed.

In the present research, the raw data were therapy sessions that were audio recorded. This procedure is common in systemic therapy, happening often in a one-way mirror room prepared for working with a therapeutic team and for recording the sessions in audio or video format. For ethical reasons, therapists always tell their clients the aims of the recordings (from training to research purposes) and obtain an explicit consent for doing them (usually in the form of a written authorization). This study followed the same orientation: audio-recording was a routine practice, for which the client was informed and signed a written document authorizing the use of the recordings for research. In this way, it was possible to have a reproduction of the talk interactions that form the specific psychotherapy cases under study.

Nonetheless, these audio data had to be transcribed. This is an essential transformation process that allows the creation of the written text that is going to be used in DA. There are many rules to guide this conversion of audio into text. As a general principle, the

transcripts must be comprehensive enough to capture verbal utterance, and para-verbal and even non-verbal features important to preserve the discourse context. However, as Wood and Kroger (2000) summarise, the rules for transcription fluctuate between an orthographic and a phonological approach. The former uses as rules the conventional spelling and grammar, with the big advantage of producing transcripts very easy and clear to read. The latter records as much detail as possible, from quasi-words to mispronunciations, and it uses specific signs to indicate features such as pitch, hesitations, overlapping and breathing patterns, in order to preserve the naturalness of talk. These more detailed transcriptions are more rich in information about the spoken discourse, yet the rules used vary from study to study and the resulting texts are sometimes difficult to read and to grasp if one is not familiar with the annotation code. Examples of transcriptions done in great detail can be found in CA studies, which usually uses variations of the so-called Jefferson system (cf. Atkinson & Heritage, 1984). Nevertheless as O'Connell & Kowal (1995) underline, what is more important is that the transcription system chosen matches the research needs of a particular project. If more detail is needed for the analysis, the transcription rules must be able to provide it. If those details are not pertinent for the study in question, the researcher should use a more simple system – using the basic principle of parsimony.

Bearing these considerations in mind, I chose to use the transcription standards proposed by Mergenthaler and Stinson (1992)²³ since:

- I. They are a very detailed system that allows the transcription of verbal and para-verbal utterances.
- II. They provide a balance between detail and intelligibility.
- III. They were developed with the consideration that they could be used by different languages (they were originally done in German, yet there are at least English, Italian and Spanish versions).
- IV. They recommend the use of standard spelling. This feature is important to the present study because all the sessions were conducted in Spanish and this report is in English. It would be close to impossible to translate text extracts that do not follow a standard spelling form. For instance, imagine translating to another language the following extract typical of a CA study (from Madill et al., 2001, p. 426):

10 C: - Um (1.5) NOT fo:::' - being a bad mother >in
inverted commas< bu' for re↑a:::cting too
str↑o:::ngly to [it=

- V. These rules are accepted as a good standard for psychotherapy transcriptions (Hill & Lambert, 2004).

²³ For the transcription rules see Appendix 4.

Using these rules (see them in Appendix 4) and in order to arrive to a good transcription of the sessions, I had to dedicate many hours to this enterprise (it took more than 12 hours of work per hour of audio recording). I started by listening to the tapes in a walkman and producing a first draft of the verbatim using a word processor software (Microsoft Word). In a second stage, I digitalised the tapes on to the computer. In this way I was able to have good sound quality with the capacity of slowing the speech down, rewinding easily, etc. Then I checked the text at least twice – correcting mistakes, adding details – until a satisfactory version was reached. Afterwards, the transcriptions were transferred to the Ethnograph v5 text editor that formatted the text in lines of 40 characters each and numbered them. Then finally the transcripts were printed into a hard copy (318 pages of text). This process is very time consuming but it is an essential step to be able to proceed to DA per se.

3.3. DISCOURSE ANALYSIS

Social constructionist DA aims to study discourse in naturalistic settings and its focus is on the language. DA explores the constructive and functional dimensions as well as variability of discourse, without forgetting the context within which it is produced.

Consequently, DA centres on: (1) how language is used to construct particular understandings (2) how these constructions vary from situation to situation, (3) what these constructions (and their variations) do in specific circumstances, and (4) how all these dimensions are framed by a given context.

Bearing these principles in mind, I began by reading all the transcripts (while listening to the audio recordings) to have an holistic grasp of the two psychotherapy cases under study. Only afterwards did I start to develop the specific research questions for the DA, which subsequently oriented the selection of themes to be explored. This stage leads to a second sample selection (considering that the first one was the selection of the cases), which is the collection of the transcript extracts to be intensively analysed.

3.3.1. Research Questions and Selection of Themes

When entering the third phase of this project, choices were materialised in a concrete inquiry, which had the general intent of exploring the potentialities of brief therapy of systemic orientation for managing migraines and tension-type headaches. This exploration was done by intensively studying two clinical cases using DA. In order to

be able to proceed, more concrete research questions started to emerge:

- How were the headache problems constructed during therapy? What did the participants do with these constructions?
- How were the therapeutic aims constructed? Were they readjusted during therapy? What functions did these aims accomplish?
- How were resources for managing headaches constructed in therapy? Did they change during therapy? If so, what were the consequences of these changes?
- Overall, how was this particular type of talk interaction helpful to change the way these people managed their primary headaches?

These research questions determined the selection of the transcript segments to be analysed. The choice of specific extracts for DA was done by: (1) reading and re-reading the transcripts, initially being very inclusive in the picks (by highlighting the

transcripts, using different colours); (2) progressively starting to pull together the selected extracts (numbering them chronologically)²⁴; (3) subsequently doing an intensive analysis of the extracts, and (4) reorganising the resulting material (going back and forth in these steps). During this process, the extracts analysed began to gravitate around several themes (closely related to the research questions):

- I. The headache problem.
- II. The therapeutic process (aims, specific interventions and changes).

For these reasons, these themes are going to be used to organise the presentation of the results with a discussion of the intensive analysis of the selected discourse extracts.

3.3.2. DA – Results with Discussion

As it is common in qualitative research it is difficult to separate the report of analysis results and the discussion of these (Banister et al., 1994; Wood & Kroger, 2000). For this reason they are going to be presented together under several sub-sections.

²⁴ See selected extracts in Appendix 5.

3.3.2.1. About the headache problem

The problem chosen to be studied in the present research was primary headaches, namely migraine and tension-type headache. In their recursive forms these are good examples of chronic pain that still challenge health professionals (from physicians to psychologists and psychotherapists). In the meantime, while scientists and clinicians are trying to understand, explain and treat these types of problems, many people are being severely affected by them, trying to make sense of their suffering and looking for relief. The clients in the two cases selected for this study were no exception.

3.3.2.1.1. Vicious cycles, Catch-22 situations and double-binds

Both clients characterised their headaches as very disturbing and affecting their lives on many levels. They took the opportunity of speaking with a health professional to complain about their headaches (and related problems), explain the severity of their situation and the need for effective help. They constructed their headaches differently, which is to be expected since one suffered from migraine, and the other from chronic tension-type headache (aggravated by migraine

attacks). Pepe complained about the fact that his migraine attacks appeared without warning, they were severe in intensity (with vascular characteristics) and lasted for several days. The pain was such that he usually could not work during those days, which caused him serious economical problems. In contrast, Carmen spoke about her headache as a daily companion that was always present and constantly pressured her (being particularly disturbing when associated with nausea). This chronic pain was a part of her life for many years, being particularly distressing in the six months preceding psychotherapy. Moreover, she felt desperate and this aggravated her suffering even more.

Conversely, there were also many points in common between the two cases. Both had done and were doing pharmacotherapy but this was not providing the relief that they needed to have normal lives. Both recognised that their headaches affected their mood in a negative way. They had high anxiety levels and depression symptoms that worked as a vicious cycle with their headaches. Moreover, both spoke about other problems in their lives that aggravated and were aggravated by their headaches. In both cases detailed concrete examples of all the above were provided with no effort.

Lets us now look at same specific excerpts.

Extract 1 (Case 1 – Session 1)

13 T: what? can you explain that better,
14 when you are more calm?

16 C: no, it's when I don't think about the
17 headache, that's when it starts the
18 pain in my head.
19
20 T: aha, aha (as laughter)
21
22 C: and maybe, I'm going to bed tonight;
23 it's what it's more; / I'm going from here,
24 go to bed fine, and in the middle
25 of the night, I've to get up to take a
26 pill, I can't handle it, the head
27 too much, a headache /

Here Pepe uses a hypothetical situation (L22 “I’m going to bed tonight”) to explain one of the characteristics of his headache that is most disturbing to him: the headache appears out of the blue, with no warning or apparent reason (L24-25 “go to bed fine, and in the middle of the night”) and it is very intense (L26-17 “I can’t handle it, the head too much, a headache”). He uses a concrete example to make sure that he is explaining himself, stressing that the pain is so severe that he has to get up to take a pain killer. His illustrations explain the severity of the problem. In another extract he stresses the severity of his pain by describing that sometimes he feels like his head is going to split and he even uses a scarf to tie around his head (extract 8). Yet, what disturbs him even more than the pain itself, is consequences of the pain.

Extract 3 (Case 1 – Session 1)

112 C: for me what kills me is that
113 tonight, as I told you, I'm going to bed
114
115 T: yes, well.
116
117 C: when the day starts I'm with a
118 headache that I can't handle, so
119 what should I do? go to work or

120 not go to work?
121
122 T: aha, aha
123
124 C: from there the problem comes, I'm
125 saying it to you, maybe I go to work and it
126 goes away, or I go to work, what happened
127 many times they have to bring me back/
128 'cause I could not do anything.

Extract 6 (Case 1 – Session 1)

446 T: m-hm, and: now, -- and: so in the
447 days that you have the headache
448 do you usually stay at home?
449
450 C: some days yes, some days no, but
451 usually I stay at home of
452 course, it's that sometimes I'm afraid
453 of going out with the headache
454 to work.
455
456 T: afraid why?
457
458 C: well + because I'm at work
459
460 T: / of feeling worse +.
461
462 C: / if I do efforts it hurts a lot +
463 more
464
465 T: more +, yes, yes
466
467 C: and avoiding that they have to bring
468 me back, 'cause they already brought me back
469 several times from work, and of course,
470 if I'm close to home anybody
471 can bring me back home, / but if I'm
472 far away and I start to feel bad is a little.
473
474 T: is a little.
475
476 C: of course, this is the problem.

Pepe's biggest problem is that since the headaches appear without warning and are very intense, he has to decide many times what to do: Go to work? Stay at home? There were times when he

went to work but the headache was so severe that someone had to bring him home. This is a considerable problem when he is working on a construction site far away from his home. Thus, usually he decides to stay at home, but this means that since he does not work he is not paid! In these segments Pepe shows his conundrum, it is a no-win situation, a Catch-22. Usually he chooses not to go to work, since many times it is the lesser of two evils. At least he is already at home, he does not have to ask any co-worker to bring him back and he is the only one that has economical consequences from his headaches. However, when the headaches are more frequent or last more days he is short of money to pay his bills, and this is a very distressing situation for him.

Extract 24 (Case 1 – Session 2)

1514 T: m-hm, and well; m-hm and well and but
1515 when you have the headache also
1516 in some ways is natural that
1517 you feel nervous because you are not
1518 working, because you know that you
1519 are not making money and + all that.
1520
1521 C: precisely +.
1522
1523 T: this makes you nervous, a little
1524 depressed 'cause it's a very delicate
1525 situation so delicate that you think if now
1526
1527 C: of course, that the bills are coming and I
1528 nothing, I'm depending from that, I don't
1529 have nothing else, and if I have to pay and I
1530 don't have money, well it's a problem.

In this talk interaction the therapist summarises some of the economical consequences of the headache. Pepe confirms this

summary, yet he stresses his problem once again, just to be sure that he is being understood. To fully grasp his problem, it is important to see it in context: he is a construction worker, who is paid by the hour, and this is his only source of revenue. If he cannot work, his monthly income is compromised, with the consequence of not having money to pay his bills. Moreover his work as a construction worker is very physically intense, which aggravates pain such as a migraine headache, making it very difficult to cope with his pain during work. In sum, he finds himself in a paradoxical situation. On the one hand, if he tries to go to work with his headache, almost always he cannot handle the pain and he has to stop working and loses his only income. On the other hand, if he does not go to work because of his headache, he is also losing his only income. Either option leads to economical difficulties that affect his mood, leading to anxiety and depressive symptoms, which in turn aggravate his problems even more (including his headaches).

In Carmen's case the circumstances are different. The headache described as a pressure sensation is a daily presence that follows her everywhere.

Extract 65 (Case 12 – Session 3)

410 T: and is there any day; when was the
411 last day that you remember that you didn't
412 feel; that you felt well,
413 well?
414
415 C: no. since September that I'm feeling this
416 down

417
418 T: m-hm
419
420 C: there wasn't a day that I can tell I felt
421 well, I felt perfectly, no.
422
423 T: so since Septembre that you
424 always have with you that sensation of
425 pressure
426
427 C: yes, yes
428
429 T: so that is a constant
430 sensation
431
432 C: yes, yes, yes
433
434 T: and after sometimes you fell the nausea
435 that's a signal things are going to get worse
436
437 C: yes. yes, yes. I feel the nausea, I feel
438 that I need to vomit
439
440 T: m-hm

In extract 65, she confirms the characteristics of a typical chronic tension-type headache aggravated by migraine episodes. According to the ICHD, chronic tension-type headache occurs 15 or more days per month and is characterised by a pressing or tightening sensation of mild to moderate intensity with bilateral location. Moreover, they describe that nausea can also be present mainly when the headache intensifies, yet they state that no vomit episodes occur (as happens sometimes with Carmen). The vomit is considered one of the possible symptoms of migraine. However, the discrimination of a migraine attack in somebody that suffers from chronic tension-type headache can be difficult to do. This is one of the reasons that leads many authors to defend a diagnostic category for daily or almost daily

headaches: the daily chronic headache or CDH (Bigal et al., 2002; Nappi et al., 1999; Sancisi et al., 2007; Silberstein et al., 1994; Solomon & Cappa, 1987). This hybrid category encompasses headaches that are present more than 15 days per month for longer than 3 months (Dodick, 2006). The previous transcript's segment hints to some of the shortcomings of the ICHD and how messy symptoms can become in the clinical world. More importantly, the client's words speak of her distress. This is even clear in the following segment.

Extract 45 (Case 12 – Session 1)

359 C: yes, that yes it's true and I'm
360 aware of it, and I have told that to the
361 doctors. when I'm in a phase within the
362 the normal, for instance now, how
363 is normal for me at this time, I try
364 to go on, I will be ok. but when
365 I'm worse, I've been in my village during
366 holidays and they had to give me
367 injections, even if I wanted to
368 overcome it, they could see it in my face,
369 they'd tell me "is there something wrong?",
370 "no, nothing" but I was feeling the nausea or
371 they saw me bad and I'd to lay down a little.

Carmen constructs her tension-type headache as a state that is normal for her. The tension-type headache is a usual day-to-day experience and she kind of got use to it. However she is thrown out of balance when she has her crises characterised by intense nausea and discomfort. It is interesting to note how she first draws a background of normality as constant pressing headache to contrast against it the

episodes where her discomfort increases to a level that she cannot handle. When she is experiencing these crises, she cannot hide her pain and people around her can see her pain behaviours. She feels the need to ask for help or at least support from others. This parallels what happens in psychotherapy: through her narrative she is asking for help and support. Pain ceases to be a private experience and it becomes the centre of her interactions with others.

Another interesting point is that usually her more intense crises are preceded by a warning signal – nausea. This unspecific unpleasant sensation is considered as one of the common symptoms that can exist in both tension-type headache and migraine attacks. Thus, it is not a differentiating feature in terms of medical diagnosis. Yet, for Carmen it is a critical signal that for her signifies that things are going to worsen. Therefore, she is always checking if she is feeling nausea and interpreting subtle sensations in her body. This hyper-vigilance and focus of attention creates anxiety that increases her unpleasant sensations, forming a positive feed-back loop that aggravates her problems.

Extract 67 (Case 12 – Session 3)

962 C: I laid down and tried to calm down,
963 it started to develop, uff the nausea
964 that I didn't control if I was towards
965 the right or towards the left, "I
966 feel bad, I feel bad, I
967 feel bad", I was speaking to myself,
968 "how bad. how bad" then when

969 they arrived, well "I feel
970 very bad, I feel very bad,
971 I'm feeling again nausea"
972
973 T: m-hm
974
975 C: I believe that is already the hysteria that
976 gets on me, an unrest, wanting to
977 complain, to say "help,
978 help me that I don't see a way out".

In this segment, she indicates that she is aware of her downward spiral but she is caught up in it and she does not see a way out. It is another Catch-22. Nausea is an unpleasant sensation that when she feels it she cannot distract her attention away from it, and this is exactly what she has to do to feel less nausea – it is a death lock situation or better a “suffering lock” dynamic. Her despair leads her to ask for help from any person who will listen to her. She hopes that there is a solution to her problem outside her vicious cycles, yet what she does not realise is that she is the one best situated to break the cycle – we can say she does not know how to do it and therapy can be an avenue to teach her the necessary skills.

It is curious that in Carmen's case there is a warning signal, which contrasts with Pepe's case where he complains of not having any. Yet in both cases, either the presence or absence of a warning signal are fuelling their vicious cycles.

Another paradox situation is the ambiguity that both clients have with their pharmacotherapy. At the beginning of psychotherapy Pepe

sees the analgesics as an essential resource to manage his headache, yet at the sometime he recognises that they do not give him enough relief or control over his headaches. Moreover, he developed stomach problems that make the intake of oral medication more problematic. In the case of Carmen, she keeps taking her medication for months and months without seeing any improvement, yet she is afraid of changing it and feeling even worse (as already happened in the past). A positive common point regarding preventive pharmacotherapy (namely amitriptyline) is that both say that taking it helps them to sleep better (possibly due to the sedative action of the amitriptyline) since, as many chronic headache sufferers, they were used to having insomnia.

To sum-up, the headache problems (as expressed in the transcripts analysed) are entangled in many vicious cycles, Catch-22 and even double-binds. Let us look on these patterns in turns.

The vicious cycles identified in the texts analysed can be seen as good evidence of the limitations of linear causality models for understanding the pain experience and associated problems. There are many published articles that state that chronic pain can lead to depression or that depression can lead to chronic pain (cf. Dersh et al., 2002). Others do not go so far, they simply state that mood disorders and chronic pain (such as chronic headaches) are co-morbidities (cf. Lipchik & Penzie, 2004). Yet when clinical data is closely analysed what emerges is better described through circular

causality models. For instance, in Carmen's case, the persistence of her suffering led her to despair, and her despair led to more suffering. Her routine hyper-vigilance, characterised by an intense focusing on her sensations, led her to detect anything that could be interpreted as nausea, as a signal that things were going to get worse. This produced more tension and stress that could increase the awareness of unpleasant sensations, attracting even more attention and hyper-vigilance, and if other sensations were detected, to more suffering and despair over her condition. It is important to note that circular causality is usually more complex than the simplest version A causes B and B cause A. Moreover, the systemic theories suggest to us to look closely at how the circularity is maintained. In the present case, positive feedback loops (that increase the problem) can be easily identified (more suffering, more despair, more despair, more suffering). Yet since this cycling pattern keeps repeating, there is probably a regulating element that at some point enters into play introducing a negative feedback loop that provides momentary relief. Indeed this suggestion led me to look again at the transcriptions, and several instances were found. For instance, the continuation of Extract 67.

Extract 67 (Case 12 – Session 3) Continuation

980 T: m-hm

981

982 C: then he says to me "cry, cry, cry if

983 you have to cry" and by the way I

984 cry very easily.

985
986 T: it's a good way of getting some relief
987
988 C: he say "cry, cry, cry", "cry, the
989 nausea doesn't go away", I say "I don't know"
990 but when I start to cry so
991 hysterically, so; "I had enough, I'm
992 disappointed," then when I start to
993 calm down I say "it seems that I'm a
994 bit better from it"
995
996 T: m-hm
997
998 C: and from the bad of the tension,
999 from crying and of trying to
1000 calm down, I try to sleep if I
1001 manage.

Here Carmen describes how she reaches a point when she cannot despair any more (she hits the bottom), she sobs to a point that relieves her despair and she feels a little bit better.

There were other patterns that emerged from analysis that can be better described as Catch-22 situations. Catch-22 is the title of a novel by Joseph Heller that tells the story of a U.S. Army Air Force Captain at the latter stages of WWII who wishes to be excused from combat flight duty. However he finds himself in a no-win situation since in order to be excused from his combat duty, he must show that he is insane by declaring it, yet this action is a proof of some sanity and thus he cannot be excused. In Heller's own words (1961, p. 52):

There was only one catch and that was Catch-22, which specified that a concern for one's safety in the face of dangers that were real and immediate was the process of a rational mind. Orr was crazy and could be grounded. All he had to do was ask; and as soon as he did, he would no longer be crazy and would have to fly more missions. Orr would be crazy to fly more missions and sane if he didn't, but if he was sane he had to fly them. If he flew them he was crazy and didn't have to; but if he didn't want to he was sane and had to. Yossarian was moved very deeply by the

absolute simplicity of this clause of Catch-22 and let out a respectful whistle.

"That's some catch, that Catch-22," he observed.

"It's the best there is," Doc Daneeka agreed.

In logical terms, for the outcome C to happen both A and B have to occur and yet A and B are mutually exclusive. For instance, in Pepe's case, to earn his pay when he has his migraines (C the desired outcome) he has to go to work while having a migraine attack (A) and at the same time feel well enough to do hard work (B), yet if A happens, B does not, and if B happens, A does not. So it is a no win situation: when he has his migraine he cannot earn his pay. This situation in turn feeds a vicious cycle: reduced income, no money to pay his bills, he feels stressed, anxious and depressed, which leads him not to take risks and to stay at home, reducing his income even more. In Carmen's case, she wants to get relief from her nausea (C), and for this to happen she has to ignore her nausea (A) when she feels the nausea (B), yet to ignore her nausea (A) she has to feel no nausea (not B), and when she feels her nausea (B) she cannot ignore it (not A). Thus she is in a Catch-22.

Furthermore, some of the patterns discerned can be considered as double binds. In their famous article "Towards a Theory of Schizophrenia" Bateson, Jackson, Haley and Weakland (1956) hypothesise that the general characteristics of a double bind situation can be summarised as:

(1) When the individual is involved in an intense relationship; that is, a relationship in which he feels it is vitally important that he discriminate accurately what sort of message is being communicated so that he may respond appropriately.

(2) And, the individual is caught in a situation in which the other person in the relationship is expressing two orders of message and one of these denies the other.

(3) And, the individual is unable to comment on the message being expressed to correct his discrimination of what order of message to respond to, i.e., he cannot make a metacommunicative statement. (reprinted in Bateson, 2000, p. 208; Bateson et al., 1956, p. 254)

Thus, if we consider chronic pain as an entity with which the patient is involved in an intense relationship (1). And, if the patient (i.e., victim) is caught in a recurrent situation within which she receives contradictory messages from her pain experience (2), for instance, “if you try to have a normal life, I’ll hurt you” and “if you despair, I’ll hurt you”. And if the patient is unable to pull herself out of the contradiction (3). Then, this person can be said to be in a double bind with her pain. An another example, we can consider the pain medication as an entity with which the patient is involved (1). And, if the patient considers that taking this medication is essential to manage his headaches, yet this medication does not manage the pain enough for him to be able to have his normal life (2). And if this person does not grasp this paradox. Then it can be said that this person is in a double bind with his pain medication.

These patterns reveal the complexity of primary headaches and associated problems, showing how they become organised. Yet it is

important to underline that these patterns are social constructions too, which exist within a particular interpretation of the discourse.

Another aspect important to analyse is how people construct the meaning of their headaches and what they do with these meanings.

3.3.2.1.2. Headache's meanings

In Phase One, when reviewing the psychologists' perspective, the meaning of the pain emerged as a significant element in the overall pain experience. It is usually conceptualised that if pain has a negative meaning (e.g., as it often happens with cancer patients) it is more difficult to manage than when it has a more neutral or positive value (e.g., as can happen in post operative situations). Cognitive concepts (such as beliefs, appraisals and expectations) are usually used to explain the attribution of meaning to a particular pain experience. Consequently, a cognitive oriented psychotherapist would typically focus on the identification of inadequate cognitions that anticipate and escort pain, in order to afterwards demonstrate their irrationality (as an initial step to change them). However, this cognitivist perspective has been one of the subjects of criticism of DA. DA of social constructionist orientation rejects the aim of explaining action by reference to underlying cognitive states, such as personality traits,

attitudes and so on (Potter, 2004). For instance, within cognitive psychology, attitudes are seen as mentally encoded dispositions of an individual towards a given entity, being relatively stable characteristics (that can be measured using attitude scales). DA raises doubts about the enduring qualities of attitudes and calls our attention to the context where they happen and what participants do with them. It is not a negation of mental life, but rather provides a different perspective to study it (Potter & Wetherell, 1995). Talk interactions within which a therapist identifies some thoughts as inadequate can be analysed and reveal that maybe they are adequate in certain particular circumstances. Or, the classification of a cognition as rational or irrational can be seen as framed by a particular context.

Having these considerations as background it can be said that after analysing the extracts, the two clients constructed the meaning of their headaches differently, even when both were referring to their experience with migraine crises. Pepe constructed his migraines as an inherited characteristic that came from his parents. He had had headaches since he was a teen and he believed that to some degree they always were going to be part of his life. And he was fine with this characteristic if he managed to bring the headaches under some control (in order to not disrupt his work and income). On the other hand, Carmen saw her more intense headaches as very suspicious, as indications of an underlying disease that the doctors did not yet

diagnose. Thus she panicked when she felt them and asked for medical assistance. Her severe headache crises started to have this critical interpretation after her mother suffered a severe stroke that left her paraplegic.

Lets us now look at some specific segments.

Extract 2 (Case 1 – Session 1)

102 T: of course, that usually that, the
103 headaches, we think always about
104 what is wrong with us.
105
106 C: that no, no, that I don't. I'm with this
107 since I was very young, I'm used to the
108 headache.
109
110 T: m-hm.

In extract 2, the therapist considers it a normal response for someone who has a strong headache to wonder about what is happening with oneself. It is a common sense view that if we have pain, it is a signal that something is wrong physically and that something should be done to fix the underlying problem. With this declaration of normality the therapist was opening the dialogue about the headache meaning with an anticipation that the patient was thinking that something was physically wrong with him. Against the created expectations by the therapist, the client flatly denies that possible meaning for his headaches. He negates the common sense view of a strong pain as a symptom, replacing it by a personal theory. He suffers from the headaches since he was young and he is used to

them, meaning that he knows by his life experience that his headaches are the problem in themselves and not a symptom of something else that he has to worry about. His personal theory is restated in extract 19.

Extract 19 (Case 1 – Session 2)

515 C: / a long time, more or less around
516 forty years or forty-five,
517 forty years
518
519 T: and when did you start with this, because
520 everybody can have a headache,
521 but those headaches
they were as they are now or lighter?
522
523 C: yes it was, they were the same, what happened
524 as I already told you, I would go to
525 the village doctor, who everybody
526 knew, then when I was young
527 the village doctor would tell me,
528 he also would tell my father: "do not worry
529 he has lot of strength in his blood".
530 I already told you the other day, I was like
531 that for a long time. I would see that this
532 was not going away, I would go to the doctor,
533 the same doctor and he would tell me "take a
534 aspirin, and so and so on."

In this segment, more interesting than the information that he lives with headaches for more than forty years, is the story that he tells about his consultations with his village doctor about his migraines. Pepe reports that the doctor, "who everybody knew" (L525), told him and his father that they did not have to worry about his headaches since they happen because "he has lot of strength in his blood" (L528-529). This justification for his migraine is worthy of note on several levels:

1. It reflects the medical view that predominated the field until the 1980s that migraine headache was caused by extra-cranial vasodilatation (vascular hypothesis of Wolff).

2. The vascular element picked up by the village doctor represents one of the characteristics of the pain that the client feels, the pulsing quality (and this core characteristic is going to be the base of one of the specific interventions for headache management).

3. This interpretation/diagnosis given by his doctor decades ago is an interesting positive redefinition of the headache problem: his blood is strong and one consequence of this strength is his headaches, but what is more important is that he has good strong blood.

This positive connotation for the headaches, and his personal theory about his migraines as a life long characteristic of his is further reinforced by the argument that his father and mother also suffered from headaches: it runs in the family (see extract 28).

Extract 28 (Case 1 – Session 3)

232 C: my father and mother also suffered
233 from headaches

234

235 T: ah, yes, yes, but almost everybody
236 on one occasion or another sometimes
237 we have an headache.

238

239 C: yes, yes

240

241 T: the problem is when someone like yourself
242 has headaches that last
243 for three or four days

244

245 C: + yes, yes

246
247 T: and that + prevents you from working. then,
248 things can start to be more
249 worrisome.
250
251 C: yes, yes
252
253 T: and if we could control it to a
254 point:
255
256 C: of course, a little relief, that the thing
257 would be lighter and

Consequently, for Pepe the problem is not his migraines per se but the lack of control that he has over them (an aspirin and many other pain killers already used do not work any more). Thus he constructs control (not cure) as the aim of therapy.

Extract 34 (Case 1 – Session 3)

1113 C: yes, yes, what I want it's to be able to
1114 control a little, control the
1115 headaches even if I will follow having
1116 headaches but that I manage to control a
1117 little. with this technique I don't feel
1118 the pain in my head so much, even when I'm
1119 with a headache. that's what I want to say
1120 the headaches would never go away completely
1121 'cause this is inherited as they usually
say.

In relation to Carmen the meaning of her headaches is composed in a totally different way. She has seen many different doctors (GPs, neurologists, psychiatrists, etc.) and none of them gave her a solution (i.e., a cure) or even a convincing theory about her headaches. The message she receives from the physicians is that her headaches are caused by her anxiety and depression. She recognised that sometimes she has lots of anxiety, even maybe some periods of depression, but

she is not convinced that these emotional states are the cause of her headaches (see extract 62). Moreover she tried the medication prescribed by them (antidepressants and anxiolytics) and she did not improve (sometimes she even felt worse, mainly when taking some of the antidepressant medications).

Extract 62 (Case 12 – Session 2)

2682 C: no I don't know, I have told to all
2683 doctors I have seen I try to
2684 explain how I feel, maybe in
2685 that moment of course, because during
2686 these five years or so I don't
2687 feel the same as I felt in
2688 the beginning. I try to say exactly
2689 how I feel and I don't know how they
2690 tell that it's depression, or anxiety.
2691 anxiety yes. maybe I have it,
2692 but depression, no, maybe in
2693 some periods but
2694
2695 T: but that is natural, the depression is
2696 normal when there is a very intense pain
2697 or a physical state like that or a
2698 physical disease is normal that some
2699 depression is felt because when
2700 we don't feel well with ourselves,
2701 we have more tendency to feel
2702 depressed
2703
2704 C: of course, yes
2705
2706 T: that
2707
2708 C: so I don't know, maybe it must be that I
2709 arrive to a point that I tell since I don't
2710 know the solution and I don't know what to
2711 do, because I would like that somebody
2712 indicated and told me this is what you have
2713 clearly, clearly, and you have to do this
2714
2715 T: m-hm, but maybe you would never
2716 know it, clearly, clearly, clearly.

We can even speculate that when the last neurologist referred her to psychotherapy, this reinforced the message that her headache is caused by anxiety and depression. Yet she struggles against this causation theory (see also extract 92).

Extract 92 (Case 12 – Session 6)

226 C: yes, it's because, that I tell you, that
227 I don't have nothing, I put in my head
228 that I don't have nothing, that I don't have
229 nothing but I still feel the pain a lot in
230 the head, and I question myself, if they're
231 migraines fine maybe during one week,
232 two weeks, but every day
233 always there, a all the time, I tell
234 it's more serious than migraines, no,
235 and I start to think about it

She sees the idea that her headaches are caused by anxiety or depression as equivalent to the theory that she does not have any physical problem, and she cannot accept this conclusion (“I don't have nothing, I put in my head that I don't have nothing but I still feel the pain a lot in the head” L227-230). Furthermore, her doubts are reinforced by her mother's stroke. After that happened, when she has more intense headaches she thinks that she is going to have a stroke too or something very serious that needs immediate medical attention. In many aspects she is like her mother and she fears to have her physical fate (see extract 81).

Extract 81 (Case 12 – Session 4)

2661 C: from before is what I'm saying, the
2662 problem is not from now from what happened

2663 with my mother, it's from before, but to go
2664 to the ER, that happens now, before, no, no,
2665 that would go away, I go to bed and it
2666 would go away
2667
2668 T: and now you think the worse
2669
2670 C: something is going to happen in my head as
2671 with my mother, I'm going to have something,
2672 something, and as I tell that it aches I'm
2672 going to have something and I'm going to
finish as her, look to this

The lack of clarity of the health professionals and the fact that she is not able to control her constant headaches strengthens her conviction that there is something physically wrong with her that the doctors have not found yet. Sometimes she admits that maybe there are less negative interpretations for her symptoms. Yet when the headaches are more intense or disturbing, she despairs. Moreover, she refuses to believe that she does not have a physical problem since for her not having an organic cause means that she is inventing her symptoms, including her pain (see extract 52).

Extract 52 (Case 12 – Session 2)

370 C: I can't explain it. I say this is a
371 pathological disease or organic?
372 I don't know if it is. but how can I believe
373 that I'm inventing this

She finds herself in a distressing situation common to many chronic pain sufferers: she feels her pain and she does not have any doubts about the reality of her experience, but when she complains

about this experience she feels doubts from everyone else. “To have pain is to have certainty, to hear about pain is to have doubt” (Scarry, 1988, p. 13). This quote is perfect to describe Carmen’s distressing experience. Moreover, this situation also reflects the mind-body split of our Western culture. If an organic pathology is not found, then the pain is seen as psychogenic. Still the patient refuses this interpretation since she knows that she is not inventing it (furthermore she took antidepressants and they did not stop her headaches). Thus, she concludes that she has something organic that was not yet identified.

Pepe and Carmen give a totally different meaning to their headaches. Each of them had a different interpretation of similar symptoms. These differences can be understood in terms of their distinct personal and family histories, and also in the way that they constructed their interactions with health professionals. To sum this up, the present DA shows how different meanings affect the way these particular people experienced their headaches and also throws some light on how and why these meanings are constructed. These aspects are important to analyse since they influence psychotherapeutic aims and interventions used.

3.3.2.2. About the therapeutic process

One of the basic strategies of brief therapy of systemic orientation is to define the goals of therapy as much as possible. This is usually done after identifying and defining the problems (i.e., the base line) and before specific interventions are proposed by the therapist. We can argue that this strategy is one of the secrets of brief therapy by design. From an early stage, a final line is defined with specific goals. This is a mutual construction between therapist and client that orients their actions and serves as a point of reference to assess the changes produced during therapy (and ultimately the progress and success of the it).

3.3.2.2.1. Aims for therapy

In both cases analysed, the aims were co-constructed between the client and therapist, having as a baseline (or starting point) the definition of the problems. In Pepe's case, control of his migraines emerged as a concrete goal to be reached that was further defined by using a pain scale. Moreover, other factors that aggravated his headache experience were also considered. For instance, to control his anxiety also emerged as one of the aims of therapy (that could indirectly help to control his headache). In Carmen's case the clear

definition of the end-goals of therapy was not so straight forward and was renegotiated several times during therapy. More auxiliary goals were considered and defined. The idiosyncratic meanings of their headache experience can justify some of these differences.

In Pepe's case the overall aim was for him to be able to control his migraine attacks to a level that he could carry on working. This aim was implicit during the definition of the problem in therapy and even became more clear after the DA around the headache problem. Thus, for him a cure was never the goal. This is explicit in the extract 29.

Extract 29 (Case 1 – Session 3)

314 T: yes, yes, for instance, let us
315 imagine, yes: if we had here
316 a crystal ball:
318
319 C: yes.
320
321 T: in which we could see the future and
322 we could see a situation where you
323 would say "I'm cured".
324
325 C: yes.
326
327 T: how would that situation be?
328
329 C: well, that's a good one.
330
331 T: a very good one.
332
333 C: sure, of course. well with
334 great joy that I could say, well
335 I'm cured. but to be truthful I don't
336 believe it, honestly.
337
338 T: aha, and:
339
340 C: I hope, as I already told you, that this
341 therapy that I'm doing now can
342 help me.

In this talk interaction the therapist suggests to Pepe to imagine a magic situation where he could say that he is cured. He entertains that possibility for a few moments recognising that it would be wonderful, yet he does not believe that it is possible (L335-336 “well I’m cured. but to be truthful I don’t believe it, honestly”. After uttering the words “I’m cured”, he stresses that he does not believe in this possibility and reinforces this disbelief with words such as “truthful” and “honestly”. His doubts about the possibility of a cure (i.e., that his migraines disappear totally) is better understood taking into consideration how he constructed the meaning of his headaches. He see his headaches as a characteristic that he has inherited from his parents, and that when under control he does not consider them as problematic (since he has had them for more than forty years). So, just control is the aim. But how can this control be defined, how can we know that it is reached? In the following passage the therapist constructs with the client an image that can fulfil those functions (i.e., defining control and the criteria to evaluate change).

Extract 9 (Case 1 – Session 1)

707 T: m-hm, let us see what they want (speak by
708 the intercom). okay. now I’m
709 going to ask another question. imagine a
710 scale from zero to ten. zero is not
711 having the problem of having the pain. and
712 ten is when you have a very strong
713 headache. / between one, two,
714 three, four, five, six, seven,
715 eight, nine and ten /.
716

717 C: where do I put my headaches,
718 very high, if it doesn't reach
719 ten, it's almost there.
720
721 T: no, ten is like, like if
722 you had to climb the walls /
723
724 C: / I, it hurts very strong, I tell you,
725 sometimes I have it very strong / I go to the
726 kitchen if I'm up to put on
727 that thing (the scarf) /
728
729 T: and you feel better with that thing you put
730 on?
731 C: well, having it on like that, is like if it
732 supports the head: it seems that I'm a little
733 less aware of the pain.
734
735 T: aha
736
737 C: but the pain hurts the same
738 it seems less / but without a
739 doubt it's very high, very.
740
741 T: seven, eight.
742
743 C: yes, yes, yes, very high, if I
744 had an instrument to measure it,
745 very high.
746
747 T: m-hm
748
749 C: sometimes no, but many times,
750 very high.
751
752 T: and when it's not so high,
753 what.
754
755 C: more sustainable / maybe I can
756 handle it to continue working with a bit of
757 a headache if it doesn't increase more,
758 it's like I'm telling you.
759
760 T: m-hm, until what number on the scale,
761 imagine, until what number would
762 you be well to work, to do your things.
763
764 C: well, I don't know / three or four.
765
766 T: three or four fine, this was pain yet
767 you could handle it and be fine, m-hm. and

Here the therapist proposes to evaluate the client's headache intensity by using an imaginary numerical scale, in which zero means no pain and ten means unbearable pain. The client accepts this construction and uses it to emphasise the severity of his problems ("yes, yes, very high, if I had an instrument to measure it, very high" L743-745). After some negotiation of meanings, they agree that his headaches lately can be quantified by the numbers seven or eight. This can be considered as the baseline of the problem. After this baseline is established, the conversation moves on to the definition of an acceptable level for his headaches. In this context, the number three or four emerges as an intensity that would be bearable to allow the client to work and thus be an acceptable aim for therapy. While analysing this segment other details emerged. For instance, when the clients indicates that a sustainable level for his headaches would be "three or four" (L764) and not three and a half, it makes the researcher wonder – is the client constructing the aim as one unit or the other (and not as an average) because when the therapist defined the pain scale she specified "between one, two, three, four, five, six, seven, eight, nine and ten" (L713-715)? Or, because the headaches lately were defined as "seven, eight" (L741)? Or, because it is his personal way of saying it? It is interesting to compare this segment

with extract 38 where the pain scale is used again, this time to evaluate changes.

Extract 38 (Case 1 – Session 4)

407 T: well, in relation to the other pain,
408 do you remember that once I told you to
409 imagine a scale from zero to ten,
410 ten a very strong pain and zero
411 no pain, where do you place it
412 now?
413
414 C: now very low.
415
416 T: very low.
417
418 C: very low, very low, very low, two or three,
419 around that.
420
421 T: two or three.
422
423 C: more or less
424
425 T: and that type of pain is tolerable.
426
427 C: yes, it is more or less.
428
429 T: if you managed a little lower? better
430 still.
431
332 C: the lower the better, but I'm telling you
333 that I'm not going to manage it totally.
334
335 T: yes, but. everybody has a headache,
336 in different ways, but if you
337 had a headache once a month,
338 I don't believe that this would be very
339 disturbing to you?
340
341 C: of course no, being used to what I had
342 before, we're getting better.
343
344 T: yes, yes, one thing is to have to stop
345 during one week and the other
346
347 C: is not to have it all day. as
348 I told you, I'm going to work, and I feel
349 it. I do the exercise in the morning,
350 I go to work, I work all
351 day long, and I can handle the day.
352

353 T: aha. very well.

In this segment, when asked to place his latest headache intensity on a “scale from zero to ten” (L409) the client answers “two or three” (L418-419), using again the format one unit or the other, adding that it is an estimation (“around that” L419). This question about numbers and units can lead us to consider other aspects of the pain scale. The construction of the baseline and the goals of therapy through a numeric scale is common in this model of psychotherapy. This is a typical tool that the therapeutic team suggests to the therapist to use. She accepts this idea, and with the client they arrive to concrete numbers (“seven, eight” as baseline and “three or four” as the desired final line). This is very useful because it gives a concrete measurement for assessing the progress of the therapy (as can be seen in extract 38). The therapist and client share the same language to quantify the headache intensity level. In this way they can easily assess how much the pain has changed from the beginning of the therapy, and how close they are to the therapeutic aims. However, the simplicity of the scale can, at the same time, be considered problematic. A complex experience such as pain is reduced to a simple number. For instance, in extract 9 the client says “but the pain hurts the same, it seems less” (L737). At first sight, this statement looks like a contradiction. Yet if we consider how much the

pain hurts (i.e., perceived intensity of the pain) as distinct from how much the pain bothers (i.e., affective components of the pain), the same utterance makes more sense. Some authors (Barber, 1996) suggest the use of at least two pain scales, one for the sensory component (how intense is the pain?), and the other for the affective component (how unpleasant or bothersome is the pain?). More importantly, what cannot be forgotten is that this is a quantification of the pain experience. It reduces the experience to numbers. This can be useful and yet it can also lead to pseudo-contradictions and misunderstandings. For these reasons, it is important to reflect upon its uses.

In relation to other associated problems, we already saw how they can aggravate the headache experience when discussing the vicious cycles, Catch-22 situations and double-binds in the previous section. In Pepe's case he recognised that his uncontrolled and unpredictable migraine crises affected his mood, creating anxiety and depression patterns that in their turn aggravated his migraine problem. Consequently, controlling his mood (namely his anxiety) also become an aim for the therapy and an object of specific interventions (as can be seen in the next section).

When considering Carmen's case, we can see that the goals are constructed differently. To start with, Carmen's desired aim was to have her headaches cured and not just controlled (see extract 94).

Extract 94 (Case 12 – Session 6)

835 C: I don't want, no; for nothing, I want
836 that someone cures me, I have something I
837 want a way out, I
838
839 T: a-ha
840
841 C: I want somebody to help me, I don't know who
842 can help me, but someone has to
843 help me
844
845 T: m-hm
846
847 C: and from there the despair, that I can't
848 overcome this, I can't overcome this, I'm
849 not able, that
850
851 T: m-hm
852
853 C: and that day well I, or that
854 night well I'm feeling bad, I go to
855 bed and try to sleep, yes I sleep,
856 I sleep badly, and it's this
857
858 T: m-hm
859
860 C: and it's one day after the other, after the
861 other, I can't stand it no more

In this segment, Carmen defines help as being fully cured. This makes sense if we consider the meaning that she gives to her headaches. To her, her constant headaches are a symptom of a serious problem that the doctors have not yet diagnosed. Besides, the fact is that her headaches are constantly there, draining her emotionally. Thus, only controlling her headache is not her primary desired outcome. However, to have as an end-goal the complete elimination of her headaches is a near impossible result to expect. Headaches, as with other types of pain, are a common occurrence

that sometimes have an important diagnostic value (for instance, in the case of meningitis). Yet in most cases they are just a nuisance, while in other cases they are a serious problem in themselves (as in her case of chronic daily headaches). For that reason, psychotherapy usually aims to manage chronic pain. Pain can cease to be chronic as an outcome of the therapeutic process (as happened with Carmen at her follow-up). However, to put that as the primary aim of brief therapy is to increase the chances of an unsuccessful outcome. Moreover, this aim makes the appreciation of small changes more difficult.

When analysing other extracts, it can be noted that Carmen also considered the management of her headaches as an acceptable outcome for therapy (see extract 74).

Extract 74 (Case 12 – Session 4)

131 C: but I say I'm not bad
132
133 T: well, let us see if this level
134 can be kept
135
136 C: oh if I could keep it at this level
137 well I'm happy
138
139 T: m-hm, it can happen that afterwards even
140 better days will come

If her headache could be kept below a certain intensity and without nausea and other unpleasant sensations, Carmen would be happy and satisfied with those results. Moreover, she sometimes even

accepts the possibility of having to learn to live with her chronic headaches (see extracts 83 and 91).

Extract 83 (Case 12 – Session 5)

168 T: m-hm, but in spite of the fact that these
169 last two weeks have been bad ones, I see you
170 with good humour, or:
171
172 C: because I believe that my husband is
173 convincing me a lot that I have to
174 get used to what I have, but
175
176 T: but not let you go down
177
178 C: yes, and also to adapt myself a little to
179 this

Extract 91 (Case 12 – Session 6)

159 C: ana, I think that, when so
160 much time has past sometimes and
161 I see no solution, well
162 then is when I tell you, I have
163 to live with this, no
164
165 T: m-hm
166
167 C: and thus what should I do, well the bad
168 days, if I can't handle it I will cry or
169 despair, and the days that I feel
170 moderately even; well I will go
171 on
172
173 T: m-hm, and you will try to take the most
174 advantages of those days
175
176 C: of course. like this morning I tell myself
177 I'm with a headaches, everything is fine, I
178 have to live with it
179
180 T: m-hm
181
182 C: as I'm already conditioned to live
183 with it yes
184
185 T: m-hm
186
187 C: if I don't find a solution
188

189 T: m-hm
190
191 C: but well I will not stop saying that
192 my head aches
193
193 T: m-hm

During therapy Carmen continues to go back and forth between wishing for a cure (her desired goal), or being able to manage her headache or even resign herself to learn to live with her pain. It is interesting to note that she places herself often in a passive role (extract 94 L841-3 “I want somebody to help me, I don’t know who can help me, but someone has to help me”; Extract 83 L172-4 “because I believe that my husband is convincing me a lot that I have to get used to what I have”). She uses a more active voice, herself as an agent, when she is expressing her pain, despair and desire for a cure (extract 94 L835-6 “I want that someone cures me”; Extract 91 L1168-9 “if I can’t handle it, I will cry or despair”). She does not have problems in owning her experience of suffering, yet she does not know what to do by herself to reach a solution (besides asking for help).

In this context the auxiliary goals assume another dimension. Carmen struggles against the idea that her headaches are caused by her anxiety. She can go so far as to recognise that being very anxious aggravates her daily headaches. Using these beliefs, the therapist

compares her headaches to a stomach ulcer in the following segment (see extract 44).

Extract 44 (Case 12 – Session 1)

272 T: but everybody is like that. everybody
273 has different limits,
274 from each other, some
275 people pass their limits and that
276 transforms itself in a stomach ulcer and for
277 others it can transformed into a headache.
278 -- the majority of people say
279 if I was like this all my life why is
280 this happening now, why
281 didn't it happen before
282
283 C: yes, yes, I ask myself that a thousand times
284
285
286 T: but that is the same answer for
287 a person that has a stomach ulcer, in
288 these type of cycles, maybe
289 the body arrives to a point, now; the
290 pain is one very direct signal from the body,
291 the body says that something is happening and
292 that you have to do something about it, "if
293 you don't respect me, you will respect
294 the pain"
295 C: yes, of course. it's something that
296 I have to learn, if I have to learn
297 something it is to control myself, my
298 husband says to me without being a
299 psychologist, he says to me, "control
300 yourself, you don't have to take all this
301 despair and problems for nothing"

The pain experience is redefined as a signal of the body telling the person that certain limits have been reached. This is a new meaning for her headaches that tries to replace the more negative one that sees her headaches as a signal of a serious undiscovered illness. The client seems to accept this redefinition, and agrees that

gaining self-control can help her to manage her problems. This aim of developing more control over her anxiety appears again in extract 47.

Extract 47 (Case 12 – Session 1)

455 C: and my husband says to me that he is sure
456 that I don't need medicines, rather I need
457 self-control and to see life from a
458 different perspective.

Nevertheless, it is important to observe that in this instance she is accepting the aim of achieving self-control as a useful one, yet at the same time she places herself in a passive position. It is her husband that says that this is something she needs to achieve. She agrees with him, but she values his opinion more than her own. In other segments, she assumes more this aim as her choice (see extract 59).

Extract 59 (Case 12 – Session 2)

2106 C: I would like to change in this respect of
2107 saying, being more calm for everything,
2108 more serene for everything, for everything,
2109 to think, to do, for everything "don't
2110 rush, be calm" but I
2111 can't, I don't know if it's from this
2112 that many problems come

However she does not know how to achieve this. The therapist tries to demonstrate that she has the resources to achieve this aim (see extract 68).

Extract 68 (Case 1 – Session 3)

1591 T: this is like a vicious cycle, now
1592 how to break this cycle? – well,
1593 but you have the capacity of breaking
1594 this cycle because you told me that
1595 there are specific times in
1596 your life not very long ago, for instance

1597 during the vacations, that you felt
1598 well
1599
1600 C: m-hm
1601
1602 T: that you felt relaxed, that you didn't
1603 have so many headaches
1604
1605 C: nothing
1606
1607 T: that you forgot all these
1608
1609 C: yes, I didn't have any pain
1610
1611 T: thus you have inside yourself the
1612 the capacity of being tranquil, serene and
1613 relaxed.
1614
1615 C: I'm not convinced (laughter)
1616
1617 T: but there are moments in you life – that
1618 you have been tranquil, serene and
1619 relaxed and without headaches
1620
1621 C: yes, all summer

In this segment the therapist explores the exceptions, that is, the situations where she already has managed to achieve this goal of being more calm and relaxed. She resists accepting this interpretation (L1615 “I’m not convinced (laughter)”) and yet she admits that it has happened in her recent past.

To sum up, Pepe defines his aim clearly as one of controlling his headaches. He even refuses to accept the possibility of a complete disappearance of his headaches. With Carmen, the aims are not so concretely defined. Yet she accepts that developing self-control over her anxiety is a good strategy to improve her overall wellness, and that this change can indirectly help her to control and/or live with her

headaches. Thus, in both cases the goals are defined. Now the question is – how to achieve them.

3.3.2.2.2. Specific interventions

Within systemic oriented psychotherapies, almost everything can be considered as an intervention, starting from the definition of the therapeutic context as a collaborative work (with specific rules and conditions that the client has to explicitly agree with), to a follow-up (set up from the beginning) to check the outcomes of therapy. Nevertheless, we can consider that there are specific interventions intentionally designed to achieve the specific therapeutic aims in a defined time frame. The present section is going to focus on these type of interventions.

In the cases analysed, several specific interventions can be identified, some aimed directly for managing the headaches, and others aimed to reach the auxiliary goals (such as to control anxiety). In Pepe's case there was a negotiation of the specific interventions to be used, followed by an agreement to try a couple of them: one specifically designed to help him during the migraine crises (named as the fist exercise) and the other based on Jacobson's progressive relaxation technique to be done daily in order to control his

nervousness. In Carmen's case, she delegated the choice of specific interventions to the therapist. They started by doing several relaxation exercises, with the client preferring the one using bio-feedback (with the help of a skin electro-conductivity apparatus). Moreover, a log or diary of thoughts to deal with cognitive anxiety was also used with positive results.

Let us start by looking more closely at Pepe's case, through the following talk interaction that occurred during the first session.

Extract 13 (Case 1 – Session 1)

(Note: C1 is Pepe, C2 is his sister-in-law who came with him to the first session)

1151 T: *Manuel was saying that when
1152 you were with dr *Gracia he was
1153 there, and dr *Gracia said that
1154 we use hypnosis?
1155
1156 C1: yes:
1157
1158 T: what do you think about that?
1159
1160 C1: yes. nothing.
1161
1162 T: you don't have any idea?
1163
1164 C1: I don't have any idea, I don't have any
1165 idea about that.
1166
1167 T: m-hm, well.
1168
1169 C2: hypnosis?
1170
1171 T: yes, we work with
1172 it, but what we
1173 want now, is to clarify the concepts,
1174 because usually people have the
1175 idea from the stage shows or
1176 similar things, and that is an idea a
1177 little, that it is not what we
1178 do. First of all,
1179 hypnosis is something that you do
1180 to yourself, these are techniques of

1181 imagination and auto-suggestion that
1182 you are going to do to yourself, you
1183 are always controlling what is going on /
1184 we only help you during the first
1185 few times that you do these techniques and
1186 after you learn to do them by yourself
1187 and they're very basic things, today we
1188 can start with a simple relaxation technique
1189 and see how you feel.
1190 what do you think?
1191 I'm noticing your foot a little:
1192
1193 C1: ha, ha (laughter)
1194
1195 C2: the relaxation is wonderful
1196
1197 C1: well.
1198
1199 T: but that is a little, it varies from
1200 person to person.
1201
1202 C1: we can try it but I
1203 don't like that.
1204
1205 C2: but, why?
1206
1207 C1: I don't like that a lot.
1208
1209 T: why? lets talk about it.
1210
1211 C1: well, it's that to speak about that
1212 the hypnosis and those things I don't like
1213 that a lot.
1214
1215 T: m-hm, why? what ideas do you have?
1216
1217 C: that I don't like it, those things are
1218 things that I don't like, when I see it on
1219 the TV I don't fancy it.
1220
1221 T: ah, but what we do has very
1222 little to do
1223 with what appears on the TV.
1224
1225 C1: well, I presume that this is not going to be
1226 like that or even similar, but those
1227 things /
1228
1229 T: on TV is show business,
1230 illusionism, magic. here it doesn't have
1231 anything to do with that. /it's relaxation

1232 and to use the imagination / there are people
1233 with these methods that enjoy them a lot,
1234 this is the only thing that I can tell from
1235 my experience.
1236
1237 C1: I don't know /
1238
1239 T: what are you doubts about it?
1240
1241 C1:/ I'm afraid of those things, I
1242 don't like those things very much.
1243
1244 T: but, what are you afraid of? can you
1245 specify that more.
1246
1247 C1: I don't know.
1248
1249 T: fear of losing control?
1250
1251 C1: well of anything.
1252
1253 T: of doing something that you wouldn't
1254 do if you weren't in hypnosis, is it that?
1255
1256 C1: I don't know / I don't like it / I can't
1257 explain it, but I don't like it, that's
1258 the truth.
1259
1260 T: m-hm, that you don't like that?
1261
1262 C1: no, no, no, no, clearly that I
1263 don't like it.
1264
1265 T: but, try to explain a little
1266 better why you don't like it?
1267
1268 C1: it's that.
1269
1270 T: you have doubts, what do you think it is?
1271
1272 C1: / I don't like those things, I can't
1273 explain it, but I don't like it.
1274 (the intercom rings)
1275
1276 T: (the therapist speaks with the therapeutic
1277 team) well, if you don't feel
1278 comfortable, we won't do it today / I will
1279 not do anything that you don't want to do.
1280 what we will do today is to give some
1281 ideas about relaxation techniques,
1282 only that / and we will see how that can

1283 help you.
1284
1285 C1: fine.
1286
1287 T: do you feel better with this?
1288
1289 C1: fine.
1290
1291 T: no, because here it is you who is in control.
1292
1293 C1: yea, yea, yea, I understand.
1294
1295 T: we are here to help you.
1296
1297
1298 C1: of course.
1299
1300 T: but we will not ask you to do
1301 anything that you don't want to do.
1302
1303 C1: of course /

In this long extract the therapist introduces the idea of using hypnosis as a technique to help the client manage his headaches. The neurologist who referred the client to psychotherapy had informed him that we usually use this technique for pain management. Thus when Pepe came to the first session he had this information. Yet, when the therapist tries to clarify the concept of clinical hypnosis, she initially notices through the client's non-verbal language (L1191 "T: I'm noticing your foot a little:") and then explicitly through words (L1207 "C: I don't like that a lot") that he does not feel at ease with the idea of using hypnosis. Even after the therapist tries to differentiate clinical hypnosis from stage hypnosis (as it is usually portrayed on TV) the client is still apprehensive with that prospect. Finally, the therapist (and therapeutic team) stops trying to convince

the client, reassuring him that he can decide which techniques are going to be used and that nothing as on TV shows is going to happen in therapy (L1291 “no, because here it is you who is in control”).

It is important to note that the word “hypnosis” signifies different things to the client and to the therapist. The client associates this word with what he sees on TV and other mass media – stage hypnosis. The therapist correlates this word with what she knows by personal experience and by readings of clinical and research material – clinical hypnosis. The therapist realises this incongruence and tries to redefine the client’s meaning but with no success. Now, with advantage of hindsight, the therapist, instead of trying to differentiate clinical hypnosis from stage hypnosis through words, could have asked his sister-in-law (who was with the client for the first session) to volunteer for a demonstration since she was more open to the idea. This strategy is inspired by several cases of Milton H. Erickson where he asked another person to demonstrate hypnosis to circumscribe the resistance of the patient (e.g., Rosen, 1982). In this manner, the potentialities of hypnosis can be demonstrated while debunking some of its myths and respecting the fears, doubts or suspicions of the client. Moreover, it gives the client the opportunity to try the experience vicariously.

However the therapist did not do this. Instead, she accepted the client’s definition of hypnosis and designed an exercise that he would

not consider as hypnotic. For instance, the therapist did not suggest to the client to close his eyes, and she avoided suggestions that could lead to any of the classic hypnotic phenomena usually associate with stage hypnosis, namely catalepsy, amnesia, age regression and hallucination (see extract 14).

Extract 14 (Case 1 – Session 1)

(Note: C1 is Pepe, C2 is his sister-in-law who came with him to the first session)

1406 T: so well, what we are going to ask you,
1407 well, now, we're going to teach you a
1408 simple technique, and afterwards what we ask
1409 of you is to do it at home sometimes and
1410 if you feel the pain to do it then,
1411 and see what happens, this is the beginning,
1412 afterwards we can teach you
1413 more specific techniques. well, I would like
1414 to ask you to focus on
1415 your breath, in the breathing in, in the
1416 breathing out and breath deeply and now
1417 count until ten, with each
1418 breath you take
1419 (T breaths in deeply)

1420
1421 C1: for me to count?
1422

1423 T: to ten. one, two, three, four and
1424 feel you muscles lighten, five,
1425 six, seven, eight, nine, ten, now
1426 look to your hand, it can be this hand
1427 (points to the left hand)

1428
1429
1430 C1: what did you say?
1431

1432 T1: to look to, to look to your hand, and
1433 continue breathing calmly, with tranquillity,
1434 you can close it as a fist, and imagine
1435 the pain in your hand, not the pain
1436 the pulsing sensation you can feel it in your
1437 hand, not the pain, the pulsing. (T speaks
1438 looking to C1's hand, C1 closes and opens his
1439 fist) when you start to feel the pulsing
1440 sensation, is it strong, no? – and – quick
1441 (p: 4s) and it's unpleasant because it's
1442 strong – and because it's quick (p: 4s) and

1443 it disturbs you, it doesn't let you work
1444 because it is strong and quick (p: 3s) it
1445 disturbs you for a long time because it's
1446 strong and quick but you know that it would
1447 go away, it can last for one, two, three
1448 days, sometimes less – (T and C2 mirror C1's
1449 movements) and when it starts to go away
1450 it becomes milder, it is not so quick, it's
1451 slower – each time slower –
1452 until that slowly – but surely it goes
1453 away (p: 6s) each time slower --
1454 each time you feel better – because you know
1455 that the pulsing sensation is going to stop –
1456 and when it stops you feel better – you can
1457 feel the muscles of your hand lighter
1458 – with the other hand you can rub
1459 this hand a little (T rubs her hand and
1460 C1 and C2 rubs their hands too) -- and what
1461 I'm asking you to do is to do this exercise
1462 when you feel the pain.
1463
1464 C1: what?
1465
1466 T: when you feel the headache
1467 do this exercise.
1468
1469 C1: to do this exercise.
1470
1471 T: start by closing your fist and squeezing it
1472 as the pulsing sensations you feel
1473 in your head and then start to space out the
1474 squeezing in your hand, do you understand?
1475
1476 C1: yes, yes
1477
1478 T: space them out slowly, always
1479 breathing deeply --- and space them out
1480 until they stop and then see how you
1481 feel. – before you take any analgesic
1482 do this and see how you feel.
1483 this is a very, very basic thing
1484 that can be done in different ways.
1485 -- there are people that do well with
1486 these types of techniques. it's
1487 a little. maybe your are thinking "ho!
1488 how is it that such intense pain that
1489 resists so many pills, now
1490 with this technique of squeezing the fist can
1491 just go away. this is a joke, no?"
1492 maybe you are thinking this? a little,
1493 + ha, ha

1494
1495 C1: ha, ha +
1496
1497 C2: he is very sceptical
1498
1499 T: he's very sceptical, but I ask you just to
1500 try it. I'm not saying that it will work,
1501 I'm not saying that. I only ask one thing
1502 try it out. nothing else.
1503
1504 C1: I will./ when I feel the
1505 headache.
1506
1507 T: you sit somewhere relaxed, and put
1508 yourself like this, and start to focus on
1509 your hand ---
1510
1511 C2: breathing deeply and looking to + the
1512 hand.

In this segment, the therapist defines the fist exercise as a very simple one that is going to be taught and practiced in the session and then afterwards has to be done at home when the client feels his migraine. The therapist asks Pepe to focus on his breathing and to imagine the pulsing quality of his headache in his hand. More precisely, she asks him to reproduce the rhythm of the pulsing by squeezing his hand closed as a fist. First, he should synchronise the rhythm of the pulsing sensation with the rhythm of squeezing his fist. After matching the two, he should start to space the squeezing of his hand until a complete stop when he relaxes his hand. The therapist, noticing Pepe's doubts, asks him just to try to do the exercise and to see what happens. He asks several questions during the exercise to confirm his understanding, and in the end agrees to give it a go. This exercise is

constructed around one of the migraine's typical characteristics, the pulsing quality of the pain. The physical exercise of squeezing the fist imitates that defining pain characteristic and the exercise's aim is to control the rhythm of the squeezing of the hand and to check what happens with the pulsing in the head. The intent is to pace that pulsing quality in order to change it. Words became movements that can change sensations.

As noted before, the therapist avoids the traditional hypnosis induction and phenomenology, yet it can be argued that many elements of the fist exercise are influenced by clinical hypnosis, more precisely by what is called naturalistic hypnosis. This type of imagination exercise is more difficult to differentiate from this type of hypnosis than from the classical hypnosis characterised by typical induction, deepening and suggestions. So, it can be argued that in some aspect the therapist utilises some hypnosis elements. Thus, did the therapist use hypnosis after agreeing with the client that they were not going to use it? In other words, did the therapist deceive the client? If we consider just the word hypnosis as representing one only reality, we can argue that there is a contradiction between what the therapist agreed to do (not to use hypnosis) and ultimately did do (use some elements of hypnosis). However, if we consider that the same word can signify two different things depending on the context (what Pepe sees on TV versus what the therapist reads in book and

experiences) then there is no contradiction or deceit. The therapist did not use hypnosis as the client constructed it (stage hypnosis), yet she used techniques inspired from a more naturalistic approach of clinical hypnosis, always respecting the need of control by the client.

This clinical vignette illustrates some of the challenges of working with hypnosis in therapy. Many myths of hypnosis spread by movies, TV programs, and stage shows make the job more difficult for the psychotherapists who want to use clinical hypnosis to help their clients (Capafons & Mazzoni, 2004). This is unfortunate, since the usefulness of hypnosis for managing chronic pain has been shown again and again, including its effectiveness for the management of migraines and tension-type headaches (Hammond, 2007).

Coming back to Pepe's case, during the second session the therapist tried again to redefine hypnosis with no success. Then she decided to use a technique based on progressive relaxation to help him control his generalised anxiety. This relaxation exercise was also rehearsed during the session and afterwards given as a daily home work assignment. Pepe did it daily and he also tried the fist exercise when he felt his migraine (see extract 30).

Extract 30 (Case 1 – Session 3)

642 T: aha. to protect yourself a little is always
643 important. and regarding the
644 techniques that we trained with here in the
645 last session, you told me that you try to do
646 them everyday?
647
648 C: yes, yes, everyday.

649
650 T: and when, in the morning, at
651 night?
652
653 C: in the morning and many nights too when
654 I'm going to bed. as I'm
655 alone in the house, well I'm there
656 sitting on the sofa
657 and I do it.
658
659 T: aha, and how do you do it?
660
661 C: well as you told me, like
662 this. first one hand, then the other.
663 then one leg, then the other,
664 my head towards one side, then to the other,
665 these ones. everything you told me.
666
667 T: very well, and do you think that after
668 doing this exercise you feel more
669 relaxed, more calm?
670
671 C: well, I think that, feel as
672 that not so much, but I believe that yes
673 that it can help me, I'm telling you,
674 I saw that it does.
675
676 T: m-hm and when you have the headaches
677 and you try to do this, do you feel
678 uncomfortable to do the
679 exercise?
680
681 C: yes when I have the headache
682 I do this one and I feel it a little. I'm
683 telling you, more than this one, it is to do
684 I'm telling you, these things, to do strength
685 with these things.
686
687 T: yes, and did you do the one of imagining the
688 pulsing sensations in your hand and do you
689 feel
690 C: yes, what happens is that with that one I
691 feel it a lot here.
692
693 T: very well
694
695 C: I almost have to stop doing it
696 because it hurts a lot.
697
698 T: aha, but, when you do the squeezing
699 it seems like if in reality it hurts

700 more?
701
702 C: yes it seems that the head answers back.
703
704 T: and afterwards, if you manage to space it out
705 in your hand?
706
707 C: then afterwards it seems like
708 the beating stops, it seems that it is
709 like a beating that when you do this is
710 like a beating, then when
711 I let go it is like it goes away. it
712 becomes more calm, even though it is still
713 aching, but it is a different
714 thing.

This segment shows that the client did both proposed exercises. He reported not to feel an immediate result with the progressive relaxation exercise, yet with regards to the fist exercise he notes an immediate response (see from line 707 to 714).

In Carmen's case, during the first session the therapist offered her several options for specific interventions (see extract 48).

Extract 48 (Case 12 – Session 1)

577 T: a: and we have different methods for
578 relaxation, some are based on
579 imagination, others are called
580 biofeedback which is with a device that
581 measures the conductivity of the skin which
582 is associated with states of distress
583 and anxiety that we can have, there are also
584 techniques of auto-hypnosis. you can
585 choose the one that you think can be
586 most helpful to you. which one would you like
587 to try first?
588
589 C: I don't know. I'll let you choose,
590 because I don't know.

After the therapist listed a menu of possibilities for Carmen to choose from, she says "I don't know. I'll let you choose, because I

don't know." (L589-590). Once again she is placing herself in a passive position, and she delegates the agent role of deciding to the therapist who supposedly should know better than her. She gives the power of decision to the therapist, as well as the responsibility of making a good choice. This action of delegating the agency to another person is a pattern that Carmen keeps repeating when looking for possible solutions for her headaches. Yet, she feels frustrations when she does not see immediate results, which leads the therapist to emphasise the importance of being persistence and patient and to give a rationale for the techniques used (see extracts 73 and 77).

Extract 73 (Case 12 – Session 3)

3042 T: and you have to be persistence, and
3043 then the work is going to evolve
3044 slowly, first to learn how to
3045 relax yourself, and this is the aim
3046 of this apparatus, or of other exercises
3047 that we will do, then we have to
3048 work on learning to see the signals
3049 that your husband sees and that many times
3050 you don't see, to act then, when
3051 you start to become more activated,
3052 m-hm. we have to start to work on these
3053 let us see: and afterwards to
3054 use these relaxation processes that you
3055 learn, to prevent the accumulation of
3056 so much tension

Extract 77 (Case 12 – Session 4)

1063 T: m-hm, it's that; but one thing we have
1064 to have very clear, because both
1065 this relaxation exercise, as
1066 these types of stretching and massages and
1067 etc, or the yoga and everything that you can
1068 do, what they are going to do is that: ; for
1069 instance, imagine that the tension is

1070 like water that goes into a glass, your
1071 problem is that it is filling, filling,
1072 filling, and everything is accumulating here
1073 until pluff.
1074
1075 C: it breaks
1076
1077 T: it breaks, and with a lot of strength. now
1078 all this type of exercises what it does
1079 is to take some of the water out
1080
1081 C: m-hm
1082
1083 T: to prevent the glass to
1084
1085 C: not to overflow

In these extracts, we can see one of the rationales that the therapist gives for justifying the importance of the relaxation exercises. They are presented as an indirect means to alleviate her headaches by disrupting some of the vicious cycles that increase her tension and anxiety. In extract 77, the therapist uses an analogy. The therapist compares the accumulation of tension and anxiety in the client's day-to-day life with the filling of a glass with water. The filling of the glass to the top until it starts to overflow is given as an image when the client's tension reaches a critical point that triggers the severe headaches. It is interesting to note that when analysing this analogy from within the systemic perspective, we can argue that the therapist is giving a rationale for a first-order change (i.e., a change that does not change the system). As with her crying (extract 67, p. 179), the relaxation exercises relieve some of the tension, even disrupting the cycles of accumulation of anxiety. Yet they do not

break these cycles, producing a second-order change (i.e., a change that changes the system, thus producing significant and lasting results). This interpretation can justify the small changes reported directly from these exercises. For instance, Carmen very quickly became proficient in achieving a good relaxing state by using the skin electro-conductivity apparatus. She even, by her initiative, fused the imagination exercises learned with elements of the biofeedback exercise (see extracts 76 and 82).

Extract 76 (Case 12 – Session 4)

759 C: yes, today having this here, I can
760 imagine it straight away, even if I want
761 to imagine the beach the countryside
762
763 T: m-hm
764
765 C: I always imagine the measuring needle,
766 always that, even when I'm bad I can
767 imagine the needle and I have to lower it
768
769 T: m-hm
770
771 C: it is easy for me, I say I can focus better
772 on that
773
774 T: yes, yes
775
776 C: I don't know
777
778 T: it is like with yoga, there are certain
779 positions that are more for meditation,
780 and that we know that with this position
781 we have to do x
782
783 C: that's right
784
785 T: a-ha, that in a certain way this is
786 associated with this, you have to relax,
787 perfect

Extract 82 (Case 12 – Session 5)

10 C: the exercise in itself I can do it very well
11
12 T: a-ha
13
14 C: in other words I don't have problems
15 to bring it down, but
16
17 T: m-hm
18
19 C: when I stop, well I say //
20
21 T: yes, but while your are doing it
22
23 C: yes, I try to forget that it hurts
24
25
26 T: a-ha
27
28 C: even though it is aching I don't
29 focus on it
30
31 T: yes, yes
32
33 C: I'm focusing that I'm going to bring the
34 needle down
35
36 T: a-ha
37
38 C: that is my goal
39
40 T: a-ha, and do you manage?
41
42 C: yes, yes, perfectly
43
44 T: m-hm

However she only manages to get temporary relief from it.

On the other hand, with another specific intervention (the diary of thoughts) aimed at stopping the cognitive vicious cycles, more positive outcomes were reported which could indicate a second-order change (see extracts 79 and 85).

Extract 79 (Case 12 – Session 4)

2468 T: yes, when you are thinking over and over.
2469 "I'm thinking it over and over, I'm thinking
2470 it over and over", "how am I thinking
2471 over and over" then let's see what happens.
2472 even when you don't write down anything,
2473 when you start to see that you are repeating
2474 to yourself, "I'm thinking it over and
2475 over", well first of all "how am I thinking
2476 over" and then you can ask yourself "why am
2477 I thinking it over and over", but first
2478 "how am I thinking over and over"

Extract 85 (Case 12 – Session 5)

277 T: yes, yes and how I can help you is;
278 you can continue having headaches,
279 but it might be that the headaches
280 don't intensify so much
281 because you are not going so deep
282 into the cycle
283 C: yes, it's where we are going; I by myself
284 have confirmed this, I know that when I
285 have an intense headache or I have this
286 typical nausea
287
288 T: m-hm
289
290 C: I go down in morale, I already have
291 told you this
292
293 T: yes, yes
294
295 C: yes, I feel more sad, then that
296 leads me to start over again
297 to; I started to write down,
298 what I wrote the day after
299 you told me about how I was
300 thinking about it over and over and I
301 decided, "here Ana is right, I have to change
302 and not keep thinking;" when I was writing
303 this
304
305 T: yes, you were more aware of what was
306 happening
307
308 C: yes, yes

In segment 85, Carmen reports how doing the assignment of writing down how she obsesses with her thoughts, helped her to become more aware of it and more importantly, gave her way of breaking this cognitive anxiety generating cycle. Consequently, she realises that by doing this, she helps herself not to fall into the downwards spiral that leads her to despair about her headaches. Significantly, in this segment, she speaks as an agent, the person that is doing it: “yes, it’s where we area going; I by myself have confirm this” (L283-284).

In summary, in both cases we saw how specific interventions came to life through custom made exercises. After agreeing on the specific interventions, they were experienced during the sessions and subsequently given as homework assignments. There were exercises aimed to control the pain directly (e.g., the fist exercise), and others designed to deal indirectly with headaches, such as relaxation exercises through progressive relaxation, imagination and biofeedback, and also cognitive exercises (e.g., the diary of thoughts). Afterwards, the utilization of the exercises at home and their practical effects were discussed in therapy, showing some positive changes.

3.3.2.2.3. Changes

Facilitating a desired change is a basic goal of any psychotherapy model. In the case of brief therapy of systemic orientation, after defining the problems, therapeutic aims and introducing specific interventions, there is a stage of evaluation and amplification of changes. Within this stage, therapist and client can assess how close they are to achieving their therapeutic aims and what else they have to do to reach them. To amplify the changes produced is an important element in this process. This can be done through the identification of successful strategies and the recognition of resources already used by the client. With this theoretical underpinning, in the two cases analysed, we can identify specific changes and potential justifications for them. Likewise, new resources can also be recognized. Moreover, it is important to appreciate that the events that occur outside therapy (i.e., extra-therapeutic changes and resources) can have a very positive impact on the overall therapeutic outcomes.

Let us now look at Pepe's case. During the 4th and final session, Pepe classified the level of his headaches around two or three (in an imaginary numerical scale, where zero means no pain and ten means unbearable pain). Since during the first session (when this scale was introduced) he defined as a positive outcome to have his migraines controlled around a level of three or four, we can argue that one of

the main goals was reached. In other words, a positive change was achieved (see extract 9 and extract 38 , point 3.3.2.2.1, p. 193). There are other segments that reflect a recognition of changes produced in therapy (see extracts 26 and 31).

Extract 26 (Case 1 – Session 3)

92 T: yes, so, there was a big
93 change because:

94

95 C: yes at the moment I can tell you that
96 the therapy that you gave me seems to
97 be working.

98

99 T: aha, yes, and because of what you are doing
100 too. that is very important.

101

102 C: yes, with what I'm doing it seems that
103 this can be, not the solution,
104 but at least help me somewhat to:

105

106 T: to + control

107

108 C: to relieve + things a little.

In this extract of the beginning of the third session, the client reports that changes are happening. The therapist stresses that the changes identified are important ones. The client agrees with the therapist and relates the change directly to psychotherapy. It is interesting that he speaks about the psychotherapy as if it was a typical medical intervention. Pepe says “the therapy that you gave me seems to be working” (L96-97). It is almost as if he had been prescribed a specific medication and is reporting to the doctor that “the *medicine* that you gave me seems to be working”. He puts the agency of the change outside himself, in an entity that he names as

“therapy”. In the next turn of talk, the therapist agrees with the client, yet adds that his role in the process is vital, in this way giving part of the agency back to the client. He agrees with this redefinition, saying that all of this can be useful for reaching the therapeutic aim of controlling his migraines.

Extract 31 (Case 1 – Session 3)

758 T: yes, yes. I think that these first
759 exercises are helping you. now, we
760 may reach a stage or phase that
761 requires the use of other techniques,
762 if these ones don't work then, but if these
763 simple, straightforward ones work.
764

765 C: yes, I'm telling you. now I would like to
766 continue, let's see, if you don't change
767 these, to see what happens with them, to
768 see if with these, I feel a little better.
769 now I have been doing what you told me
770 to do and I can tell you that I don't believe
771 that these would completely end the
772 headaches, but it can help to relieve it,
773 I think.
774

775 T: yes, yes, very well.
776

777 C: yes, I tell you that, it hurts less. if
778 after one or two months it still hurts less,
779 well we can say that we
780 achieved something.
781

782 T: yes, yes. that is important. for this,
783 if we meet again in a
784 month's time and during this time
785 things continue as in this last
786 month, then, could we tell
787 that things are improving?
788

789 C: yes, sure, if things continue like the
790 last month, then we are improving
791 something. because I tell you, last month
792 it hurt on the nineteenth,
793 I wrote it down.

In this segment, the therapist and client related the changes further to the specific interventions/exercises introduced in therapy (i.e., the fist exercise and the progressive relaxation exercise). However, the client, after agreeing that there are positive changes achieved, draws attention to the importance of checking the stability of those changes: “if after one or two months it still hurts less, well we can say that we achieve something” (L777-780).

Moreover in this session, the client also connects the control of his headaches to a positive effect on his mood (see extract 33).

Extract 32 (Case 1 – Session 3)

939 T: and it went away.

940

941 C: sure, it went away. I already told you
942 that I don't believe that this will cure
943 the headaches, honestly I don't believe
944 it, but if I do this it can
945 relieve things.

946

947 T: yes, yes, and if you manage to have your life
948 + in spite of.

949

950 C: of course + be more normal, a little more
951 relaxed, more calm, to be more
952 happy.

In this segment, we can see that achieving some degree of pain management can lead to an improvement of the client's mental health, creating a positive cycle of well being (as opposed to the vicious cycles that maintained the problems). Furthermore, psychotherapy is seen as a new resource that is there to help him, even for future problems (see extract 39).

Extract 39 (Case 1 – Session 4)

578 C: I want to ask you something, and if in
579 one year I restart feeling
580 something over again, could I come back here
581 again?

582

583 T: yes.

584

585 C: what do I have to do?

586

587 T: you have our phone number?

588

589 C: yes.

590

591 T: you could call us.

592

593 C: okay

594

595 T: you could call us and we will book another
596 session.

597

598 C: I'm going to carry on with what you told me
599 to do, because I had very good
600 results, but if any day
601 I have a problem, I saying, can I come back
602 here? if I can call directly
603 here?

604

605 T: yes, yes. because what I would like to
606 suggest now, well, now that everything seems
607 is going well

608

609 C: yes things are going very well at the
610 moment. and I'm asking you if
611 in the future if I need it, can I
612 come back here?

In this talk interaction, we can see how the client constructs psychotherapy as a useful resource, which he wants to be reassured is accessible for him in the future. He checks several times to confirm that if he needs to, he can come back to psychotherapy and asks how he can do this.

In Carmen's case the changes are not as straightforward (paralleling the construction of the problems and the therapeutic aims). Nevertheless there are several extracts that provide evidence of important changes that occurred while she was in therapy. For instance, in extract 84, she reports an important change in perspective.

Extract 84 (Case 12 – Session 5)

223 T: you are keeping your sense of humour
224
225 C: yes, I'm saying that I'm going to try
226 not to worry so much about this situation
227
228 T: m-hm
229
230 C: because everybody tells me the same thing "if
231 you had something serious during all this
232 time then something already would have
233 happened, you would not have so many
234 warnings", I'll look at it in a different way
235 Ana what can I do (laughter)
236 T: a-ha, but you also feel better from
237 this?
238
239 C: no, no I don't feel better, I try not to
240 feel so sad
241
242 T: m-hm
243
244 C: in the sense that well I don't go
245 anywhere, I'm not advancing, why should I
246 always worry about the same things,
247 when I worry more I fell worse
248
249 T: that is true
250
251 C: and I'm aware of that because I have
252 done it
253
254 T: m-hm

During the 5th session, the client even considers that there is not significant progress toward her main goal (i.e., to treat her headaches), yet she speaks about seeing the situation in a different way. She recognises that by stopping some of the cognitive cycles that create even more suffering (worrying over and over again about the meaning of her headaches), she can avoid feeling worse. Moreover, she assumes a more active position in relation to her headaches (see extract 88).

Extract 88 (Case 12 – Session 5)

2089 T: so you are telling the pain that
2090 you are going to fight against it
2091
2092 C: yes, yes I have it clear, from the other
2093 week when I left here
2094
2095 T: a-ha
2096
2097 C: you spoke about it and I saw it very
2098 clearly
2099
2100 T: m-hm
2101
2102 C: that I could not keep going around and around
2103 with something for so long
2104
2105 T: m-hm
2106
2107 C: and that I have to fight against it

In this extract she speaks as having more accountability over her opinions and actions (“I saw it clearly ... that I could not keep going around and around with something for so long and that I have to fight against it”). Additionally, she even speaks about how she applied this

proactive approach to deal with other situations in her life (see extract 89).

Extract 89 (Case 12 – Session 5)

2166 T: and there are things that we're afraid of,
2167 and all but if you fight against some
2168 fears, sometimes we are afraid, and
2169 sometimes we have many bad moments,
2170 of things that never happen
2171
2172
2173 C: just in the other day in a lift that
2174 I'm always very fearful of
2175
2176 T: m-hm
2177
2178 C: I fell claustrophobia there, I go
2179 by the stairs
2180
2181 T: m-hm, and sometimes is good to go up by the
2182 stairs
2183
2184 C: yes but, it was not because of the stairs, it
2185 was that lift was very claustrophobic
2186
2187 T: small?
2188
2189 C: it was small, and when you close
2190 the doors
2191
2192 T: m-hm
2193
2194 C: the outside doors they close
2195 hermetically and everything is very cold
2196
2197 T: a-ha
2198
2199 C: it's like stainless steel, well like a
2200 bunker
2201
2202 T: m-hm
2203
2204 C: "well I'm going to go by the lift"
2205
2206 T: a-ha
2207
2208 C: I'm alone, "I'm going up alone and
2209 well if I take too long, it's because I'm
2210 stuck in the lift" (laughter) he tells me
2211 "you know that I'm here", "yes, yes,

2212 but I'm going up by myself and if you
2213 want", "I'm going by the stairs" my
2214 husband said. I went up by myself,
2215 I looked around, "everything is fine, I
2216 don't feel lack of air", and I came down
2217 by the lift also
2218
2219 T: m-hm
2220
2221 C: "but I'm going with you, look I'm fat
2222 and I take a lot of space", "yes, yes, now
2223 you come down with me I don't mind"
2224
2225 T: a-ha
2226
2227 C: in other words I tried what you suggested
2228
2229 T: to deal with
2230
2231 C: to deal a little, like saying
2232 I'm afraid so I'm going to do it
2233
2234 T: m-hm, yes, yes that is very important
2235
2236 C: and I'm going to do it yes, I'm going to do
2237 everything that I can

In this segment she proudly reports her successful adventure in challenging one of her fears (to go in a particular lift). She tells this episode as if it was happening at the present moment and she rejoices in her accomplishment. This shows some degree of generalization of the therapeutic changes, since to face her fear of that lift was never directly suggested by the therapist.

However in the 6th and final session, she reports her frustration with not being able to find a treatment to cure her headaches. Even so, in parts of a discourse she maintains a proactive attitude (see extract 96).

Extract 96 (Case 12 – Session 6)

2541 T: but a little like you left here
2542 last week and you went to yoga, and
2543 you had postponed that decision for a long
2544 time
2545
2546 C: because when I'm going from speaking with you
2547 I say that you are right,
2548 I have to sit the pain here, and even though
2549 it keeps hurting, little by little I'm going
2550 to do this, and this, but
2551
2552 T: and you have to continue fighting the small
2553 battles, and you will overcome this

In this segment the therapist identifies an important achievement of the client. After procrastinating for a long time, the client went back to practicing yoga, an activity that was very helpful for her in the past to manage her tension and anxiety. Furthermore, the therapist also expresses a message of hope that if she carries on with her more proactive approach: “you will overcome this” (L2553).

Additionally, in both cases it is possible to identify events that happened outside therapy and that were not a direct consequence of therapy. For instance in Pepe's case, his decision to change professions had a very positive impact in helping him manage his headaches. During therapy, therapist and client had discussed the inconvenience of his job as a construction worker and how it amplified his problems (from aggravating the migraines to the problem of being paid by the hour). Yet the therapist did not directly suggest to him to change professions. This can be considered as an extra-therapeutic change. The first time he speaks about this was during the second

session after the first break when the therapist went to consult with the therapeutic team (see extract 22).

Extract 22 (Case 1 – Session 2)

926 +after break one.

927

928 T: aa, well, today we can not go very far
929 because since the last time there was
930 no opportunity for testing it, or nothing
931 well, what we were speaking is that
932 at the bottom – the object-, the goal of
933 this therapy is in a certain way; /
934 it can be to try help you to
935 find resources to:
936 decrease as must as possible the +
937 headaches.

938

939 C: yes, yes +.

940

941 T: in a way that allows you to have
942 a life as normal as is
943 possible, and the techniques with which
944 we can help you to train
945 are like the ones that we did
946 the other day, and some others, and
947 some for relaxation too.

948

949 C: I'm going to change my profession if I can.

950

951 T: aha.

952

953 C: if I can, I going to change professions, I
954 don't know well, I have already that, and I
955 would like to change professions.

956

957 T: to something that you don't:

958

959 C: for not having to do so much physical efforts
960 and for not having to be in awkward
961 positions. instead of working in
962 construction, I'm going to work on a farm.

963

964 T: aha, it is not so:

965

966 C: taking care of farm animals, to do
967 something different, / then for
968 instance I may have to lift a weight /
969 but it isn't all day long, for instance
970 in the morning for the animals we have
971 to lift a little weight, but

972 afterwards during the day we can be more
973 relaxed, even though you have to work
974 fixing something there, but
975 sure, lifting less weights
976 I want to say and with better postures.
977
978 T: aha, yes, yes.
979
980 C: it isn't the same as being all day putting
981 down a floor /, or on a roof also leaning
982 down to put on the roof tile, well, with
983 better postures.
984
985 T: and is that possible? or you are thinking
986 about it, studying it?
987
988 C: I don't know, I think that it will
989 be possible, yes, because I already spoke
990 with the person that is going to give me the
991 job and he told me that it looks fine and
992 we agree on the money part well:.

In this interaction, the therapist supports and motivates the client to go ahead with this change, since both agree about the positive impact that this can have on his quality of life (including on his migraines). Worthy of notice is the fact that the client interrupts the therapist to speak about this subject. Usually after the therapist meets with the therapeutic team (on the other side of the one-way mirror), she comes back and reports to the client the main points discussed and possible interventions to be done. Yet, the therapist rarely asks the client what he was thinking during the time when she steps out. In the present case, Pepe probably was thinking about his decision of changing professions and he felt that communicating this was very important.

In relation to Carmen's case, we can identify important extra-therapeutic resources (i.e., capacities, qualities or activities that the person has experienced outside psychotherapy, which are helpful to reach the therapeutic aims). The yoga is a good example of one of these resources (see extract 63).

Extract 63 (Case 12 – Session 2)

2913 T: and when you used to practice yoga,
2914 did you manage to relax, did you work these
2915 muscles?
2916
2917 C: yes, there was a time that I didn't know that
2918 was from tension
2919
2920 T: m-hm
2921
2922 C: as they told me that it was from depression
2923 and I was displeased, I would notice it, no
2924
2925 T: m-hm
2926
2927 C: that while I was practicing yoga, I was
2928 calmer or I tried to
2929 disconnect, "well everything is fine"
2930 I had a very nice period
2931
2932 T: m-hm
2933
2934 C: it was that summer that I stop taking
2935 all the medications
2936
2937 T: m-hm

In this segment, yoga emerges as an activity that the client used to practice and that was very helpful to help her calm the tension of her shoulder and neck area. Furthermore, during the time when she practiced yoga, she had a headache free period where she even stopped taking her medication and still felt well. After identifying this

resource, the therapist suggests and motivates the client to start again practicing yoga. After some procrastination the client finally does it (see extract 93).

Extract 93 (Case 12 – Session 6)

504 T: m-hm, then you start again to practice yoga
505
506 C: yes, yes, I started last week,
507 the last day, after therapy
508 Wednesday I said to myself
509 "I have to do something more"
510
511 T: m-hm
512
513 C: and well, I managed to relax and the neck
514 area relaxed a lot
515
516 T: when you do yoga?
517
518 C: yes, when I do it, but the pain
519 the one that is here in the sides of the
520 head and the pressure
521 it is there
522
523 T: m-hm, even after of the yoga session
524 do you feel this area relaxed
525
526 C: yes, yes
527
528 T: but the pressure you feel it still
529
530
531 C: m-hm, m-hm
532
533 T: m-hm

It is important to note once more that in this talk interaction the client reveals more agency over her actions and decisions: "Wednesday I said to myself 'I have to do something more'." (L508-509).

To sum up, the segments analysed during this section are evidence that changes happened in order to achieve the desired therapeutic aims. The talk interactions analysed show those changes. In many instances, the way the clients speak and the words the clients use towards the end of the therapy are different from those used at the beginning. Equally important, many concrete situations are described that reflect a positive therapeutic outcome – the core aim of any psychotherapy process.

3.3.2.3. Conclusions

Taking into consideration the research questions developed at the beginning of DA, the following points can sum-up the conclusions of the present research:

1. How were the headache problems constructed in therapy? What did the participants do with these constructions?

The headache problems were constructed differently by the two clients. One client defined his headaches as an inherited characteristic impossible to eliminate completely, with his problem being a lack of control over them and the consequences of this (in his life, from his mood to his work). The other client had a more complex definition for her headaches. When they were strong or associated with other

unpleasant sensations (e.g., nausea), they were experienced as symptoms of an underlying serious disease not yet diagnosed by her doctors. These idiosyncratic meanings of both clients' headaches can be understood through their particular personal experiences, family histories and interactions with health professionals. Moreover, the clients used these meanings to ask for specific therapeutic aims.

2. How were the therapeutic aims constructed? Were they readjusted during therapy? What functions did these aims accomplish?

The therapeutic aims emerged as a negative template of their headache problems. In the case where the headaches were constructed as an inherited family characteristic (which in the client's opinion was impossible to totally cure), the therapeutic aims were defined as the management of the headache problem to bring it under enough control to allow the client to have a normal life and not have his work affected so much. In the other case, the client defined her desired aim as the complete cure of her headaches. During therapy this ambitious and difficult goal evolved into more concrete and reachable aims, such as to develop skills to control the headaches and to learn how to live better in spite of their daily presence. Within this context, some of the initial auxiliary aims (such as stopping cognitive anxiety creating cycles) became more central to therapy. In both cases, having aims agreed to by both therapist and client facilitated

the design of specific interventions and provided a reference for the evaluation of changes, as well as a way to assess the overall success of therapy.

3. How were resources for managing headaches constructed in therapy? Did they change during therapy? If so, what were the consequences of these changes?

Both clients came to psychotherapy because the medical resources they had previously tried were not helping them to adequately deal with their problems. In other words, they came looking for new resources. During both psychotherapies, specific exercises were rehearsed with the intention of providing new skills that could be used by the clients to alleviate their headache problems. Some of these interventions were aimed directly toward managing the headaches. Others were aimed at stopping the various vicious cycles that aggravated and perpetuated their headache problems. Some were considered by the clients as particularly helpful and they continued to use them even after the psychotherapy ended. Furthermore, psychotherapy in itself was considered a useful resource. In other words, psychotherapy was considered helpful to the clients for managing their headache problems.

4. Overall, how was this particular type of talk interaction helpful to change the way these people managed their primary headaches?

This particular type of talk interaction (i.e., brief psychotherapy of systemic orientation) was helpful for the clients to better manage their headaches, since it allowed them to discover new resources and sometimes to rediscover old ones. Some of these resources were skills taught through exercises during therapy (and practiced afterwards at home). Other resources allowed the clients to change the ways they were seeing and dealing with their problems. Others were more diffused and difficult to isolate, yet were reflected in the changed ways of speaking about the headaches and related issues.

3.4. FURTHER CONSIDERATIONS

At the end of the nineteenth century, Anna O. named her therapy “talking cure” (Freud, 1909/1989). From then on, this designation became one of the synonyms for psychotherapy. Indeed, even today we often see the terms “talking cure” or “talk therapy” being used as a substitute for the word “psychotherapy”. Sometimes, this is done in a demeaning way, defining psychotherapy as just words, just talking. Yet from the social constructionistic perspective these designations are elevated into another dimension. Words, talk, language and discourse are seen as complex social actions that deserve to be studied in their own right. From this standpoint, psychotherapy can be considered an organised set of talk interactions that facilitates important changes in people’s lives. The present research explores this way of seeing psychotherapy. Moreover, since the participants in these particular types of talk interactions are human beings, considerations about their distinctive characteristics have to be taken into account. As Wood and Kroger (Wood & Kroger, 2000) argue, humans can be considered as part of *res naturam* as well as of the *res artem*. In other words, they can be seen as embodied beings (i.e., natural objects similar to all other physical objects) located in the natural realm, as well as self-conscious beings living within a particular social world enmeshed within the complexity of language – a realm of

culture. Traditionally, the realm of nature has been considered as more real and as a more suitable object for scientific study. Thus, materialistic assumptions, mechanistic models and realistic explanations have taken over the sciences. These assumptions (that dominate the orthodox paradigm) ignore important human characteristics such as reflexivity and social agency, which are essential to take into consideration when studying a complex social activity such as psychotherapy. Consequently, alternative paradigms of research (which provide a better approach to the *res artem*) were found more appropriate for the present research. Bearing this in mind is important when reflecting on issues such as the limitations of the present research and its implications and applications.

3.4.1. Limitations

Social constructionism DA is a methodology that emerges from an alternative paradigm of research. Consequently the criteria for evaluating particular studies using this methodology are different from the ones usually used with a traditional quantitative study. Concepts such as validity (i.e., accuracy of findings) and reliability (i.e., consistency of findings over time) make less sense within a social constructionism framework than in a positivistic one. Taking into

account the epistemological underpinnings of qualitative methodology, several authors have proposed a specific set of criteria important to consider when conducting this type of research. The one proposed by Elliott, Fisher and Rennie (1999) has attracted some consensus. They first list seven guidelines common to both qualitative and quantitative methodologies:

1. Explicit scientific context and purpose
2. Appropriate methods
3. Respect for participants
4. Specification of methods
5. Appropriate discussion
6. Clarity of presentation
7. Contribution to knowledge

They afterwards suggest seven additional guidelines especially pertinent to qualitative research:

1. Owning one's perspective
2. Situating the sample
3. Grounding in examples
4. Providing credibility checks
5. Coherence
6. Accomplishing general versus specific research tasks
7. Reasoning with readers

When reflecting in the present research (based on the above guidelines) I can say that there were a couple of them that could have been more closely followed. Let us now look at these limitations.

The present research could had been designed to provide more systematic credibility checks. Elliott and colleagues (1999, p. 222) suggest as possibilities:

- a. checking the research findings with the original participants or others similar to them;
- b. using multiple qualitative analysts, and/or an additional analytical ‘auditor’ for reviewing the data detecting discrepancies, overstatements, or errors;
- c. comparing two or more varied qualitative perspectives; or
- d. where appropriate, to “triangulate” with external factors or quantitative data.

Suggestions (a) and (b) had been especially pertinent to incorporate in a systematic way. Some *ad hoc* efforts were made to check the research finding by speaking about them with patients suffering from chronic pain. One person inclusively read the thesis and reported that apart from the more theoretical jargon, she felt that she could relate with many of the points made. Moreover, the reviews done by the director of studies (and by the examiners that are reading

this thesis) can be considered as an audit of the soundness of the present report.

In spite of all this, one of the biggest limitations of this work derives from the fact that it is a thesis for a PhD that has to be carried out by an individual researcher. As Krumboltz (2002, p. 932) puts it: “I think peer research teams can provide more than a social experience. They can stimulate ideas, provide checks and balances, motivate effort, and generate a better product than can individual efforts alone.”

Another limitation was the exclusive focus on the language spoken. Non verbal interactions are also actions relevant to be studied in psychotherapy. The inclusion of the non-verbal features would have allowed an interesting possibility for triangulation of data analysis.

The other guideline that could have been more closely followed was to accomplish a better balance between general and specific research tasks. The general aim of this project was to explore the potentialities of brief therapy of systemic orientation for management of primary headaches, yet the specific research was done with only two psychotherapy cases, which limits the scope of the findings. Once again the limitations of a PhD thesis as the work of an individual come into play.

3.4.2. Implications and applications

In spite of the previous limitations, we can draw important implications and practical applications from the present research.

Stovner and colleagues (Stovner et al., 2007) note that:

Headache is one of the most common disorders of the nervous system and several of its subtypes—tension-type headache, migraine, cluster headache and the so-called chronic daily headache syndromes—cause substantial levels of disability. Yet, throughout the world, headache has been and continues to be underestimated in scope and scale, and headache disorders remain under-recognized and under-treated everywhere. (p. 193)

Thus, any work that contributes to the further understanding of primary headaches and their treatment can be considered as pertinent. Within the modest scope of the present project, DA reveals important points.

One – The headache problems were entangled in many vicious cycles, Catch-22 situations and even double-binds, and that these patterns had the tendency to aggravate and perpetuate the problems. The above patterns are rarely taken into consideration when speaking and treating primary headaches. Yet they provide an alternative for the traditional linear mechanistic explanations, allowing a better understanding of the complex casual fields within which primary headaches are enmeshed. Furthermore, to consider these patterns can also provide ideas for possible useful therapeutic interventions. For

instance, in the cases where double binds are identified, if the client (i.e., “victim”) becomes aware of the paradoxical situation, this can break the double bind since the client can metacomunicate about it. Probably this awareness would not be enough to break all the vicious cycles fed by the paradox, yet it can be a good starting point. Moreover, these considerations also alert the therapist to check if any elements of therapy are maintaining the vicious cycles.

Two – The meaning of the headaches vary from one patient to the other, being greatly influenced by their personal experiences, family histories and interaction with health professionals. At first, this point can look like common sense, yet it is a very important one to be stressed. Health sciences (from medicine to psychology) are dominated by nomothetic knowledge that has the tendency to ignore the idiosyncratic characteristics of the person looking for help. This tendency to generalise and to try to fit the client to Procrustean beds can make it difficult to provide the best help for a particular individual who suffers from a specific chronic pain condition. Moreover, if the small differences are cherished instead of eliminated, this diversity can be used therapeutically. For instance, this principle of diversity can guide the search for exceptions, which is a typical strategy of brief therapy.

Three – These idiosyncratic meanings influence the construction of the therapeutic aims and the management of primary headaches

emerges as a more achievable goal. This supports many of the programs that already exist to help people with chronic pain where the focus is on control rather than on a cure. Nevertheless, the importance that auxiliary aims can have in the overall process of pain management (namely, by taking into account the patterns referred to in Point One) can be more fully explored.

Four – Specific interventions for managing headaches and for achieving the auxiliary aims lead to concrete changes. For instance, the fist exercise designed for helping one of the clients to control his migraine (characterised by an intense pulsing pain) was considered by him as very useful. This exercise can be adapted to other clients who suffer from pain with that vascular quality. Yet, we should never dismiss the overall therapeutic context where this and other exercises are introduced, rehearsed and monitored.

Five – The changes that occur during therapy are sometimes generalized for other situations. Moreover, the clients consider their therapy as a useful resource to help themselves manage their headaches. This recognition provides some evidence to support a multidisciplinary approach to headache management that includes psychotherapy.

In summary, the present research shows how specific discourse interactions can change the construction of a problem such as primary headaches and then help in the management of this type of chronic

pain. This demonstrates the power of words as action. Psychotherapy is often defined as talk therapy, yet traditional research does not explore the potentialities of the talk interactions that define psychotherapy. Research studies done within the alternative paradigms in general and DA in particular explore this dimension, being examples of the turn to language in social sciences. Furthermore, the present research can seed ideas for future studies that can carry on exploring these important points.

3.4.3. Seeds for future research projects

To finish the present report, I am going to point out several seeds that can be developed to become future research projects.

It would be interesting to use discourse analysis (DA) methodology to study other aspects of psychotherapy. For instance, we could study the written notes of therapists as a particular discourse in themselves (i.e., we do not take these notes as a representation of what really happened in the session, but rather as the therapist's interpretations). Afterwards, we could compare what therapists do with words during the sessions with what they do with words in their written reports. This idea was inspired by the work of

Gilbert and Mulkay (1984) which explores the different interpretative repertoires used by scientists.

Another interesting project would be to micro-analyse the talk interaction between client and therapist using conversation analysis (CA) methodology. For instance, we could explore within a psychotherapy context if there are more preferred (expected or conventional sequences) or dispreferred (not expected sequences) turns of talk.

An additional research endeavour could be to explore how patients construct their primary headache experiences by using grounded theory (GT). For instance, we could develop a grounded theory around the characterization of different headaches from the perspective of the clients and afterwards compare it to the International Classification of Headache Disorders (which is constructed from a medical perspective).

Another interesting challenge would be to explore how clients see the mind-body problem in their pain experiences by using interpretative phenomenological analysis (IPA). For instance, we could conduct semi-structured interviews of several chronic headache patients in order to explore how these people make sense of

professional jargon such as psychogenic or psychosomatic problems, functional illnesses, and so on.

To finish, the following words seem adequate:

Some years later, I formulated what I now refer to as my 'first law of research', with which I entertain students who are about to embark on their first scientific projects. The law states that, by the time an experiment has been completed, the researcher will know how it should have been done properly (Bentall, 2003, p. 6).

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APPENDICES

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APPENDIX 1

INTERNATIONAL CLASSIFICATION OF HEADACHE DISORDERS (ICHD)

In 1985 a committee with renowned headache experts was formed within the International Headache Society, and after three years of hard work the first international headache classification was published (Göbel, 2001; Headache Classification Committee of the International Headache Society, 1988). This classification and diagnostic criteria for headache disorders, cranial neuralgias and facial pain contains 13 major groups that include primary headaches (groups 1-4), secondary headaches (groups 5-11), cranial neuralgias and facial pain (group 12), and headaches not classifiable (group 13). With the exception of the last group, all others have hierarchical diagnostic subdivisions (types, subtypes and subforms, which are coded with 2, 3 and 4 digit respectively). For instance, in the case of migraine (coded as 1) there are seven types (two digit classification; e.g., 1.2. Migraine with aura), which can have further subtypes (three digit classification; e.g., 1.2.1 Migraine with typical aura). Other groups such as cluster headaches and chronic paroxysmal hemicrania (coded as 3) not only have types and subtypes but also subforms (four digit classification). This system allows a more broad classification by a general practitioner (usually up to two digits) and a more detailed classification by a headache specialist. This classification also tries to overcome some of the problems of previous taxonomies, attempting to be as clear as possible in the language used (for instance, the

traditionally known classic migraine was renamed migraine with aura) (Olesen, 2000a).

It is important to remember that this nosography classifies headaches and not patients. One person can be diagnosed with more than one headache disorder (such as 1.1 Migraine without aura and 2.1 Episodic tension-type headache); and one person can suffer from a type of headache that evolves with time into a different type (e.g., from 1.2 Migraine with aura to 1.1 Migraine without aura). This characteristic increases the complexity of the diagnosis, yet there are general rules that help the physician (e.g., if the patient has more than one headache disorder, all should be diagnosed in the order of importance indicated by the patient). Despite its complexity this diagnostic criteria became widely used, being endorsed by many national headache societies and translated into more than 20 different languages (German, French, Italian, Spanish, Turkish, etc). Even the World Health Organization (WHO) adapted it into the International Classification of Diseases 10 (ICD 10), creating an equivalence between the two classification systems (Göbel, 2001; Olesen, 2000a).

Of course there were criticisms of this first international classification, such as the need of diagnostic recognition of chronic daily headaches; the need of more precision in the criteria diagnostic (i.e., more codes going to 4 digits); and so on (Bigal et al., 2002;

Nappi et al., 1999; Olesen, 2000a; Silberstein et al., 1994). In part, as an answer to these critics and due to the evolution in the field of headache studies, a second edition of that diagnostic, the International Classification of Headache Disorders II (ICHD-II), was published (Headache Classification Subcommittee of the International Headache Society, 2004). This second edition represents a smooth development from the first one and the changes done are small and yet important. For instance, there was the introduction of new diagnostic types and sub-types (e.g., 1.5.1 Chronic migraine); there were changes in the terminology in an attempt to be more precise; and a new group was added (12. Headache attributed to psychiatric disorders)

1988 International Classification of Headache Disorders

1. Migraine

- 1.1 Migraine without aura
- 1.2 Migraine with aura
 - 1.2.1 Migraine with typical aura
 - 1.2.2 Migraine with prolonged aura
 - 1.2.3 Familial hemiplegic migraine
 - 1.2.4 Basilar migraine
 - 1.2.5 Migraine aura without headache
 - 1.2.6 Migraine with acute onset aura
- 1.3 Ophthalmoplegic migraine
- 1.4 Retinal migraine
- 1.5 Childhood periodic syndromes that may be precursors to or associated with migraine
 - 1.5.1 Benign paroxysmal vertigo of childhood
 - 1.5.2 Alternating hemiplegia of childhood
- 1.6 Complications of migraine
 - 1.6.1 Status migrainosus
 - 1.6.2 Migrainous infarction
- 1.7 Migrainous disorder not fulfilling above criteria

2. Tension-type headache

- 2.1 Episodic tension-type headache
 - 2.1.1 Episodic tension-type headache associated with disorder of pericranial muscles
 - 2.1.2 Episodic tension-type headache unassociated with disorder of pericranial muscles
- 2.2 Chronic tension-type headache
 - 2.2.1 Chronic tension-type headache associated with disorder of pericranial muscles
 - 2.2.2 Chronic tension-type headache unassociated with disorder of pericranial muscles
- 2.3 Headache of the tension-type not fulfilling above criteria

3. Cluster headache and chronic paroxysmal hemicrania

- 3.1 Cluster headache
 - 3.1.1 Cluster headache periodicity undetermined
 - 3.1.2 Episodic cluster headache
 - 3.1.3 Chronic cluster headache
 - 3.1.3.1 Unremitting from onset
 - 3.1.3.2 Evolved from episodic
- 3.2 Chronic paroxysmal hemicrania
- 3.3 Cluster headache-like disorder not fulfilling above criteria

4. Miscellaneous headaches not associated with structural lesion

- 4.1 Idiopathic stabbing headache
- 4.2 External compression headache
- 4.3 Cold stimulus headache
 - 4.3.1 External application of a cold stimulus
 - 4.3.2 Ingestion of a cold stimulus
- 4.4 Benign cough headache
- 4.5 Benign exertional headache
- 4.6 Headache associated with sexual activity
 - 4.6.1 Dull type
 - 4.6.2 Explosive type
 - 4.6.3 Postural type

5. Headache associated with head trauma

- 5.1 Acute post-traumatic headache

- 5.1.1 With significant head trauma and/or confirmatory signs
- 5.1.2 With minor head trauma and no confirmatory signs
- 5.2 Chronic post-traumatic headache
 - 5.2.1 With significant head trauma and/or confirmatory signs
 - 5.2.2 With minor head trauma and no confirmatory signs

6. Headache associate with vascular disorders

- 6.1 Acute ischemic cerebrovascular disorder
 - 6.1.1 Transient ischemic attack (TIA)
 - 6.1.2 Tromboembolic stroke
- 6.2 Intracranial hematoma
 - 6.2.1 Intracerebral hematoma
 - 6.2.2 Subdural hematoma
 - 6.2.3 Epidural hematoma
- 6.3 Subarachnoid hemorrhage
- 6.4 Unruptured vascular malformation
 - 6.4.1 Arteriovenous malformation
 - 6.4.2 Saccular aneurysm
- 6.5 Arteritis
 - 6.5.1 Giant cell arteritis
 - 6.5.2 Other systemic arteritides
 - 6.5.3 Primary intracranial arteritis
- 6.6 Carotid or vertebral artery pain
 - 6.6.1 Carotid or vertebral dissection
 - 6.6.2 Carotidynia (idiopathic)
 - 6.6.3 Post endarterectomy headache
- 6.7 Venous thrombosis
- 6.8 Arterial hypertension
 - 6.8.1 Acute pressor response to exogenous agent
 - 6.8.2 Pheochromocytoma
 - 6.8.3 Malignant (accelerated) hypertension
 - 6.8.4 Pre-eclampsia and eclampsia
- 6.9 Headache associated with other vascular disorder

7. Headache associated with-nonvascular intracranial disorder

- 7.1 High cerebrospinal fluid pressure
 - 7.1.1 Benign intracranial hypertension
 - 7.1.2 High pressure hydrocephalus
- 7.2 Low cerebrospinal fluid pressure
 - 7.2.1 Post-lumbar puncture headache
 - 7.2.2 Cerebrospinal fluid fistula headache
- 7.3 Intracranial infection
- 7.4 Intracranial sarcoidosis and other non-infectious inflammatory diseases
- 7.5 Headache related to intrathecal injections
 - 7.5.1 Direct effect
 - 7.5.2 Due to chemical meningitis
- 7.6 Intracranial neoplasm
- 7.7 Headache associated with other intracranial disorder

8. Headache associated with substances or their withdrawal

- 8.1 Headache induced by acute substance use or exposure
 - 8.1.1 Nitrate/nitrite induced headache
 - 8.1.2 Monosodium glutamate induced headache
 - 8.1.3 Carbon monoxide induced headache
 - 8.1.4 Alcohol induced headache
 - 8.1.5 Other substances
- 8.2 Headache induced by chronic substance use or exposure
 - 8.2.1 Ergotamine induced headache
 - 8.2.2 Analgesic abuse headache

- 8.2.3 Other substances
- 8.3 Headache from substance withdrawal (acute use)
 - 8.3.1 Alcohol withdrawal headache (hangover)
 - 8.3.2 Other substances
- 8.4 Headache from substance withdrawal (chronic use)
 - 8.4.1 Ergotamine withdrawal headache
 - 8.4.2 Caffeine withdrawal headache
 - 8.4.3 Narcotics abstinence headache
 - 8.4.4 Other substances
- 8.5 Headache associated with substances but with uncertain mechanism
 - 8.5.1 Birth control pills or estrogens
 - 8.5.2 Other substance

9. Headache associated with non-cephalic infection

- 9.1 Viral infection
 - 9.1.1 Focal non-cephalic
 - 9.1.2 Systemic
- 9.2 Bacterial infection
 - 9.2.1 Focal non-cephalic
 - 9.2.2 Systemic (septicemia)
- 9.3 Headache related to other infection

10. Headache associated with metabolic disorder

- 10.1 Hypoxia
 - 10.1.1 High altitude headache
 - 10.1.2 Hypoxic headache
 - 10.1.3 Sleep apnoea headache
- 10.2 Hypercapnia
- 10.3 Mixed hypoxia and hypercapnia
- 10.4 Hypoglycemia
- 10.5 Dialysis
- 10.6 Headache related to other metabolic abnormality

11. Headache or facial pain associated with disorder of cranium, neck, eyes, ears, nose sinuses, teeth, mouth, or other facial or cranial structures

- 11.1 Cranial bone
- 11.2 Neck
 - 11.2.1 Cervical spine
 - 11.2.2 Retropharyngeal tendinitis
- 11.3 Eyes
 - 11.3.1 Acute glaucoma
 - 11.3.2 Refractive errors
 - 11.3.3 Heterophoria or heterotropia
- 11.4 Ears
- 11.5 Nose and sinuses
 - 11.5.1 Acute sinus headache
 - 11.5.2 Other diseases of nose or sinuses
- 11.6 Teeth, jaws, and related structures
- 11.7 Temporomandibular joint disease

12. Cranial neuralgias, nerve trunk pain, and deafferentation pain

- 12.1 Persistent (in contrast to tic-like) pain of cranial nerve origin
 - 12.1.1 Compression or distortion of cranial nerves and second or third cervical roots
 - 12.1.2 Demyelination of cranial nerves
 - 12.1.2.1 Optic neuritis (retrobulbar neuritis)
 - 12.1.3 Infarction of cranial nerves
 - 12.1.3.1 Diabetic neuritis
 - 12.1.4 Inflammation of cranial nerves

- 12.1.4.1 Herpes zoster
- 12.1.4.2 Chronic post-herpetic neuralgia
- 12.1.5 Tolosa-Hunt syndrome
- 12.1.6 Neck-tongue syndrome
- 12.1.7 Other causes of persistent pain of cranial nerve origin
- 12.2 Trigeminal neuralgia
 - 12.2.1 Idiopathic trigeminal neuralgia
 - 12.2.2 Symptomatic trigeminal neuralgia
 - 12.2.2.1 Compression of trigeminal root or ganglion
 - 12.2.2.2 Central lesions
- 12.3 Glossopharyngeal neuralgia
 - 12.3.1 Idiopathic glossopharyngeal neuralgia
 - 12.3.2 Symptomatic glossopharyngeal neuralgia
- 12.4 Nervous intermedius neuralgia
- 12.5 Superior laryngeal neuralgia
- 12.6 Occipital neuralgia
- 12.7 Central causes of head and facial pain other than tic douloureux
 - 12.7.1 Anaesthesia dolorosa
 - 12.7.2 Thalamic pain
- 12.8 Facial pain not fulfilling criteria in groups 11 or 12

13. Headache not classifiable

International Classification of Headache Disorders 2nd ed. (ICHD-II)

PART 1: THE PRIMARY HEADACHES

1. Migraine

- 1.1 Migraine without aura
- 1.2 Migraine with aura
 - 1.2.1 Typical aura with migraine headache
 - 1.2.2 Typical aura with non-migraine headache
 - 1.2.3 Typical aura without headache
 - 1.2.4 Familial hemiplegic migraine (FHM)
 - 1.2.5 Sporadic hemiplegic migraine
 - 1.2.6. Basilar-type migraine
- 1.3 Childhood periodic syndromes that are commonly precursors of migraine
 - 1.3.1 Cyclical vomiting
 - 1.3.2 Abdominal migraine
 - 1.3.3. Benign paroxysmal vertigo of childhood
- 1.4 Retinal migraine
- 1.5 Complications of migraine
 - 1.5.1 Chronic migraine
 - 1.5.2 Status migrainosus
 - 1.5.3 Persistent aura without infarction
 - 1.5.4 Migrainous infarction
 - 1.5.5 Migraine-triggered seizure
- 1.6 Probable migraine
 - 1.6.1 Probable migraine without aura
 - 1.6.2. Probable migraine with aura
 - 1.6.5 Probable chronic migraine

2. Tension-type headache (TTH)

- 2.1 Infrequent episodic tension-type headache
 - 2.1.1 Infrequent episodic tension-type headache associated with pericranial tenderness
 - 2.1.2 Infrequent episodic tension-type headache not associated with pericranial tenderness
- 2.2 Frequent episodic tension-type headache
 - 2.2.1 Frequent episodic tension-type headache associated with pericranial tenderness
 - 2.2.2 Frequent episodic tension-type headache not associated with pericranial tenderness
- 2.3 Chronic tension-type headache
 - 2.3.1 Chronic tension-type headache associated with pericranial tenderness
 - 2.3.2 Chronic tension-type headache not associated with pericranial tenderness
- 2.4 Probable tension-type headache
 - 2.4.1 Probable infrequent episodic tension-type headache
 - 2.4.2 Probable frequent episodic tension-type headache
 - 2.4.3 Probable chronic tension-type headache

3. Cluster headache and other trigeminal autonomic cephalalgias

- 3.1 Cluster headache
 - 3.1.1 Episodic cluster headache
 - 3.1.2 Chronic cluster headache
- 3.2 Paroxysmal hemicrania
 - 3.2.1 Episodic paroxysmal hemicrania
 - 3.2.2 Chronic paroxysmal hemicrania (CPH)
- 3.3 Short-lasting Unilateral Neuralgiform headache attacks with Conjunctival injection and Tearing (SUNCT)
- 3.4 Probable trigeminal autonomic cephalgia
 - 3.4.1 Probable cluster headache

- 3.4.2 Probable paroxysmal hemicrania
- 3.4.3 Probable SUNCT

4. Other primary headaches

- 4.1 Primary stabbing headache
- 4.2 Primary cough headache
- 4.3 Primary exertional headache
- 4.4 Primary headache associated with sexual activity
 - 4.4.1 Preorgasmic headache
 - 4.4.2 Orgasmic headache
- 4.5 Hypnic headache
- 4.6 Primary thunderclap headache
- 4.7 Hemicrania continua
- 4.8 New daily-persistent headache (NDPH)

PART 2: THE SECONDARY HEADACHES

5. Headache attributed to head and/or neck trauma

- 5.1 Acute post-traumatic headache
 - 5.1.1 Acute post-traumatic headache attributed to moderate or severe head injury
 - 5.1.2 Acute post-traumatic headache attributed to mild head injury
- 5.2 Chronic post-traumatic headache
 - 5.2.1 Chronic post-traumatic headache attributed to moderate or severe head injury
 - 5.2.2 Chronic post-traumatic headache attributed to mild head injury
- 5.3 Acute headache attributed to whiplash injury
- 5.4 Chronic headache attributed to whiplash injury
- 5.5 Headache attributed to traumatic intracranial haematoma
 - 5.5.1 Headache attributed to epidural haematoma
 - 5.5.2 Headache attributed to subdural haematoma
- 5.6 Headache attributed to other head and/or neck trauma
 - 5.6.1 Acute headache attributed to other head and/or neck trauma
 - 5.6.2 Chronic headache attributed to other head and/or neck trauma
- 5.7 Post-craniotomy headache
 - 5.7.1 Acute post-craniotomy headache
 - 5.7.2 Chronic post-craniotomy headache

6. Headache attributed to cranial or cervical vascular disorders

- 6.1 Headache attributed to ischaemic stroke or transient ischaemic attack
 - 6.1.1 Headache attributed to ischemic stroke (cerebral infarction)
 - 6.1.2 Headache attributed to transient ischaemic attack (TIA)
- 6.2 Headache attributed to non-traumatic intracranial haemorrhage
 - 6.2.1 Headache attributed to intracerebral haemorrhage
 - 6.2.2 Headache attributed to subarachnoid haemorrhage
- 6.3 Headache attributed to unruptured vascular malformation
 - 6.3.1 Headache attributed to saccular aneurysm
 - 6.3.2 Headache attributed to arteriovenous malformation
 - 6.3.3 Headache attributed to dural arteriovenous fistula
 - 6.3.4 Headache attributed to cavernous angioma
 - 6.3.5 Headache attributed to encephalotrigeminal or leptomeningeal angiomatosis (Sturge Weber syndrome)
- 6.4 Headache attributed to arteritis
 - 6.4.1 Headache attributed to giant cell arteritis (GCA)
 - 6.4.2 Headache attributed to primary central nervous system (CNS) angiitis
 - 6.4.3 Headache attributed to secondary central nervous system (CNS) angiitis
- 6.5 Carotid or vertebral artery pain
 - 6.5.1 Headache or facial or neck pain attributed to arterial dissection
 - 6.5.2 Post-endarterectomy headache
 - 6.5.3 Carotid angioplasty headache

- 6.5.4 Headache attributed to intracranial endovascular procedures
- 6.5.5 Angiography headache
- 6.6 Headache attributed to cerebral venous thrombosis (CVT)
- 6.7 Headache attributed to other intracranial vascular disorder
 - 6.7.1 Cerebral Autosomal Dominant Arteriopathy with Subcortical Infarcts and Leukoencephalopathy (CADASIL)
 - 6.7.2 Mitochondrial Encephalopathy, Lactic Acidosis and Stroke-like episodes (MELAS)
 - 6.7.3 Headache attributed to benign angiopathy of the central nervous system
 - 6.7.4 Headache attributed to pituitary apoplexy

7. Headache attributed to non-vascular intracranial disorder

- 7.1 Headache attributed to high cerebrospinal fluid pressure
 - 7.1.1 Headache attributed to idiopathic intracranial hypertension (IIH)
 - 7.1.2 Headache attributed to intracranial hypertension secondary to metabolic, toxic or hormonal causes
 - 7.1.3 Headache attributed to intracranial hypertension secondary to hydrocephalus
- 7.2 Headache attributed to low cerebrospinal fluid pressure
 - 7.2.1 Post-lumbar puncture headache
 - 7.2.2 CSF fistula headache
 - 7.2.3 Headache attributed to spontaneous (or idiopathic) low CSF pressure
- 7.3 Headache attributed to non-infectious inflammatory disease
 - 7.3.1 Headache attributed to neurosarcoidosis
 - 7.3.2 Headache attributed to aseptic (non-infectious) meningitis
 - 7.3.3 Headache attributed to other non-infectious inflammatory disease
 - 7.3.4 Headache attributed to lymphocytic hypophysitis
- 7.4 Headache attributed to intracranial neoplasm
 - 7.4.1 Headache attributed to increased intracranial pressure or hydrocephalus caused by neoplasm
 - 7.4.2 Headache attributed directly to neoplasm
 - 7.4.3 Headache attributed to carcinomatous meningitis
 - 7.4.4 Headache attributed to hypothalamic or pituitary hyper- or hyposecretion
- 7.5 Headache attributed to intrathecal injections
- 7.6 Headache attributed to epileptic seizure
 - 7.6.1 Hemicrania epileptica
 - 7.6.2 Post-seizure headache
- 7.7 Headache attributed to Chiari malformation type I (CM1)
- 7.8 Syndrome of transient Headache and Neurological Deficits with cerebrospinal fluid Lymphocytosis (HaNDL)
- 7.9 Headache attributed to other non-vascular intracranial disorder

8. Headache attributed to a substance or its withdrawal

- 8.1 Headache induced by acute substance use or exposure
 - 8.1.1 Nitric oxide (NO) donor-induced headache
 - 8.1.1.1 Immediate NO donor-induced headache
 - 8.1.1.2 Delayed NO donor-headache
 - 8.1.2 Phosphodiesterase (PDE) inhibitor-induced headache
 - 8.1.3 Carbon monoxide-induced headache
 - 8.1.4 Alcohol-induced headache
 - 8.1.4.1 Immediate alcohol-induced headache
 - 8.1.4.2 Delayed alcohol-induced headache
 - 8.1.5 Headache induced by food components and additives
 - 8.1.5.1 Monosodium glutamate-induced headache
 - 8.1.6 Cocaine-induced headache
 - 8.1.7 Cannabis-induced headache
 - 8.1.8 Histamine-induced headache
 - 8.1.8.1 Immediate histamine-induced headache
 - 8.1.8.2 Delayed histamine-induced headache
 - 8.1.9 Calcitonin gene-related peptide (CGRP)-induced headache

- 8.1.9.1 Immediate CGRP-induced headache
- 8.1.9.2 Delayed CGRP-induced headache
- 8.1.10 Headache as an acute adverse event attributed to medication used for other indications
- 8.1.11 Headache induced by other acute substance use or exposure
- 8.2 Medication-overuse headache (MOH)
 - 8.2.1 Ergotamine-overuse headache
 - 8.2.2 Triptan-overuse headache
 - 8.2.3 Analgesic-overuse headache
 - 8.2.4 Opioid-overuse headache
 - 8.2.5 Combination medication-overuse headache
 - 8.2.6 Headache attributed to other medication overuse
 - 8.2.7 Probable medication-overuse headache
- 8.3 Headache as an adverse event attributed to chronic medication
 - 8.3.1 Exogenous hormone-induced headache
- 8.4. Headache attributed to substance withdrawal
 - 8.4.1 Caffeine-withdrawal headache
 - 8.4.2 Opioid-withdrawal headache
 - 8.4.3 Oestrogen-withdrawal headache
 - 8.4.4 Headache attributed to withdrawal from chronic use of other substances

9. Headache attributed to infection

- 9.1 Headache attributed to intracranial infection
 - 9.1.1 Headache attributed to bacterial meningitis
 - 9.1.2 Headache attributed to lymphocytic meningitis
 - 9.1.3 Headache attributed to encephalitis
 - 9.1.4 Headache attributed to brain abscess
 - 9.1.5 Headache attributed to subdural empyema
- 9.2 Headache attributed to systemic infection
 - 9.2.1 Headache attributed to systemic bacterial infection
 - 9.2.2 Headache attributed to systemic viral infection
 - 9.2.3 Headache attributed to other systemic infection
- 9.3 Headache attributed to HIV / AIDS
- 9.4 Chronic post-infection headache
 - 9.4.1 Chronic post-bacterial meningitis headache

10. Headache attributed to disorder of the homoeostasis

- 10.1 Headache attributed to hypoxia and/or hypercapnia
 - 10.1.1 High altitude headache
 - 10.1.2 Diving headache
 - 10.1.3 Sleep apnoea headache
- 10.2 Dialysis headache
- 10.3 Headache attributed to arterial hypertension
 - 10.3.1 Headache attributed to pheochromocytoma
 - 10.3.2 Headache attributed to hypertensive crisis without hypertensive encephalopathy
 - 10.3.3 Headache attributed to hypertensive encephalopathy
 - 10.3.4 Headache attributed to pre-eclampsia
 - 10.3.5 Headache attributed to eclampsia
 - 10.3.6 Headache attributed to acute pressor response to an exogenous agent
- 10.4 Headache attributed to hypothyroidism
- 10.5 Headache attributed to fasting
- 10.6 Cardiac cephalgia
- 10.7 Headache attributed to other disorder of homoeostasis

11. Headache or facial pain attributed to disorder of cranium, neck, eyes, ears, nose sinuses, teeth, mouth, or other facial or cranial structures

- 11.1 Headache attributed to disorders of cranial bone
- 11.2 Headache attributed to disorders of neck

- 11.2.1 Cervicogenic headache
- 11.2.2 Headache attributed to retropharyngeal tendinitis
- 11.2.3 Headache attributed to craniocervical dystonia
- 11.3 Headache attributed to disorders of eyes
 - 11.3.1 Headache attributed to acute glaucoma
 - 11.3.2 Headache attributed to refractive errors
 - 11.3.3 Headache attributed to heterophoria or heterotropia (latent or manifest squint)
- 11.4 Headache attributed to disorders of ears
- 11.5 Headache attributed to rhinosinusitis
- 11.6 Headache attributed to disorders of teeth, jaws, and related structures
- 11.7 Headache or facial pain attributed to temporomandibular joint disease (TMJ)
- 11.8 Headache attributed to other disorders of cranium, neck, eyes, ears, nose, sinuses, teeth, mouth or other facial or cervical structures

12. Headaches attributed to psychiatric disorder

- 12.1 Headaches attributed to somatisation disorder
- 12.2 Headaches attributed to psychotic disorder

PART 3: CRANIAL NEURALGIAS, CENTRAL AND PRIMARY FACIAL PAIN AND OTHER HEADACHES

13. Cranial neuralgias and central causes of facial pain

- 13.1 Trigeminal neuralgia
 - 13.1.1 Classical trigeminal neuralgia
 - 13.1.2 Symptomatic trigeminal neuralgia
- 13.2 Glossopharyngeal neuralgia
 - 13.2.1 Classical glossopharyngeal neuralgia
 - 13.2.2 Symptomatic glossopharyngeal neuralgia
- 13.3 Nervous intermedius neuralgia
- 13.4 Superior laryngeal neuralgia
- 13.5 Nasociliary neuralgia
- 13.6 Supraorbital neuralgia
- 13.7 Other terminal branch neuralgias
- 13.8 Occipital neuralgia
- 13.9 Neck-tongue syndrome
- 13.10 External compression headache
- 13.11 Cold-stimulus headache
 - 13.11.1 Headache attributed to external application of a cold stimulus
 - 13.11.2 Headache attributed to ingestion or inhalation of a cold stimulus
- 13.12 Constant pain caused by compression, irritation or distortion of cranial nerves or upper cervical roots by structural lesions
- 13.13 Optic neuritis
- 13.14 Ocular diabetic neuropathy
- 13.15 Head or facial pain attributed to herpes zoster
 - 13.15.1 Head or facial pain attributed to acute herpes zoster
 - 13.15.2 Post-herpetic neuralgia
- 13.16 Tolosa-Hunt syndrome
- 13.17 Ophthalmoplegic 'migraine'
- 13.18 Central causes of facial pain
 - 13.18.1 Anaesthesia dolorosa
 - 13.18.2 Central post-stroke pain
 - 13.18.3 Facial pain attributed to multiple sclerosis
 - 13.18.4 Persistent idiopathic facial pain
 - 13.18.5 Burning mouth syndrome
- 13.19 Other cranial neuralgia or other centrally mediated facial pain

14. Other headache, cranial neuralgia, central or primary facial pain

- 14.1 Headache not elsewhere classified
- 14.2 Headache unspecified

1988 Diagnostic criteria for:

1.1 Migraine without aura

- A. At least 5 attacks fulfilling B-D.
- B. Headache attacks lasting 4-72 hours (untreated or unsuccessfully treated).
- C. Headache has at least two of the following characteristics:
 - 1. Unilateral location
 - 2. Pulsating quality
 - 3. Moderate or severe intensity
 - 4. Aggravation by walking stairs or similar routine physical activity
- D. During headache at least one of the following:
 - 1. Nausea and/or vomiting
 - 2. Photophobia and phonophobia
- E. At least one of the following:
 - 1. History, physical- and neurological examination do not suggest one of the disorders listed in groups 5-11
 - 2. History and/or physical- and/or neurological examination do suggest such disorder, but it is ruled out by appropriate investigations
 - 3. Such disorder is present, but cluster headache does not occur for the first time in close temporal relation to the disorder

1.2 Migraine with aura

- A. At least 2 attacks fulfilling B.
- B. At least 3 of the following 4 characteristics:
 - 1. One or more fully reversible aura symptoms indicating focal cerebral cortical – and/or brain stem dysfunction.
 - 2. At least one aura symptom develops gradually over more than 4 minutes or, 2 or more symptoms occur in succession.
 - 3. No aura symptom lasts more than 60 minutes. If more than one aura symptom is present, accepted duration is proportionally increased.
 - 4. Headache follows aura with a free interval of less than 60 minutes (It may also begin before or simultaneously with the aura).
- C. At least one of the following:
 - 1. History, physical- and neurological examination do not suggest one of the disorders listed in groups 5-11
 - 2. History and/or physical- and/or neurological examination do suggest such disorder, but it is ruled out by appropriate investigations
 - 3. Such disorder is present, but cluster headache does not occur for the first time in close temporal relation to the disorder

2.1 Episodic tension-type headache

- A. At least 10 previous headache episodes fulfilling criteria B-D listed below.
Number of days with such headache < 180/year (<15/month).
- B. Headache lasting from 30 minutes to 7 days.
- C. At least 2 of the following pain characteristics:
 - 1. Pressing/tightening (non-pulsating) quality
 - 2. Mild or moderate intensity (may inhibit, but does not prohibit activities)
 - 3. Bilateral location
 - 4. No aggravation by walking stairs or similar routine physical activity
- D. Both of the following:
 - 1. No nausea or vomiting (anorexia may occur)
 - 2. Photophobia and phonophobia are absent, or one but not the other is present
- E. At least one of the following:
 - 1. History, physical- and neurological examination do not suggest one of the disorders listed in groups 5-11
 - 2. History and/or physical- and/or neurological examination do suggest such disorder, but it is ruled out by appropriate investigations
 - 3. Such disorder is present, but cluster headache does not occur for the first time in close temporal relation to the disorder

2.2 Chronic tension-type headache

- A. Average headache frequency ≥ 15 days/month (180 days/year) for ≥ 6 months fulfilling criteria B-D listed below.
- B. At least 2 of the following pain characteristics:
 - 1. Pressing/tightening quality
 - 2. Mild or moderate intensity (may inhibit, but does not prohibit activities)
 - 3. Bilateral location
 - 4. No aggravation by walking stairs or similar routine physical activity
- C. Both of the following:
 - 1. No vomiting
 - 2. No more than one of the following:
Nausea, photophobia or phonophobia
- D. At least one of the following:
 - 1. History, physical- and neurological examination do not suggest one of the disorders listed in groups 5-11
 - 2. History and/or physical- and/or neurological examination do suggest such disorder, but it is ruled out by appropriate investigations
 - 3. Such disorder is present, but cluster headache does not occur for the first time in close temporal relation to the disorder

APPENDIX 2
SUMMARY OF THE THERAPEUTIC SESSIONS
(PEPE'S CASE)

CASE 1
(Male; 56 y.o.)

SESSION NO.: 1 **DURATION:** 57 minutes **DATE:** 21/01/1997

PARTICIPANTS: The client and his sister-in-law.

THERAPIST: The author

THERAPEUTIC TEAM: --

PRE-SESSION

No data...

CREATION AND MAINTENANCE OF THE RELATIONSHIP

With the aim of creating a working relationship, the therapist (T) on a non-verbal level maintains eye contact, gives confirmation signs by head movements, sounds as aha, m-hm and empathic gestures such as smiles when the client (C) does so. On the verbal level:

- The T asks about the problem that brings the C to therapy, i.e., his headaches (most of the first part of the session). She also explores other related problems that affect the C's life. Sometimes she summarises what was said and gives some mirror answers.

- The T tries to understand the situation in detail to know what help can be offered; she does this mainly through questioning. She also checks if she has well understood the problem and its details.

- The T also asks about the C's spontaneous strategies to solve his problems, then inquiries about his hobbies and activities and tries to validate them.

In retrospective I think the C had enough time to explain himself and his problems and to answer the T's questions. Nevertheless, the T does not ask explicitly if the C has something more to add (which he thinks is important about his problem); neither does the C say explicitly that everything important about his problem was told.

As a summary it can be said that a therapeutic alliance was created since the client agrees with the exercise proposed at the end of the session and the home task. Nevertheless some doubts emerge from the C as to how the therapy can help him, though he is willing to give it a try.

SESSION: RELEVANT & OPERATIVE INFORMATION

RELEVANT & OPERATIVE INFORMATION:

A- About the problem, the headaches (HA)

A1- HA History:

- Age of onset 15 y.o. (41 years ago).
- The C says that he is not afraid that the HA is a symptom of a bigger problem since he has had it for a long time.

A2- Pain Characteristics:

- Location: usually left side.
 - Vascular pain: “tras, tras” sensation.
 - As if the head is open... very strong (on a scale from 0 to 10: “not ten, but very high”, C also says that he could work if pain was around 3 or 4).
 - **The stronger the “tras, tras” sensation, the stronger the pain.**
- When the “tras, tras” starts to slow, the pain also decreases until it ends.**

A3- Pain Onset:

- No signs - He feels well.
- Unexpected.

A4- Pain Evolution:

- Increases intensity to strong or very strong.

A5- Pain Duration:

- More than one day (2, 3 or 4 days, its varies).

A6- Pain End:

- Slowly
- The analgesics help to control the pain.

A7- Pain Increase Factors:

- Physical effort.

Note: He is a construction worker which implies doing physical effort.

A8- Pain Precipitation Factors:

- Alcohol, mainly strong alcohol or even beer, if the stomach is empty.
- Cigarette smoke mainly in a crowded pub.

A9- Accompanying Symptoms:

- Stomach problems, he feels like vomiting.
- During the HA he cannot eat even if he feels hungry because of the vomiting sensation.

A10- Medication:

- He has changed a lot of medication to manage the HA and usually when he takes a new one he feels better for some time.

- He usually uses OTC analgesics (namely paracetamol = acetaminophen) and combination analgesics (acetaminophen + caffeine + codeine) that he says works better.

- At the moment he is also daily taking a bromazepam (Lexotanil) to reduce anxiety, and a tricyclic anti-depressant (amitriptyline hydrochloride = Tryptanol).

Note: At the time of this session the T didn't know that tricyclic antidepressants were also used as preventive pharmacology to migraine.

A10.1- Secondary Effects of Medication:

- If the analgesics are taken when the pain is already strong, they increase the accompanying symptoms of nausea (feeling like vomiting).

- The preventive medication that he is taking gets him sleepy, which is not a problem since he takes it at night and this helps him with his sleeping problem.

A11- Pain Behaviour:

- If in bed the C has to get up.

- The C has to take some analgesic straight away, before the pain is strong, otherwise he gets vomiting sensations and he cannot take the pain-killers.

- Usually when he has the HA he stays at home or, if not home he goes back home.

A12- Problem Consequences:

- His work capacity is diminished, which causes some money problems since the C is paid for work daily.

- When he wakes up with a HA, he does not know if he should stay at home or go to work since he is risking having to return home if the pain increases (because he can not stand the pain).

- Some days when the pain is very strong and he is at work, he has to ask a work mate to take him home which is something disturbing for him.

A13- Spontaneous Strategies to Relief the Pain:

- **Tissue Strategy:** to tie a tissue around the head as a way of not being so aware of the pain.

- Stay home and relax.

A14- Pain Free Periods

- It varies from 15 days to 1, 2 or 3 months.

B- Other Problems

B1- Sleep problems: problem in getting to sleep.

B2- Prostate gland problems: makes him have to get up often to go to the WC.

B3- Stomach problems.

B4- Problems in the cervical vertebrae.

C- Social Net of Support

- He is single and lives alone in a small village while he has a brother who lives in the city.

- He speaks about some friends with whom sometimes he goes out to a bar or hunting.

D- Hobbies

- He likes to do some woodwork, which he says he is not very good at it but enjoys.

- He also likes to go hunting, even if he does not have company.

E- About the possible therapeutic strategies and techniques:

E1- Hypnosis:

- The Neurologist, who referred the C, informed him that we use hypnosis.

- The C does not like the idea of using hypnosis even after some clarification is given about this technique.

E2- Other Techniques:

- A pain scale is used, but it is difficult for the client to imagine it.

- **The client is keener on other techniques such as relaxation.**

SESSION: DEVELOPMENT & INTERVENTIONS

The T starts by exploring in detail the problem that brings the C to psychotherapy – his headaches (HA). When did they start, when do they appear, how do they evolve, how long do they last, how do they end, etc?

At the same time the T tries to explore how the HA problem affects other areas of the C's life. How does the HA affect his work, life-style, etc? What are the factors that increase the HA; in detail, what are the specific characteristics of the HA, what are possible precipitating factors and how can the C avoid them?

The T also looks for exceptions. She also asks how the C deals with the pain, which pain behaviours the C has, which pain medication he takes. The T then explores other problems, trying to have a clear picture of the overall situation of the C.

The T tries to clarify the intensity of the pain in different situations by using a pain scale. She also explores the spontaneous strategies used by the C to control his pain. How long are the pain free periods, his social net of support, his family, his hobbies, etc?

Afterwards, the T explains to the C the possible interventions and techniques that can be used, their advantages (they are an alternative to analgesics or at least they would help to reduce them, and being no-medical treatment there would not be secondary effects to his stomach) and limitations. The possible interventions are clarified, negotiated and then collaboration is asked.

At the end of the session, a relaxation exercise is proposed and done based on the pain characteristics described by the C. This is offered as the homework to be done whenever the pain appears (see homework section for details).

BREAKS

Two breaks were done. No data.

HOMEWORK

To do the Fist Exercise at home when he feels a headache.
...Sit in a comfortable position, with both feet on the floor, hands on your lap... focus on your breathing, breathing in and breathing out ... begin to breath deeply... now count from 1 to 10 for each breath you take...1...2...3...4 and feel the sensations in your muscles ...5...6...7...8...9...10 ... now look at one of your hands, it can be this one ... and close it, make a fist with your hand... and imagine the beating that you feel when your head aches, in your hand... when you start feeling the beating, the pulsating sensation, this can be strong and quick, it's unpleasant because it is strong and quick... it disturbs you... it stops you from working since it is strong and quick... it disturbs you for a long time since it's strong and quick... however you know that it would go away, can pass one, two or three days – sometimes less... and when it starts to go away, its becomes milder, it is not so quick, it is slower, each time slower until slowly but surely it goes away.... each time slower... each time you feel better... since you know that the pulsating sensation is going to stop... and once it stops you feel better... you can feel the muscles of your hand a little bit lighter... even more, with the other hand you can rub this hand a little and relax... I am asking you to do this exercise when you feel the headache... start by closing your fist and squeezing it as the pulsating sensations occur in your head, then start to space out the squeezing in your hand, slowly, in line with your deep breathing, you slow the pulsating sensations until they stop and then see how you feel... before you take any analgesic – do this and see how you feel....

POST-SESSION

No data

CASE 1
(Male; 56 y.o.)

SESSION NO.: 2 **DURATION:** 48 minutes **DATE:** 04/02/1997

PARTICIPANTS: The client

THERAPIST: The author

THERAPEUTIC TEAM: None.

PRE-SESSION

No data...

CREATION AND MAINTENANCE OF THE RELATIONSHIP

With the aim of maintaining a working relationship the T at a non-verbal level maintains eye contact, gives confirmation signs by head movements, sounds as aha, m-hm and empathic gestures such as smiles (these type of signs are done more often than in the first session).

With respect to the verbal level:

- The T listens to the C, his improvement, the history of his HA, his work related problems and decision to change jobs. The T tries to clarify several points through questions, confirmation statements and she then tries to motivate the C through answer completion, mirror answer and anticipation; at the same time she shows concern by understanding statements, and also reinforces the spontaneous strategies used by the client.

There is not an explicit feedback that the C felt that the T listened to, nevertheless he confirms that specific details were understood, and accepts assignments that imply change (the daily exercise).

SESSION: RELEVANT & OPERATIVE INFORMATION

RELEVANT & OPERATIVE INFORMATION:

A- Events Between Sessions:

- **There were no HA between the sessions (time span 2 weeks).**
- The C returned to work.

B- Response to Previous Tasks:

- No data since the homework was to be done if he had a HA, a condition that did not happen.

C- Client's Theories:

- The C justifies this improvement by the fact that every time he goes to the physician and there is a medication change, he feels better for some time.

Note: He changed medication in November (three months now), meanwhile he had some HA episodes (he says that maybe they are less often than they used to be). He suggests that next time he has an HA he would write it down.

- **He believes that if he does not take the medication the HA will not go away.**

D- HA History:

At the age of 15-16 years old, the C started to go out with his friends to pubs, etc., where there was noise and smoke, which could provoke a HA. At that time the HA did not last so long and usually went away with an aspirin (this was what his family physician recommended to him to take), or by going to sleep for some hours.

After time the HA got worse and about 6-7 years ago, he went to a specialist, a neurologist, and the diagnosis was "common headache". Some time, mainly in the winter when he is in bed, he tries not to take any pain-killer and test if the pain goes away by itself; however he then can not stand it and has to get up to take something.

- Lately he gets the HA while he is in bed and says that this can be related with another problem he has – with the cervical – and if he takes medication for that he also gets relief from his HA.

E- Work Issues:

- The problem of his profession is that being a construction worker is not good either to his cervical problem or to his migraine HA due to the physical effort required; besides, he does not like his profession.

- He is going to change professions from construction to a farm worker, something that he likes much more and that requires less physical effort (he will start in June, in four months time).

F- Other Medication:

- He takes Naprosyn 500 for his cervical problem (naproxen is a NSAID). He says it also helps him with the headaches.

G- Other Problems:

- **Nervousness:** he says that he gets very nervous often, and maybe this is influencing the HA. As a spontaneous strategy to relax, if he is at home, he makes some lime-tree tea and takes it.

H- About possible therapeutic strategies and techniques:

- The C maintains his doubts about the use of hypnosis, for he cannot rationalise these doubts. He speaks about what he sees on television and even after the T explains the difference from stage hypnosis, clarifies control issues and compares this with his own spontaneous strategies, he still says that he doesn't like the idea of using hypnosis.

- The C accepts the theory about the reciprocal influence of Mind-Body, i.e., how the physician's work with the body might influence the mind, such as the work of the psychologist with the mind can influence the body.

I- Therapy Aims:

- **To reduce HA frequency and/or intensity and/or duration, for example by using the fist exercise.**

- **To give him some techniques to reduce his nervousness, such as progressive relaxation.**

J- Motivation:

- **The C says he will try these exercises to test them.**

SESSION: DEVELOPMENT & INTERVENTIONS

The T starts by asking about the previous weeks since the last interview. As there was no HA episodes and the homework assignment could not be tested, the T explores the changes that have happened recently, such as the change of medication, last pain episodes, etc. Once again the T tries to clarify the possible therapeutic interventions. Some clarification is given, again, about clinical hypnosis; still the C does not want to use this technique. Some time is also spent on Mind-Body Influence and how the physician can also help the mind problems and the psychologist the body ones. Some examples are given to illustrate this point.

Meanwhile some time is spent on the HA history, how it was at the beginning when the client was an teenager, and how it got worse over the years, the medical supervision and other recent problems such as neck pain. The disadvantages of his

profession for health reasons were also explored, as well as the advantages of changing professions planned in the future.

The therapeutic aims are explored, i.e., to teach some techniques of pain management. A new problem emerges: the C says he is a very nervous person and that may influence his HA. The T explores this point and how he usually deals with it, including his spontaneous strategies to solve it.

At the end of the session the fist exercise of the first session is repeated, and a new one of progressive relaxation is demonstrated. The latter is proposed as homework to be done daily and the former to be done in case he has an HA.

BREAKS

Two breaks were done. No data.

HOMEWORK

To do the fist exercise if he has a HA and to follow doing his spontaneous strategies.

To do the following progressive relaxation exercise daily.

... If you want, you can try another relaxation technique that you can practice everyday, if you can... this one you can do even without a headache, in order to feel more calm... you have to sit in a chair... and tense the muscle, starting with the hand... right hand. Start with the right hand, straighten your arm, hand as a fist and tension, count to five... concentrate on the muscle that must be tense and hard... afterwards relax the hand slowly, and let the hand relax in your lap, compare the difference, note the difference of sensations when it's tense and now that it's relaxed... Now with left hand, left arm, one, two, three, four, five and relax... After with the right leg, straighten it up, feel the tension in the muscle... one, two, three, four, five and then relax... now the left leg... Now the muscle of the neck... you can twist the neck until you feel the muscle tension ... maintain it until five... feel the muscle, then the other side... come back to the starting position and relax... to the muscle of the back push the back of the chair with the arms until you feel the muscles of the back tense... then relax... after the muscle of the belly as a plank of wood... one, two, tree, four, five, then relax. Try to do this before you go to bed, five to ten minutes is all it takes... if you feel nervous you can do this exercise again...

(The relaxation time must be double the tension time, e.g., 5 sec. tension, followed by 10 sec. relaxation)

POST-SESSION

No data

CASE 1
(Male; 56 y.o.)

SESSION NO.: 3 **DURATION:** 34 minutes **DATE:** 04/03/1997

PARTICIPANTS: The client

THERAPIST: The author

THERAPEUTIC TEAM: --

PRE-SESSION

No data...

CREATION AND MAINTENANCE OF THE RELATIONSHIP

With the aim of maintaining a working relationship, the T follows the same strategies used in the previous sessions. At a non-verbal level the T maintains eye contact, gives confirmation signals by head movements, sounds as aha, m-hm and emphatic gestures such as smiles. At a verbal level the T shows concern through questions, answers' completion and understanding statements. The T tries to be sure that the C understands the questions done, even if several reformulations are needed. The T also validates the improvements done by the C since the previous session, and also compliments the C for these achievements (such as doing the homework as asked). The C accepts propositions that imply change.

SESSION: RELEVANT & OPERATIVE INFORMATION

RELEVANT & OPERATIVE INFORMATION:

A- Events Between Sessions:

- The C reports having had two HA episodes (on Feb. 19 and March 3). On the first day, the C got up with a HA and yet went to work and managed to keep working until the end of the day; then he went home, went to bed early and the HA disappeared. The second (one day before this session) started in the afternoon (around 6:00 PM) while attending a funeral. Afterwards the C went home, eat, rested and went to bed early and by the next day the HA had gone away. **NOTE: the HA episodes were shorter and less intense than usual and on both occasions he did not take any analgesic medication (cf. in the last session he expressed his belief that if he did not take the medication the HA would not go away! He had found a new resource...).**

B- Response to Previous Tasks:

- **The C practiced daily the progressive relaxation exercise (in the morning and sometimes also at night), and the fist exercise when feeling the HA (the C reports that he feels the pulse in his hand, then when slowing down the contractions in his hand he felt some relief from the pain).**

- **He did not use the old strategies to relieve pain (e.g., tissue strategy) or to relax (e.g., lime-tree tea).**

C- Evaluation of Changes:

- The C says that things are getting better, yet also says that only the future can confirm the achievements done. **He also mentions that now in the springtime he usually has more HA** (more than in the winter).

- Both the T and the C agree that these strategies (exercises) are better for the stomach.

D- Revision of the Therapeutic Aims:

The T and the C agree that is almost impossible to arrive to a complete cure of the HA (T: “everybody has an HA once in a while”). They also agree there if the future episodes have the same characteristics as the last two (or C: “Even if the headache was every 2 months”), things are much better since the C can go on with his daily life.

E- Work Issues:

- The C confirms that there is a good chance that he can start the farm work in June. Reflection about the advantages of changing job: it is a job that he likes

much more and is less demanding physically (compared with construction work), and where he can stop to do the exercises if a HA appears, etc.

F- About the Therapeutic Strategies and Techniques:

- The T revises how the C did the tasks, and the C exemplifies and describes how he did them.

- The C says he would like to follow trying the previous exercises and not complicate things (referring to hypnosis) if those work.

SESSION: DEVELOPMENT & INTERVENTIONS

The T, after revising an old medical report that the C brings in, asks about what has happened since the last interview (one month ago). The C says that things are going well. He had 2 HA episodes, but they were shorter and less intense than usual. The T explores the changes and what exactly the C did (if he applied the exercises, the spontaneous strategies, the analgesics, etc.). Then the T tries to explore the conditions in which the C would feel that the therapy was successful.

The T also asks again about the possible job change and explores with the C the advantages of that change.

After the break the T reinforces and compliments the C for the improvements since the last session and his collaboration in doing the recommended tasks. The T reinforces the continuation of use of the same homework, and she suggests to the C that if the HA is not very strong and if he is at home he can do some woodwork (one of his hobbies). They set the next session to 6 weeks time to see the evolution of the situation. No new techniques are introduced.

BREAKS

One break was done. No data.

HOMEWORK

To follow doing the fist exercise if he has a HA.

To follow doing his spontaneous strategies (tissue and tea).

To follow practicing the progressive relaxation exercise daily.

If he has a headache which is not very intense and he is at home, to try doing some woodwork.

POST-SESSION

No data

**CASE 1
(Male; 56 y.o.)**

SESSION NO.: 4 **DURATION:** 26 minutes **DATE:** 04/03/1997

PARTICIPANTS: The client

THERAPIST: The author

THERAPEUTIC TEAM: --

PRE-SESSION

No data...

CREATION AND MAINTENANCE OF THE RELATIONSHIP

The same as the previous session.

SESSION: RELEVANT & OPERATIVE INFORMATION

RELEVANT & OPERATIVE INFORMATION:

A- Events Between Sessions and the Evolution of Changes:

- The C reports he is much better regarding his migraine HA; nevertheless he is feeling some pain and discomfort in his neck and the occipital region of the head due to cervical problems. This pain is different from the migraine HA and it does intensify if he has to do harder work at his job as a construction worker.

- On a scale of 0 to 10 the C now places his HA around 2 or 3.

- He stopped taking the daily medication for anxiety and depression since the six months treatment period came to an end. In relation to the medication, he is only taking the one for his cervical problem (**but he doesn't take it daily as prescribed by his doctor**).

B- Response to Previous Homework:

- He keeps doing the exercises learned (the T did not check the spontaneous strategies). The C says that the exercises help him with migraine HA, but do not do much for his cervical pains.

C- Work Issues:

- As planned, he is going to change jobs (he starts to work on a farm in a month's time). **The C sees this change as very positive (inclusive for his cervical problem).**

D- Revision of the Therapeutic Aims:

- The C says that he is feeling better and that he wants to continue with the exercises and through this path (without so many medications). He asks if in the future he feels the need of more help if it is enough for him to phone the T to set a consultation.

E- Identify Resources:

- The C recognises that his efforts (in doing the exercises, etc.) are helping him to achieve a more stable situation in relation to his migraine HA problem.

SESSION: DEVELOPMENT & INTERVENTIONS

The T asks about what happened since the last session (more than one month ago). The C says that things are going well: his migraine HA is less frequent and intense. Nevertheless he complains about the pain from his cervical problems. The T differentiates this latter pain from the initial complaint of migraine HA. She also checks if a physician is following his cervical problem and recommends to the C to follow the medical prescription. She also says that the new job will probably help to improve the cervical problem since the new job is not so physically demanding.

After the T checks how the C is managing to control his migraine HA and what is the level of discomfort from it, using again as in the first session a 0 to 10 scale. The present migraine HA situation is seen as very acceptable (if it remains as it is), and that, in relation to the cervical problem, the change of jobs can improve that condition too. The T checks about the medications now used.

After the break the T says that the team sees the progress done as very positive and with a very good prognosis. She also reinforces the role of the C in the changes achieved.

The therapist reassures the C that if he needs more psychotherapeutic help in the future, he just has to phone to book an appointment. Meanwhile, a follow up interview is planned in 2 months time and the T suggests that the improvements are going to remain there and that maybe the situation can become even better.

BREAKS

One break was done. No data.

HOMEWORK

No new tasks.

POST-SESSION

No data

APPENDIX 3
SUMMARY OF THE THERAPEUTIC SESSIONS
(CARMEN'S CASE)

CASE 12
(Female; 37 y.o.)

SESSION NO.: 1 **DURATION:** >60 minutes **DATE:** 31/03/1998

PARTICIPANTS: The client

THERAPIST: The author

THERAPEUTIC TEAM: --

PRE-SESSION

The C was referred from the Neurologist with tension headache (24/3/98). A baseline interview was carried out (26/3/98), where it was found that the headaches started 7 years previously (in 1992 when the C was 31 years-old; they began suddenly around 8 months after her second child was born). During these 7 years there were better and worse headache periods. Since September 1997 (after her mother had a stroke) another bad period began. During these years she consulted several medical doctors (GPs, neurologists, psychiatrists, etc.) that usually took her case seriously but were unable to help her to solve the headache problem. For some headache crises she had to go to the ER. She had 2 CAT scans (Computed Axial Tomography) done to her head, always with normal results (the last one was done in the previous year). At the time of the base line interview she was taking 1 Nobritol at night-time (AMITRIPTYLINE 12,5 mg + MEDAZAPAM 5 mg; the former is a tricyclic antidepressant, the latter is a anxiolytic - benzodiazepine sedative). According to her, the headaches were aggravated by her nervousness and stress. In the past she took other antidepressants that didn't help her, instead they made her feel worse. At the time of the baseline interview she was having daily headaches that could be mild to severe, getting usually worse through the day (the severe ones could last up to 4 days). If she lay down she could better support her headaches. With the headaches she also felt nauseous, and usually she felt her neck

area very tense and a sensation of weight and pressing. According to her description of her headaches and associated symptoms, it seems that she suffers from both *2.2 Chronic tension-type headache* (A. Almost daily headaches; B. Pain had pressing quality, mild to moderate, and usually bilateral; C. Usually no vomit, yet nausea was usually present) and *1.1 Migraine without aura* (B. Occasionally there were more severe headache episodes that lasted several days; C. They were severe in intensity and aggravated by physical activity; D. With severe nausea). The results of the McGill Pain Rating Index (based on Sensory, Affective, Evaluative and Miscellaneous pain description words) were: PRI-S=13; PRI-A=4; PRI-E=3; PRI-M=5; PRI-T=25.

b) In the GHQ-28 she scored a total of 11 points (A. Somatic Symptoms: 4; B. Anxiety and Insomnia: 6; C. Social Dysfunction: 0; D. Severe Depression: 1, using 0-0-1-1 scoring).

c) The results of the ISRA indicated severe anxiety (Cognitive: 99; Physiological: 95; Motor: 85 and Total: 85).

d) Absorption Scale results were: Factor 1- Responsiveness to engaging stimuli: 3 classify as True (out of 7); Factor 2 – Synesthetic: 2 out of 7; Factor 3 - Enhance cognition: 1 out of 7; Factor 4 - Dissociative involvement: 3 out of 6; Factor 5 - Vivid Reminiscence: 2 out of 3; Factor 6 - Enhance awareness: 1 out of 4.

CREATION AND MAINTENANCE OF THE RELATIONSHIP

With the aim of creating a working relationship, the therapist (T) on a non-verbal level maintained eye contact, gave confirmation signs by head movements; on a para-verbal level the T used sounds such as m-hm; and on a verbal level the T questioned the client to confirm some of the information of the base line interview, gave understanding statements, and pointed to the client's resources whenever possible.

Since the sessions of this case were only audio recorded and the first half of the present interview was not recorded due to technical problems, most of these observations are based on the notes the T did after the interview. For these reasons just a general picture can be drawn, yet it can be said that a good therapeutic

relationship was established. Looking to the communication patterns (verbally and para-verbally) there are constant reciprocal confirmation utterances.

SESSION: RELEVANT & OPERATIVE INFORMATION

RELEVANT & OPERATIVE INFORMATION:

A- About the problem, the headaches (HA):

A1- HA History:

- Most of the HA history was taken during the base line interview (see pre-session for a summary).

- The C mentioned some of the pharmacological treatments previously done, she used to trust the doctors who initially gave her some antidepressant medication (she didn't specify which type of anti-depressants) since they attributed her condition to depression. However in the past she has reacted very badly to the antidepressants (she felt very down, with sensation of falling, etc.)

A2- HA Characteristics:

- In an average day (as in the day of this session) the HA is mild yet disturbs her daily activities, she feels tired mainly at the end of the day (e.g., instead of seeing television after dinner, she prefers to go to bed early). **If she is in her village (usually on the weekends) she can hold it better (i.e., she would stay speaking until later at night), and she doesn't complain as much about the HA** (she doesn't want to worry her family there). When she is with her friends in the city she complains more about her HA. Nevertheless she says that this level of pain is not so bad to live with. **Usually it is in the village that she has her better times (HA exceptions).**

- On a bad day the HA is more severe and she has more severe nausea, she usually has to lie down, and sometimes must even go to the ER (these more severe crises also had happened while she was staying in her village).

- Related symptoms: **She sometimes feels nausea; and she has her neck area extremely tense (as a rock).**

- Pain Experience Moderators: **The C recognises that stress, occupation and attention interferes with her pain experience.**

- Specific HA behaviours: When she feels the HA more severe and the nausea, she tries to lie down and rest; when others are present she holds on a little more than when she is at home; when she has the HA she moves her head and neck in a

particular way (**her husband can identify that behaviour as a signal that she has a HA**).

B- Other problems:

B1- The C expressed some desperation with her HA problem, as health professionals have had difficulty in explaining to her why she has these HA, she can not explain it either and she doesn't see a way out for it.

B2- She also expressed some low self-esteem, mainly regarding her intellectual capacities ("I'm a silly"; "I'm thick")

B3- Her mother, to whom she is very close, had a stroke and afterwards became paraplegic.

B4- She likes to have everything under control; if she doesn't have everything under control she feels she has a problem.

C- Resources:

Several resources were identified during the first interview:

C1- She has two significant others (her mother and her husband) that she can lean on.

C2- She was able to study to become a teacher.

C3- To relax: she used to practice yoga; **she loves the sea (and she can imagine it easily); she also has an aquarium that she can look to for feeling relaxed.**

D- Net of support:

D1: **Her husband is a very important person in her life and seems very supportive of her.**

E- Therapy aims:

During this first session three therapeutic aims start to emerge,

E1- The T spoke about the importance of learning to relax more often;

E2- The C spoke that her husband thinks she needs to see things and think about things in a different perspective;

E3- The T and the C spoke about the need to be able to have more self-control (regarding the effect of the tensions of day to day stress).

SESSION: DEVELOPMENT & INTERVENTIONS

...

The T looked for exceptions, i.e., if there are occasions in the C's life where, or when, she is HA free, or situations where she forgets her HA. The T gave examples of situations where other people sometimes forget their pain, and explained how attention affects the pain experience, with the aim of eliciting possible exception experiences from the C. The T also explained the difficulty of trying to control unconscious processes (e.g., the direct order "Relax!" can cause tension instead of relaxation –paradox effect). In this context the C spoke about how she usually feels better when she goes to her village, typically on the weekends, in contrast to her weekdays in the city (even her husband see the difference).

Next the T explained the power of our daily vicious cycle, how daily stressors and problems are accumulated. The T used the analogy of a glass being full with water, since sometimes we don't realise how full it is until the water pours out of it. A tension-type HA could be seen as the result of the same type of mechanism, little and big things get accumulated until it passes a point when the pain starts. Thus a possible therapeutic aim could be prevent the accumulation to reach the critical point (self-control in order to avoid the accumulation of stress). At the same time the T expressed understanding that stopping the accumulation of stress to reach the critical point is more easily said than done, and speaks about the importance of stopping the accumulative process as soon as possible. The T also tried to normalise the situation ("why me?" and "why now? I always was like this...") reasoning with the example of the development of an ulcer in the stomach.

After the T explored the exception situations (what the C does differently in them), trying to challenge alternative behaviour (i.e., more positive thinking; looking for things to do that are more absorbing and interesting, etc.). The C agreed that those things can help when the headaches are mild but she emphasised that on the occasions when the HAs are very strong it is difficult to do anything, that she has to lie down and rest (and she mentioned that these bad crises also had happened while she was at the village). Then the T expressed understanding about the difficulties to find energy to do anything when a person feels down (if somebody has the flu, it is difficult to have fun or if somebody is depressed it is difficult to find energy to do many things). Nevertheless, the T proceeded explaining that a secret of changing is sometimes to start to do small things even if the person do not feel up to it, to try to break the cycle, not waiting to feel well to doing it. Then the C spoke about past treatment failures, that she feels a bit desperate (without hope to find a solution to her HA problem) and that her husband says that she needs to see things in a

different perspective and have more self-control. The T agreed with the need of self-control, yet proposes that before dealing with the self-control issue it would be a good start to become more aware of her pain behaviours, be aware of the movements and signals that her husband can detect to know that she has the HA. From here emerged the homework proposal that she can try to confuse her husband by changing some of her typical pain behaviours (for more details see homework section). From this discussion it became clear that her neck and shoulders accumulate lots of tension and usually are as hard as a rock. The T suggested to the C to ask her husband to massage her neck and shoulders and to take hot showers to help to relax that area. Additionally, the T asked the C that as soon as she feels nausea (one of the first signals that the HA is going to become more severe) she should try to relax (to stop the accumulation to reach the critical point). In order to help the C in this last task the T spoke about different relaxation techniques that can help the C to relax faster and deeper (creative imagination, biofeedback, hypnosis, progressive relaxation, etc). Then the T tried to tailor the technique to the C by asking her which techniques she would like to try first, which she thinks would work better for herself. The C asked the T to choose and the T decided to start with some standard exercises based on progressive relaxation techniques, and with some creative imagination exercises. In order to tailor the creative imagination exercise to the particular client the T asked several questions that lead to the creation of an imagination scenario of the sea (for more detail see homework section). The T also asked the C to fill out a pain diary until the next session.

BREAKS

No breaks were done.

HOMEWORK

1. To do an experiment with her husband: on alternate days (one day experiment, one day behave normally) to try to confuse her husband by changing her typical pain behaviours (such as the neck movements). The aim of the experiment is to disrupt her pain pattern and allow her to become more aware of the pain behaviours (before her husband does).
2. To do simple relaxation strategies, such as asking her husband to massage her neck and shoulders and to take a hot shower.
3. New relaxation strategies:

3.1. Muscular relaxation in a chair (a simple exercise adapted from the progressive relaxation technique): “Ok, you can sit like this [back straight, about 10 centimetres apart from the back of the chair]. We are going to start a muscular relaxation exercise since usually it’s difficult to relax at a muscular level and after learning this it’s easier to do the other exercises. This one is relatively easy. Put your hands like this [pressing each other in front of the chest] and get a little away from the back of the chair. Breathe deeply three times and at the third time when you breathe out let your body fall back to the back of the chair and your hands and arms rest in your lap. You start by tensing your muscles, then you stop and an automatic relaxation reaction happens ...”.

3.2. Creative imagination exercise: “Now start by imagining the aquarium, the fish, the bubbles in the water, the sand ... and now as you imagine that aquarium, start to imagine that you are on a beach, a beach that you like, maybe a quiet one, maybe there is a nice temperature, you can sit down looking at the sea, the waves, the sand, and even smell the salt of the sea... enjoy those sensations... feel that you are there ...you always can go back to this place, where you can breathe deeply and feel better... to get to this place you only have to sit in a quiet space, breathe deeply three times, close your eyes and imagine the sea... after having enjoyed that place for sometime, you can open your eyes...”

3.3. Muscular relaxation standing up (another simple exercise adapted from the progressive relaxation technique): “Another exercise that you can do while you are standing up is: putting your feet at the same distance as your shoulders, with your hands united behind your back, breathe three times (tensing the muscles) and then release your arms...”

4. Fill out the pain diary.

POST-SESSION

Thinking about this first session, it was a little confused and the T could have kept a more organised line of inquiry and discussion. Even the homework could have been simplified and given in a clearer way. Nevertheless the C had time and opportunity to express her feelings and thoughts about her problems and a good therapeutic relationship started to be established. There was a back and forth between the definition of the problem(s) and the definition of the therapeutic aims. Some tentative intervention steps were given.

CASE 12
(Female; 37 y.o.)

SESSION NO.: 2 **DURATION:** >60 minutes **DATE:** 21/04/1998

PARTICIPANTS: The client

THERAPIST: The author

THERAPEUTIC TEAM: --

PRE-SESSION

No data.

CREATION AND MAINTENANCE OF THE RELATIONSHIP

With the aim of solidifying a working relationship, the therapist (T) on a non-verbal level maintained eye contact, gave confirmation signs by head movements; on a para-verbal level the T used sound as m-hm; and on a verbal level the T asked questions in order to clarify details, summarised to check if she understood the information given, repeated back some words (i.e., mirror answers) to reinforce concern, anticipated answers to show understanding, verbalized direct understanding statements, pointed to the client's resources, etc.

Since the sessions of this case were only audio recorded most of these observations are about verbal and para-verbal communication.

SESSION: RELEVANT & OPERATIVE INFORMATION

RELEVANT & OPERATIVE INFORMATION:

A- About the problem, the headaches (HA):

A1- HA History:

- The C referred again to some of the pharmacological treatments previously done (antidepressant medication) and how badly she reacted to those treatments. Regarding her current medication, she commented that one of its biggest advantages is that it helps her with her insomnia (see B. Other problems).

- The C told how one of the headache's bad periods started (she associated its beginning to an episode when she was taking a coffee and started to feel very anxious).

A2- HA Characteristics:

- The C reported that in the 3 weeks since the last session she has been average (the HAs were mild and she managed to proceed with her daily life – on the pain scale, with 5 as a maximum, between 1 and 2), with the exception of a bad crisis when she was at her village during the Easter week (she started to feel tension, nausea and her neck felt swollen, she even went to the doctor, and after experiencing strong nausea that culminated in vomiting she slowly started to feel better).

- Other related symptoms emerged: Besides nausea that the C complains as being very distressing and tension that can lead to inflammation of the neck area, she also mentioned that sometimes she vomits, has allodynia (i.e., pain from stimuli which are not normally painful), feels unsafe, and sporadically feels anorexia, depression and that people tell her that she becomes pale.

- The C described that the HAs usually start with a sensation of tension, accompanied sometimes by a mild bearable pain. If she feels nausea, that often means that the HA is going to get worse and sometimes she has allodynia, anorexia and she even vomits; during the bad crises she often feels unsafe and depressed, and she has to lie down. After the HA get to its worst (sometimes with a vomit episode), **usually after resting she slowly starts to feel better** (less nausea and with a more positive thoughts).

- In relation to HA exceptions, two more situations emerged: besides when she is at the village, **usually when she is on vacations she feels better, many times headache and tension free** (they usually spend the holidays at the beach); **another situation that emerged as helpful is when she managed to take a break and rest, which usually makes her feel better.**

- The client wondered about if her problem is functional or organic, and **if it is due to her nervousness, that she always was like that why did she only start to have the headaches in recent years?** Moreover, why cannot the doctors find what is wrong with her and fix it? **She also asked what can she do to improve?** She feels better when other people that she knows speak that also suffer from severe headaches.

B- Other problems:

B1- The C sometimes has feelings of desperation regarding her HA problem (she can not explain it and she doesn't see a way out of it); besides, when she is in a crisis she feels depressed and hopeless.

B2- She expresses anxiety at different levels (manly cognitive anxiety), fear, insecurity, low self-esteem, lack of awareness and control over certain situations. She also suffers from insomnia.

B3- In a system level, she feels that her family tries to super-protect her (a fact that she doesn't like, yet besides complaining she doesn't take actions to change the situation). She also feels unfulfilled with her life (she considers the possibility of studying further or starting to work again, but she has doubts about those plans).

C- Resources:

Several resources were further identified:

C1- Her family in general is a resource and tries to support her (her father emerges as a model of calm that she can emulate).

C2- She recognises herself as moderately intelligent.

C3- To relax: she recognises that practicing yoga again is a good strategy; massages and hot showers are seen as possible tactics too.

C4- She has a good sense of humour.

C5- She can retrieve memories of good times in her life (problem free times).

D- Homework:

D1- The C tried to do the behavioural game with her husband, but in the end she told him about the game.

D2- **The C reported that she likes to have hot showers** (one of the simple relaxation strategies suggested in the first session).

D3- **The client commented that she did the relaxation exercises previously learned; yet she reported that usually she tried to do them when she was already very nervous and that on those occasions they didn't help her.**

D4- She brought the **pain dairy of the previous 3 weeks.**

E- Therapy aims:

E1- Even if the C remains with frequent mild headaches (yet without nausea and more severe crisis), she would accept that as a good result.

E2- To help the C to become a more calm person, able to relax easily, having more self-control of her emotions and thoughts;

E3- To help the C to see life situations from a different (more positive) perspective and to recover her vitality.

SESSION: DEVELOPMENT & INTERVENTIONS

The T started by asking what happened in the last three weeks since the previous session regarding the C's headaches. The T questioned the C about details and summarised answers in order to confirm that she was getting a correct understanding of the problem (the T used the pain diary as a guide). Additionally the T inquired to obtain a better description of the headaches' characteristics, related symptoms, how the crises usually developed, etc. The T also underlined and reinforced alternative behaviours that the C has been doing and that help in the problem management (e.g., taking a break to rest). The T also called attention to the need to do the relaxation exercises or for taking a break regularly (not be waiting to feel tension or pain for doing it – break the vicious cycle as soon as possible). The T asked about the other homework tasks (namely the behavioural game).

Next the T asked about possible therapeutic aims, simultaneously trying to normalise feelings and cognitions. At the same time, other problems were discussed and the usefulness of the present medication was recognised for at least one of them (the insomnia). The T asked about if, during the previous 3 weeks, there were days where the C felt well (i.e., exceptions). The C mentioned several good days that happened, pondering if she felt better because she managed to rest more or if it was just by chance. The T reframed the situation saying that maybe both factors (her actions and chance) played a role in her feeling better. Then the conversation topic moved to the role of her anxiety in her headaches and she complained about her inability to control her anxiety. The T offered a possible rationale to the C's headaches (the analogy with a stomach ulcer was once again used) and proposed that helping the C control her anxiety was a possible strategy to prevent severe headache crises. Then the C complained about her inability of self-control, her impulsivity, the tendency of over-protection by her family, etc. These topics were intermingled with discussion about other possible therapeutic aims (to see her daily life situations from a different perspective, be calmer without losing her spontaneity and recovering her vitality). The T took the opportunity to reinforce the importance

of taking small breaks during the day as a way of calming down and regaining energy. In this context T asked about what happens when the C is on vacations if she manages to calm down? The C answered positively and described another usually headache free period, when she usually feels very calm and relaxed. The T gave a positive connotation to that fact, saying that the C has the resources to relax and she can learn to apply them in her daily life. To achieve this goal it would be helpful to make a change in the C's cognitive schema (accepting that it is impossible to do everything in a limited time). Moreover another aim could be to reach a balance between the calm of her father and the vitality that her mother used to have.

Through the end, some time was spent speaking about the advantages and disadvantages of the possibility of the C to start working again or studying further. The C once again speaks about her desperation of not having a more precise message from the health professionals to explain (and solve) her headache problem. Facing that question, the T tried to elucidate the difficulties in the understanding of the mechanism underpinning the tension-type headache and the complexity of factors that are involved in this condition. Taking the opportunity, the T once again suggested the need for the C to take several resting periods during the day (at least a small nap in the middle of the day); the advantage of facing her daily chores in a calmer way; the usefulness of having a massage or a hot shower to reduce the daily tensions and the importance of starting to practice yoga again. Before the end of the session the T checked the muscular tension in the C's shoulders (which were extremely tense) and did a breathing exercise with pressing points to relieve some of the physical tension.

BREAKS

No breaks were done.

HOMEWORK

1. To take at least one break after lunch and enjoy the hot showers, and massages.
2. To fill out the pain diary.

POST-SESSION

No data.

CASE 12
(Female; 37 y.o.)

SESSION NO.: 3 **DURATION:** ±90 minutes **DATE:** 29/04/1998

PARTICIPANTS: The client

THERAPIST: The author

THERAPEUTIC TEAM: --

PRE-SESSION

No data.

CREATION AND MAINTENANCE OF THE RELATIONSHIP

With the aim of solidifying a working relationship, the therapist (T) on a non-verbal level maintained eye contact, gave confirmation signs by head movements; on a para-verbal level the T used sound as m-hm; and on a verbal level the T asked questions in order to clarify details, summarised to check if she understood the information given, repeated back some words (i.e., mirror answers) to reinforce concern, anticipated answers to show understanding, verbalized direct understanding statements, pointed to the client's resources, etc. The client (C) replied accordingly to these forms of communication (e.g., by keeping the eye contact, using also confirmation sounds as m-hm, etc.) showing that a good therapeutic relationship was being established.

(Since the sessions of this case were only audio recorded most of these observations are about verbal and para-verbal communication.)

SESSION: RELEVANT & OPERATIVE INFORMATION

RELEVANT & OPERATIVE INFORMATION:

A- About the problem, the headaches (HA):

A1- HA History:

- The C reported that this latest bad headache period (when she has the headaches daily) started in September 1997 and continues to the present time (more than 7 months).

- The C mentioned again her current medication, saying that she trusted it and depended on it to get asleep. She restated her fear of trying a new medication due to her past bad experience with anti-depressants. Yet she expressed the desire, in the future if the headaches are managed by other means, to eventually become medication free.

A2- HA Characteristics:

- The C reported that in the last week she has had a bad crisis. It started on Friday when the C felt not well, yet tried to distract herself by window-shopping. That distraction didn't work and the C had to go back home and lie down in the middle of the day. When she lied down, it was as if all the sensations she was trying to run away from intensified, as if a critical point was reached and she no longer could control her sensations. She felt severe nausea and unilateral strong vascular headache (that later became bilateral); she was fearful and had the sensation of losing control. She cried for a while and managed to fall asleep. She got up to eat a yogurt for dinner (she didn't have much appetite), went back to bed to sleep more and spent Saturday resting in bed (still feeling nausea and headache). Since Sunday the C started to feel increasingly better, going back to the usual daily tension headache.

- Other information emerged: in a headache crises, movement increases the headache (immobility emerges as an headache exception), and the C becomes more sensitive to noise (phonophobia), and yet tolerating light very well (no photophobic). The C also reports feeling a sensation of heat in the head during the crisis.

- The C described how the headaches affect her mood: She feels happy when she is ok but she feels very sad, depressed and anxious when she has the headache crises.

- The C used the expression that she feels that she has something inside her head that is causing the problem and she is unable to take it out, to extract it.

B- Other problems:

B1- The C restated several times her feelings of desperation regarding her HA problem. She also showed pessimism and insecurity regarding the future.

B2- The C spoke again about her lack of awareness regarding her anxiety level (her husband knows she is getting nervous before she does).

B3- The C also revealed again low self-esteem through several statements.

B4- Heightened anxiety level in general, with the cognitive anxiety the highest.

C- Resources: the C's spouse is somebody she can rely on; in certain situations the C is able to relax (yoga, massage, hot shower); dry heat helps the client to relieve the tension in her neck; the C has a good sense of humour and has motivation to try new things that can help her with her problem.

D- Homework:

D1- The C reported that she tried to rest as much as possible (e.g., taking a nap).

D2- She mentioned to have filled out the pain diary since last session (yet she forgot to bring the paper).

E- Therapy aims: To be able to relax, be a more calm person with vitality.

SESSION: DEVELOPMENT & INTERVENTIONS

The T started by asking what happened in the last week since the previous session regarding the C's headaches. The C replied by mentioning a bad headache episode that began on the previous Friday, how it started until how it calmed down. The T listened attentively and questioned the C about details of that crisis and its aftermath.

The C communicated her frustration of not seeing any improvements and the desperation of not seeing a way out. The T explained that change can be a slow process that needs patience and persistency. After, the T inquired about one of the therapeutic tasks (the break after lunch) and how did she feel at the time of the interview (using a percentage scale). The C replied saying that she tried to rest as much as she could and that she was at a 40% level, since she felt hopeless, unable to expel what is causing so much distress. The T asked about the days previous to the recent crisis, if she felt fine during any of those days. The C replied by saying that she felt the average tension headache and that it is only when she is not moving in bed that she feels no tension or discomfort. The T asked directly when was the last day that the C remembers that she was totally fine. The C reported that since this last bad headache period started more than half a year ago she was never totally fine. The T summarised the information obtained, confirming the signals that indicate the transition from the average daily tension headache to the severe headache crises (nausea comes out as a critical symptom) and questioning

further about the headache characteristics. The T tried to externalise the problem by saying that its like a shadow that follows the C. After this the C expressed doubts about her headache diagnosis: How can the doctors say that she doesn't have anything wrong and yet she feels so bad? The T replied by arguing that the doctors agree that she doesn't have a serious progressive disorder (such as a tumour) that is provoking the headaches, yet the T underlined that the primary headache in itself is a big problem.

Then the C spoke about her spouse's opinion that she has to be able to control herself if she wants to control her problem, her lack of awareness about her anxiety levels, and the relationship between the headaches cycles and the fluctuation of her mood, her feelings and sensations. The T listened, asked about details and summarised the information obtained.

Then the T argued about the importance of preventing the accumulation of sensations and anxiety by having relaxation breaks during the day. With this aim the T suggested the possibility of training with different relaxation exercises that the C could practice during the day (the T underlined the importance of persistence and patience in order to see any results). Before introducing one of these exercises, the T gave feedback about the anxiety written test done by the C at the base line interview that revealed high levels of anxiety. The C recognised that the results of that test reflect how she feels and thinks about her anxiety. Next the T recalled that the C has resources to control some of the vicious circles of anxiety as shown in the periods in the C's life where she manages to relax, be serene and calm (e.g., vacations). The C doubts that she still has those resources. Then the T tried to externalise the headache problem as a monster that terrorises the C and that she feels without weapons to fight against it, yet underlying that she can learn to fight it. The C cried, showing desperation with her situation and with the doctors that tried to help her: how can they not find what is wrong with her, what is causing the headaches? The T replied by saying everybody agrees that the C has severe anxiety levels, but by the information given in psychotherapy, the C also has the capacity to control that anxiety. In order to be able to control her anxiety more often the T suggested for the C to focus more on herself and develop her self-awareness. The T used the analogy that the C carries the weight of all the responsibilities of taking care of others on her shoulders and that is reason enough for feeling tension; and that the pain can be a warning signal reminding the C that she also has to take care of herself. Furthermore the T reasoned that self-awareness is a learning process, such as when a woman learns to become a mother (e.g., learning to discriminate the

types of crying of a baby, etc.). The T also noted that sometimes an attempted solution can feed the problem, and that if something doesn't work or stopped working the best step is trying something else. At this phase of the C's life her worries, tensions and anxiety are accumulated in her body causing muscular tension and emotional distress. With the aim of changing this process the T suggested to teach the C some new relaxation exercises. The T and the C decided to start by experimenting with a biofeedback exercise using the skin electro-conductivity apparatus. The T demonstrated how to do the exercise using the sound and the visual output, and afterwards the C experienced the exercise too. The C managed to decrease the out-put signal and the T used this fact as an illustration of the C capacities and resources.

As homework the C has to do this biofeedback exercise (with or without guide imagination to help in the relaxation) three times per day. The T underlined once again the need of persistence and patience; and that the C cannot expect instant results, the objective of this exercise being to learn how to relax often and quickly (not to stop the headaches, therefore even if she feels pain or nausea she has to proceed with the homework assignment).

Before the end of the session the C asked the T directly what the T thinks about her problem. The T replied by saying that high anxiety levels such as the ones that she has can justify a tension type headache and go on explaining the mind-body interaction as a possible explanation to her problem. Moreover the T suggested to the C to go to a professional masseur to have some massage sessions, continue to use strategies such as hot shower or dry heat to relax the neck area and fill-out the pain diary once more until the next session.

BREAKS

No breaks were done.

HOMEWORK

1. To do the biofeedback exercise at least three times per day.
2. To have a professional massage and follow with her day to day strategies such as hot showers and dry heat.
3. To fill out the pain diary.

POST-SESSION

No data.

CASE 12
(Female; 37 y.o.)

SESSION NO.: 4 **DURATION:** ±90 minutes **DATE:** 05/05/1998

PARTICIPANTS: The client

THERAPIST: The author

THERAPEUTIC TEAM: --

PRE-SESSION

No data.

CREATION AND MAINTENANCE OF THE RELATIONSHIP

Idem

SESSION: RELEVANT & OPERATIVE INFORMATION

RELEVANT & OPERATIVE INFORMATION:

A- About the problem, the headaches (HA):

Since the C's mother had a stroke and become paralysed the headaches for the C have a different meaning. **From that moment, when she has a headache she starts to think the worst and she enters in a vicious cognitive anxiety cycle.**

During the last week the C only felt the normal tension in her neck and shoulders.

B- Other problems:

Some daily occurrences can very easily become stressors.

Fear of death emerged as a disturbing factor (this fear started after her mother's stroke).

C- Resources:

The C is able to relax quickly with the biofeedback apparatus (better than with imagination only).

She has a friend with a heart condition who has a calmer attitude in relation with her problem that the C can try to emulate.

D- Homework:

D1- The C mentioned that instead of the masseur, she went to a physiotherapist who did some manipulation of her neck that afterwards made her feel more relaxed.

D2- The C reported to have done the biofeedback exercise often and showed in the session that she can relax quickly with the biofeedback apparatus.

D3- The C brought the pain diary regarding the days since the last session.

E- Therapy aims:

E1- Once again the C stated that she would be happy if she didn't have bad headache crises even if the tension type mild headaches persisted.

E2- Be more self-confident and calm.

F- Improvements:

F1- During the past week the headache levels were acceptable.

F2- The C mentioned several occurrences where she applied a new attitude to deal with certain situations and she managed to feel less tense.

SESSION: DEVELOPMENT & INTERVENTIONS

The T started by asking how the client has been feeling since the last session, the previous week. The C answered that she is feeling progressively better. She was especially well on the weekend that she spent in her village, and after coming back to the city she feels some tension but of the bearable type – according to her it has been a good week. The C also mentioned that before the weekend she went to a physiotherapist doctor who did some manipulation to the neck area and afterwards she felt more relaxed. The T asked directly if she would be fine with this level of the problem (as the C had mentioned in session 2). The C replied that she would feel very happy if she only felt this mild tension in her neck and head.

Next the C referred to the homework assignment of the biofeedback exercise. She said that the apparatus now works at a psychological level – she puts it on and she feels tranquil. Then the T asked the C to do the exercise there as she does it at home. The C demonstrated the exercise. The T asked concrete questions about how she does the exercise at home and explained further the biofeedback relaxation mechanisms. Since the C managed to decrease the output very well, the T complemented her for her ability in doing it. Next the T mentioned that it would be ideal to have sensor to place on her shoulder-neck area, since unfortunately the

present biofeedback apparatus only can be placed on the fingers. While following with the biofeedback device attached, the C mentioned diverse stressful daily situations, and with the T new alternative attitudes and behaviours are discussed. Whenever possible the T noted the C's resources (based on the information given). To finish the exploration of this homework assignment the T asked the C if it is easier for her to relax with the help of the biofeedback or the imagination exercises. The C answered that with the biofeedback it is easier because she has a sensorial concrete stimulus to focus her attention.

Next the T inquired about the pain diary and after the C gave it to the T, the T questioned her about details of the diary information and took notes. Afterwards the T asked about if the C had the opportunity to go to a masseur and the C replied that she decided instead to go to physiotherapy. Then the T used the analogy of a glass that gets full of water (tension) until it pours out (headache) to underline the need of regular relaxation strategies (relaxation exercises, yoga, physiotherapy, massage, etc.) as a way of extracting some water out of the glass and therefore preventing the overflow, as well as to avoid the intake of water (e.g., by changing cognitive schemas and strategies of dealing with daily stressors). The T called the C's attention to the fact that she is already applying some of these strategies and advised for the C to proceed on this path (the C agrees with this) even if there are some setbacks on the way (amplification of changes and relapse prevention). The T once again underlined the need of persistence and patience since change can be a slow process. Then the conversation topic focuses on the cognitive changes that could help the C to see things in a different perspective.

Next the T asked the C to continue doing the biofeedback exercise at home and to follow with the physiotherapy. Then the T tried to introduce a specific task for the cognitive anxiety cycling, but the conversation topic diverted to day-to-day events where the cognitive anxiety is present and where the C cannot control herself. The T listened, giving understanding statements. Of interest, the C described other situations (apart from the headache crises) where she has to touch the bottom of the barrel to do something different, and her tendencies to go from one extreme to the other. The T explained the notion of a healthier balance by using the image of a curve – wave like – line (sinusoid line) as opposed to the zigzag line that represented her life today. Afterwards, the C revealed that lately (after her mother's stroke) the fear of death became very present in her life. The C also mentioned her character in contrast to one of her friends who deals with much more

tranquilly with her own serious health issues. The T listen attentively, trying to show understanding and normalising the concerns of the C.

Afterwards the T asked the C to follow doing the pain diary and the biofeedback exercise and to start a new assignment: to write how she thinks, the thinking pattern, when she starts to enter into a cognitive anxiety cycle (focus not on the content but on the how she does it). From there to the end of the session the conversation topic changed again to the fear of death, how the C now is much more fearful of her headaches because she is afraid that one day she would have a stroke such as happened with her mother (since they are so similar in everything). The T listened and redefined the fear of death as a learning opportunity of psychological maturation. They finished the present session, setting up the next meeting in 2 weeks time.

BREAKS

No breaks were done.

HOMEWORK

1. To follow doing the biofeedback exercise.
2. To follow with the physiotherapy.
3. To follow doing the pain dairy.
4. To start to write how she thinks, the thinking pattern, when she starts to enter into a cognitive anxiety cycle (focus not on the content but on the how she does it).

POST-SESSION

No data.

CASE 12
(Female; 37 y.o.)

SESSION NO.: 5 **DURATION:** ±60 minutes **DATE:** 19/05/1998

PARTICIPANTS: The client

THERAPIST: The author

THERAPEUTIC TEAM: --

PRE-SESSION

No data.

CREATION AND MAINTENANCE OF THE RELATIONSHIP

Idem

SESSION: RELEVANT & OPERATIVE INFORMATION

RELEVANT & OPERATIVE INFORMATION:

A- About the problem, the headaches (HA):

A1- HA history:

The C mentioned again the bad experiences in the past with anti-depressive medication given for her headache problem. She also restated that at least the present medication helps her with the insomnia.

A2- HA Characteristics:

Adding to the previous descriptions of her headaches, the C explained that the pain and unpleasant sensations (such as nausea) come and go as in waves.

The C was with a headache during the present interview; at the beginning of the interview she classified it as 7-8, through the end it was 6-7 (in a 0 to 10 pain scale).

B- Other problems:

B1- During the past two weeks she was with a cold and had her period.

B2- The C mentioned that she has hypotension (low blood pressure) which makes her feel dizzy after some relaxation exercises.

B3- The C spoke again about her previous failed work experience.

C- Resources:

C1-The C is able to relax quickly with the biofeedback apparatus-

C2- The C shows motivation to change.

D- Homework:

D1- The C went again to the physiotherapist (she complained of feeling sore after the manipulations).

D2- The C followed doing the biofeedback exercise with some success (she manages to lower the output quickly and during the exercise she feels better, yet as soon as she stops the pain or discomfort is present again and sometimes afterwards she feels some nausea).

D3- The C brought the pain diary regarding the two previous weeks.

D4- The C also wrote down some of her thoughts as requested and achieved some insights that lead her to change her attitude regarding the headache crises (she decided not to think so negatively).

E- Therapy aims:

Change of perspective was one of the aims discussed in the present session.

F- Improvements:

The C mentioned several occurrences where she applied a new attitude and perspective, even during the headache crises with nausea. The C even faced her fear of lifts by her own initiative.

SESSION: DEVELOPMENT & INTERVENTIONS

The session started by reviewing what has happened in the previous 2 weeks. The C mentioned how easy it is for her to do the biofeedback exercise. She manages to quickly lower the output of the apparatus, and while she is doing it she feels better, yet as soon as she stops the pain or discomfort is present again and sometimes afterwards she feels some nausea. The T listened attentively and explained that since she has tendency for low blood pressure, after the relaxation exercise it is normal that the tension drops a little which can provoking unbalanced sensations (light-headed or dizziness). The C accepted this redefinition and stated that now she deals with the nausea with a more positive attitude. The T followed by saying that even considering that in the past 2 weeks she had some headache crises, a cold and her period, she was with a very good attitude and humour during

the present session. The C confirmed this by saying that she is learning to live with the condition in a less stressful way (seeing things in a new perspective). The T listened and explored this change of attitude. The C explained that while doing the homework assignment of writing how she thinks, she realised that by thinking the worst she is not helping herself, thus she decided to try to think less negatively. The T underlined the need of patience to see long lasting changes.

Next the conversation topic moves to the physiotherapy that the C is undergoing. The C mentioned that she feels her back and neck sore for a couple of days after the treatment. Then the T asked about how the C is sleeping lately. The C replied that thanks to the headache medication she manages to sleep well and if the C manages to sleep well she feels less tension in the morning. Some time is spent speaking about the current medication and the possibility of changing it in the future (which she is afraid of due to her bad past experiences). The headache characteristics and patterns were also discussed with focus on the headache that happened recently.

Then the T suggested doing a relaxation exercise with the use of images, and C complained that she was starting to feel more nausea. Then the T asked about the intensity of the headache at that moment (on a scale of 0 to 10 the C indicated that the pain was between 7 and 8) and how the headache usually decreases in intensity and how she feels when she has no headache. Then the T suggested a new exercise loosely based on the gestalt empty chair with the externalization of the headache. During the exercise the conversation topic detoured to other issues (mind/body and the headaches; opinion of other health professionals, etc.). Next the T asked again about the pain intensity at that moment (the C indicated between 6 and 7). Subsequently the T underlined the small decrease and the role that displacing the attention on the headache perception achieves. Then the C commented about the changes in her way to perceive and think about her headaches (and related symptoms) that happened since the last session. Moreover the C also told about an episode where she faced her fear of lifts by her own initiative (amplification of change's example). The T listened and reinforced the C's new attitude. The T also did some relapse prevention (to not give up even if the headaches do not improve straight away) and suggested to put the problem (the headache) in its place (that it is something important but cannot rule the C's life). The T also redefined the C's sensitivity by saying that it is as if she has a part of her inner self that is still a child who needs to be taken care of by her adult self,

underlying the resources that the C already demonstrated. Then the C spoke about her failed professional adventure. The T listen, normalised and seeded for the future.

Through the end of the session the C asked directly for the T's opinion about her case. The T replied by saying that her case is complex and understandably emotionally draining because she has both tension type headaches and migraine headaches without any totally pain free period.

BREAKS

No breaks were done.

HOMEWORK

To follow the homework assignments of the previous session...

POST-SESSION

No data.

CASE 12
(Female; 37 y.o.)

SESSION NO.: 6 **DURATION:** ±60 minutes **DATE:** 02/06/1998

PARTICIPANTS: The client

THERAPIST: The author

THERAPEUTIC TEAM: --

PRE-SESSION

No data.

CREATION AND MAINTENANCE OF THE RELATIONSHIP

Idem

SESSION: RELEVANT & OPERATIVE INFORMATION

RELEVANT & OPERATIVE INFORMATION:

A- About the problem, the headaches (HA):

A1- HA Characteristics:

- During the past two weeks the C had daily headaches with some bad crises.
- The C was with a headache during the present interview (6-7 in a 0-10 pain scale).

A2- Other treatments besides psychotherapy:

- The C said that the physiotherapy is not helping in a significant way and **she expressed her wish of going back to the neurologist to try another pharmacological treatment.**

B- Other problems:

B1- **She vented how despair and tiredness are overwhelming her.**

B2- **She expressed low self-esteem again and that she feels unfulfilled with her life.**

C- Resources:

C1- Once again the C spoke of her husband as a very important person who supports her during her crises.

C2- The C also mentioned several times how what she learned during the present psychotherapy affected her positively.

C3- The C started to practice yoga again.

D- Homework:

D1- The C went again to the physiotherapist (she complained that he does not take her case seriously).

D2- The C followed doing the biofeedback exercise but she complained that its help is not appreciable.

D3- The C brought the pain diary with some thoughts written down.

E- Therapy aims:

Stopping the bad crises and increase the C's vitality emerged as the measure of a successful treatment.

F- Improvements:

The C was visibly down due to the constant pain of the previous weeks. Nevertheless, even surrounded by pessimism, some recognition of the application of a new attitude and perspective emerged.

SESSION: DEVELOPMENT & INTERVENTIONS

The T started by asking how the C has been feeling in the previous two weeks since the previous session. The C answered that she has had headaches and some bad crises. The C mentioned that she is tired of suffering and her mood has been down (opening the door to desperation and questioning the origin of her headaches). The C asked directly if the T could give her a solution to her problem (what can she do or take?). She further mentioned that she has been doing the biofeedback relaxation exercise but she is not seeing lasting results (i.e., she feels slightly better while she does the exercises but after she finishes it she feels bad again). She also mentioned that she is having bad crises in her village too. The T listened attentively, showing concern and understanding.

Next the T asked the C how would she feel if she had to deal with the scenario of her headaches remaining the same as in the previous weeks. The C replied by saying that she would have to learn to live with the headaches, taking advantage of

the better days and knowing that sometimes she would feel down with despair, questioning why. Then the T asked the C to verbalise those whys. The C went on mentioning her cognitive anxiety in dealing with the cause of her headaches that leads her to feel despair (if the headaches are so strong and constant maybe something very wrong organically is going on) and she asked for a solution or a referral back to the neurologist to try a new medication. The T replied by saying that since the present session is the 6th and that the therapeutic aims were not significantly reached, maybe the appropriate action to take is to stop the psychotherapy for the moment, referring the client back to the neurologist to try another pharmacologic intervention. The fears of changing medication due to past bad experiences were once again discussed, as well as what to do if no improvement in the headaches occurs. The T also spoke a little about the relationship between chronic pain and depression.

From there the conversation topic went to physiotherapy and yoga. The C has started to practice yoga again and she is relaxing and enjoying it. The C also has follow with the physiotherapy, but she does not feel that the physiotherapist takes her case seriously. The T expressed understanding by saying that only those who do not have pain will doubt it in others. And more, the T said that if the C does not give up applying (when she can) the new perspective, an important therapeutic aim is achieved. The T also suggested to the C to use her humour to deal with her problem. The C replied by saying that in the bad crises days this is impossible since she feels overwhelmed with the headache and associated symptoms.

Next the T asked the C to classify her current headache using a 0-10 pain scale. The C answered 6-7. Then the T questioned further about the headache's characteristics and afterwards summarised how the C copes with the average daily headaches and the bad crises. Then the C spoke about her desperation and how tired she is of the situation (she doesn't see away out of her problem). At this point the T advised the C to go back to the neurologist to try a new pharmacological treatment. The C asked directly for the T's opinion. The T answered by saying that the neurologist in question is a very good one and the C should try a new treatment with him and that is going to be easier to find a solution to her headaches that a precise explanation for why she has them.

Afterwards they spoke about her summer vacations plans and how to coordinate them with the neurology consultation and possible future treatments and contacts. The T also gave information of other psychotherapists who could be useful to contact in the future to try further other psychotherapeutic approaches.

The T underlined the importance of being persistent and not giving up of trying to find a solution. The C expressed again her despair about her headaches as she does not see a way out, since the doctors cannot tell what is organically wrong with her, etc. The T listened and expressed understanding, as well as advising the C to trust more in herself and to pursue her search for a solution.

Next the conversation topic moved to how the headaches affect the C's family life and the C said that she feels very tired of this situation (of the headache ruling her life). Then they spoke once more about the arrangement for the C to go back to the neurologist. The T suggested to the C to follow with the yoga, and with imagining the biofeedback exercise (imagining lowering the needle). The aims to increasing vitality and stop the bad crises emerged again.

Through the end, the T said to the C if she feels very down to not hesitate to ask for help (to her husband, the psychotherapist or anybody else). The T also worked on the C's self-esteem and some time was dedicated to speaking about her sense of unfulfillment and how the C can change it, how the C can find meaning in her life. At the end of the session, the T suggested that the C should write down (when she feels well) the things that she values in herself, and when she feels down to read them back to herself.

BREAKS

No breaks were done.

HOMEWORK

No homework.

POST-SESSION

No data.

APPENDIX 4

PSYCHOTHERAPY TRANSCRIPTION STANDARDS: DESCRIPTION RULES

Adapted from:

Mergenthaler, E., & Stinson, C. H. (1992). Psychotherapy Transcription Standards.
Psychotherapy Research, 2(2), 125-142.

RULES	EXAMPLES	NOTES
1. WHAT TO TRANSCRIBE?		
<p>1.1. Verbal Utterances</p> <p>All words spoken as whole words or parts of words are reproduced in standard spelling. Dialect forms are transcribed in their corresponding standard spelling forms.</p>	<p>For example, if an English speaking person's usual speech sounds the following:</p> <p>P: I know she ain't gonna lotsa trouble. it should be transcribed using standard English spelling as follows:</p> <p>P: I know she ain't going to give me lots of trouble.</p>	<p>Note that the word "ain't," although substandard, is retained in its standards dictionary spelling. For transcribing instances where a speaker deliberately uses dialect forms signalling emphasis or humour, see below.</p>
<p>1.2. Paraverbal Utterances</p> <p>All sounds or sound sequences serving as conversational gap fillers, expression of feelings of doubt, confirmation, insecurity, thoughtfulness, and so on are written.</p>	<p>For instance, in English:</p> <ul style="list-style-type: none"> - <i>Affirmative</i>: mm-hm, yeah, yup - <i>Negation</i>: huhu, uh, nah, uh-uh, hm-mm - <i>Noncommittal</i>: hm, mm - <i>Hesitations</i>: ah, eh, em, er, oh, uh, um - <i>Questioning</i>: eh, huh, oh - <i>Humor</i>: ha, haha, ho, hoho - <i>Exclamation</i>: ach, aha, ahh, bang, boom, ech, hey, kerbang, oh, ooh, oops, ow, pooh, pow, uch, wham, whew, whomp, whoo, whoops, whoosh, whop, wow. 	<p>Addition to this list might be need.</p>

	RULES	EXAMPLES	NOTES
1.3. Nonverbal Utterances	All other noise-producing actions of the speaker are recorded where they occur in the text in the form of a simple comment within parentheses.	P: (sneeze) (cough) well (sigh), I guess I caught a cold (laugh).	
1.4. Noises Occurring in the Situational Context	Any other sounds produced by the situational environment are indicated within a simple comment (in parentheses).	P: later when I (telephone rings); do you need to answer that?	
1.5. Pauses	One may use a single dash character surrounded by spaces (-) to indicate a pause of approximately one second. Multiple dashes should be separated by spaces. Pauses of greater than approximately 5 seconds should not be indicated with dashes, but should be timed and indicated.	P: I can think of - - nothing, (p:00:03:35) nothing at all. The example above indicates a pause of approximately 2 seconds and a second pause of 3 minutes and 35 seconds.	

RULES	EXAMPLES	NOTES
2. SPECIAL TRANSCRIPTION MATTERS		
<p>2.1. Incomplete Words</p>	<p>Words particles generated by word breaks, including stuttering and stammering, are indicated by the word fragment followed by a hyphen (-) and a space. A broken word is defined as an incomplete word that is not repeated.</p>	<p>P: sh- sh- she t- t- t- asked me not to call her again.</p> <p>Stuttering is defined as: (1) one or more word particles, each sharing the initial letters of the following completed word; or (2) a sequences of more than one word particle, each particles sharing initial letters, but not followed by the completed word.</p>
<p>2.2. Indecipherable Utterances</p>	<p>A single slash (/) is entered in the transcript for every utterance that cannot be clearly comprehended but can be distinguished as a separate word. A slash marking an incomprehensible word may be followed with a coded comment of the form “(? :word)” to indicated possibly correct word. Thus the “?:” indicates that the comment contains a word or</p>	<p>P: I was/(?:alone) there all/(?:night) / until he / / /.</p>

	RULES	EXAMPLES	NOTES
	<p>words that may have been uttered by the speaker.</p> <p>If one cannot determine the number of words in the utterance or any of the possible words, this should be simply indicated with the comment (incomprehensible).</p>	<p>P: (incomprehensible)</p>	
2.3. Quotations	<p>If the speaker directly quotes prior discourse, the text for each speaker is enclosed in single forward quotation marks (‘), which is the same character as the apostrophe.</p>	<p>P: I asked ‘will you do it?’ and he yelled ‘stop talking to me like that’ and slammed the door.</p>	
2.4. Changes in Manner of Speaking	<p>If the speaker changes his or her usual manner of speaking and uses a voice differing from the usual way of speaking, the words are enclosed between double quote character (“). In</p>	<p>P: she tells me not to say “yawl come bak now” and “gimme that”. what does she think this is, grammar therapy?</p>	

	RULES	EXAMPLES	NOTES
2.5. Punctuation	<p>such double quoted text, slang and literal transcription may be used.</p> <p>Punctuation markers are used to help the reader reconstruct the original flow of speech. They are not used according to traditional grammatical rules, because normal speech is rarely so well ordered. The transcriber should use punctuation marks to indicate changes in the way of speaking, emphasis, intonation, and the cadence. When in doubt, punctuation marks should not be used. Punctuation markers are always placed at the end of a word and should not split a word. The following situation are differentiated:</p>		

	RULES	EXAMPLES	NOTES
2.5.1. Completion of a thought	The clear period (.) indicates the end of a completed thought and is usually accompanied by a drop in pitch.	P: she slammed the door.	
2.5.2. Broken thought	The semicolon (;) indicates a broken thought, followed by another thought.	P: I hate the way you; did I tell you about the wedding?	
2.5.3. Hesitation	The comma (,) indicates a hesitation followed by a continuation of the same thought and is usually accompanied by a slight drop in pitch.	P: you, never seem, to look at me when I am talking.	
2.5.4. Question	The question mark (?) indicates a question, usually accompanied by a rise in pitch, or a clear rise in pitch. It should be used at the end of possible	T: do you dislike it when he does that? P: I should like! it when he does that?	

	RULES	EXAMPLES	NOTES
	questions indicated by a rise in pitch even if the statement does not contain a clear grammatical question form.		
2.5.5. Emphasis	The exclamation mark (!) immediately follows words clearly emphasised by the speaker.	P: that may not matter to him! but I do not! like it.	Note that the exclamation mark in transcription is used for emphasis and does not indicate the end of a grammatical sentence.
2.5.6. Lengthened pronunciation	The colon (:) is not used in its traditional grammatical way but is used to indicate protracted or extended pronunciation of a word.	P: well: I never really: liked that much anyway.	

3. FORMAL AND STRUCTURAL ASPECTS

3.1. Transcript Heading

The transcript should contain a header.

The following example shows the types of information that one may wish to include:

(Subject ID: 105, SESSION NO: 32, DATE:

The entire set of information should be enclosed in parentheses as a comment.

	RULES	EXAMPLES	NOTES
3.2. Speaker Codes	<p>Each turn of speech begins on a new line and is preceded by a code indicating the speaker. Speaker codes are of the format Xn, wherein X is a single letter indicating the speaker's role and n is an optional digit (if there is more than one speaker of a certain role). If n is omitted, it is assumed to be the digit 1.</p> <p>This format can handle monologue, dialogue, individual therapy, group therapy, and single therapists or cotherapist.</p> <p>A comment after the transcript header can be used to clarify the role of the speakers.</p>	<p>29.SEP.1986, THERAPIST: Dr. Smith, TEXT TYPE: psychoanalytic session, VERSION No: 1.0)</p> <p>Thus, in the following example: T: how did that make you feel? P1: I felt confused and angry. P2: you never told me you were angry about that.</p> <p>The first speaker T is a therapist and P1 and P2 are two patients. The speaker code T has an implicit digit component of 1 and is therefore the same as T1.</p> <p>(P = Son, P2 = Mother, P3 = Father, T1 = Therapist, T2 = Cotherapist)</p>	

RULES	EXAMPLES	NOTES
<p>3.3. Capitalisation</p>	<p>With the exception of proper or personal names or the first person pronoun “I” all words including the first letter of a sentence begin with lower case letters.</p>	<p>This enables the use of even the simplest word-counting programs.</p>
<p>3.4. Simultaneity</p>	<p>Simultaneous speech presents special problems, both for comprehension and for representation of the text. For two speakers however this can be easily handled by inserting a plus sign (+) at the start of simultaneous speech and continuing transcription of the initial speaker until simultaneity ends. This is followed by the entire simultaneous speech of the second speaker and terminated by another (+). The</p> <p>In the following example, the word “refused again” and “yes you” were spoken at the same time:</p> <p>P: I was going to give John the map but he +refused again T: yes you+ have told me this once before.</p>	<p>Transcription of simultaneous speech is much easier if the dialogue can be recorded in stereo with separate microphones for the patient and therapist.</p>

	RULES	EXAMPLES	NOTES
	remainder of the non-simultaneous speech is transcribed in its natural order.		
3.5. Compound Words	Compound words with standard hyphenated spellings are connected by hyphens without spaces.	P: I found the picture taped upside-down on the wall with a band-aid.	
3.6. Neologisms	Neologisms are spelled as best as possible. Words that are created by stringing other words together should be represent with hyphenation.	P: all this gaming-it-out is confusing me.	
3.7. Word Division at the End of a Line	If the text is for computer-aid text analysis, words should not be split at margins using hyphens (this creates problems for some computer-aided text analysis tools); the word should		

	RULES	EXAMPLES	NOTES
	<p>be typed in full on the next line.</p>		
<p>3. 8. Contractions</p>	<p>The apostrophe (‘) should be used to indicate contractions.</p> <p>Text analytic systems can then treat the two parts separated by the apostrophe as separate words (e.g., <i>wouldn’t</i> becomes <i>wouldn</i>, which can be treated as <i>would</i>, and <i>t</i>, which can be treated as <i>not</i>). If the contraction produces ambiguous parts, either the words should be spelled out completely or else the ambiguous parts should be followed with a slash and the clarifying word (or word connected by a hyphen without spaces as described above).</p> <p>Do not use the apostrophe to</p>	<p>P: it’s not fair that they’d get to go and I wouldn’t.</p> <p>P: he’s/had not done it and he’d/would never do it.</p> <p>In the first case <i>d</i> stand for <i>had</i> and in the second case <i>d</i> stands for <i>would</i>.</p> <p>The word ‘<i>cause</i>, for example, should be spelled out in its standard English form <i>because</i>.</p> <p>Instead of such forms as Mary’s</p>	<p>Without the additional information following the slashes the <i>d</i>’s would be processed as the same word. If ‘<i>s</i> is not clarified, it should be assumed to represent the word <i>is</i>; if ‘<i>d</i> is not clarified, it should be assumed to represent the word <i>would</i>.</p>

	RULES	EXAMPLES	NOTES
	<p>indicate apheresis (the omission of the letters at the beginning or end of a word). Do not use the apostrophe to indicate the possessive case.</p>	<p>and John's one should transcribe as follows: P: that coat is Marys and this is Johns.</p>	
3.9. Plurals	<p>The apostrophe should not be used to indicate plurals of letters, numbers, acronyms, or abbreviations. The underscore can be used for clarity, if necessary.</p>	<p>P: he always got As because he was the teacher pet. P: she only types lower cases a_s because her typewriter is broken.</p>	
3.10. Abbreviations	<p>With the exception of formal titles, abbreviations are not used unless the speaker verbally spells one. Periods are not used in abbreviations; use a space instead.</p>	<p>P: Mrs Smiths thinks I made a terrible mistake, for example. T: mm-hm. P: and it irritates me that Jane always says "e g".</p>	

	RULES	EXAMPLES	NOTES
3.11. Numbers, Fractions and the Like	<p>Numbers and fractions are written out in full where possible. Only typical figures such as dates are transcribed as numbers. The abbreviations for “ante meridiem” and “post meridiem” should be capital letters without spaces (AM and PM).</p>	<p>P: in 1981 I saw the first two-thirds of a James_Bond_007 film at eleven-thirty PM for two dollars and fifty cents.</p>	
3.12. Mistakes	<p>Slips of the tongue and other mistakes are transcribed in full.</p>	<p>P: I couldn't stand the guilt, uh quilt she gave me for my birthday.</p>	
3.13. Correct Spelling	<p>Spelling should follow Webster's standards.</p> <p>Where several marking rules apply, it is necessary to include them all in sequence, with a period or question mark going last.</p>	<p>P: he screamed 'don't shoot until you see the whites of their eyes'?!.</p>	

	RULES	EXAMPLES	NOTES
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intervening spaces. This enables the entire substitution to be counted as a single word in the case of subsequent computer text analysis.

If a title is to be used before a name, it should be separated from the name with a space.

Apostrophes should be omitted from names containing them; hyphenated names should retain the hyphens. Names (even those not substituted by pseudonyms) should be joined with underscores to form a single entity.

P: Mr +Arnold_OMalley wants to be on Hollywood_Squares and meet Eva_Gabor.

4.2. Date and Time Coding

The date, time of the day, and elapsed times of a transcript may be inserted using special coded comments.

	RULES	EXAMPLES	NOTES
4.2.1. Session date	<p>The session date is indicated with a coded comment. The <i>d:</i> indicates the comment is a session date. The date is entered in the format “DA.MON.YEAR” (a two-digit representation of the day of the month, a three-capital-letter abbreviation of the month, and a four-digit representation of the years, separated by period without spaces).</p> <p>The session date should be placed at the top of the session transcripts just after the heading. If the date is unavailable, the unknown information should be replaced by zeros.</p>	<p>Thus (d:10.JAN.1986) represents “January 10, 1986.”</p>	<p>Note that the form of this code makes it accessible to computer systems.</p>

	RULES	EXAMPLES	NOTES
4.2.2. Time of day	<p>The beginning of the session time is indicated with a coded comment. The <i>t:</i> indicates the comment is the actual time of day of the session, if available.</p> <p>All time codes are in the format “HH:MM:SS” (two-digit representations of hour, minute and second each separated by a colon).</p> <p>It is preferable to use a 24-hour clock time. The session time should be placed at the first of the session transcript on the line following the session date. If the exact time is unavailable, the unknown information should be replaced by zeros.</p>	<p>Thus (T:10:02:15) represents that the session began at 2 minutes and 15 seconds after the hour of 10 O'clock.</p>	<p>Some facilities may allow the notation of the video frames also, in which case the time codes would be in the format “HH:MM:SS:FF”; if this is used, it should be clearly indicated in a simple comment at the beginning of the transcript.)</p>
4.2.3. Elapsed time	<p>It is often helpful to insert</p>	<p>P: we saw the movie (+:00:03:00) after dinner.</p>	<p>The interval between relative time</p>

	RULES	EXAMPLES	NOTES
	<p>elapsed time codes in a transcript. The relative time within a session is indicated with a coded comment. The “+:” indicates the comment contains the elapsed time since the beginning of the session, in the format “HH:MM:SS”.</p> <p>If the minute change in the middle of a word, the time code should be placed before the word.</p>	<p>The “00:03:00” indicates this is the start of the third minute following the beginning of the session.</p>	<p>codes (if they are used at all) depends on the nature of the study. For example, these codes can be used to relate the text to other temporally ordered data (e.g., physiological recordings). These might be placed at the beginning and the end of specific events or they might be placed at regular intervals, such as every whole minute or every 5 minutes.</p>
4.3. Ambiguity	<p>Some statements may be ambiguous in print yet unambiguous when heard in a sound recording. It is to the advantages of both computer-aided analysis and human readers to convert such ambiguous utterances into</p>	<p>P: we/group thought he/James_Joyce had ignored it/rules-of-the-game.</p>	<p>This rule is primarily for use during the verification and scientific annotation phases of the transcript preparation.</p>

	RULES	EXAMPLES	NOTES
	<p>unambiguous ones. A clarifying alternative word may be placed behind a slash (/). Alternatively, a number placed immediately after the slash can be used to indicate the index number of a word's meaning in a specific content-analytic dictionary. In the case of ambiguous pronouns, it is possible to name the antecedent behind the slash or to include several words connected by hyphens.</p>		
4.4. Segment Demarcation	<p>Various segmentations of the transcript may be accomplished by using coded comments structures to indicate the start of a segment "(s:CODE)" and the end of a segment "(e:CODE)". These two are used</p>	<p>P: (s:RE) when I told *Jane that last night I dreamed (s:DREAM) I was a butterfly (e:DREAM) she laughed (e:RE).</p> <p>The coded comments "(s:RE)" and "(e:RE)" indicate the beginning and end of a relationship episode, respectively. The coded comments</p>	<p>It is permissible for different segment types to overlap or embed.</p>

RULES	EXAMPLES	NOTES
<p>to bracket a segment of type indicated by "CODE," e.g., "DREAM." Whatever word is substituted for "CODE" must be spelled exactly the same in both star-segment and end-segment coded comments.</p>	<p>"(s:DREAM)" and "(e:DREAM)" indicate the beginning and end of a dream description.</p>	

APPENDIX 5

SELECTED TRANSCRIPT EXTRACTS FOR DA

Extract 1 (Case 1 – Session 1)

T: cómo? me pueden explicar mejor eso,	13
cuanto mas tranquilo esta?	14
C1: no es, es que cuando no pienso en el	16
dolor de cabeza, es cuando empieza a	17
doler la cabeza.	18
T: aha, aha (cómo risa).	20
C1: y al mejor, me acuesto esta noche;	22
es lo que me más me; / voy de aquí, me	23
acuesto perfectamente, y a la media	24
noche tengo que me levantar tomar una	25
pastilla, no puedo aguantar, la cabeza	26
no aguanta, un dolor de cabeza /	27
T: m-hm, y-y no, y, bueno, cuando le	29
empezca el dolor de cabeza - dura	30
siempre más que un día, no?	31
C1: sí. normalmente sí, normalmente	33
tiene varios días de duración,	34
normalmente sí.	35
T: y siempre con la misma intensidad? o	37
eso + cambia?	38
C1: hombre + según, ya cuando me siento	40
que me duele la cabeza, tomo la	41
pastilla, para no evitar, porque	42
también se dejo que me duela mucho la	43
cabeza, - y tomo el medicamento me	44
pongo luego mucho peor, molestias, /	45
revolución de estomago, unas ganas de	46
devolver, y ya cuando me siento un	47
poco así que tengo el dolor de	48
cabeza, tomo las pastillas antes	49
(incomprensible, nombres de	50
medicamentos) esas cosas le digo, que	51
hay así pasajeras para el dolor de	52
cabeza.	53
T: y después también, como viene también	55
termina así de repente? o:	56
C1: no. se desaparece poco a poco /	58
T: va mas lentamente.	60
C1: exactamente, poquito a poquito. va	62
cediendo poco a poco, según los	63
efectos /	64

Extract 2 (Case 1 – Session 1)

T: claro, que normalmente eso, dolores	102
de cabeza, la gente siempre piensa lo	103
que se pasara con nosotros.	104
C1: que no, que no, yo eso no. lo traigo	106
desde muy pequeño, yo estoy hecho al	107
dolor de cabeza.	108
T: m-hm.	110

Extract 3 (Case 1 – Session 1)

C1: a mi lo que me mata es que yo esta	112
noche, como le he dicho, me acuesto	113
T: sí, bien.	115
C1: cuando va el amanecer tengo un dolor	117
de cabeza que no me quepo, entonces	118
que hago? salgo a trabajar o no	119
salgo?	120
T: aha, aha	122
C1: de ahí viene el problema, ya lo	124
digo, al mejor salgo a trabajar y me	125
pasa, o salgo a trabajar, lo que	126
muchas veces han me tenido que traer /	127
porque no podía hacer nada.	128

Extract 4 (Case 1 – Session 1)

T: es más solo el peso + y una	173
C1: aquí, aquí + como una vena / tas,	175
tas, tas, tas, tas, aquí como esta	176
vena / no lo se, por aquí para tras /	177
por aquí esto gordo / que me duele	178
una barbaridad.	179
T: como se tuviese ahí el corazón.	181
C1: / tas, tas, tas, tas. a veces que	183
me. tengo hecho ahí en casa un	184
pañuelo.	185
T: sí.	187
C1: y me lo ato aquí a la cabeza.	189
T: aha, aha	191
C1: / es como se me abre la cabeza.	193
T: aha, aha.- y bueno ese dolor que	195
siente, cuando el tras, tras es más	196
rápido le duele más y después empieza	197
a espesar?	198
C1: exactamente, queda como a calmarse,	200
a calmarse, mas lentamente, hasta que	201
desaparece.	202
T: y se va a calmando y se va +	204
desapareciendo	205
C1: exactamente + pero lentamente, no	207
crearás que desaparezca corriendo.	208
T: m-hm.	210
C1: / va afrozando, afrozando,	212
afronzando, afronzando / e que	213
desaparece.	214

Extract 5 (Case 1 – Session 1)

T: cuando esta con el dolor de cabeza	417
pierde el apetito o continuo con +	418
ganas de comer?	419
C1: no pierdo + el apetito, lo que pasa	421
es con el dolor de cabeza todo que	422
meto en el estomago se me revolve la	423
cosa.	424
T: m-hm.	426
C1: cuando tengo el dolor de cabeza, me	428
dicen 'pero comete algo', no he que no	429
me apetezca comer, es que me revolve	430
el estomago/	431
T: aha, pero cualquier tipo de comida? +	433
se es una sopa?	434
C1: cualquier cosa que coma +.	436
T: entonces?	438
C1: cuando estoy con el dolor de cabeza	440
mientras no me pasa, no puedo comer,	441
es que no puedo / tomo una pastilla o	442
algo así, cae me mal en el estomago,	443
me revolve, me pongo muy mal, muy mal	444

Extract 6 (Case 1 – Session 1)

T: m-hm, y: ahora, -- y: entonces en los días que tiene el dolor de cabeza el señor normalmente se queda en casa?	446 447 448
C1: unos días sí, otros días no, pero normalmente me quedo en casa desde luego, es que a veces me da miedo salir con el dolor de cabeza a trabajar.	450 451 452 453 454
T: miedo porque?	456
C1: pues + porque llego al trabajo.	458
T: / de se quedar peor +.	460
C1: /si hago esfuerzos me duele mucho + más.	462 463
T: más +, sí, sí.	465
C1: y evitando me tengan que venir a traer, porque ya me han venido a traer varias veces del trabajo, pues claro, si estoy cerca de casa cualquier uno me puede traer al pueblo,/ pero si estoy lejos y me pongo mal es un poco.	467 468 469 470 471 472
T: es un poco.	475
C1: claro, es ese el problema.	477

Extract 7 (Case 1 – Session 1)

T: y normalmente cuando trabaja, bueno 485
el dolor de cabeza puede venir en el 486
fin del día de trabajo? o: 487

C1: bueno, últimamente, - puede que 489
sea/, últimamente tengo algo en las 490
cervicales, yo sí he notado si 491
esfuerzo mucho las cervicales, yo creo 492
que me producen como un dolor aquí en 493
la nuca, digo yo que será de eso. 494

Extract 8 (Case 1 – Session 1)

C1: sí, sí, vamos va pasado, tomando los	528
medicamentos, yo creo si no tomo los	529
medicamento no me pasa el dolor de	530
cabeza.	531
T: y ya alguna vez hay intentado no	533
tomar los medicamentos y ver lo que	534
pasa?	535
C1: sí lo he intentado, pero como me	537
duele bastante, + recojo al	538
medicamento.	539
T: le duele más +, m-hm.	541
C1: es que es / mas rápido, como el	543
dolor es bastante fuerte, pues, quiero	544
que me pase cuanto antes, y por eso	545
recojo a los medicamentos. lo he	546
intentado varias veces, sobretodo	547
cuando estoy en la cama, por ejemplo,	548
de invierno para no levantarme / me	549
doy vueltas allí, pero ya me veo que	550
no si me pasa y tengo que me levar	551
para tomar una pastilla.	552

Extract 9 (Case 1 – Session 1)

T: m-hm, a ver o que quieren (habla por el interfono). okay. ahora voy hacerle otra pregunta. imagínese una escala de cero a diez. cero es no tener el problema de tener el dolor. y diez es cuando tiene el dolor de cabeza muy fuerte. / entre uno, dos, tres, cuatro, cinco, seis, siete, ocho, nueve y diez /.	707 708 709 710 711 712 713 714 715
C1: donde lo catalogo yo el dolor de cabeza, bastante subido, se no llega al diez muy arriba.	717 718 719
T: no, diez es mismo, mismo como se tuviese que trepar las paredes /	721 722
C1: / yo, me duele muy fuerte, le digo, a veces que me da fuerte / pasarme por la cocina si estoy levantado ponerme el cacharro ese /	724 725 726 727
T: y mejora con ese cacharro que pune?	729
C1: hombre, al lo tener así, como acompaña la cabeza: parece que se nota menos el dolor.	731 732 733
T: aha	735
C1: pero el dolor me duele el mismo parece que lo tiene menos / pero desde luego bastante alto, bastante.	737 738 739
T: siete, ocho.	741
C1: sí, sí , sí, bastante alto, se tuviera un aparato para que lo medirá, bastante alto.	743 744 745
T: m-hm	747
C1: a veces que no, pero muchas veces, muy alto.	749 750
T: y en las veces que no es tan alto, como.	752 753
C1: más llevadero / a lo mejor puedes aguantar trabajando con un poco de dolor de cabeza si no sube a más, es como le digo.	755 756 757 758
T: m-hm, hasta que numero en esa escala, imaginemos, hasta que numero si quedaría bien para trabajar, para hacer sus cosas.	760 761 762 763

C1: hombre, yo que sé / tres o cuatro. 765

T: tres o cuatro ya, era un dolor pero 767
lo podría soportar y bien, m-hm. y 768

Extract 10 (Case 1 – Session 1)

C1: estoy tomando ahora termalgin, pero	844
es muy flojito, hace poquito / hay	845
medicamentos que me hacen más y	846
medicamentos que me hacen menos.	847
termalgin me hace poquito para la	848
cabeza, uno que me vaya muy bien es el	849
analgilasa/ y optalidon también me va	850
bastante bien / pero todo eso me hace	851
mucho daño al estomago.	852
T: sí, esos medicamentos son muy malos	854
por eso.	855
C1: también tengo que tomar para el	857
estomago.	858
T: m-hm, eso se torna una cadena, uno	860
para el dolor de cabeza le afecta el	861
estomago después tiene que tratar el	862
estomago /bueno.	863

Extract 11 (Case 1 – Session 1)

T: bueno, nosotros estuvimos hablando un 1014
poquito acerca / el reto hoy es 1015
esclarecer más o menos lo que le pasa 1016
con usted y las posibilidades que 1017
tenemos de lo ayudar, - nosotros no le 1018
podemos ofrecer medicamentos, ni una 1019
cura milagrosa, no hacemos eso / pero 1020
podemos le enseñar algunas técnicas de 1021
relajamiento y otras pequeñas técnicas 1022
que le poden ayudar cuando tiene el 1023
dolor -, posiblemente, no vaya 1024
eliminar el dolor pero puede tornar el 1025
dolor más controlado, le costar menos 1026
y quizá no durante tanto tiempo. eso 1027
lo ayudaría de alguna forma? 1028

C1: hombre, yo creo que sí. 1030

T: todo que mejore un poco viene bien. 1032

C1: claro, todo que sea aliviar la cosa 1034
viene bien. 1035

Extract 12 (Case 1 – Session 1)

C1: y ahora tengo el estomago, bastante	1088
desbaratado de tanto medicamento /	1089
T: / y piensa que esas técnica sin	1091
medicamentos si realmente le pueden	1092
ayudar?	1093
C1: que sí hombre, posiblemente,	1095
posiblemente, creo que sí.	1096

Extract 13 (Case 1 – Session 1)

T: *Manuel me estaba diciendo que cuando han estado con el dr*Garcia el estaba con vosotros, dr*Garcia ha dicho que nosotros utilizábamos hipnosis?

C1: sí:

T: lo que usted piensa acerca de eso?

C1: sí. nada.

T: no tiene ninguna idea?

C1: no tengo la menor idea, no tengo la menor idea sobre eso.

T: m-hm, bueno.

C2: hipnosis?

T: sí, nosotros trabajamos un poco dentro de ese esquema, pero lo que creemos ahora, es aclarar las ideas, porque normalmente las personas tienen unas ideas un poco de los espectáculos y de esas cosas, que es una idea un poco, que no es lo que nosotros hacemos. la primera cosa es, la hipnosis es algo que va hacer el señor a si mismo, son técnicas de imaginación y auto-sugestión que el señor va hacer a si mismo, el señor está siempre a controlar lo que pasa / nosotros solo lo ayudamos en las primeras veces en esas técnicas y después usted las aprenderá a hacerlas sólo y son cosas muy básicas, nosotros hoy vamos empezar por una técnica de relajamiento simples y a mirar como el señor se siente. que piensa usted? estoy a notar ahí su pie un poco:

C1: jajá.

C2: la relajación es fabuloso.

C1: hombre.

T: pero eso es un poco, varia de persona para persona.

C1: podemos lo intentar pero eso no me mola a mi.

C2: pero, porque?

C1: no me gusta a mi mucho eso.

T: porque? hablemos sobre eso.	1209
C1: hombre, es que hablar de eso de hipnosis y esas cosas no me gusta a mi eso mucho.	1211 1212 1213
T: m-hm, porque? que ideas tiene?	1215
C1: que no me gusta, esas cosas son cosas que no me gustan, cuando veo por la tele no me hace ninguna gracia.	1217 1218 1219
T: ah, pero es que no tiene nada lo que nosotros hacemos tiene mucho muy poco a ver con el que se ve en la tele.	1221 1222 1223
C1: hombre, supongo que no va ser aquello ni muchísimo menos, pero que esas cosas/	1225 1226 1227
T: en la tele es espectáculo, ilusionismo, magia, aquí no tiene nada a ver con eso./ es de relajamiento y usar la imaginación / ha gente que con estos métodos lo pasa muy bien, es la única cosa que le puedo decir por la experiencia que tengo.	1229 1230 1231 1232 1233 1234 1235
C1: no se/	1237
T: que dudas tiene acerca de eso?	1239
C1: / tengo como miedo a esas cosas, no me gustan a mi mucho esas cosas.	1241 1242
T: pero, tiene miedo de qué? puede concretizar más eso.	1244 1245
C1: no lo se.	1247
T: miedo de perder el control?	1249
C1: pues de cualquier cosa.	1251
T: de hacer alguna cosa que no lo haría se no estuviese en hipnosis, eso?	1253 1254
C1: no se / me gusta poco / no se explicarme, pero que no me gusta, la verdad es esa.	1256 1257 1258
T: m-hm, que no le gusta?	1260
C1: no, no, no, no, desde luego eso me gusta poco.	1262 1263
T: pero, inténteme explicar un poco mejor porque no le gusta?	1265 1266

C1: es que.	1268
T: tiene dudas, lo que piensa que es?	1270
C1: / no me gusta esas cosas. no lo se	1272
explicar, pero no me gusta. (suena el	1273
interfono)	1274
T: (el terapeuta habla por el interfono,	1276
incomprensible) bueno, se usted no se	1277
siente cómodo, no lo hacemos hoy / no	1278
haremos nada que el señor no quiera.	1279
lo que haremos hoy es dar algunas	1280
ideas de técnicas de relajamiento,	1281
entonces solo / y miraríamos como eso	1282
lo puede ayudar.	1283
C1: vale.	1285
T: se siente mejor así?	1287
C1: vale.	1289
T: no, porque aquí usted he que manda.	1291
C1: ya, ya, ya, he comprendido.	1293
T: nosotros estamos aquí para lo ayudar.	1295
C1: que sí.	1298
T: pero no vamos pedir para que haga	1300
alguna cosa que no quiere hacer.	1301
C1: por supuesto /	1303

Extract 14 (Case 1 – Session 1)

T: entonces bueno, lo que vamos pedir, 1406
vamos, ahora, le enseñar una técnica 1407
muy simples, y después lo que le 1408
pedimos es que en casa lo haga de vez 1409
en cuanto y si sentir la dolor lo haga 1410
ahí, a ver lo que pasa, esto es a 1411
empezar, después le enseñaremos 1412
técnicas más precisas. bueno, una 1413
cosa quiero que usted se concentre en 1414
su respiración, en el inspirar, en el 1415
expirar y que inspire hundo y ahora 1416
cuente hasta diez, por cada 1417
inspiración que haga (T inspira 1418
hundo). 1419

C1: que cuente? 1421

T: hasta diez. uno, dos, tres, cuatro y 1423
sienta los músculos leves, cinco, 1424
seis, siete, ocho, nueve, diez, ahora 1425
quiero que mire su mano, puede ser 1426
esta mano (apunta hacia la mano 1427
izquierda). 1428

C1: que me ha dicho? 1430

T: que la mire, la mire, continúe 1432
respirando calmamente, tranquilamente, 1433
y que la cierre y que imagine el 1434
dolor en su mano, no el dolor el 1435
pulsar que siente en su mano, a dolor 1436
no, el pulsar. (T habla mirando la 1437
mano de C1, este cierra y abre la 1438
mano) cuando empezar a sentir el 1439
pulsar, es fuerte, no? -- y - rápido 1440
(p: 4s) y desagradable porque es 1441
fuerte - y porque es rápido (p: 4s) y 1442
lo perturba, no lo deja trabajar 1443
porque es fuerte y rápido(p: 3s) lo 1444
perturba a muchos años porque es 1445
fuerte y rápido pero usted sabe que va 1446
pasar, puede tardar un, dos, tres 1447
días a veces menos - (T y C2 1448
mimetizan a C1) y cuando pasa se queda 1449
más suave, ya no es tan rápido va más 1450
de espacio -- cada vez más de espacio 1451
- hasta que lentamente - pero seguro 1452
para (p: 6s) cada vez más de espacio 1453
-- cada vez se siente mejor- porque 1454
sabe que el pulsar vaya parar - y 1455
cuando para se siente mejor - puede 1456
sentir los músculos de la mano un 1457
poco más leves - con la otra mano 1458
puede frotar esa mano un poco (T 1459
demuestra, y C1 y C2 lo hacen también) 1460
-- y lo que le pido es que cuando 1461
sentir la dolor haga esto ejercicio. 1462

C1: qué? 1464

T: cuando sentir el dolor en la cabeza 1466
haga esto ejercicio. 1467

C1: haga esto ejercicio. 1469

T: empecé por apretar su mano como las 1471
pulsaciones que siente en su cabeza y 1472
va espaciando las contracciones en su 1473
mano, entiende? 1474

C1: sí, sí 1476

T: las espaciando muy lentamente siempre 1478
respirando hundo --- y las espaciando 1479
hasta que paren y después mire como se 1480
siente. -- antes de tomar lo 1481
medicamento haga esto y mire como se 1482
siente. esto es una cosa muy, muy 1483
básica que se puede hacer de otras 1484
maneras. -- hay personas que estos 1485
tipos de técnicas le resulta. es un 1486
poco. quizá el señor esta pensando "ho! 1487
como que esta dolor tan fuerte que ha 1488
resistido a tantas pastillas y ahora 1489
por una técnica así de apretar la 1490
mano va pasar. esto es una broma, no?" 1491
quizá esté pensado eso? un poco, 1492
+jajá 1493

C1: jajá + 1495

C2: es muy incrédulo. 1497

T: es muy incrédulo, pero lo pido que lo 1499
intente. no le digo que resulta, no le 1500
digo eso. lo pido solamente una cosa 1501
que lo intente. mas nada. 1502

C1: de acuerdo./ cuando me duele la 1504
cabeza. 1505

T: se siente en un sitio, relaja, y se 1507
ponga así, y empiece a concentrarse en 1508
su mano --- 1509

C2: respirando hundo y mirando a + la 1511
mano. 1512

Extract 15 (Case 1 – Session 2)

T: y bien, nosotros le hemos dicho que	141
le podíamos enseñar ciertas técnicas	142
que le podrían ayudar.	143
C: /sí.	145
T: teníamos ejemplificado una: aa, y	147
también hemos hablado que nosotros	148
también otras técnicas que le	149
podríamos enseñar, pero que el señor	150
no estaba muy a vontade + con ellas.	151
C: exactamente +, no estaba muy de	153
acuerdo.	154
T: y continúa +con esa posición	156
C: sí, yo creo que poco mas + o menos,	158
sí.	159
T: entonces bien; aa, mmm, entonces,	161
porque, nosotros; podíamos hablar un	162
poquito mas de eso, lo qué es que el	163
señor piensa o porqué que usted tiene	164
esa:	165
C: ya le digo que la verdad es que no	167
tengo un fundamento, pero no me gusta,	168
es una cosa, que no, que no, que no me	169
gusta, que no, no.	170
T: y pero tiene alguna idea de qué será?	172
C: no, no, idea ninguna desde luego,	175
pero que no	176
T: es solo por la palabra, por el	178
nombre: /	179
C: (risa) es que hay una cosa que cuando	181
la veo por la televisión parece / y no	182
me gusta.	183
T: ah, es que no tiene nada que ver con	185
lo que aparece en la tele.	186
C: resulta a quilo que no me gusta. ya	188
le digo de verdad que no, es una cosa	189
que no me gusta ni poco, ni mucho, ni	190
nada.	191
T: nada. bueno, entonces también	193
nosotros tenemos otras técnicas con	194
las que podemos trabajar. pero de lo	195
que ve en la tele que es que no le	196
gusta, por que hay personas: no fundo,	197

a mi tampoco me gusta tampoco, para + ser honesta.	198 199
C: a mi ya le digo que no +.	201
T: porque hay lo que pasa es que ponen unas personas a hacer unas figuras --	203 204
C: m-hm.	206
T: que no tienen nada por los otros se rieren y lo pasan bien, y las personas están ahí, oh, no tiene nada que ver con eso, porque una cosa, por ejemplo, lo que se hace aquí, lo que nosotros solemos hacer, lo primero es que la persona se recuerda siempre de todo.	208 209 210 211 212 213 214
C: sí.	216
T: y siempre está consciente, y siempre puede controlar todo, y en el momento que quiera abrir los ojos los abre. eso no es como lo que pasa en la tele, ni nada que se parezca. no fundo lo que nosotros hacemos aquí son técnicas de relajación un poco mas específicas. y por ejemplo, déjeme tentar explicar un poco, lo señor, usted ha hablado que cuando tiene dolores de cabeza, una de las cosas que suele hacer y que en cierta manera le alivian es atar un pañuelo:	218 219 220 221 222 223 224 225 226 227 228 229 230
C: si me duele fuerte me ato un pañuelo a la cabeza, parece que al estar mas acompañada la cabeza, como que me duele menos, que es una tontería porque eso no es una curación, pero que al estar mas acompañada parece que estoy un poco mejor. parece como si se me abre la cabeza.	232 233 234 235 236 237 238 239
T: aha, porque: y las técnicas que nosotros utilizamos, a primera vista, puede sonar tan raras como el pañuelo	241 242 243
C: sí (risas) ya.	246
T: (risas) pero.	248
C: sí pero bueno, que pueden dar buen resultado.	250 251
T: es eso, que en el fondo para mucha gente resulta, pero a primera vista si hablara así con una persona + _ bueno cuando tengo dolor de cabeza, _	253 254 255 256

C: sí, sí, comprendido + parece una	258
tontería, pero que luego después puede	259
resultar.	260

Extract 16 (Case 1 – Session 2)

T: pero podría hablar un poquito sobre nuestra manera de trabajar.	286 287
C: sí	289
T: porque nosotros. bueno, usted va a los neurólogos ellos lo que hacen es exámenes, hacen aquello tipo de radiografías, el TAC y + esas cosas;	291 292 293 294
C: sí, sí +.	296
T: y después miran esas cosas y tientan mirar si tiene alguna cosa orgánica o no.	298 299 300
C: sí	302
T: y por los vistos como han mirado todo bien y las personas que lo han visto son personas muy competentes.	304 305 306
C: sí, sí, sí.	308
T: y no le encontraron nada. nosotros nos dedicamos a otra área, nos dedicamos un poco a cosas que no pueden ser observadas por esos instrumentos, pero que también existen en + nosotros.	310 311 312 313 314 315
C: sí +, de acuerdo, sí, puede sacar de cada uno lo que aparezca.	317 318
T: y un poco así las cosas físicas a veces las personas se preguntan sobre como es que nosotros los psicólogos las podemos ayudar si ellos siente una cosa física. porque nadie duda que su dolor la siente, el dolor lo siente mucho, y es una cosa física, cómo es que nosotros siendo psicólogos y no tratando directamente de esas cosas físicas podremos ayudar a personas como usted?	320 321 322 323 324 325 326 327 328 329 330
C: sí.	332
T: y bueno: es un poco, por ejemplo, es un poco entender que: nosotros normalmente consideramos que tenemos el cuerpo y que también tenemos nuestras ideas y nuestros pensamientos.	334 335 336 337 338 339
C: sí de acuerdo.	341

T: y en cierta manera las personas	343
normalmente aceptan que lo que pasa en	344
nuestro cuerpo influencia nuestro	345
pensamiento. por ejemplo, cuando	346
usted talvez este enfermo o	347
constipado, o incluso con el propio	348
dolor de cabeza, no está en	349
disposición para hacer muchas cosas.	350
C: sí, sí, se siente uno mas acobardado,	352
mas +mas triste /.	353
T: mas deprimido +, a veces:	355
C: sí, por supuesto.	357
T: por tanto el físico, lo que pasa en	359
el organismo influye en el todo, y lo	360
contrario también es verdad. por	361
ejemplo, talvez, si está trabajando,	362
y tal vez le haya ocurrido, que esta	363
un día trabajando y que pasa uno de	364
sus compañeros tiene un pequeño	365
accidente	366
C: sí	368
T: ahí es una cosa: y, bueno es una cosa	370
que lo asusta, si dice la palabra	371
asustar?	372
C: sí, sí, sí, sí.	374
T: y, el corazón empieza a latir mas +	376
rápido.	377
C: sí +, mas deprisa.	379
T: mas deprisa, de cierta manera algo	381
que ve, algo que no es nada físico	382
pero hace que su organismo:--	383
C: sí, evolucione (?) un poco mas	385
deprisa.	386
T: aha, y por ejemplo, si está con	388
hambre o entonces se ve una comida muy	389
bueno, + cause que se saliva, no?	390
C: jajá + sí, sí bueno sí.	392
T: o + solo de pensar	394
C: sí, sí, ciertas cosas sí +.	396
T: en verano si está muy sediento y solo	398
pensar en el agua, cause que se sienta	399
un poco mejor. nosotros en el fundo	400
trabajamos con eso. así, los médicos	401
trabajan con físico para mejorar a	402

veces, por ejemplo, el señor se ha	403
sentido un poco deprimido y le han	404
dado unos medicamentos	405
C: de acuerdo, sí, sí, + comprendido.	407
T: unas medicinas + para ayudar a esa	409
parte.	410
C: que sí, sí.	412
T: nosotros trabajamos al revés.	414
C: aconsejando y diciendo otras cosas.	416
T: y otros ejercicios para ayudar al	418
físico, y es de esa manera que le	419
podemos ayudar.	420

Extract 17 (Case 1 – Session 2)

C: sí yo ya digo, yo no se, yo, se yo,	422
no es que esté muy deprimido, yo es	423
que cuando me duele la cabeza claro	424
me deprimó un poco.	425
T: claro, + pero eso.	427
C: no, no, pero es que yo me quería	429
quitar el dolor de cabeza, si no yo	430
estaba totalmente normal.	431
T: aha.	433
C: y no es que me deprima mucho, bueno	435
en ciertas ocasiones, pero no me	436
deprimo mucho, lo que tiene es que al	437
no poder trabajar, al tener que estar	438
en casa, ese es el problema.	439
T: sí, y tu:, los líos que eso causa.	441
C: claro, ya le digo, estás en casa, no	443
ganas dinero y tienes que hacer los	444
pagos, tienes que hacer las cosas y	445
entonces es cuando vienen los	446
pensamientos y viene la cosa de	447
acelerarse uno un poco mas.	448

Extract 18 (Case 1 – Session 2)

C: yo desde luego +, si cuando me duele 477
la cabeza no tomo algún medicamento yo 478
creo que no me deja de doler la 479
cabeza. 480

Extract 19 (Case 1 – Session 2)

C: / el tiempo, hace mas o menos unos	515
cuarenta años o cuarenta y cinco,	516
cuarenta años.	517
T: y cuándo ha empezó con esos, porque	519
toda la gente suele tener dolores de	520
cabeza, pero esos dolores de cabeza	521
eran como son ahora o eran mas leves?	522
C: sí era, eran igual, lo que tiene es	524
lo que ya le dije a usted, yo me iba	525
al médico del pueblo, que era muy	526
conocido, entonces cuando era joven	527
me decía el medico del pueblo, le	528
decía a mi padre: "no te preocupes	529
que tiene mucha fuerza en la sangre".	530
ya se le dije el otro día, así tiré un	531
montón de tiempo. yo veía que esto no	532
se me pasaba, volvía al médico, al	533
mismo médico y me decía "tomate una	534
aspirina, y tal y cual."	535

Extract 20 (Case 1 – Session 2)

C: hombre, si no he tomado la medicina	689
no me deja el dolor de cabeza.	690
T: m-hm.	692
C: tengo que recorrer a tomar algo	694
porque he hecho la prueba, acostarme a	695
ver si, y no se me pasa el dolor de	696
cabeza.	697
T: y cuando eso pasaba, estaba pensando	699
en su dolor /?	700
C: no, no.	702
T: el dolor era tan fuerte que no	704
lograba desconcentrarse?	705
C: no, no, antes igual que ahora; aunque	707
hago eso, no se me pasa el dolor de	708
cabeza.	709
T: eso:	711
C: y ahora también últimamente me	713
aparece el dolor de cabeza en la cama,	714
que eso era lo que antes no me	715
pasaba.	716
T: aha.	718
C: yo ahora me acuesto esta noche	720
tranquilamente, a lo mejor el primer	721
sueño lo hecho bien, pero a lo mejor a	722
las cuatro de la mañana tengo un	723
dolor aquí en la nuca, que no puedo	724
(toca con la mano izquierda en la	725
nuca).	726
T: empieza aquí en esta zona (el	728
terapeuta lleva también su mano	729
direcha hacia la nuca).	730
C: sí, sí, aquí, ya le digo, empieza	732
aquí en estos dos chismes que	733
tenemos aquí así (toca con las dos	734
manos la nuca), aquí unos latigazos	735
que no hay forma.	736
T: aha, tipo al pulsar.	738
C: exactamente y-y que no se me quita el	740
dolor de cabeza.	741

Extract 21 (Case 1 – Session 2)

C: sí, también me han visto de las cervicales. también me mandaron aquí a Salamanca, al clínico, me estuvieron haciendo unas radiografías y me dijeron que las tenía desgastadas.	809 810 811 812 813
T: claro, eso hasta de su profesión + es natural que pase.	815 816
C: claro, claro +, las tengo desgastadas las cervicales.	818 819
T: y sobre todo si ha cogido peso y todo (el terapeuta mimetiza con las manos como si tuviese levantando un peso).	821 822 823
C: sí, he cogido mucho peso, malas posiciones, muy malas cosas, ya le digo: y.	825 826 827
T: y cuando tiene dolor de cabeza también ha hablado que, bueno, todo que sea esfuerzos (el terapeuta mimetiza otra vez con las manos como si tuviese levantando un peso).	829 830 831 832 833
C: exactamente, muchísimo peor, yo si me duele la cabeza y estoy tranquilamente pues paso, si tengo que hacer a bajarme a coger peso del suelo, coger veinte kilos, cincuenta kilos, como que me responde a mí en la cabeza (el cliente mimetiza lo que esta diciendo, y termina con la mano en la cabeza).	835 836 837 838 839 840 841 842 843
T: m-hm.	845
C: eso ha sido de siempre, antes igual también. yo coger peso, hacer nervio me responde mucho en la cabeza.	847 848 849
T: m-hm, aa, y lo mismo, por ejemplo, los días que trabaja así mas con cosas pesadas siente dolor de cabeza o:	851 852 853
C: últimamente sí, últimamente si me sobo mucho / que voy a trabajar por ejemplo con vigas, por ejemplo ya le digo, o con peso, con muchos carretillos de hormigón parece que me duele mas la cabeza (el cliente mimetiza lo que esta diciendo, y termina con la mano en la cabeza).	855 856 857 858 859 860 861 862
T: aha..	864

C: yo creo que es por cosa de las cervicales.	866 867
T: eso, bueno, puede tener alguna influencia, todo los esfuerzos +físicos tiene.	869 870 871
C: sí, sí +, sí yo creo que sí, yo ya le he dicho / ya que cargo yo con peso de la forma que sea, yo creo que me responde mas aquí, mas, mas (apunta para la cabeza).	873 874 875 876 877
T: y no puede evitar cargar tanto peso tampoco?	879 880
C: toma, es que el oficio que tengo es albañil.	882 883

Extract 22 (Case 1 – Session 2)

+ after break one.	926
T: aa, bueno, hoy no podemos adelantar mucho porque desde la ultima vez no hubo ocasión de así testar, ni nada. bueno, lo que estuvimos hablando es que en el fondo - el obje-, el reto de cierta manera de esta terapia; / pode ser intentar ayudarle a que usted encuentre recursos para: disminuir lo mas que pueda los + dolores de cabeza.	928 929 930 931 932 933 934 935 936 937
C: sí, sí +.	939
T: de manera a que esto le permita tener una vida lo mas normal que sea posible, y las técnicas con las que nosotros le podemos ayudar o entrenar son un poco como las que hemos hecho el otro día, y algunas otras, y algunas de relajación también.	941 942 943 944 945 946 947
C: voy a cambiar de oficio si puedo eh.	949
T: aha	951
C: si puedo voy cambiar de oficio, no lo se vamos, lo tengo ya eso, y quería cambiar de oficio.	953 954 955
T: para algo que no:	957
C: para no hacer tantos esfuerzos y no tener que estar en una posición alta. en vez de trabajar de albañil, trabajar en una finca.	959 960 961 962
T: aha, ya no es:	964
C: al cuidado del ganado, para hacer otra cosa mas distinta, / así que por ejemplo tengo que cargar con peso / pero no es todo el día, por ejemplo por la mañana para echar al ganado hay que cargar con un poco de peso, pero después durante todo el día estás mas relajado, aunque tengas que trabajar arreglando por allí cualquier cosa, pero vamos, cargar con menos peso quiero decir y en mejores posturas.	966 967 968 969 970 971 972 973 974 975 976
T: aha, sí, sí.	978
C: no como estar todo el día poniendo un piso /, o en un tejado también doblado poniendo tejas, en fin, en mejores	980 981 982

posturas.	983
T: y eso será posible? o esta a	985
considerar, a estudiar?	986
C: no lo se, creo que sí que será	988
posible, sí, porque ya he hablado con	989
el señor que me va a emplear y me ha	990
dicho que le parece muy bien y que si	991
acordamos en la cosa del dinero pues:	992

Extract 23 (Case 1 – Session 2)

T: aha, una cosa que me gustaría	1130
preguntarle mas acerca del dolor de	1131
cabeza, cuándo tiene los dolores de	1132
cabeza siente los músculos muy	1133
tensos? (apunta para el cuello)	1134
C: no, lo que me pongo es un poco	1136
nervioso.	1137
T: se queda nervioso.	1139
C: sí, sí, como un poco nervioso.	1141
T: antes o después, o durante?	1143
C: durante el dolor de cabeza y yo creo	1145
que antes y después, y yo creo que	1146
también tengo algo de nervios, eh?	1147
T: m-hm.	1149
C: por cualquier cosita.	1151
T: aha.	1153
C: es que me pongo nervioso, no quiero,	1155
pero por cualquier cosita me pongo	1156
nervioso/	1157
T: y eso piensa que puede estar	1159
influyendo en el dolor de cabeza?	1160
C: pues pudiera también, porque claro si	1162
me quedo mas tranquilo estoy mejor, si	1163
me excito un poco es cuando, cuando	1164
peor me encuentro.	1165
T: m-hm, entonces cuando tiene el dolor	1167
de cabeza se encuentra mas sensible	1168
y:	1169
C: claro me pongo un poco, yo estoy solo	1171
en casa, ya le digo, me pongo un poco,	1172
me acongojo un poco / me pongo un	1173
poco nervioso y yo creo que la cabeza.	1174
T: anda peor.	1177
C: claro y anda peor la cosa.	1179

Extract 24 (Case 1 – Session 2)

T: m-hm, y bueno; m-hm y bien y pero	1514
cuando tiene dolor de cabeza también	1515
de cierta manera es natural que se	1516
sienta nervioso porque no está	1517
trabajando, porque sabe que no va a	1518
ganar ese dinero y + todo eso.	1519
C: exactamente +.	1521
T: lo hace sentir nervioso, un poco	1523
deprimido porque es una situación tan	1524
delicada que le hace pensar si ahora	1525
C: claro, que vienen los pagos y yo	1527
nada, dependo de eso, que no tengo	1528
otra cosa, y si tengo que pagar y no	1529
tengo dinero, pues es un problema.	1530
T: / eso es así. aa, bien, nosotros le	1532
podemos intentar enseñar unas técnicas	1533
para cuando se empieza a sentir	1534
nervioso, para tentar + relajarse un	1535
poco.	1536
C: sí, para relajarse un poco +.	1538

Extract 25 (Case 1 – Session 2)

T: m-hm, bueno, podemos, aa a unas	1549
técnicas que se puede hacer en una	1550
silla, por ejemplo como está, que	1551
consiste principalmente en tensar y	1552
relajar los músculos. sí, porque	1553
cuando tensamos los músculos y	1554
mantenemos los músculos tensos por	1555
unos segundos, cuando los dejamos	1556
descansar hay un reflejo automático	1557
de relajación (el T. mimetiza con las	1558
manos la tensión y el relajamiento) -	1559
bueno, eso es una cosa orgánica, que	1560
siempre y-y, si estuviere muy cansado,	1561
si estuviere a hacer esfuerzo muy	1562
grande, y después no lo hacemos, los	1563
músculos automáticamente se relajan.	1564
es un poco un ejercicio de este	1565
género, que podemos entrenar y el	1566
señor puede practicar si tiene tiempo	1567
una vez al día antes de acostar	1568
--porque es un tipo de ejercicio que	1569
se llama relajación progresiva, es un	1570
tipo de ejercicio que tiene un	1571
inconveniente es que tiene que	1572
quedarse diez minutos a lo hacer, que	1573
es un poco largo, diez minutos, pero:	1574
aa es es bastante simple y tiene que	1575
lo entrenar, para relajar, y después	1576
lo puede hacer cuando se sienta	1577
nervioso, y si tiene un dolor de	1578
cabeza lo puede hacer acompañado de	1579
otro que ya le enseñé el otro día, se	1580
acuerda?	1581
C: sí, sí, sí, sí.	1583
T: que era de la mano.	1585
C: de la mano.	1587
T: tentar, que ese es importante si	1589
siente el dolor de cabeza, cuando	1590
empezar sentirlo. bueno, si piensa que	1591
hace falta tomar las medicinas y eso,	1592
o puede hacerlo primero y ver como se	1593
siente y bien, y lo que interesa es	1594
que se concentre en su respiración y	1595
que respire profundamente, que sienta	1596
el aire entrar en los pulmones y	1597
salir, para relajar. (p: 00:04) (el	1598
terapeuta respira profundamente) así.	1599
después en casa, si se siente bien,	1600
puede cerrar los ojos, como quiera,	1601
(incomprensible) y siempre	1602
concentrarse en la respiración. puede	1603
por ejemplo contar hasta diez, -	1604
uno,-- dos, --- tres, --- cuatro, y	1605

dejarse relajar, - cinco -- / y 1606
 expirar, --sientase mas relajado --- 1607
 nueve, ---diez. y después puede 1608
 empezar a pulsar su mano - como 1609
 sienta el dolor, con el mismo ritmo 1610
 con el dolor primero continuando a 1611
 concentrarse en la respiración , y 1612
 después de un rato de lo hacer 1613
 empezar, el señor controla su mano, 1614
 empezar a espaciar el pulsar de la 1615
 mano y a espaciarlo, a espaciarlo 1616
 hasta relajar también su mano después 1617
 frutarla (ambos T y C hacen el 1618
 ejercicio terminando frotando la 1619
 mano). 1620

C: vale. 1622

T: m-hm, y siempre después respirar otra 1624
 vez otras diez veces / si mientras, 1625
 hasta la próxima vez tuviere ocasión 1626
 de aplicar esta técnica; porque el 1627
 problema, problema? si tuviere los 1628
 dolores y si no los tuviere mejor. ahí 1629
 sin duda. 1630

C: de acuerdo. 1632

T: pero: como este tipo de dolor que 1634
 aparece así periódicamente, para 1635
 nosotros resulta mas difícil de 1636
 trabajar porque hay muchas técnicas y 1637
 hay técnicas que son mejores para una 1638
 persona que otra, pero como no las 1639
 podéis testar nosotros no lo sabemos, 1640
 solo después de testar podemos decir 1641
 que esta no ha resultado muy bien y 1642
 podemos intentar otra, hasta ahí 1643
 bueno. 1644

C: de acuerdo. 1646

Extract 26 (Case 1 – Session 3)

T: si, entonces, ha habido un cambio grande porque:	92 93
C: si de momento ya le digo que la terapia que me ha dado parece que va actuando.	95 96 97
T: aha, si, y por lo que usted hace también. eso es lo principal.	99 100
C: si, yo con lo que hago parece que esto si pudiera ser, no la solución, pero por lo menos ayudarme algo a-a	102 103 104
T: a + controlar.	106
C: a aliviarme + un poco la cosa.	108

Extract 27 (Case 1 – Session 3)

C: ya le digo que el día diecinueve me levante con dolor de cabeza.	120 121
T: + si.	123
C: fui a + trabajar y pude aguantar el dolor. me acosté temprano por la noche y se pasó.	125 126 127
T: aha.	129
C: y anoche, a las seis de la tarde; estuvimos en un entierro, ya le he dicho, estuvimos enterrando a un difunto, y me dio un poco de dolor de cabeza, me fue a casa y estuve tranquilo allí, y de la cena, cené y me acosté.	131 132 133 134 135 136 137
T: m-hm.	139
C: y ha desaparecido.	141
T: y: ha tomado alguna pastilla?	143
C: no.	145
T: nada? ni el día diecinueve + ni ayer?	147
C: no + no he tomado nada.	150
T: aha, y qué ha hecho?	152
C: parece que ha desaparecido de momento, que está la cosa como mas aliviada.	154 155 156
T: aha, simplemente, se da cuenta de que empieza el dolor de cabeza, y qué hace?	158 159 160
C: no, ahora no he tomado nada	162
T: + aha.	164
C: por ver si esto iba, digo voy a aguantar a ver, a ver si esto se pasa o si va a mayores.	166 167 168
T: no ha llegado con la intensidad que antes llegaba	170 171
C: + no	173
T: porque + antes llegaba de manera tan intensa que tenía que:	175 176

C: ha sido mas leve, ya le digo,	178
bastante mas leve la cosa.	179
T: m-hm. y en cierta manera conseguía	181
dormir y al otro día por la mañana se	182
sentía mejor.	183
C: si bastante mejor.	185
T: + aha	187
C: esta + mañana me he levantado	189
tranquilamente, he venido aquí a	190
Salamanca, he estado haciendo unas	191
cosas	192
T: m-hm	194
C: y ahora estoy aquí.	196
T: si, muy bien, me alegro, si. y ha	198
aplicado alguna de las técnicas de	199
relajación?	200
C: si, si, si, eso lo hago todos los	202
días.	203
T: m-hm	205
C: todos los días.	207
T: y piensa que lo ayuda después a +	209
controlar?	210
C: creo + que si me puede ayudar algo,	212
vamos. pero, ya le dijo que tiene que	213
ser a largo plaza porque.	214
T: si, si claro.	216
C: pero creo que si que me puede estar	218
ayudando algo, a estar mas relajado.	219

Extract 28 (Case 1 – Session 3)

C: mi padre y mi madre también padecían dolor de cabeza.	232 233
T: ah, si, si, pero aún todas las personas en un momento u otro a veces tenemos dolor de cabeza.	235 236 237
C: si, si	239
T: el problema es cuando como usted que tenía un dolor de cabeza que persistía por tres o cuatro días	241 242 243
C: + si, si	245
T: y le + impedía trabajar. ahí, las cosas pueden comenzar a ser mas preocupantes.	247 248 249
C: si, si.	251
T: y si se consigue controlar para un punto:	253 254
C: claro, aliviar un poco, que sea mas leve la cosa y	256 257

Extract 29 (Case 1 – Session 3)

T: si, si, como por ejemplo, para	314
imaginamos, si: tuviésemos aquí un	315
globo de cristal:	316
C: si.	318
T: en el que pudiésemos ver el futuro y	320
pudiésemos mirar la situación en que	321
usted dijese 'estoy curado'.	322
C: si.	324
T: cómo sería esa situación?	326
C: toma, pues muy buena.	328
T: muy buena.	330
C: claro, por supuesto. pues una alegría	332
muy grande que pudiera decir, pues	333
estoy curado. pero la verdad que eso	334
no me lo creo, sinceramente.	335
T: aha, y:	337
C: si espero, ya le dicho, que la	339
terapia que llevo ahora pudiera	340
ayudarme. desde luego. vamos a entrar	341
en el tiempo peor, o sea, en el tiempo	342
que mas se me agarra a mi el dolor de	343
cabeza. ahora en la primavera.	344

Extract 30 (Case 1 – Session 3)

T: aha. para protegerse siempre un poco	642
es importante. y acerca de las	643
técnicas que hemos entrenado aquí el	644
último día, ha dicho que las intenta	645
hacer todos los días?	646
C: si, si, todos los días.	648
T: y cuándo, por la mañana, por la	650
noche?	651
C: por la mañana y muchas noches cuando	653
me voy a la cama también. como estoy	654
solo en casa, pues me doy cuenta	655
cuando estoy sentado ahí en el sillón	656
y lo hago.	657
T: aha, y cómo lo hace?	659
C: pues como usted me dijo, de esta	661
forma. primero una mano, luego la	662
otra. luego una pierna, luego la otra,	663
la cabeza hacia un lado, hacia otro,	664
los estos. todo lo que me dijo.	665
T: muy bien, y piensa que después de	667
hacer ese ejercicio se siente mas	668
relajado, mas tranquilo?	669
C: bueno, me parece que eso, sentir como	671
que no siento mucho, pero creo que si	672
que me puede hacer a mí, ya le dicho,	673
he visto yo que si.	674
T: m-hm y cuando tiene el dolor de	676
cabeza e intenta hacer eso, se	677
encuentra muy molesto para hacer algún	678
ejercicio?	679
C: si cuando tengo el dolor de cabeza	681
hago mucho eso responde un poco. ya le	682
digo, mas que hacer gimnasia, es hacer	683
ya le digo, estas cosas. hacer fuerza	684
con estas cosas.	685
T: si, y el hecho de imaginar la	687
pulsiones que siente la mano y siente	688
C: si, lo que pasa que eso me responde	690
aquí a mí mucho.	691
T: muy bien	693
C: tengo que dejar casi de hacer eso	695
porque como que duele mucho.	696
T: aha, pero, cuando hace la presión	698

parece como si en realidad le doliese	699
mas?	700
C: parece que me responde en la cabeza.	702
T: y después, si consiguiese espaciar en	704
la mano?	705
C: luego ya después de eso parece como	707
que se pasa el latigazo. parece que es	708
como un latigazo que al hacer así te	709
da como un latigazo, después cuando	710
sueitas como que se pasa la cosa. se	711
queda mas tranquila, aunque siga	712
doliendo, pero ya es otra cosa	713
distinta.	714

Extract 31 (Case 1 – Session 3)

T: si, si. pienso que estos primeros	758
ejercicios lo están ayudando. ahora,	759
puede haber una etapa o una fase que	760
sea necesario utilizar otras técnicas,	761
si estas no resultasen, pero si estas	762
simples, sencillas, dan resultado.	763
C: si, ya le digo. yo, ahora quería	765
seguir, vamos, si usted no me cambia	766
de eso para ver que pasa con esto, a	767
ver si así, me siento un poco mejor.	768
yo ahora he estado haciendo lo que me	769
ha mandado y ya le digo que no creo yo	770
que sirva para acabar con el dolor de	771
cabeza, pero si para aliviarlo a lo	772
mejor.	773
T: si, si, muy bien.	775
C: si, ya le digo, me duele menos. si al	777
cabo de un o dos meses me duele menos,	778
pues podemos decir que hemos	779
adelantado algo.	780
T: si, si. eso es importante. por tanto,	782
si nosotros nos volvemos a encontrar	783
dentro de un mes y durante ese tiempo	784
las cosas han ido como este mes	785
anterior, entonces, podríamos decir	786
que las cosas están mejorando?	787
C: si, claro, si las cosas van como este	789
último mes, es que voy progresando	790
algo. porque ya le digo, el mes	791
anterior me ha dolido el día	792
diecinueve, lo he apuntado.	793

Extract 32 (Case 1 – Session 3)

C: si, yo voy a aguantar seguir	906
intentándolo con esta terapia como el	907
he dicho, porque si no además no	908
adelantamos nada. voy a aguantar sin	909
tomar las pastillas, a ver, y voy a	910
hacer lo que me manden. a ver si me	911
alivia un poco, me voy relajando un	912
poco mas y puedo aliviar un poco la	913
cosa. yo creo que sí.	914
T: claro. y nos alegramos mucho de que	916
haya seguido todo lo que le hemos	917
indicado. y, muy bien, lo que nosotros	918
ahora le queremos pedir es que	919
continué lo que ha estado haciendo	920
hasta ahora.	921
C: si, si, ya le he dicho que si, que lo	923
hago, porque si no buena gana tengo yo	924
de venir aquí.	925
T: si, si, pero	927
C: como si voy al médico y no tomo lo	929
que me mandan, entonces, cómo me voy a	930
curar? y buena gana tango de andar	931
echando paseos y decir que si, y decir	932
que no. ya le digo que la cabeza me	933
sigue doliendo. que el día diecinueve	934
me dolió y ayer también, pero me	935
aguanté sin tomar nada a ver que es lo	936
que pasa.	937
T: y ha pasado.	939
C: claro, ha pasado. ya le digo que yo	941
no creo que se me vaya a quitar el	942
dolor de cabeza, yo no lo creo	943
sinceramente, pero si hago esto me	944
puede aliviar.	945
T: si, si, y si consigue tener su vida +	947
a pesar de.	948
C: claro + estar normal, un poco mas	950
relajado, mas tranquilo, estar mas	951
alegre.	952

Extract 33 (Case 1 – Session 3)

T: si resulta que vuelve a tener un dolor de cabeza bastante mas fuerte, haga también lo que hasta entonces ha hecho: la infusión, el mismo pañuelo si se siente mejor, así como el relajamiento. eso, y las otras técnicas. y, nos pensamos que si consigue dominar el dolor con estas técnicas sería muy bueno. nosotros tenemos otras técnicas que también le podemos enseñar, incluso técnicas que podría usar cuan estuviese trabajando, pero ahí ya sería un poco que se puede nombrar de hipnosis y usted ha dicho que no.	969 970 971 972 973 974 975 976 977 978 979 980 981 982 983
C: yo ya le he dicho que voy a seguir con esto si a usted le parece.	985 986
T: si, si, claro, claro	988
C: sin complicarme mas la vida quiero decir.	990 991
T: si, si nosotros ahí también estamos de acuerdo con usted. vamos a seguir esta línea	993 994 995
C: exactamente	997
T: y a ver si.	999
C: a ver si yo me encuentro bien. y hacer comprobaciones y que yo mismo pueda decir pues sí, esto me pude ayudar a mi a estar mas relajado y a no tener tantos dolores de cabeza ni tan frecuentes ni tan fuertes. y eso es yo quería, ahora seguir con esto, sin complicarme mas. que veo que no, pues luego ya veríamos a ver.	1001 1002 1003 1004 1005 1006 1007 1008 1009
T: eso, exactamente. lo que queremos decirle a usted exactamente es que en su caso pueden bastar este tipo de técnicas para resultar, pero que si vemos que las cosas pueden ser mas complicadas nosotros también podemos ofrecer otros tipos de técnicas. pero usted no se tiene por qué preocupar, son técnicas en las que se usa mas la imaginación. es la única diferencia con respecto a estas. se utiliza mas la imaginación, y es imaginar cosas e imágenes. y la ventaja que tiene con respecto a esta es que no precisa en cierta manera; que puede estar	1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025

trabajando y utilizarlas. pero si este 1026
tipo de técnicas que hasta ahora hemos 1027
estado haciendo, lo ayudan. 1028

C: claro, me ayudan. y buena gana de 1030
complicarse. 1031

T: es suficiente y para que complicar la 1033
vida. 1034

C: si esta técnica me va y cambio de 1036
oficio, a lo mejor por ahí. 1037

T: claro, eso lo ayudará inmensamente. 1039

C: ya le digo que me ayudará muchísimo. 1041
al hacer mucho menos esfuerzo creo que 1042
me ayudará bastante. 1043

T: si. y es un trabajo que a usted le 1045
gusta mas. 1046

C: claro, al ser un trabajo que me gusta 1048
mas pues estaré mas aliviado, mas 1049
divertido. 1050

Extract 34 (Case 1 – Session 3)

C: si, si, esto que quiero llegar a 1113
controlar un poco, a controlar el 1114
dolor de cabeza a que me siga doliendo 1115
la cabeza pero que la controle un 1116
poco. con esta técnica no me duele 1117
tanto la cabeza, aun que me duela la 1118
cabeza. es a lo que iba el dolor de 1119
cabeza no se me quitara nunca porque 1120
será de herencia como dicen. 1121

Extract 35 (Case 1 – Session 3)

C: hombre, por supuesto. me sería tener 1309
un cambio fenomenal, se subiera que 1310
está controlado el del dolor de 1311
cabeza, o se sé que haciendo esto no 1312
me sobe el dolor de cabeza. que cambio 1313
iría a tener! 1314

T: m-hm 1316

C: ahora ya, en cualquier lado haría la 1318
técnica esa. de sentarme un poco 1319
relajarme y estar un poco relajado, 1320
pues se cambio de oficio ahora, que 1321
creo que sí, puedo hacerlo cuando me 1322
dé la gana. 1323

Extract 36 (Case 1 – Session 4)

T: aha. muy bien desde la ultima vez, que tal?	21 22
C: pues, yo me encuentro bastante bien, ya lo he dicho en la otra vez que me encontró bastante bien. no se si será por esto o por otro.	24 25 26 27
T: + aha	29
C: la cabeza + ya le dice que me duele, no me deja de doler la cabeza, pero yo le echo la culpa a las cervicales, lo tengo comprobado.	31 32 33 34
T: aha, es de aquí de tras?	36
C: exactamente.	38
T: es distinto, anteriormente había hablado de un dolor lateral.	40 41
C: si, en las sienes.	43
T: ahora?	45
C: es cosa de la noca, y cosa de al volver por aquí la cabeza.	47 48
T: duele la cabeza aquí y no en la frente.	50 51
C: yo he hecho la terapia y me encuentro bastante arreglado. todavía no ha brotado bien la primavera.	53 54 55
T: si, si.	57
C: es primavera , pero no ha venido la salvia por así decirlo.	59 60
T: m-hm.	62
C: pero que me encuentro bastante bien. la cabeza me sigue doliendo, he.	64 65
T: m-hm	67
C: ya le digo, pero es diferente, es cosa de cervicales.	69 70
T: no es el mismo dolor.	72
C: cosa de cervicales, ya le digo se trabajo mucho las cervicales me encuentro muy molesto, cuando tuerzo la cabeza. cuando tengo que hacer las	74 75 76 77

cosas por las mañanas y tengo que	78
torcer el cuello, no lo puede ni	79
moverlo.	80

Extract 37 (Case 1 – Session 4)

T: y durante este ultimo mes?	121
C: hace poco también me dolió.	123
T: m-hm.	125
C: pero me aguanto y no me vengo para casa.	127 128
T: y durante cuanto tiempo:?	130
C: no lo se, porque me levanto con dolor de cervicales y me voy a trabajar y me aguanto el día.	132 133 134
T: aha.	136
C: por la tarde por el trabajo con el movimiento y el esfuerzo, se me han cargado ya por la tarde y por la noche noto mucho mas dolor.	138 139 140 141
T: si, si, pero es un dolor diferente?	143
C: distinto al de antes. si no fuera las cervicales yo lo tengo bastante controlado.	145 146 147

Extract 38 (Case 1 – Session 4)

T: entonces, en relación al otro dolor,	407
se acuerda que una vez le dije que se	408
imaginara una escala de cero a diez,	409
diez un dolor muy grande y cero	410
ausencia de dolor, donde se situaría	411
ahora?	412
C: ahora muy bajo.	414
T: bajito.	416
C: bajito, bajito, bajito, dos o tres,	418
para ahí.	419
T: dos o tres.	421
C: mas o menos	423
T: y eso tipo de dolor es tolerable.	425
C: si, es mas o menos.	427
T: si conseguir un poco mas? mejor	429
todavía.	430
C: cuanto mas conseguir mejor. pero ya	432
le digo de todo no le voy conseguir.	433
T: si, pero. toda la gente tiene dolor	435
de cabeza, de distinta manera, pero si	436
tuviera un dolor de cabeza por una vez	437
al mes, no creo que le molestara	438
mucho?	439
C: claro que no, acostumbrado a lo de	441
antes, vamos mejorando.	442
T: si, si, una cosa es estar parado	444
durante una semana y otra	445
C: es no tener que para todo el día. ya	447
le digo, me voy al trabajo, y noto ya	448
que. hago el ejercicio por la mañana,	449
me voy al trabajo, trabajo durante	450
todo el día, y aguanto el día.	451
T: aha. muy bien.	453

Extract 39 (Case 1 – Session 4)

C: quiero hacerle una pregunta, y si yo	578
dentro de un año volviera a sentir	579
algo otra vez, podría volver aquí otra	580
vez?	581
T: si.	583
C: que tendría que hacer alguna cosa?	585
T: tiene mi numero de teléfono?	587
C: si.	589
T: me llamaría .	591
C: de acuerdo.	593
T: me llamaría y concertaríamos una cita	595
C: yo voy a seguir con lo que usted me	598
ha dicho, porque he tenido muy buenos	599
resultados, pero por si algún día	600
tuviera algún problema, ya le digo	601
puedo volver aquí? si puedo	602
directamente llamar?	603
T: si, si. por que lo que le propongo	605
ahora, bueno, ahora todo parece ir muy	606
bien	607
C: si va la cosa bastante bien de	609
momento. como le ha preguntado ya se	610
algún día por circunstancias, puedo	611
volver a recorrer aquí?	612

Extract 40 (Case 12 - Session 1)

T: hay personas que tienen dolor de cabeza y cuando hacen algo que les gusta, como por ejemplo ver una película que les interesa, hacia al final de la película ya no tiene el dolor de cabeza. porque, porque, están concentradas; esto no significa que el dolor de cabeza no este ahí, pero han focalizado su atención hacia otra cosa. nosotros tenemos una cantidad limitada de atención, si conseguimos focalizarla hacia otra cosa ya no esta focalizada sobre el dolor.	10 11 12 13 14 15 16 17 18 19 20 21 22
C: y por que a veces lo intento y no lo consigo?	24 25
T: porque a veces es un poco como si yo ahora mismo te digo "relájate" "relájate" "relájate" te estoy a decir para te relajares.	27 28 29 30
C: m-hm	32
T: probablemente te quedas mas tensa.	34
C: si, no me relajo.	36
T: exacto, porque cuando queremos intentar ciertas cosas que en cierta manera son inconscientes, o que no podemos controlarlas directamente, y pretendemos hacerlo demasiado solo conseguimos el efecto contrario.	38 39 40 41 42 43
C: si. pues hay algunas veces que digo yo no me voy + /	45 46
T: + es lo mismo cuando te dices "no te preocupes", "no me preocupo", "no me voy a preocupar", estas te a preocupar mas.	48 49 50 51
C: seguramente le estoy dando vueltas en la cabeza.	53 54
T: porque "no: te preocupes", en el fundo te estas a decir "preocúpate", "preocúpate", "preocupate" porque esta ahí esa palabra.	56 57 58 59

Extract 41 (Case 12 - Session 1)

C: ya llega a un momento que claro me	152
dice "yo te estoy estudiando para que	153
cuando vayamos a cualquier sitio pues	154
dispérselo lo hace por yo la observo"	155
o porque alguien le pregunta "usted	156
que opina? o que le ve?"	157
T: si, si.	159
C: dice "yo no te lo visto". le digo yo	161
no te miento, es verdad al mejor me ha	162
dolido, pero no le he dado tanta	163
importancia.	164

Extract 42 (Case 12 - Session 1)

C: no se, porque por ejemplo en el	174
puente he estada trabajando mucho mas	175
que lo que hago en casa.	176
T: m-hm	178
C: porque estaba atendiendo a mi madre	180
que es parapléjica.	181
T: si, si.	183
C: estarla cambiando, y tal, supone	185
atendiendo a una persona y me gusta	186
estar con ella, atenderla, hacer	187
comidas, y ayudar en la casa. estoy	188
mucho mas ocupada, mas si quieres en	189
tensión, porque quiero abarcar mas	190
cosas, pero a lo mejor no me da tiempo	191
a decir que me siento rara o necesito	192
dormir, pero cuando llego aquí, un	193
día, dos días, al tercer día el	194
circulo cerrado, me vuelve a suceder	195
lo mismo, digo no lo entiendo.	196

Extract 43 (Case 12 - Session 1)

T: y con los dolores de cabeza muchas	219
veces se pasa lo mismo. son muchas	220
pequeñas tensiones que se van	221
acumulando, acumulando y que pasa pero	222
se van acumulando, acumulando,	223
acumulando llega al topo del vaso y	224
desbordan, y viene el dolor. la	225
cuestión es que no dejar que se llene	226
a tanto.	227
C: si, pero es que yo no puedo	229
controlarlo. eso es lo que me dice mi	230
marido "contrólalo", digo "no puedo".	231
T: pero la cuestión es que normalmente	233
lo intentamos controlar cuando esta	234
casi a transbordar. la cuestión es	235
controlar en el inicio, no dejar que	236
se llene tanto.	237

Extract 44 (Case 12 - Session 1)

T: pero eso toda la gente. todas las	272
personas tienen unos límites	273
diferentes, unas de otras. unas	274
personas ultrapasan sus límites y eso	275
se transforma en una úlcera y otras se	276
puede transformar en un dolor de	277
cabeza. -- la mayoría de la gente se	278
dice si ha sido así toda la vida por	279
que me pasa a mí esto ahora, por que	280
no pasaba antes	281
C: si, si, yo me lo pregunto miles veces	283
T: pero esa es la misma respuesta para	286
una persona que tiene una úlcera, en	287
ese tipo de ciclos, lo mismo el	288
organismo se llena, ahora; el dolor	289
es la señal más directa del organismo,	290
el cuerpo comunica que pasa algo y que	291
tienes que hacer algo, "si no me	292
respetas, respétame con el dolor"	293
C: si, desde luego. es una cosa que	295
tengo que aprender, si tengo que	296
aprender algo es para controlarme, mi	297
marido me dice que sin ser psicólogo,	298
como me dice, "contrólate, no tienes	299
que llevarte tantos disgustos y	300
problemas por nada".	301

Extract 45 (Case 12 - Session 1)

C: si, eso si es verdad y yo misma me 359
doy cuenta, y lo comento a los 360
médicos. cuando tengo la racha dentro 361
de lo normal, por ejemplo ahora, como 362
es normal para a mi ya, intento 363
pasarlos, no pasa nada. pero cuando 364
estoy mal, he estado en el pueblo de 365
vacaciones y me he tenido que poner 366
inyecciones, por mas que quisiera 367
superarlo, se me veía en la cara, me 368
decían "que te pasa?", "no, no nada" 369
pero yo veía que me estaba mareando o 370
me veía mal y me recostaba un poco. 371

Extract 46 (Case 12 - Session 1)

C: si yo soy la mas interesada, a veces	416
es verdad que yo estoy desesperada	417
T: claro	419
C: y llega un momento que no entiendo	421
porque me dan estas pastillas y me	422
sientan tan mal y me pongo a morir y	423
me pongo fatal y no los comprendo,	424
porque me dicen "tomate esto que es	425
depresión" y tal o lo que sea, y me	426
las tomo con toda la confianza, ya no	427
es confianza para mi, porque les tengo	428
mucho miedo, pero yo al principio me	429
las tomaba y no pasa nada, y mal, cada	430
vez mas tristeza y me decían "es	431
normal". como puede ser normal que	432
cada vez estaba peor, que intentaba	433
hacer algo y no podía, me caía, y	434
llamaba por teléfono a mi madre, que	435
me encuentro mal que no se lo que me	436
pasa, cuando mi madre, ya me	437
encontraba llorando y muy angustiada?	438
T: llorar es a veces muy bueno, porque	440
saca mucho	441
C: si, si, soy muy llorona porque soy	443
muy sensible, aunque sea un	444
problemilla hago una montaña porque me	445
pongo a llorar y no paro, bueno dices	446
tengo un apoyo, pues si son las	447
pastillas, me quitan esas pastillas,	448
me dan esas pastillas que sirven para	449
todo y para nada como le digo, y me	450
mantienen	451

Extract 47 (Case 12 - Session 1)

C: y mi marido me dice que esta seguro	455
que no necesito esas pastillas, sino	456
autocontrol y ver la vida desde otro	457
punto de vista.	458

Extract 48 (Case 12 - Session 1)

T: a: y tenemos diferentes métodos de	577
relajación, otros basados en la	578
imaginación, a otros que se llaman	579
biofeedback que es con un aparato que	580
miden la conductividad de la piel que	581
esta asociada a los estados de alerta	582
y de ansiedad que tenemos, también hay	583
técnicas de auto-hipnosis. tu puedes	584
elegir la que más, puedes pensar que	585
te ayude. Cual te gustaría intentar	586
primero.	587
C: no lo se. te lo dejo a tu elección,	589
por que no lo se.	590

Extract 49 (Case 12 - Session 1)

T: m-hm. entonces lo que puedes hacer es 681
precisamente eso. sentarte delante del 682
acuuario, de la pecera, haberes este 683
ejercicio, y empezares a mirar; 684
imaginemos, vamos hacer todo y guiar 685
nuestra imaginación, esto es el 686
ejercicio, nada más. bueno, vamos 687
empezar (la T inspira, etc.) y ahora 688
quiero que imagines el acuuario, los 689
peces, las burbujas de la agua, la 690
arena en el fondo (3 seg), y ahora a 691
medida que imagines ese acuuario, 692
quiero que imagines que estas en una 693
playa, una playa que te guste, talvez 694
sosegada, quizás, una temperatura 695
agradable, que te puedes sentar y 696
mirar el mar, las olas, en la arena y 697
mismo oler un poquito el olor del mar 698
y simplemente disfruta de esas 699
sensaciones (7 seg) sientas que estas 700
ahí (5 seg) y sabes que tienes 701
siempre ese sitio para ir, para 702
respirar hundo, para te sentir un 703
poquito mejor - - simplemente tienes 704
que te sentar en una silla, en un 705
sitio que consideres cómodo, respirar 706
hundo tres veces, cerrar los ojos y 707
imaginar el mar - - - después 708
disfrutar por algunos momentos, puedes 709
abrir los ojos y (incomprensible). 710

Extract 50 (Case 12 – Session 2)

C: bueno, en general el dolor de cabeza	10
no es que haya sido muy fuerte,	11
exceptuando estos días que me baje de	12
semana santa.	13
T: m-hm	15
C: porque, no se si seria la tensión, me	17
note que tenia la parte de tras de la	18
cabeza, sobre todo este lado, lo tenia	19
muy inflamado.	20
T: a-ha. como; lo tocabas y te dolía?	22
C: si, si, si, si.	24
T: a-ha.	26

Extract 51 (Case 12 - Session 2)

C: no lo se, bueno lo que si me han	253
dicho y te lo comento, por detrás es	254
que toda la gente piensa que soy muy	255
nerviosa.	256
T: m-hm	258
C: que me pongo mucho en tensión. y	260
bueno que tengo miedo, es que ya	261
cuanto me pongo así , ya lo que me	262
espera:	263
T: y que piensas en esos momentos?	265
C: que pienso, que me voy otra vez a la	267
cama, que voy a vomitar, que voy estar	268
dos, tres o cuatro días en la cama,	269
empiezo a dar vueltas, digo no puedo	270
salir de vacaciones, no puedo atender	271
a mis hijos, no:	272
T: todo, empieza el ciclo.	274
C: me desespero, en una palabra	276
desesperase.	277
T: a-ha.	279
C: y ya esta.	281

Extract 52 (Case 12 – Session 2)

C: no me lo explico. digo esto es	370
enfermedad patológica u orgánica? no	371
se si llega a ser. como me voy a creer	372
yo me invento esto	373

Extract 53 (Case 12 - Session 2)

C: y el domingo también estaba bastante	594
bien (en la escala 2 de moderado)	595
T: m-hm. bueno siempre con un dolor	597
moderado y esto dos también indican el	598
mareo?	599
C: si, cuando yo te indico moderado	601
T: m-hm	603
C: mas, bien no es el dolor, lo tengo,	605
lo tengo como la presión hacia atrás	606
T: m-hm	608
C: pero cuando indico un dos o tres, es	610
cuando a parte del dolor estaba, a lo	611
mejor, mas mareada	612

Extract 54 (Case 12 - Session 2)

C: así como revuelta, como que te	644
encontrabas mal. me acosté y al día	645
siguiente	646
T: ya te despertaste:	648
C: me desperté mal, no pero el dolor que	650
sea tan grave	651
T: m-hm	653
C: sino porque - - siento como si	655
tuviera un pequeño temblor dentro de	656
mi	657
T: m-hm	659
C: como malestar	661
T: si.	663
C: y ganas de vomitar.	665
T: m-hm	667
C: aquella tarde, estuvo toda la tarde	669
como que apática, sin ganas de comer,	670
y bueno así como mal, triste.	671
T: si.	673
C: puede ser que me baje mucho el	675
carácter, si yo me noto se me baja la	676
moral, y aquel día bueno estaba; en	677
cuanto vía mi hermana y a mi cuñado,	678
les dije que me encontraba muy mal,	679
muy mal	680

Extract 55 (Case 12 - Session 2)

C: por que es que antes no me dolía? y	972
ha sido a partir de aquel día que me	973
dio tanto dolor de cabeza, no lo se. y	974
me empieza a decir mi marido "no	975
empieces, que no tienes nada, que no	976
es nada"	977
T: m-hm	979
C: "que tienes agarrotado, y ya está y	981
te pone el dolor y ya esta, que no	982
pasa nada" eso en los días buenos, en	983
los días malos, digo "ya estoy harta"	984
está claro	985
T: claro. son situaciones bastante	987
agotantes a todos lo niveles.	988
C: y es que después en si; no lo se si	990
lo que estoy tomando realmente me esta	991
ayudando	992
T: el ansiolítico? m-hm	994
C: o bueno, ya lo tomo porque se que	996
con él duermo, pues está claro.	997
T: m-hm, y si no los tomas piensas que	999
no dormirás?	1000
C: si. puede si que en el primer día	1002
duerma.	1003
T: m-hm	1005
C: porque se acumula mucho en la sangre,	1007
no.	1008

T: m-hm 1010

C: pero yo empecé a notar el problema, a 1012
parte del dolor de cabeza, es que 1013
tenia mucho insomnio, no dormía bien. 1014

Extract 56 (Case 12 - Session 2)

C: y sin que ellos lo digan, mi carácter 1296
es nervioso, pero no creo que todos 1297
estos nervios, o yo no llego a pensar 1298
que todo esto me: 1299

T: porque te cuestionas "por que siempre 1301
he sido así, por que es ahora es que 1302
me duele , si es por este carácter que 1303
tengo, ya me dolería de mucho tiempo 1304
antes" 1305

C: claro, yo me cuestiono, claro. 1307

T: lo que ha cambiado 1309

C: me dicen "tu no tienes la misma edad, 1311
la misma vitalidad". digo es cierto 1312
pero no creo que de un paso tan así, a 1313
que me ponga tan, tan, tan mal. como 1314
no me de cuenta. 1315

T: m-hm 1317

C: yo pienso como no me doy cuenta de 1319
que me estoy poniendo tan histérica, 1320
tan tensa que después no pueda 1321
pararme, para controlarme 1322

Extract 57 (Case 12 - Session 2)

C: no, no, si en si el dolor y la	1474
presión no es que me agobien	1475
T: es mas el mareo	1477
C: es el mareo, la nausea, el malestar	1479
ese /	1480

Extract 58 (Case 12 - Session 2)

T: una comparación que he hecho en el 1548
último día y pienso que refleja un 1549
poco la situación de algunos dolores 1550
de cabeza es como los problemas como 1551
las úlceras en el estomago, son cosas 1552
que a veces surgen por la forma de ser 1553
de las personas, se van acumulando , 1554
acumulando hasta que se crea la 1555
úlceras, y una vez que esa zona esta 1556
mas debilitada cualquier cosita afecta 1557
porque esta muy sensible, de cierta 1558
manera la cabeza una de las 1559
explicaciones que se pueden dar seria 1560
eso. que fue, fue hasta que esa zona 1561
se volvió hipersensible a todo eso, y 1562
ahora cualquier cosa, cualquier 1563
tensión por mínima que sea, va luego 1564
directamente ahí. es como cuando nos 1565
dañamos en algún sitio o cuando 1566
mordemos la lengua, que parece que 1567
estamos siempre a morder en el mismo 1568
sitio. y as veces las cosas funcionan 1569
un poco así. pero; ahora alguien que 1570
tiene una úlcera que hace? que tiene 1571
que hacer? bueno, tiene que tener 1572
cuidado con la comida, tiene que 1573
intentar no estresarse demasiado, 1574
bueno tiene que hacer cosas de manera 1575
que evite las crisis, y quizás lo que 1576
podríamos intentar hacer en esta 1577
terapia es eso, que cosas podrías 1578
hacer en el día a día para evitar 1579
crisis tan grandes? 1580

C: es que no lo se. 1582

T: para proteger esa zona tan sensible? 1584

C: // lo tengo diariamente 1586

Extract 59 (Case 12 - Session 2)

C: me gustaría cambiar en ese aspecto de 2106
decir, ser mas tranquila para todo, 2107
mas serena para todo, para todo, para 2108
pensar, para hacer para todo "no 2109
tienes prisa, tranquila" pero eso no 2110
lo consigo, no se si de ahí me vienen 2111
muchos problemas 2112

Extract 60 (Case 12 - Session 2)

C: intento descansar un poco, si "voy 2146
descansar un poco la cabeza" es lo que 2147
le digo a mi marido, mientras duermo 2148
no pienso, si no estoy siempre 2149
cavilando, soy una mujer que estoy 2150
siempre dando vueltas, estoy haciendo 2151
simplemente unas lentes, no puedo 2152
pensar en simplemente estar ahí, no, 2153
lo mejor me viene pues no si yo el 2154
martes tengo que hacer esto, tengo que 2155
irme el lunes a tal sitio pues luego 2156
hago tal y martes pues no se cuanto, 2157
siempre estoy quebrándome la cabeza 2158
como si tuviera prisa 2159

T: m-hm 2161

C: como se fuera corriendo a todos lo 2163
sitios 2164

T: es difícil estarte en el momento 2166
presente y solo en ese momento 2167

C: me es difícil, creo que me es 2169
difícil, siempre con la mente estoy 2170
haciendo un montón de cosas que creo 2171
que me agobio a la hora de la realidad 2172

Extract 61 (Case 12 - Session 2)

C: lo hago, que si no puedo parar y eso	2412
si que me gustaría decir, como padre	2413
mi habla, él es tan tranquilo y tan	2414
sereno	2415
T: m-hm	2417
C: no he corrido nada de él	2419
T: y tu madre era mas activa?	2421
C: si, mi madres es como yo	2423
T: por tanto esa característica que a	2425
veces es buena, a ver si me explico,	2426
por ejemplo, tu padre es una persona	2427
muy serena	2428
C: si.	2430
T: y tu madre una persona muy activa,	2432
muy eléctrica	2433
C: si	2435
T: y en cierta manera el problema	2437
contigo es que la mayor parte del	2438
tiempo estas demasiado eléctrica	2439
C: si	2441
T: y te gustaría en ciertos momentos	2443
también tener un poco de la serenidad	2444
de tu padre	2445
C: si en muchos más	2447
T: pero de cierta manera la electricidad	2449

de tu madre es la que esta ahí, tch 2450

C: si, si, si, soy toda mi madre 2452

Extract 62 (Case 12 - Session 2)

C: no lo se, si lo comento con mas 2682
médicos que he visto que lo intento 2683
explicar como lo siento, a lo mejor en 2684
aquel momento claro, porque en el 2685
transcurso de cinco años y pico ya no 2686
siento lo mismo como al principio lo 2687
sentía. lo he intentado decir tal y 2688
como lo siento que no se como lo 2689
indican a depresión, o ansiedad. 2690
ansiedad si, puede ser que la tenga, 2691
pero depresion, no, puede que en 2692
algunas temporadas pero 2693

T: pero eso es natural, la depresión es 2695
normal cuando hay un dolor muy intenso 2696
o un estado así físico o una 2697
enfermedad física es natural que algo 2698
de depresión si sienta porque cuando 2699
no nos sentimos bien con nosotros 2700
mismos, tenemos tendencia mas a nos 2701
deprimir 2702

C: claro, si 2704

T: eso 2706

C: entonces no lo se, debe ser que llego 2708
a un ponto que digo como no se la 2709
solución y no se por donde tirar, pues 2710
me gustaría que alguien me apuntara y 2711
me dijera esto es lo tuyo claro, 2712
claro, y tienes que hacer esto 2713

T: m-hm, pero puede ser que nunca vengas 2715
a saber, el claro, claro, claro. 2716

C: claro, entonces es por lo que yo me 2718
revuelta y me desespero, es decir, 2719

pues no lo se, que grandes problemas 2720
tienes, pote a pensar que grandes 2721
problemas tienes para que estés así 2722
insatisfecha contigo misma 2723

T: m-hm 2725

C: que no te ves realizada? no lo se, 2727
tan poco encuentro un explicación, tan 2728
poco es para tanto. 2729

T: m-hm 2731

C: dicirme bueno puedo tener una 2733
temporada que no estoy a gusto connigo 2734
misma, pero cinco años con todo su 2735
transcurso, no lo se, no es para tanto 2736
y que me encuentro mal, no lo se 2737

T: es eso, yo lo veo eso como cuando 2739
mordemos la lengua, que después 2740
estamos siempre en el mismo sitio. y 2741
es difícil salir del circulo 2742

C: no lo se, me gustaría que me dijeran 2744
es que o eres de nervios y tienes que 2745
intentar ser así. pues yo procuraré 2746
decir; dado que tu eres nerviosa 2747
deberías hacer esto, tomaría mas 2748
conciencia en el asunto, pero como en 2749
si el diagnostico para mi y para 2750
ellos, no me han dicho claramente, 2751
tienes esto, como tal, no, no. si yo 2752
me pongo triste porque me duele y tal, 2753
depresión o tal. me dan para la 2754
depresión y me pongo mal 2755

T: m-hm 2757

C: me sientan mal. si me dicen "tienes 2759

jaquecas tensionales" si, pero que me 2760
dan para ello? 2761

T: m-hm 2763

C: nada. pero cuando yo dejo de tomar 2765
las pastillas y o no tomo ninguna 2766
pastilla llega el momento, pues cuando 2767
me fue a hacer el escáner ese, que 2768
estaba de la cabeza, loca, loca, loca, 2769
o sea con una super presión que no era 2770
capaz ni de levantarme de la cama, 2771
digo algo me pasa, es que no lo se, no 2772
lo saben ellos como lo voy a saber yo 2773

Extract 63 (Case 12 - Session 2)

T: y tu cuando practicabas el yoga,	2913
conseguías relajar, trabajabas estos	2914
músculos?	2915
C: si, estuve una época que no sabia que	2917
era tensional	2918
T: m-hm	2920
C: como me achacaban mas a depresión y	2922
estaba insatisfecha, yo lo notaba, no	2923
T: m-hm	2925
C: que cuando hacia el yoga, me	2927
encontraba mas tranquila o intentaba	2928
desconectar, "bueno venga no pasa nada"	2929
tuve una temporada bastante maja	2930
T: m-hm	2932
C: incluso fue aquel verano que deje	2934
todas las pastillas	2935
T: m-hm	2937

Extract 64 (Case 12 - Session 3)

C: // no se me ha quitado, que tenga	8
días mejores o peores bueno, voy	9
pasando. pero el viernes me dijo mi	10
marido, vamos nos fuera a la calle	11
T: m-hm	13
C: porque yo le dije que me encontraba	15
un poco mal y tal, díseme "vamos por	16
ahí a la calle y vamos dar una	17
vuelta a la plaza, distraerte un poco"	18
T: m-hm	21
C: bueno, fui pero con desgana, yo vía	23
que no, que no me encontraba bien	24
T; m-hm	26
C: y bueno le dije me marchaba a casa y	28
que recogerá a los niños y bueno me	29
metí en la cama y empezó a darme como	30
unos mareos	31
T: m-hm	33
C: y en este lado parece que se me iba	35
la cabeza, en el lado izquierdo. un	36
malestar horrible, un malestar	37
horrible, un malestar horrible,	38
horrible, horrible, horrible. me puse	39
como un poco histérica	40
T: m-hm	42
C: lo reconozco, no?	44

T: entraste un poco en pánico.	46
C: si. porque yo creo que ya cuando	48
tengo síntomas de esos raros ya me	49
entra mucho miedo	50
T: m-hm	52
C: tengo miedo, y bueno mi marido y mis	54
hijos empecé a decirle, que "no lo	55
controlo, que no lo controlo", "bueno,	56
relájate, llora, llora si tienes que	57
llorar, desaguete". creo que	58
necesitaba yo como que sacar pues el	59
miedo y la tensión esa	60
T: m-hm	62
C: y me puse como a llorar	64
desesperadamente, y bueno ya me	65
tranquilice y me dormí y el mareo	66
paso, pero	67

Extract 65 (Case 12 - Session 3)

T: y ha alguno día; cuando ha sido el	410
último día que te acuerdas que no has	411
sentido; que te has sentido bien,	412
bien?	413
C: no. desde septiembre que sentí este	415
bajón	416
T: m-hm	418
C: no me he sentido ningún día de decir	420
buen me encuentro perfectamente, no.	421
T: por tanto desde septiembre que	423
siempre te acompaña esa sensación de	424
presión	425
C: si, si	427
T: por tanto esa es una sensación	429
constante	430
C: si, si, si	432
T: y después a veces te da el mareo que	434
es sinal que las cosas van quedar peor	435
C: si. si, si. siento el mareo, tengo	438
como ganas de vomitar	439
T: m-hm	441
C: empieza la cabeza a tomar un	443
rumboneo, noto mas la presión interna,	444
a lo mejor la jaqueca, que no lo se si	445
es jaqueca.	446

Extract 66 (Case 12 - Session 3)

C: digo, me dices que no tengo nada, no 652
tengo nada, pero algo tengo que tener 653
cuando me encuentro mal es que 654

T: tu tienes mucha cosa, no es que no 656
tienes nada. no tienes, como hemos 657
hablado en la primera entrevista, no 658
tienes nada que pueda ser encontrado 659
por los testes físicos que te hacen. 660
pero eso no quiere decir que no tengas 661
algo 662

C: pero yo me desilusiono mucho porque 664
me dicen que no tengo nada, que 665

T: no tienes nada de maligno, no tienes 667
nada que te va a crecer, pero tienes 668
algo que te perturba mucho 669

C: muchísimo 671

T: el dolor, el dolor de cabeza, es la 673
presión, son los mareos, eso es algo 674

Extract 67 (Case 12 - Session 3)

C: me acosté e intente tranquilizar,	962
empezó a se desencadenar ahí el mareo	963
que yo ya no controlaba si estaba para	964
la derecha o para la izquierda, "que	965
mal me siento, que mal me siento, que	966
mal me siento",me decía yo para mi	967
sola, "que mal. que mal". ya cuando	968
llegaran ellos, bueno "que me siento	969
muy mal, que me siento muy mal, que	970
tengo otra veces el mareo"	971
T: m-hm	973
C: creo que ya es esa histeria que me	975
entra, ese desasosiego, esas ganas de	976
desahogarme, de decir "socorro,	977
ayudarme que no salgo de esto"	978
T: m-hm	980
C: pues me dice "llora, llora, llora si	982
tienes que llorar" y a parte soy muy	983
llorona	984
T: es una buena manera de desahogarse	986
C: dice "llora, llora, llora", "llorar	988
ya no te va el mareo", digo "no lo se,"	989
pero cuando me pongo ya a llorar tan	990
histérica, tan; "estoy harta, estoy	991
desilusionada," pues cuando ya me	992
tranquilizo digo "parece que estoy un	993
poco mejor del asunto"	994
T: m-hm	996
C: y ya entre lo mal de la tensión ,	998
entre llorar y ya en lo que me intenta	999
tranquilizar, intento dormir si lo	1000
consigo	1001

Extract 68 (Case 12 - Session 3)

T: es un poco un circulo vicioso, ahora 1591
como salir de ese circulo? - - bueno, 1592
pero tu tienes la capacidad de salir 1593
de ese circulo porque tu aquí has 1594
dicho que en determinadas épocas de tu 1595
vida no muy longincuas, por ejemplo en 1596
las vacaciones, que te has sentido 1597
bien 1598

C: m-hm 1600

T: que te has sentido relajada, que no 1602
te ha dolido tanto la cabeza 1603

C: nada 1605

T: que te has olvidado hasta de todo 1607

C: si, no me ha dolido nada 1609

T: por tanto tu tienes dentro de ti la 1611
capacidad de estar tranquila, serena y 1612
relajada. 1613

C: no estoy convencida (risas) 1615

T: pero hay momentos en tu vida - que 1617
has estado tranquila, serena y 1618
relajada y sin dolores 1619

C: si, todo el verano 1621

Extract 69 (Case 12 - Session 3)

T: el problemas es que el dolor de	1680
cierta manera te esta robando el	1681
animo, la energía	1682
C: si, me esta robando todo, ya le digo	1684
muchas veces a mi marido, digo ya no	1685
soy la misma que antes, que no, no me	1686
deja ser feliz en una palabra	1687
T: en cierta manera el dolor estate	1689
comiendo el espacio, te esta	1690
comiéndote a ti misma, te esta	1691
dominando	1692

Extract 70 (Case 12 - Session 3)

T: pero, tu ya tienes ahora una 2279
situación; el problema es que con 2280
ciertos tipos de problemas lo que 2281
hacemos es un poco a: lo que nos otros 2282
llamamos a: la soluciones que 2283
intentamos, son soluciones que 2284
alimenta el problema. tu tienes el 2285
dolor la cabeza, y la solución que 2286
utilizas es te preocupas mas 2287

C: m-hm 2289

T: eso va alimentar el problema. lo que 2291
se tiene que hacer es parar ese tipo 2292
de soluciones que no funcionan e 2293
intentar otras 2294

C: m-hm 2296

T: y intentar otras. si esto no funciona 2298
intentar otro. porque cuando el niño 2299
lloraba primero podías intentar darle 2300
de comer, pero si no dejaba de llorar 2301
a ver que le pasaba y no le vas a dar 2302
otro biberón. va intentado, intentado, 2303
intentado hasta que ves esto resulta. 2304
entonces si esto resulta muy bien, lo 2305
voy aplicar 2306

C: m-hm 2308

T: y después pasado unos tiempos puede 2310
ya no resultar eso, y tienes que 2311
intentar otra cosa. 2312

C: m-hm 2314

T: la cuestión es ir intentando pero 2316

cosas diferentes	2317
C: pues vamos a intentarlo	2319

Extract 71 (Case 12 - Session 3)

T: por ejemplo, ahora aquí (la T coloca 2630
el aparato en la mano de la C) se pone 2631
estas chismes en dedos distintos 2632

C: (incomprensible) 2634

T: pode ser, es indiferente eso. ahora 2636
si quisieres el sonido, no esta bien. 2637
(10 seg) y tu pones esto así, hasta 2638
que este en el cinco o un poquito mas 2639
alto, y después es intentar, por 2640
ejemplo has hecho yoga, puedes utilizar 2641
eso tipo de ejercicios de respiración 2642
para que baje 2643

C: (30 seg) 2645

T: bajo un poquito 2647

C: cuando intento ahora me mareo 2649

T: cuando: 2651

C: tengo los ojos muy cerrados y intento 2653
tranquilidad 2654

T: m-hm 2656

C: ahora me estaba concentrando en el 2658
sonido, bajo 2659

T: m-hm 2661

C: y siento que me va la hoja para el 2663
otro lado (risas) 2664

T: ahora que empezaste a hablar un 2666
poquito mas pero va bastante bajito. 2667

lo consigues bastante bien,	2668
normalmente las personas cuando	2669
intenta en las primeras veces tienen	2670
bastante dificultad	2671
C: no si yo intento relajarme, lo	2673
consigo	2674
T: m-hm	2676

Extract 72 (Case 12 - Session 3)

C: y intento concentrarme en el sonido 2797
ese y me imagino una aguja y digo 2798
"tiene que bajarla" 2799

T: m-hm 2801

C: entonces veo la aguja, intento verlo 2803
con mi imaginación, controlarlo, se va 2804
hacia abajo, hacia abajo, hacia abajo. 2805
como nos decía el profesor relax, + 2806
relax, relax 2807

T: relax, relax + y esa palabras es muy 2809
importante 2810

C: si, relax, bueno intento decirme "me 2812
relajo, me relajo" 2813

T: m-hm 2815

C: pero consigo o no lo consigo? 2817

T: si, eso ahora como estas hablando es 2819
natural que la aguja se mueva, y hay 2820
siempre una cierta oscilación. pero la 2821
primera vez lo has conseguido muy 2822
bien, muy bien mismo, tienes que 2823
hacerlo en casa. pero tienes que hacer 2824
esto por lo menos tres veces al día 2825

C: / 2827

T: y concentrándote en esa palabra 2829
"relax" de manera que si te consigues 2830
entrenar así, hacer ejercicios de 2831
relajación regularmente, después 2832
puedes hacerlos sin la ayuda del 2833
aparato y mas veces. 2834

C: m-hm	2836
T: y podemos mirar a un punto que cuando	2838
digas la palabra relax, te sientas	2839
relajada	2840

Extract 73 (Case 12 - Session 3)

T: y tienes que ser persistente, y 3042
después el trabajo si va desarrollar 3043
un poco, lo primer aprender a 3044
relajarte, y es eso el objetivo de 3045
este aparato, o de otros ejercicios 3046
que vamos hacer, después tenemos que 3047
trabajar a aprender a ver las señales 3048
que tu marido ve y que muchas veces tu 3049
no ves, para actuar ahí, cuando 3050
empiezas a te quedar mas activada, 3051
m-hm. tenemos que empezar a trabajar 3052
en eso haber cuando; y después 3053
utilizar los procesos de relajación 3054
aprendidos, para evitar que se acumule 3055
tanta tensión 3056

Extract 74 (Case 12 - Session 4)

C: pero digo mal no me encuentro	131
T: bueno, a ver si se mantiene en este nivel	133 134
C: oh si me mantuviera en este nivel pues bueno soy feliz	136 137
T: m-hm, puede ser que después vengan unos días mejores todavía	139 140

Extract 75 (Case 12 - Session 4)

T: m-hm. es exactamente pues pronto; es	602
exactamente hay en esos pequeños	603
puntos que hay que trabajar, lo que	604
hemos hablado el último día lo de le	605
dar muchísimas vueltas a las cosas y	606
todo eso produce tensión, esto es una	607
manera de cortar, pero tu tienes una	608
gran facilidad de relajarte	609
físicamente aquí, por lo menos da idea	610
de eso, que cuando te propones puedes,	611
puedes lo hacer	612
C: si	614
T: y tu tuviste en yoga eso también	616
ayuda muchísimo por causa de los	617
ejercicio de respiración y todo	618
C: m-hm	620
T: ahora y lo mas importante sería, es	622
eso ese trabajar en las vueltas y	623
vueltas que das a tus pensamientos y	624
aprender a cortarlos	625
C: no ser tan insegura, a lo mejor	627
también. para mi es inseguridad pero,	628
es que digo "no se por que no estoy	629
segura de hacer las cosas"	630
T: m-hm	632

Extract 76 (Case 12 - Session 4)

C: si, hoy que tengo aquí algo puesto, me	759
imagino en seguida, aunque quiera	760
imaginarme la playa un campo	761
T: m-hm	763
C: me imagino siempre la agujita,	765
siempre esta, a que este mal estoy con	766
la agujita y hay que bajarla	767
T: m-hm	769
C: me es fácil, digo me concentro mejor	771
en eso	772
T: si, si	774
C: no lo se	776
T: es como el yoga, que ha ciertas	778
posiciones que son mas de meditación,	779
y que se sabe asociada a esa posición	780
ten que se hacer x	781
C: eso es	783
T: a-ha, eso de cierta manera es	785
asociado a esto, tienes que relajar,	786
prefecto	787

Extract 77 (Case 12 - Session 4)

T: m-hm, es que; pero una cosa tenemos 1063
que tener bastante claro, porque tanto 1064
este ejercicio de relajamiento, como 1065
ese tipo de estiramientos y masajes y 1066
etc, o yoga y todo lo que puedes 1067
hacer, lo que va hacer es que a: ; por 1068
ejemplo, imaginemos que la tensión es 1069
como la agua e entrar en un vaso, tu 1070
problema es que va llenando, llenando, 1071
llenado, y se va acumulando todo aquí 1072
hasta que pluff. 1073

C: si rompe 1075

T: si rompe, y bastante fuerte. ahora 1077
todo este tipo de ejercicios lo que 1078
hace es ir sacando un poquito del agua 1079

C: m-hm 1082

T: para que o vaso no 1084

C: no este rebujado 1086

T: pero, esto tipo de cosas no; como he 1088
de explicar, no impide que el agua 1089
entre dentro del vaso 1090

C: hm 1092

T: son las vueltas y vueltas y la vida 1094
en general y as cosas que; claro que 1095
ese vaso si va siempre llenado de 1096
alguna y de otra manera 1097

C: si, si 1099

T: pero talvez se pueda llenar con menos intensidad 1101
1102

C: m-hm 1104

T: no podemos decir que no se va llenar, 1106
porque hay preocupaciones del día a 1107
día, hay preocupaciones bastante 1108
importantes y eso están ahí 1109

C: si, si 1111

T: pero a veces también por las vueltas 1113
y vueltas le añades mas agua 1114

C: hm 1116

T: entonces no podemos solo actuar en el 1118
sacar el agua, tenemos también que 1119
actuar 1120

C: en que no entre 1122

T: que no entre tanto, no es que no 1124
entre, que no entre tanto 1125

C: no entre tanto, si 1127

T: y tu ya estas haciendo cosas para eso 1129

C: si, si lo intento 1132

T: y lo estas consiguiendo por lo menos 1134

C: si lo estoy conseguido, mira ayer 1136
por ejemplo me dice en cuanto me puse 1137
un poco mal dije "no pasa nada, me voy 1138
a levantar perfectamente, si te 1139
encuentras mareada, pues te 1140

encuentras, puede ser un día malo como	1141
todo el mundo lo tiene"	1142
T: si, si	1144
C: "no te pongas tonta", bueno me	1146
levanto esta ma-nana y no me duele	1147
nada, bueno me duele aquí pero me	1148
duele nada y ya esta	1149
T: y ya esta	1151
C: voy intentar decir bueno, no tomarle	1153
tanta importancia y tomarme las cosas	1154
con mas calma, lo que sea, será	1155

Extract 78 (Case 12 - Session 4)

C: aunque a lo mejor lo que tu dices no 1993
demuestra lo que sufre pero a lo mejor 1994
sufré por otro sitio. pero si ve tan 1995
segura, tan en sus decisiones en esto, 1996
no le tiene miedo, yo es que le tengo 1997
tanto miedo a la muerte, y ahora 1998
después de lo que le ha pasado a mi 1999
madre es que tengo terror 2000

T: m-hm 2002

C: una cosa que antes yo decía es que 2004
bueno es que estoy convencida que todo 2005
el mundo 2006

T: hade llegar a una hora que 2008

C: nos va a tocar. digo por ahora tengo 2010
miedo que cuando me / digo ya, ya, ya, 2011
ya, como si fuera ya, ya. 2012

T: m-hm 2014

C: pero si ríen de mi como diciendo si 2016
hija tu eres la privilegiada que te va 2017
avisar, te esta avisado tiene cuidado, 2018
tiene cuidado, y te llevas así un 2019
montón de tiempo, les digo no os lo 2020
toméis a risa porque yo me siento mal 2021

T: es eso. eso es un poco de cierta 2023
manera una parte de tu inconsciente 2024
que te esta a decir que puede ser una 2025
cosa muy seria, es difícil para todo 2026
lo que viene, las preocupaciones que 2027
viene con eso 2028

Extract 79 (Case 12 - Session 4)

T: si, cuando te das vueltas."estoy a	2468
dar vueltas y vueltas , estoy a dar	2469
vueltas y vueltas", "como es que estoy	2470
a dar vueltas" y haber lo que es que	2471
pasa. mismo que no escribas nada,	2472
cuando empiezas a ver esto son	2473
vueltas, "estoy a dar vueltas y vuelta	2474
a esto" bueno primero "como estoy a dar"	2475
y después puedes preguntar "porque	2476
estoy a dar", pero primero "como estoy a	2477
dar las vueltas"	2478

Extract 80 (Case 12 - Session 4)

C: pero como ahora se que mi madre esta 2519
en este panorama, mira a ver si no va 2520
mas aya, lo veo tan cerca, digo ai mi 2521
madre, creo que realmente ha 2522
despertado a la realidad en ese 2523
aspecto 2524

T: si, si 2526

C: entonces, pues si, no tan como tenga 2528
los ataques de pánico, voh histérica, 2529
pero veo que lo tengo / 2530

T: claro, y es una cosa que tienes que 2532
enfrentar 2533

C: entonces como se nos asemejan tanto a 2535
mi madre y a mi, como nos parecemos 2536

T: m-hm 2538

C: lo que ella esta viviendo y sufriendo 2540
ahora 2541

T: tienes miedo de un día 2543

C: si, o sea y es lo de siempre, siempre 2545
la comparo conmigo, a ella le dolía 2546
esto, ella le dolía lo otro, ella era 2547
diabética, como me han dicho tanto que 2548
me parezco a mi madre, pienso que me 2549
va a pasar lo mismo 2550

T: lo mismo 2552

C: pues en cuanto; antes me dolía la 2554
cabeza, no le tomaba tanta importancia 2555

T: m-hm	2558
C: me va a pasar	2560
T: y ahora ya porque tienes miedo	2561
C: ahora desde que le paso a mi madre	2563
(incomprensible) lo que te conlleva el	2564
haber estudiado un poco o lo mucho,	2565
como tan poco llegas al extremo de	2566
saberlo todo	2567
T: m-hm	2569
C: me duele aquí en el pecho, a ver si	2571
va ser un infarto o una angina de	2572
pecho	2573
T: m-hm	2575
C: me voy a bajar a urgencia porque	2577
tengo aquí un dolor o una presión, que	2578
pode ser un infarto o una angina de	2579
pecho eh (incomprensible)	2580

Extract 81 (Case 12 - Session 4)

C: de antes es lo que te digo, el 2661
problema no es de ahora de lo de mi 2662
madre, si no de antes, pero de ir a 2663
urgencias, es ahora, antes, no, no, 2664
esto se me pasa, me meto en la cama y 2665
se me pasa 2666

T: y ahora piensas el peor 2668

C: me va dar algo en la cabeza como a mi 2670
madre, me va dar algo, algo, ya digo 2671
que me duele me va dar algo y voy a 2672
terminar como ella, fíjate 2673

Extract 82 (Case 12 - Session 5)

C: el ejercicio en si lo controlo bien	10
T: a-ha	12
C: quiere decir que no tengo problema para bajarlo, pero que	14 15
T: m-hm	17
C: en cuanto lo dejo pues digo //	19
T: si, pero mientras lo haces	21
C: si, intento olvidarme de que me duele	23
T: a-ha	26
C: aunque que me este doliendo no me concentro en el	28 29
T: si, si	31
C: me estoy concentrado en que voy a bajar la aguja	33 34
T: a-ha	36
C: que es mi meta	38
T: a-ha, y lo consigues?	40
C: si, si, perfectamente	42
T: m-hm	44

Extract 83 (Case 12 – Session 5)

T: m-hm, pero mismo estas dos semanas	168
teniendo sido así malas, te veo con	169
mejor humor, o:	170
C: porque creo que mi marido me esta	172
mentalizando mucho de que me tengo que	173
no acostumbrarme, pero	174
T: pero no te dejares sumergir	176
C: si, y también adaptarme un poco a	178
ello	179

Extract 84 (Case 12 - Session 5)

T: manteniendo un poco de tu humor	223
C: si, diciendo voy a intentar no preocuparme tanto del tema	225 226
T: m-hm	228
C: porque todo el mundo me repite "si tuvieras algo grave ya en este tiempo te hubiera salido, no te va a avisar tanto", me lo tomare de otro modo Ana que voy hacerle (risas)	230 231 232 233 234
T: a-ha, pero te sientes mejor con eso también?	236 237
C: no, no me siento mejor, intento no ponerme tan triste	239 240
T: m-hm	242
C: en el sentido de bueno no adelanto nada, no avanzo nada, por que me voy a preocupar siempre de lo mismo, cuanto mas me preocupo me pongo peor	244 245 246 247
T: eso es verdad	249
C: y eso soy consciente porque lo he hecho	251 252
T: m-hm	254

Extract 85 (Case 12 - Session 5)

T: si, si y lo que te podrá ayudar a;	277
puedes continuar a tener el dolor de	278
cabeza, pero puede ser que los dolores	279
de cabeza no si intensifiquen tanto	280
porque no entras en ese círculo	281
C: si, es lo que vamos; yo en si lo	283
tengo comprobado, se que cuando me	284
duele mucho la cabeza o tengo este	285
típico de mareo	286
T: m-hm	288
C: me baja mucho la moral, ya te lo	290
había comentado	291
T: si, si	293
C: si yo me encuentro como mas triste,	295
entonces eso me conlleva a empezar	296
otra vez a; lo que he empezado a	297
escribir, lo que escribí ya el día	298
siguiente que me comentabas como le	299
daba vueltas y decidí, aquí ana tiene	300
razón, tengo que cambiar y no	301
plantearme; cuando lo estaba	302
escribiendo	303
T: si, te dabas mas cuenta de lo que	305
estaba pasando	306
C: si, si	308

Extract 86 (Case 12 - Session 5)

C: porque me machaca mucho decir no 1500
tengo nada por activa o por pasiva me 1501
lo han dicho 1502

T: m-hm 1504

C: orgánico // 1506

T: m-hm 1508

C: que no tienes nada orgánico, digo si 1510
no tengo nada orgánico 1511

T: orgánico si lo tienes, tienes una 1513
gran tensión a nivel muscular y eso es 1514
orgánico, es físico y se podría medir 1515

C: "pero eso no es importante, maría, no 1517
le des importancia, sentirse así, no 1518
es un problema" 1519

T: pero el problema es que concentras 1521
toda tu dolor ahí, toda tu tensión 1522
ahí, y si tienes eso tan tenso que te 1523
puede ocasionar una inflamación y ese 1524
es el problema 1525

C: si, es un problema. no me importa yo 1527
que me duele ahí, lo que me importa es 1528
que no me duela la cabeza, no me 1529
sienta mareada, no sienta ese malestar 1530

Extract 87 (Case 12 - Session 5)

T: no y es una; si la tensión esta ahí, 2002
y el dolor esta ahí, muy bien pero si 2003
presta atención a otras cosas, no es 2004
que el dolor desaparezca, pero 2005
nosotros tenemos una cantidad 2006
limitada de atención, si focalizas 2007
toda tu atención en el dolor, lo vas a 2008
sentir mas todavía 2009

C: si, eso de antes me machacaba mucho 2011

T: m-hm, y ahora si consigues desviar tu 2013
atención, sabes el dolor esta ahí, 2014
quier estar ahí, déjate estar ahí 2015

C: si, pero me consciencializo que no me 2017
va pasar nada 2018

T: y se concentrases tu atención en 2020
otras cosas es natural que la 2021
intensidad del dolor baje 2022

C: m-hm 2024

T: y es por ahí que tienes que jugar 2026

Extract 88 (Case 12 - Session 5)

T: entonces estas a decir a ese dolor	2089
que vas luchar contra a ello	2090
C: si, si lo tengo claro, ya desde la	2092
otra semana cuando salí de aquí	2093
T: a-ha	2095
C: que lo comentaste que yo lo lleve muy	2097
claro	2098
T: m-hm	2100
C: que no podía darle tantas vueltas al	2102
asunto	2103
T: m-hm	2105
C: y que tengo que luchar contra eso	2107

Extract 89 (Case 12 - Session 5)

C: digo, tengo pánico pero intento /, lo 2151
que ha sucedido a mi madre, que me va 2152
pasar a mi lo mismo, es que a mi me 2153
duele la cabeza y me va ocurrir y tal, 2154
que me da mucho miedo de ver esas 2155
personas de cuando iba al hospital, de 2156
las ver por ahí pasando, digo para mi 2157
eso es lo peor, de no tener; a lo 2158
mejor estar como un / 2159

T: m-hm, lo futuro no lo podemos saber 2161

C: porque yo quiero siempre adelantarme 2163
a todo, es el carácter que tengo que 2164

T: y ha cosas de que tenemos miedo, y 2166
todo pero si luchas contra ciertos 2167
miedos, a veces tenemos miedo, y 2168
pasamos ciertos momentos de 2169
situaciones muy malas, por cosas que 2170
nunca suceden 2171

C: mira el otro día en un ascensor que 2173
siempre le tengo mucho miedo 2174

T: m-hm 2176

C: me quedo claustrofobia, me subí 2178
andando 2179

T: m-hm, y a veces es bueno subir las 2181
escaleras 2182

C: si pero, no era por las escaleras era 2184
por el ascensor muy claustrofobico 2185

T: pequeño? 2187

C: era pequeño, entonces cierras tu la	2189
puerta	2190
T: m-hm	2192
C: si cierran las puertas exteriores	2194
herméticas que es todo como frio	2195
T: a-ha	2197
C: ese tipo aluminio, pues como un	2199
bunker	2200
T: m-hm	2202
C: "pues voy a subir por el ascensor"	2204
T: a-ha	2206
C: yo solo, " yo solo voy a subir y	2208
bueno si tardo mucho, es porque me he	2209
quedado en el ascensor"(risas) me dice	2210
"que sabes que estoy aquí", "si, si ,	2211
pero voy a subir yo sola y si tu	2212
quieres", "yo me subo andando, hija",	2213
mi dice marido. me he subido sola si,	2214
empecé a mirar, "no pasa nada, no me	2215
falta el aire", y bajé también en el	2216
ascensor	2217
T: m-hm	2219
C: "pero voy contigo, mira que soy gordo	2221
y ocupo mas", "si, si, ahora bajas	2222
conmigo ya no importa"	2223
T: a-ha	2225
C: o sea intento lo que tu dices	2227

T: de enfrentar	2229
C: de enfrentar un poco, como diciendo	2231
me da miedo voy hacerlo	2232
T: m-hm, si, si eso es muy importante	2234
C: y voy hacerlo si, voy hacer todo lo	2236
que pueda	2237

Extract 90 (Case 12 - Session 5)

C: claro es lo que me comentan "imagina 2294
te que ahora después de el ultimo 2295
escáner" cuando me hicieran 2296

T: m-hm 2298

C: "que tienes un tumor, que haces? pote 2300
a pensarlo, tienes un tumor y te dicen 2301
reconocido que si se ve, te pones a 2302
llorar? tu ya no quieres vivir? tu ya 2303
te quieres matar ? tendrías que 2304
afrontarlo, que a gente lo afronta y 2305
vive, y que tu resulta que 2306
orgánicamente no tienes nada grave, no 2307
tienes como un tumor o todas esas 2308
cosas, pues lucha, es el problema mas 2309
pequeño pues tengo que luchar 2310

T: m-hm 2312

Extract 91 (Case 12 - Session 6)

C: ana, ya lo pienso, cuando ya ha	159
pasado tanto tiempo algunas veces y	160
veo que no tengo solución, pues	161
entonces es lo que comento digo, voy a	162
tener que vivir con ello, no	163
T: m-hm	165
C: y entonces que hago, bueno los días	167
que tenga malos, si no pueda lloraré o	168
me desesperaré, y los días que tenga	169
medianamente aunque; bueno pues para	170
delante	171
T: m-hm, y intentar aprovecharlos al	173
máximo	174
C: claro. como esta mañana digo bueno me	176
duele la cabeza, no pasa nada, tendré	177
que vivir con ello	178
T: m-hm	180
C: como ya estoy condicionada a vivir	182
con ello si	183
T: m-hm	185
C: si yo no encuentro una solución	187
T: m-hm	189
C: pero bueno no deajo de decir que me	191
duele la cabeza	192
T: m-hm	194

Extract 92 (Case 12 - Session 6)

C: si, el por que, que te comento, que 226
no tengo nada, me vuelvo en la cabeza 227
que no tengo nada, que no tengo nada 228
pero que me sigue doliendo muchísimo 229
la cabeza, y me hago preguntas, si son 230
jaquecas bien puede ser una semana, 231
dos semanas, pero todos los días 232
constantemente, a todas horas, digo ya 233
es un poco mas grave que jaquecas, no, 234
y empiezo a darles vueltas 235

Extract 93 (Case 12 – Session 6)

T: m-hm, has vuelto a yoga entonces	504
C: si, si, llevo ya desde la semana,	506
del mismo día que deje contigo pues el	507
miércoles ya me planteo digo "tengo que	508
hacer algo mas"	509
T: m-hm	511
C: y bueno, se que me relajo y que el	513
cuello me relaja mucho	514
T: cuando haces el yoga?	516
C: si, cuando lo hago, pero que el dolor	518
este que si pone aquí hacías los	519
laterales de la cabeza y la presión,	520
ahí lo tengo	521
T: m-hm, mismo después de la sesión de	523
yoga sientes esta zona relajada	524
C: si, si	526
T: pero la presión continuas sintiéndola	528
C: m-hm, m-hm	531
T: m-hm	533

Extract 94 (Case 12 - Session 6)

C: no quiero, no; para nada, yo quiero	835
que me curen, yo tengo algo, yo quiero	836
una salida,yo	837
T: a-ha	839
C: yo quiero que me ayuden, no se quien	841
me tiene que ayudar, pero me tienen	842
que ayudar	843
T: m-hm	845
C: y de ahí la desesperación, que no	847
salgo, que no salgo, que no soy capaz,	848
que	849
T: m-hm	851
C: y aquella día bueno pues, o aquella	853
noche pues la tengo mal, me voy a la	854
cama y intento dormirme, si duermo,	855
mal dormir, y ya esta	856
T: m-hm	858
C: y es un día tras otro, tras otro, no	860
puedo mas	861

Extract 95 (Case 12 - Session 6)

C: si, pero es que no me cabe en la 1219
cabeza que me digan no tenga nada, ni 1220
por activo, ni por pasivo, pero de 1221
donde me viene todo esto 1222

T: tener algunas cosa, esta ahí 1224

C: es que me dicen no tienes nada, 1226
entonces digo que pasa es que me lo 1227
inventó, es que yo quiero estar así 1228
sufriendo 1229

T: no tienes nada que se pueda detectar 1231
fácilmente o que si pueda detectar con 1232
las cosas tradicionales, o etc. o etc. 1233

Extract 96 (Case 12 – Session 6)

T: pero un poco como has salido de aquí 2541
la semana pasada y has ido al yoga, y 2542
has adiado esa decisión por bastante 2543
tiempo. 2544

C: porque cuando salgo de hablar contigo 2546
digo si tiene toda la razón, el dolor 2547
lo tengo que sentar aquí, y aunque me 2548
duela poco a poco yo voy hacer esto, 2549
el otro, pero 2550

T: y tienes que ir luchando en esas 2552
pequeñas batallas, y lo vas conseguir 2553