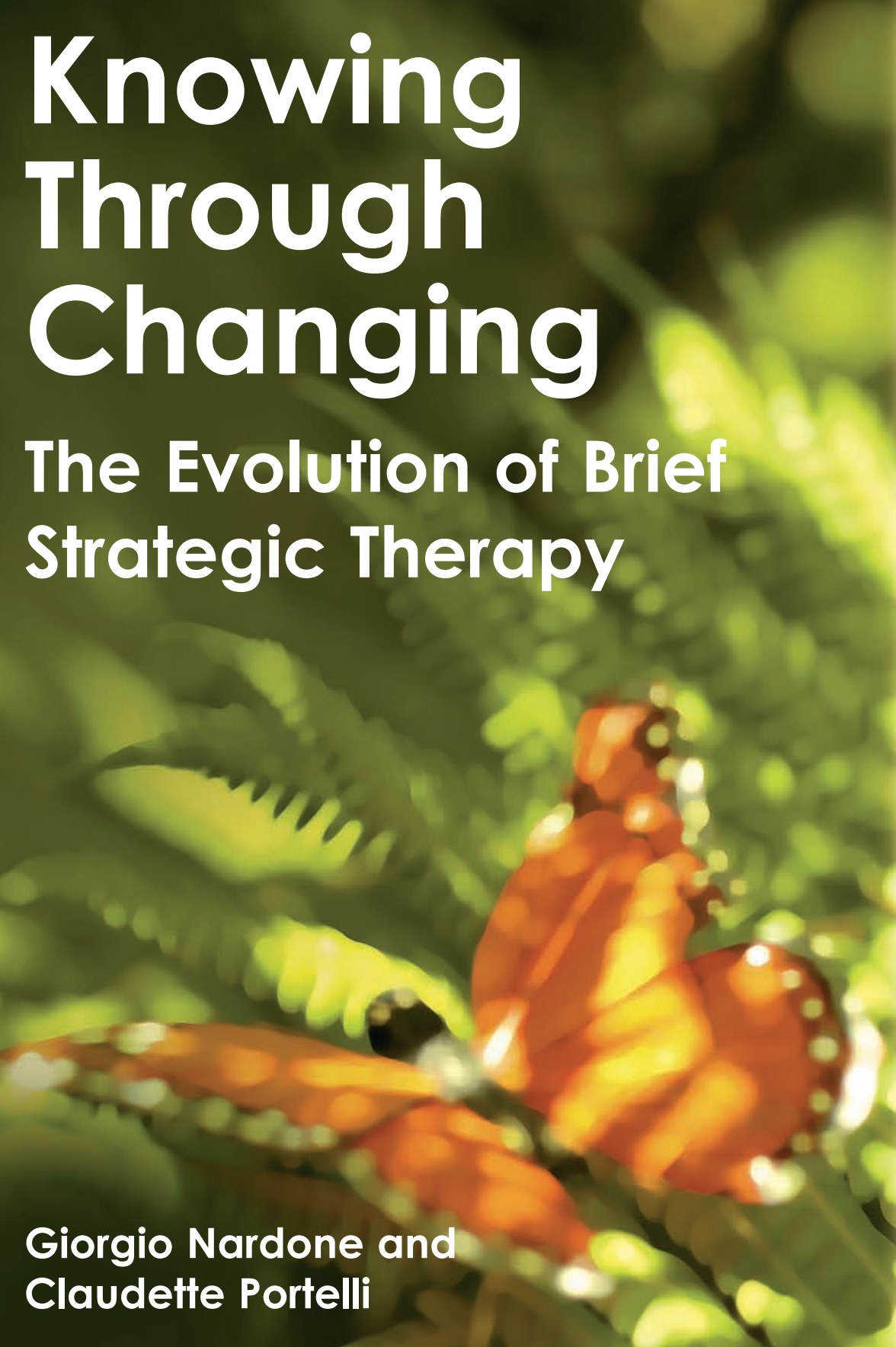
Knowing Through Changing

The Evolution of Brief Strategic Therapy



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Chapter 1

Strategic-Constructivistic Problem-Solving Theory

"Good practice does not exist without good theory."
Leonardo da Vinci

The art of changing problematic situations by applying strategic interventions that start off virtuous circles to replace vicious ones is part of a millennial tradition. In other words, *strategic problem-solving* interventions are certainly not a novelty. We find illustrious examples in antiquity, within both the Western and the Eastern cultural traditions.

We should emphasize that our use of the term *strategic problem solving* refers to a particular model of problem solving, which is based on a specific, highly advanced epistemology and logic that distinguishes this model from others.

A well-known Islamic story can help us clarify the premises of *strategic logic*, as well as what the role of a *strategic problem solver* should be.

It is told that, at his death Ali Baba, left an inheritance of 39 camels to his four sons, with the stipulation that half of the camels go to his eldest son, a quarter of them to his second son, an eighth to his third son, and a tenth to his youngest son. The four sons immediately started an intense argument about the will: how could it be possible to divide 39 camels in that manner? While the sons were animatedly discussing how to solve this dilemma, a Sufi (a wandering sage) happened to ride by on his camel. He listened to their problem, and decided to help them. He got off his camel and added it to the 39 camels. Then, as the brothers looked on in

astonishment, he started to divide the camels: twenty to the eldest son, ten to the second, five to the third son, and four to the youngest. Then he got back on his camel and rode away, leaving the brothers dumbfounded.

On hearing this story, we might be left wondering, like the four brothers, if the division of the camels was made possible by some magical intervention. But the wise man did actually not perform any kind of magic: he simply applied rigorous mathematical logic by adding an *x* variable (as is allowed in mathematical equations) in order to make possible an otherwise impossible operation. At the end of this operation, all he did was to take back his *x* variable, i.e. the fortieth camel, which was his own. This rigorous type of logic makes it possible to provide a simple solution to an apparently complicated problem that would seem impossible to solve from the perspective of traditional Aristotelian logic, which relies on the premises of "true or false" or "no third value".

We believe the story of the 39 camels is a good metaphor for the attitude of a strategic problem solver. Like the wandering sage in the story, the modern *technician of change*, who sets out to reach an objective, applies his tools and professional skills and then takes them back, starting off a change process that will lead the system to evolve. However, the problem solver's strategies are not the product of a sudden spur of creativity: they are based on applying a precise and rigorous logical model of intervention. More specifically, strategic problem solving is based on a specialized branch of mathematical logic known as *strategic logic* (Elster, 1979, 1985; Da Costa, 1989a, 1989b; Nardone, Salvini, 1997; Nardone, 1998; Nardone et al., 2000).

One of the features that distinguish strategic logic from traditional types of logic is that it makes it possible to develop models of intervention based on preset objectives and the specific characteristics of the problem at hand, rather than on rigid, pre-constituted theories. In other words, we do not blindly follow some rigid, deterministic perspective that dictates how to proceed and purports to provide, *a priori*, an exhaustive description of the phenomena at hand.

In fact, even the most sophisticated theories can, if they are also highly deterministic and absolutistic, become a powerful lens that deforms the reality to which it is applied—to the detriment of truly effective interventions, because the adopted strategy will be more heavily influenced by the theory of reference than by the characteristics of the problem to be solved.

Schopenhauer pointed out the influence exercised by theory and models in people's relationship with the realities that they face. From Heisenberg's principle of indetermination to modern constructivist epistemology, it has become increasingly clear how powerful a chosen theory can be in the interpretation of the phenomena to which the theory is applied. "It is the theories that determine what we are able to observe," Einstein stated in the 1930s.

Although this awareness is now universal within modern philosophy of science, most current theoretical and methodological approaches in psychology and psychiatry, as well as psychotherapy, are still based on strong descriptive and normative theories. On the contrary, our strategic approach operates on the premise that any strong theory that establishes *a priori* strategies or interventions should be relinquished. We therefore avoid defining the nature of things, or trying to determine a definitive, universal mode of intervention. It is always the solution that adapts to the problem and not the contrary, as in most traditional models of clinical psychology and psychotherapy. In short, strategic logic wants to be flexible and tries to adapt to its object of study.

Our approach has its roots in modern constructivist epistemology, according to which there is no ontologically "true" reality, but many subjective realities that vary according to the point of view that is adopted. Reality is considered to be a product of the perspective, the instruments of knowledge, and the language by which we perceive and communicate (Salvini, 1988).

Consequently, the value of a theory depends on its ability to conceive a real intervention measured in terms of efficacy and effectiveness in solving problems. While abandoning the reassuring positivistic thesis of the existence of a "scientifically true" knowledge

Chapter 6

Advanced Focused Strategies

"Therapy should always be designed to fit the patient and not the patient to fit the therapy."
Milton H. Erickson

Having described the phases and the process of advanced brief strategic therapy and how a first session can be turned into a therapeutic change-oriented process, we established that the best way to enable the reader to have a better understanding of the model and its application to various human problems is to present specific case examples.

Empirical experimental research in the clinical field (Nardone and Watzlawick, 1993; Nardone, Verbitz, and Milanese, 1999) has allowed us to detect a series of specific forms of interaction between the subject and his/her reality, which led to the formulation and maintenance of specific typologies of psychological disorders. This information enabled us to formulate specific protocols for the treatment of the various forms of mental disorders, which to this day have a high, scientifically recognized efficiency and efficacy (Nardone and Watzlawick, 1993; Nardone 1996).

The common dominator of all pathologies, on which we based our specific protocols, is the respective pathology's form of persistence. Paradoxically, the psychological problem is kept alive by the individual's efforts to change and by the efforts of other people who are drawn into the complex cybernetic network of retroactions (Nardone, 1996).

The therapeutic intervention first follows the structure of the persistence, and then reverses its direction by using the same force of the pathology to produce change.

Anxiety and phobic disorders

Fear, panic and phobias are undoubtedly the topics with which we are mostly associated and to which we are attached, given by our long experience in this field of study. Our first work on obsessive-phobic disorders dates back to the late 1980s. The first published research dates back to 1988 (Weakland and Ray, 1995) and it showed that 19.2 percent of the resolved cases took place between the first and the tenth sessions, 61.5 percent were resolved between the tenth and the twentieth sessions, 3 percent were resolved between the twentieth and the thirtieth and 15.3 percent at the thirtieth and the thirty-fourth sessions.

During these last fifteen years, at CTS, we have treated thousands of patients with phobic and obsessive disorders, and this inestimable exposure permitted us to set up a series of specific strategies tailored to the particular type of persistence of each form of recurrent pathology. At present, the efficacy of the advanced treatment model for anxiety, phobia and panic attacks is equivalent to 95 percent (Nardone and Watzlawick, 2004), with a mean efficiency of seven sessions, during which the majority of the cases (81 percent) got unblocked within the fifth session and in 50 percent of these cases there were no traces of the relevant symptoms after the first session.

Panic attacks with agoraphobia

This generalized type of phobic disorder is maintained by the attempted solutions of "avoidance" and "asking for help". Those who suffer from this pathology constantly avoid exposing themselves to some presumed danger, or else require the constant presence and assistance of a person they trust in order to confront them.

Our research and intervention on phobic-obsessive disorders (Nardone, 1996) has shown that, when a subject asks for help and receives it, this attempted solution confirms and nourishes the problem. To interrupt this vicious circle quickly, we have devised a specific, elaborate reframing:

> Well, first of all there's something I want you to think about during the coming week. I want you to think that, each time you ask for help and receive it, you will be receiving, simultaneously, two

> messages. The first obvious message is "I love you, help you and protect you". The second message, which is less obvious but stronger and subtler, is "I help you because you can't make it on your own, because you will be sick if left on your own." Please note that I am not asking you to stop asking for help, because I know well that at the moment you are not capable of not asking for help. I am only asking you to think that, every time you ask for help and receive it, you contribute to maintaining and worsening your problems. But please, don't make an effort to avoid asking for help, because you are not yet able *not* to ask for help. Only think that, every time you ask for help and receive it, you are helping make things worse.

Thus, we state that the patient's problem undeniably requires help from other people, but even though this help may at first seem to give beneficial effects, it will eventually lead to a worsening of the disorder. The technique used here is *fear against fear*. The fear of increasing the severity of the problem is much worse than the fears that constantly drive the person to ask for help. Every fear is limited by some greater fear. As the Romans used to say, "*Ubi major minor cessat*."

So, in this prescription, which is arrived at by means of the already described intervening and discriminating questions, we do not ask the patient directly to stop asking for help. Instead, we use a paradoxical type of communication, which stresses the patient's inability to do without help. In other words, we induce the person to act, without directly asking for action.

This prescription is normally given at the end of the first session, together with the log.[11] By the second session, the patients usually

[11] The log is a prescription given in the first session of the treatment of phobic disorders, with the intent of shifting the patient's attention, at the moment of need, from the symptoms onto the performance of the exercise, even though it is presented to the patient as a means of monitoring the panic attack. The prescription reads, "For this task you will be needing a pocket-size notebook on which you will reproduce the scheme I have prepared for you: date and time, place, and persons present, situations and thoughts, symptoms and reactions. This notebook will become your constant companion, which you will need to carry throughout the day; and, every time you feel you are starting to have one of your panic attacks or you feel fear arising, you will immediately draw out your notebook and fill in, date and time, place … OK? However, it is important that you carry out this right then at the moment when you feel you are having your attack, not before, otherwise it will be just a fantasy; nor after, because it will be a memory … we need you to do at the very moment so as to have a sort of an instant photo of the situation. So, even if you have the same sensation a hundred times, for a hundred times you have to draw out your notebook and fill in at the very moment. OK?"

Chapter 7

Integrating Science into Practice

"Unless you try to do something beyond what you have already mastered, you will never grow".
Ralph Waldo Emerson

Science and practice: research in clinical field

The purpose of this chapter is to recapitulate and provide a trenchant evaluation of the efforts put into the study of psychotherapy, while advancing possible alternatives for the study of effective and efficacious therapy. Naturally, no singular work presumes to address every contribution made in this field of study and this chapter is no exception. Finally, we will expose the intervention-research method used at the Centro di Terapia Strategica (CTS), which is in continuous evolution.

In the past decade, the integration of practice and science has become a major concern and the dominant commitment of most clinical scientists. This movement was triggered off by the always growing investment in managed care and in the health sector, which demanded greater accountability and improvements in clinical practice.

Since its foundation, the CTS has always endorsed the importance of giving equal weight to science and practice. Even though we always regarded research as an essential means of making our clinical work more effective, we never came to play part in that group of scientists who vowed to scientific faith, while forgetting that we are first and foremost, practitioners whose prime responsibility is to help those who ask our assistance.

Western, Novotny, and Thompson-Brenner (2004a) maintain that "the idea of creating a list of empirically supported psychosocial treatments was a compelling one, spurred in part by concerns about other widely disseminated practice guidelines that gave priority to pharmacotherapy over psychotherapy in the absence of evidence supporting such priority" (p. 632). This growing concern called for effective research that goes beyond describing what clinicians do in everyday practice, but that develops "measurable" means that can help obtain more useful treatments.

The first research approach that was promoted internationally in order to reduce the gap between research and practice was evidence-based clinical practice[22] (Chambless and Hollon, 1998), which followed the approach of evidence-based medicine. In the USA, a task force was formed, which came up with a list of "empirically supported treatments" (APA, 1995). This provoked disquiet among researchers and practitioners alike (Elliot, 1998). The controversy stemmed from the attempts of some clinical scientists to dictate which therapies could be retained as "acceptable" practice and which not.

Critics argued that the task force used very narrow definition of empirical research (Taylor, 1998; Henry, 1998). Qualitative research and case studies have long been a valuable part of the empirical foundation for psychotherapy but were demeaned or ignored by many for whom "empirical validation" equates to "randomised clinical trial RCT" (Koocher, 2003).

Starcevic (2003) was among those who perceive this method as very inappropriate in the study of the efficiency and efficacy of psychological treatments. Evidence-based mental health has treated psychological and pharmacological interventions identically in its search for best evidence of what works in the mental-health field (Parry, 2000).

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[22] They are treatments that are tested with randomized controlled clinical trials (RCTs) (Herbert, 2003; Morrison, Bradley, and Western, 2003). "Randomized controlled trials" are a methodological procedure that compares groups of patients: experimental groups and placebo groups who receive no active treatment, in order to establish the usefulness of the treatment examined.

"This book is a brave and noble stand against the drug lords of modern psychiatry. Over the years Nardone and his colleagues have researched practical and effective ways of helping others without the toxic effects of medication and long-term economic entanglement. His work helps re-liberate the helping professions, freeing them to be active agents of beneficial change."

Bradford Keeney, PhD
Distinguished Scholar of Cultural Studies, Ringing Rocks Foundation

"Logical, clear and brilliant! This book is a must read for every therapist and student of therapy."

Cloe Madanes
Director, The Robbins-Madanes Center for Strategic Intervention, La Jolla, CA

"Giorgio Nardone and his collaborators are leading-edge contributors to psychotherapy. In *Knowing Through Changing* they offer the latest advances in their strategic model, and provide practical examples and easy-to-follow transcripts. This is a therapy of heart and hope that demonstrates that even the most seemingly intractable problems can be ameliorated."

Jeffrey K. Zeig, PhD
Director, The Milton H. Erickson Foundation

"The authors of this fascinating and informative book combine explanation of the evolution and theory of Strategic Therapy with examples of its use in the treatment of many recognized disorders. The scripts given illustrate the technique in a way which will be useful to therapists of all levels of experience. There is also a stimulating discussion of the benefits of Strategic Therapy when compared to more traditional approaches used hitherto in the study of psychotherapy. All in all, this book will be of value to anyone interested in the theory and/or practice of psychology-based therapy."

Ursula Markham
Founder of The Hypnothink Foundation

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