

Evolved Strategies for the Treatment of Depression

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Abstract

The research on Depression, aimed toward constructing effective protocols, has progressed since our last work (Brief Strategic and Systemic European Review, 2004, N.1, 114-124) on both the operative and informative planes. Depression seems to be a pathology based on an extremely rigid precedence that is broken. The depressive Perceptive Reactive System (PRS) is based on a typical Attempted Solution: Renunciation, which intervenes the moment the credence is broken and leads to the formulation of a new credence which is equally firm and dysfunctional. The characteristics of the credence and the modalities by which Renunciation emerges allow us to identify four variants of depression: Radical Depressive, Illusive Deluded by Self, Illusive Deluded by Others, and Moralistic. Intervention, guided by Strategic Dialogue, allows the patient and psychotherapist to simultaneously discover the original credence and its replacement by a more functional credence. By using stratagems, communicative and prescriptive, the patient will be lead down a path in which change does not seem auspicious, but inevitable. For each of the four variants of depression, we have identified logical intervention criteria that suggest the use of more precise strategies and the selection of the most useful and appropriate relational type.

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Introduction

The article published in the first number of the Review lays our groundwork for the development of a specific intervention protocol for depression. Since then, our research has progressed consistently (the ensuing manuscript is now ready for publication) and we refined both our intervention capabilities and our knowledge of the depression phenomenon. We shall therefore refer to the aforementioned article in order to contextualize our research until this point, and will use this space to make a few clarifications.

We wish to here remind our readers of some key concepts that are indispensable for the comprehension of the following:

Depression presents itself as a pathology based on a rigid belief that is broken.

Depressed patients seem to adopt a common Attempted Solution: *Renunciation*, which can be behavioral, ideal, or both.

Renunciation casts the patient in role of *victim*, meaning he who suffers powerlessly.

The patient renounces in that he thinks or is convinced that he simply *lacks* the tools (perhaps he *no longer* has them, or has even *never* had them), all this according to a syllogism of the following type:

I am incapable – therefore I renounce – therefore – I am a victim.

The person, however, can renounce in as many and equally different ways and he casts himself as a victim. These allow us to identify the some variations in the depressive PRS.

Let us remind our readers of the four typologies of Depression identified according to the different modalities of renunciation:

The Radical Depressive (*delegates*)

The Illusive-Deluded by self (*gives up with delegation*)

The Illusive-Deluded by others (*gives up with delegation*)

The Moralist (*expects of others...*)

Credence

Credence is a descriptive belief of a phenomenon that a person considers to be true and is one of the ingredients that contributes to self-deception. Self-deception is the (unintentional) theory that structures one's personal view of the world.

Unlike one might be inclined to think, credence does not influence behavior, for it is in itself driven by various behaviors. Credence is therefore

constructed from a corrective emotional experience. Experiences of the same type, and consequently, repetitive perceptions concur in constructing a particular credence. This in turn activates behaviors, which consequently confirm the credence itself.

Generally speaking, credence concurs in forming a pathological form of self-deception only when it becomes firm to the point when it allows no correction whatsoever. What can start as a simple difficulty can become a problem and later yet a pathology, given the progressive strengthening of the credence. In this sense we can say that the pathology is founded on inflexible credence that allow no margin for “correction.” In the case of depression, we don’t only find a hardening base credence, but – and this presents itself as new – a true “rupture” of the credence in itself. Faced with an unexpected event, unfathomable in virtue of the credence’s rigidity, the credence itself is stressed and breaks: everything that worked up until this point no longer works; everything in which one believed suddenly crumbles. It is not important for the event to occur concretely in itself, whether it be dramatic or traumatic. This can be represented by something that takes the form of a catastrophe, given precisely the fact that it was previously viewed as impossible in light of one’s image of the world. It can also take the form of a Correctional Emotional Experience, (e.g. “I have been betrayed by others”). The rigidity of a credence does not allow for any restructuring, for example, “it is possible, in a given time, that others, or ‘certain’ others, may betray me.” The credence is therefore permeated unconditionally. The person, who at this point is not yet depressed, has only two options: he can renounce immediately, or he can renounce after a series of unsuccessful attempts to reconstruct the broken credence. It is only when renunciation takes the place of any other possible or previous Attempted Solution that the person substitutes his PRS for an PRS of the depressive type. From this point onward, the so-called “initial” credence is replaced by a new credence, equally firm and based on a feeling of incapability and powerlessness. In the four types of depression, the (new) credence seems to present a different value, potentially summarized as “I think” and “I believe.” In this sense, Radical-Depressive and Moralist belong to the category of “I believe,” “I am absolutely convinced that...!” and “I have uncompromising certainties.” The Illusive deluded by self and others belong to the category of “I think,” therefore leaving themselves a margin of doubt. This of course is not irrelevant to therapy. We can summarize everything as such:

Through repeated perceptions of a certain type, the person builds a firm credence and consequently a firm PRS. A “certain something” determines the rupture of the credence and of the PRS.

The person, incapable of acting due to his rigidity and to therefore “absorb the impact,” enacts *Renunciation* as the only possible Attempted Solution. A new and equally dysfunctional credence is formed based on impotence and powerlessness. The new credence can take the form of certainty or of doubt.

Certainty or doubt become key identifiers: the Radical-Depressive and the Moralist commonly express certainties, while those Illusive-deluded manifest doubts.

Renunciation

Renunciation is the Attempted Solution that characterizes all the types of depression we have identified. However, we initially referred to Renunciation as a generalized and total form: that which suggests – and we often imagine – the image of a powerless and motionless depressive bearing the weight of endless suffering.

This modality of Renunciation, that we can term global, characterizes however the more serious and encroaching depressive states. Those treated by psychiatrists more often than psychotherapists, inasmuch as Renunciation is so greatly generalized, that the chance of considering a way out is also involved. Global renunciation exists, however, and what is interesting is that it doesn’t characterize a specific variation of depression, but seems to permeate transversally to all variants and typologies of depressives. This means that a global form of renunciation can manifest itself indiscriminately in any identified variant. We have further discovered that next to this completely paralyzing form of renunciation lies also a partial form. Partial renunciation only concerns one aspect of a person’s life, such as behavioral, ideational or even relational.

This does not mean, however, that the effects of partial renunciation are blander. The effects, understood in terms of suffering, incapability or impossibility, can nonetheless be weighty and cover different aspects of a person’s life. We mean by this that there is a sort of “knot,” a critical area, a point in which the person renounces and where the effects of renunciation can rampage.

Partial renunciation, like *Global renunciation*, is not specific to one variant of depression, but poses itself transversally to all.

It is interesting to note, almost with preventive intentions, how partial renunciation is susceptible to evolve into a global form. Without the intervention of a corrective emotional experience, of anything capable of unblocking something static, partial renunciation will grow and strengthen itself. The same Attempted Solution (Renunciation, in this case) is applied on a larger scale to the point of becoming global, thus also increasing suffering.

Let us identify, even if marginally, some elements that are equivalent to renunciation and that we find quite interesting, such as putting off (procrastinating), not deciding, and waiting.

One point we do wish to dwell upon is the following: Depression, intended as SPR based on Renunciation as Attempted Solution, does not always go hand-in-hand with a depressed mood. From our point of view, the identifying characteristic of depression is the use of a specific Attempted Solution, in its various forms, and not a symptomatic and purely phenomenological assessment of the problem. We are not concerned with how things appear, and while this may compromise the state of one's mood, we are concerned with how the system works. How does the patient construct, project and suffer his own reality and why does he continue to do so.

As a result, intervention will be aimed toward breaking the dysfunctional credence and modifying the Attempted Solution. This means substituting a pathological SPR with a functional one.

The Logic of Intervention

The depressed state is characterized, as stated earlier, by the Attempted Solution expressed in Renunciation and its different modalities: delegating, giving up and expecting of others. Activated by an unacknowledged original credence, such a state can create or recreate a dysfunctional credence that wraps the person in a problem with no exit.

The Brief Evolved Strategic Intervention aims to interrupt the persistence of the Attempted Solution that keeps the person depressed. This is done through strategies, techniques and tactics, each of which carefully molded to a specific clinical variant (Radical Depressive, Illusive Deluded by self/others, and Moralist). In order to reach our objectives, we begin already in the first session using a specific and very effective technique: Strategic Dialogue. This allows us to work on two different levels: that of the pathological structure and that of the operative-informative simultaneously. In the first phase we use questions of illusory alternative and/or interrogative paraphrases that assess time, space and modality. Following, a confirming paraphrase. This allows us

to consolidate our relation and confirm that we are “on the right track.” The strategy used is “winning without fighting.” The questions and answers constitute a different vision of the problem for both the patient and the therapist, and eventually break the credence.

The primary logics guiding the intervention are:

The paradoxical logics that operate in the vein of “saturation,” and are operatively seems in prescriptions such as Worst Fantasy and How Worsening. These prescriptions are supported by strategies such as “Twist to straighten,” and “Fight fire with fire.” These have been especially effective in both cases of “Illusive deluded,” typologies in which we are dealing with I think more than with I believe. The objective is to create an aversion to the Attempted Solution where the Perceptive Reactive System is based on doubt more than rigid credence.

Indirect logics of the self-determining prophecy (such as when we find a strong resistance to change, given the typology of the Attempted Solution or credence such as in the case of the Moralist) or of the certainty like that of the Radical Depressive. In these cases the persistence of the problem is given by the fact that the person “does too little or nothing at all” to change. The logic is therefore add to change: “we change, by adding little.” Prescriptions and language are based on stratagems such as “creating from nothing.” Emotionally strong reformulations (i.e. “Renunciation is daily suicide”), positive connotations, “what if”, positive exceptions and “miracle question fantasy” become the chosen maneuvers.

We might find the need to operate two logics simultaneously, but only if the problem at hand requires us to.

Our language will be evocative in the first session in order to make the problem be “felt” in a different way. We will be more direct and confrontational in later sessions. Therapeutic relationship should always remain outside the symmetrical scheme and be complementary in order for the therapist to lead the person away from his problem.

Variants

Variants, as specified earlier, do not respond to classification criteria but qualify the specificity of the Attempted Solution. The very Attempted Solution, Renunciation, present in all depressed patients, can manifest itself in different ways (compromising, giving up, expecting). As such, credence can also vary, and, once broken, activates renunciation and consequently the depressive PRS (Perceptive Reactive System). Different yet is the moment of

the credence's rupture and its collocation in time, just like the new credence, equally dysfunctional. Defining these variants has proved essential, insofar as we have established that each responds to specific therapeutic treatment because each follows a different logic. Therefore, the techniques, tactics and maneuvers, just like language and therapeutic relation, have been weighed and modified in order to prove most effective in the case of each individual variant.

Radical depressive

This definition has identified a precise pathological type characterized by a certainty ideated by the patient: I am wrong. The most frequent temporal variant is that expressed as "I have always been wrong." This can be a credence the person has constructed throughout his life or through confrontations with others and himself; it can result from systematic attribution, for example, "you have always been like your mother;" it can take the place of an assumption following accidents or illness; it can also result from diagnoses qualifying depression as an organic disease, diagnoses often embraced by this type of persons in that they reflect their ideational logic. Their position is that of victim of nature, in the biological meaning of the word. This monothematic ideation affects mood, which is characterized by nihilism and absence of hope that varies in degree from case to case. The Attempted Solution is characterized by renunciation, not only in doing but more so in thinking, that manifests itself in constant deliberation with whoever lives in the same relational web as the patient. The position is one of expectancy toward others: "I cannot, I do not know how, you go ahead." On the behavioral level we often find significant inhibitions. These can also be partial: the person is not entirely blocked by the problem, while nonetheless maintaining an unaltered type of ideation. We mustn't forget a nurtured physical symptomatology that can be quite specific (for example, and only, "headaches") or else resemble hypochondriac characteristics. The role of victim is the result of the Attempted Solution of renouncing due to the insurmountable "biological disadvantage." The emerging quality of this depressive type is the certainty of a credence that has never been broken. No improvement of the current state, even though it has occurred in some cases, is perceived as a "cure," perhaps even temporary, but always viewed as an unsatisfactory improvement in the direction of an unfounded wellbeing. The PRS is based on control that has never existed.

Intervention

Clinical discourse, conducted with the technique of Strategic Dialogue through questions of illusionary alternative, aims to identify and redefine the problem with the patient. Redefine in order to restructure, in other words, jointly create a new way to read the problem at hand from the very first session. In this case, the clinical objective to break the credence will be pursued following the logic of addition, without ignoring or negating of course the biological nature of the patient's depression. We must seek, on the other hand, to bring the patient to have feelings of lightness among so much rigidity through reformulations, metaphors and aphorisms. The logic of addition means in this particular case adding new ideations and opening the imaginary.. From here, we prescribe the Miracle Question Fantasy to then continue the task of identifying the positive exceptions, if any, and transcribing them for the therapist. In sum, we must shift the attention from the global to the particular, following the strategies of "creating from nothing" and "riding the sky without knowing the sea." If necessary, prescriptions regarding the family-system, like the "30-minute evening show," in which the patient can, and actually should lament his suffering, his unease, his misfortunes etc. The therapeutic relation should initially be complementary with the therapist in down position in order to let the patient roam freely, express his point of view, and only then shift to the one up position of the therapist who begins guiding the session with Strategic Dialogue and therefore takes control of defining the problem establishing doubly functional links.

Example

A young woman approximately thirty years old enters her doctor's office stating, "I'm sorry, but I'm can't control my crying." She moves with some difficulty and claims to suffer from a case of fibromyalgia that often grips her at the knees but in other joints as well. She works as an office secretary and lives with her parents. She has never had a boyfriend; only private fantasies carried out as daydreams.

What problem, specifically, brings you here?

I couldn't say... you see, when I first came in I was crying... this is not uncommon for me: I often become sentimental over things that others seem to be indifferent about. This is happening more frequently now... too frequently. My rheumatologist of five years told me I should come here for help. He says I seem more depressed than usual. It's true: I feel helpless.

Do you feel as though your sensitivity has always made you vulnerable towards others, or has this vulnerability just recently "exploded," so to speak?

I have always been an emotional person, and have cried easily over anything. I have never felt like other people and never partook in my peers' activities as a child or teenager. I have never had a social life outside of school. I have always been a diligent worker in everything, but have led my life almost exclusively alone. I love and feel a great tenderness for my cats... I then became fibromyalgic; some doctors said I could be experiencing the early stages of rheumatic arthritis, and have since been in constant care of many doctors and hospitals. My current rheumatologist claims I am more depressed than usual because I am not taking all my prescriptions. As a result, I have sharp pains that often confine me in bed.

Has your emotional state always impeded you from sharing your peers' interests or have you sometimes tried to partake in their activities?

I was occasionally forced to go to parties, where I always felt like a fish out of water. The only thing I enjoyed doing (and am no longer able to due to my physical pain) was playing the clarinet in the town orchestra. If I am ever invited to go out I always (and rather ably) decline. Now I don't even need to make up excuses because I am physically ill and furthermore... I can't be seen crying like this all the time.

Have your parents always supported you or were you sometimes encouraged to live and act differently?

When I was a teenager they were proud of the fact I never caused them any trouble, but they soon started nagging me about having more friends, about going out to the hairdresser, even... but as you can see, I haven't had a haircut in twelve years! In these cases, my parents are impossible to deal with. These are the only times I really get angry, and then... start crying.

Do you find yourself crying because of your physical condition or is this something uncontrollable?

Yes, I occasionally cry because of the pain, but crying in general seems to be a characteristic of mine. How should I put this... I also cry when I feel well. I'm different from other people. I've always been this way.

R) Please correct me if I am mistaken, but what I have gathered is that your always feeling different has made you an expert, so to speak, in avoiding any sort of confrontation, leading to an even greater feeling of detachment. You no longer need to make up excuses, for your illness gives you a solid alibi. You even occasionally refuse treatment, which sets up a perfect wall of defense against the outside world.

Yes, this is how I am. It makes no sense whatsoever for me, at thirty, to start doing things I have never done. I would never be able to. I carry out my

dreams in open daylight, and thus live how I choose. These daydreams, however, can also be painful... when they end...

R) It would appear as though it is your convictions that have led you to dig the hole in which you have crawled...

Yes, exactly... but you know... one can't do anything against nature; it's not worth the suffering...

R) So it would seem best to give up... If I am not mistaken, you're like the prisoner sentenced to death in Kafka's short story, who prefers to hang himself rather than wait for a death imposed by others!

The patient doesn't answer or even cry. Dumbfounded, she stares at her therapist for a few long seconds... She states laconically: I had never looked at it that way!

Illusive Deluded by self

In this case, the person has *personally* conjured the belief of having made a mistake and the ensuing conclusion is that he is simply incapable. The emerging characteristic is that of having proven one's inadequacy. The person has "proved to himself that he is not who he thought he was." All this can follow a concrete episode that constitutes the "proof" for such condemnation, or else a doubt and its subsequent, inevitable need for explanations that brings the person to a reversed reconstruction of the clues. These can only converge toward a clear and condemning judgment. The position is that of being *victim of myself*; and the process concludes with "this should not have happened." These people, unaware of being perfectionists, are very intransigent and, unable to consider error, when such error occurs it is often and easily mistaken for a catastrophic failure. The original credence was based on a sort of axiom: "I know I am capable." The critical event, whether concrete or the result of deduction, has transformed it into "I thought I was capable. I am no longer the way I thought I was." The broken credence can no longer be reconstructed by hardening the ideational system given by the Attempted Solution. The depressive solution is once again reached by *Renunciation*, which in this case is achieved by a progressive *giving up*. The person, no longer recognizing himself as what he thought he was, cannot find his usual tools to overcome hardship. He therefore begins to *give up*, somehow dragged by a never ending vortex. In these cases we often find *partial renunciations* that when persistent can in time become global.

Intervention

As always, the first step is that of identifying the goal to reach. These patients are often people who would like to change but are incapable of changing. Better yet: they wish to return to the way they were, which is risky, for what came before is based on the original credence “*I am always capable,*” that caused the equilibrium to break in the first place. Strategic Dialogue is once again the tool that will allow us, from the very first session, to lead the patient from a rigid vision to one that allows room for alternatives. Breaking a dysfunctional credence always means passing the obstacle of the Attempted Solution. This variation will often follow paradoxical logic whose goal is to saturate the system to the point of rupture. This logic, based on strategies such as “Twist to straighten,” “Extinguish fire by adding wood,” has its natural application to prescriptions such as “How to worsen” and “Worst fantasy.” “Circular versus linear and linear versus circular” is the strategy that gives the therapeutic relationship its bearings in a subsidiary channel to the point of drawing the patient away from his rigid pathological position.

Illusive-Deluded by others

The characteristic feature of this variation is given by the fact that a specific event, - always related to relationships with others – single and unexpected more often than a series of smaller issues, casts the person in the position of *conscientious victim*. The person, caught by surprise by the event, cannot regain his balance inasmuch as his previous and acknowledged credence expressed the certainty of “*not having problems with others.*” The credence is shattered and the person, lost under the belief of being a victim of others, *renounces by giving up* when faced with his own incredulity. Convinced he has suffered a grave injustice, *he expects of others* the due compensation for the damage suffered. This type of person not only expects, but *demand*s others to return things to their original state. He wants the mindless security of his previous state returned to him. Once the credence breaks, it transforms into a paralyzing state of action: I have been *let down and betrayed* by others. It would seem as though the illusion of not having any problems with others has created a painful disillusion. In this variation we also find, more often than in the case of the Illusive Deluded by Self, Attempted Solutions of the *global* type that cast the person in a state comparable to mourning. His position therefore becomes somewhat nihilistic, and the desired expectation impossible: “things will never be the same.” The wound is thought of as impossible to heal. Auto-commiseration becomes the prevailing feeling,

along with seeking comfort and sharing the position of “victims who have suffered...” Frequent mental rumination and obsessive dwelling over what should never have occurred characterize the ideations of an SPR who is now most definitely depressed in that renunciation is his only enacted Attempted Solution. The previous illusion of control has been inevitably and forever lost.

Intervention

The final objective is to reconstruct a credence that is less firm and that allows the person to make functional adjustments when faced with difficulties. The therapeutic process is aimed, with the tools of Strategic Dialogue (questions of illusory alternative and paraphrases), toward substituting the view “*others have let me down,*” with the view “*I used to believe that others were a certain way,*” therefore redistributing the various degrees of responsibility and blame. By conducting Strategic Dialogue, intervention criteria in prescriptive terms also emerge. In this variation we often find the indication for prescriptions that follow the logic of saturation from strategies such as “Twist to straighten.” The elective maneuver will be that of prescribing “what to do and what not to do, think or not think, in order to worsen the situation further.” If the theoretical paradox is appropriate we can move to the operative paradox, the so-called Worst Fantasy.

Rupture maneuvers can subsequently require a reformulative web in order to fix the terms of change.

Example

A woman of sixty, with a degree in literature, who works in a public school... she carries herself humbly with a slow but cadenced speech, and complains about a state of moral unease with frequent crying episodes. Moreover, she feels in a state of complete loss that causes enough mental confusion so as to make life in the workplace difficult. All this follows the death of her last remaining parent (her mother) just a few months prior. She has never married, and has always lived with her parents while taking care of them. She now lives alone, but has two married brothers who live in her same city and with whom she hints to be having some conflict.

Do you find yourself experiencing these troubles because of your mother’s death or because of your relationship with your brothers?

I’m constantly reminded of my mother, but conflict with my brothers regarding her will have drained me. My parents’ will leaves more things to me since I have always taken care of them. My brothers, on the other hand, wish

to nullify this in light of the law and expect an equal share of my late parents' possessions.

Have you tried to do anything to convince your brothers otherwise, or did you feel too hurt and therefore renounced?

Their stand regarding the matter completely paralyzed me. This all was completely unexpected, as I was hoping to be praised for all the effort I put into our parents' wellbeing. I can no longer speak to my brothers because I start crying if I do. I have given up.

What do you feel more, hurt or anger?

After a brief pause and a hinted smile, she answers: I feel anger. Yes, I am really angry about their ingratitude...

R) Please correct me if I am mistaken, but it would appear as though you are currently a person in great difficulty not so much due to apparent, natural grief you feel for your mother's death, but mostly because of your brothers' ingratitude...

She nods repeatedly.

Would you say that you are more angry with your brothers or with your inability to defend yourself in their regard?

I am leaving my defense to an attorney... I am angry with them because they shouldn't have behaved this way with me...

Have you done or taken anything to alleviate your suffering?

Yes, I've been taking anti-depressants, hypnotic drugs and anxiolytic for the past four months but with no apparent sign of improvement... That's why I've come here...

Do you feel the need to discuss your problems or do you have a tendency to keep these hidden?

I speak about them any chance I have; with my friends, at work and even in the stores where I shop.

When you speak of these problems, do you feel better or worse?

I feel worse because everyone tells me to make a greater effort, that we're all faced with similar issues at some point in life and they go away sooner or later... but they don't! Furthermore, a friend of mine tells me to be hard on my brothers, which I am simply incapable of doing... They are all that is left of the family, they are the ones I should be counting on...

R) Please correct me if I am mistaken, but it would appear as though you feel victimized by your brothers, who are not respecting your parents' "will" (both written and desired). You have given up on their stand: in your opinion this should have never happened... It seems as though you haven't heard of the Latin saying "homo homini lupus!"

The Moralist

The moralist is absolutely uncompromising. His intransigence in his own regards, those of others and the world around him is the result of a rigid moral belief system that produces a personal, severe but inapplicable jurisprudence on one hand, and a just, honest, correct self-image on the other. The thought-process, aimed at persecutory idealities, finds its Attempted Solution in Renunciation, which shifts the PRS towards depression rather than paranoia. His position is founded on an uncontrollable certainty that the patient will rarely even discuss and that seems to reflect the following conviction: *I am right; the world is wrong*. The Attempted Solution shows here an almost paradoxical characteristic, that of *giving up on the practical level*, while *fighting with the thought-process*. The person fights because he *expects* others and the world around him to be different, to his liking, of course! The thought-process is unidirectional and unconditionally tainted with biases, recriminations, resentment and anger, each of these calling for great mental uneasiness.

Here it is not always the case that a firm belief has been broken, which in turn would be caused by a significant traumatic event. More often than not, we find a belief that has hardened disproportionately. This comes to the point when renunciation does not constitute the solution (still in terms, of course, of Attempted Solution), but becomes the control mechanism of an aggressiveness that can well be destructive. In this case we do not find a low self-esteem, but the incapability to enact one's qualities, for *the world is wrong*. Renunciation thus casts the person under the condition of feeling like the *world's victim*.

Intervention

Therapeutic procedure, which as always takes its first steps from Strategic Dialogue, raises the elective indication for a choice of prophetic logics. Questions of illusory alternative, reformulation and metaphors have the function of interrupting the patient's syllogism: "if I am right then others must be right" (this concept is applicable to all other equivalents: I am just, I am honest, etc.) and should lead the person to *add* new ways of observing the same reality. The prevailing strategy that guides the maneuvers is certainly "creating from nothing," which leads to self-deceiving operative strategies. The prescription of "As if" is a direct application of this. It will function to break the effect of the credence's formation and to add to behavioral repertoires. Linked to this will be the "Circular versus linear, linear versus circular" stratagem. This is used particularly on the communicative level as

well as the purely prescriptive one. In this case, therefore, yet another important objective is to break the prevailing symmetrical relationship these people apply to the world, including the therapist, to then be defeated and resort to renunciation.

Example

G. is a forty year-old married man and father of two school-aged children. He has come in on his wife's demand, but also by personal choice given that over the past couple months his mood has swung between moments of strong discouragement and anger. He knows the therapist because his oldest, 11-year-old son remains in her care following an accident playing soccer. After the accident, the child underwent twelve surgeries that could still not prevent the complete loss of an eye. The family spent a very trying year in and out of various hospitals. The wife sees her husband as bossy and reprimanding during the day. Tired and disheartened, he angrily crashes on the sofa in the evenings.

What is the problem, in your opinion?

My son's episode has really taken its toll on me. A lot has changed since then. I used to only get angry when things weren't going well, but that was all. I now find any excuse to lash out against my wife and those who like her seem to have resorted to faith and the church. First and foremost, my father-in-law. All they do is go to church and pray! I fear this is somehow affecting my children, so I take any opportunity to provoke and argue with them, showing them they are wrong. I have nothing to thank God for! I am too tired and too demoralized.

Are you no longer able to confront the situation or has it forced you completely up against the ropes?

I feel so much anger. None of this should have ever happened. We've been struggling with this child since my wife's pregnancy, and now this!

Do you keep fighting on the practical plane or have you completely given up?

I yell and scream, but then I just complain. I sit down and it all ends there. They're all wrong, about everything. What should I do? How can I accept this? I could kill every last one of them...

How do you feel more, angry or powerless?

I have a lot of anger that I unleash on my wife when she tells me I should have more faith. They should all take a good look around themselves! They go on as if nothing were wrong. Nothing has changed not will it ever change.

R) Please correct me if I am mistaken, but it seems as though you're under the impression that people and the world around them aren't working like they should.

Yes, things would be so easy otherwise... Just the other day in the post office people were complaining about letting a disabled person cut the queue. I jumped up immediately and told them they ought to be ashamed. I now know the feeling.

Do you feel as though you're always in the right or do you ever have some reservations?

I can't stand it when things around me aren't carried out. I've got it out with everyone. I can't even watch television anymore without my family turning it off because I yell and scream. I can't handle all the things happening around me, and then I lose all my energy.

Do you feel as though one's destiny holds a fair balance between the good and the bad or do you think you've walked a particularly unfair road?

No, I'm aware that there are people who have suffered a lot in life, but there are also those who have never suffered at all. This is exactly what I cannot stand, things shouldn't be this way. I have so much anger inside.

R) It seems to me that you are angry because you find yourself powerless in light of all this and nobody seems to understand, follow or help you...

Yes...

Please correct me if I am mistaken, but it would also appear as though you're desperately trying to convince others how to do things and wish they could only understand. Unsuccessful, you see yourself like a fish under attack by a flock of seagulls.

Yes, exactly!

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