

Therapy as research, research as therapy¹: the twenty year-old commitment of the Centro di Terapia Strategica (CTS)

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Abstract

This article is a brief overview of the progress of the action research carried out at the Centro di Terapia Strategica (CTS) over these last twenty years. The major shift took place in mid-eighties-early nineties were rigorous yet not rigid protocols for specific pathologies were developed from general models of therapy. Over time specific strategies regarding technique, language and relationship were put together for each specific disorder studied, which rendered brief strategic interventions always more efficient and effective, and replicable in various socio-cultural contexts, by various trained therapists. A specific protocol was also put together for the first session. This research project has broaden even more in these last years, thanks to the collaboration of various affiliated centers around Europe and in the U.S.

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*“Unless you try to do something
beyond what you have already mastered,
you will never grow”.*

Ralph Waldo Emerson

The integration of practice and research has been a major concern and dominant commitment of the Centro di Terapia Strategica (CTS) in Arezzo, Italy, back since 1985. During these last two decades, *action research* has been conducted with the objective of developing advanced models of strategic brief therapy. Our research has been always based on the study of video/audio-taped sessions, which are then studied in detail by the affiliated researchers/therapists under my personal supervision (Nardone and Portelli, 2005).

However one of our most out-breaking results, has been the *formulation of protocols for the treatment of specific types of mental disorder*—mainly phobic-obsessive and eating disorders (published in Nardone and Watzlawick 1993; Nardone, Verbitz, and Milanese, 1999) which were scientifically recognized to show the highest efficacy and efficiency outcomes in the psychotherapy field (87% of solved cases in a median duration of seven sessions).

Back in the mid-eighties-early nineties, our main endeavor was to develop from the general models of therapy, specific protocols of treatment for particular pathologies, i.e. rigorous sequences of therapeutic maneuvers with heuristic and predictive power, capable of guiding the therapist by making use of particular therapeutic stratagems, to break the specific pathological rigidity of the disorder or problem presented. Following this first significant change, the protocols were designed in such a way as to lead the patients to reorganize their perceptive-reactive system toward a more functional balance. The focus of this laborious and prolonged work, applied to thousands of cases in a period of over ten years, was that of *identifying the most adequate ways to solve each of the specific problems studied*. This also led us to new assumptions regarding the structure and procedures of problem solving and regarding the maneuvers related to therapeutic relationship and language. Thus specific treatment protocols were developed, comprising specific maneuvers regarding the strategy, language and therapeutic relationship for each specific disorder or problem studied (Nardone & Portelli, 2005).

Our research proceeds in studying strategies related to the improvement of the *technique, communication, and therapeutic relationship/alliance*

(Nardone, 1993; Nardone et al., 2000). Close examination of everyday practice led us to a better understanding of the studied disorders and to identify specific strategies related to the therapeutic technique, communication, and relationship that led to more always more efficient and efficacious treatment protocols.

These protocols are rigorous yet not rigid, since they are *self-corrective* and adjust to the answers or effects obtained from the interventions introduced—just as in a chess game, after an opening move, successive moves depend on how our adversary plays (Nardone & Watzlawick, 2004).

In a chess game, if the player manages to find moves that reveal the adversary's strategy, he is then able to attempt a formalized sequence that will lead to a final checkmate move. The same takes place in therapy: if an intervention manages to reveal the modality or persistence of the specific disorder, then the therapist can develop a specific treatment protocol that will eventually lead to the resolution of the presented problem.

In brief strategic therapy, the *outcome measurement* is not only carried out at the end of the therapy, but it is held at every single phase of the therapeutic process. Just as in mathematics, we look out for all possible answers to every single maneuver, and then check them out through empirical experimental procedures. Such methodology leads to a narrowing down of the possible answers (to a maximum of two or three for every single intervention), thus in this way allowing us to device the next move for each possible answer. Therefore we proceed to obtain a measurement of the effects and predictive values for every single maneuver, and not just for the overall therapeutic process.

The *systematic process of research* carried out on various forms of psychological disorders turned out to be an important instrument of knowledge. In fact the data gathered during our research enabled us to produce an epistemological and operative model of the formation and persistence of the pathologies under study. This guided us to further improvement of solution strategies, in a sort of spiral evolution nourished by the interaction between empirical interventions and epistemological reflections, which led to the construction of specific, innovative strategies (Nardone and Watzlawick, 2004).

Applied research on our clinical work (Nardone and Watzlawick 1990; Nardone, 1993, 1995a; Fiorenza and Nardone, 1995; Nardone, Milanese and Verbitz, 1999) has enabled us to detect a series of specific models of rigid interaction between the subject and reality. These models led to the formation of specific typologies of psychological disorders, which are maintained by

reiterated dysfunctional attempts to solve the problem. This leads to the formation of what we call a *pathogenic “system of perceptions and reactions”*,ⁱ which expresses itself as an obstinate perseverance in using supposedly productive strategies that have worked for similar problems in the past but that now, instead, make the problem reverberate (Nardone and Watzlawick, 1990).

Thus, the evolved model of the strategic approach goes beyond the nosographic classifications of psychiatry and clinical psychologyⁱⁱ by adopting a model of the categorization of problems in which the construct “perceptive-reactive” system replaces the traditional categories of mental pathology.ⁱⁱⁱ

This goes against the current tendencies of many therapists who had initially rejected the traditional nosographic classifications, but who now seem to want to resume their use. From our point of view, classification is just another attempt to force the facts, an attempt to make patients fit in one’s theory of reference, without holding any concrete operative value.

In light of these theoretical epistemological assumptions, it seems essential to make what we call an “operative” diagnosis (or “diagnosis intervention”) when defining a problem, instead of a merely “descriptive” diagnosis. Descriptive perspectives such as that of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* and most diagnostic manuals give a static concept of the problem, a kind of “photograph” that lists all the essential characteristics of a disorder. However, this classification gives no operative suggestions as to how the problem functions or how it can be solved.

By *operative description*, we mean a cybernetic-constructivist type of description of the modalities of persistence of the problem, i.e. *how* the problem feeds itself through a complex network of perceptive and reactive retroactions between the subject and his or her personal and interpersonal reality (Nardone and Watzlawick, 1990).

On these premises, we affirm that the only way to know a reality is by intervening on it, because the only epistemological variable that we can control is our strategy, i.e. our “attempted solution”. If and when a strategy works, it enables us to understand how the problem persisted and maintained itself. We get to know a problem by introducing change or, as the title of this book suggests, knowing through changing.

This is in line with Lewin’s (1951) concepts of change and stasis. He said that in order to understand how a process works one must create a change and observe its variable effects and new dynamics. On this assumption, we have come to know a reality by operating on it, gradually adjusting our

interventions by adapting them to the new elements of knowledge that emerged.

The *advanced therapy model* is the final result of such an empirical experimental process, guided by models of mathematics logic, which can be continuously checked and verified, and which furthermore, owing to its formalization, can be replicated and didactically transferred.

Finally, such a model is *not only highly effective and efficient but even predictive*. This last feature enabled us to develop an artistic practice into advanced technology, without losing its creative aspect, which is necessary for its ongoing innovation process. All this happens while respecting the criterion of scientific rigor.

Obviously, every intervention has to take into account, and should be tailored to, every single patient. As indeed Erickson affirmed, every person possesses unique and unrepeatable features, such as his interaction with himself, others, and the world. Thus, each case always represents something original. Consequently, every human interaction, even the therapeutic one, is unique and unrepeatable, thus the therapist has to adapt his logic and language to the patient's. Only if the therapist manages to understand the underlying logic and use the "language of the patient", he can proceed to "successfully" and thoroughly investigate the problem presented and its specific modality of persistence. Once the peculiarities of the problem persistence are known, he will be able to use the logic of problem solving that seems more suitable. The therapist can now formulate every single maneuver, adapting it to the patient's logic and language. In this way, the therapeutic intervention can truly maintain its capacity to adapt itself to every new person's peculiarities and situation, while remaining rigorous to the intervention's structure.

The strategy is adapted and mould onto the structure of the problem and its persistence, while the therapeutic relationship and the language used need to be specifically tailored to the specific patient. Therefore, even when we adopt a protocol of specific treatment, as for example phobic-obsessive disorders or eating disorders, every maneuver is always different but it always remains the same, because each intervention undergoes changes in its communicative and relational aspect, while it remains the same maneuver at the level of the strategic procedure of problem solving. So we are calling for rigor but not for rigidity.

So, anticipating the suggestion by Western et al. (2004a) for better research and practice, our premise was always that of identifying specific treatment strategies or protocols rather than entire therapy manuals for each disorder or problem studied. We always considered this to be the sole

functional means that can help therapists tailor their interventions to the particular patient and his/her problem.

As the reader might have gathered so far, these protocols were not the product of spontaneous bursts of genius or great mastery, but of years of research based on everyday practice. Our first works were related to obsessive-phobic disorders but then our clinical studies embraced other issues such as eating disorders, child problems, family problems, obsessive-compulsive disorders, and depression, for which we have designed specific protocols. During this long-term experience we have treated and studied hundreds and hundreds of patients coming from all over Italy and further afield. This confirmed the '*replicability*' of this method (Nardone and Portelli, 2005). Each specific protocol was applied to patients from different socio-cultural backgrounds suffering from specific disorders, and the protocols were effectively applied not only by the great masters or gurus of this approach, but by various trained therapists with varying levels of clinical experience.

Furthermore, another major study carried out at CTS, concerned the first session and how to acquire the maximum with the minimum from the first encounter. In fact during these years of clinical-intervention research, our strive was to formulate a particular process of change-oriented questioning that can help us guide a person through a process of learning that will provide him with the impression of having reached certain conclusions by himself, even though those conclusions have actually been subtly induced by the therapist. This is in line with the Spanish Jewish philosopher and poet Solomon Ibn Gabirol's words, "A wise man's question contains half the answer."

Thus the formulation of this particular model of conducting therapy, i.e. the strategic dialogue, marks the major evolution of the constructivist-strategic approach in recent years.

The model, used in all CTS-affiliated clinics from 1987 to 1995, comprised open-ended questions that followed a more directive manipulative logic of intervention. Resistance to change was overcome with a highly suggestive, hypnotic directive intervention, where the prescription was the apex of the session. With this approach it took two to three sessions to have a more comprehensive description of the perceptive-reactive system, to suggestively capture the patient and overcome resistance, and thus make it to the unblocking prescription.

In the advanced model all this takes place in the first session, by means of a more indirect and subtle mode of intervention based on a self-deceiving logic. This advanced type of questioning conceals an *illusion of alternatives*.^{IV} This is one of the most elegant injunctive forms used by Milton Erickson to overcome in a gentle way the patient's resistance to change (Watzlawick, 1990a; Nardone and Watzlawick, 1990; Nardone and Salvini, 2004). Even though both models share the same objective, the process of arrival changes; the advanced model is very much more efficient.

In the past ten years, our model and the specific protocols were not only used by our scholars in various regions of Italy, but also in other European countries and in the USA. The contribution of these scholars was fundamental in the gathering of good-quality data from routine practice, which helped render these protocols and the over all therapeutic techniques always more efficient and effective. Over the years, this collaboration developed into a sort of practice research network or inquiry community, where exchange of information and data is carried out periodically via Net and during our monthly meetings at Arezzo. We agree with Parry's (2000) promising vision of *practice research networks*. These can generate a great opportunity for bringing together clinicians who work in diverse fields and socio-cultural backgrounds to pool data related to practice outcome, following the same set of measures in order to allow analysis of national or international datasets.

In 2003, following the First European Conference of Brief Strategic and Systemic Therapy organized in Arezzo, a European Network was officially set up to facilitate exchange of data, training, and comparisons between different modalities of brief strategic and systemic therapies, and also between the different personal styles of therapists following the same model. Even though this network is still in the "newborn" phase, various collaborations have already taken off. These works will indubitably be the source of our next research-practice project.

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ⁱ By *perceptive-reactive system* we mean an individual's redundant modalities of perception and reaction toward reality. These are expressed in the functioning of the three independent fundamental typologies of relationship: between Self and Self, Self and others, and Self and the world (Nardone, 1991).

ⁱⁱ We should not underestimate the concrete pathologizing power of psychopathological and psychiatric labeling (Watzlawick, 1981; Nardone, 1994; Pagliaro, 1995), i.e. the "self-fulfilling prophecy" produced by the diagnosis in the person who receives it and the persons around him. Diagnostic labels, being performative linguistic acts (Austin, 1962), eventually create the reality that they are supposedly describing. Moreover, in the field of eating disorders, we also have the problem of the enormous popular diffusion of psychodiagnostic constructs, which has led to a growing emphasis on these disorders. The great interest and alarm that these disorders produce due to continual publicity have made the symptom an important attention-grabbing vehicle for those who suffer from it.

ⁱⁱⁱ In the case of phobic-obsessive disorders (agoraphobia, panic attacks, compulsive fixations, and hypochondria), for example, we observed a series of specific and redundant dysfunctional attempted solutions: the tendency to avoid fear-laden situations, constant requests for help and protection from relatives and friends, and attempts to control one's spontaneous physical reactions as well as the surrounding environment. The relationship with self, others and the world of those persons who suffer from these disorders appears to be completely based on the above mentioned mechanisms of perception and reaction.

^{iv} Illusion of alternatives is a technique that consists of creating a framework where the individual is presented with a seemingly open choice between two alternatives, but which in reality lead to the same effect—in our case, change.

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