

Brief Strategic Interventions for Obsessive Compulsive Disorders: acquiring the maximum with the minimum in the first session

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Abstract

This paper is based on the latest results obtained from the empirical-clinical research carried out by the Centro di Terapia Strategica (CTS) of Arezzo Italy on Obsessive Compulsive Disorders. Our most recent work concerns the conduction of the first session, with the intent of rendering it an always more effective and efficient crucial phase of therapy especially with these highly resistant patients. This paper offers a rigorous yet not rigid tool that help guide the strategic therapist to understand and exploit the seemingly unreasonable underlying logic, and to obtain an always more precise operative diagnosis so as to activate immediate and inevitable change right from the first session.

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*“What hands are here? Ha! They pluck out mine eyes.
Will all great Neptune’s ocean wash this blood
Clean from my hand? No, this my hand will rather
The multitudinous sea incarnadine,
Making the green one red”.*

Macbeth Act two Scene II W. Shakespeare

Obsessive-Compulsive Disorders (OCD) are often described as intimidating cases both by inexperienced and expert therapists because their perceptions and actions seem entirely over-the-lines. The typical perceptive-reactive system of obsessive-compulsive syndromes is maintained by the recurrent carrying out of a specific ritual or rite. Obsessive-compulsive ideas emerge as repetitive fixations which are often unreasonable but from which the patient cannot free himself. The irrational yet compulsive need to carry out a specific ritual is what usually intimidates the therapist, who feels lost and helpless. However, even though obsessive-compulsive ideas and consequent rituals go beyond the ordinary notion of things, they are *not illogical but follow a non-ordinary logic* (Nardone and Portelli, 2005b).

It is important to note that at first, these persons feel that the compulsion gives them full control over a specific situation, but only over time they start feeling that what seemed to protect them eventually is suffocating them. As Samuel Johnson states (1709-1784) <<*The chains of habit are too weak to be felt until they are too strong to be broken*>>. In fact, they come to therapy when they start showing great difficulty in carrying out and completing their daily activities, when their problem becomes diffused and represents a pathological meticulousness that affects most aspect of the individual’s life. Yet even at this point, a therapist cannot come to persuade an OCD patient to stop having obsessions or ruminations or to prevent himself from executing rituals through the use of rationalistic explanation. To be able to change their dysfunctional balance, we need to assume the same non-ordinary logic to be able to devise adequate therapeutic strategies that re-oriented it towards its self-annulment. The patient will only follow if he feels understood and if the therapist manages give him the illusion of holding “a more efficacious way” to manage his needs and reach the purpose of the rituals.

The focus of our first meeting with obsessive-compulsive patients is on creating an atmosphere of acceptance and interpersonal contact in order to acquire power of intervention. Especially with these patients, it is extremely

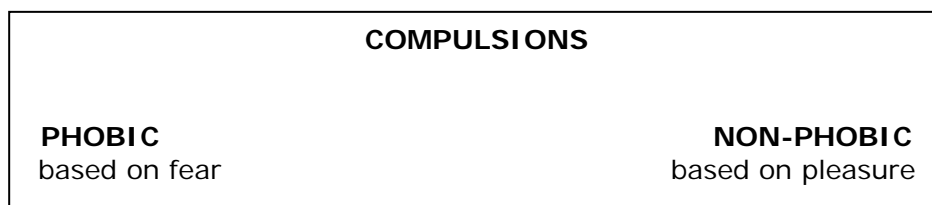
important to support and accept their fixations and their contorted and seemingly illogical rituals (Nardone & Portelli, 2005b).

To do so the therapist must key in the patient's perception and follow the traces of the ritual to reveal the underlying logic of the obsessive-compulsive symptomatology. Only in this way the therapist can have the patient's collaboration to reorient the problem toward its self-destruction (Nardone & Portelli, 2005b).

In other words, therapy needs to follow the seemingly crazy logic that underlies the patient's ideas and actions, by inexplicitly conveying to the patient that what he is thinking and doing makes sense (Portelli, 2005). Then the intervention proceeds by giving the patient constructing an intervention based on the same underlying logic, which fit to the particular case.

During these fifteen years of action research in this field of study, our efforts were aimed in coming to have an operative description of the disorder and to formulate specific intervening-discriminating questions which help us reveal more effectively and efficiently, the underlying logic of the patient and the consequent reactions. Through our study we managed to pinpoint specific discriminating-intervening questions and construct a rigorous yet not rigid protocol for the first session, which subtly bring to light the underlying belief of the specific case while avoiding in upraising the patient's resistance to change. It is important to state that these discriminating-intervening questions are no recipe but are guidelines that help the strategic therapist get in tune with the patient so as to reveal the underlying belief and attempted solutions of the patient, which will guide his choice of suitable techniques, fitting language, and in establishing an adequate therapeutic relationship which magnifies the compliance of these highly resistant patients (Hubble, Duncan & Miller 2004).

A first important discrimination that needs to be carried out, regards the underlying obsession or fixation. The empirical-experimental data carried at CTS in these last fifteen years revealed that OCD hold a perception of reality based either on a *fear or a pleasure*. That is, a compulsion can be carried out either to reduce fear or to obtain a desired pleasure. In other words, compulsions are not only phobic-based but can be dictated by a search for pleasure. This seems to go against various theories that describe compulsive acts as always unpleasant, unwelcome and a reaction to anxiety and anguish (Beech, 1974; Stanford-Clark & Bridges, 1990).



Compulsions based on pleasure such as most bulimic behaviours (bingeing eating or vomiting syndrome) compulsive shopping, sex mania, gambling etc, are often more difficult to stop, this because besides being hooked on a compulsion, which becomes an absolute need, the patient is often very reluctant to let go the ensuing acquired pleasure. If a therapist wrongly assumes that these compulsions are based on fear, his entire intervention will be off beam.

Often there are compulsions which start out from a phobic-based obsession but which on recurrent repetition of an act, the patient might start acquiring some sort of pleasure (Labroit, 1982). An example is self-harm behaviour which can start as a tension reliever but which often turns into a pleasurable transgressive act.

Whether a compulsion is phobic or non-phobic based determines the mode of intervention. Thus it important, that right from the first session, we come to discriminate whether the compulsion is phobic or non-phobic based, so as to effectively start working towards the solution of the problem. The underlying logic determines the intervention (see box).

Another important discrimination is whether the compulsion comprises of repetitive visible actions or else of recited mental formulas, tunes in the head, images or ideas that recur repeatedly at a mental level. Once more this discrimination is important in devising the adequate intervention. The *counter-ritual* should use the SAME DYNAMIC and MEDIUM of the ritual but should render it a much bigger torture. Thus we should not devise a mental ritual to eliminate ritualised behaviour, and similarly mental rituals cannot be annulled through ritualised actions.

To change an uncontrollable phenomenon, one has to pass through the same phenomenon by following its same logic (Portelli, 2004). For example in the case of ritualistic mental formulas repeated compulsively, we have set up stratagems based on the logic of “*killing the snake with its own poison*”. An exemplary case is that of a young woman who came to our clinic reporting that she had fallen victim to a series of ritualized obsessive thoughts. Several times a day, before and during certain actions, mostly ordinary daily stuff, she felt a compulsion to mentally repeat formulas made up of words or numbers.

OCD based on a Phobia

Possible Treatment: (This section will be better developed throughout the article.)

- Interruption of the rite: normally the simple interruption of the sequence of the ritual, creates an EMOTIONAL CORRECTIVE EXPERIENCE which change the perception regarding the necessity of the ritual. The person feels that he can stay without the ritual, i.e., that rite is not indispensable and that he can do other things.
- Overcoming the underlying fear which renders the rite indispensable
OTHERWISE WE WILL NOT REACH DEFINITE/RADICAL SOLUTION OF THE PROBLEM, IT WILL REPRODUCE ITSELF IN THE SAME OR A DIFFERENT FORM.

OCD based on Pleasure

Possible Treatment:

- Render the rite a true torture, by giving the ILLUSION of having found something better that increases pleasure and yet it interrupts the pleasure. E.g. vomiting and the hour interval.
- Render a transgression a given prescription- compulsion loses its significance and transgressive aspect. E.g. compulsive shopping- imposed €20 spending everyday.

PHOBIC RITUALS

ACTIONS
Visible behaviour

THOUGHTS
mental formulas, words, images

This slowed down all her activities and had the effect of mentally torturing her, since she considered herself a very rational person and could not accept the idea of being forced to do irrational things.

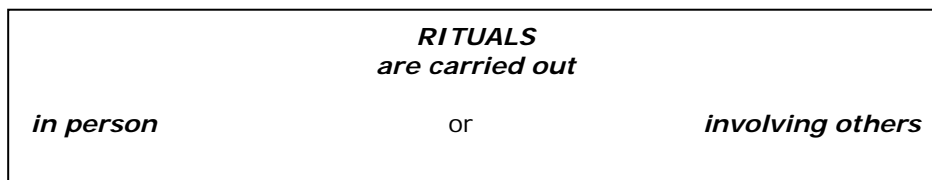
In cases such as this, we use a prescription that ritualizes the ritual, as described above, following a different type of non-ordinary logic. We take possession of the compulsive symptom by transforming it. The young woman was given the following prescription:

<<From this moment until we meet again, every time you feel like repeating one of your formulas, you must repeat them in the opposite way. Say all the repetitions you usually say but do so the other way round. For example, if you feel like repeating the word “man”, it becomes “nam”. So you will repeat in your mind “nam, nam, nam ...” as many times as necessary. If the formula is made up of more words and numbers, the exercise will be more difficult. In any case, you have such a well-trained mind, right?>>

In this way we led the pathology toward its self-destruction, following its own dynamic and passing through the same medium.

It is important that during the first session we come to discriminate whether the person carries out his rituals in person, or whether he involves others. This is a crucial determining factor that dictates the choice of the intervention.

We observed that the great majority of OCD patients carry their rites in person, often asserting that they do not trust others. However, in most severe cases, where the compulsion persists on for at least two years, the situation starts slipping out of hand and often these patients start doubting their abilities and thus tend to ask others for help or reassurance.



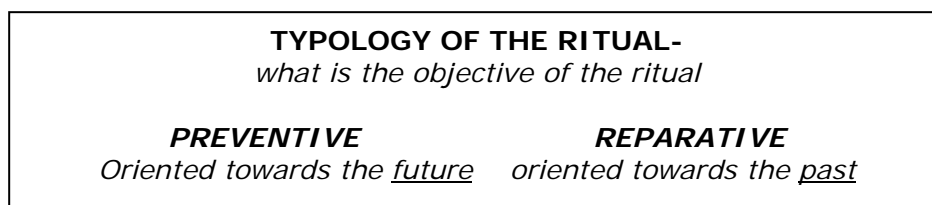
The later, in order to perform the compulsions in the best reassuring way or to avoid getting in contact with the feared situation, they ask relatives for help, who either carry out the rituals on behalf of the patient or else are in charge of checking whether the patients have executed the ritual in the right way. Generally family members help the patient in his rituals, thinking this will alleviate his fatigue and anxiety or because they are forced to and blackmailed (suicide attempts, to leave their jobs, etc) by the same patient.

In both cases, we need to work with the family members, who become *hostage* of the patient. We have to involve these persons in therapy by appointing them co-therapists and

- Either bring them to *actively observe without intervening*
 - or to make them *send back the questions* made by the patients, “*What would you say in my case?*”
 - or *introduce minor sabotages* “Today I do not feel well, please excuse me but I will not be able to help you”, thus following an ancient Chinese stratagem, <<*Lying by saying the truth*>>.

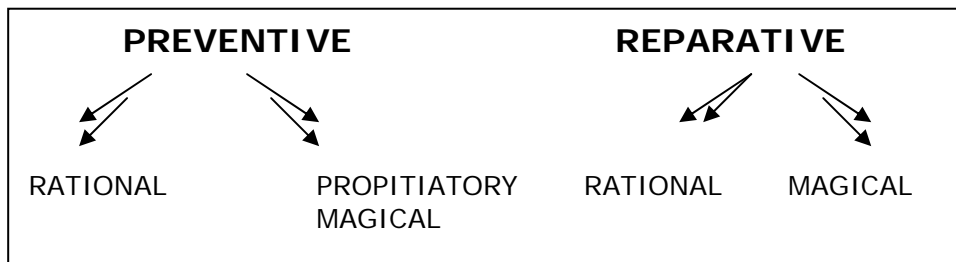
In most cases this is no easy task but it is imperative **to start blocking the family’s attempted solution to “help”** and show them that as Oscar Wilde’s maxim reads “*With all the good intentions we produce the worse consequences*”.

Another discrimination of paramount importance for the choice of the type of intervention regards the typology of the ritual that exposes the objective of the ritual. We have identified two types of rituals: Preventive and Reparative (Nardone and Portelli, 2005).



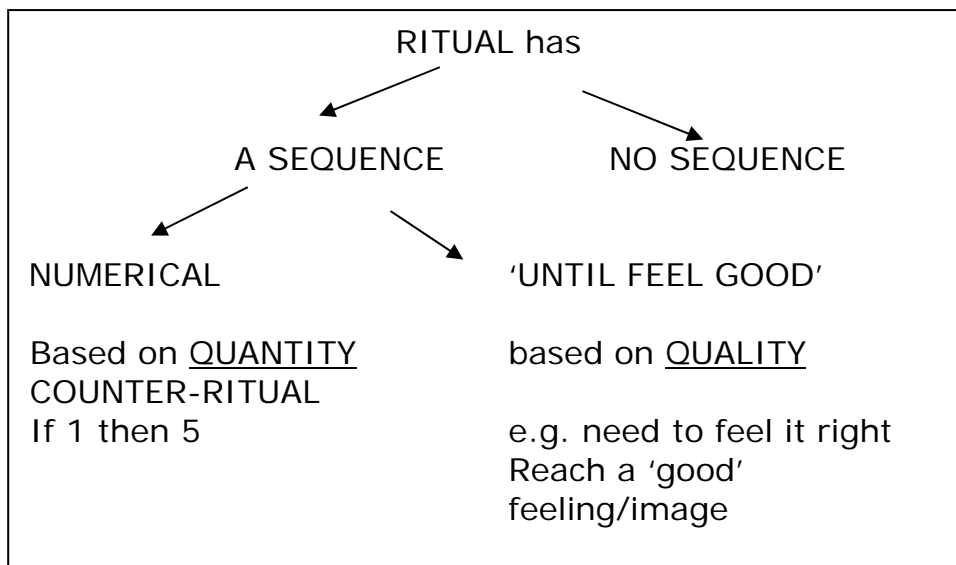
Reparative rituals are carried out to intervene and repair after a feared event has taken place, so that the patient will not feel in danger, and so it is oriented toward the past. Preventive rituals are focused on anticipating the frightening situation to propitiate a good outcome or to prevent harmful consequences; therefore it is oriented toward the future. However, recent empirical experimental results revealed that there are two further variants for both preventive and reparative rituals: rational and propitiatory/magical rituals (Nardone & Portelli, 2005b). Rational-preventive rituals are specific actions that arise from the patient’s belief that doing so would prevent certain feared situations from happening, for example getting contaminated or infected, losing control, losing body energy, and so forth. The other type of preventive rituals is a form of magical thinking highly linked to fatalistic religious beliefs, superstitious convictions, confidence in extraordinary powers or faith, and so

forth. Even reparative rituals can be rational, i.e. follow common sense, e.g. washing one’s hands when they feel dirty but they can be even magical and highly irrational, e.g. carrying out a certain dance-ritual to purify oneself.



In certain cases the same ritual can be both repairing and preventive. Our action research revealed that in such cases the ritual often have no specific sequence. We noticed that in such cases, a counter-ritual was not enough to subvert completely the perceptive-reactive system of this particular patient. These resulted to be those patients (10-15% of the cases) whose problematic got better but was never completely solved.

However the great majority of cases treated at the CTS from 1990-2005, did have a sequence, which was either *numerical* or *analogical* (or better until a feel good feeling/image is reached).



When the ritual holds a sequence, that is based on the SEARCH FOR QUANTITY and thus is numerical, the intervention proceeds in giving the patient a specific numerical pre-set counter-ritual, which fits the particular pathological obsessive compulsive ideas and actions.

For example, if the compulsion is that of checking for a number of times something, so as to be sure that it was done correctly, the prescription, using the numerical logic of the pathological control, will be that of making the patient carry out his checking exactly a prescribed number of times, every time he feels the need to check.

"From now to the next session, every time you perform a ritual, you must perform it five times- no more and no less. You may avoid performing the ritual at all; but if you do it, you must do it exactly five times, no less, no more. You may avoid to do it but if you do it once you must do it five times...". The logical structure of this ostensibly simple prescription is that of an ancient stratagem: <<lead the enemy up the attic and then remove the ladder>>. The way the prescription is communicated is of paramount importance. The communication is based on a redundantly repeated, hypnotic linguistic assonance and on a post-hypnotic message, expressed in a more marked tone of voice.

The structure of this maneuver reads, if you do the ritual once, you have to do it five times. The prescription inexplicitly implies, that the therapists acknowledges the need of the compulsive ritual but at the same time it is him/her who is now in control by saying how many times it has to be repeated. Furthermore the therapist gives the "injunctive" permission to avoid performing the ritual.

In this way the therapist assumes the control of the performance of the ritual. The patient was before forced by his phobia to carry out his rituals, now he is impelled by the therapy to do so. This means that the patient indirectly acquires the capability to control the symptomatology instead of being controlled by it. If we manage to achieve this by means of the prescription, the patient will start to question his perception, that of being absolutely possessed by his phobic obsession. The fact that he is now capable to control the previous pathological actions by following the therapeutic indications means that he could arrive to a point to even stop them. And usually, this is what happens. Most often, patients come back to the following session declaring to have literally stopped performing their rituals, because to do so meant having to repeat it for 5 times. They report that doing their rituals got really boring and they confess that strangely they did no longer feel the need to perform them to reduce their fear, cause the fear did never presented itself.

The rationale behind this effect is that of assuming the same logic of the persistent pathology. We have managed to drive its force against itself by means of specifically devised stratagems. In this way, we have made the patient undergo change without any efforts that go against his previous position, by simply utilizing a counter-ritual to break up the 'self-feeding dynamic' of the disorder. This technique helps the patient in regaining control over the symptom (Portelli, 2004).

On the other hand, when rituals are based on the SEARCH OF QUALITY, if 1 then 5 does not work, thus we need to construct a COUNTER-RITUAL that is more efficacious and less time-consuming. But the therapist should keep in mind that if the counter-ritual is too complex and time-consuming, the patient will opt to continue with his ritual.

To construct a counter-ritual *ad hoc* for a ritual based on the search of QUALITY:

- *The strategic therapist should follow the same underlying logic, by following the traces of the ritual to construct a counter-ritual that fits.*
- *The counter-ritual should subvert the ritual from within.*

If the ritual is too complicated and elaborated to describe, we invite the patient to study the ritual. “*In the following days, I would like you to pay attention and measure when you reach the ‘feel good’ sensation...*”. This is not only DIAGNOSTICAL but also INTERVENTIONAL task since it brings the system to a short-circuit. By making the person shift attention from the ritual onto the search of quality/ measurement parameters, we dismantle the entire system. By giving the person the impression that we need to study his ritual better so as to intervene more effectively, we make him concentrate on the task of measuring the sensation, and this blocks him from eventually reaching the ‘feel good sensation’.

As mentioned earlier, 10-15% of the cases treated at CTS, those more resistant to change, presented compulsions without a specific sequence. Often when the ritual has NO SEQUENCE but follows a CONCEPT/ IDEA, they entail both preventive or reparative. However there always seems to be a prevailing preventive ritual. In such cases we noticed that rather than a specific sequence, there was *an objective that needed to be reached and then maintained so overtime*, e.g. protect and maintain one's house clean, protect and maintain a relationship 'pure', avoid contaminating the world, etc. Thus, in such cases treatment changes. Since it does not have a sequence it is useless to prescribe a **counter-ritual with a sequence** because it can in no way function. One can not ask a person who needs to keep the house clean, "if you clean it once, clean it five times"- is practically impossible and not effective. In these fifteen years, this type of problematic got better but was not resolved (Nardone, 1996). Empirical experimental results made us recognize that in such cases we had to act on their underlying belief, which could be fear of dirt, fear of contamination, etc.

For example a patient who fears contamination, will continuously wash, clean, and sterilize themselves, their houses, and other belongings to prevent them from being infected or contaminated. Their objective is to reach total, perfect cleanliness or sterilisation and thus, when this state is reached, they need to clean and clean to maintain it so.

Even though they state that their biggest fear is dirt, paradoxically, it is when everything is totally clean, totally sterilized, that fear of contamination starts to grow and thus elicits the need to carry out the compulsive rituals. In such cases working on the ritual is not enough; we have to work on the underlying fear which is triggering these preventive and reparative actions.

In such cases, we should start raising doubts in the patient regarding the underlying fear. Through the use of the strategic dialogue (Nardone, Salvini, 2004) we should make the patient question whether he should really fear complete cleanliness rather than dirt: "*When does the problem eventually raise, when you are dirty or when you are totally clean?*" Usually, the first answer is, "When I'm dirty." But when asked, "*When do you feel you need to carry out your rituals, when you are a bit dirty or when everything is spotless and you have to protect and safeguard it?*", the patient starts having doubts, because he eventually needs to remain clean when everything is spick and span. Moreover the patient is lead to reflect on certain dynamics which are often left unnoticed. "*When are you more tensed when you are outside surrounded by dirt or when you are home and you need to keep everything perfectly clean?*". Often patients reply, "*Well, tension arises once I'm home*

and need to keep everything under control". Thus the patient is lead through a series of question with an illusion of alternative, which brings him to a self-discovery which goes against all that he has believed in so far. At this point we introduce a reframing paraphrase to better emphasize and redefine this self-discovery (Nardone & Salvini, 2004).

"In other words, correct me if I'm mistaken, your fear arises mostly when everything is perfectly in order and clean, because it is then that you have to maintain it intact, true? Therefore in reality, you should fear more total cleanliness rather than dirt."

Through the use of the strategic dialogue which is an argumentation based on *seeding doubt*, we start reframing the patient's rigid perception and reactions, while we start preparing the patient to comply with the idea, that to become immune to dirt, he should not search for total cleanliness but the very opposite, he should start introducing "a small disorder that helps maintain order".

If we had to prescribe a small risk or disorder without arriving to this discovery together with patient, there is a big chance that the patient will not follow the prescription. The prescription should be a jointly agreed-upon discovery reached through a dialogue which puts <<fear against fear>>. The person comes to understand that the only way out is to introduce "**a small disorder that maintains order**"(Nardone & Portelli, 2005b).

So through the use of the Strategic Dialogue, we drive the patient to a state of confusion, which helps us alter and change his/her rigid perceptive parameters. In otherwise following the stratagems "*To take the enemy up the attic and remove the ladder*" (Nardone, 2003) *together* with "*To muddily the waters to make the fish swim to the surface*" (Nardone, 2003) we create a state of confusion and bring the patient to accept something he/she would have never accepted through the usual use of rational explanation.

Thus at this point the prescription "A SMALL DISORDER THAT MAINTAINS ORDER" becomes a consequence, a continuation of the strategic dialogue, because a little bit of dirt seems the only way to protect the person from total cleanliness which is responsible in increasing the person's fear.

<p style="text-align: center;"><i>CHANGE IN PERCEPTION</i> <i>FEAR OF DIRT --> FEAR OF TOTAL CLEANLINESS</i></p>

So the prescription will read <<*Thus following what we have said so far, from now to the next time we will meet, I would like you to carry out an experiment. Everyday you should deliberately touch with your finger something dirty, something you know is dirty and then touch something within the house which should be kept dirty for five minutes, not a minute more, nor a minute less. Once the five minutes have passed, you are free to wash the chosen object the way you want. But for five minutes, not a minute more nor a minute less, you need to keep something dirty within the house. Five times for five minutes a day, OK?>>*

POSSIBLE PRESCRIPTIONS:

Thus every time you feel like cleaning you should be afraid of reaching TOTAL CLEANLINESS

- *By AVOIDING REACHING TOTAL CLEANLINESS*
- *or By INTRODUCING A BIT OF DIRT IN THE ABSOLUTE CLEANLINESS*

Both these possible prescriptions indicated in the box above, follow the idea that, in order to become totally immune and in control of something, one should not avoid or prevent it. On the contrary, one should start to take and endure it in small doses until there comes a day when it will have no effect on one. In other words, we render FEAR a RESOURCE and NO longer a LIMITATION (Nardone, 1996).

We observed that, in the majority of the cases, by simply redefining the situation and setting a series of concrete emotionally corrective experiences, the patient is brought to break free from his attempted solutions and his rigid self-feeding perceptive-reactive system (Portelli, 2004).

By introducing a bit of dirt in total cleanliness or better a small disorder to maintain order, we subvert completely the rigid perception and consequently alter the usual reactions. In line with Thom's theory (Butterfly effect), we can say that we set a small change that triggered off a chain reaction of further changes. If the therapists manages to carry out this manoeuvre, his intervention becomes a one-session therapy, then an avalanche effect will follow.

Thus in conclusion, it is important to underline the fact that what has been described so far is an on-going self-correcting protocol for the conduction of the first session which aims in giving the therapist guidelines to help him understanding and consequently exploit the underlying logic, so as to construct efficient and effective treatments for these highly complex and resistant patients. It is imperative to note that especially with OCD patients who need to feel in constant control, the chosen intervention should trigger an immediate and inevitable change (during or soon after the first session), otherwise they can easily lose faith in the therapist and thus withdraw from therapy. This further supports and validates our constant concern and commitment in achieving an always more efficient and effective first session, by arriving to a significantly 'accurate-enough' operative diagnosis, which allows us to start introducing change. As we, in line with Aristotle words, believe that "A good start is half of the work".

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