

## **The advanced strategic language and communication in paranoia case**

Branka Skorjanec <sup>1</sup>

### **Abstract**

The language, the rhetoric and the global therapeutic work (in other words, *what* to say and *how* to say) should be adapted to the logic of the problem functioning. This is exactly what the brief strategic therapy is applying in the last ten years. Every problem is unique and must be afforded with specifically constructed protocols. Many protocols have been already divulgated, the following one is an example of how to synchronize the strategic work with the particular functioning of the paranoia.

<sup>1</sup> *Affiliated Psychotherapist (Bassano del Grappa-Veneto)  
at Centro di Terapia Strategica (Arezzo)*

## Introduction

A strategic therapist considers problems/pathologies as a consequence of failed attempted solution. These repeated unsuccessful solutions distort progressively the construction of real (patient's perception/reaction system).

One of these attempted solutions, which we find in almost every problem/pathology is **the excess of control**. The excessive control may be internal (thoughts, actions, "I am worthless") and external (context, persecution ideas, "the others hate me"). If we consider the excessive control as a *fil-rouge* in evolution we can compose a range of symptomatic situations, due to the level of complexity, from the minimum (e.g., a simple phobia) to the maximum (e.g., the paranoid doubts and the paranoia). So the paranoia is considered by the strategic therapists as the most exasperated point of control. Unfortunately, it's more and more frequent as the person become more expert in controlling.

## What is the paranoia?

As mentioned elsewhere, **the more one controls, the more one loses control** in different ways and forms. This means that the therapeutic approach should be modified depending on the specific problem. The work adopted for a phobia case does not function at all with a paranoia case and vice versa, so we must pay a lot of attention in order to prompt a perfectly suitable protocol according to the specific patient and/or problem. This means considering three directions:

- A – techniques (the practical pathways)
- B – communication (synchronizing with patients' expectations)
- C – relation (the emotional distance/closeness).

**The higher we get on this complexity scale, the less important the strategies are and more important the communication and the relation become.** In our case, if we don't establish a very good relation with a paranoid patient, he/she might perceive us as untrustworthy people and the therapy might be experienced as a persecution.

The basic feature of the paranoid functioning is that the patient does not doubt any more, is exclusively sure. Adamantine. His/her way of thinking is actually correct and rigorous. However, starting up from erroneous

assumptions it brings to delirious ideas that entrap progressively. The main difference between a schizophrenic and paranoid patient is that the first one *creates something out of nothing* and the latter starts from a very small nucleus of truth that soon becomes enormous. A sand dust becomes a mountain.

The behavior and the perceptive system of the paranoid patient evolve in two very different directions:

1 – patients may renounce to life experiencing that it is too difficult to cope with it; they have no more reactions, no more attacks. In this category the **depressive** aspect is predominant;

2 – they start to react extremely aggressively as a *fearless warrior* would. Here **aggressiveness** is dominant.

These characteristics should be understood before operating the first therapeutic maneuvers because the protocols are quite different.

### **The techniques**

Often in brief strategic therapy we can find “magic” prescriptions which interrupt the problematic situation in very short time but this is not the case with the paranoid patients. The prescriptions are few, simple, minimal, we work always in accord with patient on very small steps as **the really important thing is the relationship** and not the prescription.

First of all, we must interrupt the failed attempted solution of the people surrounding the patient, who normally try to “correct” the paranoid ideas of the patient, by asking them for a **complete silence** about all arguments. Then, we give the patient the **space** to pour out the ideas, either with the help of the family (he/she talks and the family listens) or, in case of lack of family, by asking to write down all ideas whenever, whatever and as much as he/she desires or need to. After that, we ask him to behave once a day in a single and very small occasion “**as if**” he/she deserves something (internal control) or “as if” the others appreciate him/her (external control).

### **The relationship**

The depressive paranoid patient wants the complicity with the therapist and the full acceptations of his ideas. The therapist should stand aside him/her “accepting” and, as the Blaise Pascal’s rhetoric teaches us, adding continuously small elements to these delirious ideas and changing them from

the inside. Small changes that **underline the structure** of the thoughts and not the semantic content; the rule is : amplify in order to offer more and other contents. Metaphorically, *push the struggling swimmer down in the water to make him go up to breath.*

The aggressive patient is a real challenge for the therapist (literally and not only metaphorically). If the therapist plays fearfully, he risks even the aggression. First of all, the therapist should establish a clear command, that he is the one to lead, no doubt about that, from the very first moment of the therapy. We must understand that the person having persecution ideas is aggressive with all the world *including* the therapist and in this protocol, exceptionally, **the symmetric relationship should be actively imposed**; in this case, the winner is, and must be, the therapist. Why? Because it is exactly what the paranoid patient expects from the therapist. These are the “barracuda-patients”: if the therapist escapes or seems hesitant, the barracuda bites and the therapy (and patient) is lost. It’s absolutely necessary to cope the patient and make him **feel** (experience) that the therapist does not fear him/her.

Starting the therapy with emotional experiences instead cognition, is once again a typical way of working of the brief strategic therapy: a small emotional experience triggers bigger changes.

### **The communication**

As mentioned, the communication should not be the simple mirroring and/or the use of the same words of the patients but the **synchronization of the therapeutic work to the rules and the logics of the problems**. This is valid for both, verbal and non verbal languages.

As far as the *non verbal language* is concerned, we treat depressive paranoid patients in a quite soft, reflexive, fluid way. With the aggressive patients a voice should be tough, clear and calm, the posture of the therapist should be typical of a self-confidence person with no fear and the eye look should be fixed, challenging and located in the middle of the eye; the patient must feel won down. Contrary, if the therapist has not this power, the patient would not feel him as a good leader.

A person with persecution ideas should not receive compliments; contrary, every achieved step should be judged as “insufficient” .

The *verbal language* is quite complicated as it is based on logic of paradox and on logic of contradiction (the paradox is the presentation of two contrary assumptions at the same time and the contradiction is the presentation of two contrary assumptions in temporal sequence). By combined use of these

logics, the therapist acquires a communicative power over the patient. The rule is: follow the paradox with the contradiction.

Example of the communication:

**The patient** (challenging): ...*I don't believe you can help me....*

**The therapist:** ...*neither do I, probably I will not be able, better said, I am even more skeptic that you are (**paradox**) but you must do what I ask you (**contradiction**)...*

The particularly aggressive attitude must be “destroyed” verbally, the words affording this aggressiveness should be direct, sharp and clear such as in example: ... *you try to be terrifying but result just fearful like a snake biting itself, like a dog barking because fearing someone.....*

The difficulty of this communication is the continuous high attention of the therapist and the **coherence between the verbal and non verbal languages**. If correctly established and played the effect is the power in the therapy. This is possible exclusively through permanent training of the therapist and far away from considering the therapist as a shoulder to cry on.

## **Resume'**

The example of the paranoia case is an excellent application of the flexible strategic way of working where the therapist starts up not from a previous theory but builds up the theory through the therapeutic process adapting it to the logic of patient's problem, to his way of acting and his language, passing through emotions, actions and cognitions (in this order).

## **References**

The above work is extrapolated from the clinical work of Giorgio Nardone and mentioned during several seminars addressed to the affiliated strategic therapists in last five years.

*Address reprint requests to:*

Branka Skorjanec  
Brief Strategic Center of Arezzo;  
[skorjanec2000@yahoo.it](mailto:skorjanec2000@yahoo.it) [skorjanec@hotmail.com](mailto:skorjanec@hotmail.com)  
[www.terapiastrategicaveneto.it](http://www.terapiastrategicaveneto.it)