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FIRST DAY

From psychiatric diagnosis of pathologies to the identification of perceptive reactive systems that maintain the problem

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The first part of my presentation won't be purely theoretical but... applicative methodological. That is what has evolved in the last twenty years at the Centro di Terapia Strategica di Arezzo thanks to the collaboration, firstly, with Watzlawick, Weakland, De Shazer... Camillo, Zeig, with the goal of achieving not a descriptive knowledge of the problems of pathologies but, rather, an operative knowledge. This is a fundamental concept. When Ernst Von Glasenfeld, who defined the term constructivism, radical constructivism, points out the need to substitute the illusion of truth with the operative construct of operative awareness, he is showing us the way, the idea that intervening means practically doing things with ourselves and with our patients. Being aware of our being operative, of our capabilities, as being aware of how a certain class of problems function, makes our work better, more focused, more technological. When I speak of technology I wouldn't want you to misinterpret it as a cold reductive view of what is, instead, the diversified and warm human relationship when they interact; by technology I mean an advanced method, with effective and efficient techniques that can be transmitted. A method that, as in a chess game, allows us to foresee the possible reactions to our moves, allowing us to be predictive, to make a move and anticipate, in a limited array of possible reactions, and have a counter-move ready depending on the person's response. This has been an important aspect of my work, since 1985, when under the direct clinical supervision of John Weakland at the MRI, I started studying phobic-obsessive disorders by looking at the nonfunctional solutions. This means using the solution as a key to understanding a problem, and when I'm able to replicate it on a significant number of people who have the same class of problem, it becomes something predictive. When the solution that solves a problem is able to solve the same problem for many different people, in different situations, I can devise predictive intervention instruments, that are effective and efficient. This is what a technological method does, and it's what has allowed technology to take a man to the moon, using an experimental method which doesn't rely on why the problem exists, which is not based on complexity but on what functions. This is what great people in history have done, Leonardo da Vinci, Edison...

When we look at a person with a pathology, we are looking at two logical levels that interact, we are here very thankful to Russel, we have the logical level of interaction, the patient's originality, the originality of his family history, of his language... to which I must adapt. We are here on a level of non-prediction, of non-repeatable. It's a constant originality, every person is different from another, every context is different from another. But if we move to the level of the problem, of the structure of the solution, we then can identify how certain pathologies have a structure that repeat itself in different people. Therefore, at the level of the structure of the solution we can devise strategies that are

¹ Translated by Ranieri Brook Barbieri

applicable to problems that function in such way, in different persons. In this case we comply with the intervention's adaptability to every individual, and at the same time we are able to devise rigorous and more technologically advanced intervention plans. Let's start with some concrete examples. When, in 1985, I started studying the first group of phobic patients, I used the MRI's intervention model. I observed all the patient's attempted solutions to devise a focused intervention. Shortly after, what emerged was what I now call an operative diagnosis of the phobic disorder. For example, those who suffer from panic attacks have three recurring attempted solutions: a voluntary attempt to control their physical symptoms, controlling their breath with the paradoxical effect of increasing it; they have an attempted solution of avoidance, avoiding situations where the problem can emerge increases their sense of incapability; and third, a search for help and reassurance, surrounding themselves with people who can intervene, help, who are available to play the role of savior. This has made it possible to devise stratagems *ad hoc* for this type of problem. This allows me, in the second session, to have a set of aimed questions that discriminate if the person belongs to this class of problems or to a different one. Obviously, there is the need to adapt the way of posing questions, the type of relationship, to the particular individual and to his contextual situation. Therefore, it's the same questions that need to be adapted to the person in front of me, they change on a relationship level, they remain the same because they suit the structure of his problem. The same intervention-research modality has been applied, through the years, to many pathologies. Using solutions that worked on at least 100 cases, with 70% of effective interventions, therefore with effective solutions, we have been able to devise the desired strategy, that also describes how the problem functions on an operative, cybernetic, constructive level. Hence, other than a phobic person, who carries the fundamental strategies of control that leads to a loss of control, of avoidance and of a search for help which will become the focus of the therapeutic intervention, we could have an obsessive-compulsive who might seem like someone who has panic attacks, because of the presence of panic attacks which, though, have a completely different structure because of the enacting of rituals. The rituals have the initial purpose of reassuring him, but after being repeated they become something from which he can't free himself. We would then have an operative diagnosis of a perceptive reactive system, as we call it, based on the person's avoidance of critical situations with the fundamental enacting of rituals, which at the moment reassure him but then reconfirm and nourish the problem. The intervention, in this case, will have to block the rituals so to block the dysfunctional relation between ritual and phobia. Otherwise there will be no access to intervene on the rest. The construct of perceptive reactive systems has become particularly important because it's a sort of cybernetic technological modeling of the redundant models, of perceiving and reacting to reality, present in the many cases we have studied. These initially functional attempted solutions are now rigid in space and time and start to not work, but people keep enacting them structuring a, just as rigid, pathology. If we think of diets, a very socially relevant thing, we see an attempt of controlling food intake to reduce weight and be slim. The American Psychological Society published a very interesting research where the sample was studied for 5 years, therefore a longitudinal research, with thousands of people following a diet and thousands of people who weren't on a diet. After five years 80% of people following a diet recorded a weight increase of 30%, this means that "following a diet makes you gain weight". Those who don't follow a diet keep their original weight. That is the perceptive reactive system of those who follow a diet? It's the idea that I should control the food intake, control the amount of calories, control the type of food; I try to hold myself back, hence producing a transgression effect. The more I forbid myself a certain food, the more I will crave it, the more I will end up eating it. Or I produce the rebellion effect: the more I limit myself the more something inside me rebels conducting me into doing it. Or the surrendering effect: seeing as I can't follow a diet I surrender, I let myself go and become obese. Therefore the construct of the perceptive reactive system is something that can substitute the psychiatric nosography.

What is the difference between the DSM IV, and the European ICD 10, and a sort of classification

based on perceptive reactive systems? They all seem to be classifications, but, the psychiatric one gives us a sort of photographic image of disorders without telling us anything about how to change them. A classification based on pathogenic perceptive reactive systems, by describing how the problem is maintained, tells us which are the advantageous leverages for producing a change. We have on one side a sort of photograph and on the other a moving image; on one side we have the movie of the interaction between a person and his reality, on the other we have a presuming objective still image, which I must say, often doesn't even fit the disorder. We have two extraordinary examples regarding the last DSM. One regards the social phobia: did you know that the MIT, the Massachusetts Institute of Technology, more than a year ago, conducted a research to verify the criteria through which the DSM's diagnostic labellings are constructed? This study demonstrated how research that lead to the devising of the criteria are completely inconsistent and follow erroneous methodologies, nevertheless they have great power due to financing by pharmaceutical companies. More than 80% of institutions that take care of constructing the DSM's diagnostic criteria are financed by pharmaceutical companies. Unfortunately this is a problem over which we have little intervention power but that it's important to be aware of, it's important to know why certain classifications are far from what we operatively see in our profession. It's interesting to read the criteria of social phobia, what was once called shyness has become social phobia; seeing as it's social phobia and it's part of anxiety disorders, it leads to depressive symptoms and, how incredible, it must be cured with a predominantly pharmaceutical intervention. The second example regards eating disorders: a very critical field for diagnostic criteria. We notice how the DSM IV still reports the two traditional concepts, anorexia and bulimia, without considering all the different evolutions of eating disorders: eating to vomit, vomiting disorder, binge eating... are all still considered accessories by the DSM, as if they were the problem's exception while, instead, they are the rule.

The perceptive reactive system allows to precisely study the procedures an individual puts into action with regard to his pathology, these are what feed the pathology, that nourishes it, therefore becoming the leverage point for introducing the therapeutic change. When we were studying vomiting disorder... called bulimia nervosa, term that I have always questioned because it means "hungry like a bull" but no one has ever seen a bull eat and vomit, whilst those who eat and vomit actually vomit, therefore the term vomiting syndrome... we applied to this disorder solutions that worked with bulimia, those who have a compulsion towards uncontrolled eating, or anorexia, those who have a tendency towards abstinence, and they didn't have any effect. We were forced to think that if the solution doesn't work then it doesn't even describe the problem. We needed to find a different way to understand this problem by its change, therefore, we started thinking that the main difference between those who eat and vomit and those who have an irrepressible compulsion towards food is that: while for those who uncontrollably eat, pleasure lies in food and for those who abstain pleasure is in abstinence, for those who eat and vomit the pleasure is in the sequence between appetitive and consummatory fantasies, the blowout and the vomit. This type of observation led us to think that the perceptive reactive system was no longer the same as the other two pathologies: although initially based on the two pathologies, it had become an emerging quality, as water is related to hydrogen and oxygen, something that requires a completely different intervention. Therefore, it's not a coincidence that if it's the sequence that gives pleasure the situation will be changed by an intervention that breaks the sequence. We decided to ask our patients... this is the hardest thing to have them do, hence, the language, the adaptation to each individual, the ability to influence, the hypnotic suggestion and the work on the family's dynamics are fundamental... we asked them to comfortably keep eating and vomiting but to accept the rule that: once they were filled up and ready to run and vomit they would have to wait for an hour, and only after one hour they were allowed to vomit; breaking the sequence. This immediately demonstrated how the intervention led to incredible changes of the pathology; by increasing the intervals, in the following weeks, passing from one hour to two, three hour intervals, most of the people stopped vomiting with a three hour interval and 50% of cases usually stopped after just one hour. This means that the solution is

effective and that the solution is capable of describing the problem. Seeing as this protocol was devised 10 years ago, we have now applied this solution to thousands of cases and the technique works. This demonstrates that the perceptive reactive system of those who vomit is based on their incapability to control this pleasurable sensation that demands them to fulfill the eating and vomiting sequence. An important aspect is that this type of operative classification is also resistant to a transcultural application. This method is currently being applied by colleagues and students in different countries and it is successful even in distant cultures. This means that pathologies are isomorphic, at the level of the problem's structure, in different cultures; obviously the communication and context level of the therapeutic intervention will need to be adapted to the different cultures. Therefore, the attempt of a diagnostic classification based on perceptive reactive models as an international concept that can substitute rigid nosographic conceptions. It mustn't be a new rigid model but a guide line for tailoring solutions that work with different persons, in different contexts, in different situations; otherwise we risk putting together a cookbook of recipes that are tout court applied and therefore fail. This usually creates resistances in the field of systemic approach: the traditional systemic and strategic perspective is to flee any kind of diagnostic classification and to avoid repeating the same technique on different patients. The underlying idea is that a new technique must be created for each patient. However, taking Milton Erickson as example, if we analyze his cases, as many authors did, we notice how despite what he says it isn't true that he invents a new therapy for each patient, adapting the intervention to each patient, to his language, to his situations, to his context. He applies the same method to cases with the same type of persistence of the problem. It's evident. As Piaget teaches us, what children do discovering reality through a new perception, they discover what works to manage reality, then they have a cognitive anticipation for all situations that work in the same manner, therefore this is a natural process that regards, and must regard, psychotherapists as well. We must overcome the resistance to change of systemics and strategics who, for years, have refused the possibility of producing a classification of technical interventions. If we look at all the greatest therapists we see how they use methods that repeat in similar situations, with the creative ability of tuning with the situation, with the person. We must avoid thinking that we aren't able to have an anticipatory knowledge that can lead us to devise effective therapeutic solutions, we can achieve such knowledge but it must be something that technologically suits different situations without definitively fitting every patient, because in need of always being adapted. Seeing as after twenty years we have produced a series of specific treatment protocols for different pathologies, together with other collaborators, we are working on a sort of manual of perceptive reactive systems; I think it would be interesting to have guidelines that can lead the therapist to be more focused, of course without being a replica of the diagnostic nosographic system.

Case demonstration:

Second part: how to make a diagnostic inquiry become a therapeutic intervention

N: hi Manuela. To begin with, what has led you to come on stage in front of so many people, the urgency of solving a problem or the desire of putting a famous therapist to the test...?

P: neither of the two [laughs], I was present at the conference you held with Loredio and I regretted not raising my hand to expose my situation, so I thought "I didn't do it that time, I must do it now".

N: it's like saying that last time they took your place.

P: [laughs] yes, right...

N: and this time you thought "I don't want to lose my place, i'll stand up"

P: I let someone take my place...

N: good, good, ok. Would you like to describe the problem that made you decide to confront with me or would you like me to ask you some questions?

P: well, actually the problem are three problems, therefore either I choose one or I say all three of them.

N: hmm, let's choose it together, start by saying all three of them and then we will grade them together.

P: ok. One is an eating problem in the sense that I'm constantly on a diet, always. The second one is a psychosomatic problem in the sense that I psychosomatize all my emotions. The third one is a dependency on independence.

N: ok, hmm, well, I like the definition. Ok, we can try to explore all three areas seeing which one we like best, and start the intervention from one of the three, even if I would like to ask you: do you think they are three distinct areas or are they interdependent?

P: perhaps what they have in common is control

N: ah! Correct me if I'm wrong, you are telling me that being on a diet without success, that your somatization and your dependency on independence are based on your tendency to have control over things?

P: exactly.

N: hmm, and this control that you exercise over things, does it work or does it lead you to lose control?

P: some times it works, other times it doesn't work anymore.

N: ah, ok. So it's as with the diet: you lose weight and then you regain weight.

P: yes, but I lose weight quickly, I mean that if things require a long time I don't like them anymore and therefore I abandon them. But losing weight quickly I also regain it quickly.

N: hmm, therefore you're aware that it's not a good solution but you're unable to avoid it because you want a quick solution, but you also know that if the solution is quick it won't be definitive and that there'll be fall backs.

P: yes.

N: but you still can't do without it.

P: no.

N: ah, so we have reached an important point, your constant attempt to maintain control gives you the

illusion of having control but, after, makes you lose it.

P: exactly.

N: ok, good. Do you think that if you keep trying to keep control you can solve your problem or will you just complicate it?

P: I'm aware that I'm complicating it but I can't avoid doing it.

N: ok. And what do you think prevents you from blocking the attempt of controlling which makes you lose control, the fact that you have certain sensations, overwhelming emotions, or external pressures?

P: is it possible that it's both?

N: of course, can you describe them or is it difficult?

P: yes, I tend to control emotions, otherwise they become too strong. I know I'm overwhelming, and seeing as I can't allow myself to be so, also because the external world wouldn't allow me to, I don't express it, but I end up doing it in some other way.

N: ok, let me see if I've understood well, you're telling me: "I'm a person who has such strong sensations and emotions that I can't let out because socially inconvenient, who knows what people would think if I let myself go, therefore I try to block them"?

P: let's say so.

N: "but then I lose control in situations where I wouldn't like to, food, somatization, and this constant search for independence".

P: [nods]

N: have you ever been able to let yourself go or are you always so controlled losing control?

P: no, it happened to me and after I regret it, therefore...

N: ah, ok... therefore, in your life, if I haven't misunderstood, there has also been some event when you've decided "ok, i'll let myself go because I'm happy to", but then it cost you a lot.

P: yes.

N: ok, and if you'll allow me to be a little intrusive, otherwise stop me, did this decision of letting yourself go, which cost you a lot, regard an emotional affective area or other areas?

P: several areas.

N: and every time it cost you so much?

P: if not always, it did some times and they were very significant.

N: well. Those times when you decided to let yourself go and you did it finding yourself shipwrecked on the rocks, were these situations where you controlled your letting yourself go or you didn't have any control in this?

P: no, I didn't hold any control then, that's why I shipwrecked on the rocks.

N: ok. You know there is a beautiful aphorism that says: "pleasure is the rock where people love to shipwreck"?

P: [nods – laughs]

N: the problem, if you allow me a small interpretation, is that you seem to fluctuate from an excess of control that makes you lose control to a letting yourself go without control.

P: [nods]

N: well, they're the two sides of the same coin. They're not opposites, they're exactly the same thing; therefore the more you control yourself the more you lose control. If you let yourself go without control you'll hurt yourself, this seems to be the story of your life up to now.

P: [nods – laughs]

N: therefore, from your perspective, in order to stop controlling yourself and lose control, and to be able to let yourself go in a controlled way, what should we change in your ways of perceiving and reacting towards things?

P: I don't know.

N: you have no idea?

P: [nods]

N: when you let yourself go and you shipwrecked on the rock, did you declare you were letting yourself go or you just did it?

P: I just did it.

N: hmm, If you had declared to people: "I'm letting myself go, therefore I believe I'll seriously hurt myself", do you think it would have changed something or would it have been the same thing?

P: no, perhaps it would have been different.

N: can you tell me what would have been different?

P: perhaps someone close to me could have controlled what was going on.

N: so, in this case, if I'm not wrong, you would have delegated to someone else the control on your letting yourself go?

P: yes.

N: ah. This is interesting... are you able to trust someone or do you usually not trust others?

P: yes, I do trust.

N: but you're unable to ask them to control.

P: I do ask, and it happens. But when it happens I then feel controlled and it bothers me because I don't feel independent anymore.

N: there we are.

[they both laugh]

N: and this is the third problem.

P: exactly.

N: until this point we have analyzed the first two. Therefore you find it difficult to delegate to someone else because by delegating you feel being controlled.

P: [nods]

N: and you don't want to be controlled, ok. But if you choose to delegate to someone else something that you're not able to do in that moment, because if you keep doing it you're under the control which will make you lose control, if you're the one delegating the control is he the one controlling you or are you controlling him?

P: I should be the one controlling him but in reality he is controlling me and I just need to run away.

N: therefore the third problem becomes very important, the myth of independence, or the dependency on independence. Do you remember how, during the other case demonstration in Rome, I introduced a particular concept, the one of counter-dependency, that is the dependency produced by the rebellion for independence. Can you picture yourself in this or is it something else?

P: no, I didn't. Not in that moment.

N: ok. And now that we have analyzed these different aspects...?

P: now I do a little, the difference is that she did it for others, I do it for myself.

N: ah! This is an important difference, as a matter of fact you somatize.

P: yes.

[they both laugh]

N: she didn't, this is another difference. You have three problems, she only had one.

P: yes.

N: you know, sometimes to fight for ourselves is much harder than fighting for others, ok. Allow me to summarize, and tell me all the point you don't agree with. You decided to participate because you saw the case demonstration in Rome and you regretted not volunteering. You come here and present three types of problems that are interdependent: constantly being on a diet and therefore failing with the diet, having psychosomatic symptoms and being dependent on independence. We have explored together how you seem to have control over everything. But as it ends up with the diet it also ends up with the rest. The more you tend to have control the more you lose control, also because, as we said "pleasure is the rock on which people love to shipwreck", and you are a person... When you decided voluntarily to do it, to shipwreck, you shipwrecked even more ramblingly and this confirmed that there is the need to shipwreck. But the two extremes touch each other: either you let yourself go and you shipwreck or you try to control yourself and shipwreck anyhow. Then you said that sometimes you're able to delegate and I've asked you if you've ever been able to declare your fear, your limits, and you've told me that if you had done it something might have been different. But when you delegated to someone without entirely declaring your problem you then became rigid because you felt you were controlled.

P: yes.

N: and therefore you defended yourself, and I must remind you that only those who are fragile become rigid, and every time you become rigid you become more fragile. Do you agree with this...?

P: exactly.

N: ok. Therefore you also agree that if things continue in this way they can only get worse, and won't get any better?

P: yes.

N: and you've agreed that if you were to declare, if you were able to delegate to someone else, declaring your limits, you could have different reactions. But you need to trust the fact that you can control who controls you, otherwise you're not able to do it.

P: yes.

N: because if you feel that he is the only one controlling you become rigid.

P: yes.

N: good. Then imagine doing the following experiment: start by publicizing your weaknesses instead of keeping things to yourself, obviously starting with the people closer to you. Publicizing your weaknesses doesn't mean taking an optimistic stand or surrendering so that anyone can stab you as a modern Saint Sebastian, although it could be a strategic trick. Let's use an example: if I were to tell you that "I actually don't feel so sure as I seem, because I have a lot of insecurities, and that every time I expose myself it's very stressful and I always have to confront myself with this thing", I would have declared a weakness. Does this seem like a weakness or a strong point?

P: a strong point.

N: perfect. I would then like you to learn using this trick. Declared fragility isn't perceived as fragility but as a strong point. If I declared to someone: "listen, I need to tell you that I could lose control, so stay close to me", am I declaring a weakness or does the other perceive me as someone who has the courage of declaring a weakness?

P: the latter.

N: therefore what does the other think about me? Am I stronger or weaker?

P: stronger.

N: it's a way to increase control by voluntarily losing control. You can delegate controlling. It's a fine ambivalent artifice and I would like you to do it on a daily basis. At least once a day you'll ask for someone's help declaring a weakness, starting from little things. Regarding food, working in the same direction, you heard what I said in Rome, I suggest you the paradoxical diet. Even in this case, if you allow yourself something you'll be able to renounce to it, if you don't allow yourself it, it will become unbearable. Therefore eat just and only what you like best just and only during the three meals, can you do it?

P: yes, I've done it before.

N: and does it work?

P: it works.

N: ok. Therefore you've arrived with one of the three problems already on its way towards solution. ok. The third problem, the one of somatization, I think it's the consequence of the rest. Thank you for spending your time with me.

P: thank you.