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The art of enjoining: Prescribing to the individual, to the couple, to the family

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In order to introduce the topic on prescriptions and of how prescriptions can be built to fit the problem and to transform the problem into a solution, and of how such a solution can be suggested, offered to the patient or to the patients in the most efficient communicative manner, I would like to start with a short diversion on the subject. The majority of you know how brief therapy, during its first years, was assimilated to a very prescriptive and direct approach. The first declared strategic therapists, such as Jay Haley, Cloe Madanes, and others like Milton Erickson, have been pointed out as directive therapists, and prescription was seen as the terminating part of the therapeutic intervention. The prescriptive intervention, whether directed towards the single individual, toward the couple or the family, was considered to be the boundary between the problem's persistence and change.

I'm eager to talk about this because since I started working on developing specific prescriptions for specific pathologies, one of the main topics of debate between Paul Watzlawick, John Weakland and myself regarded how to make prescriptions less directive possible. That is being directive through not being directive. This is a crucial topic. When talking about prescriptions we firstly need to talk about how to package the prescription, how to present it; otherwise we risk devising the best therapeutic maneuver which won't be followed up by our patients. Therefore it becomes useless. You all know that the two souls of a strategic approach are problem solving on the one side, that is the strategy that builds the solution which fits the problem, and communication on the other side. Communication which, as we saw yesterday and the day before, is the means to prepare the ground for change, to introduce change during the therapy and to offer prescriptions in a way which ensures that it will be carried out, observed and complied. This is a social subject. We can find a substantial difference between a behaviorist approach and a strategic approach in the usage of language: a behaviorist approach uses a directive language, based on explanation and on the indication of a directive to be followed; in a strategic approach there is no directive, but rather an indication given with a suggestive and persuasive language, which ensures that the person will put into action such indication, although it may appear strange or bizarre.

Therefore, before talking about prescriptions, it's necessary to talk of how a prescription must be suggested. Although it may appear that the prescription is suggested in a directive manner, in order to make sure that it's followed at best, I believe that it must be enjoined, using the term enjoined (from the Latin: "*induce into doing*"), so to overcome the patient's typical resistances towards change, towards following indications. This is a concept of Pragmatic of Communication, from the School of Palo Alto,

1 Translated by Ranieri Brook Barbieri

that is often forgotten: the concept of resistance to change.

Unfortunately many of the authors I have loved and appreciated have added fuel to this fire, as my friend Steve de Shazer did when he wrote that «resistance doesn't exist». This was actually a metaphoric and provocative way that he used to present a different manner to overcome resistance. You all know that the concept of resistance doesn't come from psychotherapy; it derives from biology: when Claude Bernard talks of the homeostasis concept he is concretely showing us a resistance to change.

Homeostasis is the tendency of all systems, from the most minimal to the most complex, to maintain a constituted equilibrium. Unfortunately, the system tends to maintain the equilibrium even when this is dysfunctional. Therefore, when someone asks us to intervene, we are always confronted with a resistance to change. If you recall the demonstration I performed on the first day, a question was posed regarding how collaborative the volunteer was; and I underlined that those who seem most collaborative are often the most resistant to change... because of their being collaborative. Hence, when we work for a therapeutic intervention, especially when ending a session with a prescription, it's necessary to keep in mind that we need to overcome a resistance, even when we are dealing with the apparently most collaborative person. There are different ways to go about the resistance to change; we will describe some of them and will see in detail how to devise different types of therapeutic prescriptions.

A first important note regarding prescription, although it seems banal and seldom said, is that the prescription must be the last communicative act of the session. Otherwise it is lost. What does this mean? If, after you have given a prescription, the patient starts talking again, you must repeat the prescription. This is because experts of communication and of suggestive impact, as Professor Ricci Bitti, teach us how our first impression and the last communicated message are those which last longer. Therefore it would be a mistake to not have the prescription as the last communicative act, as often ingenuously happens with my students when supervised: «I've already said the prescription! Why should I repeat it? He will think I'm not so smart if I repeat the prescription!». Instead, repetition is another important characteristic of the prescription.

As you have noticed, I'm now talking about communication, and I will later talk about problem solving. I will say that the more the prescription is observed and carried out by the patient, the more you will be able to make it redundant. I'm purposely using this term because redundancy is different from repetition. As Roland Barthes, a famous expert of language, would say: redundancy is an inexpensive expense. An interesting definition that gives a clear idea; when I make an indication redundantly vibrate I make it rumble inside the person as a series of echoes. If, instead, I just communicate it in a non suggestive manner, in a non musically redundant manner, probably nothing of it will remain.

One of the most evident examples of this effect is given by the prescription that we have been using, for over 25 years, with obsessive-compulsive patients who present a reparatory form of disorder. They are those who wash their hands because afraid of being contaminated or those who need to propitiate something by repeating some rituals. This prescription will not be followed and will have no effect unless given in a redundant and suggestive way.

Therefore, for those situations where the patients tells me: «every time I have the feeling of being contaminated I have to wash my hands», or the patient who says: «before going to bed I need to check all the faucets, I need to check all the doors, I need to make sure everything is secure»; we have devised a prescription for all these situations, something made *ad hoc* for this form of disorder, which strategically makes use of the problem's own structure against itself. But, again, this is the problem

solving aspect of the prescription which we will soon talk about; for now I will just deal with the communicational aspect.

I will now tell you the prescription without redundancy: “every time you perform the ritual, you have to carry it out 5 times. It's important, every time you carry out the ritual you have to repeat it 5 times. Don't forget it, every time you do a ritual you have to do it 5 times”. If you suggest the prescription in this way you can be sure that the patient won't carry it out because, although it seems similar to the following, it has no emotional impact. You must, instead, use a musical redundancy, a suggestive impact, you must look the person straight in the eyes, lean a little forward … and say: «I will now ask you to do something that I know will be very challenging for you: ... from now till the next time I see you ... every time you carry out one of your rituals, you must repeat it for exactly 5 times, not one time less nor one time more. You can “not do” the ritual ... but if you do it you'll have to repeat it for 5 times. Not one time more nor one time less. … I'll repeat ... you can “not do it” ... but every time you carry out one of your rituals, if you do it once you'll have to do it 5 times ... not one time less nor one time more». When the prescription is given in this manner, you can be sure it will be carried out by the patient. The difference seems banal, but, instead, it's fundamental.

During direct supervision in co-therapy, students often have difficulty in repeating the prescription because they have the feeling it makes them look stupid. But, in truth, this is what makes the difference. This is not repetition, it's redundancy! Furthermore, the prescription has been purposely devised, as should be done with most prescriptions, so to give a musicality to the articulation of the injunction. This way it will remain in the head of the person as something that doesn't only involve the left hemisphere, the comprehension, but it will mostly link with the right hemisphere, the sensation.

The above was said just to introduce communicative, verbal, para-verbal and rhythmical aspects of prescriptions. You have noticed how I also took some pauses: «you can “not do it” ... Pause … but if you do it once you do it 5 times, not one time more nor one time less». Pauses are very important when prescribing. If I want something to remain in the persons sensations, it's important to create an empty space before and an empty space after what I will say; this space will produce a frame around what I said.

It's often difficult teaching the arts of prosody, of pauses and of change of voice to students who have just started their training. To them this seems more like reciting a theatrical script than doing therapy. But this is what the art of rhetoric has always taught us, and conducting therapy has much more in common with the ancient Sophist's rhetoric than with rational explanations which can be found inside a scientific laboratory or with what we are used to hearing when attending a lesson or a university course. There are teachers who also work on suggestive aspects in order to improve their students' communicative capabilities; but unfortunately these are infrequent cases.

Therefore, the first aspect of prescriptions I was eager to introduce was the art of communicating it, the art of reciting it, because without this rhetoric art the prescription will surely result in being less effective.

Another interesting aspect, before tackling how prescriptions can be built based on the problem's functioning, is how to devise prescriptions based on the chosen objective for change. This is another seldom discussed subject. We are used to thinking: I give you a prescription, you carry it out and change occurs. But it's not always like this! And not every prescription expects an immediate change! Hence, if we want to give a basic classification to the types of change obtainable with prescriptions, we should at least consider three types of change:

There is a change we could call catastrophic, as in the theory of catastrophes or in physics, which means an immediate change: the lightning that makes the tree fall, the earthquake that rips the ground open... here we are referring to those prescriptions that, when put into action, immediately break the vicious circle that fosters the pathology. This is the case of the above mentioned prescription. If the obsessive-compulsive patient who repeats rituals goes home and carries out the therapeutic counter-ritual, therefore repeating 5 times his original ritual; by following the therapist's order, he will get to the point of interrupting his rituals, declaring that he got bored of having to repeat it for 5 times. The explanation of this effect is that what is important of the structure of the prescription, is that the symptom, the compulsion is dominated by the therapy. We take hold of the obsession's power. But when taking hold of the obsession's power I say: «you can do it 5 times or you can "not do it"», hence giving permission of "not doing it". I hold the obsession's power, I give permission of not doing it, and usually people choose not to do it because it's boring to do it 5 times. Therefore the perception of that reality is completely changed. This could be defined a catastrophic change, an immediate change. But not all problems can be changed in such an immediate manner.

Let's take a different example: imagine a woman, as in the case I have in mind, who comes to you saying: «I have a phobia of penetration. I can't experience penetration because I feel a terrible pain every time my partner's genitals come close to my genitals». As we would say "the closure of the safe". In this case, differently from the one before, the idea of a catastrophic prescription seems less indicated because of a stronger risk of increasing the "closure", of increasing the resistance to change. Here it is best to induce a gradual change, what we would call a change by subsequent phases. In these cases we usually use a prescription suitable to this style of enclosure: we prescribe to the couple, or to the individual with the partner's help, to have at least 3-4 erotic encounters per week with the prohibition of penetration. As two young lovers who are sexually discovering each other, they must achieve the maximum pleasure possible, without penetration. They must take on the commitment: during these encounters, their genitals must be in contact and do what we call the "*Belle statuine"*[2], that is remaining still with their genitals in contact for one minute, after which they must begin giving each other pleasure once again.

People usually come back saying: «it was easy, we had fun... we actually enjoyed it....», we then ask: «were you scared?», «no, no! I wasn't scared at all». We continue with: «from now till the next time, you have to do exactly the same thing... start with foreplay... try to get as exited as possible... then you get close to each other and we would like you to start a micro-micro-micro penetration... just... 3 millimeters... not more than 3 millimeters. You have to remain in that position for a minute. After, once the minute has passed, you have to restart giving each other pleasure». Most people come back saying: «ah, it wasn't so difficult!». We then ask the woman: «did you feel any pain?», «no, no! I didn't feel any pain, actually...!», «actually...?! Avoid going too fast! It's best to go slow!» and we prescribe 3 millimeters more. Can you imagine how things go...?! We keep adding half a centimeter each session until, frequently, patients come back asking: «do you think we have reached a full penetration yet?!». After 5-6 cm, 7 cm...! This is a gradual change, which is suitable when a catastrophic change may be too strong.

When introducing a gradual change we often end up witnessing the third type of change, which is the most interesting, the geometrical-exponential change: the avalanche effect, the rolling snowball which becomes bigger and bigger until reaching the size of an avalanche. Going back to the initial prescription of the "*Belle statuine*", after the initial micro-penetrations there is a 50% of cases where

2 *Belle statuine* (beautiful statues) is an Italian children's game, somewhat similar to the American game "Red light, green light" or to the British game "What's the time Mr. Wolf?", where the players have to freeze in a given position.

the prescription is violated and the couple has complete, satisfactory intercourse. In these cases the change is not gradual but, rather, geometrical-exponential: it starts slowly, then it accelerates until becoming unstoppable.

These three categories of change are very important. It is very important to be able to select which of the three types of change is most suitable for that particular problem to solve, for that particular person and for that particular context. This helps to be even more strategic.

Regarding the therapist's relation with the patient, there are four more characteristics to be considered before looking into how to prepare and devise the prescription. These characteristics refer to patient's type of resistance to change.

In a famous article, Paul Watzlawick, classified three different types of resistance. In 1997, working together at writing the book “Terapia Breve Strategica”, we identified four different types.

We will start with the above mentioned assumption that even the most collaborative patient is resistant to change. Therefore the first type of resistance will be when we have a collaborative patient, or someone apparently collaborative. In this case it's obvious how using a very evocative language, using one's own personal influence at a non verbal level, therefore overloading the therapeutic relationship and the communication with suggestive artifices is contraindicated. This is because if the person shows to be collaborative, although they might not fully be collaborative, it would be inappropriate to treat him as if he was someone who opposes or who shows other difficulties. This is the case in which it would be better to start with a gradual change. Hence, during the first session, using the strategic dialogue techniques we have talked about yesterday, negotiate with the patient the first moves necessary to achieve change and carry on verifying if change occurs gradually or if, at a certain point, it accelerates with an avalanche effect. But again, in these cases, a prescription that aims at producing a catastrophic effect would be unsuitable; such a prescription would require a relationship and a communicative style which isn't suited to someone who appears to be collaborative.

The second category of resistance to change are those cases who would like to cooperate but who are not able to. The most important category constituting this type of resistance are phobic-obsessive patients: those who suffer from panic attacks, those who suffer from compulsive obsessions... in these cases, at the end of the first session it's essential to use a prescription that aims at triggering a catastrophic effect. Language, in this case, will necessarily be greatly suggestive, and the prescription will have to, indirectly, leads to discovering something different. This is the case in which the prescription should produce a corrective emotional experience, that is, it must be constructed in order to have the person discover something different and change his own perspective. It's the “if you do it once you'll do it 5 times, not one more nor one less” prescription. When the obsessive-compulsive patient puts the counter-ritual into practice he discovers to be no longer possessed by the obsession and, being this a prescription, he is free of choosing to not follow it. Even more fitting is the example of those who suffer from persecutory manias, often confused with the diagnostic criterion of social phobia; those who think that everyone hates them. We suggest these patients an experiment: to concretely measure all ineluctable signs that suggest that other people hate them. To go out every day, studying people for at least an hour, looking at people with the clear intention of noticing the signs of their refusal or aggressiveness. Being proposed as a sort of systematic survey, this prescription is often accepted. We tell them: «bring us these data, so that we will understand how to fight it. Study your enemy so to better battle him». The curious thing is that people come back saying: «it's very strange, this week I didn't notice anyone who hated me. I did look carefully... but instead, many times, they just smiled at me...», so you'll say: «how is that possible?». Here we are seeing not only the techniques to

overcome resistance but, also, how to devise a prescription. This prescription is made to reverse on itself the perceptive-reactive model that nourishes the pathology. You all know how those who feel refused or persecuted tend to flee contact with others. They become rigid, they look downward and, when staring at others, they scowl. If I aggressively defend myself I will obviously produce the same thing in others, they will also defend themselves; therefore when looking at them I will find confirmation that they hate me, without realizing that I am the one who has produced it!

Imagine entering a room full of people, thinking that they all hate you: you will be tense, you'll look downwards, won't greet anyone, you'll sit down and look around suspiciously. Others will think the same thing about you and will look at you in the same way; this will confirm that they hate you! Now change everything: enter the room thinking of being nice and liked. You'll enter looking at everyone with an open smile, laid-back, you'll greet and others will do the same. You will have the confirmation of being liked.

This is the logic of a self-fulfilling prophecy. When we tell the persecutory paranoid patient to study the signs of refusal, we put him in the position of being obliged to look, of doing something that, before, he wouldn't do! And when looking for the signs, others will look back! Seeing as we all are a little vain, usually, when someone looks at us we will tend to look back and smile; this creates an interactive dynamic that completely changes the interaction. This is an indirect prescription which creates a catastrophic change effect generating a corrective emotional experience. As Paul Watzlawick would have said, all this happens due to a planned casual event: the event is accidental for the patient and planned for the therapist. Hence, we must plan something which produces an apparently spontaneous, natural effect... you see how distant we are from directive prescriptions?! Everything must happen as if it were a natural discovery, not as a strong directive.

The third type of resistance to change is the one mostly studied by systemic therapists: it's when confronted with a directly opposing patient, the patient who is always challenging you. If you have a patient who is constantly challenging you, any effort towards creating agreement with him will be wrecked by his boycotting. The more you try being close to him, the more he will distance you. The more you attempt to persuade him, the more he will resist. In this case, as in all cases with paradoxical dynamics, it's necessary to enact a counter-paradox. Communication will have to move towards the same logic of someone who boycotts, therefore the therapist will usually say something like: «you know, perhaps we could try something, but I don't think you'll be able to», or: «there is something we could study together, but I know that if I suggest it to you, you will refuse doing it», or again: «perhaps I'm not the right therapist for you. You came here traveling so many miles, but I must tell you that I'm probably not the right person for a case like yours» and the patient usually says: «everyone has told me that you're the best one, I came here purposely for you!»... these counter-paradoxes will drive the patient out of his paradoxical situation. Once again the prescription we will construct will not aim at producing a catastrophic change effect because this will result in a patient's greater resistance. It won't aim at a gradual change because the patient will attempt to boycott it. In this case we will have to use prescriptions that create a geometrical-exponential change effect; prescriptions that have an initial apparently harmless effect which transforms into an increasing acceleration towards a breaking point. Once this effect is triggered the patient is not able to stop it.

As you can see, three different types of resistance to change, three different types of change to utilize, three different types of therapeutic communication and relationship.

The forth category that we added in 1997 is the one that refers to those people that are neither able to boycott nor to collaborate. You will think: who are they? A much wider category than what we might

think. They are all those who carry an important pathology as delusion, or all those people who have an extremely rigid ideology or morality forcing them to see things only from a narrow perspective with strong barriers. In these cases, either with delirious schizophrenics or with people who consider themselves intelligent and able but with very strong morals, we must take into account their perspectives. The strategy must avoids having the patient perceive that we are attempting to change his convictions. Even when this is strictly necessary for changing the problem. In these cases we mustn't directly prescribe, here it's necessary to tune in with the patient's logic and have him get to the point, at the end of the session, of almost suggesting us what he should do to change. As you have seen this is the spiral, the funnel of questions with alternative answers, the paraphrase of the strategic dialogue: lead the person in to suggesting us what we should suggest to him. It's curious how with an intelligent person we could do this with the strategic dialogue, whilst, with a delusional person, we carry out a counter-delirium with him: enter the patient's delirium and lead it to its exasperation. This difference was well expressed by Moni Elkaim, when he traced the distinction between my demonstration and the conduction of a therapy by Whitaker: if I'm facing a person who is rigidly bounded to immovable categories, I'll have to lead him from his complication to a simplification, until reaching the breaking point. Instead, when the person is in a delirium, I need to start from his simplification and proceed in increasing the complexity, until he'll want to get out of it. Therefore they're the two sides of the same coin.

In order to conclude this first part of the presentation and, as anticipated, move on to the demonstration, I want to, once again, state how the prescription is one of the most important elements of therapy. Nonetheless, if the prescription isn't created during the session, through a strategic dialogue which produces the necessary atmosphere for the injunction, there is a very low chance that it will be carried out. I believe that, nowadays, the evolved brief strategic therapy isn't as prescriptive as it was in the past. We have moved towards a “softer” model. The correct term would be, using the realm of logics, that during the first phase, from the 60's till the end of the 80's, the intervention was mainly manipulative, that is I influence you to manipulate you towards change. In the last years the intervention is mainly based on forms of self-deception induced in the person's perception. We guide the person into changing his self-deceptions, from being dysfunctional towards being functional, using a much less directive modality, in a softer manner, more enveloping and, I must say, much more capable of bypassing resistance to change, especially when we have so called chronic pathologies, people with a long history of an invalidating pathology.

This concludes the first part. I would like now... seeing as yesterday there were two people who...

Case demonstration:

N: so, yesterday we had a brief chat and you asked if I was available for a session. I told you that I was, but also that it would have to be in this context. Therefore here we are. Would you like to introduce the problems that brought you to talk with me or would you like me to ask some questions?

P: I'll try to see if I can focus the problem. My problem is that I'm not able to study, I can't concentrate on reading and on learning, I can't memorize and write, I can't fix important things on paper. When I read to learn, I start getting anxious thinking that what I'm doing is useless; when I try to write things to fix them in my memory I think it's useless and... I buy a lot of exercise books, pens... to take notes, but... they're all... I buy a lot of books thinking that they will automatically get in to my mind...

N: ok, ok... very well. Let's try now to understand, through some specific questions, how this thing works. You must forgive me but if you tell me more I'll get lost in what you're telling me. Ok? I'm curious of something you said, you said: «I start reading, and as I'm reading I start getting anxious». Did I misunderstand you or is it so?

P: it's so.

N: ok, it's as saying that when you realize that you're learning exactly what you'd like to learn you get scared and freeze.

P: yes.

N: hmm... in the exact moment when you feel that you're learning and a sense of anxiety rises, rises, rises, what do you do then? You try to control the anxiousness or you surrender?

P: I think that it's the starting of the usual mechanism and I surrender.

N: ok, good. Therefore, if I'm not wrong, this means that it's not just a recent problem but something that has lasted for a long time.

P: it's been at least twenty years that I've been trying to solve it in different ways.

N: congratulations! This means that in twenty years you have never been able to change the situation or have there been some changes?

P: once I finished university I felt free from being obliged to study, that was a liberation. Since then there have been some brief moments but... it's been almost always impossible.

N: ok. If I'm not wrong, you have left university and...

P: no, I finished... I got my degree and that was a liberation. I then mostly learned in the field...

N: oh! Forgive me, but if you went through university it means that you have been able to learn and pass all the exams, or am I wrong?

P: yes, with great difficulties, yes.

N: ah! Ok. So, how did you deal with your learning difficulty in that situation? As you have told us or in a different way?

P: I felt obliged, therefore, although with great difficulties, this obligation led me towards the end. I anyhow need to show that I can do it.

N: ok. This means that when you're cornered by duty or by your sense of guilt you're able to learn, although suffering a lot?

P: yes, I would say so!

N: ah! Therefore, if I'm not mistaken, we've discovered a resource! If we cornered you with duty or

with sense of guilt would you be able to do it?

P: yes. It's frustrating but yes.

N: so, as Alexander the Great, we'll need to burn our own ships in order to conquer our enemy's ships and sail back home! Am I right?

P: yes.

N: ok. But once you finished university you weren't obliged to give any more exams, you didn't need to show to be what others expected you to be, and therefore the problem had apparently diminished.

P: in fact. It's still there.

N: ok. Therefore the end of university didn't correspond with what seemed to be an improvement, it was a more rigid structuring of your problem. You weren't obliged to conquer your enemy's ships to sail home because your ships were not set on fire.

P: actually yes.

N: ok. Good. And how did you attempt to solve this problem after university? Could you make a sort of list of your attempted solutions?

P: when I would come across difficulties at work I would try to find the specific solution on books, trying to learn it... but it was always difficult so I would ask a colleague to teach me. Therefore I would learn from others.

N: this means that every time you had the doubt of not being able of doing something well at work you tried to be reassured, you asked someone for help, you delegated someone else. And was this enough to solve the problem or it didn't solve the problem?

P: no. Because I didn't always find people's availability to do this.

N: ah! But when you found people's availability to help you, did things get better or did they get worse?

P: no, because, actually, the problem was still there... it was also a question of personal satisfaction. Anyhow, I wasn't able to advance as I would have liked.

N: ok. Therefore, correct me if I'm wrong, every time you asked for help either you didn't receive it and it was a disaster, or you received it and the disaster arrived later?

P: yes. When realizing that I had the need to resort to the same mechanism.

N: and your self-esteem kept going down, down, down... you always felt more incapable. Are you still working or are you not working?

P: yes, I'm working.

N: and are you still using the same techniques or have you changed strategies?

P: no, I'm still using those.

N: ah! Therefore you keep having, if I'm not wrong, a granted failure. I mean: I ask for help, I don't receive it, I fail. I ask for help, I receive it, I solve this situation but then I feel more incapable and I fail anyway.

P: and I often forget what they teach me.

N: ah. Ok. Well. And at work, forgive me, is it the same mechanism you have explained in the beginning? That is: I apply myself and, when I feel I'm understanding, anxiety starts growing and I block myself, or does it work in a different way?

P: often also at work, when I have to put in action... I apply myself at work and I have this anxiety of having to do well... to show that I can do it well.

N: Aaahh!!! So you try to do it well, the more you try to do it well the more you fall into crisis and the more you ask for help. Ok. In this case there aren't others pushing you with a sense of guilt, there isn't a sense of duty or the need to do well at university... in this case you're the one pushing yourself. You took their role!

P: yes.

N: but you see, they would set fire to your ships and tell you “go and conquer their ships!”. Instead, you don't burn your ships! You actually keep them close behind because you ask others for help. It's as if you jumped in the battle and then said “I'm afraid, come in my place!”. Am I right?

P: it's like that!

N: what is your profession?

P: I'm a doctor, in an Emergency Room.

N: ah! That's interesting! And allow me a question: in your interventions, aside from what you think, do other's around you consider you better or worse than others?

P: everyone considers me very efficient in my work.

N: ah! But the more they tell you, the more you hear the skeptic in you saying “it's not true! You're incapable!”?

P: yes, it's like that.

N: you know, one of my friends in my books, my friend Frederick Nietzsche, writes in regards of self-esteem that there are people who are born with the gift of believing in themselves, and their luck is never being able of seeing inside themselves. There are others who are born with a skeptic inside with whom they have to fight every day, and it's a fierce battle. Even if one day you win, the next day you have to start over. A dear Chinese friend of mine, from whom I have learned many things,

once gave me a metaphor which I have used for other things, he says: “every night I go to bed with a tiger next to me and, when I wake up, I never know if it wants to lick me or if it wants to eat me”. You seem to be in the same condition. But others say you're capable. They actually say you're very efficient. But at what price! Therefore, forgive me, what is the exact objective you would like to reach here with me now? Is it to not have the fear of not doing well and do things without fear, or to feel capable of doing things and have a strong self-esteem?

P: I would like to have a strong self-esteem.

N: good. And do you think that, in order to have a strong self-esteem, you just need to feel capable or do you firstly need to overcome the fear of not doing well?

P: overcome the fear of not doing well... I think...

N: therefore, I think that, trying to do well and have a strong self-esteem, without overcoming your fear of not doing well, is a strategy that doesn't quite fit. Ok? We need to firstly overcome the fear of not doing well so to after build a self-esteem!

P: ok.

N: but you said something very important: that there is only one strategy you repeat. Since you're afraid of not doing well, you ask for help and if you don't receive it, you're forced to do by yourself. But even if you do well its cost is too high, am I right?

P: yes.

N: if they help you, you're safe, but your self-esteem collapses.

P: yes, every time. Yes.

N: we've said, therefore, each way it's a granted failure. Ok? Do you think that if someone continues, in order to defend themselves from their fear of not doing well, asking for help, whether they receive it or not, the act of asking for help makes their fear of not doing well increase or decrease?

P: in this moment it's increasing my fear of not doing well. I ask for help and then I realize that I have more fear than before.

N: I think that, not only at present, but in all your history... the act of asking for help has increased your fear of not doing well instead of diminishing it! You know, it's a beautiful trap. I ask for help, I feel protected... at the moment I'm fleeing my fear, but later I have the confirmation that I'm even more incapable. Therefore, the next time, the fear of not doing well will be even greater. I'll ask for help, I'll receive it, they'll confirm even more my incapability. I'll have to ask always more, always more. I know that right now you're not able of not ask for help, but I want you to think that every time you ask for help and you receive it, not only you're maintaining your fear of not doing well, which nourishes your low self-esteem, but you're worsening it, you're increasing your problem, you're exacerbating your problem... to the point that you could really become incapable of doing it, even when you're obliged to. Therefore, I'm not asking you to stop asking for help, because it would be too much; I'm asking you to think, every time you're asking for help: “I ask for help, I receive it, I'll feel safe, but my feeling of incapability will grow and this will cause my fear of not doing well to

increase”, or “I ask for help, I don't receive it, I'm obliged to do and I do well, but it doesn't count because it was a sort of emergency situation”. It's paradoxical that you work in an Emergency Room, because you're in a continuous emergency situation. I only ask you to think that every time you delegate, every time you ask for help you're anyhow worsening the problem. I would then like to receive some news via email, ok?

P: all right. Thank you.

So, as we have structured this presentation, we will now have some comments by Teresa. Then... if you want, Pio, you can join us... and then, as we did yesterday, we will have this half hour to answer any questions and to explain everything we have done.