# Historic Notes on Brief Strategic Therapy

Giorgio Nardone [1]

**Abstract**

This is a short exposition of the historic milestones of Brief Strategic therapy and its evolution over the years. The first model of brief strategic therapy was formulated by the famous group of scientists of the Mental Research Institute in collaboration with Milton Erickson. Brief Strategic Therapy has developed from its first formulations till the present day, initially in trends marked by some important authors' ideas and charismatic personality, then it underwent change, by developing more differentiated models, which, even though they all kept a common theoretical base, they came to differentiate themselves and characterize different clinical models and intervention techniques.

[1] *Centro di Terapia Strategica, Arezzo, Italy*

The aim of this article is to present a short yet thorough description of the genealogy of Brief Strategic Therapy. The first model of brief strategic therapy dates back to the first works of Mental Research Institute group in Palo Alto (Watzlawick et al., 1974; Weakland et al., 1974). They had carried out research on communication and family therapy collaborating with Milton Erickson, the Master of hypnotherapy. The result was a systematic model of brief therapy that could be applied to a wide variety of disorders, with truly surprising results.

However, the pragmatic tradition and philosophy of stratagems as a key to problem solving have a much more ancient history. Strategies that still seem modern can be found, for example, in the persuasive arts of the Sophists, in the ancient practices of Zen Buddhism, in the Chinese Arts of Stratagems, as well as in the ancient Greek art of Metis[7].

From its origins, brief therapy has spread world-wide even though there was a lot of resistance, especially from the followers of the traditional clinical theories and practice. Many researchers and therapists have made this approach to human problems and their solutions well-known internationally (Watzlawick-Weakland-Fisch, 1974; Weakland et al. 1974; De Shazer, 1982a, 1982b, 1984, 1985, 1988a, 1988b; Haley, 1963, 1975; Madanes, 1990, 1995; Nardone, 1991, 1993, 1995; Nardone, Watzlawick, 1999, 2001; Omer, 1992, 1994; Cade-O'Hanlon, 1993; Bloom, 1995; Watzlawick, Nardone, 1997; Nardone, 2000; Nardone, Rocchi, Giannotti, 2001; Watzlawick, Nardone 2004).

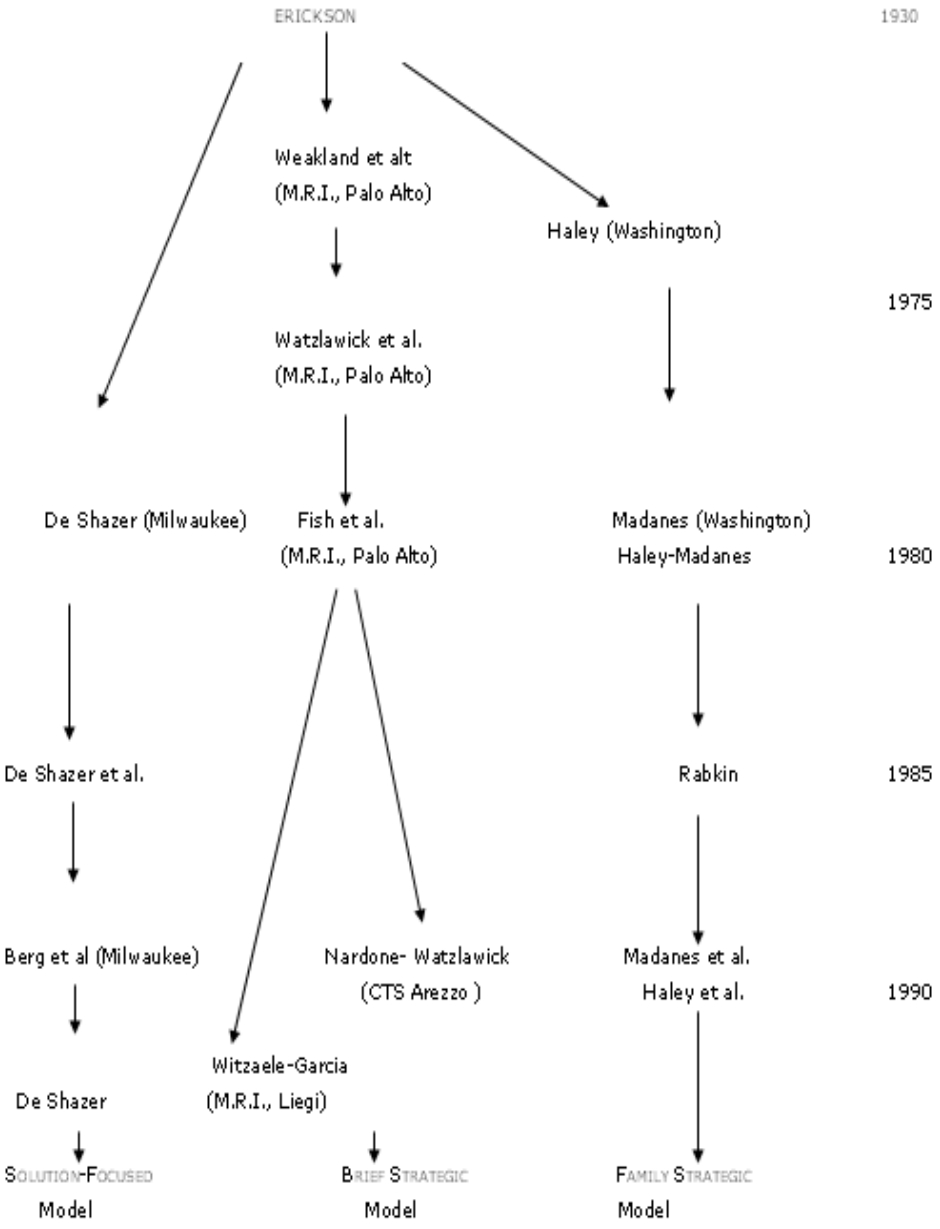
Brief Strategic Therapy has developed, therefore, from its first formulations till today, initially in trends marked in some important authors' ideas and charismatic personality, then it changed showing differentiated models, which, even if keeping a common theoretical base, came to characterize themselves as clinical models and intervention techniques.

To avoid tedious repetitions, as with a lot of books published on the topic, we can schematize the first evolution of strategic approaches to therapy with a chart, a sort of genealogical tree of Brief Therapy.8

As seen from the chart, the approach to brief strategic therapy based on procedures of strategic intervention, from Erickson's first experiences onwards, has a branched evolution characterized by the greater emphasis given by the authors of the main models to some specific assumptions or techniques which have marked their features.

The group from the Palo Alto focused their attention on the vicious circle of the problem persistence, this attention on the part of the same disorders bearers led to the realization of the need of intervention with maneuvers devised to stop and reorganize dysfunctional attempted solutions. In the same way the marked connotation on communicative directivity of Haley's model therapists, and his founding the intervention on the reorganization of power games into the family hierarchical and communicative dynamics, or, the attention given by the Milwaukee staff in creating solutions from "exception" to the problem, independently from its formation and persistency. That first phase of evolution, which lasted more than twenty years, was followed towards the end of the 80's and early 90's by a historical period characterized by some authors attempts to build up approaches that summarized the most significant contributions coming from three traditional models of brief therapy. After this phase of theoretical and application-oriented synthesis, the last few years have seen a more specific type of technique development towards more focused directions.

[7] The Greek tradition of cunning intelligence, audacity, and skillful abilities. It is renown for its powers of practical wisdom.




**Graph 1. The genealogy**

In particular, we notice the tendency to the applied study of specific strategies of therapy which were not only single techniques for recurrent forms of resistance to change, but strategic plans of an articulate therapeutic sequence ad hoc studied for particular pathologies. Also for that reason, we believe schematizing by a further development of the preceding genealogical tree useful.

From the second chart we can have the schematized representation of how from Haley-Madanes approach the therapy for sexual abuses and disorders related to violence has developed; from De Shazer's Model we can observe the evolution of the treatment for drug and alcohol addicts, from Palo Alto former viewpoint and synthetic approaches, the author has got an evolution of the therapeutic protocols for phobic-obsessive and eating disorders developed.

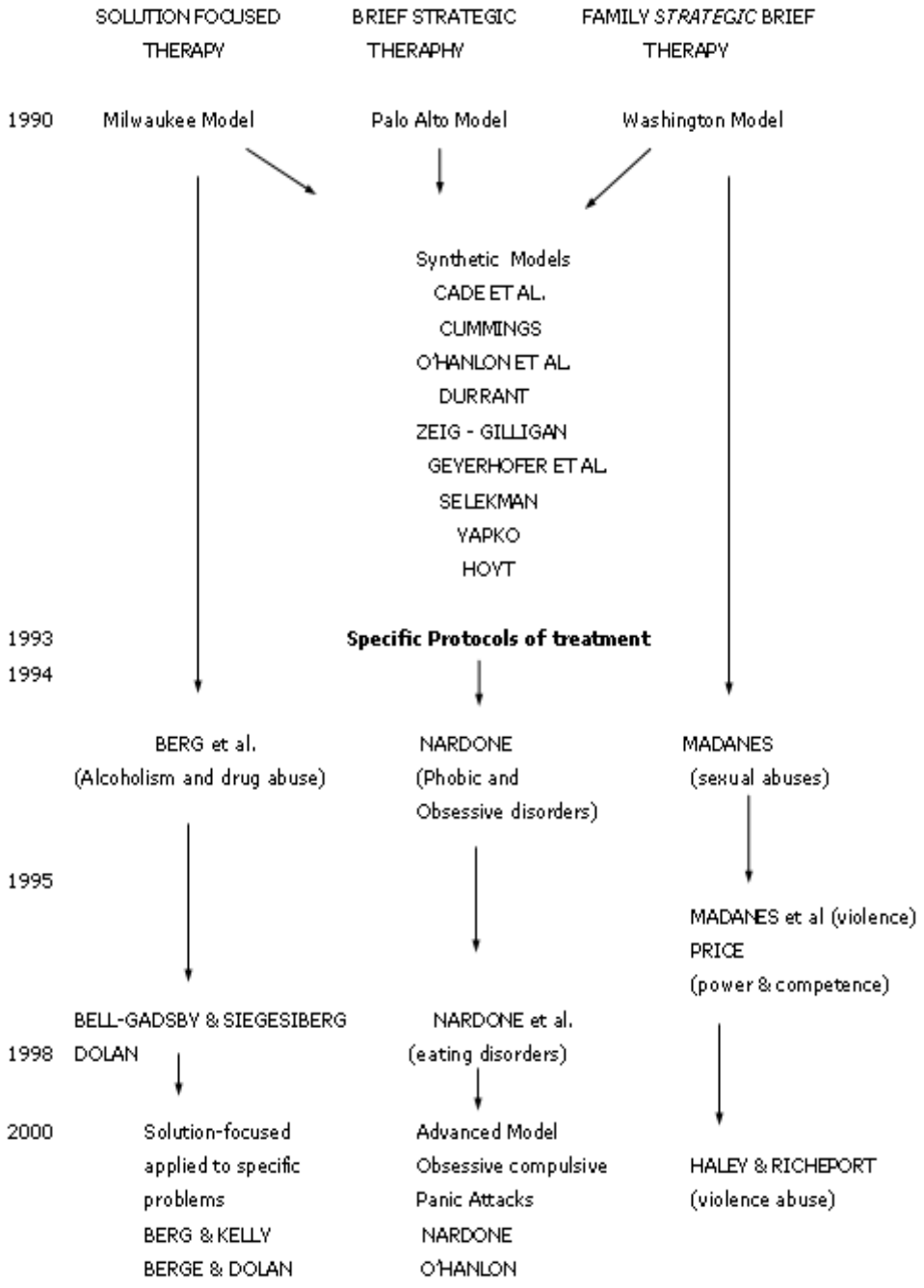
At this point, after having summarized simply what the development of brief therapy has been, from its first Ericksonian rough formulations to the building of real theoretical-applied models and their following evolutions, we can go deeply into the topic of the present written: that is, the exposition of the model of advanced brief strategic-solution therapy, developed by the author at C. T. S. in Arezzo, this work, carried out first under J. Weakland and P. Watzlawick's supervision and then oriented by a specific methodology of research, towards the formation of an advanced approach characterized by the setting up of specific protocols of treatment for particular pathologies.

Since 1985, evolving by means of empirical-experimental method the Centro di Terapia Strategica (Strategic Therapy Center) in Arezzo, Italy, has conducted research for the development of advanced models of strategic solution-oriented brief therapy. The most important result has been the formulation of protocols for the treatment of specific, widespread types of mental disorders, phobic-obsessive diseases and eating disorders (Nardone-Watzlawick 1993, Nardone et alt 1999) with the scientifically recognized highest efficacy and efficiency actually found within the psychotherapy field (87% of solved cases in 7 sessions median duration of therapy).

The key idea was to develop from general models of therapy, specific protocols of treatment for particular pathologies, that is, fixed sequences of therapeutic maneuvers with heuristic and predictive power, capable to guide the therapist to the breaking, through particular therapeutic stratagems, the specific pathological rigidity. Then after this first big change, the protocols lead the perceptive-reactive system to the reorganization in a functional balance. This laborious and prolonged work, applied to thousands of cases in a period of over ten years, focused on the pinpointing of the best way to solve some specific problems led us then to new assumptions as regards both the structure of Problem Solving procedures and the features of therapeutic communication too, in their development step by step, from the beginning to therapy conclusion.

In other words, the strategy adapts itself tactic by tactic to the answers deriving from the interventions acted: as in a chess game, we proceeds with an opening followed by moves that depend how our adversary plays.

If the adversary's strategy, that is the modality of disorder persistence, appears among the well known ones, we will be able to attempt a formalized sequence of checkmate in few moves that is a specific protocol of treatment. The measurement of effects, in this case, will not be only between the beginning and the end of the therapy, but it will be directed to every single phase of therapeutic process, because as in a strictly mathematics model, we look for the possible answers to every single maneuvers, which are then checked, with the empirical-experimental procedure.


SOLUTION FOCUSED THERAPY
BRIEF STRATEGIC THERAPHY
FAMILY *STRATEGIC* BRIEF THERAPY
1990
Milwaukee Model
Palo Alto Model
Washington Model
Synthetic Models
CADE ET AL.
CUMMINGS
O'HANLON ET AL.
DURRANT
ZEIG - GILLIGAN
GEYERHOFER ET AL.
SELEKMAN
YAPKO
HOYT
1993
1994
Specific Protocols of treatment
BERG et al.
(Alcoholism and drug abuse)
NARDONE
(Phobic and
Obsessive disorders)
MADANES
(sexual abuses)
1995
MADANES et al (violence)
PRICE
(power & competence)
BELL-GADSBY & SIEGESIBERG
1998 DOLAN
NARDONE et al.
(eating disorders)
2000
Solution-focused
applied to specific
problems
BERG & KELLY
BERGE & DOLAN
Advanced Model
Obsessive compulsive
Panic Attacks
NARDONE
O'HANLON
HALEY & RICHEPORT
(violence abuse)

**Graph 2.**

Such methodology leads to reduce certain possibility of answer into a maximum of two or three for every single intervention, allowing, in this way, to then device the next move for each varying answer. Therefore we go on with a gradual measurement of effects and predictive value of every single maneuver and not only of the whole therapeutic process.

This way of conducting the therapy as a *systematic process of research* also leads to a more advanced understanding of the modes of persistence of those specific disorders. This in turns lead to further improvements of solution strategies, in a sort of evolutionary spiral nourished by the interaction between empirical interventions and epistemological reflections which lead to the construction of specific, innovative strategies (Nardone Watzlawick, 2004).

In our study of the various forms of psychological disorders, this methodology turned out to be an important instrument of knowledge in fact, the data gathered during our research intervention enabled us to produce an epistemological and operative model of the formation and persistence of the pathologies under study.

This methodology, whose primary aim was the devising of an effective and efficient clinical intervention, thus enabled us to acquire further information on the disorders in question, thus opening new perspectives of knowledge.

Applied research on this subject (Nardone, Watzlawick 1990; Nardone, 1993, 1995; Fiorenza, Nardone, 1995, Nardone, Milanese, Verbitz, 1999) has enabled us to detect a series of specific models of rigid interaction between the subject and reality. These models lead to the formation of specific typologies of psychological disorders which are maintained by reiterated dysfunctional attempts to solve the problem. This leads to the formation of what we call a pathogenic "system of perceptions and reactions"8 which expresses itself as an obstinate perseverance in using supposedly productive strategies that have worked for similar problems in the past, but that now, instead, make the problem reverberate (Nardone, Watzlawick, 1990).

Therefore the evolved model of the strategic approach goes beyond the nosographic classifications of psychiatry and clinical psychology9 by adopting a model of categorization of problems in which the construct "perceptive-reactive" system replaces the traditional categories of mental pathology.10

This goes against the current tendencies of many therapists who, having initially rejected the usual nosographic classifications, now seem to want to resume their use. This is

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

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

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

the case, for example, of Selvini Palazzoli *et al.* (1998), who divide anorexics into four typologies that correspond to four personality disorders listed in DSM-IV: dependent, borderline, obsessive-compulsive, and narcissistic. From our point of view, classification is just another attempt to force the facts to make them fit one's theory of reference, because it turns out to lack any concrete value from the operative point of view.

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

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

On that basis, we maintain that it is possible to know a reality by intervening on it, because the only epistemological variable that we can control is our strategy, i.e. our "attempted solution" that, when it works, enables us to understand how the problem persisted and maintained itself.

The final result of such a hard empirical-experimental process, guided by models of Mathematics Logic, is a model of advanced therapy, because it can be checked and verified, which then, due to its formalization can be repeated and didactically transferred.

Finally, such a model is not only effective and efficient but even predictive, this last feature enables a therapeutic typology to develop from home-made and artistic practice to advanced technology, without reducing or losing that rate of artistic creativity necessary to its constant innovation process, that in this case, happens respecting the criterion of scientific rigor making such a therapy truly reliable.

All we affirmed is valid for the study of the intervention structure and its constitutive logic, but another explanation is necessary about the adaptation of the intervention to every single person, family and socio-cultural context.

As on this subject every criterion of control and "predictability" gets away. As indeed Erickson affirmed, every person owns unique and unrepeatable features, such as his interaction with himself, the others and the world always represents something original.

Consequently every human interaction, even the therapeutic one, results in being unique and unrepeatable, within this the therapist has to adapt his logic and language to the patient's one proceeding, in that way, in the investigation of the features of the problem to be solved, until the revealing of his/her specific modality of persistence. Once the peculiarities of the problem persistence are known, he will able to use the logic of problem solving which seems more suitable, following in its constitution and application to the model above related; but formulating every single maneuver adapting it to the patient's logic and language. In this way, the therapeutic intervention truly keeps its capacity to adapt to every new person's peculiarity and situation, but keeping even the strategic rigor to the level of the intervention structure. To further clarify this important concept, it is useful to underline all that it is possible to rearrange is the strategy, to the level of intervention structure which adapts to the structure of the problem and to its persistence, what always changes is the therapeutic interaction, the relationship with the patient and the type of

communication used. Therefore even when we adopt a protocol of specific treatment, as in the case of phobic-obsessive disorders and the variations of eating disorders, every maneuver is always different but it always remains the same, because this one changes in its communicative way, but it remains the same maneuver at the level of strategic procedure of problem solving. So in line with G. Bateson's words (1984), which read "*Rigor alone leads to death due to asphyxia but creativity on its own is sheer folly*" we are claiming for rigor but not for rigidity.

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*Address reprint requests to:*
Giorgio Nardone
Centro di Terapia Strategica
Arezzo, Italia
gnardone@giorgionardone.it