The Strategic Dialogue:
to achieve the maximum with the minimum in the first session

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Abstract

Our title refers to that aspect of psychotherapy which involves the interaction between the client's position (their perspective, values, strongly held beliefs, as they pertain to a problem) and the clinician's therapeutic stance. We have observed that expert therapists not only execute a model of psychotherapy but also adopt "attitudes" themselves that serve to facilitate therapeutic movement in their clients. The aim is not necessarily to alter the client's position as such, but rather to weaken those aspects of the client's attitude that seem to contribute to their getting stuck. By "dancing" with the client – by emulating their steps, the clinician can find some opportune moment to introduce a variation in the steps in hopes of instigating a change. We plan to illustrate this dance by example and stories.

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«Problems cannot be solved
at the same cognitive level of their creation.»
- Albert Einstein -

The strategic dialogue represents both the finishing line and the starting point of the research work, clinical applications and managerial consultancy carried out by the Centro di Terapia Strategica of Arezzo (Strategic Therapy Centre) over a period of over 15 years since its foundation, honored by Prof. Giorgio Nardone and Prof. Paul Watzlawick. This course of study has witnessed the efforts and contributions of other colleagues, collaborators, scholars and patients, coming from all parts of the world, who were often unaware of the help they were providing during our dialogues.

The strategic dialogue, as the advanced technique to conduct a therapeutic session capable to induce radical changes in the interlocutor, represents the synthesis of all that have been achieved so far in this field of study; that's why strategic dialogue can be referred to as the *finishing line*. This fine strategy by which one can achieve the maximum with the minimum, developed itself through a natural evolution from the previous formulation of specific treatment models for particular pathologies, composed of therapeutic stratagems and of a sequence of maneuvers constructed *ad hoc* for the different types of problematics. It was thanks to the proclaimed success in terms of efficiency and efficacy of such protocols that lead us to think up and

render the first session a true and proper intervention rather than just a preliminary phase. Thus the *questions* became always more strategic, the *paraphrasing* became highly reframing, the language evoked more *sensations* and finally the *prescriptions* became the spontaneous evolution of the dialogue, strategically carried out to render it no longer an injunctive strain. In this way, from a constructive method of research, to get to know a problem through its solution became a logical operative and strategic means of conducting the first and often the sole therapeutic encounter or consultancy. On the other hand, the strategic dialogue is a *starting point*, because its experimentation together with its surprising effect that concern both its power to promote change and even its possible application to different contexts, have opened up new and promising prospectives both in research and intervention. From our point of view, all this is due to a method that induces change but which is not the product of the "expert's" directives to the "inexpert" but the result of a joined discovery of two, derived through their dialogue, which was purposely structured to fulfill this objective.

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The questions, rather than guiding only the therapist to understand the persistence of the problem to be solved, became the vehicle by which the patient is led to 'feel' things in a different way and in this way conducting his reactions to change, by bringing to light his resources which have been jammed by the previously-held, rigid and pathological perceptions.

In the wake of this, the style in conducting the first session has been completely modified, starting from the formulation of the investigation of the problem to be solved. The questions have been modified in their interrogative form and are no longer open-ended, such as:"*when you have a panic attack what do you feel?"*, but have become close-ended, holding a sort of illusion of alternatives: "*when you have a panic attack, you fear of dying or of losing control?*". This makes the person reply by taking up one of the planned answers.

But obviously this question is only possible thanks to ten years of experience in the study of the panic attacks, in all its forms and getting to know it through its solutions. This helped us understand that those who suffered from this type of pathology have a series of redundancies that repeat themselves. This does not apply only to this type of pathology but to all types of pathologies.

This is not reformulating a new type of diagnostic model, on the contrary, because in this case: we are "knowing through changing" and not "knowing (first) to then change".

The diagnostic procedure already becomes an intervention, better still the most important of all interventions. In fact if I had to say to a person suffering of panic attacks:

- "*When you have a panic attack do you fear of losing control or of dying?"* and the patient replies (like the majority of the cases seen in the last decade):

-"*I fear of losing control*", I have already lessened by half the possibilities.
Just like a funnel that gets narrow and narrow, we are guided until we
come to know how the problem functions. But since this discovery is made by
the therapist and patient, together, we define this dialogue as a *discovery*
reached by two.
Thus imagine that the patient replies: "*I'm afraid of losing control*".
The second question will be:
"*You are afraid of losing control, in situations you can predict or these are*
absolutely unpredictable?"
In the majority of the cases we have seen that the person replies: "*Well, I*
don't know!... but if I had to stop and think for awhile, I might say this

happens in certain situations"
Thus we reply:
"*And can you predict these situations*?"
The patient replies: "*Well yes, now that you made me think about it, I can*
predict when this might happen. For example when I have to go somewhere on
my own… or if I'm in a crowd… or if I'm closed space… or if I'm in elevated
places…", depending on the type of phobia.
Let us try to analyse now how we have managed to obtain thanks to these
two questions: we have already obtain quite a vast amount of information
because now we know that the person does not fear of dying but rather of
losing control and that this takes place in situation he can predict. But this is
what the therapist has come to understand, while if the patient has started to
have an always clearer map of his problem, with precise co-ordinates and
starts wondering that in reality, he does not fear of dying- something that he
might already knew but which now he has come to put into focus- and that all
this takes place in predictable situations.
To proceed beyond this point, it is useful to do a step backwards which
will allow us to leap two steps forward. With this intent, it is important to use
a paraphrase which will help us confirm that we are moving in the right
direction and that anchors the perception of the patient regarding the function
of the problem to the new prospective.
Thus we can tell the person:
"*Please correct me if I'm wrong* (thus taking up a one-down submissive
position)*… but you are telling me that you suffer of panic attacks and this*
correspond to a fear of losing control and that this takes place in a situation
you can predict".
The patient will reply: "*Yes I believe so!*"
Thanks to this expressed approval and to the agreement establish between
the expert and that person asking for help, it seems as if we are moving along
a multi-lane highway, and through a sequence of manoeuvres, we
progressively eliminate lateral lanes, to end up with just one lane: that leads to
change.
Doing so, we are only proceeding along a narrowing-down logic that leads

to the solution, while we are at the same time acquiring something else, which is as important. By declaring *"Please, correct me if I'm wrong"* we make the patient feel as if he is leading the discovery process of our dialogue. In such way, he will not feel disqualified but rather gratified.

In this way we are establishing an emotionally positive relationship that amplifies the collaboration and the subject's expectations of therapy.

Furthermore, he will be more aware not on what might have caused the problem but how he can manage it and how it functions. The patient goes through this process with the illusion of leading it all.

Proceeding with the strategic questioning, the third question suitable for this case:

"When facing such situations, do you tend to avoid or face the situation?"

In virtue of these questions we come to discriminate whether the person tends to avoid due to his fear or rather tends to give up only after facing the situation unsuccessfully. Both replies open up a different scenario and require diverse strategies in the evolution of the dialogue.

Imagine, the person replies: *"I tend to avoid situations"*.

Thus the following question should be:

"But if you can't really avoid it, what do you do: you ask for help or you face it on your own?" and generally the person replies: *"Well, I ask for help"*.

This is a very important question since it discriminates whether the person is dependent on someone or whether he tries to make it on his own, and these will orient us to a completely different evolution of the treatment. This because, in the case of the former, we focus in breaking the dependency and bring the person to discover his resources, while in the latter, we base our intervention in dismantling the trap in which the person has drawn himself into. Thanks to this answer, we have added another piece of strategic knowledge; the person either avoids threatening situations, or else asks for help in order to be able to face them.

Now we can paraphrase once more to confirm and redefine:

"Correct me if I'm wrong, so you are a person that suffers of panic attack, that might take place in situations you can predict and thus you tend to avoid such situations. But if you can't possibly avoid, you need somebody who accompanies you, who can act promptly in case you will feel sick".

"That's it!" replies the patient.

Thanks to these maneuvers we hold already a lot of operative information on how the problem functions; at the same time even the patient's mind starts focusing on the functioning of his problem and how he usually tends to manage it; his dysfunctional attempted solutions are revealed with great clarity.

Moreover, the person feels understood and contemporarily acknowledges that he is in front of a competent therapist because the latter is putting forward decidedly crucial questions. This will highly increment the patient's therapeutic expectancy and will reinforce the relationship between the

therapist and the patient. Hubble, Duncan and Miller (1999), declare that is

responsible of over 70% of the generated change in therapy.

And if to this we add, as in our case, the opening up to new prospectives that make the patient feel that there is a possible solution, the therapeutic gradient is boosted even more.

Once this is achieved, usually we proceed to put forward other successive strategic questions and reframing paraphrasing:

"*You tend to speak a lot about your problem or you keep everything for yourself*?"

Let's imagine that the person replies:

-"I *speak about it with everyone*".

From a strategic point of view, we have a much clearer picture: we hold enough information to start the most active phase of change. In fact, we now have clear the function of the problem based on the three basic dysfunctional attempted solutions usually put in practice by the person suffering of panic attack. Now we can proceed to guide indirectly the patient towards change; it is as if we are launching a snowball, which rolls and rolls until it becomes an avalanche. With this objective in mind we proceed to ask:

- "*And when to speak about it do you feel better or worse*?"

And the patient replies: "*Well I feel better because I feel relieved*".

And thus we ask:

"*You told us that when you speak about the problem, in that moment you feel better because you feel relieved. But after some time, do you feel better or you feel worse*?"

Usually the person will look at you and reply:

-"*Now that you made me think, afterwards I feel very frustrated*".

Thus the paraphrase that follows is:

-"*Therefore, if I'm not mistaking, you tend to speak a lot about your problem and when you disclose it, you feel better because you feel relieved but soon after you feel even more frustrated because you recognize once more your incapability*" .

And the person who is nailed down to perceive things through a new prospective, usually answers:

-"*Yes, that is true!*"

We are starting to introduce change in his perception and emotions in regards to his attempted solutions: which were first perceived as useful but which in the long run end up to render the situation worse.

Following this wake of introducing changes through evoking new sensations regarding the failed attempted solutions operated by the subject, we proceed with another question:

"*And when you ask for help in order to be able to face a threatening situation, and this person helps you, do you feel better or worse?*"

Usually the person replies:

-"*Better! Yes however afterwards… I feel worse because I feel always more incapable*".

-"*Ah! So please correct me if I'm wrong but when you ask for help and you receive it, at the very moment you feel better because you feel save but soon after you feel always more incapable, because when you receive help from others, this proves even more the fact that you can not make it on your own, and this makes you feel worse and worse…*".

And the person once more replies:

-"*Yes, that is true!*"

Once more we are introducing change through a series of questions and paraphrases that make the person *feel* rather than *understand*.

To feel that when he speaks about her problem or asks for help, this worsens the situation; thus this renders fear no longer a limit but a resource. In fact, a bigger fear, i.e., that of worsening the situation, will lead to cease the smaller fear, i.e., that which induces to ask for fear.

From our point of view, it is decisively important the difference between 'to feel' and 'to understand', because there is a dated illusion regarding human beings: "they need to understand something in order to change it" even though we are faced every day with different proof. Every single one of us has, at sometime or another, felt the frustration of wanting to free oneself from something but was unable to do so. For example, we understand well that we are sharing our life with the wrong person, so we would like to break free but we feel that we are so attached to that person that we can not make such a step. Is there a better proof that shows the difference between feeling and understanding?

From a strategic point of view, therapy should aim in making the person feel differently towards something and not understand it differently; to change the perception regarding something and not to change the cognition, because if I change the perception I'll be changing the emotional reaction, thus changing the behavioral reaction and as a final effect I eventually change the cognition. While the great majority of psychotherapies works in changing cognition, behavior or emotions. But all that which triggers off every process is what we feel, how we perceive, and all the rest follows.

Returning to our case, through the use of questions and paraphrasing the patient feels differently and feels that every time he asks for help and receives it or speaks about his problem and is listened, the situation gets worse even

though in that very moment he feels better. This allows us to ask of him something which otherwise would have been impossible to ask; avoid asking for help and to continuously speak about it. The person can accept this now because he first felt the need to stop it and then understood that this could help him.

The patient went through a process of discovery together with the therapist. The discovery was conducted by the patient because he was the one

to give answers to the questions, so he feels induced and not forced. The therapist have only confirmed, paraphrased his answers and have constructed the process though a series of focal questions.

In this way one can already from the first session, guide the patient to discover new perceptions that determine new reactions to the problem. In reality, by doing so, we are subtly introducing a chain reaction of changes: knowing through changing.

Haven reached this point of the session, to further reinforce the effects of what has been reached so far, we introduce a maneuver that by means of the strong evoking sensations will impress firmly the necessity and inevitability of change, something which up till that moment was not even contemplated by the person.

"*Please allow me to reassume all that which had been said and if I'm not mistaking, otherwise please do correct me, you are a person who suffers of panic attack that takes place in situations you can predict, which you tend to avoid. But if you can not avoid them, then you ask for help and speak quite a lot about it. And when you do so, you first feel relieved and feel better but afterwards this makes you feel worse, because if others listen to you, this means that there is truly something wrong with you. Same applies to when you ask for help in order to face a situation you can not avoid, and thus at the very moment, having help from others makes you feel save but after you feel even more incapable because if others need to help you, this means that you can not make it on your own*".

The person replies:

-"Yes, things are in this way!"

-"*Well, what we have said so far, brought to my mind a phrase written by a well-known poet, Fernando Pessoa, which said 'you bear the wounds of the evaded battles' and I add –the wounds of the evaded battles never truly heal*".

Just like a scorching blade, this aphorism leaves a mark in the person. We regard the aphorism as the strongest literary form of communication, being it highly and immediately evocative; it brings a person to feel something and not explain it, while entailing no great effort because it immediately leaves its

effect and the interlocutor remains bewildered with his pupils dilated, looking just like a cat in front of the car-lights. The aphorism will leave a mark inside his mind just like a brand stamp.

But what have we done so far? Certain questions, certain paraphrase, followed by an aphorism. However, through doing seemingly 'little', we have really achieved 'a lot' since we have introduced a very radical change in the patient's perception. This because now the person holds a clear, felt perception, that certain things he had been doing to safe him from fear, ended up maintaining and even worsening the situation. We did not 'explain' that the attempted solutions worsen the problem besides maintain it, but we have made them 'feel' it. This is an 'emotionally corrective experience'; the vision of a new reality through a process of discovery, which the person thinks he has

lead in first person.

Now thanks to what has already taken place in the session, the patient will be more open to accept suggestions and put into practice direct prescriptions. Thus prescribing different behavior modalities, becomes a joined achievement of the therapist and the patient. 'Directivity' turns into 'collaboration'. Such an evolution of the therapeutic communication has led the first session to become not only a diagnostic and preliminary phase prior to the intervention, but it became a true therapeutic stratagem in itself. The investigation transformed itself into a true intervention.

In this way, we reduce to zero the natural resistance present in all individual or extended human systems, which tend to oppose to any changes that might alter their discomforting and pathological equilibrium. In fact through the use of the Strategic Dialogue such limit is transformed into a resource, because the therapist, just like a wise strategist, uses subtle maneuvers to guide his interlocutor to feel as the main protagonist of the scene; in this way the latter gets more easily persuaded of the what he has come to feel and discover.

We believe that the "magic" of this technique resides in its inured essentiality, which the first Seven Wisdoms of the Hellenic Tradition, express as *«being not too much, just enough.»*

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