

"Post-graduate School of Specialization  
in Brief Strategic Therapy  
directed by Prof. Giorgio Nardone"

**Obsessive-Compulsive Disorder treatment:  
cognitive-behavioral approach versus  
brief strategic advanced model.**

Specialization thesis of  
Dott.ssa Agata Rakfalska-Vallicelli

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## **Obsessive-Compulsive Disorder treatment: cognitive-behavioral approach versus brief strategic advanced model.**

*For those obsessed there is no choice:  
the obsession has already chosen for them, before they do.*

*E. M. Cioran*

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## 1. Introduction

Obsessive-compulsive disorder (OCD) is a common psychiatric disorder affecting adults, children and adolescents and causing significant disability. According to the research made by Kessler<sup>1</sup> and collaborators, in 2005 –the lifetime prevalence of OCD is 1,6 % of U.S. adult population. Cross-cultural epidemiologic studies have confirmed that the prevalence of OCD is between 1%–2% of the general population in Europe, Canada and Asia.<sup>2</sup> According to the other data, even 5% of population experience this mental illness<sup>3</sup>.

**This thesis is aimed to** present two different treatments of OCD – cognitive-behavioral therapy and brief strategic therapy.

**This thesis is aimed to** respond on last article of Caleb W. Lack<sup>4</sup> who suggested increased dissemination of effective therapies for OCD patients. That’s why this writer would like to describe advanced model of brief strategic therapy developed by professor Giorgio Nardone and professor Paul Watzlawick at the Brief Strategic Therapy Centre in Arezzo, Italy. For the last 25 years professor Giorgio Nardone and his collaborators have treated more than 25.000 cases with an efficacy of 86-89% for OCD (more information in chapter 5.b.).

**This thesis is aimed to** give hope for many patients who experience OCD and who have been looking for effective psychotherapeutic treatment without pharmacological intervention.

What is OCD? The essential features of Obsessive-Compulsive Disorder (OCD) are recurrent “obsessions” (e.g. persistent ideas, thoughts, impulses, images) that cause marked anxiety or distress, and “compulsions” or repetitive behaviors (e.g. hand washing, ordering, checking) exhibited to prevent or reduce anxiety or distress. The obsessions and compulsions are time-consuming and significantly interfere with the individual’s normal routine, occupational functioning, usual social activities and/or relationships with others.

According to brief strategic model, OCD is the overwhelming need to constantly check reality, which is expressed in a series of ritualistic actions or thoughts. Their redundant repetitions play the role of reassuring the person in control of what can happen or the effects of what happened. Over the time a person is convinced that s/he has control over what is happening or has happened, through constant

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<sup>1</sup> Kessler RC, Berglund PA, Demler, O., Jin, R., Walters, E.E. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*. 2005 Jun;62(6):593-602

<sup>2</sup> Rasmussen, S.A., Eisen, J.L., (1992). *The epidemiology and differential diagnosis of Obsessive-Compulsive Disorder*. In: Series dupbar med communication, pp. 1-14.

<sup>3</sup> Nardone, G., Portelli, C. (2013). *Ossessioni, compulsioni, manie*. Ed. Ponte alle Grazie.

<sup>4</sup> Lack, C. W., *Obsessive-compulsive disorder: Evidence-based treatments and future directions for research*. *World Journal of Psychiatry*. (2012). December 22; 2(6): 86-90.

repetition of certain actions or thoughts. If the individual stops doing rituals, a fear appears that something bad might happen, so the person again returns to controlling, checking and repeating the mental formulas or activities. What was a solution to cease anxiety at the beginning, becomes a new problem. We will discuss these dynamics in next chapters.

The Description of how a person with OCD is functioning, can explain how difficult the treatment can be. Did you ever wonder how many years a patient with obsessive-compulsive disorder (OCD) needs to get proper treatment? According to OCFoundation,<sup>5</sup> it is 14- 17 years. Patients very often hide their symptoms in fear of embarrassment or stigma. Many people did not know there was even a name for their illness, so they assumed there was no treatment. Low public awareness and lack of proper training in health professionals contribute to incorrect diagnosis and ineffective treatment. People have to see several doctors and spend several years to get to the right treatment. It should change.

In next chapter this writer is going to present descriptive and operative diagnosis of Obsessive-Compulsive Disorder.

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<sup>5</sup> <http://www.ocfoundation.org/treatment.aspx> (19.oct 2013)

## 2. Definition of Obsessive-Compulsive Disorder

### a) according to DSM V and ICD 10.

Obsessive-compulsive disorder is a class of anxiety disorders which is characterized by intrusive thoughts that produce anxiety (obsessions), repetitive behaviors that are engaged in to reduce anxiety (compulsions), or a combination of both.

Below there is a table of diagnostic criteria for OCD according to DSM-5 (Diagnostic Statistical Manual of Mental Disorder, 5<sup>th</sup> edition, APA, 2013) and ICD-10 (Mental and Behavioral Disorders of International Statistical Classification of Diseases and Related Health Problems – 10<sup>th</sup> Edition, Revised, WHO, 1994).

ICD – 10 clinical descriptions and diagnostic guidelines	DSM-5 criteria
<b>Definition</b>	
<p><b>Obsessional thoughts:</b> distressing ideas, images, or impulses that enter a person's mind repeatedly. Often violent, obscene, or perceived to be senseless, the person finds these ideas difficult to resist.</p>	<p><b>Obsessions:</b> persistent ideas, thoughts, impulses, or images that are experienced as inappropriate or intrusive and that cause anxiety and distress. The content of the obsession is often perceived as alien and not under the person's control.</p>
<p><b>Compulsive acts or rituals:</b> stereotyped behaviors that are not enjoyable that are repeated over and over and are perceived to prevent an unlikely event that is in reality unlikely to occur. The person often recognizes that the behavior is ineffectual and makes attempts to resist it, but is unable to.</p>	<p><b>Compulsions:</b> repetitive behaviors or mental acts that are carried out to reduce or prevent anxiety or distress and are perceived to prevent a dreaded event or situation.</p>
<b>Diagnostic criteria</b>	

<p>1. Obsessional symptoms or compulsive acts or both must be present on most days for at least 2 successive weeks and be a source of distress or interference with activities.</p> <p>2. Obsessional symptoms should have the following characteristics:</p> <ul style="list-style-type: none"> <li>• they must be recognized as the individual's own thoughts or impulses.</li> <li>• there must be at least one thought or act that is still resisted unsuccessfully, even though others may be present which the sufferer no longer resists.</li> <li>• the thought of carrying out the act must not in itself be pleasurable (simple relief of tension or anxiety is not regarded as pleasure in this sense).</li> <li>• the thoughts, images, or impulses must be unpleasantly repetitive.</li> </ul>	<p>1. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day) or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.</p> <p>2. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty ruminations in the presence of a Major Depressive Disorder.</p> <p>3. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.</p>
<b>Differential Diagnosis</b>	
<p>Differentiating between obsessive-compulsive disorder and a depressive disorder may be difficult because the two types of symptoms frequently co-occur.</p> <p>In an acute episode, precedence should be given to the symptoms that developed first; when both types are present but neither predominates, it is usually advisable to regard the depression as primary.</p> <p>In chronic disorders, the symptoms that most frequently persist in the absence of the other should be given priority.</p> <p>Occasional panic attacks or mild phobic</p>	<p>Obsessive-compulsive disorder must be distinguished from:</p> <ul style="list-style-type: none"> <li>• Anxiety disorder due to a general medical condition.</li> <li>• Substance-induced anxiety disorder.</li> </ul> <p>Recurrent or intrusive thoughts, impulses, images or behaviors may occur in the context of many other mental disorders. OCD is not diagnosed if the thoughts or activities are exclusively related to another disorder, such as Body Dysmorphic Disorder, Specific or social phobia, Hair Pulling in Trichotillomania. Worries or ruminations are mood-congruent and aspects of the condition and are not ego-dystonic in Major Depressive Episode. Worries are related to real-life circumstances in</p>

<p>symptoms are no bar to the diagnosis. However, obsessional symptoms developing in the presence of schizophrenia, Tourette’s Syndrome, or organic mental disorder should be regarded as part of these conditions. Although obsessional thoughts and compulsive acts commonly coexist, it is useful to be able to specify one set of symptoms as predominant in some individuals, since they may respond to different treatments.</p>	<p>Generalized anxiety disorder. Distressing thoughts are exclusively related to fears based on misinterpretation of bodily symptoms in Hypochondriasis. Ruminative delusional thoughts and stereotyped behaviors differ from obsessions and compulsion because they are not ego-dystonic and not subject to reality testing in Schizophrenia. Movements are typically less complex and are not aimed at neutralizing an obsession in: Tic disorder, Stereotypic movement disorder. Activities are not considered to be compulsions because pleasure is usually derived in: Eating disorder, Paraphilia, Pathological gambling, Alcohol dependence or abuse. Condition is not characterized by the presence of obsessions and compulsions and instead involves a pervasive pattern of preoccupation with orderliness and cleanliness and must begin by early adulthood in: Obsessive compulsive personality disorder. An additional diagnosis of OCD may be warranted if there are obsessions or compulsions not related to the other mental disorder.</p>
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<sup>6</sup> Table 1. Comparison between OCD diagnostic criteria according to DSM-5 and ICD-10 RV.

All these descriptions give a static concept of OCD, a kind of “photograph”, or lists of the essential characteristics of a disorder, but they don’t give any operative suggestions as to how the problem functions or how it can be solved<sup>7</sup>.

**b) according to operative diagnosis of Brief Strategic Therapy**

The Brief Strategic Approach is based on operative diagnosis, which means that a correct theoretical knowledge of OCD (and other psychological problems) can be achieved only after applying effective solutions, inverting the entire diagnostic

<sup>6</sup> Adapted from *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines (10th edn), Vol.1. Geneva: World Health Organization (1993)* and *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (2013). American Psychiatric Association*. From: <http://www.ncbi.nlm.nih.gov/books/NBK56452/> Date:19.oct.2013

<sup>7,8</sup> Bartoletti, A., Nardone, G. (2007). Toward an operative knowledge of psychological problems: The strategic Diagnosis. In *Journal of Brief, Strategic and Systemic therapies*. Volume 1, nr 1. pp 123-134.

process from a nosographic “first knowing, then changing” to an operative “knowing through changing”, in other words, knowing a reality through the strategies that can change it. Strategic diagnosis is a solution-based process<sup>8</sup>. Operative description means a cybernetic-constructivist type of description of the modalities of persistence of the problem, i.e. how the problem works and feeds itself through a complex network of perceptive and reactive retroactions between the subject and his/her personal and interpersonal reality (the perceptive reactive system or PRS).<sup>9</sup> The first step represents an “operational hypothesis” that can (and must) be constantly self-corrected by the effects of the therapeutic strategies that we use to solve the problem. The strategic therapist has found the “reducers of complexity” in the constructs of attempted solutions (AS) and perceptive-reactive system (PRS)<sup>10</sup>.

Obsessive-Compulsive disorder is a good example which shows how attempted solutions worsen the situation and become a new problem. As it is written in article of Bartoletti and Nardone<sup>11</sup>, when a person faces a certain problem, the first reaction is to try to solve it, either relying on past experiences by reapplying interventions that have been successful in solving similar problems in the past, or by attempting new solutions. If these strategies do not work, rather than applying alternative solutions, there is a tendency to apply the chosen strategy more vigorously, often based on the illusion that “more than before” will be more effective. Such attempts to reiterate the same ineffective solution eventually give rise to a complex process of retroactions in which the efforts to achieve the change actually keep the problematic situation unchanged. So the **“attempted solutions” themselves become a problem.**<sup>12</sup>

### How is OCD formed?

OCD is an overwhelming need to check reality, which is expressed in a series of actions or thoughts rituals. Their redundant repetition plays the role of reassuring the person in control of what can happen or the effects of what happened. It

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<sup>9</sup> Nardone, G., (1993), Nardone, G.,(2005). In: Bartoletti, A., Nardone, G. (2007). Toward an operative knowledge of psychological problems: The strategic Diagnosis. In Journal of Brief, Strategic and Systemic therapies. Volume 1, nr 1. pp 123-134.

<sup>10</sup> PRS – perceptive-reactive system – an individual’s redundant modalities of perception and reaction toward reality. There 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 (In: Nardone, G. (1991). Suggestione, Ristrutturazione= Cambiamento. L’approccio strategico e costruttivista alla psicoterapia breve. (Milan, Giuffrè).

<sup>11</sup> Nardone, G., (1993), Nardone, G.,(2005). In: Bartoletti, A., Nardone, G. (2007). Toward an operative knowledge of psychological problems: The strategic Diagnosis. In Journal of Brief, Strategic and Systemic therapies. Volume 1, nr 1. pp 123-134

<sup>12</sup> Watzlawick, P., Weakland, J. H., Fisch, R. (1974). Change: principles of problem formation and problem solution. New York, NY: W.W. Norton &Co.



becomes absurd, from the perspective of a non-expert observer, i.e. what emerges from a rational need of control then becomes totally irrational. Some examples taken from the newest book of Nardone and Portelli (2013, "*Ossessioni, compulsioni, manie*") have been presented in this work.

It is healthy to be careful not to be dirty or to take a bath after getting dirty, but it is insane to clean oneself for hours and hours in doubt of having touched something dirty or contaminated and, after being washed for a long time, still doubting that one had not washed enough and thus be forced to wash again.

Or, before you go to bed, it is certainly healthy to check that the doors, taps, or the valves of gas are closed, but it is definitely absurd to wake up several times at night and check for a long time everything, again and again.

It can be healthy to imagine than you pass an exam, but it becomes unhealthy to structure a propitiatory ritual of thoughts that you cannot avoid before taking any exam.

### **What motivates a person to activate compulsive actions and thoughts?**

Basing on the information presented in the latest publication<sup>13</sup> on OCD, five types of motivations may be enumerated as follows:

**1. Doubt that triggers the need for a reassuring answer.**

For example doubt of being infected or of being infected by a disease through contact with a foreign agent → "I must prevent (reasonable protections, preventive or reparatory) putting into practice a series of actions or thoughts that run through my mind, and that's why I repeat them until they become an uncontrollable compulsion. The unreasonable becomes totally reasonable.

**2. Ritual that derives from the excess of ideological rigidity or the morality or the superstitious belief.**

- "I'm afraid of having committed a sin, I must pray to atone for the sins and to be forgiven" → a reparatory ritual related to a form of punitive religiosity.

- "I renounce something I like, in order to resist a temptation, but it's rather difficult to force me to do that, so I do a preventive ritual, like washing myself with very cold water every time I feel erotic impulse I have to block.

- Propitiatory rituals – for example - morning rituals of prayer to make sure that everything goes well during the day.

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<sup>13</sup> Nardone, G., Portelli, C. (2013). *Ossessioni, compulsioni, manie*. Ed. Ponte alle Grazie, pp. 12-15

**3. Exasperation of rational reasoning processes until they become completely unreasonable.**

- "Before making a decision I have to analyze all possibilities, otherwise I risk being wrong" → the person becomes unable to take any decision.
- "The more I try to find security, the less I find it." – In order to attempt to prevent errors, the individual becomes unable to act.
- "When I'm insecure and I'm afraid I'd made a mistake, I check repeatedly what I have done - until I am no longer able to bring my job to an end" (for example, an accountant convinced he had made a mistake).

**4. Acts of healthy prevention led to the extreme.**

- Prevention transforms into mania – e.g. a house becomes a temple of cleanliness, but when preventive avoidance is not possible, the individual proceeds to exasperated disinfection, or to abuse cleaning products that are considered almost magical.
- Mother attentive of the health of her children starts to keep them away from the situations considered dangerous.

**5. Effects of a traumatic experience - to defend what trauma has produced, the individual develops a series of thoughts or behavior to quell and/or immunize.**

- Women who are victims of abuse: when they come back home after the traumatic event, wash themselves so exasperatedly as if they could "wash out" the incident. It becomes uncontrollable compulsion (ritual of purification). What makes the rite "functional" is that, in its execution, anxiety and distress, associated with the sense of dirt, are alleviated by compulsive washing, which, however, invalidate their personal lives and relationships.

**How OCD is maintained?**

As you can notice, the attempted solutions to avoid a fearful situation or to immunize from the pain or to alleviate the high level of anxiety, works at the beginning, but after some time, the individual is unable to stop them.

After the disorder has been built, the anguish for the person is no longer the original fear, which forced him/her to trigger the chain of ritualized actions, but the inability to cease the execution of the rituals. This is the paradigmatic example of how a solution becomes problem.<sup>14</sup>

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<sup>14</sup> Nardone, G. (2000). Oltre limiti della paura. (BUR)

So what are **the most common attempted solutions of OCD patients** (which serve to manage discomfort and anxiety)?

- Avoidance of anything that scares him/her (the first attempted solution which feeds the problem),
- Constant demand for reassurance or help (family members who become involved in the pathological mechanisms),
- Implementation of a ritualized sequence of actions in order to fight the fear or manage the pulse of pleasure (compulsion based on phobic perception or an irrepresible tendency to search for pleasurable sensations – a sensation seeker).

In most cases, when the disorder is a structured sequence of rituals, the phobia that originally triggered it fades into the background and the attempted solutions become the problem<sup>15</sup>.

**The typical rituals are:**

- washing,
- disinfection,
- control,
- mental repetition of formulas,
- counting,
- torturing the skin,
- other rituals which are unusual and original.

**Types of rituals:**

- numeric or countable – rituals that are repeated a number of times (for example, “Before going to work I have to turn on and turn off the light three times”).
- to sensation – rituals that are repeated for some time in order to create a sensation of “well-being” (for example, “Many times a day I have to wash my hands in a specific way until I feel they are clean”, sometimes it lasts even 30 minutes.)

**Types of compulsive rituals:**

- Preventive - performing actions or thoughts to prevent something from happening (for example, performing particular movements in the same manner before you leave home to avoid accidents, or using the bathroom several times before you go to work to prevent a problem with incontinence ). These rituals are focused on anticipating the frightening situation to propitiate the beast or to avoid the worst

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<sup>15</sup> Watzlawick, P., Weakland, J.H., Fisch, R. (1974). Change. Principles of problem formation and problem resolution. Norton.

outcome, therefore it is oriented toward the future.

Rational – preventive rituals are specific actions that arise from the patient's belief that doing so would prevent a certain feared situation from happening, for example getting contaminated or infected, losing control, losing body energy and so forth.

- Reparatory - performing actions or having thoughts that should protect the person from something that could have happened (washing his/her hands as an attempt to eliminate dirt left on them or checking whether a job has been done several times for fear that it is wrong, or repeating the name of a certain person to exorcize his/her negative gaze). These rituals are carried out to intervene and repair the damage after a feared event has taken place so that the patient will not feel in danger, therefore it is oriented toward the past.

- Propitiatory - performing actions or having thoughts (magic) to make something positive happen or to avoid something negative (for example, arranging the objects in a particular position to bring good fortune or to avoid misfortune). These rituals are a form of magical thinking highly linked to fatalistic religious beliefs, superstitious convictions, confidence in extraordinary powers or faith, and so forth.

Interactive patterns of OCD are those which maintain or worsen a system balance. We cannot forget about the impact of family members on the patient with OCD problem. Family members are very often involved in the dysfunctional mechanisms of repetition of actions, or control of their execution and when they want to step back, the individuals who suffer from OCD become more anxious and aggressive. That is why a very important part of the treatment is to work with the family members in order to move them aside from the pathological vicious circle and restore the patient's responsibility for the problem.

As you could notice, the differences between a classical descriptive diagnosis and an operative diagnosis are fundamental. The first type describes the symptoms of disorder, and the differences between disorders or syndromes. In differential descriptive diagnosis (DSM-5), OCD, for example, is distinguished from Hypochondriasis (where the obsessive thoughts are related to the health issues) or Pathological Gambling (because the basic emotion in this disorder is seeking for pleasure but not avoiding anxiety, as it was described previously).

According to the operative diagnosis applied in the brief strategic therapy to describe the functioning of OCD, the therapist relies on the **perceptive reactive system (PRS)** of the person. PRS is the way in which the person perceives the reality

and reacts to it in relation to himself/herself, the others and the world..

The individuals who experience Obsessive-Compulsive Disorder perceive the reality as unpredictable and frightening, that is why they tend to control the reality. More and more control leads to the belief that if they do not control the reality, it cannot function right and something bad may happen.

Brief strategic therapy distinguishes compulsions based on fear (e.g. washing hands in order to prevent contamination) from the ones based on pleasure ( e.g. compulsive shopping, vomiting syndrome or pathological gambling, etc. ), where the rituals that are repeated for a long time become pleasurable.

General differences in the description of OCD lead to different research models and methods of treatment.

Next chapter presents cognitive-behavioral approach to therapy.

### 3. Paradigm of Cognitive –Behavioral Therapy (CBT)

In 1976, a psychiatrist Aaron Beck posed the question about a new form of therapy that emphasized patients' changing dysfunctional cognitions: "Can a fledgling psychotherapy challenge the giants in the field—psychoanalysis and behavior therapy?". Since that time cognitive-behavioral therapy (CBT) has emerged as one of the most dominant psychotherapy modalities —the more general term that subsumes Beck's particular variant is called cognitive therapy<sup>16</sup>.

Cognitive behavioral therapy (CBT) is one of the most thoroughly studied forms of psychotherapy. It was developed by American psychotherapists in the 1960s. Since then the methods of cognitive behavioral therapy have been constantly evolving.

Cognitive behavioral therapy (CBT) is the umbrella term for a particular group of psychotherapies. Cognitive psychotherapy includes many different orientations, within the same theoretical mainstream: from the constructivists (Kelly, 1955), to the evolutionists in the style of Mahoney (1979), to Ellis's (1978) rational-emotional therapy, to the cognitive-behavioral therapy of Beck and Emery (1985) and to the cognitivist authors who have reintroduced psychodynamic concepts and formulations.

CBT combines two therapeutic approaches: cognitive therapy and behavioral therapy. The applied method of treatment depends on the illness or problem to be treated. Depending on what seems to make sense in an individual case, elements and methods from both approaches are used in therapy. However, the basic assumption of therapy is always the same: **What we think, how we feel and how we behave are all interconnected – and all of these factors have a decisive influence on our well-being.**

CBT:

- is a problem-oriented treatment.
- helps in recognizing current problems and finding solutions to them.
- aims at the client being able to cope with his or her own life again without therapeutic help, as quickly as possible.
- does not deal primarily with the past. It does not focus primarily on uncovering the deeper origins of problems.
- is based on a cooperative partnership between the therapist and the client. The therapy is shaped together.
- requires a lot of self-initiative. A successful therapy assumes that the client will continue to work on the problems between sessions.

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<sup>16</sup> Gaudiano, B., A. (2008). Cognitive-Behavioral Therapies: Achievements and Challenges. Evidence Based Mental Health. 2008, Febr; 11 (1): 5-7.

In CBT the client deals with the question:

- whether his or her own thoughts and convictions have a negative effect on well-being.
- whether certain types of behavior contribute to problems.

<p><b>Etiological Theory</b></p>	<ul style="list-style-type: none"> <li>• Psychopathology is the result of faulty information processing.</li> <li>• Distorted and dysfunctional cognitions produce negative affective states and maladaptive behaviors.</li> <li>• Each disorder is characterized by different, but predictable patterns of information processing distortions.</li> </ul>
<p><b>Techniques &amp; Strategies</b></p>	<ul style="list-style-type: none"> <li>• Active, goal-oriented, problem-solving approach.</li> <li>• The therapist and the patient engage in “collaborative empiricism”.</li> <li>• Identify, evaluate, modify, and replace the distorted cognitions with the ones that are more accurate and adaptive.</li> <li>• Behavioral experiments used to test out and correct distorted predictions.</li> <li>• Other “classic” behavioral techniques included as a part of the treatment (e.g. exposure to feared stimuli).</li> </ul>
<p><b>Mechanism of Action</b></p>	<ul style="list-style-type: none"> <li>• Correcting distorted cognitions produces improvements in affect and behavior.</li> </ul>
<p><b>Desired Outcomes</b></p>	<ul style="list-style-type: none"> <li>• Initial symptomatic improvement.</li> <li>• Later functional improvement.</li> </ul>

Table 2. The General Cognitive-Behavioral Therapy Model. Adapted from Forman and Herbert<sup>17</sup>.

The term “cognitive” comes from the Latin *cognoscere* meaning “to recognize” or “to be aware of”. The point of cognitive therapy is to get a clear idea about the patient’s thoughts, attitudes and expectations. This aims to reveal and change inappropriate and distressing beliefs. Because they are often not only the things

<sup>17</sup> Forman, E., Herbert, J.,(2006). Acceptance and commitment therapy: Similarities and differences with cognitive therapy. Available at: <http://www.scientist-practitioner.com>.

and situations themselves that cause problems, but the importance that the patient attaches to them too.

A typical example of such a distressing thought pattern is generalization. In some situations many people tend to jump to conclusions and assume the worst, for example: "My husband has left me – I must be a bad partner, I will never find anyone ever again!" In psychology this generalized way of thinking is called "over-generalizing." A general "truth" is deduced from a single incident and applied to similar situations. The fact that many relationships fall apart and that the reasons are rarely found in just one of the partners is thereby overlooked.

Another distressing error in reasoning is "catastrophizing": If something disturbing happens, people immediately draw exaggerated conclusions about the scope of the supposed disaster ahead. Cognitive therapy helps to think more clearly and to control the patient's thoughts better.

Exaggerated patterns of thoughts and beliefs such as over-generalizing or catastrophizing sometimes develop into self-fulfilling prophecies and make life difficult for the people affected. Cognitive therapy helps people learn to replace these thought patterns with more realistic and less harmful thoughts.

Behavioral therapy is rooted in American "behaviorism." This theory assumes that human behavior is learned and can therefore be unlearned or learned anew. Behavioral therapy aims to find out whether certain behaviors make life difficult for the person or cause his/her problems to be more severe. In a second step, s/he works on changing these behaviors.

People who have developed depressive thoughts frequently tend to withdraw and no longer pursue their hobbies. As a result, they feel even more unhappy and isolated. Behavioral therapy aims to recognize this pattern and then to find ways for someone to become more active again.

In anxiety disorders behavioral therapy often includes learning methods to help the person to calm down. For example, s/he can learn to reduce anxiety by consciously breathing in and out deeply so that the body can relax. When doing so s/he concentrates on his/her breathing instead of the thing that has brought on the anxiety. This kind of technique can help him/her to calm down..

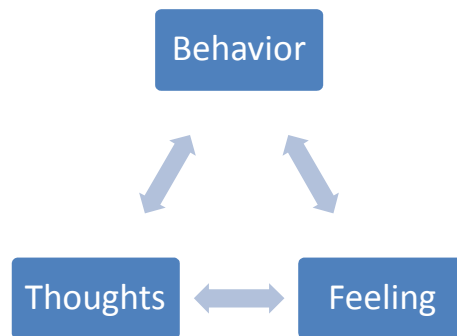
In CBT it is important to have a close and trusting cooperation between the psychotherapist and the client. Together they work out their treatment goals and they speak regularly about the progress achieved and any possible difficulties that may crop up. Sometimes it takes a while to find the right therapist.<sup>18</sup>

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<sup>18</sup> Information on CBT was taken from IQWiG (Institute for Quality and Efficiency in Health Care). Fact sheet: Cognitive behavioral therapy. Perspective can make a difference. (Last update, dec.2012). <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0016271/> (Date: 10/12/2013).



The assumption underlying CBT is that our thoughts, our behavior and our well-being mutually influence one another:



Sometimes harmful thoughts or types of behavior make us feel bad. This is best explained with an example: *Imagine meeting someone you know on the street. You say hello, but the person does not greet you in return. There are different ways of reacting to this*<sup>19</sup>.

Reaction	Damaging	Neutral
thoughts	"He has ignored me – he doesn't like me anymore."	"He hasn't noticed me – maybe he doesn't feel well. I should give him a ring and find out how he is doing."
feelings	Someone who thinks in this way feels downcast, sad and rejected.	With these thoughts, no negative feelings come up.
behavior	The consequence of this thought is to avoid this person in the future, although the assumption could be completely false.	This thought leads to reconnecting with the person to find out if everything is all right.

Table 3. Example of relation between behavior, thoughts and feelings according to CBT.

<sup>19</sup> Information on CBT was taken from IQWiG (Institute for Quality and Efficiency in Health Care). <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0016283/> (Date: 01/01/2014).

## **How does CBT differ from other psychotherapies?**

Cognitive behavioral therapy (CBT) is a problem-oriented strategy. It focuses on current problems and on finding solutions to them. Unlike psychoanalysis, for example, it does not deal primarily with the past. Also, the main goal of CBT is not to discover what causes the problems, but rather to tackle them here and now. The most important thing is helping people to help themselves: they should be able to cope with their lives again without therapeutic help as soon as possible. This does not mean that cognitive behavioral therapy completely ignores the influence of past events. But it mainly deals with recognizing and changing current distressing patterns of thoughts and behavior.

The CBT model proposes that psychopathology is the product of faulty information processing that manifests itself in distorted and dysfunctional thinking, which directly leads to negative emotions and maladaptive behaviors. Thus, the CBT therapist helps the patient to identify, evaluate, and then modify distorted cognitions to produce more realistic and adaptive evaluations. This is typically first accomplished through rational disputation techniques introduced by the therapist during session, followed by behavioral experiments designed to test out the validity of the patient's assumptions and predictions. For example, the therapist may first help a patient with social phobia to review the evidence for and against the notion that his/her boss thinks that s/he is a "failure." Then, between sessions, the therapist may ask the patient to request direct feedback from his/her boss about his/her job performance, and compare this information with his/her prediction about what his/her boss would say. It is assumed that correcting patients' distorted cognitions in this manner will produce a direct improvement in both mood (e.g., the patient will feel less anxious) and behavior (e.g., the patient will perform better at work and be more social around coworkers).

Initially, CBT was used mainly for treating depression. But it soon became clear that its basic principles can also help with other problems, disorders and illnesses. Therefore, different methods of CBT were developed that specifically aim to help in certain diseases or illnesses, for example eating or sleep disorders, anxiety or panic disorders, obsessive-compulsive and addictive disorders.

**The methods used in CBT demand a great deal of commitment and self-initiative from the client.** For the therapy to be successful people have to cooperate actively and to work on their problems between sessions as well. This might be a great challenge, particularly if someone is very ill, for example with a severe depression or anxiety disorder. This is why sometimes medication is used at first to relieve the worst symptoms quickly so that psychotherapy can be started.

In the first session, the patient briefly explains his/her current problems. S/he tells the psychotherapist about his/her hopes and expectations regarding the therapy and they discuss the treatment goals and the therapy plan. If the patient's personal goals change over the course of therapy, it will be adapted.

The therapy often includes recording the patient's thoughts in a journal over a certain period of time. Then s/he scrutinizes the results together with the psychotherapist: *Do I assess things appropriately and realistically? What happens if I behave differently than I normally do in a certain situation?*

One method of behavioral therapy that is frequently used with anxiety and obsessive-compulsive disorders is called "exposure therapy." In this treatment the client is gradually confronted with the triggers for the anxiety. The aim is to help the client learn how to cope with this anxiety and agitation. If, for instance, someone has developed a compulsion to constantly wash his or her hands because of a fear of germs, the therapist could, after thorough preparation, ask the person to touch something that he or she perceives as dirty. After that the client would try not to wash his or her hands immediately. According to the cognitive orientation, the change and solution to the problem are reached through the patient's gradual learning of new cognitive schemes. Such learning is necessary and it takes place through conscious processes.

CBT also uses methods like relaxation exercises, stress and pain management trainings and strategies to solve problems. Because problems and life situations are different from person to person, as are the wishes and aims associated with the therapy, psychotherapy is always tailored to individual needs.

Nevertheless, the primary theoretical mechanism of action in CBT is proposed to be cognitive change, which is expected to lead to improvements in other symptoms via cascading and reciprocal effects. The most immediate focus of CBT, then, is on symptom reduction; although improved functioning is also a longer-term goal of treatment<sup>20</sup>.

Researchers and clinicians who study effectiveness of CBT are applying **Evidence Based Method of Research**. "Evidence-based" means: supported by scientific evidence and proof. It means not relying only on the views of experts, but on the most objective knowledge as well. These kinds of tests are called clinical studies, randomized trials or controlled trials.

The core idea, when one wants to test a new medicine for example, is to randomly divide a group of volunteers into at least two groups. One of the groups uses the new medicine, and the other gets another treatment or a placebo (dummy tablet). The people need to get assigned to their groups completely by chance so that the

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<sup>20,21</sup> Gaudiano, B., A. (2008). Cognitive-Behavioral Therapies: Achievements and Challenges. Evidence Based Mental Health. 2008, Febr; 11 (1): 5-7

two groups are really comparable: the only difference between the groups has to be the treatment. At the end, the experiences and outcomes of the participants can be compared. Just how these trials need to be done to deliver a useful result depends on the illness, the treatment and the consequences of both.

By its very nature, CBT can be more easily disseminated and implemented than other approaches because of the development of highly specified, manualized treatment protocols designed to be delivered over shorter-term durations (e.g., 12–20 sessions).<sup>21</sup>

There are many criticisms of an approach of EBM (Evidence Based Medicine) , especially as they seem to be represented by the entire views of psychotherapy. It is important to note that the procedures of EBM standards are often not applicable in the field of psychotherapy because they are based on observation and research, never devoid of theories or values references. The basic assumption of EBM is scientific realism, which postulates that there is an independent reality and that the truth is reached through scientific methods.<sup>22</sup>

The approach of Empirically Supported Treatments (ESTs) is constructed on the basis of the medical model, where the step towards the improvement of the symptom is characterized by the diagnosis and the prescription of a treatment<sup>23</sup>.

To explore this issue it is worth reaching the last chapter of “*Dizionario Internazionale di Psicoterapia*” (2013), which talks about empirical research in psychotherapy.

Reassuring, the 10 principles of Cognitive- Behavioral Therapy are:

1. CBT is based on an ever-evolving formulation of the patient and his/her problems in cognitive terms.
2. CBT requires a good client-therapist relationship.
3. CBT emphasizes collaboration and active participation.
4. CBT is goal-oriented and problem focused.
5. CBT initially emphasizes the present.
6. CBT is educative; it aims to teach the client to be his/her own therapist, and emphasizes relapse prevention.

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<sup>22</sup> Starcevic, V., (2003). Psychotherapy in the era of evidence-based medicine. In: “Australian Psychiatry”, 11, 278-281. In: Nardone, G., Salvini, A., (2013). Dizionario internazionale di psicoterapia. Ed. Garzanti.

<sup>23</sup> Bohart, A.C., O’Hara M, Leitner, L.M. (1998). Empirically violated treatment: Disenfranchisement of humanistic and other psychotherapies, In: “Psychotherapy Research”, 141-157. In: Nardone, G., Salvini, A., (2013). Dizionario internazionale di psicoterapia. Ed. Garzanti.

7. CBT aims to be time limited.
8. CBT sessions are structured.
9. CBT teaches patients to identify, evaluate, and respond to their dysfunctional thoughts and beliefs.
10. CBT uses a variety of techniques to change thinking, mood, and behavior.<sup>24</sup>

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<sup>24</sup> Adapted from *Cognitive Therapy: Basics and Beyond* by Judy Beck (1995). Online: <http://brownbackmason.com/articles/10-principles-of-cognitive-behavioral-therapy-cbt>. Date: 30/12/2013.

#### 4. Paradigm of Brief Strategic Therapy - advanced model

Brief Strategic Therapy (BST) has developed a problem- and solution-oriented model based on the studies of Palo Alto School and more than twenty five years of clinical research at the Brief Strategic Therapy Center of Arezzo.<sup>25</sup> The first model of brief strategic therapy was formulated by a famous group of scientists at the Mental Research Institute in Palo Alto<sup>26</sup>, who synthesized the results of their own research on communication and family therapy with Milton Erickson's technical contribution on hypnotherapy. The result was a systematic model of brief therapy that could be applied to a wide variety of disorders and give surprising results.<sup>27</sup>

What does this writer mean by strategic approach? Strategic approach is based on the logic of its operational construction and on objectives to reach. In strategic approach tactics, techniques and maneuvers are developed ad hoc for the problems in analysis, which allows for the achievement of goals.<sup>28</sup>

Since 1985, by means of an empirical experimental method, the Strategic Therapy Centre in Arezzo, Italy, has conducted research on a development of advanced models of strategic brief therapy. The most important result has been the formulation of protocols for the treatment of specific types of mental disorders like phobic disorders<sup>29</sup>, eating disorder<sup>30</sup>, or OCD disorder<sup>31</sup> – with high efficacy and efficiency outcomes, which were scientifically recognized to be actually the highest in the psychotherapy field (87% of solved cases in a median duration of 7 sessions)<sup>32</sup>.

Specific protocols of treatment for particular pathologies, i.e. rigorous sequences of therapeutic maneuvers with heuristic and predictive power have allowed a therapist to:

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<sup>25</sup> In: Bartoletti, A., Nardone, G. (2007). Toward an operative knowledge of psychological problems: The strategic Diagnosis. In *Journal of Brief, Strategic and Systemic therapies*. Volume 1, nr 1. pp 123-134.

<sup>26</sup> Watzlawick, P., Weakland, Fisch, R. (1974). *Change: principles of problem formation and problem solution* (New York, NY:W.W. Norton &Co.).

<sup>27</sup> Nardone, G., Portelli, C. (2005). *Knowing through changing*.

<sup>28</sup> Nardone, G. (1993). *Paura, panico, fobie. La terapia in tempi brevi*. Milan: Ponte alle grazie

<sup>29</sup> Nardone, G., Watzlawick, P. (1993). *L'arte del cambiamento*. BUR

<sup>30</sup> Nardone, G., Verbitz, T. and Milanese, R. (1999). *Le prigioni del cibo. Vomiting, Bulimia, Anoressia: la terapia in tempi brevi* (Firenze: Ponte alle Grazie).

<sup>31</sup> Nardone, G., Portelli, C. (2013). *Ossessioni, compulsioni, manie*. (Firenze: Ponte alle Grazie)

<sup>32,24</sup> Nardone, G., Portelli, C. (2005). *Knowing through changing. The evolution of Brief Strategic Therapy*. (Crown House Publishing Limited).

- use different therapeutic stratagems,
- break the specific pathological rigidity of the disorder or problem presented, which was maintained by reiterated dysfunctional attempts to solve the problem,
- lead the patients to reorganize their perceptive-reactive system toward a more functional balance.

Specific treatment protocols were developed, comprising specific maneuvers regarding the strategy, language and therapeutic relationship to each specific disorder or problem studied.

Every intervention has to take into account and should be tailored to every single patient. As indeed Milton Erickson affirmed, every person possesses unique and unrepeatable features, such as his/her interaction with himself/herself, the others and the world. Consequently, every human interaction, including the therapeutic one, is unique and unrepeatable, thus the therapist has to adapt his/her logic and language to the patient.

The essential theoretical and practical foundations of the strategic approach to psychotherapy are as follows<sup>33</sup>:

- The models of intervention are constructed based on objectives rather than on the instructions of a strong a priori theory.

Brief Strategic Therapy is not based on rigid and pre-constituted theories, or on deterministic perspective that dictates how to proceed and provide, *a priori*, an exhaustive description of the phenomena at hand.

The Strategic therapist needs to have some “reducer of complexity” available that will allow him/her to start working on the reality that needs to be modified and to gradually reveal its functioning. “Reducer of complexity” has been found in the construct of *attempted solutions*. Attempts to reiterate the same ineffective solution eventually give rise to a complex process of retroactions in which the efforts to achieve change actually keep the problematic situation unchanged. “Attempted solutions” themselves become the problem.<sup>34</sup> So in order to change the situation, the person must stop its persistence. S/he has no power over a formation process that occurred in the past.

Strategic approach is based on the idea that the problems of each person come from their way of perception of reality which drives them to assume congruent way

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<sup>34</sup> Watzlawick, P., Weakland, Fisch, R. (1974). Change: principles of problem formation and problem solution (New York, NY:W.W. Norton &Co.).

of reaction and behavior.

This statement is a direct consequence of the constructivist radical theories which define each reality as the product of the perspective taken by the subject of his/her cognitive processing and the type of language used by him/her to communicate this reality to himself/herself, to others and to the world. Therefore, the change and problem solving must pass mandatory for changing the mode of perception and reaction to how the person faces the reality. If s/he changes only the behavioral reactions, the change is superficial, the system does not break and usually after some time, the system retrieves the pre-existing equilibrium. The change in the mode of perception includes both cognitive and emotional aspects. After this priority change, the subject acquires, also at the level of cognition, the conscious control and management, for example, in the situations previously experienced as frightening and uncontrollable.

At the operational level, the treatment should affect the patient in the direction of the perceptive-reactive practical experiences, which will enable the leap necessary for the change. This type of interaction is based on the use of therapeutic communication, suggestive techniques, paradoxes, behavioral traps and others. These stratagems are able to lead the subject to alternative live perceptive-reactive experiences against the threatening reality, and it should be pointed out that s/he is fully conscious at the moment of such perceptive experiences. After the subject has had the first concrete experience of change in respect of the symptoms - the result will still be a clearer realization of being able to do something that earlier was considered impossible.<sup>35</sup>

Circular causality is between how a problem persists and the ways people try and fail to solve the problem. If the patient wishes to make a change, it is important to concentrate on the dysfunctional solutions that are being attempted. If s/he blocks or changes the recursive dysfunctional solutions, s/he interrupts the vicious circle that nourishes the persistence of the problem, opening the way to real, alternative change. The breaking of this equilibrium necessarily leads to the establishment of the new one, based on the new perception of reality. Practical experiences that change the person's perception of reality produce a change on the emotional, cognitive and behavioral levels.<sup>36</sup>

- The logic used during the dialogue with the patient and in the construction of strategies is the constitutive deductive, not hypothetical deductive; the solution is thus adapted to the problem, not the problem to the solution.

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<sup>35</sup> Nardone, G. (1993). *Paura, panico, fobie. La terapia in tempi brevi.* Milan: Ponte alle grazie

<sup>36,38,39</sup> Nardone, G., Portelli, C. (2005). *Knowing through changing. The evolution of Brief Strategic Therapy.* (Crown House Publishing Limited).



Strategic logic wants to be flexible and tries to adapt to its object of study. BST has its roots in modern constructivist epistemology, according to which there is no ontologically true reality, but many subjective realities that vary according to the point of view that is adopted. Reality is considered to be a product of the perspective, the instruments of knowledge, and the language by which we perceive and communicate<sup>37</sup>. Strategic therapist cannot use a linguistic code that is based on causal reconstruction, but a code that focuses on the process of change.

The latest evolution of advanced brief strategic therapy revolves around the first session and the use of strategic dialogue (SD). The strategic dialogue is an intervening and discriminating instrument that evolves the language used, the relationship established, and the logic of the intervention, and is characterized by its all time orientation toward change. SD is a particular process of change-oriented questioning that can help the therapist to guide a person through those conclusions that have actually been subtly induced by the therapist. This is in line with the words of Solomon Ibn Gabirol: "A wise man's question contains half the answer"<sup>38</sup>. By adopting the strategic dialogue, the therapist seems to take up a one-down position. S/he humbly asks a series of seemingly simple questions to the patient, who has the illusion of being the conductor of the dialogue. But, in reality, this method leads the patient toward the discovery of alternatives, useful for solving problem<sup>39</sup>.

More information about strategic dialogue can be found in Nardone and Salvini book from 2004 : "*Il dialogo strategico. Comunicare persuadendo: tecniche evolute per il cambiamento.*"

- Instead of performing interventions based on an investigation of the causes of phenomena, a strategic therapist induces change by applying therapeutic stratagems: it is the fitting solution that explains the problem.

Strategic interventions are focused on identifying the most "functional" ways of knowing and acting, increasing what von Glasersfeld has called "operative awareness"<sup>39</sup>. A strategic psychotherapist is not interested in discovering deep realities and the *why* of things, but only *how* things work and *how* to make them work as well as possible. The goal is to adapt knowledge to the partial realities that s/he has to work on, developing strategies based on the objectives to be reached, that s/he can adapt step by step to the evolutions of "reality". It also means leaving the search for the causes of events in the backgrounds and concentrating

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<sup>37</sup> Salvini, A.,(1988). , Pluralismo teorico e pragmatismo conoscitivo: assunti metateorici in psicologia della personalità, In: Fiora, E., Pedrabissi, I., Salvini, A., Pluralismo teorico e pragmatismo conoscitivo in psicologia della personalità (Milan, Giuffrè).

on increasing his/her capacity for strategic management of the reality instead in order to reach his/her goal. Thus, the first step is to avoid adopting deterministic position. And the second step is to try to understand how the problem persists (starting with the questions to ask) , focusing on the persistence of a problem itself, not on its past formation.

- Constant self-correction is built into the model which allows the therapist to avoid the continuation of attempted solutions that produce no positive results and often exacerbate the problem that they are meant to resolve.

The concept of change and stasis elaborated by Lewin assumes that in order to understand how a process works one must create a change and observe its variable effects and new dynamics. According to this statement, to know a reality, one has to operate on it, gradually adjusting interventions by adapting them to the new elements of knowledge that emerged.

**Action-research method** (Lewin, 1956), carried out at the Brief Strategic Center of Arezzo, has led to progressively developed rigorous – yet self-corrective – strategic protocols for specific problem, which have high effectiveness. The protocols are simple guidelines, which are far from being rigid and pre-ordinate, but are tailored on the prevalent PRSs (Perceptive- Reactive Systems) and ASs (Attempted Solutions).<sup>40</sup>

How can the action-research method be described? This research methodology (developed by Kurt Lewin and the first-and second-order cybernetics) based on empirical - experimental process, controlled in all its phases of implementation, by which you know a problem by intervening on the same problem. In this way, a circularity between theory and clinical practice is established. Specifically, the study of techniques of intervention provided their application on a sample of patients with OCD (at least 100) and it was considered valid only if it met the criteria of effectiveness, efficiency, repeatability, predictability, and transferability<sup>41</sup>.

This systematic process of research carried out on various forms of psychological disorders turned out to be an important instrument of knowledge. The data gathered during the research enabled to produce an epistemological and operative model of the formation and persistence of the pathologies under study. This has become a sort of spiral evolution nourished by the interaction between empirical

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<sup>40</sup> In: Bartoletti, A., Nardone, G. (2007). Toward an operative knowledge of psychological problems: The strategic Diagnosis. In Journal of Brief, Strategic and Systemic therapies. Volume 1, nr 1. pp 123-134.

<sup>41</sup> Nardone,G.,Portelli, C. (2013). Ossessioni, compulsioni, manie. (Firenze: Ponte alle Grazie)

interventions and epistemological reflections, which led to the construction of specific, innovative strategies<sup>42</sup>.

All the years of research have allowed to construct the protocols of treatment for many different disorders and many different perceptive-reactive systems.

The engine of change according to brief strategic therapy are:

- Techniques (protocols, maneuvers),
- Communication (language of change),
- Relation (position one up, one down, symmetric or complementary relation, tuning in the direction of change).

Below, the writer reassumes the similarities and differences between Brief Strategic Therapy and Cognitive-Behavioral Therapy.

	<b>Brief Strategic Therapy</b>	<b>Cognitive-Behavioral Therapy</b>
<b>Similarities</b>	<ul style="list-style-type: none"> <li>- They use the modern constructivist epistemology that believes that the subject is an active builder of his/her own reality and s/he is not a helpless victim of it but the author of his/her relationships with himself/herself, the others and the world.</li> <li>- They formulate strict protocols of intervention both based on the dialogues and the therapeutic prescriptions.</li> <li>- They use an empirical method and experimental techniques for the validation and verification of the results.</li> <li>- They are definitely effective in treating OCD (heals in times much shorter).</li> </ul>	
<b>Differences</b>	<ul style="list-style-type: none"> <li>- Derived from the theory of change</li> <li>- Therapist first uses stratagems which create real corrective emotional experiences in the perceptions and reactions of the patient, and then acquire the capacity of changing the situation.</li> <li>- Change → insight</li> <li>- Change occurs quickly with unlocks of symptoms which can appear almost magical, as the therapeutic techniques induce the person to change at first the perception and reaction towards his/her reality and then acquire the managerial skills.</li> </ul>	<ul style="list-style-type: none"> <li>- Derived from the theory of learning</li> <li>- Therapist guides the patient through the process based on the awareness and voluntary effort to learn how to fight or manage the disorder</li> <li>- Consciousness → change</li> <li>- The change happens gradually through learning the ability to control their thoughts and actions.</li> </ul>

<sup>42</sup> Nardone, G., Watzlawick, P. (eds) (2004). Brief Strategic Therapy: Philosophy, technique and Research. (Maryland, USA: Rowman & Littlefield Publishers, Aronson Group).

	- Resistances is bypassed by using stratagems that create a change beyond the voluntary effort of the patient.	- Therapist goes through the willingness of the subject, often stumbles by the resistance to change which can be strong.
	- Methodology of research - working for effects of discovery and subsequent acquisitions.	- Methodology of research - working for progressive acquisition of knowledge
	<b>- 80% of cases of total extinction of the disorder</b>	<b>- upwards of 75 % of the patients experience improvement in their OCD symptoms during treatment.<sup>43</sup></b>
	- Communication is a performative and injunctive relief, that is a hypnotic and evocative language which makes the patient feel even before s/he understands. For this purpose both the languages of logic and analog are used, there are suggestive metaphors as well as verbal and non-verbal hypnotic communication.	- Communication is logical - rational and indicative, the typical language of explanation and formal education.
	- The therapist established relation which is complementary to the problem of the patient. Relational positioning can be used to de-escalate heightened confrontations in the therapy session, to put the client at ease so s/he can open up, to bind resistance, to build rapport, to motivate the client to do something different, and reinforce change. <sup>13</sup>	- the therapist is more direct and assumes the position of the expert (one-up position), though many psychologists suggest that the therapist should also be empathetic. <sup>44</sup>
	The therapy is adapted to the patient, not vice versa.	

<sup>45</sup> Table 4. Comparison between CBT and BST.

According to cognitive and behavioral therapy, the first step is to lead the patient through the path of consciousness and to teach him/her to fight with the rituals. The patient has to acquire a capacity to control his/her own thoughts and actions, which can be really difficult (because of strong resistance to change). So first is the

<sup>43</sup> More about effectiveness of CBT and BST methods you can find in chapter 5. Institute for Quality and Efficiency in Health Care (IQWiG) – OCD. Can psychotherapy help? <http://www.informedhealthonline.org/obsessive-compulsive-disorder-can-psychotherapy-help.438.en.html> Date: 29.12.2013

<sup>44</sup> Hybarger, C. (2007). Strategic positioning of the therapist in session: creating a strong therapeutic alliance. In. Journal of Brief, Strategic and Systemic Therapies (2007). Vol 1, n 1.

<sup>45</sup> Nardone, G., Portelli, C. (2013). Ossessioni, Compulsioni, Manie. Ed. Ponte alle Grazie

comprehension of the situation and then the change.

According to OCD's brief strategic treatment, the change and solution to personal and interpersonal problems can only be reached by way of a change in perceptive and reactive modalities through which the patient experiences reality (change 2°, according to P. Watzlawick distinctions). As a practical consequence, the therapist utilizes the way of interacting that influences the patient to have the kind of tangible perceptive-reactive experience that can lead to qualitative leap necessary to produce changes in the patient relationship with the realities experienced as problematic.

In BST, the first is change and then the explanation of the logic of the solution. Having produced such a change, the therapist proceeds toward a cognitive reframing by which the patient acquires a new perspective (cognitive and behavioral modalities with respect to the problem). Where the cognitivist resolves the problem of compulsions, obsessions or fear, the strategist resolves the same problem by using techniques that find way around the patient's resistance to change and present experiences of new and concrete ways of perceiving and relating to fear.

Moreover, the communicational style of strategic therapist aims to exercise a marked and deliberate personal influence on the patient and utilizes hypnotic language and injunctive procedures, while the communicational style of cognitive therapists aims to produce a change in the patient's cognition and consciousness and is therefore based on the language of reason and conscience.<sup>46</sup>

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<sup>46</sup>Nardone, G. (1996). *Brief Strategic Solution-Oriented Therapy of Phobic and Obsessive Disorders*. Northvale, New Jersey, London – Jason Aronson.

## 5. Treatment of Obsessive-Compulsive Disorder

There are different ways to treat OCD. These include psychotherapies, drugs (antidepressants), or a combination of both. Above, this writer has presented cognitive-behavioral model and brief strategic advanced model. The two different approaches to understanding the problem and constructing the solution, lead to different models of treatments. Below, the reader may find the maneuvers and techniques of the most effective psychotherapeutic treatments for Obsessive Compulsive Disorder.

### a. According to cognitive-behavioral approach

Cognitive (CT) and behavior therapy (ERP) combined with antidepressant medications are currently used to treat the obsessive compulsive disorder<sup>47</sup>. They do not provide a "cure" for OCD, but they control the symptoms and enable the people with OCD to restore normal functioning in their lives.

Cognitive-behavioral therapy refers to two distinct treatments: exposure and response prevention and cognitive therapy. Although these treatments are increasingly offered in combination, they will be discussed separately.

### Exposure and Response Prevention (ERP)

The mostly widely practiced behavior therapy for OCD is called **exposure and response prevention (ERP)**.

The "exposure" part of this treatment involves a direct or imagined, controlled exposure to objects or situations that trigger obsessions that arouse anxiety. Over time, exposure to obsessional cues leads to less and less anxiety. Eventually, exposure to the obsessional cue arouses little anxiety at all. This process of getting "used to" obsessional cues is called "*habituation*."

The "response" in "response prevention" refers to the ritual behaviors that people with OCD engage in to reduce anxiety. In ERP treatment, patients learn to resist the

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<sup>47</sup> Description was taken from the website of The Centre for Addiction and Mental Health (CAMH) in Canada  
[http://www.camh.ca/en/hospital/health\\_information/a\\_z\\_mental\\_health\\_and\\_addiction\\_information/obsessive\\_compulsive\\_disorder/obsessive\\_compulsive\\_disorder\\_information\\_guide/Pages/ocd\\_treatments.aspx](http://www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information/obsessive_compulsive_disorder/obsessive_compulsive_disorder_information_guide/Pages/ocd_treatments.aspx)  
Date: 03/oct/2013

compulsion to perform rituals and are eventually able to stop engaging in these behaviors.

### **How does ERP work?<sup>48</sup>**

Before starting ERP treatment, patients make a list, or what is termed a "hierarchy" of situations that provoke obsessional fears. The patients who have created a hierarchy of situations that cause distress participate in exposure tasks and then they are asked to pay particular attention to thoughts and feelings related to these situations. For example, a person with fears of contamination might create a list of obsessional cues that look like this:

1. Touching garbage.
2. Using the toilet.
3. Shaking hands.

Treatment starts with exposure to the situations that cause mild to moderate anxiety, and *as the patient habituates to these situations*, he or she gradually works up to the situations that cause greater anxiety. The time it takes to progress in treatment depends on the **patient's ability to tolerate anxiety** and to resist compulsive behaviors.

Exposure tasks are usually first performed with the therapist assisting. These sessions generally take between 45 minutes and three hours. Patients are also asked to practice exposure tasks between sessions for two to three hours per day.

In some cases, direct, or "in vivo," exposure to the obsessional fears is not possible in the therapist's office. If, for example, a patient was being treated for an obsession about causing an accident while driving, the therapist would have to practice what is called "imaginal exposure." Imaginal exposure involves exposing the person to situations that trigger obsessions by imagining different scenes.

The main **goal** during both in vivo and imaginal exposure is for the person to stay in contact with the obsessional trigger without engaging in ritual behaviors. For example, if the person who fears contamination responds to the anxiety by engaging in hand-washing or cleaning rituals, he or she would be required to increasingly resist such activities - first for hours, and then days following an exposure task. The therapy continues in this manner until the patient is able to abstain from ritual activities altogether.

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<sup>48</sup> The Centre for Addiction and Mental Health (CAMH) in Canada. Date: 03/oct/2013  
[http://www.camh.ca/en/hospital/health\\_information/a\\_z\\_mental\\_health\\_and\\_addiction\\_information/obsessive\\_compulsive\\_disorder/obsessive\\_compulsive\\_disorder\\_information\\_guide/Pages/ocd\\_treatments.aspx](http://www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information/obsessive_compulsive_disorder/obsessive_compulsive_disorder_information_guide/Pages/ocd_treatments.aspx)

To mark progress during exposure tasks with the therapist and in homework, patients are trained to be experts in rating their own anxiety levels. Once they have made progress in treatment, participants are encouraged to continue using the ERP techniques they have learned, and to apply them to new situations as they arise. A typical course of ERP treatment is between 14 and 16 weeks.

Obsessional thought → compulsive ritual

Goal: obsessional trigger //→ resistance to compulsive behavior

Moreover, self-directed exposure-response prevention is applied for people with mild OCD. Below, the three self-directed ERP manuals with step-by-step strategies have been presented:

- Baer, L. (1991). *Getting Control*. Lexington, MA: Little, Brown & Company
- Foa, E.B. & Wilson, R. (1991). *Stop Obsessing!* New York: Bantam
- Steketee, G. & White, K. (1990). *When Once Is Not Enough*. Oakland, CA: New Harbinger Press.

### **Cognitive Therapy**

As mentioned earlier, people with OCD often become anxious about their thoughts (or obsessions) when they interpret such thoughts as dangerous and likely to occur. Thoughts of leaving the house with the stove on, for example, can result in a debilitating anxiety that sends the person running back to check again and again.

### **How does cognitive therapy work?**

In CT, the focus is on how *participants interpret their obsessions*: what they believe or assume to be true about them, what their attitude is toward them and why they think they have these obsessions. For example, the person who fears shaking hands may believe it will pass on germs that may cause him or her to become ill. This interpretation of this fear can be challenged and re-interpreted so that shaking hands is no longer viewed as a high-risk activity. Achieving these results takes time, but can provide effective relief.

CT also helps *participants identify and re-evaluate beliefs* about the potential consequences of engaging or not engaging in compulsive behavior, and to work toward eliminating this behavior. For example, a person who compulsively washes his or her hands for 30 minutes at a time may believe that he or she is doing so to guard against infection. When this belief is challenged and confronted as false, it can help control the behavior.

One tool used in CT to help people identify, challenge and *correct negative interpretations of intrusive thoughts* is the **thought record**. In the thought record, participants record their obsessions and their interpretations associated with the



obsessions. The first step is for the person to begin to record each and every time they experience an intrusive thought, image or idea. The important details to record include:

1. Where was I when the obsession began?
2. What intrusive thought/image/idea did I have?
3. What meaning did I apply to having the intrusive thought/image/idea?
4. What did I do?

### **An Example of a Thought Record**

Situation: Sitting at home watching television.

Intrusive Thought: "God doesn't care."

Appraisal of Intrusive Thought:

1. I am a bad person for thinking blasphemous thoughts.
2. God will punish my family and me.
3. I must be losing my mind if I can't stop these thoughts from happening.

Ritual: Engage in prayer. Engage in behaviors of atonement.

After people learn to identify their intrusive thoughts and the meanings they apply to them, the next steps are:

- Examine the evidence that supports and does not support the obsession.
- Identify cognitive distortions in the appraisals of the obsession.
- Begin to develop a less threatening and alternative response to the intrusive thought/image/idea.

These patterns are identified in session together with the therapist; again during actual exposure exercises; and then the person continues to record information on the thought record between sessions<sup>49</sup>.

### **How effective are cognitive and behavioral techniques?**

Effectiveness of ERP treatment depends on a number of factors and requires that the patient be motivated to get well. Studies documenting the benefits of ERP treatment have found that upwards of 75 per cent of patients experience improvement in their OCD symptoms during treatment. The majority show long-term improvement, two and three years after treatment. Patients who benefit less

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<sup>49</sup> Description was taken from the website of The Centre for Addiction and Mental Health (CAMH) in Canada  
[http://www.camh.ca/en/hospital/health\\_information/a\\_z\\_mental\\_health\\_and\\_addiction\\_information/obsessive\\_compulsive\\_disorder/obsessive\\_compulsive\\_disorder\\_information\\_guide/Pages/ocd\\_treatments.aspx](http://www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information/obsessive_compulsive_disorder/obsessive_compulsive_disorder_information_guide/Pages/ocd_treatments.aspx) Date: 03/oct/2013

from ERP include those who do not exhibit overt compulsions and those with moderate-to-severe depression.

According to information guide of CAMH – Canadian Centre for Addiction and Mental Health - only a small number of studies have tested the effectiveness of CT for OCD. The studies that have been done, however, have found CT to be effective.

Although behavioral and cognitive therapy can be separate, many therapists combine the two strategies. Patients can benefit both from exposure exercises and cognitive restructuring exercises. Behavioral and cognitive therapy are increasingly delivered in a group setting because there are benefits in meeting and working with people who have the same difficulties.

Many people with OCD benefit from supportive counseling in addition to treatments aimed at reducing the symptoms of OCD. Individuals may see a therapist one-on-one, or they may involve the partner, spouse or family in counseling.

Researchers from the Cochrane Collaboration<sup>50</sup> looked at whether psychotherapies are helpful for adults with OCD. They analyzed eight randomized controlled trials that looked at groups of people, who either had cognitive therapy, behavioral therapy, or CBT. People in another group, the control group, did not receive any psychotherapy at first, but were put on a waiting list. That means that they were not able to get psychotherapy until after the trial had been completed.

Most of the trials, but not all of them, used the exposure and response prevention technique. Most of the people in the trials, including those in the control groups, also took medication for their OCD. Altogether, about 300 men and women took part in these trials. Most of them were between 35 and 40 years of age. Both individual therapy and group therapy were tested. The researchers concluded that cognitive and/or behavioral therapy can help adults with OCD. Men and women who had these treatments were able to clearly reduce their compulsive behavior. Psychotherapy also helped them ease their anxiety. Both individual and group therapy worked. It did not seem to be a difference whether therapy lasted a bit more or less than three months. Other types of psychotherapy for OCD have not been tested enough in trials, so it is unclear whether they can also help.

It is important to remember that a lot of the men and women in the trials also took medication for their OCD. So we cannot be sure how well these kinds of psychotherapy work on their own. Also, the trials suggest that people with more

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<sup>50</sup> Cochrane Collaboration - <http://www.cochrane.org/>

severe forms of OCD might benefit a bit less from the psychotherapies tested. However, larger trials are needed to be sure of this<sup>51</sup>.

Another research<sup>52</sup> has reviewed studies that compared psychological interventions to treatment as usual groups who either received no treatment, or were on a waiting list for treatment or received usual care. Researchers have found eight studies, which together suggested that cognitive and/or behavioral treatments were better than treatment under usual conditions at reducing clinical symptoms. Baseline OCD severity and depressive symptom level predicted the degree of response. However, the conclusions were based on a small number of randomized controlled trials with small sample sizes.

Caleb W. Lack in his article "*Obsessive-compulsive disorder: Evidence-based treatments and future directions for research*"<sup>53</sup> has shown that the psychological treatment of choice for OCD, in both adults and children, and backed by numerous clinical trials, is cognitive-behavioral therapy (CBT), particularly exposure with response prevention (EX/RP). It is superior to medications alone, with effect sizes ranging from 1.16-1.72. While there is a lower relapse rate than in medications (12% vs 24%-89%), it is important to note that **up to 25% of patients will drop out prior to completion of treatment due to the nature of treatment**<sup>54</sup>. The course of therapy generally lasts between 12-16 sessions, beginning with a thorough assessment of the triggers of the obsession, the resultant compulsions, and ratings of the distress caused by both the obsession and if they are prevented from performing the compulsion. A series of exposures are then carefully planned through collaboration between the therapist and client and implemented both in session and as homework between sessions.

Meta analysis made by Lack<sup>55</sup> indicates that pharmacology with serotonin reuptake inhibitors (SRIs) shows large effect sizes in adults (0.91), but only moderate effect sizes in youth (0.46). Unfortunately, even with effective medication, most treatment

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<sup>51</sup> Institute for Quality and Efficiency in Health Care (IQWiG) – OCD. Can psychotherapy help? <http://www.informedhealthonline.org/obsessive-compulsive-disorder-can-psychotherapy-help.438.en.html> Date: 29.12.2013

<sup>52</sup> Gava I., Barbui C., Aguglia E., Carlino D., Churchill R., De Vanna M., McGuire H., (2009). Psychological treatments compared with treatment as usual for obsessive compulsive disorder .Published Online: Jan 21, 2009 - See more at: <http://summaries.cochrane.org/CD005333/psychological-treatments-compared-with-treatment-as-usual-for-obsessive-compulsive-disorder#sthash.KkrfZjB3.dpuf>

<sup>53,47</sup> Lack, C.W. Obsessive-compulsive disorder: Evidence-based treatments and future directions for research. *World Journal of Psychiatry*. (2012). December 22; 2(6): 86-90. Online- 19/10/2013.

<sup>54</sup> Simpson HB, Liebowitz MR, Foa EB, Kozak MJ, Schmidt AB, Rowan V, Petkova E, Kjernisted K, Huppert JD, Franklin ME, Davies SO, Campeas R. (2004). Post-treatment effects of exposure therapy and clomipramine in obsessive-compulsive disorder. *Depress Anxiety* 2004; 19: 225-233. In: Lack, C.W. Obsessive-compulsive disorder: Evidence-based treatments and future directions for research. *World Journal of Psychiatry*. (2012). December 22; 2(6): 86-90Online- 19/10/2013

responders show residual symptoms and impairments. There is also a **very high relapse rate seen across numerous studies** (between 24%-89%). SRIs can be successfully supplemented with adjunctive antipsychotics, but even then only a third of patients will show improvements and there are serious health concerns with their long-term usage.

#### **b. According to brief strategic advanced therapy model**

Knowing how problem is forming and persisting is a key to create an effective treatment. The aim is to change this dysfunctional system which makes OCD more resistant to change (resistant even on pharmacological treatment). The unique, possible way to prevent it is to be more aware when behaviors or attitudes are structured as inevitable or irresistible and when they become a ritual (when a stereotypical action or thought guarantees or reinforces the desired effect).

Any form of Obsessive Compulsive Disorder can be solved on the level of comprehension or on the cognitive level: only experience can allow vanishing the "ghost" that persecutes the patient.<sup>56</sup>

The following operations are a number of control rituals built ad hoc and prescribed to be dealt with in a progressive sequence of all the situations considered appalling, until the patient gets to the final ritual that must correspond with a final defeat of the symptoms and the complete solution to the problems.

The therapeutic intervention focuses on **three attempted solutions** recognized as usual power of the disorder:

- Avoidance,
- Request for reassurance, help and protection,
- Control of anxiety-laden situations through performing rituals: preventive, propitiatory and reparatory.

So the first step is to block AS which worsen the situation, for example:

- Reframe: "The more you avoid the fearful situation, the more frightening it becomes. "
- Reframe: "The more you ask for help, the more incapable you become. It invalidates you more and more".
- Create counter rituals (five major techniques which are described below).

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<sup>56</sup> Nardone, G., Portelli, C. (2013). Ossessioni, compulsioni, manie. Ponte alle Grazie

Intervention must be fitted onto the specific perception and phobic belief. The mode of therapeutic intervention can be divided into two major classes:

- What happens during session (through strategic dialogue)- the restructuring of the perception of reality made during the clinical interview through the use of specific therapeutic communication techniques, which are meant to short-circuit the redundant dysfunctional patterns that imprison the mind of the patient. Direct communication of expert in OCD and type of relation created by the therapist and the patient play a really important role in OCD treatment.
- Therapeutic prescriptions or injunctions to be implemented in the space of time between one session and another, in real life, in which the goal is to change the patient's actions that feed the disorder and learn how to get them out.<sup>57</sup>

Therapeutic Intervention will be represented by maneuvers able to stop these counterproductive vicious circles. For this reason, the strategy must fit with the internal rules of the game in progress, and will be composed of a series of tactics and techniques specifically created and adapted to lead to victory.

The structure of this pathology is mainly conserved by the patient's efforts to control phobic fixations by performing disparate kinds of preventive or reparatory, or propitiatory rituals. The following prescription has been developed specifically to break this pathogenic vicious circle.

### **Techniques and logic of therapeutic change:**

Five major techniques used in OCD treatment are adapted to different types of rituals the patients have and the logic of beliefs which stand under them<sup>58</sup>.

#### **1. Counter ritual based on programmed repetition of compulsive ritual.**

*"From now to the next session, every time you perform a ritual, you must perform it five times – no more and no less than five times. You may avoid performing the ritual at all; but if you do it, you must do it exactly five times"*

Stratagem: "Lead the enemy into the attic and remove the ladder."

Type of change: catastrophic that is abrupt extinction of the symptoms

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<sup>57</sup> Nardone,G.,Portelli, C. (2013). Ossessioni, compulsioni, manie. (Firenze: Ponte alle Grazie)

<sup>58</sup> Adapted from - Nardone,G.,Portelli, C. (2013). Ossessioni, compulsioni, manie. (Firenze: Ponte alle Grazie)

produced by the prescription, which short-circuits the persistence of the disorder.

The structure of this maneuver is: if the patient does the ritual once, s/he can do it five times. The therapist is the one who tells you how many times to repeat it; thus, the therapist is taking control of the patient's symptom. Then the therapist gives the patient the "injunctive" permission to avoid performing the ritual.<sup>59</sup> In this way the therapist assumes control of the performance of the ritual. The patient was before forced by his/her phobia to carry out his/her rituals, but now s/he is impelled by the therapy to do so. This means that the patient indirectly acquires the ability to control the symptomatology instead of being controlled by it. If the therapist manages to achieve this by means of the prescription, the patient will start to question his/her perception, that of being absolutely possessed by his/her phobic obsession. The fact that s/he is now capable of controlling the previous pathological actions by following the therapeutic indications means that s/he could arrive at a point even to stop them. And usually, this is what happens<sup>60</sup>.

This technique is applied to take possession of the symptom and to use the patient's strength to relieve it. .

2. **Progressive introduction of the violations**, more important parts of phobic impositions.

In strategic terms: Stratagem "of the progressive violation until the total violation", or use of revealed stratagem.

Type of change: seemingly gradual but really geometric-exponential, or the patient creates small incremental changes that create geometric acceleration of the process, such as the rolling snowball rolling enlarges, up to become an unstoppable avalanche.

3. **Progressively postpone the compulsion** by expanding the time to postpone it until the patient puts into action the rites only in fixed times. Rituals become increasingly smaller until the reset of the compulsions.

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<sup>59</sup> Nardone, G., Watzlawick, P. (2005). Brief Strategic Therapy. Philosophy, Techniques, and Research. Oxford: Jason Aronson

<sup>60</sup> Nardone, G., Portelli, C. (2005). Knowing through changing. The evolution of Brief Strategic Therapy. (Crown House Publishing Limited).

In strategic terms: Stratagem of "postpone to learn how to do without it."  
Type of change - seemingly gradual but really geometric-exponential, that is: a small change triggers a chain reaction of transformation, such as "If I am able to postpone, I can also do without it."

4. **Ritualize the pathological compulsion** in specific space and time during the day, first with numerous, annoying appointments, then gradually reduced until the onset of "ritualized ritual."

In strategic terms: Stratagem of "ritualized ritual to take a control."

Type of change: gradual progressive stages, or "putting your foot in the door to gradually make space to the whole body." The disease is dismantled piece by piece.

One case in which this kind of techniques were used is going to be described in chapter 6.

5. **The need for the small disorder that maintains order must be introduced to the logic of the patient.** . The aim is to break the rigidity of the compulsive control up to the point when the overwhelming need is eliminated completely.

Other version: "small dirt which saves you from large dirt".

In strategic terms: Stratagem of "restructuring the belief to cancel its power."

Type of change: gradual and progressive steps, which can be transformed into geometric-exponential.

For example, the patients who fear contamination of some sort continuously wash, clean and sterilize themselves, their houses, and their other belongings to prevent them from being infected or contaminated. But paradoxically at the moment when everything is totally clean and sterilized the fear of contamination starts to grow and thus the need to carry out the compulsive rituals arises. Once more it is the attempted solution that maintains and complicates the situation.

In such cases, by using discriminative and intervening questions, the therapist should start raising doubts in the patient about whether s/he should really fear complete cleanliness rather than dirt: "When does the problem eventually arise, when you are dirty or when you are totally clean?". Usually, the first answer is "When I am dirty". But when asked: "When do you feel your need to carry out your rituals, when you are a bit dirty or when everything is spotless and you have to protect and safeguard

it?” , the patient starts having doubts, because s/he eventually needs to remain clean when everything is speck and span. “In other words, correct me if I am wrong, your fear arises mostly when everything is perfectly in order and clean, because it is then that you have to maintain it intact, true? Therefore in reality, you should fear more dirt than total cleanliness.” So in this way strategic therapist starts reframing his/her perception and thus his/her reaction toward the fear-provoking situation. The therapist has to start introducing the idea that “**a small disorder helps maintain order:**”

*So, from now to the next time we will meet, I would like you to carry out an experiment following the idea that what you should be afraid of is perfect cleanliness. I would like you to carry out this experiment. From now till the next time we meet, when you clean, you have to deliberately leave some small space dirty for 30 minutes. After that time, you are free to clean this space the way you want. Every day you decide which space you want to leave dirty for some time. We will talk about it next time we meet.*

This prescription follows the idea that in order to become totally immune and in control of something one should not avoid or prevent it. On the contrary, one should start to take and endure it in small doses until there comes a day when it will have no effect on one.

In the majority of the cases, by simply redefining the situation and setting a series of concrete emotionally corrective experiences, the patient is free from his/her attempted solutions and his/her rigid self-feeding perspective-reactive system<sup>61</sup>.

**Systemic –strategic view** on how OCD is functioning and maintaining dysfunctional situation is related to attempted solutions of family members, like parents, spouses or friends. During the first session it is essential to block the family’s attempted solutions which maintain and worsen the problem.

What are the typical attempted solutions of the family members?

- Talking about the problem and showing the absurd of rituals, trying to convince the patient to stop repeating them.
- In order to help the patient, family members assist during the execution of the rituals, and reassure that the rituals were made well.

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<sup>61</sup> Nardone, G., Portelli, C. (2005). Knowing through changing. The evolution of Brief Strategic Therapy. (Crown House Publishing Limited).



- Doing the rituals in place of the patient, which confirms the existence of dysfunctional reality (for example, the germs exist because even my mother has to clean the bathroom many times a day), and which maintains the dysfunctional belief.

One of the most important systemic maneuvers:

- Stop talking about the problem – Conspiracy of silence
- Do the list of rituals in which parents are involved and every day start to boycott the smallest one, even when the patient does not allow for that.
- In different cases parents have to help the patient to ritualize the rituals by prescribing them in predefined time and space.

More information about systemic part of OCD treatment can be found in the newest publication of Nardone and Portelli (2013) – “Osessioni, compulsioni, manie”.

**Four stages of treatment – communication and relation**

Unlike strategic therapy developed in Mental Research Institute in Palo Alto, the advanced model of brief strategic therapy has evidenced four stages of therapy<sup>62</sup>.

First Stage – Start of the game

As usual, the focus of the first meeting with the patient is on creating an atmosphere of acceptance and interpersonal contact in order to acquire powers of intervention. With obsessive-compulsive patients, it is extremely important to support and accept their fixations and their contorted and sometimes disagreeable rituals. The therapist should immediately establish a counterproductive relationship. The therapist who tries to persuade patients that their compulsions are absurd, and who attempts to make them control their compulsion to perform rituals and change their manner of action behaves just like people motivated by “plain common sense”, and consequently s/he does not achieve any success with phobic patients. The logic of common sense does not work, it only gives them impression of not having been understood, and makes them think that they really must be sick since they are unable to act like “normal” people.

When defining the problem and agreeing on the goals of the treatment, the therapist should apply the strategic dialogue<sup>63</sup>, utilize the logic and the language of

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<sup>62</sup> Nardone, G., Portelli, C. (2005). Knowing through changing. The evolution of Brief Strategic Therapy. (Crown House Publishing Limited).

the patient and avoid any expression of opinions that might be opposed to the patient's point of view.

The obsessive mechanism of "attempted solutions" is mitigated as an effect of the paradox. An active effort to do something spontaneous will inhibit the spontaneity. In obsessive persons, attempts to control rituals and fears produce the opposite effects of maintaining and incrementing them. At the end of the first meeting, the therapist prescribes techniques to do between sessions, based on the logic of belief. The type of applied techniques depends on the patient's attempted solutions (for example, type of rituals – preventive, propitiatory or reparatory), family involvement or gravity of the problem.

### Second Stage – Unblocking of the pathology

In this stage the strategic therapist concentrates on unblocking the vicious circle and creating the first change in the individual behavior. Very often, if the patient stops to do the rituals, the level of anxiety arises. It is confirmed that the function of the compulsions was to cease the anxiety. At this point, it is really important to teach an individual how to "take a control over" the paralyzing level of anxiety. The most effective maneuver is "The Worst Fantasy" which is described in many books of professor Giorgio Nardone, like "Knowing through changing" (2005). All the techniques and maneuvers described above have to be given in the form of hypnotic suggestion, describing exactly the behavior to be carried out in slow rhythmical, redundant language.

When the situation is unblocked, a pure obsession, pathological doubt or, like it has been mentioned before, the high level of anxiety can remain. Analyzing every individual situation and studying relevant techniques is prescribed.

### Third Stage – Consolidation and reorganization of the rules of the game

The goal in this stage is to consolidate changes and to rebuild other aspects of life that were neglected when the patient was really ill. What often happens in this stage is relapse, in other words, an individual makes some steps back and comes back to past dysfunctional habits. It is important how the therapist redefines the situation – "We are waiting for that to happen. If not, we are going to prescribe the relapse or predict that another one can happen the following weeks". Very few patients report that the anticipated relapse has occurred; the majority come back and report that there was no relapse and instead they felt a little better. In this stage, we also continue to prescribe other maneuvers (according to

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<sup>63</sup> More information you can find in: Nardone, G., Salvini, A. (2004). Il dialogo strategico. Comunicare persuadendo: tecniche evolute per il cambiamento. Milan. Ponte alle grazie.

protocols), in order to create a lasting change. The therapist also explores the other aspects of the patient's life to reassure that the other types of rituals have not appeared. Because OCD is like "a mental cancer" – either you completely dispose of it or it returns under other forms.

#### Fourth stage and last session – End of the game

When the obsessive situation is reduced to a minimum, the therapist proceeds to redefine the situation, emphasizing the capacity shown by the patient in fighting with the problem through exceptional collaboration and motivation. In those cases, the intervals between sessions are lengthened with the obvious intention to reinforce personal autonomy and to show the greater trust in the patient's newly acquired abilities.

In the following session the therapist proceeds with further positive redefinition of the situation, and the change that has been obtained until the end of the therapy is reached and the goal is achieved<sup>64</sup>. In the last session the therapist puts the final picture frame around the accomplished work of art.

#### **Effectiveness of the brief strategic model of treatment of OCD**

The brief strategic therapy usually collects data on the efficacy of the treatment directly over the field, in line with the method of action research . Empirical data refer to how many therapists apply the model in daily clinical practice on real patients asking for help with their disorder. Empirical data also refer to the long-term stability of the therapeutic outcome . These outcomes are assessed by the therapist and the patients themselves through rating scale which is relative to the changes made with respect to therapeutic goals agreed at the beginning of therapy. This survey applies a sample of subjects (a large group, spread throughout the world).

Brief strategic model uses more qualitative than quantitative criteria for the verification of the effectiveness of the therapy, focusing on the concrete processes of therapeutic change. Qualitative verification allows to free it from the tyranny of valuation models based on the statistical data collected in the laboratory<sup>65</sup>.

#### **The objectives of the action research method are:**

- Efficiency - Cost / benefit ratio.

- Replicability – Solutions are successfully applied to the same class problems.

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<sup>64</sup> Nardone, G. (1996). Brief Strategic solution-oriented therapy of phobic and obsessive disorders. London. Jason Aronson.

<sup>65</sup> Nardone, G., Portelli ,C. (2013). Ossessioni, Compulsioni, Manie. Ed. Ponte Alle Grazie

- Transmissibility - Able to be taught and learned from others.
- Predictability – Able to predict the possible outcomes in each stage of the application process in order to be adaptable and self-correcting

**In 2003** the evaluation of the results relating to the effectiveness and efficiency of all differential protocols of treatment for different forms of psychopathology started.

The results of this study, which was conducted on a sample of 923 patients with OCD, show **89% of the effectiveness of the treatment and the duration of treatment of 7 sessions.**<sup>66</sup>

From **2010 to 2012** a systematic study of the outcome of therapy for OCD was conducted at the Brief Therapy Center in Arezzo (Italy). There were **127 cases** of OCD patients where brief strategic treatment was applied. **The efficacy was 88% which means 112 cases were solved.** “Solved” means that people were free from OCD, free from pharmacological treatment and they could lead a normal life. These negative outcomes, as the experience of Strategic Therapy Center for compulsive disorders shows, mean that if the symptoms are not completely settled, they tend to reoccur.<sup>67</sup>

The effectiveness related to the complete healing from the disorder, which includes three meetings of control at 3, 6 and 12 months after the extinction of phobic symptoms and compulsive belief, stands at an average of 7 sessions for the entire treatment. If the symptoms release in the whole sample, the outcome is achieved within the first 4 sessions - **in 2/3 months** from the beginning of the therapy. This aspect should not be underestimated: it is different to be free from the debilitating disease in 2 / 3 months and not in 2/3 years. The efficiency of a treatment, underlines the real therapeutic efficacy.

This is the reason why the techniques and strategies of communication are studied and tested at Strategic Therapy Centre in Arezzo. That makes therapeutic interventions more targeted at the characteristics not only of the disease but also the unrepeatability of the individuality of the patient.<sup>68</sup>

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<sup>66</sup> This data is also presented in this books: Nardone, Watzlawick (2005), Brief Strategic Therapy; Ray, W., Nardone, G., (2007). Insight may cause blindness and other essays; Elkaim, M. (2007). Comprendre et traiter la souffrance psychique: Quel traitement pour quel trouble?.

<sup>67</sup> Nardone, G., Portelli, C. (2013). Ossessioni, Compulsioni, Manie. Ed. Ponte Alle Grazie

<sup>68</sup> Nardone, G., Portelli, C. (2013). Ossessioni, Compulsioni, Manie. Ed. Ponte Alle Grazie

## **6. Example of OCD treatment according to brief strategic therapy (advanced model)**

Here, the writer would like to present the two cases of OCD treatment where brief strategic therapy was applied. In the first case, called “Bride with a fear of incontinency”, the writer would like to present 3-session therapy of OCD (obsessive thoughts and phobic reactions).

The second case concerns a middle aged man who was fighting with OCD for more than 10 years. After unblocking the problem and seeing the first important results, the patient called applied methods as a “mental pill”.

Below, the case studies have been presented in a detailed way.

a. Case study 695 – Bride with a fear of incontinency.

Very often on the basis of an obsession one can develop phobic reactions.

One excellent example of how we can intervene quickly and successfully on OCDs is that of a young woman who was a victim of her preventive compulsions. She came to the private practice two months before getting married. She presented a problem grotesque in its nature and tragic in its effects: the terror of incontinency.

In other words, on the basis of past problems with celiac disease and gastric problems, she had begun to have doubts that she could lose control of her rectum during the wedding, and she was scared that she would have to go to the bathroom many times during the ceremony.

The patient has never had this concrete experience, but on the basis of a doubt that this could happen she ran for cover.

<b>First session</b> (28.06.2013)	<b>Patient: 695</b> <b>Co-therapist:</b> Agata Rakfalska Vallicelli
<b>Duration:</b> (14 min 10 sec)	
<b>Stage of therapy:</b> First	

**Definition of the problem**

A couple came one month before their wedding. A patient (a future bride) for many years had had a problem with the incontinency occurring in all “stressful situations”. Every time she found herself in a stressful situation , she felt the stimuli which made her run to the bathroom and defecate ( even 2-4 times before the event). Since she was diagnosed with celiac disease, the situation worsened. Never before had she been in psychotherapy. Her goal was to solve this problem before the ceremony (resistance 1°– patient was collaborative).

**Perceptive- Reactive System** – obsessive compulsive disorder with psychosomatic component.

**Attempted Solutions:**

- avoid stressful situation (like going to buy her wedding dress),
- preventive ritual – going to the restroom every time she felt stimuli from rectum,
- talking about this problem with family members,
- visiting physicians (Gastroenterologist) who should find the solution.

**Communicative maneuvers / In session metaphors**

Reframe: talking about the problem is like putting fertilizer to the plant which makes it grow and grow and finally suffocate.

Reframe mental mechanism of obsessive thoughts (fear of inconsistency) and compulsive actions (going to the restroom and striving herself to defecate as a prevention). The more she wants to control her rectum, the more she loses control of it.

The intestine as the target of her anxiety.

**Prescriptions:**

- Ritualized ritual – every 3 hours the patient has to go to the restroom and verify whether she has a stimuli or not (for 10 days),
- Conspiracy of silence,
- Every morning when she prepares herself to go to work, she has to think (for a few minutes) about the day of the wedding and imagine all the worst things that can happen to her (version of WF – Worst Fantasy Technique).

**Logic of persistence of the problem:** belief

**Stratagem:** “Lead the enemy into the attic and remove the ladder.”

**Second session**

(09.07.2013)

**Patient: 695****Co therapist: Agata Rakfalska Vallicelli****Duration:** (10 min)**Stage of therapy:** Second**Definition of the problem**

The couple one month before their wedding (date: 27.07.2013). The patient is fearful of her incontinency in stressful situations (like the wedding). She was diagnosed with celiac dysfunction. AS – talking about the problem, avoiding stressful events, preventive ritual – going to the restroom every time she feels stimuli from her rectum).

**PRS (OCD)****Effects of the prescriptions:**

- unblock – she discovered, by going to the restroom every 3 hours, that she has not a stimuli all the time.
- paradoxical effect of morning WF – the more she was thinking about the worst situation that could happen during the wedding, the less ideas came to her mind or the more she was thinking about the positive aspects of ceremony,
- no talking about the problem to avoid worsening the situation.

**Present Situation**

In the last 10 days she has not had a need to go to the restroom, only during the farewell of celibacy of her fiancée. She claims she feels better.

**Communicative maneuvers / Metaphors**

- Reframe the effects of WF (Worst Fantasy) –when she decides to look at the ghost's eyes, she makes them disappear. *"Evoke, Touch and Make them vanished."*



**Prescriptions:**

- Ritualized ritual – - going to the restroom and checking if she has a rectum stimuli every 4 hours.
- Conspiracy of silence.
- Worst Fantasy Technique in the morning.

**Stratagem:** “Lead the enemy into the attic and remove the ladder.”

<b>Third session</b> (24.07.2013)	<b>Patient: 695</b> <b>Co therapist: Agata Rakfalska Vallicelli</b>
<b>Duration:</b> 9 minutes	
<b>Stage of therapy:</b> Third	

**Definition of the problem**

The patient came back 3 days before her wedding. Although she was in front of this emotional but “stressful” situation, she was calm. Her psychosomatic problem (preventive compulsion) has not appeared for the last 14 days.

**PRS (OCD)**

**Effects of the prescriptions:**

- Being forced to go to the restroom every 4 hours made her obtain the control over her rectum stimuli.
- Paradoxical effect of morning WF – the more she was thinking about the worst situation that could happen during the wedding, the less ideas came to her mind, or the more she was thinking about the positive aspects of ceremony.
- No talking about the problem to avoid worsening the situation and to help to find a solution.

**Present Situation**

In the last 14 days she has not had a need to go to the restroom before a stressful situation. She said she was ready to get married.

**Communicative maneuvers / Metaphors**

- Reframing the effects of WF –when she decides to look at the ghost’s eyes, she makes him disappear. *“Evoke, Touch and Make it vanished.”*

**Prescriptions:**

- Conspiracy of silence,
- Ritualized ritual - going to the restroom every 5 hours
- WF in the morning before the wedding, and in the car, and while driving to church.

The patient was to come back in September, after their honey moon. At the beginning of September she called Strategic Therapy Center and confirmed that all the symptoms did not appear any more. The wedding went well and none of her imagined fears came true. She is not forced to go to the restroom to control her rectum any more, and everything became more regular without her intervention.

The therapist was satisfied with the work they had done together, s/he had restored the responsibility for a change in the patient. They stayed in touch so that she could feel free to call and schedule an appointment if the situation changed.

Until today she has not called.

*b. Private case study – “My mental pill”*

This is the case of a 39-year-old man who was struggling with OCD from 2004, but without results. He was happily married, he had a really good job, but he wasn’t able to live his life because of some phobic obsessions and compulsions.

**During the first session** through the strategic dialogue, the therapist defined the problem, described the goal and analyzed its attempted solutions. It was really important to create a good relation with this middle aged man who was really rational and analytical. It was not helpful for the treatment.

From 2004 to 2011 he was carrying out preventive rituals of checking gas, closing doors, and so on. He was doing only pharmacological treatment with Zoloft,

Depakin, Prozac (he had taken even 7 pills a day). After 7 years without seeing any important improvement and having some really bad side effects, he decided to stop this kind of treatment. After one year free from drugs, he decided to undergo the psychological treatment.

At the present time, his biggest problem was to drive a car to work and come back. He was obsessed with the conviction that he had run over a pedestrian, which caused him to return repeatedly to the place of the presumed “crime” or drive a number of times around it to check if it really happened. He went out from the car and walked to the place of “crime” to reassure himself that his belief was unfounded. This situation resulted in his driving to work for 1h 40 minutes in the morning and 3 hours in the evening (instead of 40 minutes). You can imagine what kind of distress it caused. He drove always the same motorway, because he knew it and he could act preventively where the dangerous points were. He did not take any new route because it was too difficult and stressful, and he had to be even more focused on the street. He did not trust his perception, so every time he was crossing the traffic lights or pedestrian crossing, he had to turn off the radio, slow down, look in the back mirror and lateral mirrors (preventive ritual). He was really concentrated on every movement he made, he wanted to be sure that he did everything correctly. He was so unsure about his sense of sight that he performed a number of tests aimed to rally drivers. Of course, everything was well. He wanted to be sure that everything was fine with his senses, but the more tests he did, the more doubts he had.

So, at the end of the first session the therapist gave him the following prescriptions:

- How to Worsen Technique (HW),
- Violate the ritual – that is, every time he drives to work he has to modify some part of the rituals he was doing while driving.
- Write a list of the all rituals.
- Conspiracy of silence (with his wife, who was worrying about him and every day asked him about his day).

After two weeks, **during the second session**, the effects of the prescriptions were examined:

- HW – to worsen his situation he needs to search for new solutions which could improve his perception and reassure that he is able to drive. Why? Because – the more he looks for this kind of solutions, the worse he perceives his perception abilities.
- He did not talk with his wife about this problem and she did not ask about it.

- What kind of rituals did he modify? – he was able not to turn off the radio, but only turn down the volume. He tried not to check in back mirrors.

He confirmed that he chose the safest route to work where there was no risk (even though it was longer). But even though he drove this safe route day by day, he became more anxious, more fearful about what may happen. Even though he was driving very carefully, he was afraid that some pedestrians could go out on the street or a cyclist or a mother with a trolley. He did not trust his senses.

The therapist and the patient also analyzed what “safe driving” really meant. For the patient “safe driving” meant to control every aspect of itinerary, to control all circumstances, to be concentrated and careful. But as it was established the more he concentrated on different aspects of the drive, the more rigid this drive became. The more rigid he was, the much easier it was to “break him”. An analogical image taken from physics may be applied here: “if you have some hard material, you only need to find its weak point to break it. However, if you have a flexible material, it is difficult to break it because it adapts to the circumstances. The more rigid it is, the easier it becomes to break.”

The driver can drive really safe when s/he is more relaxed, less stressed, and more natural in his/her movements. When s/he adapts to the situation, s/he becomes more flexible, and it is less possible to break him/her and to make him/her fail (analogical language: comparison rigid-flexible).

After presenting this evocative image, the therapist prescribed the following indications:

- Every day he has to violate the driving rituals (like the last time) and maintain the change.
- Introduce some small risk during the drive (for example choose more difficult route).
- WF – The Worst Fantasy Technique (30 minutes).
- Conspiracy of silence.

During the conversation between the therapist and patient (**third session – second stage of therapy**), they noticed some small changes the patient made. The patient decreased an amount of time that he drove to work (1 hour in the morning, 1,5 hour in the evening). Every day after lunch he was doing the WF, with a paradoxical effect. The more he concentrated on the image of the worst fantasy related to his fears, the more his mind was thinking about something else. He continued to violate rituals while driving (mirrors and radio). He also disclosed that very often he was terrorized by the thought of having run over the pedestrians and he had to stop the car and return to the hypothetical scene of crime. His obsessive, intrusive thoughts which came out while driving, increased his anxiety level and

consequently carried out compulsive behaviors – he stopped the car, and walked to the place of presumed crime. If he did not see anything, he was turning back to this place a few times to reassure himself and calm down.

The patient started to accept some risks in his life – he started to use the car even when he was not going to work (for example to go shopping or for a trip out of town), and he stopped to use a taxi at work (he avoided using a company car at work because of his problems). He started using the company car and driving by himself in a big city. He discovered that the level of anxiety did not increase.

So, the patient was ready for some new prescriptions:

- WF 5 x 5''
- Counter ritual at place of reparatory rituals ( if 1, do it 5 times).
- Undertake some new small risks.
- Conspiracy of silence if needed.

**In the next 2 weeks (forth session, second stage of therapy)**, the patient revealed that he was not able to do the counter ritual, if 1, do it 5 times. He was sick in these weeks, there was snow on the street and the situation on the road was really difficult. He did the Worst Fantasy 5 times a day for 5 minutes (at 9am, 12pm, 3pm, 6pm, 9pm) with the same paradoxical effect. He took some small risks – he started to drive new routes and he discovered that the level of anxiety did not increase because he did not know a priori what kind of road he was taking (if it was dangerous or not). Paradoxically, the better he knew the road, the higher the anxiety was because he wanted to control every potentially dangerous aspect of the situation on the road.

He noticed that during his driving to work, the level of anxiety was lower (like 2 years ago, when he was taking medication but this time he did not take any drugs. He almost stopped controlling mirrors, radio, speed limits, etc (preventive rituals).

The man also revealed some new aspect of anxiety disorder. He was afraid of losing control over himself and he was scared that he could harm somebody (especially kids or elder people). What were his Attempted Reactions? He was avoiding situations when he was one-on-one with a person and there were no witnesses. For example in the restroom or in the lift when somebody was in front of him. He did not trust himself.

Prescriptions:

- WF in the morning inside the car, before going to work and in the evening before coming back home (5 minutes).
- He has to use the same WF techniques related to his fear in one-on-one situation.
- Continue to undertake some small risks.
- Continue to undertake some small challenges related to the situation one-on-one, that is, to stop avoiding it.

- Continue to violate rituals (while driving).
- Counter ritual - if 1, do it 7 (turning back ritual).

**The patient came back after 3 weeks (Fifth session)** and he said that he felt less fear, he was much calmer and he was thinking less about all this problematic situation.

He was driving to work the same, old route (which was really dangerous before) and he checked the mirrors only a few times. He went out of the car to check “the crime scene” also a few times, but it did not take him more than 1 hour to get to work. He did WF twice a day in the car and then the evoked fear disappeared. The same technique he was applying when he found himself with other men in one-to-one situation. Once he was at the airport going out from the restroom and some boy was running towards him. He said that his first reaction was to escape from the situation but then he decided to pause and wait. Nothing bad happened. The small boy passed him by. Everything was all right. That was his *corrective emotional experience* which took off from him the weights of a necessity to maintain continuous control of his behavior. Because he did not avoid the situation, he faced it and he noticed that nothing bad had happened. He felt calm and self-confident.

For the next 4 weeks, the patient was prescribed the following indications:

- WF if needed
- Undertake some small risks (violate rituals while driving to work).
- If 1, do it 10 times (ritual of turning back on and checking the “crime scene”).
- As If technique (As if you were out of problem, what would you do differently?).

The patient came back after almost 4 weeks (**sixth session, third stage of therapy**) when the spring started. There were many cyclists on the street, many parents with children in trolleys, teens on the roller skates. This situation scared him. But he was able to drive to work in less than 1 hour. He could not carry out the technique If 1-do it 10 times. He was checking as much as he needed. Sometimes more, sometime less. The therapist and the patient analyzed the situation one more time and they realized that while the patient was driving, his phobic doubt increased, he was asking himself (Should I stop the car and turn back or not, or should I drive further?). After some time he stopped the car, he got off the car and checked “the crime scene”. Then he could come back to the car and drive to work. Finally, the therapist and the patient understood the dynamic of this ritual and they were ready to change the prescription (self-corrective protocols).

After this session, the patient was asked to:

- Use WF as needed
- Maintain and strengthen changes he achieved till now (take a small risk, face situation one-to-one)
- While driving on a new route with his wife, he should stop asking her: “Was everything all right on this cross road?”, and tell her to use the standard question: “And in your opinion?”.
- Postpone the ritual – when the doubt increased while driving, he had to stop the car and wait for 10 minutes. When after this time he thought that it was rational to control “the place of crime” he could do it, or he could decide to continue driving without checking.

During the next session which took place after 6 weeks (**seventh session, third stage of therapy**), the patient was able to turn back the car only once in 2 weeks and check the mirrors only once while driving. He scored his results on the scale from 0-10, as 6,5 (mentally) and 7,5 (practice).

Score 6,5 – means that he still had this pathological doubts which increased anxiety level while he was driving. And he did not like it.

Score 7,5 – means that he felt more confident while driving. He was more courageous and drove in many different places fearlessly.

Confidence in his own senses was increasing. He was driving his car when needed, he decreased also the doubtful questioning directed to his wife. Also his wife noticed that he was calmer and more relaxed at home. They went on vacation to the UK where he had to drive a car in left-hand traffic. He coped also with this situation without many difficulties.

His goal was to reach 10 - that is – he wanted to stop asking himself undecidable questions. He wanted to be free from doubting mind.

9 – he wanted to stop controlling/checking while driving.

8 – he wanted to maintain this situation and stop turning back or stopping while driving to work.

#### Prescriptions:

- Use WF as needed.
- Maintain and strengthen changes he achieved till now (take a small risk, face situation one-to-one).

- **Postpone the ritual** – when the doubt increased while driving, he had to stop the car and wait for 15 minutes. When after this time he thought that it was rational to control “the place of crime” he could do it, or he could decide to continue driving without checking.

After two months of summer (**eighth session, third stage**) – the man came back telling the therapist that he was able to drive to work normally (in 2 months he turned back 5 times). He assessed his perception trust at the level of 80%. Sometimes he continued checking some small section of the route. During the conversation with the therapist he understood that the intrusive questions which popped up in his mind while driving were irrational, undecidable and unanswerable. When he answered the undecidable and irrational question, he made it rational and logical. But this answer generated new questions and new answers and new questions. Like opening Chinese boxes. The only way to stop this process was to stop answering the first question. It is not possible to block the questions, but the questions can be left without answers. It is not an easy exercise but if applied, it is very effective.

After this emotional reframing, the patient was asked if in this long period he noticed any new obsessions or compulsions. At the beginning he did not want to admit that he had started checking mails many times at the end of the day at work. He had a very responsible job and he had to send very confidential e-mails so he could not fail. Since 2010 it has never happened, but later he started to consider that it might have happened (and anxiety level was increasing).

His score: 8.

Score 10 – driving car without turning back or stops, without doubts. Stop checking e-mails.

Score 9 – when he is stressed, he can be mentally insecure, but he has to be physically “certain”. Distress does not count to his organization of the day.

#### Prescriptions:

- Use WF as needed,

- Maintain and strengthen changes he achieved till now (take a small risk, face situation one-to-one),

- Postpone the ritual – when the doubt increased while driving, he had to stop the car and wait for 20 minutes. When after this time he thought that it was rational to control “the place of crime” he could do it, or he could decide to continue driving without checking.

- He could check e-mails once during the day. But when he checked them twice, he had to do it 5 times. No more, no less.



During the **ninth session** which took place after 2 months, he told the therapist some good news. He was expecting his first child, even though his wife and him just gave up because of all his health problems. As he took strong medicines for many years in the past he was not able to have a baby. Now when the situation has improved, “the miracle happened”. The second news was that he was distinguished for his determination, he achieved success at work and he was entrusted with a new task. It required from him a continuous contact with the mass media, public speeches, even live one. Initially he was happy with it, but after some time he understood how stressful it was.

These two important events unfortunately resulted in his resigning from doing some indications. He did not have many problems with a car – he drove everywhere, even far away, but he started turning back once a day. Then it was better. However, he was terrified that he could have sent a wrong e-mail to a wrong person. So he was checking them in the evening a few times. He started checking plugs at work too.

This situation also confirms that OCD is like a “mental cancer” because as long as you do not eliminate it totally, it can reproduce in various forms. That is why it is so important to continue doing indications and checking if OCD symptoms do not replicate.

This kind of relapse was predicted, it was a normal phase of the therapy. But the therapist should always have his/her eyes wide open.

However, the patient was in a good shape, he was happy because of all positive changes in his life and he was faithful because he understood “how his OCD worked”. We made one step back, to make 2 steps forward.

#### Prescriptions:

- WF as needed.
- Block the answers to inhibit the questions while driving (pathological doubt).
- Checking mails. He has to check them once, then when he wants to do it again, he has to wait for 10 minutes and then he can do it freely or he can give up doing that.
- Checking plugs – If 1, do it 10 times.

Reassessing the last 9 months of treatment, it can be assumed that strategic techniques, establishing strategic relationship and using an adequate language of communication were the key components of the therapy. The patient’s enormous motivation and his commitment to recovery (resistance of the first type - the collaborative) should also be appreciated. The therapy still continues and we are ready to act strategically.

## **7. Conclusions**

The writer wishes to dedicate her dissertation to all those suffering from OCD and their parents.

By this publication she wants to give them a glimmer of hope for healing, despite the fact that many international publications point out that the symptoms may only be reduced and pharmacological therapy is necessary . As mentioned before, OCD is like a “mental cancer” – either you eliminate it totally, or it can reproduce in

various forms.

The effectiveness and efficiency of **brief strategic treatment** discloses that it does not have to be so- **112 of 127 cases were solved** (research study from 2012,– see chapter 5). “Solved” means that all symptoms disappeared, a person has changed his/her way of perceiving reality and responding to it. The patients were free from medications, they were able to rebuild their lives from scratch.

*So, are there still obstacles to effective treatment of OCD?*

- Lack of proper training in health professionals. People with OCD often get the wrong diagnosis from health professionals and need to see several doctors and spend several years in the incorrect treatment before getting the right diagnosis.
- Less public awareness of OCD. Until recently, many people did not know there was even a name for their illness and with no name, they assumed there was no treatment.
- Difficulty finding local therapists who can effectively treat OCD.
- Not being able to afford proper treatment.
- Hiding symptoms. Some people choose to hide their symptoms, often in fear of embarrassment or stigma. This causes many people with OCD not to seek the help of a mental health professional until many years after the onset of symptoms.

I think that the most important point is a lack of proper training in health professionals and little public awareness of OCD. This article aims at giving some advice to both doctors and patients. It is important that people with OCD receive treatment that is specific to OCD, from a fully qualified therapist. Some forms of traditional psychotherapy are not effective in relieving symptoms of OCD.

In this paperwork the writer decided not to develop the theme of obsessive-compulsive disorder among children and adolescents, even though the statistics show that the number of children with OCD has increased. In Strategic Therapy Center in Arezzo the conducted researches and results demonstrate also high effectiveness of brief strategic therapy of OCD treatment with children and teens.

Modern treatments for OCD have radically changed the way in which the disorder is viewed. While in the past OCD was regarded as chronic and untreatable, a diagnosis of OCD may now be regarded with hope. Actually, the most effective treatment for OCD is brief strategic therapy with **89% of the effectiveness of the treatment and duration of treatment of 7 sessions**<sup>69</sup>. Cognitive-behavioral therapy combined with

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<sup>69</sup> Nardone, G., Portelli, C. (2013). Ossessioni, Compulsioni, Manie. Ponte alle Grazie

drug therapy (antidepressants) has the **effectiveness of 75 % of patients who experience improvement in their OCD symptoms during treatment** <sup>70</sup>.

So Brief Strategic Therapy should be The First-Line Treatments for OCD and OC Related Disorders. If you are interested in it, you should check information on the website of Strategic Therapy Center in Arezzo (Italy) - <http://www.centroditerapiastrategica.org/en/index.php>.

Thank you for reading.

Dott.ssa Agata Rakfalska- Vallicelli

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<sup>70</sup> Institute for Quality and Efficiency in Health Care (IQWiG) – OCD. Can psychotherapy help? <http://www.informedhealthonline.org/obsessive-compulsive-disorder-can-psychotherapy-help.438.en.html> Date: 29.12.2013

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