

Research Article

Strategic psychotherapy and the “decagonal model” in clinical practice

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Abstract

Starting from the strategic model, this research focuses on its critical aspects, to suggest a dynamic and structured model, called “decagonal model” to be applied in clinical practice and organised by actions (what), purpose (why), time/place (when/where) and modality (how). Framing the patient’s symptomatology in a specific nosographic framework (structural component) is therefore useful to take a picture of him and to recognise the habitual toxic patterns and tendencies of his personality, but the strategic operations to be put in place are to place the emphasis on the functional aspect of his personality (functional component), working on his resources, on the solutions attempted, on the vicious circles reproduced, on emotional literacy and awareness.

Contents of the manuscript

The strategic model [1] originates from the systemic psychology current and refers to that complex of hypotheses and research capable of overcoming the traditional psychodynamic perspective by focusing exclusively on the individual, as a universe in its own right. It is an internal current with a constructivist matrix that refers to von Bertalanffy’s general theory of systems, to the radical constructivism and cybernetics of von Glasersfeld and von Foester, to the studies on hypnosis and suggestibility of M. Erickson, to the studies on language and on the ability to suggest. Erickson, to Watzlawick’s studies on language, communication and circular randomness, to the construct of the double bond and attempted solutions of the Palo Alto School of Bateson, Haley and Jackson, to von Neumann’s game theory and De Shazer’s studies on groups and the family.

The scientific production of this strand of research is heterogeneous, partly due to the internal divisions of their researchers into three main currents from the 1970s onwards: a) De Shazer and the Milwaukee School, with its derivations continued with Berg, on the solution-focused strategic model; b) Weakland and Watzlawick of the Palo Alto School, in their turn subdivided into two distinct strands, that of Fisch and Witzaele-Garcia (Brief Therapy Model) and that of Watzlawick

and Nardone (Strategic problem-solving model), the latter then continued in Italy with other schools of the same orientation such as that of Petruccelli (which however embraces Haley’s thought to a greater extent); c) Haley, Madanes and Rabkin, on the family strategic model [2-4].

The strategic logic [1] is based on these theoretical foundations. The short strategic approach to therapy is evidence-based and is recognized as best practice for some important psychopathologies: obsessive-compulsive disorder, binge eating, juvenile anorexia, panic attacks, family violence and antisocial behaviour. This model has four specific phases: knowledge of the problem and attempted solutions, the definition of the objectives to be achieved, behavioural prescriptions and specific techniques and strategies, the conclusion of the therapy. The intervention never exceeds twenty sessions (even if often excellent results are obtained even with half the sessions), including the three follow-up sessions at three, six and twelve months.

The theoretical framework of strategic psychotherapy [1] is based on specific epistemological assumptions as highlighted so far. These assumptions refer briefly to:

a) functioning of the human mind, understood as an organized structure on a “system of interdependent relationships



between oneself - others - world”, where man is at the center of the systemic relationships between all the components, according to a scheme of first (objective reality) and second (subjective) order, and no longer linear but circular (the search for a first cause (linear logic) fails because the phenomenon follows a logic of circular causality, and on three levels of functioning of the mind (visual, auditory and kinesthetic or emotional, which also includes all the other senses;

b) use by the subject of his personal “*functioning*”, understood as the set of ways in which each of us, in a subjective way, perceives reality, attributes a certain meaning to it and reacts to it. Through the experiences of interaction (with oneself, others, and the context), the mind constructs the criteria and ways in which to interpret reality, that is, its habits to perceive-react. Our reactive perceptive system works as a filter that selects the meanings to be given to things, as a frame that frames a phenomenon interpreting it in one sense or another, according to its criteria (emotional, motivational, logical, values and according to the states of the mind).

c) elaboration, by the subject, of “*attempted dysfunctional solutions*” to the problems encountered, that is what we do to solve a problem is often exactly what keeps it or makes it worse. Subjective perceptions and reactions to reality produce (even relatively quickly) habits of thinking, behaving, reacting and interacting in a certain way.

What differentiates one psychotherapy approach from the other, however, is the implementation, in clinical practice, of the specific rules of case management and related protocols that may have been devised, concerning *evidence-based* and *best practice*.

The strategic approach, as can be deduced from its constitutive history, suffers from an excessive fragmentation of thought, which sees within the same matrix more schools and more visions (often of the same problem); if in common for all there is therefore the clinical logic of starting from the problem to identify the attempted solutions and vicious circles, in order to identify the exact functioning of the person, on the other hand there is the need to use psychodiagnostic ‘labels’ to frame the subject: In fact, some schools are radically opposed to the use of Diagnostic and Statistical Manual of Mental Disorders (DSM-V) [5], Psychodynamic Diagnostic Manual (PDM-II) [6] or International Classification of Diseases (ICD-11) [7], in favour of a completely innovative approach linked exclusively to the study of the problem in order to identify the solutions, regardless of the co-presence of one or more deep-rooted psychic disorders (which would possibly represent only the “rigid” manifestation of a series of vicious circles never interrupted and fed dysfunctionally over time); other schools, on the contrary, prefer to start from the nosographic label, on the basis of the symptomatology described and identified during the first clinical interview, and then to continue as indicated above according to a functional, elastic and dynamic logic of the analysis of the problem and of the solutions. The same interpretative problem is denoted by the absence of a uniform protocol of behaviour to be followed with the client (the term “patient” is avoided precisely in order not to

categorise him and make him feel already rigidly embedded in a psychopathological nosography), notwithstanding the organisational settings already stated.

In the writer’s opinion, the most favourable thesis, also concerning the scientific evidence shared by the community, is to adhere to a “median” position that takes into account both the strictly nosographic instance and the functional instance. Compared to the psychiatric thesis (which rigidly clusters the patient’s symptomatology) and the constructivist / systemic-strategic one (which sees the psychopathological disorder out of the medical context and out of the nosographic “labels”, to favour a more functional and reactive approach, starting not from the symptomatology - and therefore from the “why” but from the “how” - but from the attempted solutions, from the vicious circles and the relational context), the writer adheres to the “median position”, arguing specifically that Framing the patient’s symptomatology in a specific nosographic framework is useful to photograph him and recognise the habitual toxic patterns and tendencies of his personality; however, this does not mean to contain his personality rigidly or to crystallise it forever, as the personality is plastic (just like our brain) and shapes itself according to newly reached awarenesses and corrective emotional experiences. The more rigid a personality is, the more its capacity to model itself is free. In certain conditions, where psychopathology seriously compromises the functions of reality, such as judgement and awareness, this condition is evident and one cannot ignore the objectivity of the symptoms manifested. In this, the strategic approach is too extreme. Therefore, if on the one hand, it is always useful to frame his personality structure (structural component) according to the present symptomatology with the use of shared nosographies thanks to scientific evidence, on the other hand, it is fundamental to put the accent on the functional aspect of his personality (functional component) and therefore to work on his resources, on the attempted solutions, on the reproduced vicious circles, on his emotional literacy and awareness, always bearing in mind that a personality functioning cannot be clustered as it is the sum of all the functional and dysfunctional traits of the patient and therefore each patient is a universe of personality in itself that can also change over time as a result of experiences, whether positive (and functional) or negative (and dysfunctional).

Here, therefore, adhering to the median thesis, also about the structure of the Perrotta Integrative Clinical Interview (PICI) [8-12], the writer suggests a model of strategic approach in clinical practice organised by actions (what), purposes (why), time/place (when/where) and modalities (how); indeed, in adherence to what has been stated so far, such a model could be a good starting point on which to reason and frame the clinical method according to a structured and sequenced logic. Below is the detail of the “*decagonal strategic model*” Table 1.

1. *Welcoming the client*: This is the action that aims to prepare the client for the therapeutic relationship and to facilitate communication and openness and availability towards him. It is a general approach that must be taken constantly and becomes fundamental especially at the



Table 1: Decagonal Model (schematic form).

Action(What)	Purpose(Why)	Time/ Location (When/ where)	Methods(how)
1. Welcoming the clien	Background to the establishment of the therapeutic relationship	General approach	Empathetic, welcoming, non judgmental, methodical, orderly and authoritative
2. Receiving the narrative of the problem complained of by the client	Establishing the therapeutic relationship and identifying compromised dimensions	First session	Active and participative listening, adapting to the client's mode of communication (without being dominated/managed). Containing/limiting where necessary
3. Comprehensive personal and family anamnestic history	Establishing the therapeutic relationship and understanding the client's internal and relational dynamics	First session	Targeted and precise questions, investigating the personal and family sphere, including relational and medical profi les
4. Drawing up the therapy	Strengthening the therapeutic relationship and instructing the client on the pathway	First session	Explaining the contents of the therapy contract, the legal details and the proposed course of treatment
5. Outlining the client's main psychological functioning	Strengthening the therapeutic relationship and understanding the client's internal and relational dynamics	Second session	Identifying the client's attempted dysfunctional solutions and their vicious circles
6. Identify the client's psychological functioning in detail	Strengthening the therapeutic relationship and understanding the client's internal and relational dynamics	Second / Third session	Use communication and strategic language to identify the client's resources, goals, mistakes and self-deceptions, avoiding labelling the symptomatology
7. Deconstructing the dysfunctional components of the client's psychological functioning	Strengthening the therapeutic relationship and understanding the client's internal and relational dynamics	Successive sessions	Using communication and strategic language to identify dysfunctional aspects of psychological functioning to be corrected, circumventing the client's psychological resistance
8. Restructuring the dysfunctional components of the client's psychological functioning	Alleviate or solve the problem	Successive sessions	Using communication and strategic language to correct dysfunctional aspects of functioning with clear, direct, precise prescriptions, functional to the client's objective and scope, encouraging new corrective emotional experiences
9. Closing the route	Reinforce new customer skills and awareness to keep change active	Last session	Using communication and strategic language to consolidate and make the client independent and autonomous
10. Follow up sessions	Check the results obtained and reinforce them over time	1-3-6-12 months (as needed by calendar)	Using communication and strategic language to consolidate and make the client independent and autonomous

beginning of the process where the client still has to perceive the therapist in his clinical and authoritative role, as the solver of the problem. He must therefore be empathetic, welcoming, non-judgmental, open to differences, methodical, orderly and authoritative (but not authoritarian); he must instil in the client security, preparation, availability, coherence, tranquillity and protection, thus becoming a firm, constant, solid and certain point of reference.

2. **Receiving the narration of the problem complained of by the client:** This is the action that has the purpose of profitably establishing the therapeutic relationship, identifying the impairments to one or more of the nine-dimensional areas of the client: a) "personal" (i.e. the relationship with his or her internal psychological parts); b) "familial" (i.e. the relationship with his or her family of origin); c) "affective" (i.e. the relationship of friendship and significant emotional bond); d) "emotional" (i.e. the relationship with the family created as a result of the sentimental and filial relationship); e) "sentimental" (i.e. the bond of deep feeling towards a person and their offspring); f) "work" (i.e. work relationships); g) "social" (i.e. the socio-environmental relationships where the person lives, domiciles or resides); h) "intimate-sexual" (i.e. physical and carnal

relationships entertained); j) "psychophysical well-being" (i.e. the area of relationships with one's body and mind). One or more of the areas indicated may, however, overlap, until they are fully identified, depending on the case in question and the functional inclinations of the client. It is carried out during the first session of the clinical interview, according to a modality of active and participative listening, adapting to the client's communicative modality (without letting oneself be dominated or managed by the latter), containing or limiting it if necessary in its manifestations.

3. **Drawing up a complete personal and family anamnesis:** This is the action that has the purpose of establishing in a more and more robust and adherent way the therapeutic relationship with the client, to understand the most significant internal and relational dynamics. It is a fundamental operation because it is the starting point of the clinical work that will concretely form the "therapeutic contract", analysing, in fact, all the significant relationships (with oneself, with the others and with the external world), including the dynamics of the person and the family. Useful is the request made to the patient to present, in the first interview session, the documentation already possessed of previous psychological and health interventions, to have a



general picture as complete and detailed as possible, trying to define in a strategic key the different functional dynamics of the client, including the discomforting profiles (intended as behaviour able to cause an effect perceived negatively by the client), deviant (understood as behaviour capable of provoking an external event perceived negatively by the client because it is socially improper or inappropriate or in violation of rules of conduct and morals) or disturbing (understood as behaviour capable of provoking an effect perceived negatively by the client because it is socially reprehensible or wrong or maladaptive concerning the environment).

4. *Drawing up the therapeutic contract*: This is the action that aims to strengthen the therapeutic relationship and instruct the patient on the path he will take. It is advisable to draw it up at the first session, after an initial analysis of the problems reported by the client, also clarifying the legal and relational profiles deriving from the drawing up of this agreement. Usually, at the same time, if this has not already been done, it is necessary to obtain the client's signatures for informed consent to treatment and authorisation for the law on privacy, following national and international regulations.

5. *Outline the client's main psychological 'functioning'*: This action aims at strengthening the therapeutic relationship already started and at understanding in a more and more detailed way the specific internal and relational dynamics of the client that feed dysfunctional psychological functioning [13], favouring "attempted dysfunctional solutions" (understood as strategies used to solve a problem but which, on the contrary, maintain it or even accentuate it) and "vicious circles" (understood as reiterations of dysfunctional behaviour that reinforce the problem and consolidate it), paying attention to all the patient's communication (verbal, paraverbal and non-verbal) [14]. This action is sketched out in the first session, but it is developed and perfected during the second, and then finally ascertained in the third session, in a detailed and specific manner.

6. *Identify the client's psychological functioning in detail*: This is the action that aims to strengthen the therapeutic relationship already started and to understand more and more completely the specific internal and relational dynamics of the client that dysfunctionally feed the psychological functioning, now fully recognised in all its components (functional and dysfunctional, understood as "personality traits or state personalities", according to Allport's theorisation and subsequent revisions) [15]. This action is concluded between the second and third session, depending on the case under examination and the client's collaboration [16]. During this action, the therapist uses communication and strategic language in a constantly refined way [17], through:

a. The "paraphrases", i.e. the exposition of a text in one's own words enriched by clarifications, re-elaborations, examples and comparisons.

b. The "paradoxes", i.e. prepositions formulated in apparent contradiction with common experience or the elementary principles of logic, but which on critical examination prove to be valid.

c. The "restructuring" (or in strategic language "reframing"), i.e. psychotherapeutic interventions (in the form of a technique or process or instrument) aimed at changing dysfunctional conduct and solving a problem, using a cognitive, analogical or metaphorical logic.

d. The "recollection" and the "mirroring", i.e. the process by which we send back to our interlocutor by feedback, with our behaviour, the behaviours and strategies that we have observed in him, and trigger the reaction by conformation (mirroring).

e. The "re-enactments", i.e. recalling a given event, circumstance or person belonging to our past.

f. "Rephrasing", which consists of repeating, in one's own words and as clearly and concisely as possible, what the client has just said about one's condition and/or situation, without enriching the conversation with one's elements as happens in paraphrasing.

g. The "restitution", i.e. those moments in the diagnostic process when information about a specific subject is translated into formulations, so that the subject can understand and use them.

h. "Proverbs", i.e. popular sayings containing synthetic truths that are socially accepted and considered correct, and therefore shared as positive experiences.

i. 'Metaphors', a rhetorical figure consisting of the replacement of a proper term by a figurative one, following a symbolic transposition of images.

j. The "alternative illusion questions", i.e. questions that put the client in front of two choices, one of which is surely unacceptable, so that the patient has the illusion of making a choice but in reality accepts and shares the one desired by the therapist.

k. The "irony", i.e. the often paradoxical alteration, to underline the reality of a fact through the apparent dissimulation of its true nature or entity.

l. "Humour", i.e. the ability to detect and represent the ridiculousness of things, in so far as it does not imply a hostile or merely amused stance but the intervention of a witty and thoughtful intelligence and a deep and often indulgent human sympathy.

The aim is to identify all the immediate (immediately available) and mediated (however usable) resources, focusing on the short, medium and long term objectives, recognising the errors that the client has incurred during his interpretations of reality, to favour the destructuring and reconstructive action of individual functioning. "These 'errors' can be sensory, perceptive, behavioural or cognitive, and therefore hyperactivations, illusions, hallucinations, pseudo-hallucinations, attempted dysfunctional solutions, vicious circles, dysfunctional behaviour, irrational beliefs, self-deception and cognitive distortions (or bias).



Finally, also in this phase, but in general throughout the therapeutic pathway, it is necessary to avoid as much as possible interpreting the signs and symptoms suffered using “psychopathological labels”, to avoid that the patient rigidly approaches his condition and excessively focused on his pathological categorisation; this does not mean, however, that one should ignore the symptoms. According to the strategic school, labelling (i.e. classifying symptoms according to a precise psychopathological nosographic framework) is an operation that risks trapping the patient in that pathological representation and therefore useless and substantially harmful for the positive conclusion of the therapeutic pathway; in the writer’s opinion, this approach is incorrect for the following reasons which justify both labelling and functional analysis of the client’s perceptual system:

a) The international clinical language is based on labelling, which in turn depends on precise organisational and interpretative rules, shared by the whole scientific community, precisely to favour a better overview of the patient’s psychopathological condition; failing to do so means making a partial intervention since the recognition of certain traits or (rigid) state conditions would not only make understanding between therapists of different clinical orientation more complicated but would not help the client who – aware of his status – would not work consciously on his condition.

b) The more the dysfunctional traits are rigid, the more the client’s personality takes on the connotations of a well-defined psychopathological status and therefore the manifested symptomatology cannot be ignored or underestimated just because the centrality of the work is on the identification of the client’s psychic functioning; all the more so in serious personality disorders and in psychotic patients, where the symptomatology is so pervasive and evident as to leave no room for any other interpretation.

c) Labelling has an educational function. Labelling the patient does not only mean making him aware of it, but it means offering him the opportunity to know his disorder in-depth, even in a technical sense, and therefore to anticipate it from time to time when he risks falling into self-deception and mental pitfalls (determined by his condition). Someone could object and say that such restructuring is possible regardless of the labelling, working on his psychic functioning, deconstructing and reconstructing it; to such an objection it is possible to answer by underlining the importance for the client to define himself in a label, also in the key of strengthening the therapeutic relationship, provided that after the labelling the strategic phases identified in the model here explained are followed.

However, another point appears very interesting and that would seem to be more in line with the classic strategic approach that would like to avoid the use of labelling: it appears frequently, in clinical practice, that the psychopathological label used does not correspond to the client’s totality and that it almost acts as a diversion concerning his real personological complexity. This objection, in the writer’s opinion, appears well-founded, since the client’s personality is a universe in itself,

studded with a series of variables determined by the multitude of functional and dysfunctional traits that are not always fixed but changeable and mouldable according to the emotional experiences of life. For this reason, the writer has proposed a new interpretation of personality and psychopathological disorders, through the PICI-1 [8-12], which reclassifies the disorders present in the DSM and PDM into 24 categories (for adolescents and adults) or 18 categories (for children and pre-adolescents) in personality disorders, identifying individual dysfunctional traits to consider them as “creative adaptations of the mind which, by structure and functioning, are shaped based on the main traumatic event, according to the internal response to external stimuli, reinforcing themselves positively or negatively according to them” [18-58].

7. Deconstructing the dysfunctional components of the client’s psychological functioning: This is the action aimed at correcting the dysfunctional components of the individual’s functioning, to alleviate or resolve the problem favourably. Deconstruction belongs to a therapeutic moment after the first sessions, within a framework of redefinition of the same, and requires an increasingly conscious use of strategic language, as the main opponent to change will be the client himself with his resistances (understood as emotional obstacles, such as pleasure, fear, anger or pain, which prevent access to unconscious and internal contents – and therefore the re-elaboration of them at a conscious level): by going around them, one can then proceed towards the set objectives, breaking the dysfunctional balance that reinforces the vicious circles and favouring the integration (during restructuring) of internal contrasts.

8. Restructuring the dysfunctional components of the client’s psychological functioning: This is the action aimed at correcting the dysfunctional components of the individual’s functioning, to alleviate or solve the problem favourably. Restructuring belongs to a therapeutic moment after the first sessions and is always after deconstruction, within a framework of breaking the previous dysfunctional balance, to facilitate the client’s cognitive alignment (understood as a cognitive operation that dissolves dissonance and allows a peaceful integration of all the instances present, from an emotional, behavioural and cognitive point of view) and the stabilisation of the “new” functioning. In this therapeutic moment, the indication of the single “prescriptions” (intended as explicit indications of action aimed at breaking the vicious circle, be they direct, indirect or paradoxical) is fundamental to achieve the prefixed objectives. For them to be perceived by the client as useful and functional, the therapist has to calibrate them adequately to make them efficient and effective, paying attention to the following four parameters: a) “direction” (is the prescription directed to obtain the benefit identifiable according to a logic of better organisation and less waste of resources?); b) “distance” (is the prescription aimed at obtaining an identifiable and functional benefit for the achievement of one or more objectives, in the shortest possible time and with the maximum profit?); c) “power” (is the prescription aimed at obtaining an identifiable and functional benefit, avoiding unnecessary overexposure



to stressful sources for the client?); d) “necessity” (is the prescription aimed at obtaining an identifiable and functional benefit necessarily and appropriately?). Therefore, the conscious and safe use of strategic language is fundamental, using clear, direct, precise prescriptions, functional to the client’s objective and scope, favouring new “corrective emotional experiences” (understood as concrete emotional experiences that allow the client to “repair” the traumatic influence of previous negative experiences, according to Alexander’s definition). In this therapeutic moment also the client’s “why” plays an important role, aimed at obtaining easy and direct answers to unresolved or tormented questions and dilemmas: in strategic psychotherapy, the psychoanalytical “why” is abolished and replaced with the “how”, in the sense of functioning, as the why is too subjective, not easily investigable and often unresolved precisely because of its internal components. Then why does not help to solve the problem and often does not offer solutions, while the how helps to identify one or more solutions starting from the attempted solution and therefore from the problem. In the writer’s opinion, such radicalism is counterproductive, as the “why” can become educational moments able to make the client reflect on certain aspects, searching inwardly for the hidden answers; correctly, strategic psychotherapy does not reinforce the operations on the search for the answers to the proposed “why”, however, I think they can be useful to help the client to disentangle himself emotionally, working in the meantime on his emotional literacy. After all, almost always, when we look for the answer to the “why” we want nothing more than a sensible and logical answer, even if it is not the right one.

9. Closing of the clinical process: This is the action that aims at strengthening the client’s new skills and awareness, to keep the change active. It represents the last session of the pathway and the therapist, always using the strategic language, consolidates the learned skills making the client as independent and autonomous as possible.

10. Follow-up: This is the action that aims at verifying the results obtained, reinforcing them from time to time during the medium and long term, according to a schedule decided with the client that varies from a bi-weekly up to an annual frequency, according to a specific need.

Conclusion

The proposed model responds positively to the need of suggesting an organisational and functional model based on the current scientific knowledge and of the results of the research on strategic psychotherapy, applicable also in the hypothesis of “single-session” where all the suggested actions are compacted, to favour subsequent follow-up meetings to verify and maintain the results obtained. The limits of the present research concern the practical and applicative profiles of the model, which is necessarily affected by its implicit theoretical construction; however, the model appears theoretically functional and structurally adequate concerning the dictates of the discipline. There are no conflicts of interest to highlight.

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