Epistemology, history and foundations of Brief Strategic Therapy. Giorgio Nardone's Model

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ABSTRACT
Giorgio Nardone's evolved model of brief strategic therapy is a psychotherapy that is currently considered to demonstrate high efficacy and efficiency for a variety of emotional disorders. This article presents the history and epistemological foundations of brief strategic therapy, based on systems thinking, cybernetics, general systems theory, and constructivism. The evolution and historical development are analyzed from the opening of the Mental Research Institute in Palo Alto to the creation of the Strategic Therapy Center in Arezzo Italy. The theoretical foundations of brief strategic therapy focused on the present and solutions are presented, starting from the premise that attempts at solution actually maintain the problem and proposing that based on strategic logic the solution always adapts to the problem and its object of study

Brief Strategic Psychotherapy, a model developed by Giorgio Nardone, is currently one of the most ever-growing psychotherapeutic models in the world that exhibit a methodology, as well as efficacy and efficiency in its interventions (Nardone and Portelli, 2017). Since its beginnings, which stretch all the way back to nothing less than the well-known Mental Research Institute of Palo Alto, California, until today, it keeps on spreading strategic knowledge at global level. Among the epistemological contributions that the Palo Alto school has made there are those which demonstrate that human interactions can generate pathologies: changing the focal point of psychotherapy from the intrapsychic to the interactional, allowing the formulation of therapeutic interventions based on these findings, leaving behind models based on the unconscious, the neurotransmitters and early childhood traumas (Fiorenza and Nardone, 2004). The interactive model between the subject and their social context changed the paradigm of world psychotherapy. An epistemological change was brought on that allowed, in turn, to modify the logic of interventions. This new model was based upon the idea that linear causality was inefficient to attend to and treat human problems. In the systemic-cybernetic model it is contemplated that human problems are built on communicative interactions that the human being establishes with others (Nardone, 2004; De la Cruz, 2003). According to this perspective, phenomena must be studied as a whole, in their relation to others and with their context. The focus should be on the study of the system,

where family plays a dominant role. The interactive system, its structure and organization would explain the dysfunction and, through them, the symptom could be cured. Given this, throughout all those years a series of family-based intervention models were developed (Fiorenza and Nardone, 2004). The Mental Research Institute proposals and findings symbolized a change in the traditional way of doing psychotherapy, allowing the emergence of models that left behind an eminently clinical tradition to become more psychosocial, where communication plays an important role (Nardone and Watzlawick, 2018). With this historical development in mind, below we present the epistemological bases, evolution and foundations of Giorgio Nardone's brief strategic psychotherapy model. We seek to spread the main epistemological proposals and contributions of this therapeutic model to psychotherapy. In the current post-pandemic context, there is a growing need for relying on efficient and effective interventions that can contribute to the development of mental health for the world's population. We consider brief strategic therapy can contribute in this regard.

The development of Brief Strategic Therapy: Historical Background. The Mental Research Institute in Palo Alto, California.

After the Second World War, in the fifties, the United States held the scientific Cybernetics conferences, promoted by the Josiah Macy Foundation and organized by Warren McCulloch. They summoned a number of experts in feedback, complexity, cybernetics and its implementation in various sciences. In this context, in 1958, Don Jackson founded the Mental Research Institute (MRI), an institute devoted to research on the field of mental health. Don Jackson, Haley and Weakland began their ground-breaking work in the emerging family therapy, studying communicative models in families with schizophrenic members (Fisch and Schlanger, 2012). The Mental Research Institute, under the leadership of Don Jackson included Paul Watzlawick to its team, whose studies on changes and pragmatics of human communication were revolutionizing the field of therapy. Paul Watzlawick, psychologist, Austrian and well-educated and very knowledgeable about philosophical logic, had lived in El Salvador and joined the Palo Alto team in 1961 (Nardone, 2000). Paul Watzlawick was one of the greatest exponents of human communication theory. His research field was focused on the pragmatic effects of communication: all research and interest on communication until then had been focused on syntactic and semantic features but not on pragmatic features of communication (Watzlawick, 2007). In 1961, Watzlawick along with Richard Fisch, John Weakland and Jay Haley were studying hypnosis without trance methods and brief therapy, focused on the development of a shorter form of therapy. They had been influenced by the famous psychologist and psychiatrist Milton Erickson. Erickson's influence was most noteworthy in the development of the brief therapy model, from stepping away from traditions about psychopathology to the habit of assigning homework to patients (Fisch and Schlanger, 2012). These techniques implemented by Erickson, with not-so-traditional features, were more than once mistaken for "shamanism" but concealed a rigorous and consistent

model, as well as a creative one (Nardone and Watzlawick, 2018). The Mental Research Institute (MRI) allowed the emergence of family systems therapy (Nardone, 2004).

Creation of Brief Therapy Center

When Don Jackson passed away in 1968, it was Richard Fisch who proposed the creation of the brief therapy center (BTC). The team was composed of Watzlawick, Weakland and Fisch. They launched the Metal Research Institute to fame, all thanks to research on human communication (Fisch and Schlanger, 2012). The research group aimed to look for new ways of more flexible and shorter psychotherapeutic interventions that could adapt to diverse human problems. Their findings in communication theory and pragmatics supported the development of new psychotherapeutic techniques.

The approach towards great hypnotherapist Milton Erickson's works allowed the incorporation of his vision and techniques, finding that, in his experience, various problems could be solved, in a quick and definite way, in a brief therapy modality (Nardone and Portelli, 2017).

The team also found that communication theory could be implemented to a variety of contexts that transcended the family. A systemic model only focused on the family would become rigid and constricting (Nardone and Balbi, 2018).

Thus, the brief therapy center of the Mental Research Institute accomplished the development of a strict, but also flexible, therapeutic model. Its work concentrated on the reduction of treatment duration, all through a more operational and pragmatically-focused therapist, this way achieving the first major revolution in the therapeutic field (Ceberio and Watzlawick, 2006).

Giorgio Nardone's evolved model

Giorgio Nardone studied at the University of Siena, in Italy, where he graduated with a thesis related to philosophy of science. He held Karl Popper in high regard and wanted to become a great epistemologist like him. That's when he, while being a student of Professor Mariano Bianca, got involved in a research project that subsequently would change the course of his life. He would study epistemology concentrating on the study of various models of psychotherapy. He would mainly focus on the epistemological features and methodological soundness of them. While taking part of the aforementioned research project he found out that the Mental Research Institute's (MRI) therapy model covered the strict methodological criteria that he was studying (Nardone and Watzlawick, 2018). This is how he began the journey that would take him to expand his knowledge and delve into the field of psychotherapy. Thanks to a scholarship, he traveled to Palo Alto, California, to the heart of the very Mental Research Institute. Having studied epistemology, he took the lens of science's epistemological method with him. After a long stay in the Mental Research Institute, his life took a turn: from being focused on

epistemological features to the clinical features of psychotherapy. Moreover, he was fascinated by the results he could witness and record during his interaction with great mentors like Paul Watzlawick. This astonishment and fascination took him to change his major. After leaving philosophy of science, his mentor Mariano Bianca wrote a letter of recommendation for him to the director of the Psychology Specialty and that is how he started his studies in clinical psychology. All of this was happening while still having connections with the Mental Research Institute. His college studies came to an end in 1985. Then, Paul Watzlawick took him as his disciple and became his mentor, thus starting a new research in Palo Alto.

During his stay in Palo Alto he quite often treated patients suffering from schizophrenia, psychosis and relationship problems. Nevertheless, much to his surprise, while returning back home to Italy, he realized that most cases that ended up in counseling were in fact patients with phobic and obsessive disorders, in contrast to the Mental Research Institute ones. That is how he put into practice what he had learned, using the original model from the Mental Research Institute, but adapting it to those disorders found during his clinical practice in Italy. He broke away from those traditional protocols focused on family therapy and the need to treat patients with their families. It was a blatant family-therapy dogma violation, which was far more focused on theory than the disorder itself and the importance of family more than the individual (Fiorenza and Nardone, 2004). By treating patients individually, a new therapy protocol emerged, arising surprise and interest from his great mentors Paul Watzlawick and John Weakland.

After four years and more that 100 treated patients, a new model of evolved brief strategic therapy was consolidated and launched, with a first paper about it being written in 1988. Adding all that information and experience into six chapters of what his first book would be, he published ''The Art of Change'' in 1992 (Nardone and Watzlawick, 2012). Paul Watzlawick gave him the honor of co-publishing it. It became a bestseller and manifesto of brief strategic therapy. Afterwards, thanks to the achieved success, he began to research various types of disorders like eating disorders, bulimia, anorexia, among others. This way, the model of research-action with an experimental empirical basis expanded and that is how, in 2000, an important article called “Brief Strategic Therapy'' was published. It was a longitudinal study developed throughout 10 years including 3640 cases, with an average of seven sessions (Nardone and Portelly, 2017). Among the main results we can find a 95% effectiveness regarding phobic and anxiety disorders, including panic attacks and post-traumatic stress disorder; 89% effectiveness when it comes to obsessive-compulsive disorders; 91% effectiveness in sexual dysfunctions, 83% effectiveness regarding eating disorders; and 83% effectiveness in depressive disorders (Nardone and Watzlawick, 2004). Reporting the exclusive use of brief psychotherapy in the applied protocol for all patients, which is a very important feature to highlight, the model reported in this study high effectiveness and efficiency without the use of any drugs (Nardone and Portelli, 2017). By 2004, with the systematization and incorporation of new techniques, new contexts could be permeated through, transcending the clinical one to successfully reach sports, coaching, education, management and arts. After more than 35 years of the evolved therapy model practice, making use of non-linear logic and

knowing the problem through its solution, the model has proven to be more effective and efficient than the traditional cognitive behavioral model, being more effective in eating disorders, obsessive-compulsive disorders and anxiety disorders (Nardone and Balbi, 2018). Below we can see a comparative table between brief strategic therapy and cognitive behavioral therapy, on Chart 1.

Chart 1.
Comparative table between brief strategic therapy and cognitive behavioral therapy.

Item	Brief Strategic Therapy	Cognitive Behavioral Therapy
Epistemology	Constructivist - radical	Constructivist - rationalist
Causality	Circular	Linear
Objectivity	Relative objectivity	Absolute objectivity
Use of intervention protocols	Yes	Yes
Acceptance of use of drugs in its intervention protocols	No	Yes
Theoretical foundation	Change theory	Learning theory
Therapeutic communication	Inductive and performative language. It seeks to call to action by means of stratagems, metaphors and analogies.	Logical-rational language. It seeks to explain and inform.
Diagnosis	Operational. Knowing through change.	Descriptive. Objective representation of signs and symptoms.
Therapeutic Focus	Focused on the solution	Focused on the problem to solve
Therapeutic Strategies	It makes use of therapeutic stratagems that seek to call to action. Breaking the vicious circle of tried but dysfunctional solutions and modifying the perceptive-reactive system.	It makes use of a rational strategy that seeks to provide information about the disorder. It guides patients leading them to learn to manage and regulate their complaint.
Therapeutic Techniques	Prescriptions, suggestive metaphors, hypnosis without trance, strategic dialog, among others.	Behavior modification, self-instructions, systematic desensitization, social-skill training, among others.
Therapeutic Time	Present and future.	Present.

There are many studies that prove the effectiveness and efficiency of brief strategic therapy. We can mention, among the most recent ones, a controlled and randomized clinical trial carried out in Italy with hospitalized patients and outpatients. Patients were looking for treatment for obesity and binge-eating disorder. The results recorded from the implementation of cognitive behavioral therapy and brief strategic therapy were compared. After a six-month monitoring, a general recovery and a higher percentage of remission of binge-eating disorder was noticed on patients treated with brief strategic therapy in contrast to the ones treated with cognitive behavioral therapy (Castelnuovo et al., 2011). A study comprising patients diagnosed with obsessive-compulsive disorder proved the effectiveness of brief strategic therapy in the treatment

of these disorders (Pietrabissa et al., 2016). In the same vein, the treatment of 60 Italian female patients with binge-eating disorder and obesity was evaluated in a subsequent randomized clinical trial whose objective was to determine the effectiveness of brief strategic therapy in comparison to cognitive behavioral therapy. In that study it was concluded that brief strategic therapy was clinically and statistically more effective than cognitive behavioral therapy in binge-eating disorder treatment (Jackson et al., 2018). In another longitudinal study carried out with a group of patients with bulimia nervosa and binge-eating disorder, brief strategic therapy was proven to be effective in the treatment of symptoms of binge-eating disorder and bulimia nervosa (Pietrabissa et al., 2019). In a recent study carried out in various countries implementing brief strategic therapy to 1150 cases with different psychopathological diagnoses, a complete solution for symptoms was recorded reaching 80% of cases with an average of 5.4 sessions and 5.3 months of treatment. These data have to be taken into consideration because of implications for patients given the shorter treatment period, lower cost associated with it and the absence of use of drugs. Having proven both effectiveness and efficiency of brief strategic therapy (Vitry et al., 2021), in a post-pandemic context, treatments that have both short duration and proven effectiveness are needed and required. Brief strategic therapy shows to be an alternative to be taken into account given its relevance at both clinical and public health level.

Creation of Centro di Terapia Strategica from Arezzo, Italy

Paul Watzlawick, well-known psychologist and psychotherapist, member of the Mental Research Institute in Palo Alto, California, founded the Center for Brief Strategic Therapy in the city of Arezzo, Italy, along with Giorgio Nardone, who is considered his intellectual heir. From its beginnings the center was recognized for its high academic and technical level, allowing the creation of a range of innovative techniques and to design various specific treatment protocols for each disorder (Nardone, 2002).

Professor Giorgio Nardone's work can be described as innovative, which allowed him to develop treatment protocols, based on the systematization of his experience, focused on the search for ever faster solutions for diverse pathologies. His empirical-experimental clinical research, that combines therapeutic interventions and formulation of strategies aligned with said pathologies, has been able to be empirically validated, with the goal of efficiency and effectiveness. He uses the experimental empirical method developed by Kurt Lewin, applied to the clinical field, which could be summed up as follows: "it knows the problem through its solution" (Nardone and Portelli, 2017).

Among the propositions that have arised from the experience brought by the CTS from Arezzo and Professor Nardone's clinical work, we can find strategic dialog which represents one of cutting-edge techniques of the evolved model and combines a more evocative language, using paraphrases and a strategically developed dialog (Nardone and Salvini, 2011). Traditionally Aristotelian rational logic can be found in the way that us, human beings, solve and face problems and tackle objectives and goals (Fiorenza and

Nardone, 2004). On the contrary, protocols have an organized and structured sequence of technical procedures that follow Batesonian tradition, are capable of adapting and self-correct according to the progress or the intervention, through the feedback that the consultant gets, this way being flexible within the interaction with the symptom itself. The model was created in a way that became a model that can be replicated, could be transmitted and was predictable while keeping efficiency and effectiveness, combining the scientific method with the sublime art, almost turned into magic, that is transmitted through the therapist's words and gestures, transformed into a modern magician (Nardone, 2008; De la Cruz, 2013). The therapist follows an established protocol, but adapts the therapeutic method to each patient, to their cosmovision, to their way of relating, to each pathology's specific features. The flexibility of the model allows the therapist to be adaptable to every patient, permitting a space so they are able to create, use their creativity, and innovate. In that sense, it is artistic (Zaldivar, 1995; Riveros, 2013). There is art in the way a prescription is written, when using a metaphor, when designing a piece of homework, when using the body and prosody. The technical procedure of each protocol is complemented by the creative and artistic flexibility in the execution (Nardone, 2013). Brief psychotherapy is, this way, turned into an artistic space of creation and not only a rigid procedure to be fulfilled.

Epistemology and foundations of Brief Strategic Therapy

From Aristotle to Newton, including Descartes, Aristotelian logic dominated the western world proclaiming the supremacy of the so-called "Goddess of Reason'', laying the foundation of traditional linear logic and helping us to understand the world, our relationships with ourselves, with each other and with the world. With the advancements done in studies of atom-oriented physics, the emergence of new theoretical constructions took place. The discoveries that emerged from quantum physics in contrast to the Newtonian physics model, allowed the later appearance of new ideas in the rest of the sciences. Systems theory and cybernetics helped to strengthen the model and brought an epistemological framework to it that pushed the theoretical development of the then emerging family systems theory. Maruyama, Bertalannfy, Wienner, Shannon, Von Foerster and Prigogine's contributions, among many others', were vital for the emergence of what later would be known as first-order cybernetics, or cybernetics of observing systems. A stance in which the observer studies the system while being external to it (Watzlawick, 2007). In first-order cybernetics the therapist intervenes to solve the problems that families or patients carry on their shoulders as an external reality to the therapist about what has to be intervened, to be modified and to be brought to a solution. Later, with the emergence of second-order cybernetics, constructivism and observer inclusion in what is observed, the questioning of certainty and objectivity grew stronger. The deepest foundations of Newtonian science started shaking and the bases of our reality's perception were called into question. The existence of a single reality was doubted (Nardone, 2003). The observer was included in the observed thing, who

participated in the observation, ruling out the possibility of the existence of any objective observations, given that it was impossible for the observer to observe without including itself in what it observes. In second-order cybernetics the therapist intervenes on meanings rather than behaviors (Nardone, 2000; De la Cruz, 2008). These are the epistemological bases of Brief Strategic Theory, which are focused on constructivism, observer inclusion, the questioning of objective reality, and second-order cybernetics.

Building solutions

From an Aristotelian linear causality perspective, it is presupposed that, in order for us to solve a problem, we must discover the causes and find the origin of said problem and, by doing so, we can be led to the solution. However, by implementing this strategy to complex human problems this ends up being ineffective (Fiorenza and Nardone, 2004). Human interactions are not based on traditional Aristotelian logic, but rather they are based on ambivalence, logic, belief, paradox and contradiction. Hence, it is required to break away from rigid limits enforced by an action-planning model in which the objectives and goals to achieve lead to the solution to the problem (Nardone, 2010; Nardone and Bartoli, 2019). It is proposed that human problems in their diverse shapes are the result of interactions that the very human beings establish, of the way in which each person builds up their own reality, this way building up the prisons and reality that they will later suffer from (Nardone, 2008). The problem gets feedback from the interaction between the subject and its reality through a complex series of perceptive and reactive retroactions (Watzlawick, 2007). Brief strategic therapy does not focus on the past, rather focused on the present and, from there, aims to the future, building up a new reality and a different future. It presupposes that, by modifying the “tried solution", the symptomatic sequence is broken, allowing the emergence of therapeutic change. In conjunction with the consultant, the therapist sets therapeutic goals to achieve: realistic goals that can be attained by trying to cement self-effectiveness (Nardone, 2008; Nardone, 2010; Nardone and Brook, 2010).

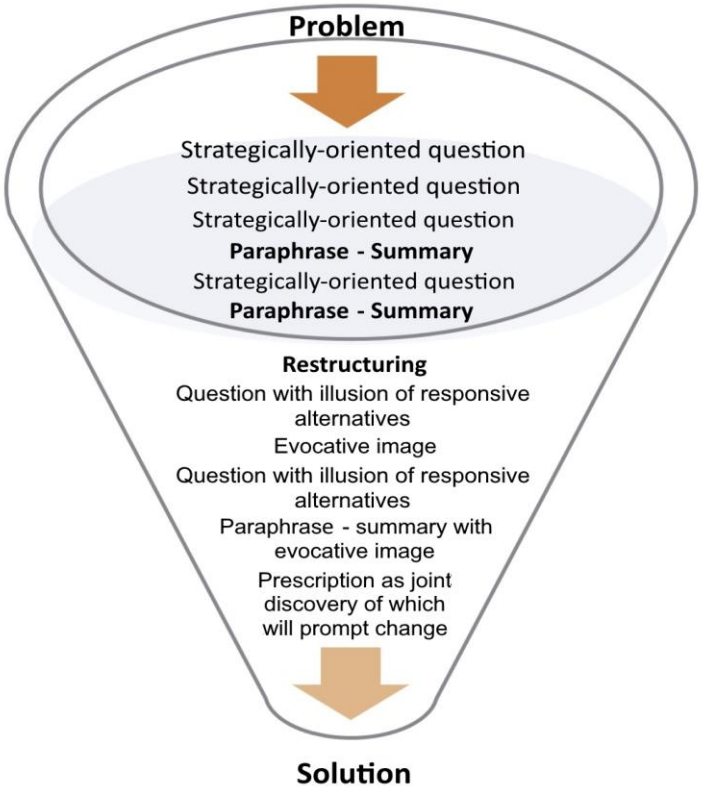
In brief strategic therapy, everything that the consultants do to solve the problem, which paradoxically are the same things that produce it, is identified. This is how it is considered that there is another way to intervene based on the presupposition that in order to solve human problems it is not necessary to study the causes nor to look for the origin of the problem, but rather to focus on the problem’s way of functioning (Watzlawick, 2008). This way, the focus of the intervention is changed, leaving behind the concentration on the search for the origin of problems, which follows linear causality, aiming to find solutions following a circular causality.

That way, we get to know the pathology through the solution of it. If the therapeutic model leads us to a quick and effective healing of the disorder, this tells us that its structure fits said pathology. The implementation of this with a big sample of people who suffer from the same pathology would shed light on the idea that the solution explains the problem, that is, that we are able to know the problem through its solution

(Nardone, 2008). Nardone, through his model, teaches us that, in order for us to come to a solution to the different psychopathological disorders, we should move our attention focus on the practical features of therapeutic techniques that are more efficient, without sticking to the "objective" description of disorder features (Nardone, 2010). This change of focus from the description of the disorder's clinical features onto the practice of solution, looking for the most suitable treatment for each disorder, leads us to knowing the problem thanks to its solution. Looking for the adjustment of the therapeutic practice to the clinical symptom, joining research and action, using the systematization and incorporation of other techniques already used both by the Mental Research Institute as well as other experts in psychotherapy, including new techniques, true gems result from inventiveness and experience. The evolution of pathologies, cultural aspects and digital context enhance clinical practice and allow the synergistic emergence of a robust model that over the years has proven to be one of the most efficient and effective for a variety of pathologies (Nardone, 2020).

As we can see below on Image 1, the process of strategic dialog simulates a funnel that gets progressively narrower (Nardone and Seleckman, 2013). Said process leads the therapist and patient to the awareness/knowledge of the problem. They in conjunction make the discovery together through questions and strategic paraphrases. The cooperation between therapist and patient becomes evident. Throughout this discovery the perception of the patient goes through a change. Below we present the structure of a strategic dialog.

Image 1.
Strategic dialog protocol



Note: Adapted from "Hartarse, vomitar, torturarse" (p. 58), by Nardone and Seleckman, 2013, Herder.

T: What is the reason for your visit?

P: It's been a while since I can't control my anger. This pains me a great deal.

T: And this lack of control, does it happen a few times a week or every day?

P: A few times a week I get filled with this anger and desperation. I bottle all the anger up until I can't stand it anymore and I explode by punching the wall.

T: Ok, I understand. So, you explode by hitting the wall, and that would be only with your fists, or with any other part of your body too?

P: Typically, I hit the wall with my fists when I can't stand the anger anymore. Sometimes I use my head too. A year ago I got wounded on my head, blood came out, so I had to go to the emergency room. Usually, it's just with my fists.

Then, the therapist paraphrases, looking for a first agreement on the definition of the problem.

T: If I understand you correctly, and please correct me if I'm wrong, you came because you have a problem that pains you for some time and, that is, you can't control your anger. Sometimes you punch the wall because you can't stand the anger you feel. There has been an instance in which you hit the wall with your head and you had to be taken to the emergency room. Is that right?

P: Yes, indeed, that's right. The angrier I feel, the more I hurt myself. A bunch of thoughts come to me that torment me a lot.

T: I understand. These thoughts that come to you, are they always the same or do they change?

P:They're always the same. They remind me of how stupid and moronic I am… arguing with my mom… I blame her and my (deceased) father for what happens to me… At 32 years old, I haven't accomplished anything, I just lost my job, my couple left me a few months ago, I haven't finished college, my life is a complete mess [crying]... I'm a fool, a failure, my parents didn't support me, they messed up my life… that helplessness fills me up with rage and anger.

Then the therapist paraphrases with the goal of making the patient feel their closeness and emotional contact. This way, the therapist also transmits a restructuring of the disorder.

T: I understand. You go through a great emotional pain that is relieved through physical pain… It seems you punch the wall in an attempt to numb your deep pain because you consider your life to be a complete mess. It's a pain that you are trying to run away from, a tangible pain for which there is no miracle drug that can cure it.

P: Yes. I try to run away from my thoughts, my memories, my life. I'm escaping from knowing I'm a failure… I seek refuge and punching indeed relieves me from this pain. It's just temporary, though, because later on it comes back even stronger.

The agreement is strengthened and a restructuring paraphrase is used.

T: Indeed, punching works well at the very moment you do it. The physical pain that you feel when punching has the effect of distracting you and making you forget the great emotional pain, but when the effect subsides you find out that the emotional pain is still there, waiting for you, ready to hurt you with deeper and more painful wounds.

P: Yes, indeed, that's how it works. By punching I calm myself down, but then it comes back again even stronger and hurts more.

Now the therapist makes use of a question with hope for responsive alternatives.

T: Ok, then all of this is what you do and have been doing to relieve the pain. Does it really work or is it something that only brings about a temporary relief which, afterwards, prompts deeper pain?

P: I can tell that these anger outbursts that lead me to punch the wall only relieve me momentarily and at the end of the day, nothing has changed. I keep on getting temporary relief, but my emotional pain is still there.

The therapist makes use of an evocative image.

T: Look, a person that carries a deep wound and keeps on scratching on it without letting it scab, the only thing they accomplish is making it become more and more infected. In order for a wound to heal, firstly, it must be cleaned and disinfected, so that it can be let alone to scab, leaving it to naturally end up healing itself.

P: Yes, you're so right, the only thing I've achieved is to further infect my wounds.

The therapist makes a question with hope for alternatives.

T: So far, and according to what we have been analyzing, if this situation continues, will the pain you feel get relief or will it stay and be fed more as time goes by?

P: I definitely realize that if I don't do anything different I'll keep on getting the same results and nothing will have changed.

Throughout the sequence of strategic dialog the therapist is creating the need for change, this way, easing the reception of the prescription as a joint discovery, fostering cooperation from the patient in the therapeutic process.

T: As we saw and analyzed together, we can begin by disinfecting and letting the wound heal itself. In order to do that, allow me to suggest that you get a few paper sheets and every night before going to bed, you write a letter describing with great detail everything that has made your life turn into a complete mess. Write about everything that you've told me, write about everything that you can come up with relative to all this. After you're done, put the letter in an envelope and bring it for our next session. While it's true that remembering all this will be painful, it's important to do it for the wound to heal up. Regarding the punching against the wall: whenever you feel the craving and impulse to hit the wall, go to the bathroom, stand up right in front of the mirror and ask yourself: "Do I want to heal the wound or do I want to keep on opening it and infecting it?". Then, you can decide if you want to do it or not.

The instructions were accepted by the patient, who expressed a noticeable improvement during the next sessions. Both the prescription and the instruction about the patient looking at himself in the mirror strengthen the aversion created in the strategic dialog process. Additionally, it alters the recursive pattern of the symptomatic behavior. After the implementation of the strategic dialog, the patient perceives the procedure is a possible way out, giving this a better openness to accepting the prescription. As can be seen, the model can adhere to the structure of the dialog and its sequence, this way maintaining the methodological preciseness. Nevertheless, it is flexible given that it is adapted and modified for every individual patient. The dialog

contents, the relationship between therapist and patient, as well as the techniques are adapted to every patient and specific disorder.

Strategic logic and change

In brief strategic therapy we start with the presupposition that strategic logic is to be adapted to its object of study. From this perspective, the solution is always the thing that should be adapted to the problem and not the other way around. This method seeks to avoid an universal and objective way of intervention. We leave behind the thesis that states that there is any scientifically true knowledge, in search for a more functional knowledge (Von Foerster, 1991; Von Glasersfeld, 2014).

The Cartesian idea is still valid that change is the effect of a gradual and slow process of awareness or insight by the patient, after which they choose to behave in a different way, modifying their actions and cognitions. The brief strategic therapy model considers change to be a constant, a continuous process that sometimes, due to the disorder, gets obstructed, but thanks to therapeutic intervention we can unblock it allowing its natural evolution. It considers that we, human beings, construct our representations out of reality, representing ourselves, others and the world, shaping a perceptive-reactive system that keeps its homeostasis and resists change (Fiorenza and Nardone, 2004). In a more positivistic and traditional point of view, it is thought that we can get a real interpretation of an objective world. So, the therapist would have a privileged access to an absolute truth and, thanks to that objective and real knowledge they would be able to treat and heal the patient. On the contrary, brief strategic therapy inherits from sophists and constructivist tradition the idea that we cannot apprehend the world in a real objective way (Segal, 1994; Nardone and Protelly, 2017; De la Cruz Gil, 2021a).

What we call "reality" is rather the product of the perspective from which we perceive phenomena, the instruments of knowledge that we make use of and the language with which we shape said reality and convey it (Nardone and Portelli, 2017).

Every piece of knowledge coming from our consultant is just an approximation to reality. It is a product of the cognitive and perceptive particular processes out of which the therapist constructs reality. The strategic focus thus is the step from a deterministic and positivist knowledge to an operational knowledge. This allows us to manage reality in a functional way. It is focused on pragmatic features, centered around the change process and observation of the persistence of the problem. It seeks to know how things work and it is concerned about how to make them work better, to bring about wellness to the consultant in a more efficient and effective way (Nardone, 2010).

Functional diagnosis and perceptive-reactive system

This model represents Gregory Bateson's constructivist epistemology. It doesn't make any use of explanatory theories about symptoms or disorders. It is possible to know the problem through the solution, which implies being able to change reality by treating it (Nardone and Salvini, 2011; Nardone, 2013). Science seeks to know problems, firstly, through a normative theory, thanks to the description of human nature and of all its pathological deviations (Nardone, 2013). From the moment that a person is given a psychiatric diagnosis all behavior they engage in will be a confirmation of said diagnosis. Assuming a constructivist approach implies abandoning theories, classifications and deterministic and rigid models (Nardone, 2008). That is why, in brief strategic therapy, when defining a problem we use an operative diagnosis or intervention diagnosis rather than a descriptive diagnosis. In traditional diagnosis the disorder is described like a picture, without any suggestions about how the problem works and how it could be solved (Nardone, 2002). The evolved model goes beyond descriptive nosographic classification used in psychiatry on the DSM, adopting the categorization model in which the "perceptive-reactive" construct-system substitutes the DSM category (Nardone, 2004).

The perceptive-reactive system involves the redundant modalities used by the person towards reality, their relationship with themselves, others and the world (Watzlawick, 2012). The operative description that is used by the evolved model involves a kind of cybernetic-constructivist description focused on the modality of the persistence of the problem. That is why it is possible to know a reality by intervening on it. In order to solve a problem, it is more important to know more about how it endures and how it works. It lacks relevance to know how the problem emerged and what were the causes. The only epistemological variable that we can control is the therapist's own strategy, that is, their own tentative solution which, by working, allows the therapist to understand why it persisted and what kept the problem going (Nardone, 2004).

Brief strategic therapy seeks to increment operative awareness, which involves the transition from a knowledge as the representation of objective reality to a knowledge as representation of the most adapted reality (Von Glasersfeld, 2014). This way, these modern sophists rely on a strategic logic focused on objectives, adapting their intervention to the specific features of each problem. A change in causality is made clear, going from a linear causality to a circular causality, interested in knowing how to break away from a problem's sequences and patterns (Nardone, 2008; De la Cruz Gil, 2021b).

Conclusions

Brief strategic therapy is a non-normative model that conceives human problems as the result of interactions between the person and their reality.; going from studying the why to studying the how a problem works. It looks to intervene by modifying a reality thanks to the intervention on that reality itself. It is based on the presupposition that in

order to solve human problems it is not necessary to study the causes nor the origin of the problem: rather, we must focus on the functioning of the problem. This way, we know the problem through its solution, the solution being the one that is adapted to the problem.

Brief strategic therapy uses operative diagnosis or intervention diagnosis instead of descriptive diagnosis. It goes beyond the descriptive nosographic classification used in psychiatry in the DSM model, substituting it with the construct of perceptive-reactive system.

It leaves behind every dogmatic theory, that is why it can be found far away from the systemic branch of family therapy. It does not pretend to demonstrate the validity of any theory. It avoids focusing on previous hypotheses. It seeks to achieve the objective set by the consultant, concentration on the present, developing actions that try to fulfill therapeutic objectives.

The great theoretical development in the strategic field has opened the possibility to transcend the clinical fields, taking it to create a true school of thought, now encompassing various fields such as management, direction, coaching, sport performance, organizations, leadership, educational field, among others.

Brief strategic therapy has proven to have effectiveness and efficiency in various controlled clinical trials. In its therapeutic protocols there is no use nor inclusion of drugs. The reduced number of sessions and its wide effectiveness in various emotional disorders allow it to have clinical relevance.

In the post-pandemic context it is required to have access to effective and efficient interventions. In this sense we consider that Brief strategic therapy can contribute to the development of mental health. We suggest its inclusion in healthcare and public health programs is considered.

Conflict of interests

There is no conflict of interests.

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