

## **Proposal of a strategic protocol for depression**

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### **Abstract**

The ideation of an intervention protocol for the depression arises from the quest of whether the perceptive-reactive system is unique or whether there exist diverse typologies and variants. Another hypothesis was to verify whether the hypothetical variants modulated and differentiated in significant ways, both the approach and the treatment of the problem. Starting off by identifying the attempted solutions, we came to recognise that in Depression the attempted solution is that of Renunciation, present in the role of the victim taken up by the patient. However we came to understand that there are three different typologies: Victim of oneself (with a variant), Victim of others, and Victim of the world. Renunciation has three sub-modalities: Delegation, Giving up, and Pretension. Each one of these corresponds to one of the three different typologies of the Victim identified. Through the Research-Intervention process a fundamental point has emerged, which we believe is crucial i.e. the existence of the myth. The myth is a representative construction of reality, which is experienced by the patient as having been shattered, manifesting its dysfunctionality. This brings the patient to feel as if he was losing control over this reality or of having never been in possession of such control: this leads the subject to believe that the only possible solution is to renounce. The identification and the contemporary modification of the myth is the mainstay of the diagnosis and of treatment of depression. The therapeutic course entails the use of selected stratagems and metaphoric reframing in the first phase, the use of prescriptions in the second and consolidation of the obtained results in the third phase.

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Our present work, which is still in progress, originates primarily from the generic necessity of having a systemic protocol for depressive patients: a field where we feel non-efficacious. But from the very beginning, we have asked ourselves and posed as a hypothesis of our research, the quest of whether the perceptive-reactive system of depressed patients - something we looked into- has a unique modality of construction and of persistence of the problem or whether there were any variations. In fact, we believed that the identification of variations might have permitted us to construct extremely efficacious protocols of intervention that are capable to allow us to intervene from the beginning of therapy in a very "surgical" mode.

In our choice of the cases, we have used the DSM IV diagnostic-descriptive criteria so as to keep up with the necessary uniformity of the actual canons of research.

We have set our work according to the Research-Intervention Principle, which characterises the construction of protocols of Strategic Therapy, by searching for the attempted solutions. This allowed us to understand HOW the problem is maintained, so as to arrive to individuate the perceptive-reactive system.

We have individuated in all of our depressive patients- approximately 50 cases- a typical attempted solution: RENOUNCEMENT.

### **The Victim**

RENOUNCEMENT poses the patient in the role of the victim. The patient RENOUNCES since he believes and is convinced, that he has no means (no longer has or never had them) or that the situation is, due to its own nature, unchangeable (for example due to back luck, adverse destiny, etc).

There are numerous studies that have demonstrated how an uncontrollable or inevitable event produces in human beings (but also in animals) a series of psychological events: passivity, mental retardation, lowering of one's self-esteem, sadness, anxiety, hostility, diminished adequate aggressive drive, biochemical modifications at the cerebral level. These events take in consideration the more or less evident vulnerability.

People tend to search for the causality of life events, even for the uncontrollable and inevitable ones, following with extreme facility, a casual non-circular logic. In this way, the construction they hold during the depressive episode develops itself like a belief rather than as an epistemological construction. The cause might be therefore, attributed to external factors (Others-World) and it entails, as an emotive experience, absence of hope, or might be attributed to oneself, in which case it leads to disesteem and self-blame. In this causal research, the found responses take in account the manifestation of vulnerability and the position of the victim.

But there is another logical link between the position of renouncement and that of the victim: the emotional link is represented by anger. If the mode or the context in which the renouncement takes place, consents to express the anger that accompanies it, the situation is not dysfunctional (for example, if I'm able to get angry and express my anger towards those who come between me and the reaching of our desired objective).

But in that very moment when anger can not be expressed or is not even acknowledged, the person will feel CONDEMNED, therefore feels like a VICTIM. The depressed patient is profoundly angry, even though often he is not capable to express it or even acknowledge it. The depressed patient feels like a VICTIM because the

condemnation is felt as an injustice (for example, "... after all I have done for them!"). The patient might be VICTIM OF ONESELF, OF OTHERS, or OF THE WORLD, because to oneself, to others or the world are attributed all the responsibility of his state of being. Often, however, the patient acknowledges that he deserves the condemnation, because in his eyes he perceives himself as a mean fellow and thus rightly condemned to a miserable existence: this is the case of some of the victims "of themselves" who hold a strong self-persecutory drive.

In order to understand the specificity of the most general attempted solution: "I RENOUNCE BECAUSE I'M NOT ABLE" however it is necessary to uncover the WAY or HOW the person renounces. In fact, from an operative point of view, it makes a therapeutic difference if the patient feels he is "victim of oneself" rather than "victim of others or of the world". One renounces and plays the victim in various modalities:

- The "victim of oneself" DELEGATES ("I'm wrong because I'm not capable or it is not in my nature. And since the world is right and I am the incapable one, OTHERS SHOULD TAKE OVER). This patient shows absolute renouncement or else GIVES UP ("I thought I was made in a way... capable of succeeding, but I'm no longer capable").

- The "victim of others" GIVES UP (I believed but others have deluded me. I'm fine but the others do not appreciate me"). I thought I was in the right, I was given the illusion, and then I was deluded because things turned out to be different from my expectations.

The "victim of the world and of nature" DEMANDS ("I am in the right, and the world is wrong. I HAVE principles but the world does not function according to these principles". He is highly active at a theoretical level and inactive at a practical level since things are not the way they should be.

### **The Myth/Belief**

At this point we have inserted a determining and discriminating element for our work: the existence of a representative construction, often unknown to the subject that is etched: the MYTH/BELIEF.

The Myth/Belief plays part of the representation, which the subject is not always aware of, that presumes a fideistic adhesion.

Watzlawick, Weakland and Fisch (1974) speak in this regard about UTOPIA that might be:

NEGATIVE = a world without solutions;

POSITIVE = a world without problems.

If the UTOPIA is internalised or projected, it will lead to the assumption of certain behaviours. For us, the representative construction found in depressive positions, seems to contain, in effect, utopic elements, and it is very close to what Weakland (1990) defines as the myth, "... from my point of view, myths are explicative schemes, or better modes of utilising language to correlate, put in order and give sense to what has been observed regarding nature and life. Therefore myths are like maps: they give form and order to our comprehension of a certain territory and guide our steps while going through it rather than if avoided and like old geographic maps warn us: "from this point onwards there are monsters".

That which differentiates utopia from the myth/belief is that utopia represents an ideal state to be reached, while the myth/belief is contextualized in the present and it offers

indications to orient us on the territory. If, as J. Weakland sustains, the Myth is the map, thus Utopia is Treasure Island.

The Myth/Belief orients in a rigid way the patient to move around in the territory of life. Its infringement and the impossibility of reconstructing it, might lead the patient to RENOUNCE, as his final possible attempted solution: I'm not capable- therefore I renounce- thus I'm a victim. As a consequence, the myth characterises even the diverse modes in which patients renounce and it disposes itself transversally to these.

The myth/belief is a behavioural and imaginative representation with its own specificity. In our work with depressed patients we have identified three fundamental myths, therefore three different typologies of maps used by the patients to orient themselves on the "territory" of daily life.

- The Myth/Belief that we might call "**the never possessed strength or the lost strength**". Therefore a myth with two variations. In version which we will call "the never possessed strength", the myth recalls the figure of the "biological disadvantaged" ("I'm not able to due to my own nature"). This represents the exception. In fact there can not be identified a specific event that "shatters" the Myth: it was always in this way. He, who uses this Myth (or belief, or map) by renouncing, becomes victim of oneself. It is that person who thinks or believes he should be in a certain way but that he never had the instruments to fulfil it and thus feels impotent. The perceptive-reactive system is based on a NEVER POSSESSED CONTROL: we can name the perceptive-reactive system as RADICALLY DEPRESSED. The patient thinks that he has such a difficult problem that he does not know what to do apart from that of carrying its weight on his own (like Sissyfy). In relation to the correlated emotions, his renouncement is described by a sense of self-pity, by a lamenting sentiment that often degenerates in an overbearing complaint. It is a mere complaint in itself.

In the "the lost strength", the Myth/Belief goes back to the figures of Samson and Achilles. In the very moment the myth gets shattered or broken, the person becomes aware of not possessing ANY LONGER the instruments and the strength that he believed he possessed, thus he feels impotent, renounces, and he feels like the Victim of oneself, but the perceptive-reactive system is different from the previous one, because there is a shattered illusion: ILLUSION-DELUSION that proves that he NO LONGER HOLDS THE CONTROL he believed he had. At an emotional level, the aggressive component is very strong and it is directed towards oneself, while acknowledging that he had no other option besides that of investing all his force to sacrifice himself in the position of the victim, so as to still hold, however, a strong identity that expresses a clear position: "I can not do anything, others have to act".

- The Myth/Belief of the "**betrayed**", that who poses himself as a victim of others. That is the person who puts in practice strategies or who initially believed that others or the world were in a certain way, while he ends up experiencing the failure of his expectations, beliefs or strategies. Things have functioned but only to a certain point. "... I gave my maximum, I believed in others or in him/her ... this should not have happened".

The perceptive-reactive system is based on the loss of control, the control he thought he had but which is now no longer present. Renouncement takes place because the person fears of not having the weapons necessary to re-conquer the initial position. The inhibited aggressiveness is expressed as a form of disesteem towards oneself: one perceives himself as incapable. In the meantime, he nourishes regret towards those who have betrayed him. Therefore, in all times and in all situations, he behaves as a person who had an ILLUSION-DELUSION. In this case we can find neuro-vegetative correlates of an anxiogenous type with a whole array of symptomatologies relative to alarming reactions.

- The Myth/Belief of the “**defeated inquisitor**” represents the victim of the World and of Nature. It is that person who would like others to be like him and wants them to be like him. For the person, others are in the wrong. If only they were like him, everything will be fine. In this case, the depression is most often a consequence of a traumatic event that shatters his vision of the world.

The Perceptive-reactive system is based on a sense of failure in keeping control. Amongst the emotional correlates we can find an anxiogenic control over oneself and others, as an antithesis to the concept of tolerance towards oneself and others. Aggressiveness is strongly inhibited since it can not shatter the rigid image he holds of himself: he, who is impermeable to impulses. Therefore, anger and resentment become irritation, delusion, frustration and a consistent dissatisfaction. He is the MORALIST.

Therefore, we have three myths/beliefs here:

- “**the never possessed strength o the lost strength**”;
- “**the betrayed**”;
- “**the defeated inquisitor**”.

When these myths/beliefs are infringed and can not be reconstructed by the patient, they lead the person to take up behaviours, attitudes, ideas, emotional correlates, each in their specificity, which we will define, for the purpose of their clarification and application, as:

- **Radically depressed;**
- **Illuded-deluded;**
- **Moralist.**

These indicate the different perceptive-reactive systems correlated to the Myths.

Each single myth presents variations: we have identified a few, others will be revealed through out the “course of our work”.

The use of the Myth/Belief is not a literature habit of ours, but rather a key we used that at the same time resulted to be a strong therapeutic lever which, due to the strong emotional resonance of the metaphoric language raised the blockade. This takes place mostly because this type of language is accessible to all. In fact, metaphoric language allows us to gather the essential nature of an experience.

One should not forget that change takes place not at rational level but by “making the patient feel something”.

“Metaphors correspond to special modes of describing an original experience- through the use of isomorphism ... Because these use concrete things ... to illustrate intangible

complex and relational aspects of life ... they are vivid and unforgettable. Metaphors confine within them and define the intangible and the abstract, but this process limits and selects the perceptions and the actions... limiting their sense to the interior logic of the metaphor. Metaphors are therefore, both DESCRIPTIVE and PRESCRIPTIVE” (Laweley et al., 2003)

(A curious but significant clause: we have ascertained how the identification of a myth of reference and the following reframing, have an important effect in blocking, very rapidly, even situations which we can define as “on the rise” depression. They are those patients who do not present depressive moods and that we can not refer as so, but who feels seriously lost due to the recent infringement of the Myth. These may come to RENOUNCE and therefore become depressed.)

### **The Logic of the Manouvers and Moves**

- In the first phase of therapy, our objective can not be to move the patient from the renouncement position. The depressed patient is in that position to show us that nothing is possible and even though he is asking for help, we can not be more capable than he is. Giving him possible solutions or way outs might be a trap for the therapist. Explicit suggestions are most often unsuccessful.

- Rather, by using strategic questioning and successive paraphrasing we can try to delimit the territory on which we are roaming. Through the use of the same definition of the situation, given by the patient, we redefine the scenario until we arrive to an identification of the myth/belief.

We outline a new design, which should be taken hold of by him before we even come to definite it ourselves: we should not “awake” but lead to the “discovery”.

We should arrive in this way, already in the first session, to reframe the problem in such a new way, to make the patient recognise and acknowledge, consequentially, its dysfunctionality. **At this stage change is already in activation.**

- Only after having created this breach in the patient’s representation, we can make him experience new concrete representations that will allow him to assume a different prospective. This will become the “trampoline” for the modification of the perceptive-reactive system that is the role of the victim.

### **Treatment Protocol**

The identification of three different perceptive-reactive systems, all ascribable to the depressive syndrome, made us come to calibrate with more precision the treatment protocol.

As one can see from the table regarding the three different perceptive-reactive systems, we found the stratagems that orient the therapist in the choice of the intervening manoeuvres. The stratagems (Nardone, 2003) are utilised with their double function: they inspire the logic of the manoeuvres as well as fulfilling the function of communication.

Certain stratagems have resulted to be more efficacious in certain perceptive-reactive system than in others. For example, the stratagem “**creating out of nothing**” that underlies

solution-oriented prescriptions, seem to be more efficacious with perceptive-reactive systems of the “**Radically Depressed**” and “**Moralist**”.

The stratagems “**to put out the fire by adding more wood**”, “**Kill the serpent with its own poison**”, “**to bend in order to straighten**” sustain problem-solving prescriptions that seem to be more efficacious with the perceptive-reactive system of the “illuded-deluded” in both “**Victim of oneself**” and “**Victim of the World**” versions.

The manoeuvres, that follow the stratagem that underlies their logic, present even more specificity.

In particular, we have a single manoeuvre common to all three perceptive-reactive systems: i.e. *the metaphoric reframing*.

The strategic questioning allows us, by successively “closing doors”, to arrive in a quite inevitable way to metaphoric reframing, as necessary consequential logic. This is used in order to start shattering the dysfunctional myth/belief and it will be the theme for all the successive prescriptions, both problem-solving (How Worsen, Worst Fantasy and all paradoxical ones) and solution-oriented (Miracle Question Fantasy Prescription, As if, Positive Exception) ones.

#### **From the Stratagems to Manouvers: examples**

“**To create out of nothing,**” means creating something that does not exist but if it is conceived as existent, it will produce concrete effects. The myth in itself responds to this logic. We conduct the patient, through the use of strategic questioning, successive paraphrasing and reframing, to get to know one’s myth (equivalent to an invented reality) and its dysfunctionality. As an effect this will lead to the breaking of the Myth and the opening up to different more functional prospective.

-“**To put out the fire by adding more wood**” is the expression codified in an aphorism of a paradoxical principle. This is the logic that underlies the prescription, mostly known for, denominated as “worst fantasy” by which we invite the patient to voluntary force oneself to feel as bad as possible within a given ritualistic space of time

- “**Kill the serpent with its own poison**”. We retort the serpent against itself when we say to a patient, who for an example laments from a sense of ineptitude and guilt feelings: “You are right ... you are truly guilt. Worse, you are guiltier than what you believe. It is even worse than being guilty: you have the presumption to undertake everybody’s sins... to believe you are the Lamb of God, that you shoulder all the sins of the world.”

- “**To bend so as to strengthen**” means to get one to complicate the problem so as to be able to see way outs. In line with this point of view, at the end of the first session, we suggest to the patient that underwent illusion-delusion, to think about all the possible ways he can deliberately worsen his situation: “From now till the next time we meet again, I would like you, every day, to think about what you could do if you were so crazy to deliberately want to worsen the situation rather than how to better it. All that you could do or not do, say or not say, if you wanted to make things go even worse. Obviously limit yourself in thinking about it and avoid putting anything into practice!”

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