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Psychological Interventions

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Contents

1. Learning Objectives

1. Define the concepts of health according to the main theoretical approaches to psychological treatment.
2. Understand the mechanisms of change associated with each approach.
3. Become familiar with the most common techniques.

This unit is organised according to the main theoretical orientations in clinical psychology. Its purpose is to offer a synthesis of how each approach conceptualises health, psychological distress, and the processes of change. In doing so, it outlines the underlying theoretical assumptions, the therapeutic goals derived from these perspectives, and the principal psychological techniques commonly employed within each orientation. The unit aims to provide a coherent overview that helps integrate theoretical understanding with clinical practice.

2. Psychoanalytic and Psychodynamic Techniques

2.1. Conception of Health

In the psychoanalytic approach, mental health is defined in terms of an ideal intrapsychic functioning, differentiating between what is healthy and what is pathological. However, defining mental health involves addressing questions of values, such as the purpose of individual happiness, social adaptation or conformity with dominant ethics. Different psychoanalytic theorists, such as Freud, Jones, Isaacs and Klein, have offered diverse perspectives on mental Health (Tuset Bertrán & Talarn Caparrós, 2020). Freud[1] refers to the capacity to love and to work. Jones (1942) highlights first the capacity for happiness, followed by adaptation to reality in relational terms and efficiency in the achievement of goals. For Isaacs (1952), mental health would be defined by the capacity to become aware of unconscious mental fantasies and to elaborate them consciously. Finally, Klein (1960) speaks of personality integration, emotional maturity, strength of character and balance between inner life and adaptation to the external world as the foundations of mental health.

[1] The phrase "Love and work are the cornerstones of our humanity" (*Liebe und Arbeit sind die Eckpfeiler unseres Menschseins*) is attributed to Sigmund Freud although it does not appear in any of his writings.

2.2. Conception of Change

In the psychoanalytic model, unlike other therapeutic approaches, symptoms are not regarded as problems to be eliminated but as expressions of underlying conflicts and as ways of communicating something that the person cannot express otherwise. Furthermore, symptoms are understood to function as defence mechanisms against anxiety, although they can also generate it. In some cases, symptoms may even be produced by healthy parts of the personality as an attempt at self-healing. Therefore, in psychoanalytic therapy, the aim is not to eliminate symptoms at all costs, since doing so without understanding their meaning may lead to further problems or increase the person's suffering (Tuset Bertrán & Talarn Caparrós, 2020).

2.3. Therapeutic Techniques

2.3.1. Relational Elements

Psychoanalytic psychotherapies focus on exploring the emotions and feelings of both the client and the therapist, using psychoanalytic theories to understand these aspects. In addition to the practical elements formalised in the therapeutic contract, such as the duration of sessions and fees, therapists must also consider their internal frame, which involves being in a condition that allows them to understand and provide long-term help to the people they analyse by managing countertransference. This is achieved through personal analysis and supervision. The working alliance between therapist and analysed person is fundamental in psychoanalytic psychotherapy and is defined as the collaborative capacity to investigate the person's mental functioning. This collaboration is established over the course of treatment and is not agreed upon in a single session. It is a continuous process throughout therapy, although its foundations are established at the beginning of treatment.

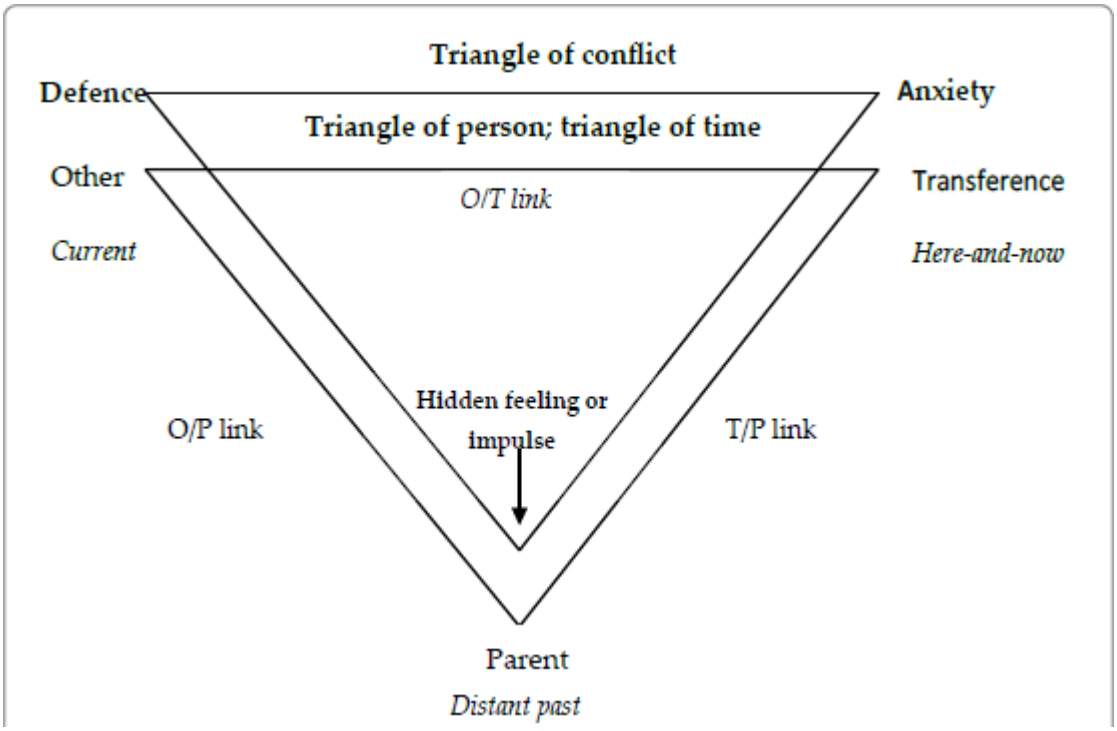
There are two fundamental relational elements: transference and countertransference. Transference is the process through which emotions, experiences and reactions from the past are transferred into the present life of a person. It is a universal phenomenon that involves the overlapping of past situations with current ones, which can distort the perception of the present. In any human relationship, including the therapeutic one, transference is always present and is essential to

understanding the person's psychic functioning. It is considered the most important phenomenon in psychoanalysis and psychoanalytic psychotherapy, with its analysis and understanding being key to the study and treatment of the analysed person. As shown in Illustration 8, the therapeutic relationship from a psychoanalytic perspective can be better understood through frameworks such as the triangle of conflict and the triangle of relationships proposed by Malan (1963, 1979).

A therapist reflects with a person experiencing ongoing distress and difficulties in forming intimate relationships: "It seems that your difficulty in expressing your needs and emotions (D) may be related to a fear (A) of being vulnerable and getting hurt in your close relationships (I). When you mention your close relationship with your mother and your resentment towards your father (P), it appears that these relational patterns may have influenced the way you interact in your current relationships (O)."

Figure 1

Malan's (1979) Triangle of Conflict and Triangle of Relationships



Countertransference refers to the therapist's emotional responses to the communications of the analysed person (Eskelinen, 1981). These responses are essential

for understanding and analysing the person's transference, allowing the therapist to provide effective help. It is crucial that the therapist can distinguish between their own personal experiences and the feelings that arise in response to the person. To achieve this, the therapist needs to undergo personal therapy and receive supervision from an experienced professional. Personal therapy helps to resolve the therapist's internal conflicts, contributing to a more objective countertransference, while supervision helps to identify nuances in the person's communication and to improve therapeutic interventions.

2.3.2. Technical Elements

Psychoanalytic psychotherapies are characterised as exclusively verbal treatments, in which the therapist and the analysed person engage in dialogue without the exchange of written documents or audiovisual recordings. Within these therapies, the therapist uses three types of verbal interventions: confrontation, clarification and interpretation.

In confrontation, the therapist highlights aspects of the analysed person's behaviour or speech that they may have overlooked, helping them to reflect on themselves. Clarification, on the other hand, aims to refine the person's communication by summarising it and conveying it clearly and concisely, linking it with underlying feelings or motivations. Finally, interpretation involves deducing and communicating to the analysed person the unconscious meaning present in their verbal and behavioural expressions, with the goal of making the unconscious conscious and deepening the understanding of the person's psyche. These interventions are based on various elements such as the person's personal history, transference, countertransference and the therapist's theoretical knowledge. Their quality is evaluated according to their capacity to advance the therapeutic process and the exploration of the person's psychic functioning.

2.3.3. Psychoanalytic, Supportive and Focal Psychodynamic Therapies

Psychoanalysis, as a therapeutic technique, provides the foundation for psychoanalytically oriented forms of treatment, addressing elements such as the setting, working alliance, transference, countertransference, confrontation, clarification and interpretation (Tuset Bertrán & Talarn Caparrós, 2020). The person undergoing analysis

commits to free association, in which the aim is to communicate repressed material, including the narration of dreams and past experiences. This justifies the presence of the couch, which facilitates the person's comfort and promotes a sense of freedom and neutrality.

The analyst's work focuses on interpreting transference, overcoming resistances and promoting the transferential process to resolve the neurosis. This is achieved through continuous sessions that involve the repetition of interpretations and exploration of resistances until these are integrated by the person. The end of analysis is marked by the resolution of transferential neurosis and childhood conflicts, which is evidenced by signs such as symptom reduction, release of inhibited potential, increased capacity for containment and improved interpersonal relationships.

Supportive psychotherapy, on the other hand, focuses on reducing the person's anxiety so that they can return to their pre-crisis state while encouraging new behaviours. The therapist adopts a didactic and directive role, and treatment may be short or long term, depending on the person's needs. Techniques such as clarification and, occasionally, confrontation are used, while transferential interpretations are avoided.

Finally, brief and focal psychotherapies focus on addressing specific problems or traumas. The technique involves focusing on the central problem and working actively and directly towards its resolution. Treatment has a defined duration, and clients are selected on the basis of their ability to face conflict, motivation for treatment, good insight and capacity to establish an adequate therapeutic relationship. Tools such as diagnostic interviews, early therapeutic alliance, planning and focusing, focal interpretations and strengthening of the person's ego are used, within a limited treatment period, generally lasting between six and nine months.

3. Behavioural Techniques

3.1. Conception of Health

From the behavioural perspective, both adaptive and maladaptive behaviour are governed by the same learning principles. Three main mechanisms are identified to explain the learning of new behaviours: classical conditioning, which explains how neutral stimuli can elicit conditioned responses through association; operant

conditioning, which establishes that the consequences of a behaviour determine the likelihood of its future repetition; and vicarious conditioning, which posits that behaviours can be learned through observation of a model, although acquisition does not necessarily guarantee performance. These approaches are not mutually exclusive and are combined to explain clinical practice and promote effective behavioural change.

3.2. Conception of Change

Behaviour Therapy (BT) adopts an optimistic view of change, based on the assumption that maladaptive behaviours can be unlearned and replaced by adaptive ones. It focuses on addressing symptoms directly, without concern for hypothetical underlying causes, thus promoting behavioural change in a direct way. To facilitate change, the antecedents and consequences of problematic behaviours, as well as the biological and social factors that determine them, are analysed in detail. The strategy for change is based on collaboration between therapist and client, where specific and measurable goals are identified. Clients are active participants in the process of change, engaging in therapist-guided activities, and are taught to transfer what they learn in therapy to their natural environment. BT employs a range of techniques derived from operant, classical and vicarious conditioning to facilitate behavioural change (Labrador, 2008; Miró Martínez, 2020).

3.3. Therapeutic Techniques

3.3.1. Techniques for Reducing Anxiety, Obsessions and Stress

Various techniques exist for reducing anxiety, obsessions and stress, all of which are based on the extinction paradigm. The main techniques, described below, are systematic desensitisation, in vivo exposure, interoceptive exposure, flooding and response prevention.

Systematic desensitisation is a pioneering anxiety reduction technique introduced by Wolpe (1961) which involves the gradual exposure of the person to anxiety-provoking situations through a hierarchy of stimuli. These may include visual images, therapist-guided imagery, imagined exposure, virtual reality or real-life exposure. The aim is to associate the feared situation with a state of deep relaxation, thereby breaking the link between stressful stimulus and anxiety. The main components include constructing a

hierarchy of situations, progressive or autogenic muscle relaxation training, and visualising each situation while in a relaxed state.

In vivo exposure, derived from systematic desensitisation, consists of confronting the person directly with the anxiety-provoking situations or stimuli in their daily life. Through repeated and prolonged exposure to these situations, the person learns that they do not represent a real threat and that the resulting anxiety can be tolerated without avoidance.

Interoceptive exposure is another anxiety reduction technique involving controlled exposure to internal sensations that typically trigger anxiety or panic attacks, such as tachycardia or breathlessness. The person learns to tolerate and manage these sensations through repeated practice and by preventing avoidance responses. Interoceptive exposure involves a sequence of progressive trials in which the duration and intensity of exposure to feared sensations gradually increase, aiming to habituate and reduce the associated anxiety. During practice, which may include simple yet uncomfortable exercises such as breathing through a straw, individuals are encouraged to record their physical sensations and associated thoughts. Relaxation exercises can be interspersed between trials. At the end of the chosen exercises, progress is celebrated and individuals are encouraged to face situations that elicit intense physical sensations, such as visiting an amusement park, as an additional step in interoceptive exposure.

Flooding involves direct exposure to the feared object or situation without using breathing techniques or coping strategies. Unlike other exposure methods, a gradual hierarchy is not constructed; instead, the person is exposed massively and continuously to the feared stimulus. This can result in high levels of distress, sometimes leading to treatment discontinuation. Although some therapists use relaxation techniques beforehand, ideally the exposure is conducted without them. Despite its intensity, flooding is highly effective for overcoming phobic fears, often achieving faster results than other exposure methods.

Response prevention (Meyer, 1966) is mainly used in the treatment of obsessions and compulsions. It involves instructing the person to refrain from performing compulsive behaviours normally carried out in response to obsessions, allowing them to experience anxiety without engaging in avoidance or neutralising behaviours. This process helps to break the link between obsessions and compulsions and to reduce associated anxiety. For example, a person with a cleaning obsession may be encouraged

to touch a contaminated object and refrain from washing for several hours. As treatment progresses, clients gradually learn to tolerate the anxiety associated with not performing ritualistic behaviours.

3.3.2. Operant Techniques for Increasing Behaviour Frequency

There are four main techniques for increasing the frequency of desired behaviours: reinforcement, shaping, chaining and contingency contracts.

Reinforcement is a fundamental behavioural technique used to promote appropriate behaviours through the use of elements that increase the likelihood of their future repetition. The main challenge lies in identifying and administering appropriate reinforcers, as they are not universal and vary in effectiveness depending on the person and context. It is advisable to consider the person's age, interests and preferences, as well as the target behaviour, when selecting a reinforcer. Novel and naturally occurring reinforcers should be explored, and frequent behaviours can be used as reinforcers. Reinforcement should initially be immediate, contingent and frequent, shifting gradually from continuous to intermittent schedules to consolidate behaviour. Social attention, including praise, eye contact and approving gestures, is also a powerful form of reinforcement.

Shaping is a behavioural technique that involves repeatedly reinforcing small improvements or approximations towards a desired final behaviour. Instead of waiting for the behaviour to appear in its complete form, intermediate steps towards it are reinforced. This technique is mainly used to facilitate the learning of behaviours that are not yet part of the person's usual repertoire. When applying shaping, it is important to progress gradually and to break the behaviour down into smaller steps if necessary. Progressing too quickly can be counterproductive, particularly when working with people who learn slowly or have difficulties. Shaping has been successfully used with various populations, such as people with intellectual disabilities, and has proven effective in acquiring skills such as personal hygiene and language. Task analysis is a related technique that involves identifying and teaching each element in an orderly behavioural progression. This provides a systematic plan for both the individual receiving training and the therapist, ensuring success by focusing on small variations of the

previous behaviour. This approach can be beneficial in guiding the training process and effectively achieving the desired goal.

Chaining is a behavioural technique aimed at forming a complex behaviour from simpler behaviours that are already present in the person's repertoire. It involves reinforcing combinations of these simple behaviours to build a new, complete, and functional behaviour. This technique is mainly used in teaching independent living skills such as dressing, eating, or maintaining personal hygiene. To apply chaining, the desired behaviour is first analysed to identify the behavioural subunits that compose it. It is important to consider the level of detail required according to the person's behavioural repertoires. The practitioner should consider which behavioural fragments are already available to the client and how these can be combined to achieve the final behaviour. There are different approaches to chaining. In forward chaining, the sequence of operations is followed from the beginning to the end, helping the individual gradually coordinate the various actions required. For example, when learning to drive a car, the necessary operations are taught step by step to perform the task. In contrast, backward chaining starts from the last step of the chain and gradually works backwards. For instance, in the process of putting on trousers, the individual could first be taught the final step, such as pulling up the zip, and then move backwards to learn the preceding steps. There is also a variation of chaining in which the entire task is presented from start to finish on each attempt, and the individual repeats the full chain until all steps are learned. This approach can be useful to ensure that the individual can correctly perform all the steps of the chain within its complete context.

A contingency contract, also known as a behavioural contract, is a written agreement between two or more people that specifies the behaviours each party is expected to carry out and the consequences that will result from these behaviours, as well as the consequences of failing to meet the agreement. This contract involves a reciprocal exchange of rewards based on the behaviours outlined in the agreement. Contingency contracts do not need to be lengthy or complex; rather, they should be simple and clear. The key aspect is that the expected behaviours and the consequences of meeting or failing to meet them are clearly defined. It is important for contracts to be specific and to include information about who is expected to perform the behaviour, the precise behaviour to be carried out, when the behaviour and the consequence will take place,

and the characteristics of both the behaviour and the consequence. It is essential to write these details in positive terms, focusing on the desired behaviour rather than the behaviour to be avoided. Contracts can be renegotiated or terminated at the end of the agreed period. Writing and signing the contract helps emphasise the goals being pursued and ensures that agreements are not left open to interpretation or memory. A good contract should ensure that success is possible for all parties involved and may include additional bonuses if the minimum targets established in the contract are exceeded. Renegotiation and termination should be allowed when setting new patterns of behaviour and reinforcement. The ultimate goal is to reduce dependence on the contract and to maintain the new behaviours and reinforcements informally within the natural environment.

3.3.3. Operant techniques aimed at reducing the frequency of behaviours

There are four main techniques used to decrease the frequency of undesirable behaviours: extinction, response cost, time out from reinforcement, and satiation.

Extinction is a technique that involves withdrawing the reinforcement of a behaviour that has previously been reinforced. It is important to note that at the beginning of applying this technique, an increase in the intensity or frequency of the behaviour being targeted for elimination may be observed, particularly if it has previously received systematic attention or reinforcement. In addition, an increase in aggressive behaviours may occur, known as extinction-induced aggression. This technique does not usually produce immediate results and may require consistency and perseverance to achieve the desired change. Spontaneous recovery of the previously extinguished behaviour is possible if extinction is not combined with the reinforcement of incompatible behaviours.

Response cost, or negative punishment, involves the removal of a positive reinforcer contingent on the occurrence of an undesirable behaviour. This means losing certain privileges or previously acquired reinforcers as a consequence of the inappropriate behaviour. It is important to use this technique in combination with positive reinforcement of the desired behaviour and of incompatible behaviours. It is crucial to avoid the person losing all their reinforcers, particularly at the beginning, and to ensure

that the response cost can be easily replaced. Those involved should understand the value of the response cost in relation to the behaviour that is to be reduced.

Time out from reinforcement involves removing the environmental conditions that allow access to reinforcement, or removing the person from the environment, for a specified period as a consequence of engaging in an undesirable behaviour. It is advisable to combine this technique with positive reinforcement of alternative behaviours. To apply time out from reinforcement, several steps should be followed. First, ensure that the person is capable of performing an alternative behaviour to the one being targeted for reduction. Second, apply the procedure consistently, regardless of complaints, resistance, or promises of change from the person. Third, prepare an isolation area where the person can be removed from the environment without distractions, ensuring it is close enough to allow immediate implementation. Fourth, establish an appropriate duration for the time out, generally around four minutes or no more than one minute for each year of the child's age. Fifth, provide a warning before applying the time out, indicating the inappropriate behaviour. Finally, once the time out period has ended, reintegrate the person into the environment and provide positive reinforcement, as long as the undesirable behaviour does not reoccur. If the behaviour persists at the end of the time out, the person should be informed that they will remain in that area for an additional period until the inappropriate behaviour stops.

Satiation involves the excessive presentation of a reinforcer in order to reduce its value and decrease the likelihood of the associated behaviour. This can be achieved in two ways: first, by having the person perform the problematic behaviour repeatedly and rapidly, such as smoking several cigarettes in succession; second, by providing the reinforcer that maintains the behaviour for an extended period or in an excessive amount, such as eating several chocolate cakes in a row. However, it is crucial to design the sessions carefully to avoid inadvertently reinforcing the behaviour. This technique has been shown to be effective in the treatment of tics and in reducing hoarding behaviours.

3.3.4. Modelling

Modelling is an observational learning process in which the behaviour of a model serves as a stimulus for others to adopt similar behaviours. For this process to be

effective, several aspects must be considered during the acquisition of the observed behaviour, such as the observer's attention, the characteristics of both the model and the observer, and the methods used to present the model. Coping models, which gradually demonstrate competence when facing difficulties, are more effective than mastery models. In addition, it is important to promote the retention of the behaviour through the observer's active participation and the verbal coding of what has been observed. During the performance of the behaviour, gradual training, practice, corrective feedback, and initial assistance are essential.

4. Rationalist cognitive techniques

4.1. Conception of health

The rationalist cognitive approach, also known as the cognitive behavioural approach, introduced by Ellis (1955) and Beck (1967), holds that knowledge is constructed through the gathering and objective analysis of evidence. From this perspective, mental disorders are considered the result of dysfunctional patterns of thinking. Mental health, in this view, is defined as the ability to maintain rational and adaptive thoughts, as well as balanced emotions, whereas states of psychological distress are characterised by the presence of irrational thoughts and cognitive distortions that lead to negative emotions and dysfunctional behaviours. In other words, mental health is understood as the capacity to process information in an objective and adaptive way, while distress arises when cognitive processes are affected by irrational beliefs and negative automatic thoughts.

4.2. Conception of change

In rationalist cognitive therapy, a directive therapeutic approach is adopted in the management of sessions, requiring the person's active participation through questioning and discussion, as well as the completion of between-session tasks. Although a collaborative approach is encouraged, the therapist acts as an expert who guides the therapeutic process, sets the session agenda, and directs the exploration of the person's thoughts and beliefs. Collaborative empiricism is emphasised, in which therapist and client jointly review the evidence to validate or refute the client's beliefs, share the formulation of the problem, and agree on the tasks and techniques to be used.

The objectives of cognitive behavioural therapy focus on identifying, challenging, and modifying the person's automatic thoughts, cognitive distortions, and irrational beliefs, promoting logical and rational thinking as well as a realistic view of situations. Tasks and self-monitoring records are used to analyse the presence and influence of thoughts and beliefs in relevant situations, and these are reviewed during sessions to identify and change dysfunctional patterns of thinking and behaviour. Although the importance of the therapeutic relationship is acknowledged, the techniques employed are considered the main factor in achieving effectiveness, focusing on modifying the irrational logic of dysfunctional cognitive content in order to prevent future problems.

4.3. Therapeutic techniques

From the perspective of cognitive behavioural therapy, emphasis is placed on addressing the distorted thoughts and beliefs that underlie emotional distress, with the aim of restructuring them. Before beginning the process of identifying and challenging dysfunctional thoughts, time is dedicated to explaining the cognitive model to the person and establishing a working framework in which therapeutic goals and between-session tasks are agreed upon, primarily involving self-monitoring records.

The most characteristic technique for modifying dysfunctional thoughts is cognitive restructuring. In this technique, the therapist works collaboratively with the person to examine the evidence for and against their automatic thoughts, helping them to generate more balanced and adaptive alternatives. Through this process, individuals can modify their patterns of thinking and change their perspective on situations, which has a significant impact on their emotional state and behavioural responses. Cognitive behavioural therapy is based on the A-B-C model[2], where the activating event, associated beliefs or thoughts, and emotional and behavioural consequences are identified.

Throughout therapy, records are kept and dysfunctional thoughts are reviewed and challenged in session. The evidence supporting or contradicting these thoughts is explored, and the cognitive biases that contribute to their maintenance are analysed. This process is carried out through specific questioning that helps the person reflect on

[2] Activating events, Beliefs, Consequences.

the usefulness and accuracy of their thoughts and consider alternative perspectives. During these phases, tools such as situation and thought records, as well as cognitive restructuring techniques, are used to promote changes in the way the person thinks about and perceives everyday experiences.

Another related technique is the downward arrow (Burns, 1990), which involves identifying the core irrational beliefs and underlying schemas beneath surface thoughts. Rather than directly challenging negative thoughts, the process begins with these thoughts and explores what would happen if they were true. Based on the client's responses, a series of questions are asked to infer the underlying assumptions within each thought, allowing access to deeper beliefs and schemas about the self. This technique seeks to uncover the roots of dysfunctional thinking to facilitate its modification and promote a deeper cognitive change in the individual.

5. Contextual techniques

5.1. Conception of health

From a contextual perspective, deficit-based views are challenged, and psychological distress is understood in interactive and contextual terms. Problems are considered part of the human condition, and emphasis is placed on promoting general therapeutic principles such as acceptance and psychological flexibility, rather than focusing on specific techniques targeting causal mechanisms. These approaches highlight that mental health is not defined solely by the absence of psychological distress, but rather by the ability to adapt effectively to life challenges and to engage in actions that are consistent with one's personal values.

5.2. Conception of change

Although there are various approaches referred to as contextual, the general conception of change is based on promoting psychological flexibility and acceptance of present experience. These therapies view change not as the elimination or suppression of symptoms, but as the development of a more flexible and adaptive relationship with one's thoughts, emotions, and bodily sensations. Rather than attempting to control or avoid distress, individuals are encouraged to develop the capacity to tolerate it and to engage in actions that are consistent with their personal values. Change is understood

as a continuous process of personal growth and the development of skills to live a meaningful and fulfilling life, despite the presence of difficulties or symptoms. The aim is to promote mindfulness and clarity about personal values, as well as the ability to make conscious and committed decisions in accordance with those values.

5.3. Therapeutic techniques

As contextual therapies encompass a broad range of approaches, this section is divided into techniques from Acceptance and Commitment Therapy (ACT), mindfulness-based therapies, and Functional Analytic Psychotherapy.

5.3.1. Acceptance and Commitment Therapy

Acceptance and Commitment Therapy (ACT) is based on the idea that discomfort and suffering are natural and inevitable parts of human life. This therapy focuses on actions that are meaningful to each individual, recognising that resisting normal suffering can lead to pathological suffering. By functionally analysing the person's behaviours, both within and outside therapy sessions, the aim is for individuals to come into contact with their experiences and the consequences of their actions in relation to distress, which is crucial for successful treatment.

The main goal of ACT is to promote flexibility in responding to distress. It begins with the recognition that resisting discomfort restricts a person's life, while focusing on controlling or fusing with it results in a loss of direction. The therapy seeks to develop a broad and flexible repertoire of actions that allow the person to move towards personal goals linked to their individual values. Unlike other therapeutic approaches, ACT does not focus on the presence or absence of certain emotional states considered negative, but on how the individual responds to them.

To achieve these goals, a range of techniques are used, most notably values clarification and defusion practice. Values clarification involves identifying what gives meaning to a person's life and distinguishing between values, goals, and actions. It focuses on moving towards what one desires and aspires to, recognising that values are the core of therapeutic work and the compass that indicates whether one is moving in the right direction.

Defusion practice, on the other hand, focuses on freeing the individual from processes of cognitive fusion, in which negative thoughts and emotions control behaviour. This is achieved through acceptance, openness, and awareness of private experiences without attempting to alter them. Through exercises such as the "always-on radio" metaphor, the ability to observe thoughts and emotions with distance is encouraged, thereby promoting greater flexibility and responsibility in choosing actions that align with personal values.

5.3.2. Mindfulness-based techniques

Mindfulness-based techniques (Kabat-Zinn, 2006), encompass a range of practices that cultivate awareness of the present moment. The power of breathing is emphasised as a fundamental tool, focusing on observing the sensations associated with breathing without attempting to control it, both formally and informally throughout the day.

Seated meditation is considered the core of formal mindfulness practice, where time is set aside to sit in an active posture and initially observe the breath, later incorporating other objects of attention. This practice involves learning to tolerate physical discomfort and to remain present with whatever arises, cultivating a "choiceless awareness".

Body scan involves systematically directing attention to different parts of the body, not with the aim of achieving relaxation but to develop full awareness of the present moment. Yoga as meditation and mindful walking are practices that foster connection with the body and the environment, performed slowly and attentively. Yoga focuses on stretching and strengthening the body, while mindful walking involves walking slowly with full awareness of the present moment, without trying to reach any particular destination. These techniques encourage mindfulness in all daily activities, including mindful eating, in which attention is paid to the sensations experienced while eating, cultivating a more conscious and attuned relationship with food.

5.3.3. Functional Analytic Psychotherapy

Functional Analytic Psychotherapy (FAP) is distinguished by its focus on the therapeutic relationship as the main driver of change. To intervene effectively, it centres on Clinically Relevant Behaviours (CRB), which include the person's behaviours both during the session and within the therapeutic context. It is essential that the therapist

remains attentive to these behaviours, as they provide crucial information about the individual's behavioural patterns. When CRB are not evident, the therapist must have the skill to evoke them using a variety of techniques such as writing, free word association, or mindfulness, adapting to the specific client and their needs.

The therapeutic rules of FAP serve as a guide for the therapist throughout the intervention process. These rules, which include attending to CRB, evoking problematic CRB, reinforcing positive CRB, and offering interpretations of the person's behaviour, should not be seen as rigid prescriptions but as flexible suggestions tailored to the client's individual needs. Their main purpose is to make use of opportunities to promote clinical change, enhance self-awareness, and foster personal growth.

In clinical practice, the therapist must be skilful in naturally evoking problematic CRB and reinforcing positive ones. For example, to address a type 1 CRB, such as the person's lack of task completion, the therapist might link this behaviour to the problems the client is seeking to resolve in therapy. Conversely, to reinforce a type 2 CRB, such as increased emotional openness, the therapist may express genuine appreciation for the client and acknowledge the progress made, thereby creating a safe and trusting therapeutic space for the individual.

6. Humanistic techniques

6.1. Conception of health

From a humanistic perspective, health is understood as a state of overall wellbeing that encompasses physical, emotional, cognitive, and social aspects, in which the person feels in harmony with themselves and their surroundings. From this viewpoint, a person in balance is someone who has self-awareness, recognises their own emotions, thoughts, and actions, and is able to exercise their freedom of choice autonomously, acting in a way that is consistent with their personal values and goals. It is also emphasised that human beings strive to find meaning in their existence, discovering purpose through their experiences and interpersonal relationships (Pubill González, 2023).

6.2. Conception of change

Humanistic psychotherapies emphasise the uniqueness of each individual and their active role in the process of change and growth. These therapeutic practices are characterised by a holistic and collaborative approach, where therapist and client engage in a meaningful dialogue to explore and transform the significance of life experiences. The aim is to help the person face the task of building their identity autonomously, recognising their personal and idiosyncratic world.

Humanistic interventions focus on unblocking developmental cycles interrupted by stressful or traumatic life events, in which the person may feel trapped by their past and rely on defence mechanisms such as projection, retroflection, and introjection. These approaches do not view disorders as meaningful categories, but rather focus on the person's experiences and aspirations, providing tools for introspection and self-discovery to unlock their potential for change and foster self-management.

Although the various humanistic models share general principles and a symmetrical therapeutic relationship, they employ diverse methodologies that have converged into technical integration to enhance their effectiveness.

- Psychodrama (Moreno, 1946) encourages the enactment of significant scenes to release rigidity and promote spontaneity and creativity. For example, representing a scene of dependency may help explore and resolve internal conflicts.
- Gestalt therapy, inspired by the work of Perls and colleagues (1951), views the person as a holistic whole composed of polarities, where contact with reality and the cycle of experience are fundamental to personal growth. For instance, María, by labelling herself as a victim, blocks her own development.
- Person-centred therapy, influenced by Rogers (1951), focuses on an egalitarian relationship and the exploration of the "here and now" to facilitate the person's autonomous and congruent development.
- Body-oriented approaches, such as Lowen's Bioenergetics (1958) or Sensorimotor Psychotherapy by Fisher and Ogden (2009), focus on bodily tensions and blockages to release trauma and promote emotional empowerment.
- Existential approaches, such as Berne's Transactional Analysis (1961), aim to help the person develop their existential project by analysing and modifying internal blockages and relational dynamics.

6.3. Therapeutic Techniques

Humanistic interventions revolutionised the field by transforming the way the therapeutic relationship, intervention techniques and the session environment are conceived. Within this approach, the relationship between two experts is prioritised: the person, in their experience and challenges, and the therapist, in psychological intervention. This model promotes trust and mutual recognition as essential factors. Regarding the therapeutic space, it is characterised by the absence of intermediary elements, fostering an environment of closeness and authenticity. Humanistic therapeutic attitudes focus on establishing a relationship of trust through the therapist's unconditional positive regard and authenticity, who shares their perceptions in an enriching and empathic way. An optimal distance is maintained that allows for empathic understanding and support of the client, thereby encouraging their inner growth through constructive confrontation and the recognition of their own expertise. These attitudes encourage the client's emotional openness and enhance change within the therapeutic process (Pubill González, 2023).

6.3.1. Phenomenological Techniques

Techniques based on a phenomenological perspective are valuable tools for exploring the person's inner and interpersonal world. These techniques, grounded in humanistic philosophy, are based on the principle that the observer and the observed are inseparable, implying that reality is a co-construction between the individual and their environment. In this sense, humanistic techniques aim to promote awareness and self-knowledge. The main self-knowledge techniques include (Pubill González, 2023):

- **Externalisation:** Involves separating or distinguishing the person from the problem or pattern of functioning through drawings, clay modelling, among others. This Gestalt technique helps the person to explore their experience from a different perspective.
- **Sculptures:** This is a Gestalt technique in which the client uses their body to represent how they feel in a particular situation. The therapist guides the person to explore different postures and to become aware of their bodily experience.
- **Guided fantasies:** Through guided imagination, the client explores symbolic situations that allow them to access deeper aspects of their emotional experience.

This Gestalt technique facilitates self-knowledge and the resolution of internal conflicts.

- **Dream work:** The therapist uses the client's dreams as material to explore their inner world and underlying conflicts. This technique, inspired by Jungian psychoanalytic therapy, helps the person to understand and process their dream experiences.
- **Metaphorical stories:** This is based on exploring personal stories or external narratives that resonate with the client's experience. The therapist uses these stories to facilitate the client's reflection and self-knowledge.

6.3.2. Techniques for Working with Emotions

Techniques aimed at evoking emotions seek to increase awareness of emotional conflicts that cause present difficulties, focusing on the here and now. The body plays a central role in directly accessing emotions (Pubill González, 2023):

- **Body Focusing:** This technique facilitates the person's contact with their emotional experience, enabling them to speak from it rather than about it. The aim is to enhance awareness and the capacity to resolve the difficulty.
- **Grounding:** This is a bioenergetic technique that helps the client become aware of how they position themselves in relation to the ground and how this affects their wellbeing. Analogies with their personal life are explored, and a more stable and confident stance is encouraged.
- **Therapeutic writing:** Used to express and evoke emotions, this technique involves writing letters, diaries, poems or fictional works to externalise and process emotional conflicts. It is an essential component of humanistic therapy, helping to prepare for and address grief and unresolved conflicts.

6.3.3. Restructuring Techniques

Humanistic restructuring techniques aim to help the client face unresolved emotional situations, find new meaning in what has happened and focus on the present. The most well-known include (Pubill González, 2023):

- **Empty chair:** Used in Gestalt therapy, this technique helps to resolve conflicts with people who are either living or deceased. The client speaks from the heart to an

empty chair representing the other person and then changes position to gain a deeper understanding of the situation from different perspectives.

- **Two-chair technique:** Also from Gestalt therapy, this allows the exploration of internal dilemmas. The client takes opposing positions and engages in dialogue with themselves, seeking a flexible and effective resolution.
- **Restructuring fantasies:** Guided by the therapist, these fantasies promote cognitive and emotional change, encouraging the client to take responsibility for what has occurred and to activate their sense of agency in managing everyday life.
- **Rituals:** Used to bring closure to life stages or blocked situations, these combine various techniques with a strong symbolic component to facilitate the transition towards the future.
- **Scene dramatisation:** Derived from psychodrama, this technique enables awareness of relational conflict, the development of empathy and the emotional restructuring of unresolved situations, whether past or present.

7. Sociocognitive Techniques

7.1. Conception of health

Sociocognitive approaches, inspired by constructivist epistemology, emphasise the processes of meaning-making and the sense that individuals attribute to their experiences They consider human beings as proactive agents who interact with their environment to make sense of it, rather than as passive reactors to external events. From this perspective, thoughts, emotions and behaviours are recognised as channels through which knowledge of reality develops, with cognition understood in its original sense from the root *cognoscere*. An important element of health for various sociocognitive orientations is coherence among the different parts of identity. Psychological distress, in these frameworks, arises when, in the effort to maintain such coherence, we persist in using constructions of the world that have been repeatedly invalidated.

7.2. Conception of Change

From this perspective, events and experiences are not represented objectively, but are interpreted by the system that observes, interprets and participates in them

(Neimeyer, 2009). Thus, the therapist does not possess an absolute truth or the key to "curing" pathology but can help those who seek their support to find a framework of meaning that is more useful for progressing towards a personally or socially satisfying process, coherent with their identity. This generates an interaction between the psychological need to maintain continuity and the impulse towards change, which develops in a balanced way through the reconstruction, when necessary, of one's sense of identity (Feixas & Soldevilla, 2024). This constructivist epistemological approach is also integrated into a range of psychotherapeutic orientations beyond those strictly sociocognitive, spanning from humanistic approaches, particularly in their existential forms (Frankl, 1946; Yalom, 1980), to relational psychoanalysis (Atwood & Stolorow, 1993), all of which focus on the process of meaning-making and the development of an existential project.

7.3. Therapeutic Techniques

Although there are various schools within sociocognitivism, this section focuses on techniques derived from George Kelly's (1955) Personal Construct Theory (PCT), which has probably generated the broadest range of techniques. While the detailed explanation of the theory itself belongs more within the fields of personality and individual differences, some key ideas are summarised here.

Constructs are personal elements that may vary in content and use but are largely shared within a given family or cultural framework. They are bipolar, as they are based on the perception of difference, allowing us to classify experiences in opposing terms such as high and low, nurturing and toxic, satisfying and unpleasant, among others. They function as schemas that we use to understand and categorise our experiences, both discretely and dimensionally.

These constructs are organised hierarchically, with core constructs that are fundamental to identity and resistant to change, and peripheral constructs that are less central and more flexible. Both types are used to make sense of and predict our experiences. As we interact with the world, we create new constructs and relate them to existing ones, thereby increasing the explanatory power and internal coherence of the system.

PCT describes how we use these constructs to navigate the world through the cycle of experience. This cycle begins with an anticipation about the object or event to be known, followed by involvement in the relevant constructs and the process of knowing. Then comes the encounter with the object, where the initial hypothesis is tested. Subsequently, the construct is either confirmed or disconfirmed, triggering an emotional response that leads to reviewing and potentially redefining the construct. This constructive revision is crucial for preventing distress or psychopathology, as continuing to apply invalidated constructs can lead to negative outcomes.

It is important to highlight the central role of the Repertory Grid Technique as a means of assessing personal constructs. For this reason, it is advisable to review materials from assessment modules or consult the work of Guillem Feixas and his team (p. ej. Feixas et al., 2003) who also provide open-access software[3]. One of the indicators within this technique is implicative dilemmas, situations that arise when a person faces a conflict between two constructs. In therapy, an implicative dilemma occurs when someone wishes to make a change in one construct but another construct prevents this movement (Tschudi, 1977).

Imagine, for example, a person who holds an idealised view of themselves as independent and self-sufficient. This construct of "independence" is very important to them and guides their decisions and actions. However, they also deeply value emotional connection and support from others, which conflicts with their ideal of independence. In a therapeutic setting, this person might face an implicative dilemma when they need to accept emotional support from loved ones while experiencing grief.

7.3.1. Self-characterisation

Originally developed within a model known as Fixed Role Therapy (González Encinas et al., 2019), Kelly proposed this technique in which the person is asked to write a brief description of themselves in the third person, as though they were a character in a play. The task is not about factual accuracy, but rather about the narrative coherence that makes sense to the person. They are encouraged to feel comfortable and to use their natural linguistic register. For instance, the person might describe themselves as a

[3] http://www.tecnicaderejilla.net

character with particular personality traits, family characteristics and behavioural patterns. This description is then discussed in the therapy session to better understand the person's perspective, identify their underlying constructs and grasp their idiosyncratic vocabulary. Writing in the third person and adopting a friendly tone is encouraged to limit self-criticism, especially in clients experiencing sadness or low mood.

7.3.2. Fixed Role Technique and Therapy

Based on the constructs identified in the self-characterisation, a new role is developed and practised intensively in the person's social environment for an agreed period. The goal is to broaden or modify the person's view of themselves and the world around them. Through repeated practice and reflection, the person can explore and adapt their self-concept and understanding of the world, thereby promoting personal growth and flexibility in self-perception and interpersonal relationships.

7.3.3. Laddering Up

This construct exploration procedure involves analysing the higher-level implications of constructs within the person's system (Hinkle, 1965). Starting from a construct identified during conversation or via the repertory grid technique, the therapist explores its implications through a series of questions. For example, if the person mentions that they value honesty, they are asked about the implications of being honest or dishonest, and so on. The procedure is repeated until the relationships are exhausted or repetitions occur, indicating that a core construct has been identified. There is also a variant called laddering down, where the subordinate implications of the construct are explored.

7.3.4. Moviola Technique

The Moviola Technique, inspired by the cinematic device of the same name[4], is used in constructivist psychotherapy to review significant lived situations. The scene is recreated by moving forward and backward through the sequence of actions and events, exploring sensory experiences and behaviours, as well as the person's interpretation of

[4] A film editing machine that allows you to rewind and fast-forward a film, cut it, or insert scenes into it, as well as synchronize its soundtrack.

what occurred. A dynamic narrative approach is used to access the client's subjective experience, identifying emotions and feelings. This process is repeated over several sessions to train the person to distinguish between the immediate experience and their explanation of it, enabling re-evaluation and restructuring of its meaning within the therapeutic context.

7.3.5. Magic Wand Technique

The Magic Wand Technique is used in dilemma-focused therapy to explore potential changes in a person's way of being and their implications. Starting from a discrepant construct, such as a person feeling that they do not love themselves enough, the therapist uses an imaginative approach by inviting them to imagine being magically transformed into someone who does love themselves. The person is then asked to reflect on how this change would feel in different contexts and significant relationships. Through this process, areas of discomfort or internal conflict may emerge, allowing the therapist to identify implicit dilemmas within the client's experience. The therapy focuses on resolving these dilemmas rather than on symptom elimination or achieving specific goals. The person is encouraged to reflect on how they might address the internal conflict in a way that aligns with their sense of identity and personal values.

8. Systemic techniques

8.1. Conception of health

The systemic model, which emerged alongside family therapy, has evolved and now has multiple contemporary applications. This approach represented a new conceptualisation distinct from individual centred models, adopting metatheoretical assumptions drawn from general systems theory and complexity theory. Problems and human activity are viewed as interpersonal rather than explained solely at the intrapersonal level (Feixas, 2020).

Communication plays a central role in the systemic model because the focus is on the interaction between people rather than on what happens inside each person. From this perspective it is impossible not to communicate, since every human activity carries the value of a message and is connected to others. Traditional concepts such as the self, self esteem, personality and so on cannot fully capture this broader view.

Interaction patterns within the family are fundamental in the systemic model. Functional and dysfunctional patterns are identified. Among the dysfunctional patterns is paradoxical communication[5], characterised by incongruent messages that can be particularly disruptive for children and adolescents. The model also examines dyadic interaction patterns, such as complementarity[6] & symmetry[7], as well as triadic interaction[8], which may generate coalitions that affect the development of group members.

8.2. Conception of change

In systemic therapy it is understood that change is not simple or linear. It is observed that when one family member improves, problems often emerge in other members. This occurs because the family system functions as a whole, and when one aspect is altered the system tends to restore balance through the emergence of new symptoms. These ideas relate to general systems theory and to cybernetics, which emphasise negative

[5] Paradoxical communication is a dysfunctional form of interaction in which incongruent messages are conveyed at different logical levels, generating confusion and distress. It is a type of communication characterised by eliciting a response from the other person and then criticising that very response. For example, encouraging a child to express their emotions and opinions, but later criticising them for doing so.

[6] Complementarity refers to a dynamic in which people assume distinct but complementary roles that fit together harmoniously. This means that each member performs different yet interdependent functions within the family system, such as care and protection, decision making, and mutual support. It can be beneficial if the roles are exchanged flexibly, but if it becomes rigid, it may hinder the development of the person in the position of lesser power.

[7] Symmetry refers to a dynamic in which people tend to place themselves at the same level of power or authority, maintaining a relationship of equality in their roles and actions. This means that both members may take the initiative, offer advice, or lead different aspects of the relationship. Symmetry can be beneficial when it promotes cooperation and balance among family members, but it may also lead to conflict and competition if not managed appropriately.

[8] Triadic interaction refers to the relational dynamics among three people or entities within a family or social system. This can manifest through alliances, where natural proximities exist between certain members, such as when the father and child enjoy activities together while the mother does not participate. Coalitions may also occur, which are associations between members against another, often explicitly denied but present in the family dynamic. When these coalitions involve recruiting a child against the other parent, it is known as triangulation, which can have detrimental effects on the child involved, diverting their energy from addressing their own challenges towards parental conflict.

feedback[9] as a mechanism for maintaining homeostasis[10]. For example, a thermostat regulates temperature through negative feedback.

Systemic therapy distinguishes between first order and second order change. First order changes do not alter the system's structure, whereas second order changes affect the system's parameters. For example, changing how a couple relate to their parents represents a second order change because it alters the family system dynamics. First order changes are often superficial and do not address the root of the problem, whereas second order changes involve modifying the system's rules or beliefs. It is important to understand that second order changes are necessary to achieve meaningful transformation in the family system.

Systemic schools are often associated with the lead therapists who developed a characteristic style based on systemic notions. Although they have distinctive styles, ideas are exchanged between schools in practice and techniques are frequently integrated across approaches. While there are many schools, they can be broadly simplified into three: the Mental Research Institute MRI, structural strategic, and the Milan school.

The MRI, founded by Don D. Jackson in 1958 with later contributions from figures such as Paul Watzlawick and Gregory Bateson, focuses on analysing problems through circular interactional patterns. Difficulties are seen as natural in human development, but when they are repeated they create distress. Solutions that are applied often maintain the problem, creating a destructive feedback cycle. For this reason the MRI school emphasises breaking this cycle by seeking solutions that do not perpetuate the problem rather than focusing solely on the difficulty itself.

Both the strategic and the structural schools focus on analysing triadic relationships in families (Feixas & Miró, 1993). Their main exponents are Jay Haley and Salvador

[9] Negative feedback is a concept used in systems theory and cybernetics, referring to a regulatory process through which a system responds to a change in its state by returning to its original condition. In other words, when an imbalance or deviation occurs in the system, negative feedback acts to counter that change and maintain the system's stability. It is a self-regulating mechanism that helps the system remain within certain limits or specific parameters.

[10] Within systemic theory, homeostasis refers to the dynamic balance that family or social systems strive to maintain to function stably. This balance involves regulating interactions and behavioural patterns within the system to preserve its structure and stability. Family homeostasis refers to the tendency of the family to maintain its patterns of communication, roles, and norms, even when these may be dysfunctional or cause conflict.

Minuchin, who collaborated and shared ideas at the Philadelphia Child Guidance Clinic. Both schools stress the importance of studying family structure and organisation, including the clarity of hierarchies and boundaries between subsystems. Psychosomatic families studied by Minuchin are characterised by enmeshment, overprotection, rigidity, conflict avoidance and the involvement of children in parental problems. For these schools, change involves improving family structure and establishing an effective therapeutic connection with the family.

The Milan school, which arose in the 1960s, developed from the interest of a group of Italian psychoanalysts in systemic ideas, maintaining close links with figures such as Watzlawick and deepening Bateson's concepts. Although the original group dissolved, therapists such as Boscolo and Cecchin carried on the work and contributed to the development of a constructivist approach in family therapy. Their theoretical and clinical contributions, such as the theory of psychotic games (Selvini Palazzoli et al., 1988) and their interview method (Selvini Palazzoli et al., 1980), have had significant influence in family therapy. They emphasised forming a prior hypothesis about the family's motives and expectations at the start of each session, which is adjusted and revised during the therapeutic process, while part of the team observes from behind a one way mirror in order to preserve therapist neutrality.

8.3. Therapeutic techniques

8.3.1. Structural techniques

Structural family therapy techniques, developed by Minuchin (1974), focus on building a solid connection with the family and understanding its structure and dynamics before applying specific interventions to promote change. In the initial phase of therapy the therapist uses techniques such as tracking, which involves gathering interactional and structural information about the system, to obtain detailed data on family dynamics including alliances, coalitions and hierarchies. This allows the therapist to understand the underlying structure that guides behaviour and relationships within the family system. Once a robust understanding of family structure has been obtained, the therapist may use maintenance techniques that respect the system's current rules and roles. This can involve, for example, temporarily allowing certain roles or behaviours that do not disturb the system's balance while preparing to intervene more effectively. The

therapist may also employ mimicking[11] to establish closer rapport with the family and foster a sense of familiarity and trust. Once a solid base of trust and mutual understanding is established, the therapist can apply restructuring techniques such as destabilisation, which involves forming intense alliances with particular subsystems to provoke changes in boundaries and family dynamics. It is crucial, however, that the therapist compensates for these intense alliances in order to preserve neutrality and avoid taking sides in family conflicts.

8.3.2. Circular questioning

Circular questioning, introduced by the Milan school (Selvini Palazzoli et al., 1980), is a popular intervention technique among systemic family therapists. It consists of questions designed to reveal the relationships and differences between family members as well as their reactions to particular situations. These questions explore how relationships are mutually constructed within the family system. They can also help test therapeutic hypotheses by observing family members' reactions while they discuss someone in their presence. Circular questions also allow the therapist to investigate the meaning of family members who are silent or absent. They are classified into several types according to their purpose, timing and investigative aim, and are used to challenge family beliefs and open up new perspectives for change. An attitude of curiosity is fundamental when formulating these questions and allows the development of multiple hypotheses about the family system.

8.3.3. Task prescription and therapeutic rituals

Task prescription and therapeutic rituals are strategies used in family therapy to promote change in family dynamics and to address presenting problems. These tasks can be divided into two main modalities: in session tasks and homework. In session tasks often involve enactments where a family member performs an action in the present moment of the session to alter a particular family function or structure. For example, in a situation where a mother complains that her child is uncontrollable, the therapist

[11] Mimicking involves subtly imitating certain behaviours or gestures of family members during the therapeutic session. Its aim is to establish a closer connection and foster trust.

might ask her to sit on top of the child as a symbolic demonstration of authority to break the rule of the child's uncontrollability. Homework tasks are specific activities or changes assigned to family members to carry out outside the therapy session. These tasks are reviewed in the following session to assess engagement with therapy and to gain understanding of the family system dynamics. For instance, in a case of poor school performance a father may be asked to supervise the child's homework, thereby changing the family dynamic related to responsibility for school tasks.

Generally, these tasks aim to alter the family interaction pattern associated with the problem in the hope that this will lead to change in the problem itself. They may be one off or periodic tasks, designed to address specific conflicts or to promote healthier communication within the family.

8.3.4. Family rituals

In family therapy the use of rituals, introduced by the Milan team, involves complex tasks with symbolic meaning performed by the whole family with a ceremonial tone. These rituals are a form of prescription in which the therapist, while maintaining neutrality, seeks to explore alternative explanations within the family. One example is proposing that the family act according to two different explanations of a problem on different days of the week (Boscolo et al., 1987). This suggests that the therapist accepts multiple interpretations of events without insisting on a single correct explanation. By transmitting this message flexibility is promoted and fixed views of the problem are altered. Although many families do not follow the ritual rigidly, the very possibility of doing so can change their way of thinking. This can lead to the creation of a third, more viable alternative. In this process the therapist acts as facilitator and questioner rather than imposing a definitive explanation.

8.3.5. Reframing

Reframing in therapy consists of changing the meaning attributed to a symptom or to the interaction that surrounds it. There are two main types of reframing: positive symptom redefinition and positive connotation.

Positive symptom redefinition, used mainly by structural therapists, seeks to reinterpret problematic behaviours in a more favourable way. For example, a child crying

during a session may be viewed as an indication that they also have something important to communicate.

Positive connotation, proposed by the Milan team, attributes a positive value to the problematic behaviour and to the relational context in which it occurs. The aim is to understand each family member's actions from a neutral stance, avoiding judgement. This paves the way for paradoxical non change interventions, which challenge interactional patterns and short circuit the functionality of the symptom.

8.3.6. Paradoxical interventions

Paradoxical interventions involve the therapist prescribing, in a controlled and specific way, that a person or family carry out the behaviours that constitute the problem. Their roots lie in Adlerian ideas and in Frankl's logotherapy, and they are rationalised in systemic therapy by the therapeutic paradox, where change is demanded yet any attempted solution is rejected. These interventions can be of three types:

- **Request for slow change:** This intervention involves suggesting that small changes are more appropriate than large ones, warning of the risks of changing too quickly. It is used to facilitate gradual adaptation of the family system to new dynamics without provoking excessive resistance.
- **Prescription of no change:** In this approach the therapist asserts that change is not desirable and that the current situation is acceptable as it is. This is done to challenge expectations of change and to generate reflection on the functionality of existing symptoms or behavioural patterns.
- **Symptom prescription:** This consists of instructing the family to continue manifesting the symptom in a specific context. The aim is to alter the perception of the symptom and its function by exposing it in a controlled scenario where it loses its habitual utility, which can lead to its eventual disappearance.

Each of these paradoxical interventions is used strategically to challenge dysfunctional interactional patterns and to promote therapeutic change in the family system. They have been employed across various systemic schools and are considered to have high potential impact, but they must be used with caution after thorough analysis of their functionality and possible harmful effects.

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