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RESEARCH PAPER

TREATING GUILT-INDUCING SELF-TALK IN OCD WITH DRAMATIZED SOCRATIC DIALOGUE: A STEP BY STEP INTERVENTION

Angelo Maria Saliani, Claudia Perdighe, Vittoria Zaccari, Olga Ines Luppino, Alessandra Mancini, Katia Tenore, Francesco Mancini

Abstract

Objective: Fear of moral guilt and conseque:nt increased attention to personal actions and intentions are the main ingredients of the self-criticism in patients suffering from obsessive-compulsive disorder (OCD). This pathogenic attitude takes shape in a typical guilt-inducing self-talk.

The purpose of this work is to describe in detail a novel cognitive therapeutic procedure for OCD called "Dramatized Socratic Dialogue" (DSD).

Method: DSD is a theory-oriented intervention that combine elements of Socratic dialogue, chairwork, and cognitive acceptance strategies derived from Mancini's model, which posits that obsessive-compulsive (OC) symptoms stem from a fear of deontological guilt.

Results: DSD appears to have many strengths, being a theory-oriented treatment and focusing, as a therapeutic target, on the cognitive structures that determine pathogenic processes and OC symptoms. Furthermore, it is a short, flexible and tailor-made intervention.

Conclusions: Detailed description of the intervention could foster future research perspectives and thus be used in evidence-based effectiveness studies to establish whether DSD reduces OC symptoms and to investigate its mechanism of action.

Key words: dramatized socratic dialogue, cognitive-behavioral therapy, obsessive-compulsive disorder, moral self-criticism, guilt-inducing self-talk

Angelo Maria Saliani[1], Claudia Perdighe[1], Vittoria Zaccari[1,2], Olga Ines Luppino[1,3], Alessandra Mancini[1,3], Katia Tenore[1,3], Francesco Mancini[1,2].

[1] School of Cognitive Psychotherapy (APC-SPC), Rome, Italy
[2] Department of Human Sciences, Guglielmo Marconi University, Rome, Italy
[3] Italian Academy of Schema Therapy (IAST), Rome, Italy

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Corresponding author
Angelo Maria Saliani
School of Cognitive Psychotherapy
APC-SPC, Viale Castro Pretorio 116 - 00185 Roma
E-mail: saliani@apc.it

Introduction

Current available psychosocial interventions for obsessive-compulsive disorder

Obsessive-compulsive disorder (OCD) is a mental disorder impacting about 1.2% of the population, with a lifetime prevalence of about 2–3% (Brakoulias et al., 2017; Kessler et al., 2005; Ruscio et al., 2010). Typically, OCD is characterized by obsessions (i.e., persistent thoughts, images, doubts, or urges) and compulsions that are ritualistic, along with disabling overt or covert actions that the individual feels they must perform to relieve the emotional stress elicited by the obsessions and/or to prevent some feared negative events (American Psychiatric Association, 2013). Cognitive-behavioral therapy (CBT) leads to statistically reliable improvement in a percentage ranging from 60% to 75%, with the exposure and response prevention (ERP) technique being the psychosocial intervention of choice in the treatment of OCD (Abramowitz, 1997; Ferrando & Selai, 2021; Franklin & Foa, 1998; Olatunji et al., 2013; Öst et al., 2022). Cognitive therapy (CT) is effective, too, in treating OCD, both alone and in combination with ERP, and CBT treatments that include CT interventions appear to be more tolerated by patients and to reduce dropout, compared to ERP alone (Abramowitz, 2006; Fisher & Wells, 2005; Rector et al., 2019; Rosa-Alcázar et al., 2008; Whittal et al., 2008).

CT commonly uses cognitive restructuring techniques of belief domains typically associated with OCD, such as inflated responsibility, overestimation of threat, intolerance of uncertainty, perfectionism, overestimation of importance of thoughts and importance of controlling thoughts. Specific cognitive interventions addressing the issue of acceptance, integrated into evidence-based CBT techniques, have demonstrated clinical relevance for the treatment of OCD.

The rationale behind these cognitive procedures lies in enhancing motivation, treatment collaboration,

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and acceptance of risk, ultimately making the patient less vulnerable to the issues and mechanisms involved in maintaining the disorder (Gragnani et al., 2022; Mancini et al., 2006; Zaccari et al., 2021).

Unfortunately, only 25% of patients are asymptomatic by the end of the CBT treatment (Fisher & Wells, 2005). In addition, 15.6% of eligible patients refuse CBT, and 15.9% drop out of treatment, suggesting that over 30% of OCD patients who are recommended for CBT either refuse it or do not complete it (Leeuwerik et al., 2019). This is even more relevant if we consider that the long-term stability of clinical improvements depends on a full remission obtained during CBT (Elsner et al., 2020) and a continuation of the exposure training over time (Külz et al., 2020). Finally, substantial uncertainty remains about the psychological mechanisms that mediate the effects of CBT treatment (Schubert et al., 2022; Wilhelm et al., 2015; Wolters et al., 2019). In summary, CBT is effective, but almost a third of OCD patients who could benefit from it refuse or interrupt the treatment prematurely, and three out of four patients show residual symptoms at post-treatment still suffering from a compromised quality of life.

Last, the nature of mechanisms that account for therapeutic change is still unclear. Some crucial questions that need to be answered are: How can we increase the short- and long-term effectiveness of CBT for OCD patients? How can we reduce drop-out and treatment refusal? How can we treat residual symptoms? Which mechanisms mediate therapeutic changes in CBT?

Overcoming current limitations of OCD treatment and addressing moral self-criticism

A potential key aspect to consider in answering these questions is the role of guilt in OCD. Indeed, the role of proneness to inflated responsibility and fear of guilt in the development and maintenance of OCD has been well documented (Arntz et al., 2007; Ladouceur et al., 1995; Mancini et al., 2004; Mancini & Gangemi, 2004; Melli et al., 2017; Rachman, 1993; Salkovskis, 1985; Shafran et al., 1996; Shapiro & Stewart, 2011; Steketee et al., 1991). Obsessive-compulsive activity appears driven by the aim of neutralizing or preventing the possibility of feeling guilty (Chiang et al., 2016; Mancini, 2018).

In line with these results, the literature documents that patients with OCD describe their family members as demanding and critical (Barcaccia et al., 2015; Pace et al., 2011; Tenore & Basile, 2018; Tenore et al., 2020) in the presence of a type of parental discipline characterized by the threat to the continuity of the relationship itself (Mariaskin, 2009), experiences of reproach that lead to the withdrawal of affection by ignoring the child and are not prone to forgiveness (Tenore & Basile, 2018; Tenore et al., 2020). Furthermore, patients with OCD report significantly more painful memories of guilt and reproach that induce a sense of guilt (Basile et al., 2018a).

It is plausible that from these experiences, the expectation that guilt has catastrophic consequences may arise, and therefore (Cameron, 1947; Pace, 2011), obsessive-compulsive behaviors can be considered as strategies used by the child to avoid criticism and obtain approval (Cameron, 1947; Pace, 2010).

These findings, which focus on experiences of reproach, criticism, and threats to the relationship, could also be contextualized in light of other distal and proximal factors that contribute to increasing the risk of obsessions and compulsions, such as the presence of emotional abuse in early childhood and traumatic experiences (Kadivari et al., 2023; Santoro et al., 2023) that play a role in the development and maintenance of OCD and are associated with greater severity of obsessive-compulsive symptoms (Boger et al., 2020). Additionally, it has been found that difficulties in emotion regulation, rumination, attachment, dissociation, and symptoms of post-traumatic stress are potential mediators of the severity of OC symptoms (Boger et al., 2020).

Recently, a distinction has been made between two fundamental types of guilt, namely altruistic and deontological. The former is characterized by sorrow for the pain felt by another individual—not necessarily caused by one's own fault or transgression—and the moral need to alleviate it. The latter is characterized by the painful feeling of one's own moral degradation, deriving from the perception of having violated a deontological norm, regardless of whether the violation has caused suffering to someone else or not (Basile et al., 2011; Mancini & Gangemi, 2021).

Theoretical and empirical contributions have highlighted that it is the fear of deontological guilt that plays a preeminent role in the development of OCD that is associated both with checking and washing symptoms (Mancini & Gangemi, 2015). The Lady Macbeth effect, in line with this perspective, frames the abnormal disgust sensitivity of patients suffering from OCD as a response to the need for protecting one's own moral integrity threatened by ethical guilt (D'Olimpio & Mancini, 2014; Ottaviani et al., 2019).

Fear of guilt in individuals suffering from OCD is expressed in self-talk characterized by anticipated external criticisms or negative self-appraisals of being a bad, wrong, and/or unworthy individual. Moreover, anticipated criticism and negative self-appraisal seem to predict OCD symptoms and the negative meaning attributed to intrusive thoughts (Riskind et al., 2018), and it is reasonable to hypothesize that it is the intrapsychic outcome of early relational experiences of reprimand (Barcaccia et al., 2015; Basile et al., 2018a; Luppino et al., 2023; Pace et al., 2011).

In patients suffering from OCD, such self-talk is elicited when an obsessive thought appears, when patients resist compulsion/avoidance urges, when they judge themselves for suffering from a mental disorder, or in any situation where they feel scared for committing (or having committed) an unforgivable mistake. Self-talk examples include: "If I have this image in my mind, then maybe I am a pervert," "If I can't keep my intrusive thought away, then I will make trouble and I can only blame myself for it," "I'll be lousy if I don't wash thoroughly," "I'm a bad father; I'll end up ruining my children's lives with these absurd rituals!" or "I'm a scammer. If they knew my thoughts, they would judge me a bad person," and so on.

Notably, these sentences do not contain definitive judgments of being guilty; rather, they contain anticipated accusations related to a possible scenario linked to one's own moral performance. In other words, the pattern is: "If you are not careful, if you behave badly, if you don't fix it ... then you will be guilty and unforgivable." Fear of moral guilt and consequent increased attention to personal actions and intentions are the main ingredients of the internal dialogue that characterizes obsessive self-talk. In the current paper, we will refer to this typical self-talk of patients suffering from OCD with the term guilt-inducing sentences (GISs). Additional examples of GISs will appear in our section "The dramatized Socratic dialogue: Step by

step."

Despite the growing amount of research showing the existence of a close link between self-criticism, guilt, and OCD, only a few studies have examined the effectiveness of interventions targeting moral self-criticism and guilt (Cosentino et al., 2012; Gragnani et al., 2022; Perdighe & Mancini, 2012; Petrocchi et al., 2021; Tenore et al., 2020).

Considering these gaps, the purpose of the present manuscript is to illustrate an assessment and treatment procedure that identifies and treats GISs in a Socratic and dramatized way. We called this procedure dramatized Socratic dialogue (DSD). DSD is not, strictly speaking, a new technique, but an integrated procedure that combines the fundamental principles of Socratic dialogue, cognitive acceptance, and chairwork in an innovative and coherent way with Mancini's OCD model (Mancini, 2018; Semeniuc & Soponaru, 2022; Tenore et al., 2018), in which it is conceptualized, as a significant purpose for patients with OCD, the avoidance of deontological guilt. From this perspective, obsessions signal to the patient the risk of violating (or having violated) a subjectively mandatory ethical principle and compulsions are activities aimed at preventing or at least reducing this risk and the guilt that would derive from it (Basile et al., 2014; D'Olimpio & Mancini, 2014; Mancini & Barcaccia, 2014; Mancini & Gangemi, 2004, 2015, 2017; Ottaviani et al., 2019).

DSD will be described in detail in this article and exemplified by extensive excerpts from a therapy session in the Appendix.

Theory

In this section, the rationale for developing the DSD procedure will be illustrated. Specifically, its three basic components will be summarized: Socratic dialogue, chairwork, and cognitive acceptance. Finally, we will explain how and why their combined use may be beneficial in the treatment of OCD.

Socratic dialogue

CT has as its main objective that of challenging dysfunctional beliefs, and one of its best-known procedures is the so-called Socratic dialogue. Socratic dialogue is not strictly speaking a technique, but rather a method of conducting the interview based mainly on asking the patient questions in order to both investigate their maladaptive beliefs and challenge them and thus promote therapeutic change (Clark & Egan, 2015; James et al., 2010; Overholser, 2011). Examples of questions useful for the first purpose are: *What would have been the worst consequence if you had not been able to calm your anxiety?* or *let's assume by hypothesis that someone really judges you a selfish person; what's wrong with you being judged a selfish person?* and so on. The basic pattern in this kind of question is always the following: *If what you fear were to happen, what would this imply, and what would it mean for you?* It aims to stimulate the search for the core beliefs that underlie negative automatic thoughts. Examples of questions useful for the second purpose (the more properly therapeutic one) are: *Ok. You are convinced that you are a bad person: What proves that this is really the case?* or *Let's put aside for a moment whether this belief is absolutely true or false; let's ask ourselves what consequences it produces: Does it improve or worsen your life?* In very general terms, this type of questioning is aimed at bringing out in the patients' mind the doubt that those dysfunctional beliefs they so stubbornly entertain are ultimately not so obvious and justified. This dialogic mode of challenging dysfunctional thoughts is present in both the earliest and most well-known forms of cognitive treatment, namely in Beck's (1976) CT and in Ellis's (1962) rational emotive behavior therapy.

Although Socratic questioning often positively influences the therapeutic process, it sometimes requires adaptations to overcome the difficulties posed by the treatment of various psychopathological disorders (James et al., 2010; Kazantzis et al., 2014, 2018; Overholser, 2011), and OCD is no exception to this clinical observation (Saliani et al., 2011; Saliani & Mancini, 2012, 2018).

Chairwork

The term "chairwork" refers to a series of experiential psychological interventions that use chairs for therapeutic purposes. It is therefore not a specific technique but a very broad and flexible method that can be adapted to various objectives and interventions. The first therapeutic areas in which it was used are psychodrama (Fox, 1987; Moreno, 1948) and Gestalt therapy (Perls, 1973). Since then, chairwork has been used in numerous psychotherapies, including CBT in both its traditional forms and those related to the so-called "third wave" (Arntz & Weertman, 1999; A.T. Beck et al., 1979; J.S. Beck, 1995; de Oliveira,2016; Dimaggio et al., 2020; Gilbert, 2009; Goldfried, 2013; Greenberg, 2002; Leahy, 2003; Pugh, 2017, 2018, 2019; Young et al., 2003).

In general terms, it is possible to distinguish two main types of chairwork: that in which patients interact with parts of themself (internal chairwork dialogue) and the one in which they interact with others, as if others were physically present (external chairwork dialogue) (Kellogg, 2004). External dialogues can be used to help individuals work through grief and loss, heal from interpersonal abuse, manage relational problems, and strengthen their assertiveness. The internal dialogues focus on the resolution of inner conflicts, on contrasting the inner critic and self-hatred, and on the differentiation and integration of multiple "parts" of the self.

More specifically, chairwork can take the form of a two-chair (or more) dialogue in which the therapist asks the patient to make different parts of the self interact; that of the empty-chair in which the patient engages in an imaginary dialogue with another person (e.g., a parent); or that of role-playing in which patient and therapist engage in a certain psychologically significant interaction. In clinical practice, chairwork combines the different techniques and strategies of interaction, depending on the objectives and phases of the intervention (Kellogg & Garcia Torres, 2021).

Despite a widespread and effective use of chairwork in reducing self-criticism and guilt (e.g., Shahar et al., 2012), its systematic application in the psychological treatments of OCD is described only in a small number of studies (Basile et al., 2018b; Thiel et al., 2016).

Socratic dialogue, OCD, and the acceptance of the risk of being guilty

The dialectical criteria that usually inspire "disputing" in CT are of two types: logical-empirical and pragmatic (Ruggiero & Sassaroli, 2013). The *logical-empirical* type rests on a principle of truth/falsity and is expressed with typical questions, such as: *What evidence do we have to believe this?* or *What*

facts and what arguments show that this is really the case? The purpose here is to question the consistency and realism of a belief.

The *pragmatic* type concerns the usefulness of a belief and is expressed with questions such as: *What is this belief for?* and *Does it really help you get what you need?* The purpose here is to bring out the partial or total ineffectiveness of the belief in satisfying the needs of the individual. This criterion is completed by a sub-criterion, which we define as *economic*, which is about efficiency, and asks for the costs/benefits of a belief, regardless of its usefulness/effectiveness, and is expressed with questions such as: *Ok. Assuming that this belief has sometimes proved useful, what overall price do you pay because of it?* and *What costs and benefits does it produce?* or *Overall, does it make your life better or worse?* The aim here is to let the costs and the inconvenience (or poor efficiency) of a belief emerge.

Although very therapeutic, the application of these three dialectical principles (logical-empirical, pragmatic, economic) is rarely enough to undermine a belief related to obsessive-compulsive symptoms. Why? For at least three reasons. First: Many beliefs underlying OCD symptoms are exaggerated but not, strictly speaking, irrational (e.g., believing that the doorknob of a public restroom is contaminated with potentially contagious germs is not illogical); second, OCD patients do not accept uncertainty about their beliefs, even when they recognize that they are probably unfounded; third, and most important: Patients suffering from OCD do not just evaluate whether an idea is true, useful, or advantageous, but above all, if it is *right*. In other words, they often know that certain ideas are exaggerated and have negative consequences but are not sure whether it is legitimate to ignore them. That is, their main concern is neither logical nor practical but deontological (Mancini, 2018). Therefore, insisting on proving that a belief is false or unlikely or counterproductive only risks fueling lengthy debates that lead away from solving the problem (Saliani et al., 2011; Saliani & Mancini, 2018).

For these reasons, in conducting Socratic questioning with an OCD patient, it will always, sooner or later, be necessary to consider a fourth dialectical criterion that we define as *ethical*. Examples of questions inspired by this principle are: *Is it fair to believe that a human being is never allowed to have faults? Is it right to believe that if someone has a fault then she or he is unforgivable? (If yes, why, and what rule or authority justifies this harsh judgment?) Why if a person who is respectable to you checks just once, do you continue to consider him as a nice guy and if you check once, you judge yourself to be terribly reckless and careless?* The aim here is to let emerge the right to accept the risk of possible faults rather than discuss whether the fault is true or false (Basile et al., 2018b; Mancini, 2018; Saliani et al., 2021).

A further technical difficulty in treating OCD patients concerns the intrusive nature of obsessive thoughts: Is an intrusive thought disputable or not? By its very nature, an intrusive thought imposes itself on the mind and is often already experienced as absurd and unwanted, therefore disputing it to persuade the patient to abandon it only risks causing paradoxical and counterproductive effects. The obsession will therefore be tolerated and accepted, and the underlying appraisal will instead be disputed (Kazantzis et al., 2018). For example, if an individual is obsessed with a blasphemous thought, this thought will not be disputed but the belief that if blasphemy comes to their mind, then it means that they are a despicable person (Mancini, 2018).

Combining Socratic dialogue and chairwork to deal with OCD

Therapeutic interactions with patients suffering from OCD require a strategic and well-calibrated use of the dialectical criteria that both include the challenging of beliefs and attend to relational aspects (Balestrini et al., 2011). OCD patients, out of their fear of making crucial and unforgivable mistakes, do not tolerate imperfect explanations or partial solutions, raise doubts and objections which can often frustrate the therapist's attempts to challenge their dysfunctional beliefs, and lead to endless discussions or, at worst, quarrels. Furthermore, the Socratic dialogue, if not conducted with caution, can be experienced by the patient as an implicitly blaming interaction, with consequent risks of breaking the therapeutic alliance (Saliani et al., 2011; Saliani & Mancini, 2012, 2018).

More specifically, the most frequent risk is that the Socratic questioning is experienced by patients as a sort of dispute between them and their therapist to establish who is right and who is wrong, who thinks better, and who worse. The dramatization of the Socratic dialogue with chairwork allows clinicians to remove this risk because, thanks to it, there is no longer a discussion between therapist and patient but between a healthy part and a pathogenic part of the patient's self. This probably facilitates a cognitive distancing from dysfunctional ideas and makes the alliance between the therapist and the patient immediately and concretely evident against the accusatory and reproachful inner part (Dimaggio et al., 2020; Dimaggio & Stiles, 2007; Pugh, 2019). The specific way in which Socratic dialogue, acceptance, and chairwork are integrated and implemented is detailed in the following section and exemplified in the Appendix entitled "Dramatized Socratic dialogue in action," containing extensive excerpts from a DSD session.

The dramatized socratic dialogue: step by step

Session 0 (time: about 50 minutes)

Psychoeducation and investigation of guilt-inducing sentences

The treatment based on DSD typically lasts six to eight sessions, lasting 50 to 60 minutes each, carried out once a week. The DSD sessions are preceded by a Session 0 (S0), which includes an introductory phase of psychoeducation in which the therapist explains the concept of fear of deontological guilt and its role in the development and maintenance of OCD. Obsessive-compulsive (OC) symptoms are conceptualized as phenomena caused and maintained by accusations, reproaches, or threatening warnings from an internal guilt-inducing voice (GIV). Afterwards, the therapist asks the patient to recall a recent obsessive episode or any other episode in which they have experienced a strong fear of deontological guilt, and the therapist helps the patient with Socratic questioning to identify the negative automatic thoughts that have occurred to them in that circumstance. The questions used in this phase can include: *When you have that intrusive thought, what do you tell yourself? If that thought came true, what would it mean to you?* Also, *If you had stopped checking (or washing), what consequences would have occurred, and what would you have told yourself?* The

therapist explains to the patient that those automatic thoughts could be seen as GISs coming from a sort of hypercritical internal-voice, and the therapist asks the patient for a "name" for the voice. In the absence of a particular name chosen by the patient, this voice will simply be called GIV.

The GISs are transcribed and read together; the patients are asked how they make them feel, and if they (GISs) are comprehensive. If not, the patients are asked to correct them or add others to best represent the internal critical voice (GIV). At the end of S0, the therapist explains that in subsequent sessions they will work together to build a healthy voice (HV) capable of effectively neutralizing the GIV. The therapist adds that they will do it through a role-playing exercise, and that they will use four chairs to allow the characters present in the session to "interact" with each other (patient, therapist, GIV, and HV).

A week after S0, six sessions of DSD follow at a rate of one session per week. The procedure lasts approximately 60 minutes and consists of four phases that are repeated at each session, starting from the same episode identified in S0 or from new events triggering GISs that occurred during the prior week. In any case, the target of the intervention will be the GISs that determine the symptoms, not the symptoms themselves. More examples of GISs:

You're the usual bungler. You'll end up in some trouble!

You don't try hard enough to heal; you'll go crazy and be a bad mother!

That asbestos is going to poison your kids, and you're just standing there? Congratulations!

You will end up getting infected and transmitting the virus to someone. You are a filthy infector!

You leave your sperm lying around the house, and your babies will touch it. Disgusting!

You will lose your notes and miss appointments. You are a very careless person!

You will be fired for your mistakes, and you can only hate yourself for it!

With your carelessness, you will cause the death of some patients. You are a killer!

You think perverse thoughts to arouse yourself sexually. You're a monster!

In your heart you want the death of another person. You horrify me!

First step of all DSD sessions (time: about 10 minutes)

Introduction of the healthy voice and the four chairs

The therapist asks the patient if during the week the GIV was ever activated with its typical thought-sentences (GISs), like those already identified in S0. If no new triggering event occurred, the therapist refers to that of the previous week. In the therapy room, there are always four chairs: two for the therapist and patient (facing each other at a distance of about 1.5 meters), and two other chairs on either side that are momentarily empty (these are the GIV and HV chairs). The four chairs virtually occupy the corners of a regular quadrilateral.

Then, the therapist tells the patient: *This one you are sitting on now is your chair. It is the chair of [patient's name], and the one I'm sitting on is the therapist's chair. This empty chair on the side is the GIV chair. Now, please, sit in the GIV chair, step in the GIV's shoes, and address to [patient's name] your critical sentences. Do it with conviction, and out loud!*

Once the GIV has directed its criticism at the patient's empty chair, the therapist asks the patient to go back to her/his chair and say how the GISs make her/him feel. It is useful to explore the somatic sensation and where in the body it is felt (e.g., patients often, in this phase, report feeling a weight on their chest, shoulders, or neck, or a stomach cramp, etc.) and then compare it with the feelings that will be experienced at the end of the procedure.

After listening to the patient's feelings with attention and empathy, the therapist introduces the HV by saying: *In the fourth chair sits the HV or whatever you prefer to call it. The HV cares about your well-being and is calm, affectionate, empathetic, reasonable, honest, and self-confident, and, if necessary, it can also be strong and decisive with those who treat you unfairly. To remember these characteristics of the HV, keep in mind the CARHOS acronym: calm ... affectionate ... reasonable ... honest ... self-confident.* The CARHOS attitude is particularly important because it not only represents an antagonist of GIV but also a new and healthier psychological modality (in many ways opposite to the GIV), which the patient's internal dialogue can be inspired by. Once the HV is introduced, the therapist, moving into its chair, explains that initially she/he will "play" it, and the patient will play the GIV.

Second step of all DSD sessions (time: 15–20 minutes)

Dramatized Socratic dialogue through modeling and role play

The therapist, in the role of the HV, starts a Socratic "dispute" with the GIV (played by the patient), using almost exclusively questions to bring out the inconsistency, the ineffectiveness, the costs, and, above all, the illegitimacy of the GISs. The four dialectical criteria that guide the disputing: logical-empirical, pragmatic, economic, and moral/deontological. In this phase, the therapist performs a modeling of the HV (keeping in mind to hold a CHAROS attitude, as described in the previous step). The CHAROS attitude represents the exact counterpart of the critical and pathogenic attitude of the GIV.

The Socratic dispute can start in this way: *Hi, GIV. I would like to ask you a question: Why do you address those sentences to [name of the patient]?* The GIV responses can of course vary widely, but they inevitably refer to one or more of the four dialectical domains the therapist expects. Typical responses of the GIV include: *Because that's right!* or *Because he deserves them!* or *Because he should be scolded!* (moral criterion) or *I do it for him; I warn him of dangers!* (pragmatic criterion) or *I give him simple advice to improve himself, and it would cost him nothing to follow me!* (pragmatic and economic criteria) or *because it's the truth, I just tell him how things are!* (logical-empirical criterion of truth).

The HV puts the GIV in crisis by replying to each of its answers with a further question that casts doubt on the logical and empirical consistency and/or the efficacy and/or the efficiency and/or the legitimacy of what has been stated. Examples include: *GIV: What exactly does it mean that this is right? What principle authorizes you to reproach him in this way?* (moral criterion) *How would your sentences help him get what he needs?* (pragmatic criterion) *Your sentences that you call simple advice, what consequences do they cause in this person's life, and over all these years have they made their life better or worse?* (pragmatic

and economic criteria) *What evidence do you have to say with such confidence that this is really the case?* Also, *how would your answer prove with certainty that your sentences are true?* (logical-empirical criterion of truth). The questions are asked and, if necessary, repeated, showing firmness and perplexity towards the answers received up to the so-called *Socratic aporia*, that is, until the GIV is no longer able to respond, or its responses have lost strength and conviction.

Notably, GISs are generally weakly justified with respect to the four criteria (in particular, the moral criterion), for which the GIV is always in the most uncomfortable dialectical position. It is enough that the HV leaves to the GIV the onerous task of demonstrating the logical and empirical consistency, the usefulness, the convenience, and the legitimacy of its sentences to quickly put it in crisis. The task of the HV is therefore not to convince, explain, or answer (it would quickly lose its rhetorically advantageous position) but to raise doubts, to object, to question. Intriguingly, Socratic questioning has the power to overturn the roles of the internal dialogue that OCD patients are accustomed to undergoing in everyday life, as they are in the position of having to continually account to the GIV their thoughts, behaviors, emotions, intentions, and impulses. In a DSD session, it is instead the GIV that has to account to the HV for its exaggerated accusations.

A final note relating to Phase 2 concerns obstructive responses coming from the GIV. In some rare cases it happens that the patients playing the role of the GIV refuse to give honest answers to the questions of the HV, instead limiting themself to dogmatic attitudes or, worse, openly hostile responses, for example with reactions such as: *I don't have to explain anything; that's just the way it is!* or *Because I like to torment him!* or *Because I want to make his life hell!* In these cases, the HV does not give up; it keeps asking for an account of this attitude with questions such as: *Does this seem a reasonable answer to you?* or *Who or what authorizes you to respond in this way?* Or it can interrupt the GIV and return to a dialogue with the patients, first exploring their feelings and then asking them to judge the attitude of the GIV, like: *How do you judge such an attitude?* and *If that attitude was aimed at a person we care about, how would we react?*

If strictly necessary, the HV temporarily abandons the Socratic questioning and openly suggested solutions to the patient, for instance with: *It is evident that the GIV has no valid arguments; it only knows how to threaten and offend; it seems a stupid bully!* or *We are wasting time reasoning with someone who behaves like this, so we will learn to ignore it! What do you think?* Then, it returns to dialoguing with the GIV, clarifying the new conditions, such as: *Listen: If you are willing to give us honest and respectful answers, we'll gladly continue to talk to you. If instead you just keep mistreating and giving dogmatic answers, we will be forced to treat you like a broken record that always plays the same annoying track; we will learn to ignore it! The choice is yours.* In these circumstances of extreme hostility coming from the GIV, the strategy to get out of the impasse is fundamentally based on two points: 1) stressing the importance of the patient-therapist-HV alliance (e.g., *We are three against one, so we are stronger than it!*); and 2) unmasking the GIV, showing how morally unfair and logically inconsistent it is (even with humor, if the patient's sensitivity allows it). In other words, it is important to continue to focus on an ethical criterion to reduce the moral power of the GISs coming from the GIV (e.g., *You are not fair, so we are not required to listen to you!*).

Phase 2 always ends with an assessment of the effect on the patient of the HV-GIV dialogue. The therapists go back to their own chair and ask the patients (after having invited them to sit in their own chair) how they feel and what they think: If the effect is satisfactory, they move on to Phase 3 of the procedure; if the effect is unsatisfactory, they ask the patients what has gone wrong, what they need, and if they have anything to suggest to the HV to correct its intervention. Afterwards, the therapist repeats the intervention, considering the patient's indications until an appreciable positive effect is obtained. Only then do they move on to Phase 3.

It is important to keep in mind that the aim of DSD is not to convince patients with persuasive speeches but to help them become aware of the deleterious effects of GISs and raise doubts about their legitimacy. To achieve this, the therapist will not have to make great dialectical efforts, but simply remain unpersuaded by the GIV, and never tire of asking it to account for its critical statements. Sometimes, showing a perplexed, dissatisfied, and questioning facial expression will be enough. If at the end of the second step the patient begins to show a healthy perplexity about the GIV associated with emotional relief (even a small one), the objective of this phase can be considered achieved.

Third step of all DSD sessions (time: 15–20 minutes)

Sharing of the principles applied in the second step, and reversal of roles

Having obtained the expected effect in the second step (i.e., an appreciable reduction in the discomfort caused by the GISs), the therapist explains the rationale and principles of the Socratic disputing and, after making sure that the patients fully understand, asks them to sit on the HV chair and talk to the GIV, starting with the same question from the second step: *Why do you address those sentences to [patient's name]?* The GIV in the third step is played by the therapist. In other words, a role play is performed as in Phase 2, but with reversed parts. The therapist will have to play the guilt-inducing part in a realistic and credible way, strictly inspired by the GIV previously interpreted by the patient. The therapists will continue this role playing until they feel truly challenged and put into crisis by the patient's questions and interventions: At that point, they will declare they give up and stop the role play. If the patients as the HV encounter difficulties, they can call a time out: The therapists temporarily come out of the role of the GIV to help the patients and give them suggestions. Once the impasse has been overcome, role playing can resume.

At the end of the role playing, the therapist and the patient return to their chairs and to their original roles. The therapists compliment the patients for their performance, normalize any difficulties, ask what they think and feel, and if they are satisfied with how they played the HV role, and, only if strictly necessary, suggest repeating the exercise. When the patients show a certain degree of satisfaction with their performance as the HV and feel that the negative sensations experienced in the first step have vanished or have been reduced, the third step of the procedure can be considered concluded.

Fourth step of all DSD sessions (time: about 10 minutes)

Debriefing

Therapist and patient together summarize the most significant moments of the session and share reflections, doubts, technical difficulties, solutions, and any insights relating to the connection between GISs, life history, guilt sensitivity, and symptoms. Finally, they focus on the rationale of the therapeutic intervention and on how to take full advantage of it. As soon as the patients demonstrate mastery of the procedure, they will be instructed, as a homework assignment, to practice independently whenever guilt-inducing self-talk is activated.

Notes

- The first time the patient and therapist perform DSD, it may happen that a single session is not enough to complete all the steps required. In these cases, the first session will be used to correctly complete the first two steps of the DSD, and in the next session the other two steps will be taken.
- Usually, six to eight sessions are enough for the patient to learn and master the DSD procedure. However, for the HV and the principles of Socratic dialogue to be stably internalized, it will be necessary for the patient to practice regularly between sessions, and to continue even after the end of treatment. When the patient notices that new and healthier self-talk is activated spontaneously in response to typical guilt-inducing thoughts, this means that the process of internalizing the HV is well underway.
- Before concluding the six to eight treatment sessions, a final session is always necessary, entirely dedicated to summarizing the work done thus far and the results obtained, assigning homework, predicting any future difficulties, and sharing strategies to deal with them.
- Once the first six to eight sessions are complete, it is useful to schedule some booster sessions a month apart. In these sessions, the patient's overall condition will be assessed, and the DSD procedure will be replicated. When the patient shows that the progress achieved is stably maintained, the therapist moves on to the booster and follow up sessions at 3 months, 6 months, and finally at 1 year.
- If the patient responds well to the DSD treatment, there should be a significant reduction both in symptoms and the suffering caused by them; but, if necessary, an additional number of ERP sessions can be provided to achieve further improvement of symptoms. Any implementation of the ERP should be easier if accompanied by any new, positive self-talk learned thanks to the DSD.

Conclusions

In this article, a new manualized type of psychological intervention to treat OCD was presented. The intervention was described in detail, called the DSD (dramatized Socratic dialogue). DSD is based on a cognitive model of OCD, according to which obsessions and compulsions are caused by the fear of being deontologically guilty, and by the consequent attempt to prevent this scenario (Mancini, 2018).

As is known, there is already an effective psychotherapeutic treatment for OCD, the ERP technique, which unfortunately leaves several problems unresolved, including: 1) about a third of patients refuse this treatment or do not complete it; 2) among those who complete it, about three out of four continue to show residual symptoms; 3) even when the treatment works, uncertainty remains about the mechanisms that cause the change; and 4) ERP was born in the 1960s (Meyer, 1966), and, in its original form, is fundamentally based on the habituation mechanism (Benito & Walther, 2015), not on therapeutic principles derived from the most recent psychopathological models of OCD. DSD was therefore developed for the following purposes: to provide a 1) manualized cognitive procedure alternative to ERP and standard CBT if the patient refuses them (or interrupts them prematurely) or does not obtain fully satisfactory results; 2) more emotionally tolerable and comfortable treatment for OCD than ERP; and 3) psychological treatment directly derived from a scientifically based psychopathological model of OCD.

In more detail, we believe that DSD might be useful in reducing OC symptomatology and residual symptoms through a long-term mechanism of action. As it targets a proximal determinant of the symptom (that is, it aims to deeply undermine the appraisal that induces and maintains obsessions and compulsions) rather than the symptomatology itself, it could help reduce psychological vulnerability with deeper and more lasting benefits. Furthermore, we contend that it could be better tolerated by patients and lead to low refusal and drop-out rates, as it does not require high and prolonged levels of emotional stress as is the case with ERP implementation. In fact, DSD aims to counteract self-talk that causes anxiety not to achieve habituation through long and stressful sessions of exposure to anxiety-provoking stimuli.

We propose testing the treatment's effectiveness in future empirical studies, considering the emotional impact of guilt-inducing self-talk as an independent variable and symptoms as a dependent variable. In the event of a positive outcome of the DSD treatment, and thus the detection of a low level of guilt apprehension, the treatment's mechanism of action could be demonstrated. During clinical trials, by measuring guilt-inducing self-talk and the severity of symptom, it could be verified whether DSD is able to reduce the former and whether this reduction determines the improvement of the latter.

The main strengths of DSD appear to be: 1) it is a theory-oriented treatment; 2) it is a treatment that therapeutically targets the cognitive structures that determine the pathogenic processes and symptoms, not the symptoms themselves; 3) it is a procedure that allows therapists to plan tailor-made interventions thanks to the initial assessment of the GISs (guilt-inducing sentences, unique and different for each patient); 4) it is a short treatment and easily adaptable to various real-care contexts (including online therapies); 5) it does not require patients to tolerate high and long-lasting levels of emotional distress, and therefore promises to be a more comfortable and tolerable treatment than ERP; and 6) being manualized, it is an intervention that can be easily replicated and used in evidence-based effectiveness trials.

Looking ahead, it will be useful to proceed first with a pilot study on a single case that allows a preliminary analysis of the feasibility and effectiveness of a DSD. Second, the sample could be expanded, and a randomized controlled trial designed. In the event that a DSD proves to be effective in reducing OC symptoms, an analysis of the therapeutic mechanism that determines the change would be crucial: In particular, it would be verified whether, consistently with the OCD model that inspired

the development of DSD, the symptomatic improvement is mediated by a reduction in fear of guilt and therefore by a change in guilt-inducing self-talk. This change should consist of a reduction in the credibility and strength of GISs and, consequently, in less fear and greater acceptance of the risk of guilt. Because of this change, patients should be able to remove the moral importance of intrusive thoughts and "let them go" without resorting to compulsive solutions and avoidance, producing a natural, symptomatic improvement. To investigate this mechanism, it would be necessary to both combine the use of scales to measure the severity of symptoms such as the Y-BOCS (Goodman et al., 1989; Italian version by Hénin, 2012) with questionnaires that evaluate the fear of guilt such as the FOGS (Chiang et al., 2016; Italian version by Cosentino et al., 2020) and build an ad hoc instrument to measure the psychological impact of guilt-inducing self-talk.

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APPENDIX
DRAMATIZED SOCRATIC DIALOGUE IN ACTION

Extract from Session 0 (psychoeducation and investigation of the GISs)

Alex, a nurse by profession, is obsessed with the fear of forgetting his work shifts, making a mistake in some drug therapy, or performing some emergency procedures incorrectly, and he makes endless checks to reassure himself. The therapist (T), after having explained the concept of fear of deontological guilt and its relationship to OCD, inaugurates the phase of investigation of the GISs by asking Alex to describe a recent episode in which he strongly feared that he was guilty of something:

Alex: It happened this morning while I was giving medicines to patients. I checked and double-checked the prescriptions. It was hell.
T: What happened?
Alex: I was afraid of making a mistake in the drug or the doses or the schedule of therapy; I was afraid of causing some trouble. After giving it, I went back to check, read, and reread the medical records to see if I had given the right therapy. I kept thinking about it even when I finished my shift. Every now and then, with an excuse, I called the hospital to see if everything was ok.
T: What were you afraid of, exactly?
Alex: Intoxicating some patients.
T: What would you have told yourself if it really happened?
Alex: Are you joking? It would be a nightmare! I would have thought that I'm the usual bungler! I'm a bad nurse! I am a killer! That this time I had made a big deal, and I would have been fired and sued!
T: If you had stopped checking, how would you have felt, and what would you have thought?
Alex: Impossible to stop.
T: What made it impossible?
Alex: I would feel very strong anxiety. I would feel like an irresponsible person, one who plays with people's lives. Unforgivable!
T: Ok. Let me summarize: a bungler, a bad nurse, a killer, an irresponsible person who plays with people's lives, an unforgivable guy. They sound like severe judgments, like very harsh accusations, don't they?
Alex: Yes, something like that.
T: You see, it seems that there is a part of you, very critical, that constantly reminds you that you can make serious mistakes and addresses to you very harsh sentences that resemble real accusations. This internal voice never misses an opportunity to goad you and scold you; it makes you feel anxious and guilty and leads you to do continuous checks to reassure yourself. This is how OCD symptoms take shape. We will call the automatic critical thoughts coming from this internal voice, guilt-inducing sentences—GISs.
Alex: I understand, but what can I do about it?
T: For now, it is enough to name this inner voice and identify the GISs it tells you. What name would you give it?
Alex: Let me think ... the Daimon ... it was the moral conscience for the ancient Greeks. I want to call it Daimon!
T: Daimon … sounds like a perfect name! From now on it will be Daimon for us.
Alex: Ok.

The session then ends with the sharing of the list of typical GISs. Subsequently, the therapist will explain that the following sessions will serve to learn how to deal with Daimon and its GISs, and that they will do a role-playing exercise for which four chairs will be used. The technique is introduced by pointing out the main purpose of the intervention: to reduce Alex's fear of guilt and increase his ability to face the GISs.

Extract from Session 1 (DSD steps 1–2)

At the beginning of the session, the therapist asks Alex if during the week there were episodes in which Daimon (D) scared him with warnings and accusations. Alex dwells on the episode of the day before, when he was afraid of forgetting the new hospital shifts. The therapist asks the patient to move to D's chair, to face Alex's empty chair, and to tell him all the GISs related to that episode:

Alex as D: Ok … I'll try … "You'll end up missing a shift in the hospital! You're a mess, you know it, too, but this wouldn't be a little mess! You will end up getting your colleagues in trouble, but, above all, yourself because the boss will get very angry, call you incompetent, and fire you! So, be very careful! You are too anxious! You will surely forget one of the new shifts, and there will be trouble. It would be unforgivable!"
T: Ok. Now, please sit back in your chair, Alex.

– The patient sits back in Alex's chair –

T: Alex, how did those sentences make you feel?
Alex: Bad, very bad. I feel I am in danger; I feel anxious and guilty.
T: Where do you feel these negative emotions in your body, and what sensations do you feel exactly?
Alex: Right here on my chest and shoulders ... something like a weight, a burden weighing me down.
T: I understand ... it must be very distressing. Now I want to introduce you to a character very different from Daimon, some kind of healthy voice. It cares a lot about you and is calm, affectionate, empathetic, reasonable, honest, and self-confident, but also strong and firm when it comes to protecting you from someone who treats you unfairly. What name would you like to give it?
Alex: Mmm … Healthy Voice is ok.
T: Healthy Voice (HV), very well! To remember its characteristics, keep this acronym in mind: CARHOS. C stands for calm, A for affectionate and empathetic, R for reasonable, HO for honest, and S for self-confident, ok?
Alex: CARHOS … I'll keep that in mind.
T: Good! Initially I will be playing the role of HV, while you will play the role of Daimon (D), so I ask you to move back to Daimon's chair. I'll move to Healthy Voice's chair.

– The patient sits in the chair of D, and the T sits on that of HV –

T as HV: Hi, Daimon. I would like to ask you a question: Why are you addressing those sentences to Alex?
Alex as D: I do it for him.
T as HV: Can you explain this to me?
Alex as D: I warn him, so he doesn't get into trouble.
T as HV: Why should Alex get in trouble? (logical-empirical criterion)
Alex as D: Because he forgets things.
T as HV: Does it often happen to him that he forgets things? (logical-empirical criterion)
Alex as D: Well, yes … sometimes.
T as HV: So, sometimes? (logical-empirical criterion)
Alex as D: Many times!
T as HV: Ok. How many times has this happened in the last month? (logical-empirical criterion)
Alex as D: A couple. Two weeks ago, he lost his scooter keys, and a month or two ago he left his smartphone in the car.
T as HV: So, in the last couple of months, it has happened a couple of times, an average of once per month, right? (logical-empirical criterion)
Alex as D: Yes, more or less.
T as HV: Here, these two incidents: Could we consider them big trouble? I mean, did they cause serious consequences? (logical-empirical criterion)
Alex as D: Well, he found the keys: They were in his gym locker. And the smartphone was in the car ... so ... no serious consequences.
T as HV: So, Daimon, I would like to ask you: Two small mishaps, not serious, happened in about 2 months, are enough to say that Alex is a bungler, one who forgets things, one who often makes trouble? (logical-empirical criterion)
Alex as D: No, but last year he really forgot a hospital shift!
T as HV: Were there very serious consequences? (logical-empirical criterion)
Alex as D: Well, colleagues called him, and he arrived after half an hour. The colleague who was off the shift covered that small delay, and Alex returned the favor the following week.
T as HV: And how many times has this happened since Alex became a nurse? (logical-empirical criterion)
Alex as D: It was the only one.
T as HV: How many years has Alex been a nurse? (logical-empirical criterion)
Alex as D: Seven years.
T as HV: Ok, Daimon, two small oversights in the last 2 months, and one small delay at work in 7 years … what do they suggest to you? (logical-empirical criterion)
– A few seconds of silence –

Alex as D: Ok, I understand what you mean. Alex doesn't look so terrible. But after all, if you notice, you agree with me.
T as HV: About what?
Alex as D: It is thanks to me and my warnings that Alex just makes "little" mistakes.
T as HV: Are you really sure?
Alex as D: Yes, absolutely.

T as HV: Could you prove it? (logical-empirical criterion)
Alex as D: Yes, of course.
T as HV: Ok, prove it, will you? (logical-empirical criterion)
Alex as D: It is evident! He made only a few mistakes. If I had not goaded him, he would have made many more.
T as HV: Well, this is your opinion, but can we consider it as proof? (logical-empirical criterion)
Alex as D: Mmm … yes … I mean, yes, for me.
T as HV: Right, for you.

– Silence –

T as HV: Listen, Daimon, emotionally what effect do your sentences have on Alex? (pragmatic criterion)
Alex as D: They make him a little anxious, I guess, but that's right.
T as HV: What else?
Alex as D: He seems stressed.
T as HV: Ok, when he is so stressed by your sentences, do you think his mind works better or worse? (pragmatic criterion)
Alex as D: I don't know; you should ask him.
T as HV: Ok, let's forget Alex for a moment. In general, when people are stressed, how does their mind work? (pragmatic criterion)
Alex as D: It works badly, I guess.
T as HV: And when someone's mind malfunctions, does memory improve or deteriorate? (pragmatic criterion)
Alex as D: It gets worse.
T as HV: Ok, and if people's memory worsens, are they more likely or less likely to make mistakes and forget? (pragmatic criterion)
Alex as D: More likely.
T as HV: Ok, Daimon, what does this tell us about the effect of your critical and warning sentences on Alex? (pragmatic criterion)

– A few seconds of silence –

Alex as D: Ok … they confuse him even more, but you see, sometimes my sentences have really helped him. Two days ago, I told him to check a medication dosage, and he noticed an error in the dosage. It was thanks to me.
T as HV: Daimon, really, I believe you, but the point is: at what price!? (economic criterion)
Alex as D: What do you mean?
T as HV: I mean, your critical phrases may sometimes be useful to him, but *sometimes* … and all the other times? For most of the times we have seen that they make him anxious, confused, indecisive, and even more prone to error. And they have a huge negative impact on him: a lot of stress, a lot of wasted time, a lot of sacrifices, and no enjoyment. So, the question is: Are your sentences beneficial? I mean, taking everything into account, in all these years have they made Alex's life better or worse? (economic criterion)
Alex as D: Worse … okay.
T as HV: So?

– A few seconds of silence –

Alex as D: But it's not my fault that he's stressed out! I mean, I am Alex's conscience; this is my role. My job is to remind him that he mustn't be wrong; that's all. He is the one who takes it badly, he is exaggerated, he is too anxious, too insecure. He is the problem, not my sentences.
T as HV: So, someone harasses someone else with accusations and reprimands, the latter is stressed because of these, but it is his fault that he is stressed! Did I get it right? (logical and ethical criteria)
Alex as D: No … yes … that is … I'm not sure.
T as HV: Daimon, the scheme is the following: I torment you with my accusations and you are upset by it, but then I also accuse you because you are upset. It's a bit like saying: First I kill you and then I blame you for being dead. How do we put these two things together? And, above all, how do you morally judge such an attitude? (logical and ethical criteria)
Alex as D: Okay, okay, it doesn't sound very fair ... but Alex needs me. He wouldn't know what to do without me. If I gave up, Alex could lose the right way; his life might become a mess, and he a bad person.
T as HV: This is what you think, but what proves those things are really going to be like this? (logical-empirical criterion)
Alex as D: I do not know, but he must do everything possible not to make mistakes. He must do his best.
T as HV: Daimon, listen: Human beings, even the attentive and responsible ones, do they never do less than the best? Doesn't it happen to them, sometimes, that they are not flawless? Doesn't it happen to them, that they have faults? (ethical criterion)
Alex as D: I guess so, but it shouldn't.
T as HV: Ok, in your opinion it shouldn't happen, but then, in everyday life, does it happen or not? (logical-empirical criterion)
Alex as D: Yes, it does.
T as HV: Does that make them bad people? (ethical criterion)
Alex as D: No … not necessarily.
T as HV: Okay ... and if it happens to Alex? (ethical criterion)

Alex as D: Well … he should make sure *not* to let that happen.
T as HV: He should … but what if it happens?
Alex as D: I don't know … it sounds unacceptable and unforgivable to me.
T as HV: It sounds unacceptable to you, no doubt, but who or what authorizes and justifies such a condemnation? (ethical criterion)
Alex as D: It's my way of seeing things.
T as HV: Your way … no doubt. Is it enough to say that it is also, objectively, and morally, right … fair … balanced … reasonable? (ethical criterion)
Alex as D: I don't know ... I mean … ok, maybe I am too hard on him.
T as HV: I think so, Daimon. I appreciate your honesty.
Alex as D: (Daimon nods without saying anything)
T as HV: Listen, I would like to repeat the question I asked you before. If Alex, like any human being, shows an imperfection every now and then, would he stop being a worthy person and deserve to be condemned without appeal? (ethical criterion)
Alex as D: Well, I have a hard time saying it, but ... no. I think … I mean … he would still be a good guy, overall, the same old Alex (smile).
T as HV: (Smile)

– A few seconds of silence –

T as HV: Would you please go back to Alex's chair? I'll move to mine.

– Alex and the T go back to their chairs –

T: What do you think of the dialogue that just happened between Daimon and Healthy Voice, and how does it make you feel?
Alex: It's a strange feeling. I mean, for me it's a new way of looking at things. It is a bit as if I felt lighter, more relieved.
T: Do you feel this feeling of relief somewhere in the body?
Alex: Here, on my chest, and here, on my shoulders.
T: Good. If you recall the GISs, what effect do they have on you now?
Alex: They keep making me uncomfortable, but less than before. I feel less anxious and stronger. I feel I can give them less importance, and I can let them go.
T: Very good! Is there anything that helped you?
Alex: I felt defended, appreciated, and I saw that Daimon is not so convincing.
T: I think you are right; Daimon tells you very harsh things, but when it has to explain why it talks to you that way, it seems to run out of arguments.
Alex: Just like that.

Extract from Session 1 (steps 3–4)

After the second step, the T (therapist) prepares the role reversal and trains Alex to play the role of Healthy Voice (HV). T reminds Alex of the characteristics of HV (CHAROS) and explains the dialectal principles he (as HV) applied in order to counter D (Daimon). T points out to Alex that D's sentences are typically poorly justified from a logical, empirical, pragmatic, economic, and, above all, ethical point of view, and that therefore it will be sufficient to ask D to account for the evidence, the rational motivations, the usefulness/effectiveness, the convenience/efficiency and the legitimacy of its sentences to let their inconsistency emerge naturally. Having made sure that Alex has understood the elements characterizing the way of proceeding with HV, the T proposes to him to reverse the roles: So, Alex will play HV. He will do it with a certain freedom and according to his own style but keeping in mind the shared principles of the Socratic questioning. D will be played by the T:

Alex as HV: I am a little nervous (smile). Okay, I'll try. Why are you saying those sentences to Alex?
T as D: Why he needs them and why he deserves them.
Alex as HV: What are they for? (pragmatic criterion)
T as D: To avoid mistakes.
Alex as HV: What mistakes?
T as D: Mistakes at work.
Alex as HV: Whenever? Alex is a good nurse and makes few mistakes! (logical-empirical criterion)
T as D: So last year, he forgot his shift. Do you remember that?
Alex as HV: It only happened once; why do you keep bothering about it? (logical-empirical criterion)
T as D: Because that's right! If Alex makes few mistakes, it is thanks to me. Yesterday, for example, I told him to check a dosage, and he realized there was an error. How would it have gone if I hadn't alerted him with my sentences?
Alex as HV: There would have been no mistakes. Alex is very careful; it would not have happened. He is highly appreciated by the patients and doctors of the hospital. (logical-empirical criterion)
T as D: Ok, what if he was wrong?
Alex as HV: What you say makes no sense; he was not wrong.
T as D: Okay, but if he hadn't listened to me, are you sure he wouldn't have made a mistake?
Alex as HV: Ehm, yes … sure.
T as D: How can you be so sure?
Alex as HV: Ehm … well … because he is … he is a good nurse.

T as D: Good nurse … sure.

HV seems to have fallen into D's trap of blaming and demanding perfect explanations. The T notices the impasse and kindly stops the role play to both help Alex understand what is not working and remind him of the principles of the Socratic dialogue to use to effectively counter D:

T: I'm calling a time out! For a few seconds I'll go back to being the therapist. How's it going, Healthy Voice?
Alex as HV: Well, I started out confident, but now, honestly, I'm struggling.
T: What is wrong, in your opinion?
Alex as HV: I don't know. Daimon is so pressing; it asks me questions that make me struggle, and, I mean, maybe it is right.
T: It is *not* right. It is just very adept at blaming and taking control of the dialogue.
Alex as HV: That's it. But what can I do?
T: Two points: first, it is Daimon who must explain to us why he harasses Alex with its guilt-inducing sentences. It is the one who must answer the questions, not you. Second, your main goal is not to prove that Alex will never make mistakes, but that *Alex has the right to make mistakes and be at fault!* Quiet, right? If you free Alex from the burden of proving his "innocence" with certainty, everything will flow more naturally. Therefore, if Daimon becomes pressuring you, do not answer, or give short answers and always reply with another question. For example, "I can't say with certainty that Alex won't make mistakes, so what?" or "You keep repeating that your sentences are useful to Alex, but we don't understand how a single episode can be enough to prove their usefulness. Can you explain it to us?" or "You say that Alex deserves your reproaches, but what unforgivable fault would he have committed to deserve them?"
Alex as HV: Ok, they sound good. I can try.
T: Well, let's get back to role playing. Any doubts or difficulties, we can stop and resume as often as we want. I'll now go back to being Daimon, and you will continue to be Healthy Voice.

– The T returns to D's chair and resumes the dialogue with HV –

T as D: Well, you haven't answered me yet.
Alex as HV: I don't have to answer you. You torment Alex, so you just confuse him.
T as D: On the contrary, I help him. He needs me.
Alex as HV: How do you help him? With your accusations? With your reproaches? (pragmatic criterion)
T as D: Yes, he needs them.
Alex as HV: Can you prove that Alex would make more mistakes without your reproaches? (logical-empirical and pragmatic criteria)
T as D: Sure.
Alex as HV: Well, prove it. I listen to you. Come on! (logical-empirical and pragmatic criteria)
T as D: It's obvious! No need to prove it.
Alex as HV: It's obvious … is that all?
T as D: That's all.
Alex as HV: Your sentences only serve to blame and frighten Alex. (pragmatic and ethical criteria)
T as D: Shouldn't I tell him anything? And what if he is wrong?
Alex as HV: Even assuming that he is wrong ... so what? (ethical criterion)
T as D: Are you telling me he should give a damn and play around with patients' lives?
Alex as HV: You just terrify him and distort the meaning of my words. Of course, he doesn't have to play with the patients' lives. Alex is attentive and is a good nurse. He makes few mistakes, but if he makes a mistake, no condemnation! He is a human being; this is life, and he would continue to be a good nurse and a good person. (ethical criterion)
T as D: Too comfortable like this! You lead him on the wrong path. I will continue to warn him and prod him.
Alex as HV: Go ahead. His therapist and I will tell Alex to ignore your sentences!
T as D: Alex will not be convinced by you. He trusts me.
Alex as HV: Should he trust someone who torments him and complicates his life? (pragmatic-economic and ethical criteria)
T as D: That's not true. Without me, Alex's life would take a turn for the worse!
Alex as HV: The endless checks of the last few years—are those a good turn? (pragmatic and economic criteria)
T as D: They are necessary.
Alex as HV: Necessary for what, to drive him mad? You're just an unfair critic! (pragmatic-economic and ethical criteria)
T as D: Think as you like. I will insist. I will continue to prod Alex.
Alex as HV: We won't let you do it that easily. Alex now knows your tricks and has the right to counter them. (ethical criterion)

Alex overcame the initial difficulties and although he displayed a less Socratic and more aggressive style than that used by the therapist previously, he played the role of Healthy Voice effectively enough to counter Daimon's threats and accusations. The therapist then goes on to explore Alex's feelings and introduces the debriefing phase. During the debriefing, Alex will gain an important insight into his childhood:

T as D: Okay … I give up! Now I go back to the therapist's chair. Would you please move to Alex's chair? In this last phase of the session, we will go back to being simply Alex and his therapist.
Alex: Ok.
T: I'm impressed with the way you played the role of Healthy Voice. Congratulations! What effect did it have on

you?
Alex: Good feelings.
T: Did you find my Daimon realistic and challenging?
Alex: Yes, I did. It was very similar to the real Daimon.
T: Good. How does it make you feel, and what do you think about the way you faced it?
Alex: The fear has not disappeared, neither during the role playing nor now, but it is as if I were stronger, more confident. I felt that I was on the right side and that we were fighting an injustice. It helped what you told me earlier, when you stopped role playing. That is, I didn't have to give too many explanations, and that our goal was not to prove that Alex is never wrong, but to clarify that he has the right to make mistakes. This gave me energy.
T: Yeah, that's a really important point. I sensed your energy, and although I tried to be a determined and persistent Daimon, your straightforward questions and answers really cornered me. When I gave up, I couldn't really argue anymore. Over time, you will be able to improve and master the Socratic method, but considering it was the first time you tried it, you were very effective!
Alex: You know, at a certain point it was as if I had unmasked the impostor, as if I had discovered his tricks and knew how to defend myself. He has always said the same things, for a lifetime: "You are wrong" … "You have to be more careful" ... "It will be only your fault" … blah, blah, blah. The only regret is not having seen it so clearly before. It won't be easy; his words still scare me a lot, but I feel that something has changed.
T: I believe so, too.
Alex: You know, while we were doing the first and second role playing, the relationship with my mother and my primary school teachers came to mind. I was a hyperactive child; I was never still; I was clumsy; I unwittingly broke a lot of things. I grew up like that, feeling like an elephant in a glassware shop, always with the feeling of shattering something, with their reproaches in my ears. It was so … it was normal. Their reproaches stressed me out, but they were, somehow, right.
T: Has anyone ever really understood what was going through your mind? And has anyone ever tried to help you kindly and effectively with your hyperactivity?
Alex: I don't think so. The message was that … I don't know how to say it, that it was a matter of politeness: Well-behaved children know how to stay calm; they are careful and do not get into trouble. I wasn't that kind of kid, but I tried. I don't think I've ever really succeeded.
T: Was it your fault?
Alex: I thought so. I still think so today. Even in this moment, at least a little. Don't you think that they were right, after all?
T: Alex, honestly, I believe that it's very easy to scold a child; I also believe that it is useless. Not only that, I think it complicates things, just like Daimon's critical sentences: What are they for, really? Where do they lead? Criticizing is very easy; much more difficult is it to understand why a child is restless, what he thinks, what he feels, and to kindly help him to cope with his difficulties. So, no, I don't think they were right at all. I don't judge anyone. It's not easy for anyone to be a good parent or teacher, but they were wrong, not you.
Alex: It's strange, you know.
T: What?
Alex: I have a hard time believing it, but it's a good feeling to hear that.
T: What kind of feeling are you getting?
Alex: Relief … a kind of lightness. Will it last?
T: I think so. The path won't be easy, but we're on the right track. We are very close to the heart of your problem … and its solution.
Alex: I really hope so.