PARADOXICAL AND DIRECT APPROACHES IN FAMILY THERAPY*

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Six weeks ago I was asked to consult about a treatment problem in which numerous approaches had been tried, but an impasse had developed and continued. The presenting problem focused on a 20-year-old young woman, Bonnie, who had been seriously depressed and hospitalized after a suicidal attempt. She had a deep inertia and belief that she was a colossal failure and could never get going with her life. She had been treated with antidepressant medication and with supportive individual psychotherapy, to no avail. After hospitalization, she was enrolled in a day treatment program to help her in a directive fashion to organize her activities and proceed with a more effective way of life. However, she retreated to her bed at home and was not able to get up until 2 p.m., when it was too late for the day treatment program. At the same time, she was becoming panicky about the urgent need to change quickly and to "grow up and leave home." A family therapist was called in who met with the family in an effort to help the parents and siblings in a series of structured tasks that might assist the patient to get going. After several months, there had been no progress whatsoever. Family, patient, and therapist felt the situation was untenable, with seething tensions about what to do. The question of long-term hospitalization in a state institution was considered, an issue about which I was now asked to consult by the therapist. During this meeting, a number of severe phobic symptoms and questionably delusional ways of thinking were mentioned as problems, but the most affect-charged problem experienced by the family members was the patient's inability to get out of bed until early afternoon, despite her own professed wishes to do so, as well as those of the family, and for her to get started with "adult life." All programs seemed to have collapsed because this major problem could not be solved. I was impressed with the solicitousness and concern of both parents and the strong wish of the young woman to be more like them. Both parents, in their fifties, were holding down full-time jobs, plus taking "full time" college courses to upgrade their work skills to enable them to move up to higher-level jobs. On further inquiry, I learned that there was another side to their aspirations. The father was hoping to finish his education quickly so that he could be on a new job for a couple of years before

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he would be eligible for retirement at age 55, when he planned to stay home and sleep all day. The wife described how she had been raising children until she was 35 and had been forced to sit around, as she saw it, looking after the children in an idle way for at least 15 years, before she was able to proceed with her work life. The parents were working so intensively and saw so little of each other that their marriage was in difficulties and they were thinking about the possibility of a divorce, a notion that was very much on their daughter's mind, although they assumed that she did not know about this intent or possibility.

Without elaborating here on further details of the total family picture, I approvingly noted their shared concern about how to help the daughter cope, but added that since so many treatment efforts had been tried and failed, I could not be optimistic that anything I might propose would work. I assured them that I would think seriously about it and discuss it with the primary therapist, and that we would make whatever suggestions we could in a letter to follow. Based upon principles that I shall develop shortly here, we wrote the following letter to the family.

"We have been talking over our observations and thoughts about our meeting. We are impressed with how much you, Bonnie, are helping your parents in their problems with one another at this difficult time in their lives. However, Bonnie, you are trying to change too fast. In this situation, changes that are too quick or too drastic can be upsetting for everybody. In order to make sure this does not happen, we recommend that you, the parents, make sure Bonnie stays in bed until 3 p.m. every weekday except Wednesday. On each of these four in-bed days, you, Bonnie, should tell each of your parents as soon as they come home exactly what time you got up. It is important that all three of you talk to each other each of these four days about Bonnie's staying in bed, and you, the parents, help her not to change from this plan for the time being.

We are not sure yet whether or not you will need family therapy because you already have many strengths and resources as a family to help one another. Our next appointment will be on..." [stipulated date a month later].

When the family returned, they expressed puzzlement and perplexity about the letter and about why we had recommended this approach, but they had, nevertheless, gone ahead with it as best they could, cooperating to keep Bonnie in bed longer than her customary 2 p.m. arising time. But they soon became bored with the whole question of whether or not she was in bed; it had become a non-issue. The parents started talking about other aspects of their lives with each other, and Bonnie, surreptitiously at first, started getting up at 9:30 a.m. to

go jogging, to resume contacts with friends, and to look for a job. In this second session, I expressed dismay at their inability to hold things steady and the same, but I conceded ruefully that they seemed to be having fun working things out without our help.

This vignette of a case still early in progress illustrates a distinction between traditional, straightforward, direct methods of therapeutic intervention and what has been called in recent years "paradoxical intervention." The straightforward, direct method involves symptom relief through pharmacologic intervention, supportive psychotherapy with both individual and family, and various measures to assist the patient to plan and organize life more effectively. With the selective information that I have provided, it is not difficult to see that this patient and her parents, like a number of us in busy, active, working-lives, could easily be caught up in an internally contradictory family value system of achievement and continual activity that is at sharp odds with the wish to rest and relax, and to be inactive.

At this phase of the family's life, Bonnie was the only one who was eagerly manifesting the latter aspect of the family wishes, at the same time that her illness was tenuously uniting ("helping") the parents to stay together. There had been a major tugging and pulling between the patient and her parents, as well as between the patient and various therapists about her inactivity, but both straight directives and therapeutic interpretation that provided presumed insight had been equally ineffective. Because the problem actively involved the family as a unit beyond the presenting patient, a systemic approach seemed to me to be indicated and called for the active participation of all the family members. By bringing out one aspect of the goals of the family and supporting this in a consistent and positive fashion, the inconsistencies and contradictions within the family system, ordinarily kept dissociated in different compartments, could be brought together: that is, a simultaneous antithesis or contradiction could be created. With my paradoxical intervention, her sluggish inertia could no longer be experienced as alien to the family and instead became something integral to the family, to be supported, valued, and regarded as good for the family as a whole. I might add that the dynamic impact of this intervention would, in my experience, be undermined by spelling out the rationale of the intervention for the family; they then would very likely compartmentalize and re-intellectualize their experience. With this family, such interpretations, indeed, had been tried and had failed.

The simultaneity of the opposing wishes and values in each family member brought out fresh ideas and a new zest for which they were now quite appropriately taking credit.

Before describing more about paradoxical principles in a family systems approach, I shall describe a second, somewhat more complicated case example. This family consisted of two parents, both age 34, and a daughter age 13, who were deeply enmeshed in turmoil with one another, with almost no external sources of support. This latter point is noteworthy because a family systems approach must first establish and identify a family boundary. The identified patient in this family was the wife who had symptoms of anorexia nervosa, with bulimia, plus a so-called borderline syndrome. She had a long history of quite bizarre behavior, with odd if not delusional ways of reasoning about her behavior, using complex, circumstantial language. Her husband and daughter had "adjusted" their own behavior in a manner that was, as I shall describe, remarkably complementary to hers (and conversely).

At the time of referral to me, the husband told me that he was "wearing out," that the daughter was tense, irritable, and becoming like her mother, and that his wife, according to the most recent medical report, would die if she did not receive intensive treatment. She was, in fact, a woman of five feet, seven inches in height, but weighing 65 pounds. Her normal weight was 135 pounds. For thirteen years she had gorged massively three times a day to induce vomiting. She had been amenorrheic for twelve years. A metabolic and nutritional consultant who examined her a little later told me that he regarded her stabilized state as incredible, because any slight metabolic deviation would have produced renal insufficiency, complicating her severe calcium and potassium deficiency. She had lost all her teeth because of her metabolic imbalance, and had been hospitalized a year before in a state of extreme cachexia. Medical treatment, working at the level of the biologic system, with psychoactive drugs and other means, had enabled her to survive, but it had not enabled her to recover.

In response to the referral request, I had planned an initial family consultation, with the understanding that she might be admitted to a behavioral therapy unit, where a life-saving effort with intensive medical treatment could be made if necessary. However, her medical status was stable, though obviously serious. When I asked why they were coming for treatment, the vomiting and weight loss were not mentioned. What she said instead about the "presenting

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problem" was: "There's a problem of retaliation." Before describing anything about the current symptoms, both husband and wife went on to describe the conflict that she had had with her mother, and which he said that he had "inherited." As the story unfolded, what became most apparent was that each member of the family experienced the vomiting as an extremely hostile, aggressive, upsetting act, in which she was "throwing money down the toilet." She described the enormous amount of food that she consumed and vomited as being "wasted." Her husband instantly pointed out that her father too had been concerned about saving money, indeed he had been a banker. She felt extremely guilty about the "hurtfulness" that this "waste" imposed upon her husband and daughter, but cyclically, after a few hours of remorse and reduced tension, she would settle back into renewed build-up of tension and anger, followed by gorging and vomiting, ad nauseam. The husband expressed admiration for the "determination" with which she continued this "program" for years, and he went on to describe how it was "necessary" for him to buy the food. He was, however, frustrated about how to supervise the vomiting in the bathroom. The 13-year-old daughter, in turn, "mothered" him in his distress. They described how their lives were consumed by this cycle, including time not only for obtaining the food, but also for cleaning up the kitchen and the bathroom where she would seclude herself. Literally, no "ordinary" relationships in the home with one another or with friends had taken place for years. In addition to pharmacologic and medical treatment, she had been in psychoanalytically-oriented psychotherapy for three or four years, during which the pattern had stabilized, but with no fundamental change.

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At a point in the consultation when I felt able to identify the cyclical impasse of the family system, I decided to introduce a paradoxical family intervention. Such an intervention initially minimizes change, and insists upon homeostasis and stability; sometimes this may involve "prescribing the symptom." But one does have a choice of "symptoms." I joined with them in identifying the focal problem as the waste of food and asked them to document for me specifically the scope of the waste. I wrote down a list of the food that they described her as having consumed the previous day. For example, for lunch alone, she had gorged on seven pieces of chicken, two and a half quarts of mashed potatoes, a full apple pie, and a quart of ice cream, all of which had been

vomited about twenty minutes after eating. Some thirty dollars worth of food had been wasted in this gorging and vomiting on the preceding day, by precise calculations for each item.

I began my more specific intervention by commenting that this was truly a long-standing and serious problem, but changing such a problem too quickly could lead to other, even more serious difficulties. Therefore, I recommended that we begin with only minor changes, but emphasized the importance of following these changes in detail. I expressed a confidence that their ability to "stick-to-it" and to help each other would serve them well. They quickly both stated that they were desperate and certainly would follow my proposals. I told them: "This major problem of wasting so much food must not be changed. I want you to continue to prepare the food every day, in the same quantities as you've been doing." I explained that together they should make out a list of foods and their cost, just as we had done for the preceding day, and to continue to buy and prepare the same quantities as in the past. I then added that I recommended"only one little change for the time being," namely: after the food had been prepared on the table, they should take it directly and put it into the toilet. They should skip the step of having her put it in her mouth and stomach before it went into the toilet. Amazingly, neither she nor her husband regarded this suggestion as very drastic or surprising. Instead, they had a series of objections about details, such as that the amount of food that she had prepared would clog the toilet if they put it in all at once. We therefore worked out a plan in which the food would be cut up into small pieces at the table so that it could flush down easily. The husband remained uneasy about the whole plan because he felt that there still was going to be a great deal of food wasted. I said, "I'm sorry about that. We have to stick with the problem for the time being. Later on we'll see if some change can be possible. But it would be dangerous to change too much right now, and we need to continue with wasting the same amount of food for the time being."

It should be noted that a crucial part of the plan was that the husband, who had been deeply concerned about the wife's gorging and eating but had been excluded as she went into the bathroom with her complex rituals of inducing vomiting and then making a great mess and cleaning it all up, now was to be more directly involved in supervising the whole process and collaborating with her instead of

being both solicitous and angry in the other room. Finally, I noted, rather casually, that this plan applied to the three times a day in which she ordinarily gorged and vomited, namely at lunch, dinner, and late evening, but that at other times when there was not going to be gorging and vomiting, a "session" as she called it, then she could take into her mouth and swallow a small amount of food of her choice. At that point I terminated the session and asked them to return in ten days. From that point on, in over a year, this lady who had previously vomited three times a day for 13 years has not vomited at all.

An important feature of the pattern that had been taking place over the years was the dynamic interaction between the husband and wife. Having grown up in a family with a mother who was verbally very critical of the physical appearance of the woman, and was highly rejecting of any physical touching or contact, she had entered into the marriage with the idea that her husband was seemingly a rather soft, gentle man. When he had been away on extended job assignments, she had become pregnant (13 years earlier) and her vomiting had begun as part of the nausea and vomiting of pregnancy. With his being away and her feeling not only lonely but unattractive, she felt rejected as she had been by her mother and, in turn, felt "retaliative." Quite explicitly, the pattern of gorging and vomiting was a manifestation of her anger, but when the gorging and vomiting actually was taking place, the husband would become distressed and solicitous about it until the episode was over, at which point her tension would be reduced and then he would become quiet and seem to her more withdrawn and unavailable. In turn, then her sense of again feeling lonely and rejected would build up and lead to another bout of orgiastic gorging and vomiting. Because she would become so frantic and upset if there was not food available on which to gorge, he would then go out and buy huge quantities of food for her, which she described as his method of keeping the marriage "normal." They both described him as being a "nice guy" and as being very "accommodating" while she was in the kitchen and bathroom.

On the day before the second interview, this sequence had included his watching football on the television all afternoon and evening and refusing to talk with her. She had not been occupied in the bathroom but was trying to interest him. She felt lonely and rejected, followed by a great surge of motivation to gorge

herself. She also was aware that she felt physically chilled, and it occurred to her that if she did gorge herself, the food and vomiting then would make her feel "warm." But when she told her husband she wanted to gorge, he said, no, down the toilet. It was then that she had a creative "solution." Instead of gorging herself, she went and cuddled up on her husband's lap and became warm in a new way. The husband, who had been hoping for such physical advances from her for years, now was nonplussed. He discovered, to his dismay, that he did not know how to respond to her. At this point we could move on to a new stage of therapy; the structure of the family system had changed.

The wife said that this event had been the most "dynamic experience," the most "eye-opening experience" she ever had had in her life, and that the effect was in sharp contrast to her lack of "real understanding" from the interpretations made to her in past psychotherapy. She regularly had set aside her "insights" about such interpretations and they never really had affected her behavior. When she saw all that food going down the toilet, food that she had deliberately placed there and had not "involuntarily" vomited, she "realized" for the first time the implications of what she had been doing; I did not need to elaborate any interpretations.

Toward the end of the second meeting, I warned them that change was taking place too fast, that they were getting out of "balance" (equilibrium) too quickly, and that such rapid change might be dangerous. Therefore, I insisted that the gorging and vomiting be re-introduced at least twice, but now at a designated time, Tuesday evening and Friday evening, with deliberation and planning (and, therefore, now fully within her ego control). She became frantic with alarm at losing her newly gained control, but he now cuddled and supported her, at least while this difficulty was being met. Those two planned but highly stressful instances of vomiting were the last that have occurred in the subsequent months.

The family homeostatic system thus moved to a new kind of problem, to a relational one that would deal directly with the problems of warmth, distance, closeness and rejection in the family system--problems which also now involved the daughter in a crucial way. With respect to the vomiting-gorging-wasting problem, we shifted to a nonparadoxical behavioral approach suggested by my cotherapist, Dr. Ronald Kokes, in the third session: she could cease "wasting" food down the toilet, so long as there was no gorging or vomiting. If she were to vomit even once, then she would have to resume preparing the large quantities of food and dispose of it down the toilet for two full days. Actually, this never occurred, and she gradually but steadily gained weight, over 20 pounds in a few months. Meanwhile, the whole family has transformed its way of living and relating--but that is a story for another occasion.

This case illustrates a long-standing, cyclical impasse in which paradoxical systems-oriented intervention was used, but not (I must strongly state) with the random stimulation of oppositionalism or negativism. Instead, it was used with an understanding-in-depth of this family's dynamics, of their family boundaries, and of the possibility of containing the problem within a new family treatment system.

Finally, this approach involves a very valuable way of thinking about psychotherapy that deeply impressed me as carried out by the Selvini-Palazzoli team in Milan. Paradoxical intervention is best used in the form of an explicit hypothesis-testing approach to treatment. Unlike most therapists, Selvini and her colleagues formulate and actually write down what their hypothesis explicitly is and what the intervention is expected to produce.[7] Then they observe and describe the changes that follow and whether or not their predictions are supported and their hypothesis is correct. In accord with Popperian philosophy, they note, and I would agree, that one learns as much or more from the failures as from the successes. Failures narrow the options and alternatives about what is possible. This, then, is a focal,

problem-oriented approach to therapy and not a random, scattered attention to all possible difficulties that might be mentioned by family members or inferred by the therapist. In the simple example I have described, there were a number of pro lems on which one might have focused. By focusing on minimal change rather than on maximal change, the system's deviance-amplifying characteristics, within defined boundaries, were utilized. The further change, and the maintenance of change, then were initiated from within the family, and from within the individual family members.

Family therapy may be either paradoxical or direct and nonparadoxical. My own preference is to use nonparadoxical methods first whenever they seem likely to work for a suitable treatment goal; but certain problems, usually characterized by a repetitive treatment failure or impasse, yield remarkably well to a thorough and consistent application of paradoxical principles in the context of a therapeutic system with a sustained and identifiable boundary.

When paradoxical interventions are used with families, a systemic transformation is sought, just as in psychoanalysis, but the primary "system" is the family, not the individual personality. In addition, the direction of paradoxical intervention in psychoanalysis and in family therapy usually is the opposite: while analysis usually begins by amplifying "deviance," by disrupting homeostasis, family therapy usually begins by stabilizing, ritualistically if necessary, the family homeostasis.

This approach, in which homeostasis is positively connoted[7] and supported by the therapist, may seem strange indeed. Traditionally, family therapists have regarded family homeostasis as the supreme problem presented by families as systems. The immediate and most obvious objection to support homeostasis is, of course, the fear that the symptoms simply will be perpetuated and that not only the individual patient's difficulties but also the family's presumably disordered way of functioning would be even more enduring. What is the likelihood that change will emerge in family systems that for so many years have been described as highly pathogenic?

First of all, I must stress the fundamental principle that in any enduring system there is a dynamic equilibrium between tendencies toward change and toward a "steady state" between "deviance" amplification of change and "deviance" reduction of homeostasis. The concept of an open system maintained in a steady state implies that input, outgo, and growth--the "natural" forces of deviance are more or less balanced by counteractive forces. When Walter Cannon dubbed these self-regulating or self-equilibrating properties of the biologic systems with the term homeostasis he also suggested that the concept might apply to social organizations. However, he especially emphasized and was impressed by the stability side of the equation in biologic systems. For example, thermo-regulation of warm-blooded animals, despite rapid external temperature changes, is a truly impressive example of finely-tuned feedback. However, in other biologic functions such as heart-rate regulation, it is important that deviations swing with much wider amplitude, with the baseline itself also changing, but more gradually, with physical conditioning.

In my view, those who have applied systems theory to psychological and social systems have vastly overemphasized the power of homeostatic tendencies and often have overlooked altogether the equally crucial and inevitable change-producing, deviance-amplifying aspects of living systems. Change does not need to be pushed or forced; it occurs "naturally from within." Nevertheless, psychotherapists, including family therapists, often write and act as if only through their heroic input will change ever be induced in "resistant," "stabilized" patients and families, most of all in schizophrenics and their families.

Most present-day treatment of schizophrenics emphasizes direct pharmacologic and behavioral supports and is, in fact, preoccupied with maintaining the "equilibrium" of the schizophrenic, not in structural or system growth or other change of either patient or family. The schizophrenic has been regarded as in a highly tenuous and vulnerable state, subject to decompensation either from overstimulation

or understimulation. Overstimulation has been regarded as producing deviance amplification, with fragmentation and disorganization of the individual's personality system. Understimulation has been viewed as leading to the so-called negative (deficit) symptoms of social withdrawal, inertia, flatness of affect, and a chronic residual state, which could be regarded, from a systems standpoint, as the endpoint of excessive deviance counteracting forces.

From the therapeutic standpoint, these approaches exemplify concern with the principle of equilibrium. Wing,[8] for example, has described therapy with schizophrenics much as if one were helping the patient walk a tightrope from which he is likely to fall to one side or the other. The implication is that the patient has such an extraordinary vulnerability, a permanent handicap, that the therapist is foolhardy, if not irresponsible, who allows or encourages amplification of any of the problems. Understandably, a reduced range and quality of functioning often results with this type of therapy. Whether such extreme caution is necessary depends upon one's concept of the degree of vulnerability of schizophrenics. Such therapy is explicitly nonparadoxical but maintains a homeostatic equilibrium by avoiding change. On the other hand, the possibility of significant systemic growth of new potentialities is sacrificed. These methods are direct and "safe," unlike, some would feel, the direct interpretive stirring of change.

By comparison, paradoxical therapy with family systems begins with deliberate, focused support of the stabilized side of the family equilibrium and thus is "safe," even excessively cautious, from the family's viewpoint. Dynamically freed from pressure to change, the family then characteristically initiates change, at a pace akin to growth, quietly and syntonically.

The idea of not only tolerating but positively connoting even serious difficulties, as in the families of schizophrenics, is in accord with my view that these families have assets and resources for contributing to therapy that have been very

inadequately recognized. Applied to the family unit, this viewpoint is similar to that expressed by Searles[9] who has eloquently described the positive, reciprocal aspects of the relationship between the schizophrenic and his much-maligned mother.

Additionally, the use of paradoxical interventions with families eliminates the confrontational tone which has been justly criticized as characterizing some forms of family therapy. Blaming and suggesting that things should be done differently--certainly a form of implicit blaming--is avoided with the paradoxical emphasis upon support of the way things are.

Once the battle for structure, to use Whitaker's term,[10] has been won by the therapist, and his leadership for the family treatment system has been established, then the therapist can prescribe that certain "small" aspects of family functioning should be carefully maintained, in a self-conscious manner, often with special sequences, timing, and ritualization. But because family patterns "normally" are maintained out of awareness, such prescriptions for deliberate stabilization of any detail put in motion, inexorably, processes of change that will reverberate throughout the family system.

As Selvini-Palazzoli and her colleagues have emphasized,[7] the participation of all family members in the paradoxically prescribed pattern powerfully magnifies the process of change. But, because the therapist has been supporting and confirming the main patterns that the family members themselves have regarded as fixed and usually as necessary, the family's tendency to extrude, oppose, or question ideas of change, this outsider is undercut. After the therapist has become the family's staunch ally, he expresses even more concern than they about the problems and dangers of change. When change does begin, often with dramatic speed, it is initiated and supported by the family members themselves, and not pushed or forced by the therapist. At that point, the therapist and family alike need to reconsider

the need for therapy. Often, this is a timely moment to interrupt, at least to pause. Sometimes a new phase of therapy then begins. The therapist needs to recognize that a new and unfamiliar problem is likely to have surfaced. New hypotheses about the balance maintaining the problem will be required. And a new opportunity and challenge for therapeutic skill, ingenuity, and creativity will be at hand.