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## Paradox as a family ingredient

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## Paradox as a family ingredient

### Abstract

Several problems are evident when examining the use of paradox in family therapy. Experts in the field vary on the definition of paradox; how to label and categorize paradox; when to use or not use paradox; and the very nature of paradox as a therapy ingredient. Many experts express the opinion that paradox is part of the essence of life and relationships, particularly the therapist/client relationship. In this paper it will be assumed the reader has a knowledge of family therapy and a frame of reference or theory base from which they operate. How paradox can be defined; the nature of therapy as a paradoxical situation; and "types" of paradox will be explored. Case examples will be used to exemplify pertinent points. It will help to first look at the complexity of defining paradox before discussing how paradox can be categorized.

PARADOX AS A  
FAMILY THERAPY INGREDIENT

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## Paradox As A

### Family Therapy Ingredient

Several problems are evident when examining the use of paradox in family therapy. Experts in the field vary on the definition of paradox; how to label and categorize paradox; when to use or not use paradox; and the very nature of paradox as a therapy ingredient. Many experts express the opinion that paradox is part of the essence of life and relationships, particularly the therapist/client relationship.

In this paper it will be assumed the reader has a knowledge of family therapy and a frame of reference or theory base from which they operate. How paradox can be defined; the nature of therapy as a paradoxical situation; and "types" of paradox will be explored. Case examples will be used to exemplify pertinent points. It will help to first look at the complexity of defining paradox before discussing how paradox can be categorized.

#### Defining Paradox

The author is not the first to mention the controversy and confusion regarding paradox. Hartmen & Laird (1983) also mentioned the debate over the definition and uses of paradox. Dell (1981) discussed different theories and explanations of how paradox is defined and used. He expressed concern that any new or unconventional, unorthodox, methods may be called paradoxical just because they are "different". West & Zarski (1983) said

paradox as used in systemic family therapy is a procedure. Tom (1984a) said paradox as developed by the Milan group is a "pattern of clinical practice" (p. 113), and a new type of therapy. Paradoxical intention was called dereflection, "focusing on the opposite thing," by Frankl (1975). He also called paradox a process. Schwartz (1982) said paradox is a class of therapeutic strategies. Greenburg (1973) called paradox a tool.

To further compound the problem of definition, therapists do not seem to be able to say, for example, if reframing is a type of paradox, or if paradox is a type of reframing. Webb-Woodard & Woodard (1982) called an intervention reframing, when they labeled a blind handicap as competence. In her article, Papp (1980) talked about direct versus paradoxical (indirect), types of interventions. Fay (1976) said paradox is one part of a general multimodal technique or procedure. In a more general way, therapists have also defined paradox.

Hare-Mustin (1976) defined paradox: "A paradox is any seemingly self-contradictory or absurd event which in reality expresses a possible truth" (p. 128). Raskin & Klien (1976) pointed out that Haley's view was that the therapist "wins" by losing when paradox is used. Mazza (1984) said the use of paradox is a way of thinking rather than a method. Fay (1976) explained the problem: "Paradoxical methods cut across theoretical orientations and diagnostic boundaries" (p. 118). The idea of

using paradox yet calling it something else was exposed by Fraser (1984). He further felt some therapists do not even perceive what they do as paradoxical.

The author proposes that one way to understand or define paradox is by viewing it as an "ingredient" in much the same way various edibles are ingredients in recipes and foodstuffs. Paradox may be an ingredient served up as the base, flour in pasta; as an enhancer, salt, pepper, cinnamon; as a necessity, leavening agent in some breads; or as a fun additive, raisen eyes on a ginger bread cookie. Thus the personal view of the chef (culture, the characteristics of the consumer/patron, or how Mom fixed it), may affect whether the chef uses an ingredient, what it is called, how much is used, and whether or not the "eater" likes it. As with culinary matters, some cooks abhor certain spices like curry, others may create many dishes based on curry flavor. Before discussing problmes encountered in delineating types of paradox, some comments on the nature of the client/therapist relationship and resistance is needed.

#### Paradox in the Therapeutic Relationship

The belief that paradox exists naturally as part of the therapist/client relationship needs to be explored before the types of paradoxical ingredients can be illustrated. Haley (1963) said therapy is a mix of play and seriousness; and that the client is supposed to go to a therapist and be spontaneous, real, and

expressive about his/her problem, yet the therapist is supposed to be detached and uninvolved personally, but interested and sincere. Another paradox he pointed out was that the "inadequate" client is the poor unblamed victim. Yet blame is inferred or the client would not seek help. He expressed further that people seek help when they cannot solve their own problem, yet in therapy the goal is to get the client to solve their own problem.

Tom (1984a) further described the therapist role as being one of observer, yet participant. Similar paradox that exist in life would include relationships like the student asking the teacher for help, yet wanting to learn on his own; the child wanting limits set by parents, yet rebelling; and the patient asking for help from the expert therapist, yet holding steadfast to a symptom in an almost prideful way with their "unsolvable problem" (Greenburg, 1973).

Greenburg (1973) also said clients are basically resistive and try to control or prevent the therapist from helping while at the same time the client insists they cannot control themselves or their problem. L'Abate & Farr (1981) said families may want change, yet work to keep the family system homeostasis. This idea is also expressed about the Milan group by Tom (1984a). The root of this idea comes from the double-bind theory, familiar in family therapy. Haly (1963) and the Milan people identified resistance particularly when the family presents with one problem person.

Any indication the family should do something different infers to them they are to blame or that something is wrong with the family.

Tom (1984a) discussed at length the paradoxical emphasis in the Milan group mode of treatment. The Milan group, he said, based the use of paradox on a more Eastern as opposed to Western way of thinking, circular, rather than linear. Linear thinking, tied in to cause and effect, connotes "blame", whereas with circular thinking, problems are part of a system.

The more opposite the therapist's intervention is to the family's belief system or perception, the more resistive the family will be to the intervention (Stanton, 1984). Tom (1984a) stated: "The therapist's assumption that "things must change" may in its enactment have the effect of keeping things the same" (p. 124). He further stated that the more therapists try to change family beliefs, the more families may try to change the therapist's beliefs, particularly if approached directly.

The leaders seemed to agree that many resistive symptoms in families and family members could be dealt with only by being or using the unexpected in adapting to the client (Hare-Mustin, 1976). Some therapists seem to have the opinion that seemingly common sense and rational cures and interventions do not always work and can even perpetuate problems when a family is stuck in a pattern, or when a symptom or client is unyielding to direct interventions. They then advocated doing irrational or absurd interventions to

cause change (Held & Heller, 1982). If one approaches what the patient is most reluctant to abandon as the key to the dilemma, a paradoxical view of the therapy is usually held (Mazza, 1984). In addition to those already mentioned in this section, Napier and Whitacker (1978), Rappoport (1967), and Rosenbaum (1982) have contributed to the notion that paradox is a valid part of the therapeutic relationship that can be used to advantage in treatment. This view of the therapeutic relationship will be clearer as the types of paradox ingredients are explained and case examples used.

#### Types of Paradox

It is not always clear if therapists are discussing "types" of paradox or mode of delivery. By the very nature of paradox, there is some overlapping of ingredient and method. This is similar to thinking of "minced" pie and mincing something up into small peices. Mozdzierz, Machitelli, & Lisiecki (1976) listed 12 types of paradox; Bogdan (1982) referring to the Milan group, listed 4; Fisher, Anderson, & Jones (1981) 3; L'Abate & Farr (1981) also referring to the Milan group, mentioned 6; Raskin & Klien (1976) 3 types; and Tom (1984a) grouped interventions into 2 types. For purposes of clarity and simplicity, the author attempted to divide paradox into four general categories similar to the way the basic food groups are depicted.

Paradox ingredients are thus explained: (1) therapist's reaction as different, unexpected, absurd, exaggerated; (2)

therapist taking "one down" position of confusion, weakness, or defeat; (3) keeping the problem or using the problem as the solution; and (4) reframing, redefining, or relabeling the symptom or problem. Viewed as ingredients, they can be used alone, or mixed together in a variety of ways, as the case examples will show.

#### Therapist Reaction as Paradox Ingredient

The idea that resistance is part of the natural therapeutic relationship needs to be kept in mind, along with ideas about the therapist's versus the family's perception. As with vitamins and minerals, this ingredient is frequently part of other ingredients that will be further explained. The very nature of the paradoxical and resistive client/therapist relationship may be used to advantage if the therapist reacts in a different, creative, some call it, paradoxical manner. Hare-Mustin (1975) said the therapist's matter of factness reduces anxiety, particularly if the therapist reacts to a "horrible" or bizarre symptom as if it is no different than other behaviours. The Milan group (Tom, 1984a) called this the "position of neutrality". Fay (1976) said introducing distortion into a rigid system can help the system to reform along more adaptive lines. She further explained that if someone's own irrationality is mirrored back to them, perhaps with benevolent mimicry, the client may react by rebelling against the irrationality of the imitator.

Mozdzierz et al. (1976) felt the therapist's reacting with perhaps a "twinkle in the eye" in a different way, may give the client a new perspective of their problem. The role of absurdity, humor with empathy, exaggeration, and using the metaphorical symbolic language of the client family are suggested by many well known family therapists, and fit in this category of ingredient.

The above ideas about paradox can be shown by case examples: Greenburg (1973) discussed a married father with children who had a profession in management and suffered headaches, tension, and dizziness. He was angry over being told repeatedly he was alright, as he saw himself as a failure. The therapist suggested he give in to being a failure and work hard at becoming a "happy" failure. Reacting to a suicidal person by suggesting it is surprising they are still alive after all they've been through (Fraser, 1984), may be a different reaction than trying to point out the "bright side".

#### "One-Down" Position as Paradox Ingredient

This ingredient is mixed in by the therapist taking a position of weakness in order to get more power (Napier & Whitaker, 1978). The therapist apologizing to the family for trying to get them to change, when they do not need to, is described by Held & Heller (1982). A therapist can also admit ignorance about the type of problem and suggest the family educate him or her further on the subject. L'Abate & Farr (1981) said the Milan group frequently uses this one down position. Telling the family it will be a

difficult task to help them and will take lots of commitment and energy they are not ready for, can also entice them into being non-resistive. A frequent response used with court ordered clients in the author's setting is: "What do you need to do to get rid of me, and the court order requiring therapy?"

In the author's opinion, the one-down position and therapist's reaction are more closely related to each other in the way that fruits and vegetables and the grains are "grown" from plants; whereas meat, fish, poultry, and dairy products come from animals. The last two ingredients are less apt to be called paradoxical. Therapist's reaction and one-down position can be delivered in combination with keeping the problem or reframing.

#### Keeping the Problem as the Solution, as a Paradox Ingredient

This seems to be a favorite type of paradox used by those adept at family therapy. Clients are told to go slow; not to improve too fast; to only make small changes; they are not able to change; and that a crisis or relapse will occur (Weakland, Fisch, Watzlawick, & Bodin, 1974). A favorite maneuver is to point out disadvantages and adverse affects if the symptom disappears. The use of a team or consultant lends itself to offering split opinions, with one saying keep the problem because of negatives if do change; the other opinion being belief they can and should change. Andolfi (1974) told people they could change but probably should not. Telling them things may get worse, and that the

effort is not worth it, are other examples. Held & Heller (1982) told of a situation where a dad was told his alcoholism was his way of sacrificing himself and that his drinking served to cover up a "horrible" thing the family was not ready to face.

A simple situation described by Hare-Mustin (1976) involved a family with six kids, a semi-invalid dad, and a girl who cried all the time. The mother was quite concerned. The girl was given the task to cry a little every day, as she needed to cry. The mother was told teen girls cry a lot. Raskin & Klien (1976) told a depressed woman that being depressed is a valuable experience and she needed to learn how to be depressed in a correct manner by practicing.

Greenburg (1973) told a mother of three with a perfectionist problem about housekeeping that in fact being perfect was a worthwhile goal and she needed to spend more time cleaning her house to achieve the goal. Some therapists prescribe adding elements to symptoms to escalate the symptom's nuisance, causing rebellion about having the symptom. The act of giving people permission to keep a problem seems to ease the anxiety and anger. Raskin & Klien (1976) backed up this idea that changing the attitudes of helplessness and meaninglessness about the symptom are important. Having people practice the problem or ritualizing a pattern to be performed at a specific time, allows clients to keep a problem, yet may motivate them to get rid of it.

### Reframing or Redefining as Paradox Ingredient

Reframing or redefining as paradox comes in varieties: reframing the perception of the symptom as one that is good, and can be kept or practiced; reframing the pattern or roles in the family; shifting the emphasis or focus of the symptom. Protinsky, Quinn, & Elliott (1982) explained that when a child is the symptom bearer in the family, the problem can be reframed as the child's way of keeping attention on himself by sacrificing himself to aid other parts of the family. Fisher et al. (1981) reframed the "bad" kid as the "good" kid in that the kid cares the most in this sacrificing way.

DeShazer (1975) reframed nagging as "...helpful clarification of the issues of the relationship" (p. 26). Power or manipulation maneuvers of family members can be called "love" or "caring" (Papp, 1980). A boy's problem behavior was reframed as providing the family entertainment (Mazza, 1984). In the same case, siblings were rewarded when another sibling "messed up", rather than the usual punishment approach used with the culprit. The author has used a reframing approach by suggesting that parents get rewarded when children engage in certain negative behavior, rather than the children getting consequence. This works particularly well when children are attention seeking or when the marriage seems shaky.

An example of Frankl's "dereflection" (1960, 1975) was his reframing sleeplessness to trying to stay awake; or abstaining

from sexual performance to focus on other ways of touching. Fisher et al. (1981) said this is shifting the emphasis from the symptom to the rules that maintain the family or marital system. Stanton (1984) reframed an enmeshed mother/son relationship as one that needed to be closer. They were told to do everything together, including Mom attending school with her son, and the son sitting on Mom's lap.

#### Conclusion

The use of paradox seems to be growing in the field of family therapy as efforts are made to work with client families others seem unable to help. While the case examples used were simplified, they give a general idea of how paradox as an ingredient is used. However simple paradox may seem, how absurd or humorous some of its aspects, it should not be used lightly or without knowing the family dynamics and understanding the full realm of the problem.

When using paradox it is helpful to understand the ingredients and ways they can be mixed, as reframing may overlap with taking the one down position, or telling someone to keep the problem may be combined with exaggeration. The idea that paradox exists in the nature of the therapeutic relationship, as well as some knowledge about perception are helpful. A therapist may need to explore who has used paradox, study specific case examples, and see paradox used, to get a working base for its use. While the therapist's orientation to therapy may not matter, paradox may not

be to all therapist's tastes. Some would find it difficult or against their natural or learned ethical or personal beliefs, depending upon their own perception of paradox as an ingredient.

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