PARADOXICAL INTENTION STRATEGIES: A REVIEW OF RATIONALES

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This article summarizes contributions to the paradoxical perspective made by psychoanalysts, family therapists, logotherapists, Adlerian, and Morita therapists. In the analysis, six categories of rationales offered by these writers are deduced: overcoming resistance, disturbing systems, altering client perspectives, reversing excessive effort, learning theory, and intrapsychic factors such as disorientation or reframing. Attention is drawn to the fact that no information from clients is presented to substantiate any rationale; caution in accepting them is therefore advised.

Since the 1960s a group of psychotherapeutic techniques has gained prominence in which the therapist, instead of joining with the client to oppose the symptom, instructs the client to continue, intensify, or extend it. The object of this paradoxical maneuver is to lessen or eliminate the problematic behavior through the unusual means of encouraging it. Such instructions have been used with a variety of target behaviors: phobias and obsessions (Frankl, 1975), schizophrenia (Selvini Palazzoli *et al.*, 1978), help-rejection (Watzlawick *et al.*, 1974), family fights (Haley, 1976), suicide threats (Fay, 1976), anorexia (Selvini Palazzoli, 1974), binge-eating (Moley, 1983), and many others. The approach is variously called paradoxical intention (Frankl, 1960, 1975, 1978), paradoxical intervention (Tennen *et al.*, 1981), paradoxical therapy (Fay, 1976, 1978), counter-paradox (Selvini Palazzoli *et al.*, 1978), and the therapeutic double bind (Haley, 1963; Watzlawick, 1965, 1976; Watzlawick *et al.*, 1967; Watzlawick *et al.*, 1974). Similar approaches include provocative therapy (Farrelly & Brandsma, 1974), paradigmatic psychotherapy (Coleman Nelson, 1962; Strean, 1964), direct analysis (Rosen, 1953, 1962), anti-expectation techniques (Greenberg, 1973), and hyperbolic therapy (Grossman, 1964). Paradoxical intention strategies now form an important class of interventions available to the practitioner (for a thorough exposition see Riebel, 1981, or Weeks & L'Abate, 1982). In fact, Feldman (1976) considers them one of the four main classes of therapeutic strategy.

However, the writers describing paradoxical intention (PI) strategies offer very different rationales. Varying preexistent states and processes are believed to exist in the client: anticipatory anxiety (Frankl, 1975), a faulty feedback loop (Jackson, 1977; Jackson & Yalom, 1977), reactance theory (Tennen *et al.*, 1981), negativism and the desire to dethrone the therapist (Mozdzierz *et al.*, 1976). The PI strategies are variously described as operating on these diverse factors. Raskin & Klein (1976) believe that there are three levels on which the strategies work: interpersonal power, learning, and redefinition.

Thus, there is no agreement on what constitutes the *effective factor* in PI strategies. To date, no thorough review has appeared collecting and comparing these approaches and their rationales. Even a recent comprehensive survey (Weeks & L'Abate, 1982) gives only cursory attention to the plurality of explanations. This article attempts to fill the gap. It includes practitioners and techniques that employ the approach of asking the client to produce, continue, or increase the problem behavior.

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Frankl and Logotherapy: Counteracting the Effects of Effort

Viktor Frankl, the creator of logotherapy or "therapy through meaning," claims credit for inventing and naming PI in 1929 (1975), and it forms an important segment of his work. Frankl has instructed clients with specific fears to attempt to produce an anxiety attack, to fail an exam, or make a thoroughly miserable public speech. The client sees the humor in the situation, experiences a lessening of anxiety as he or she plunges into the paradoxical task, and the problem behavior diminishes.

Excessive striving to attain or avoid specific emotional states is considered by Frankl to be the source of the problems that he treats with PI strategies, such as insomnia, stuttering, test anxiety, and sexual dysfunction. The strategy interrupts the vicious circle created by the excessive effort by introducing a counterintention to lessen the original effortful behavior (1975, p. 227). The striving is seen as part of a larger problem of excessive focus on the self which prevents a natural unfolding of goals and attainments.

The Interactional View: The Paradox as a Therapeutic Tool

Communication theory was developed to explain important properties of interactions between individuals. Building on Bateson's ideas and the concept of the double bind (Bateson *et al.*, 1972), a group of associates at the Mental Research Institute in Palo Alto (MRI) seek to clarify and correct communicational defects in the family system. Using the brief therapy model, this group seeks to resolve the presenting problem and induce observable changes in the way the clients interact. The ultimate aim of therapy is to achieve second-order change, that is, to help the client break out of his or her constricting conceptual framework. Because of a homeostatic mechanism (pressure to remain the same), this is difficult for the clients to do directly, so the therapist employs PI strategies to impose a demand that the clients cannot respond to in the familiar way. The MRI group has most consistently espoused paradoxical approaches for a wide variety of target behaviors and in fact hold that therapy as an enterprise rests significantly on paradoxes set up by the therapist.

A paradox in this view consists of two messages on different levels, one of which both qualifies and contradicts the other. This is not mere contradiction. Two traffic signs giving conflicting instructions ("Stop"and "No stopping any time") are merely contradictory, whereas a sign ("Ignore this sign") which itself conveys two messages ("Read this sign" and "Ignore what you have read") forms a paradox (Watzlawick *et al.*, 1967, pp. 215–217).

Paradox can be harmful when surrounding circumstances make it impossible for the individual to comment on the paradox or to escape from it (the pathogenic double bind). The "mirror image" of the pathogenic double bind is the therapeutic double bind, or PI strategy. Again, two conflicting messages are sent. The explicit message (or report, in the language of communication theory) is, "Keep having your problem, or have it more." The implicit message (command, or metacommunication) is, "This is a helping relationship." The clash of these two messages, according to the MRI rationale, creates a paradox from which the client can only escape by giving up the problem.

This view is explicitly rendered by Haley (1963) throughout his book, *Strategies of Psychotherapy*.

> Directive therapy places the patient in a paradoxical situation which he cannot resolve as long as he continues with his symptomatology. Rather than giving him an advantage in controlling the relationship with the therapist, his symptoms place him at a disadvantage as long as they continue. Defining the situation as benevolent, the therapist provides an ordeal. The patient is thereby caught in an "impossible" situation, a therapeutic paradox. If the therapist was benevolent only, the patient could deal with this. If the therapist was only treating the patient badly, the patient could deal with this. However, when the therapist is hard on the patient within a framework of help as long as the symptoms continue, the patient can only abandon his symptomatology (p. 67).

Here the "benevolent" framework qualifies the "ordeal" of the therapeutic instruction.

Resistance is also mentioned in the MRI publications. On an individual level it may take the form of a desire to defeat the therapist (Watzlawick *et al.*, 1974). On the interpersonal level it takes the form of the homeostatic mechanism inherent in family systems (Watzlawick *et al.*, 1967, pp. 134 ff.). The desire to defeat the therapist and remain the same is used in framing paradoxical strategies so that no matter what they do, the clients are changed.

Intrapsychic factors are little mentioned in the MRI literature, as the concern of the authors is with systems and observable change. However, Watzlawick (1976) suggests that there are two levels of reality operating for the individual—the

first-order level of actual lived situations, and the second-order level of opinions about or attributions of meaning to those situations. He says that

the overwhelming majority of human problems involve only the second-order reality. . . . It is my contention that all effective psychotherapy consists of a successful change of this frame of reference or, in other words, of the meaning and value that a person attributes to a particular aspect of reality and which, depending on the nature of this attribution, accounts for his pain and suffering (p. 120).

It is important to note that by "meaning" Watzlawick does not intend the transcendent purpose or meaning of life which is so important to Frankl. Watzlawick intends rather the individual's opinion or interpretation of his or her circumstances and feelings, which is more on the cognitive than the transpersonal plane.

Albany Group: Reactance

An important addition to the theoretical discussion of PI strategies was made by Tennen *et al.* (1981). Like the MRI group, they view therapy as a process of interpersonal influence, and note that the client can respond to any directive by complying or defying. PI strategies can be framed to call forth either response: The therapist might direct the client to have a relapse, expecting him or her to defy the instruction and not have one; or the therapist might suggest that the client produce an anxiety attack, try to do so, and fail. It is important for the clinician to distinguish between the types before framing the intervention.

Tennen *et al.* suggest that the basic factor motivating the client to change as a result of PI strategies is reactance or a desire to restore freedoms believed to be threatened. Reactance is the individual's desire to retain perceived free behaviors (Brehm, 1966). If one or more are threatened or eliminated, the individual will, according to the theory, seek to restore them.

Therapy may constitute just such a threat. This may seem surprising, since therapy is held out to be a helping relationship. Yet we should not forget that the client may not experience it as such—especially if faced by a therapist who believes it should be an ordeal! Therapy is an implicit confrontation (Keen, 1976), by its very nature reminding the client of personal inadequacies. Rosenbaum (1982, p. 86) reminds us that the client may see the therapist not as a benign helper but as a critical authority figure. When the therapist makes overt directives, the threat to the client's freedom is obvious (by obeying, the client loses the freedom to disobey). In nondirective approaches the "threat" may be less obvious, but the therapist is nonetheless influencing the client's behavior through subtle signals and reinforcements, and by virtue of his or her standing as an expert is able to threaten the client's sense of freedom. The consequence is that, according to reactance theory, the client will try to restore the freedom.

In the therapy context, a reactance arousal can be understood most simply as a psychological state construct, the behavioral and transactional manifestations of which are most often noncompliance, rebellion, and entrenchment in already established, often pathological behavior patterns (Tennen *et al.*, 1981, p. 15).

This, then, is an explanation put forward for resistance. It is the client's attempt to regain perceived freedoms by noncompliance with the therapist's overt or unspoken attempts to influence. Instead of seeing reactance as a possible negative or complicating factor in therapy (as for instances does Brehm, 1976), Tennen *et al.* see it as a potential positive force, insofar as it makes possible the class of PI strategies. Knowing about the client's potential to react and rebel, the therapist can frame interventions in such a way that the rebellion takes the client forward. As the authors see it, proper assessment of the client's reactance capability will help the therapist choose the type of strategy (defiance-based or compliance-based) best suited to each case.

Reactance is seen as continuous between therapy and nontherapy situations, making resistance seem a natural response to the therapy situation and use of resistance by the therapist an integral part of his or her task.

Milton Erickson: The Illusion of Alternatives

Milton Erickson, the master hypnotist and therapist whose work was made accessible by the writings of Jay Haley (1967, 1973) worked in a very directive fashion, setting goals of observable changes through assignments, hypnosis, and surprise. Erickson allied himself with motivations already present in the client, such as pride, competitiveness, or a desire to please, in order to further the likelihood that the client would be susceptible to therapeutic influence. If resistance was one of the motivations, Erickson redefined it as a valuable quality or instructed the client to resist, thereby taking control and including it in the therapy.

Erickson generally used the language of the double bind to describe the paradoxical strategies,

but it was his personal version of the double bind. "In essence, the double bind provides an illusory freedom of choice between two possibilities, neither of which is really desired by the patient but [which] are actually necessary for his welfare" (Erickson & Rossi, 1975, p. 144). Erickson would offer the client two choices, one of which the client must take: "Do you want to deal with this symptom first, or that symptom first?" Not mentioned in the interchange is the fact that the two are merely subtypes of change: Change itself is taken for granted. This is the way Erickson incorporated resistance, by letting the client exert it in rejecting one of the proffered alternatives.

I compare this strategy to the logical category "complex question," which is a statement combining two questions into one (Carney & Scheer, 1964). The classic complex question is, Have you stopped beating your wife? Combined in the surface question is a hidden question, Do you beat her now? Either answer to the surface question implies an affirmative to the hidden question.

Erickson's complex question often took this form: "Do you want to get well Wednesday or Thursday? I really don't know which it will be. . . . " The enuretic client hearing this "didn't know I was putting him in a double bind because the question wasn't 'Will I have a dry bed?' The question really was, 'Which night?' " (Erickson & Rossi, 1975, p. 147). Through letting the client decide which day to recover, Erickson left unexamined the hidden question, "Do you want to get well at all?"

Erickson also noted the intrapsychic effects of his interventions. Some were purposeful inductions of confusion. "One could get vertigo trying to figure out the sense or illogic of such a proposition. One cannot figure it out so one cannot refute it, so one tends to go along" (Erickson & Rossi, 1975, p. 154). One client said eight years after receiving a confusion type of double bind that he had had "a peculiar feeling as if I couldn't move when you were talking to me" (p. 146).

Erickson did not use double binds as isolated strategies but rather as one possible tactic among many in a larger therapeutic relationship in which the client's language, goals, and opinions were incorporated.

Paradigmatic Psychotherapy: A Preparation for Insight

Paradigmatic psychotherapy comes from the psychoanalytic tradition and evolved as a set of solutions to specific problems and resistances. Unlike approaches which adopt paradoxical or indirect strategies as preferred tactics for most conditions, paradigmatic techniques are described as intermediate steps, precursors to the ideal mode of classical interpretation.

Marie Coleman Nelson calls paradigmatic psychotherapy "a setting forth by example"; "an active form of mirroring" (1962, p. 120). The client is seen as an aggregate of introjects and multiple identifications who does not have a strong sense of self. "Thus the therapist may elect to impersonate in his communication with the patient any one of these selves, in order to enable the patient to ventilate fantasies, experiences and feelings associated with the particular imago" (p. 121).

The paradigmatic therapist can use various techniques: mirroring the client, duplicating in therapy sessions an experience the client reports, assuming the role of an introject, entering into a client fantasy, and following the client's recommendations for treatment (Coleman Nelson, 1962). Then "the ego strengthening that occurs through their use finally renders paradigmatic tactics superfluous, and the final phase of treatment is conducted as a classical analysis with spontaneous understanding by the patient of what has gone before" (p. 122).

Essentially, the client is seen to be unable to tolerate the therapist's true opinion, and paradigmatic techniques were developed in order to sidestep a futile effort to persuade. Sherman (1968) believes that

> the more forcefully a therapist tries to impart insight the more resistive does the patient become. Interpretation of resistances seems to shift the content of resistance but not its continued existence. Patients seem driven by some inner necessity of undeniable strength to oppose the efforts of the therapist, no matter what these efforts consist of. . . . If, instead of opposing irrational behavior, I accept it as rational and even supported it, the patient would still maintain his attitude of opposition to my efforts and thus be impelled to reasonable behavior (pp. 74-75).

Joining the symptom, then, represents a kind of resignation by the therapist to the client's current state of defensiveness.

Paradigmatic therapy has been recommended for borderline clients (Coleman Nelson, 1962), paranoids and masochists (Sherman, 1961), and adolescents (Strean, 1961). Strean, however, came to believe that the strategies could be used at certain strategic times for any patient (1964).

These strategies are not directive. The para-

digmatic therapist merely adopts unexpected roles, sharing fantasy or allowing the client to see his or her own processes from the outside as they are enacted by the therapist. They are paradoxical in that the therapist temporarily abandons the role of guardian and restorer of "normality." Ultimately, the therapist intends to return to classical interpretation (Coleman Nelson, 1962; Sherman & Coleman Nelson, 1968).

Selvini Group: Breaking a Fundamental Rule

Mara Selvini Palazzoli worked with anorexics (1974) and, along with her collaborators, with families having a schizophrenic member (Selvini Palazzoli *et al.*, 1978). Deriving their theoretical approach from communication theory, general systems theory, and cybernetics, they view the family as a complex system which has evolved its rules over time. "Since the symptomatic behavior is part of the transactional pattern peculiar to the system in which it occurs, the way to eliminate the symptom is to change the rules" (pp. 3-4).

For instance, an anorexic may develop her symptom as the only way she has to assert independence in a rigidly ruled family. Prescribing a (temporary) continuance of the self-starving behavior violates the family's rule while winning rapport with the identified patient. The therapist wins either way: If the client complies, the therapist has successfully asserted authority and prepared the way for the next step; if the client defies, he or she must give up the problematic behavior.

Therapy, therefore, consists in breaking the family's rules. "When we are able to discover and change one fundamental rule, pathological behavior quickly disappears" (p. 4).

Weeks and L'Abate: Symptom as Friend

Weeks & L'Abate (1982) provide the first lengthy text devoted exclusively to paradoxical approaches. After briefly outlining predecessors and current practitioners, the authors offer their own rationale. They see paradoxical approaches as comprising a new mental set, using dialectic rather than traditional linear or transactional views of causality. Grounded in communication and systems theory, this version views the symptom not as an enemy to be opposed but as a "friend," a meaningful behavior which served some purpose in the past and can now serve a function in the present.

> Most theories of psychopathology and psychotherapy have described symptoms in strictly negative terms. The symptom has traditionally been construed as that behavior which is alien, bizarre, uncontrollable, and representative of an externalized weakness. The symptom has been construed as an enemy to its bearer and to the psychotherapist. Thus, the task of the client has been to resist, defeat, or "cure" the symptom.
>
> Paradoxical psychotherapy considers the symptom to be a friend. In treating the symptom as a friend, one would embrace and cooperate with it. One would join the symptom rather than fleeing from it, and learn from it in the same way one learns from carrying on a dialogue with a friend (p. 27).

Weeks & L'Abate introduce a concept from Transactional Analysis (Karpman's Triangle) to describe the point at which the therapist enters and changes the system. Victim (scapegoat), Rescuer, and Persecutor are roles adopted by the family members and stabilized in the pathogenic system. "The primary task of the therapist is to expose the power of the Victim and help the Victim to use his or her power in different ways" (p. 51). Although this version of paradoxical therapy enlists the client's resistance in breaking the entrenched system, this approach is less manipulative than others we have reviewed in that Weeks & L'Abate describe a genuine respect for the client's previous adaptation and seem more congruent in their interaction than do others reviewed here.

Other Explanations

1. Mozdzierz *et al.* (1976) write from the Adlerian perspective, which sees "neurosis as an evasion of the responsibilities inherent in life tasks and . . . neurotic symptoms as a means to this end—safeguards for self-esteem or excuses" (p. 173). Therapy consists in guiding the client to full responsibility and constructive social participation. "Viewed within this context, a paradoxical strategy employed by a therapist is a means of transforming behavior into a cooperative venture between the patient and the therapist" (p. 173). The essential problem is seen to be an avoidance, and resistance to the therapist its immediate manifestation, which PI strategies overturn.

2. Morita therapy is an integrated approach building on Zen principles (Pelletier & Garfield, 1976; Sato, 1958) developed early in this century in Japan. One maneuver is to prescribe total bed rest to the collapsed client, until he or she is bored enough to demand work (which he or she has been avoiding). The Morita rationale resembles Frankl's on two counts: the aim is to interrupt a cycle of self-centeredness, and excessive effort is seen as the cause of the immediate problem: "a

conflict arising from the fruitless struggle to get rid of and flee from the inevitable" (Kora & Sato, 1958, p. 221). Among instructions given to the client are

> to realize there is no absolute peacc of mind. The patient should realize that the more he seeks for absolute peace of mind, the more worried he becomes. . . . To realize by personal experience the rule that emotional excitement when left alone always recedes in accordance with its natural course. The patient should understand that if he tries to flee from the suffering or worries right away, they will become strongly rooted on the contrary. To wait for the time to pass and to work normally with suffering or worries is the best way to calm down the wave of emotional excitement. (p. 233)

3. Greenberg (1973) uses his "anti-expectation techniques" such as encouraging failure or agreeing with clients' negative self-statements, in two circumstances: to treat a problem directly, and to overcome resistance. The resistant help-rejecter

> tends to externalize his problem emphasizing how the world is beyond his control while demonstrating the ability to control the therapy situation by fending off therapist attempts at exploration, interpretation or direction (p. 145).

The PI strategy demolishes the expected gain for such resistance.

The other indication is "to give the patient a clear feeling that he can exert some control over his behavior" (p. 148). Greenberg uses paradoxical strategies to upset the client's notion of what he or she can control, and what is beyond control.

4. Farrelly (Farrelly & Brandsma, 1974) ridicules and teases clients, exaggerating their problems and minimizing their chances for success. His purpose in doing this is to mobilize their anger against themselves and to provoke them into using new behaviors (pp. 36-37). He acknowledges their power of will (p. 37) and to respond to expectations (pp. 42-43). The two central hypotheses that guide provocative therapy concern the client's self-concept and overt behavior.

> If provoked by the therapist (humorously, perceptively and within the client's own internal frame of reference), the client will tend to move in the opposite direction from the therapist's definition of the client as a person.
>
> If urged provocatively (humorously and perceptively) by the therapist to continue his self-defeating deviant behaviors, the client will tend to engage in self- and other-enhancing behaviors which more closely approximate the societal norm (p. 52).

In this view, the client will naturally oppose the therapist and differentiate from him or her; provocative or negative statements form the ground against which the client rebels.

5. Rosen, with direct analysis (1953, 1962) with psychotic individuals, had as his goal the cultivation of an intense client-therapist relationship characterized by love and dependency, through which the regressed client finds a way to grow successfully through developmental stages which had been imperfectly completed. The model for the therapist is the foster parent.

> I have come to realize that being a "good" foster parent to the psychotic individual involves more than loving kindness or warm acceptance. At times—like an actual parent—one must be stern, or critical, or disciplinary, not only in order to protect the psychotic and others from his violence, but also to give him assurance that the situation is under control, to indicate that he cannot kill another person merely with a glance or a wish, and so on. All of this is part of being an effective "foster parent" (1962, p. xiv).

Thus, the techniques of slighting, ridiculing, or imitating the client's beliefs form part of the overall plan of including discipline, education, or any other aspect of life that the therapist believes appropriate to the therapeutic alliance.

6. Grossman (1964) developed "hyperbolic therapy" within the framework of psychoanalysis, using techniques to strengthen the client's ego functioning, help him or her test reality, and reduce dependence on the symptoms. He notes that when the therapist agrees with the client's irrational side, it is very difficult for the client to resist, and that there is no secondary gain to being ill (p. 410). Thus resistance and the advantages of the problem are acknowledged. Grossman also notes intrapsychic effects of the intervention.

> These measures attempt to push the patient to reveal and express both the area of the self that is being criticised and the internal (perhaps unconscious) standard against which the feeling or behavior is evaluated. If this is accomplished the patient cannot escape facing the real problem lodged inside himself (pp. 410-411).

Successfully applied, the strategies bring out and externalize dilemmas that had been hidden within, making them available for therapeutic work. The therapist

> thus frees the patient to utilize *his* energies for more accurate perception and reality testing (usually regarded as ego functions). From the point of view of the patient's object relations, the therapist re-externalizes attitudes of the patient which were originally introjected from the parents. This time, however, the atmosphere is one of a sustaining relationship (p. 411).

Grossman activates client ego functions and frees him or her to experiment with new roles by taking over one of the roles that the client had been enacting.

In the above sections, I have discussed thera-

peutic approaches in which the therapist maneuvers the client indirectly, "tricking" him or her out of the problem. Using a distinction introduced by Rogers, I have previously (Riebel, 1981) characterized such approaches as *incongruent*, in that what the client hears from the therapist does not accurately reflect the therapist's true aims or opinions. "Have a relapse" really means "Do not have one."

Following are descriptions of tactics which could be called *congruent* paradoxical strategies, in that the therapist is being quite honest when he or she calls on the client to produce, continue, or intensify the problem behavior. The ultimate goal is nevertheless the same.

Behavior Therapy: Changing Patterns of Learned Behavior

According the behaviorist model of illness and cure, all behavior, including thoughts and emotions, is learned as a result of conditioning and reinforcement. Therapy is a program of experiences that will extinguish unwanted behaviors by presenting new combinations of response and reinforcement. Anxiety is seen as an almost universal element in neurosis (Wolpe & Lazarus, 1966), and reciprocal inhibition eliminates it by presenting a competing response in the presence of the anxiety-provoking stimulus.

> If a response inhibitory of anxiety can be made to occur in the presence of anxiety-evoking stimuli it will weaken the bond between these stimuli and the anxiety. . . . The essence of the therapist's role is to encourage the outward expression, under all reasonable circumstances, of the feelings and action tendencies previously inhibited by anxiety. Each act of assertion reciprocally inhibits to some extent the concurrent anxiety and slightly weakens the anxiety-response habit (pp. 12, 13).

Thus, behavior therapy elicits the undesirable behavior patterns in order to eliminate them. Specific techniques include systematic desensitization (gradually exposing the client to the feared stimulus; Wolpe, 1969); massed practice (repeatedly evoking problematic behavior until such contrasting factors as fatigue set in and make it aversive; Bandura, 1969); flooding (evoking feared stimuli in the client's imagination without resulting in the dreaded consequence; Bandura, 1969); implosion (flooding plus evocation of dreaded consequences as well; Meyer & Chesser, 1970); and abreaction (a form of catharsis; Wolpe & Lazarus, 1966).

Behavior therapists do not rely on client defiance or acknowledge the existence of resistance, believing instead that "since behavior demonstrably originates in learning it is only to be expected that its elimination will be a matter of 'unlearning'" (Wolpe, 1958, p. ix). Behavior therapists elicit the behavior—sincerely asking the client to produce the symptom—in order to make it available to be extinguished.

Gestalt Therapy: Internal Resistance

Quite the reverse of the behaviorist model, instead of repudiating resistance, the Gestalt therapist makes it the core of the client's problems in life as well as in therapy. Avoidance of one's own impulses and fragmentation of the personality are the sources of the difficulty. To restore unitary functioning and a sense of identity, disowned fragments of the self are reclaimed and introjected aspects of others are expelled (Perls, 1969*a*; Perls *et al.*, 1951). Full awareness of the present, uncontaminated by blocks and resistances, is valued as a goal and also as the means by which the goal is attained (Naranjo, 1972). Thus a Gestalt therapist will direct a client to continue or intensify a feeling which the client wishes to avoid, seeking to break down layers of defense against native impulses.

Perls (1969*b*) defined therapy as trying "to frustrate the person until he is face to face with his blocks, with his inhibitions, with his way of avoiding. . . . When we find the place where the person is stuck, we come to the surprising discovery that this impasse is mostly merely a matter of fantasy" (pp. 38-39). The problem, then, is resistance against oneself, and resistance against therapy is the result of the therapist's efforts to halt this avoidance. Instructions which require the client to plunge ever deeper into the unpleasant present are a reflection of the central therapeutic goal.

The Gestalt therapist does not issue instructions with the expectation that the client will defy them and be changed thereby. Rather, the therapist believes that by complying, staying with the problem, the client will naturally go past it, breaking through blocks and impasses. Instructions to "stay with the tightness" and "go into the fear" forbid the client to try to be different than he or she is right now. It is a fortuitous by-product (though predicted by the therapist) that staying with the present is the very thing that changes it.

There is, then, a paradox to Gestalt therapy. The therapist is not trying to trick the client out of the symptom, as with a defiance-based strategy, but rather, paradoxically, abandoning the attempt

to change as a way of making change possible (Beisser, 1972; Enright, 1980).

The Rationales Summarized

Rationales offered for the use of PI strategies fall into six major categories.

Resistance

Resistance is believed to occur on two levels, individual and systemic. Resistance within the individual is the client's reluctance to make use of the help he or she has requested. As a construct it has been part of the psychotherapy language for decades (Wolberg, 1954). The concept is given various meanings and occupies positions of varying importance in therapeutic systems—central to the nature of distress in the existential perspective (Bugental, 1965, 1978) and the Gestalt view, an obstacle to therapy to others, and not acknowledged to exist at all by behaviorists (Wolpe, 1969). Recently a suggestion has been made that resistance can largely be forestalled. Enright (1981) believes that there are internal obstacles that could hinder therapy, but that they are not unavoidable. He suggests that resistance can be circumvented if a few basic issues between client and therapist are clarified at the outset. It is beyond the scope of this article to engage in the debate over the legitimacy of the concept of resistance; for our purposes, it has been accepted by some of the authors reviewed.

Resistance is also believed to exist on the systemic level (Haley, 1963; Watzlawick *et al.*, 1974). Effort to change a family's habits will activate attempts to remain the same. According to Whitaker (1978, pp. 164-165) the family will try to remain the same by neutralizing the therapist or inducting him or her into the system. Shapiro (1972) is so impressed by the power of normal systemic resistance that he commends therapists for making any progress against it at all. Specific types of resistance are noted.

1. *The homeostatic mechanism*, posited to be a natural part of any system (Haley, 1963, pp. 162 ff.; 1976, pp. 67-68; Selvini Palazzoli *et al.*, 1978).

2. *Reactance*, posited to be a natural motivating factor at the intrapsychic level and a normal response to the therapeutic situation (Tennen *et al.*, 1981).

3. *Desire to defeat the expert* (the help-rejecting complainer) (Mozdzierz *et al.*, 1976; Watzlawick *et al.*, 1974).

4. *The client's inability to confront certain realities about himself or herself*; inadequate ego (Coleman Nelson, 1962; Grossman, 1964; Sherman & Coleman Nelson, 1968).

5. *Disinclination to change oneself*; an ambivalence about or ignorance of the true aims of therapy (Greenberg, 1973; Watzlawick *et al.*, 1974).

6. *Character*. Perls (1969*b*, 1972*a*) holds that each personality layer is a defense and resists being breached or eliminated. The therapist's job is by definition to break through the entrenched layers.

7. *Unrealistic attitudes*. Resistance to the normal levels of tension and difficulty inherent in life is seen by some to be part of the problem. The Adlerian perspective sees neurosis as an evasion of responsibility (Mozdzierz *et al.*, 1976); Morita therapy sees some types of neuroses as an illusion that there can be a worry-free existence (Kora & Sato, 1958); to Frankl (1979), self-centeredness is part of the problem.

Disturbing the System

I have mentioned specific ways in which therapists set out to interrupt extant systems. Apart from these carefully planned maneuvers, there are others, less precisely orchestrated, whose outcome the therapist may not know in advance; he or she intends merely to shake up the system, to make *some* change in order to see what happens and to create an opening. "Benevolent sabotage," say Watzlawick *et al.* (1974, pp. 145-146) "turns the dynamics of the family's interaction virtually upside down." This prepares the way for the next therapeutic step. Some examples will be useful here.

A couple with a stable pattern of arguing about his drinking is instructed to drink together, but with the *wife* always one drink ahead. "The introduction of this new rule into their interaction virtually wrecks the old pattern" (Watzlawick *et al.*, 1967, p. 251). The familiar sequences are altered and new responses have to be introduced into the relationship.

A teenage girl was behaving insolently toward her mother, and the therapist suspected that the father was secretly encouraging her. Instead of interpreting, the therapist instructed the father to give her a dime whenever she was insolent. "Carrying out this prescription makes overt a 'spontaneous' behavior that until then was covert. . . . But once the 'game' is overt, it becomes impossible

. . . to go on playing it blindly" (Watzlawick *et al.*, 1967, p. 123).

Selvini Palazzoli (1974) notes that anorexics cling "like leeches" to their families, yet complain endlessly about them. Prescribing the symptom uproots this tightly bound system and displaces the players from their accustomed places (p. 235). Selvini Palazzoli and her associates (1978) found that altering one fundamental family rule was sufficient to initiate important changes.

A "system" may also be an intrapsychic one. Erickson believed (Erickson & Rossi, 1975, p. 153) that paradoxical strategies "can also be used to facilitate the first stages of the therapy process where it is sometimes necessary to break up a patient's old and inadequate frames of reference (their meta-levels) to facilitate the possibility of creating new and more adequate frameworks." I would also suggest that the "vicious circle" mentioned by Frankl (1975) is a kind of intrapsychic system, wherein one element predictably produces a certain other element.

Disturbing the intrapsychic system can be accomplished by the therapist's taking over the role usually occupied by the client (Farrelly & Brandsma, 1974; Grossman, 1964), requiring the client to take on a new one. It is difficult to maintain the identity of God when the therapist claims to be God, too.

An internal system can be disrupted if the therapist engages in a paradoxical commendation of the illness. Instead of exhorting the client to change—which only entrenches him or her further—the therapist may praise the advantages of being cared for in a mental hospital.

> By the rules of *his* game it is understood and thus unquestionable that he *should* change—in fact, his entire "game" is based on this premise. "Why should you change?" is therefore no longer a move in *his* game; it establishes a new game altogether, and he can no longer go on playing the old one (Watzlawick *et al.*, 1974, p. 134; emphasis in original).

Here, as in many PI strategies, value is placed on disturbing the pathological status quo as a preliminary step to making the next therapeutic intervention.

The reader will note that the idea of "games" has figured in several of these citations. I believe that the authors use the term as Transactional Analysis writers do, to indicate a predictable sequence of structured transactions, with an unconscious payoff (Berne, 1964, 1976; Steiner, 1971, 1975). To refuse to take one's assigned role in the game or script necessitates a rewriting of the script.

Perspective

Related to the process of disturbing the system is the process of shifting the client's perspective on the problem. Raskin & Klein's (1976) third type of explanation for the efficacy of PI is "redefinition"—that is, the client begins to see the problem as a willed behavior and begins to feel less victimized. Watzlawick (1976) emphasizes reframing as a way of gaining a different perspective.

Peters & Grunebaum (1977) suggest that humor and exaggeration help the client develop an "observing ego" and see new alternatives. Fay (1976) mirrors the client in a "benevolent mimicry" so that he or she can see the self as others do. Farrelly (Farrelly & Brandsma, 1974) uses *reductio ad absurdum* to "help the client define, affirm, defend and learn to laugh at himself" (p. 69).

Humor occupies a special place in the "perspective" rationale. It has value in helping cement the client-therapist relationship (Close, 1972); it can help create a more detached attitude toward the problem (Mozdzierz et al., 1976); and it can be the actual vehicle for the strategy (Farrelly & Brandsma, 1974). There is a playful quality about many of the reports of therapists enacting parts of clients' inner dilemmas, as friendly impersonation and role playing take place.

Effort

One untoward result of exerting effort has been widely noted in the literature. Striving to solve a problem may merely perpetuate it. This has been reported regarding sexual problems (Berne, 1970; May, 1969; Watzlawick *et al.*, 1974); mental censoring (Enright, 1980); and attempts to remove symptoms (Pelletier & Garfield, 1976). Conversely, striving for some desired state may prevent its attainment: intimacy (Blanchard, 1972), sleep (Frankl, 1975), authenticity (Shostrom, 1968), the search for enlightenment (Sperber, 1979; Trungpa, 1973; Watts, 1951, 1958, 1961, 1972); and even nonstriving (Bugental, 1978). Dolliver (1972) sums it up by saying, "In some areas, the paradox exists that a person cannot simply try harder, but that he must lessen direct effort in order to succeed" (p. 53).

Though the effects of effort are usually noted with respect to the individual, the systemic counterpart exists, which Watzlawick *et al.* (1974) call

the "problem-maintaining solution"—that is, a solution, attempted by the family before coming to therapy, which only perpetuates the problem.

PI strategies, then, in both individual and family settings, have been employed to interrupt the cycle of failed effort and escalation.

Learning Theory

Learning is held by behaviorists to explain both adaptive and maladaptive developments and is the core of the behaviorist rationale. Undesirable traits are targeted for extinction. The client undertakes a series of experiences during which the behavior is elicited without being reinforced, with a negative reinforcement, or without the dreaded consequence ensuing. The behavior, or the problematic anxiety, is thereby extinguished (Bandura, 1969; Wolpe, 1958, 1969; Wolpe & Lazarus, 1966).

The aspect of reward and nonreward of behavior is acknowledged by some of the other writers reviewed. They note that in PI strategies the client's defenses no longer work (Greenberg, 1973), or that secondary gain is no longer available (Grossman, 1964). It is implicit in the other therapies reviewed that therapy forms a learning experience for the client insofar as his or her old patterns of behavior are, in this setting, not met by the usual response. A new association between behavior and response is established. However, for most of the writers cited here, this is a necessary but not sufficient element in the therapeutic process.

Intrapsychic Factors

Apart from resistance, reactions taking place inside the client during the administration of a PI strategy have been until recently little discussed in the literature. The writers were generally more interested in describing the structural properties of the intervention or the group dynamics it creates. Nevertheless, a few speculations have been made about the internal response of the client. They fall into five subtypes.

1. *Confusion or disorientation.* I have already cited Erickson on the value of confusion and on the report of a former client who reported a sense of "not being able to move." Rossi reports that Erickson deliberately used shock tactics in order to pave the way for change. "Shock could be creatively used in psychotherapy (with or without hypnosis) to break up maladaptive attitudes and patterns of behavior so the therapist could help the patient realign his life learnings in a more constructive manner" (1973, p. 9). Here we see again the intent to break up a system. Later Rossi connects the value of confusion with the creative process. "A creative moment occurs when a habitual pattern of association is interrupted. [Various events precipitate] a momentary void in awareness. In that fraction of a second when the habitual contents of awareness are knocked out, there is a change for pure awareness" (p. 18). Other writers note the moment of being stunned (Selvini Palazzoli *et al.*, 1978). The value of the "fertile void" is acknowledged by Van Dusen (1958) and Perls (1972*b*).

2. *Cognitive restructuring.* Greenberg's (1973) goal is to assist the client to use his or her ego to frame the problem cognitively, suggesting that the use of statements that are even *more* self-defeating encourages this process. Watzlawick (1976) values the technique of reframing as a way of restructuring the client's second-order reality. This too is an appeal to the cognitive faculties. Omer (1981) would call this "symptom de-contextualization" and believes it is a unifying theme in the rationales for PI strategies.

3. *Ego functions.* Grossman (1964) and the paradigmatic therapists (Coleman Nelson, 1962; Sherman, 1961, 1968; Strean, 1961, 1964) seek to activate the nondefensive functions of the ego, to permit externalization of divisions, and to make hidden material available for further therapeutic work.

4. *Transference issues.* Rosen (1953, 1962) directs all therapeutic transactions toward intensifying the transference. As above, this elicits material otherwise difficult to unearth.

5. *Paradoxical tasks.* Recently the client's experience of facing the paradoxical intervention and being thrown back on his or her own resources has begun to draw attention. Zeig (1980*a,b*) suggests that the technique of symptom prescription essentially

> enables the patient to discover and demonstrate to himself that he has such resources, and that he can initiate the change that he requests. . . . Symptom prescription gives the patient an opportunity to recognize, evaluate and change (or accept) his *own* behavior, and this can be done consciously, or outside conscious awareness (1980*a*, p. 22).

Rosenbaum (1982), rather like Haley, sees the paradoxical task in the therapeutic relationship itself. The therapist is both powerful and impotent, charlatan and sage, "consistently inconsistent." The client's problem is that he or she reifies the symptom and is unable to see himself or herself apart from it. PI strategies—or rather, the ther-

apist's paradoxical role—forces the client into a new *experience.*

By showing the patient how the therapist can be more than one thing at a time, he is showing that a person is not a thing, some stable lump of unchanging essence. . . . In this view, then, *the essential function of a paradoxical intervention is to de-reify the patient's (and the family's) conception of a situation, to provide an epistemological jump* (1982, pp. 88, 89).

Rosenbaum emphasizes the struggle that the client goes through as he or she entertains this difficult idea, and eventually breaks through the rigid ideas that have kept him or her immobilized.

It should be kept in mind that the five intrapsychic factors outlined above, as discussed or rather casually implied in the PI literature, represent *speculations* about the client's responses to the strategies: Evidence from clients is not introduced to support them. This remark applies, in fact, to all rationales discussed in this paper. Except for a brief section in Weeks & L'Abate (1982), there has been a singular absence of information from clients in the literature, and any rationale represents the mind of the therapist at work, not known responses from the subjects in question.

Conclusions

The plurality of rationales for PI strategies reflects several factors. First, PI is really a cluster of techniques intended for use in a wide array of therapeutic situations. Varying target conditions are involved. The contract may include one client, a couple, or a family. The degree of disturbance ranges from mild to pronounced. The goal of the strategy may be immediate resolution of relatively overt symptoms, a deepening of awareness, or one of many possible intermediate goals.

Apart from these differences based on variables within the therapy setting, the rationales reflect the theoretical orientations of the writers. Theorists devoted to brief therapy and the exercise of interpersonal influence as a therapeutic agent hold that the effect of the strategy is a function of a problem set for the client by the therapist. Theorists believing that the problem is caused by unrealistic or excessive concern with oneself hold that the strategy is effective because it alters the individual's perception of oneself and one's goals. Theorists who subscribe to learning theory as a basis of behavior acquisition also subscribe to it as the basis for behavior alteration.

Though this plurality of explanations may suggest the discouraging conclusion that we do not really understand paradoxical strategies at all, it does imply that their power may derive from more than one source. Different practitioners describe this phenomenon in the language with which they are familiar, whether it be a sense of meaning, interpersonal influence, learning, or humor and perspective.

As suggested earlier, there is almost no evidence solicited directly from clients to explain the effectiveness of PI approaches. In my opinion this constitutes a serious hiatus in our understanding of them, and not until systematic research has elicited and analyzed this information will we be able to claim real understanding of the strategies. Until then, the rationales reviewed above serve as temporary landmarks guiding the practitioner wishing to use them.

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