

### Paradoxical directives

Whereas straightforward directives are successful for family members who do what the therapist asks, paradoxical directives are more effective for members who resist completing tasks. The pattern of resistance is not uncommon. It appears in many families, particularly those with a schizophrenic member or an addict and those in which one or more members are characterized by a "personality disorder" (Stanton, 1981). These families are very effective in getting the therapist to work hard for improvement while they resist his or her efforts (Haley, 1976).

Resistance typically takes the form of failure to complete homework assignments. In most instances the family remains stable because one family member continues to be the "problem." As long as one person is the problem, other more serious issues can remain hidden: out of sight, out of mind. When therapists attempt to change the family member's problem, however, they are threatening the family's stability and thus will encounter the family's resistance to change (Haley, 1976). When meeting with such resistance, the experienced therapist may choose to give a paradoxical directive rather than a straightforward directive.

**Anticipating noncompliance.** Weeks and L'Abate (1982) list five types of family transactions that point to the appropriateness of paradoxical directives/tasks:

1. *Fighting and bickering.* Members of the family relate to one another primarily through fighting and bickering. Family members are at odds regardless of the issue. Family members are highly volatile and reactive. Straightforward directives/tasks are ineffective with this type of family.

2. *Noncooperativeness and failure to complete assignments.* The family is not as expressive as the families whose members fight with each other. Members may cooperate verbally but undermine each other nonverbally. One or more members generally act out their aggression through other means, such as drinking, drugs, or work. Members will often agree to complete homework assignments but fail to take personal responsibility when they have left the session.

3. *Continuation of the problem regardless of the intervention.* The family fails to respond to any type of intervention. The therapist often feels discouraged with this type of family because he or she sees little change.

4. *Separation and polarization.* This pattern is characteristic of families whose children can easily separate them. Adolescents are especially effective in challenging or separating their parents.

5. *Disqualifying one another.* Family members contradict or disqualify each other's statements. Family members show no support of each other and fail to set limits for the children.

Peggy Papp (1980) describes three steps in giving a paradoxical directive:

1. Clearly explain the problem and the benefits of the change.

2. Prescribe the change. The therapist should describe what the client has been doing because of the problem (Stanton, 1981). This also implies that the therapist to take also implies that the behavior can "be" but however, it must defiance creates.

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1. Clearly explain the benefits the symptom provides to the family. The explanation comments directly on the interactional sequences that both are a benefit and create the symptom.

2. Prescribe the symptom: encourage the family to continue what they have been doing because to change would result in the loss of benefits to the family (Stanton, 1981). If the family follows the therapist's directive, it is allowing the therapist to take control by continuing its symptomatic behavior. Compliance also implies that the symptomatic behavior is amenable to change (that is, the behavior can "be continued"). If the family defies the therapist's directive, however, it must discontinue the symptomatic behavior. Either compliance or defiance creates change.

3. Restrain the family when it begins to show improvement. The restraint of "growth" allows the therapist to take a position that keeps the paradox working. In essence, the therapist is saying, "I'm not sure this change is wise. I realize the symptoms have improved, but are you really sure you want to give up the benefits? I'm concerned." The therapist is careful not to change posture or take credit for the change. This sort of "reverse psychology" must be genuine and avoid sarcasm. In other words, the therapist must have some empathy for the family's need to develop the symptoms to preserve their collective stability.

This three-step process can be illustrated by the case of a recovering alcoholic and his wife. The wife had taken care of her alcoholic husband for five years. The husband had been sober for six months and now wished to take control of the family finances and other matters. The wife reported that she wanted her husband to "take control" but resented helping him do such things as balancing the checkbook. The husband felt that the wife was unsupportive and often got angry with her attempts to help him.

The symptomatic husband appeared to be in an inferior position to his wife, who was trying to help him. Yet in reality the symptomatic spouse was in a superior position because he refused to be helped, even though requesting the wife's help. The wife offered help, but did so in a way that was not helpful.

The therapist discussed the benefits of their relationship. If the husband gave up his symptomatic behavior—that is, anger, complaints, and threats to resume drinking—then he would lose his superior position in the relationship because he no longer would frustrate his wife. If the wife were able to help her husband take charge of the household, then she would lose her superior position. If they were to change, each might lose his or her imagined preferred position.

In an attempt to change the family, the therapist directed the couple to continue arguing over the checkbook and other household responsibilities because any change might be too threatening for their relationship. The therapist was communicating several things with that directive. He was saying, "It would be nice if you could share responsibilities, but I'm not sure you are ready to change." When the couple reported that they were fighting less, the

therapist celebrated their change but cautioned the couple to slow down—otherwise, each might panic over losing a preferred position in the family. When giving those directives, the therapist was careful to communicate that he was concerned about the couple, somewhat surprised, but a little more hopeful for change.

**Application.** Jay Haley (1976, pp. 72–74) outlines eight stages he considers important when giving paradoxical directives:

1. *Defining a therapeutic relationship.* The therapist must join with family members to establish a trusting relationship. The trust between the therapist and family allows the therapist to give a paradoxical directive in a way that still shows concern for the family.

2. *Defining the problem clearly.* The problem should be clearly and concretely defined. Weeks and L'Abate (1982, p. 75) ask the following questions, which are useful in defining the problem: "Who is involved in the problem? Where does the problem occur? How frequently does the problem occur? What happens when you experience this problem?" It is important to identify the sequence of events that maintain the problem.

3. *Setting goals.* Goals should be stated in concrete terms so everyone will know whether the goals have been achieved. Goals can be established by asking family members how they would like things to be after treatment ("What would you be doing after we have finished?"). The therapist must make sure that the goals are reasonable and set an appropriate time period for their accomplishment.

4. *Designing a plan.* All tasks should be provided at the end of the session. A directive to any member should be stated clearly and connected to other family members in the system. The therapist should make sure the client has understood the directive. The therapist should present the task with an authoritative voice if he wants the family member or members to resist him (Rohrbaugh, Tennen, Press, White, Raskin, & Pickering, 1977). If the therapist wishes the client to perform the task, he or she will need to encourage the client to complete the task.

5. *Disqualifying the current authority on the problem.* The authority is generally a spouse or other family member who is trying to help solve the problem (Haley, 1976). In some cases, the authority may be people outside who have influence on the family. Unfortunately, family members often attempt to do more of the same to solve the problem. Thus, those who attempt to solve the problem may be an obstacle to its resolution. Consequently, the person who is attempting to solve the problem is actually maintaining it and must be disqualified.

6. *Giving a paradoxical directive.* Paradoxical directives or tasks should be designed to fit the client's special interest (Weeks & L'Abate, 1982). The directives should play to the client's style, values, and abilities if possible. The authors have found that written directives can be phrased in language that

appeals to special types of clients, such as lawyers or doctors. The directive or task should be tailored to the family members' schedules so that the task does not occur spontaneously.

7. *Encouraging symptomatic behavior to occur.* When improvement occurs, the therapist should restate the rationale and encourage the client to continue to follow the directive. If the client fails to comply, the therapist should be solemn and suggest that the client is not cooperating. The therapist should avoid behaving in a way that the family might view as insincere or sarcastic (Stanton, 1981). The therapist should then request that the client continue the symptomatic behavior. The therapist should not back off if the family is resistant, or he or she will lose credibility.

8. *Avoiding taking credit for change.* If improvement occurs, the therapist should avoid taking credit for it. If a task does not produce the desired result, the therapist should accept responsibility for the failure. If the therapist accepts credit for change, he or she risks a relapse for the client, who is acting to please the therapist.

Weeks and L'Abate (1982) suggest that the therapist have a firm grounding in systems theory and the principles of paradoxical intervention before working paradoxically. They also recommend that the beginning therapist have supervision to prevent isolation and self-doubt. As with all other techniques, the therapist must have confidence in the intervention and understand the changes that are likely to occur. This is sometimes difficult because each task is created anew for each unique family and situation. With supervision and experience with a wide range of uses, therapists progressively sharpen their skill, and with increased skill, their confidence increases. The authors have used the following paradoxical tasks in their own clinical work:

1. A fiercely independent single parent who was reluctant to give her son more autonomy was asked to do even more for him, lest she experience the anxiety of being on her own.
2. A boy who threw frequent "out-of-control" temper tantrums was asked to continue having his tantrums but to have them in a special place at home and only after school, when he could really have ample time to throw one.
3. A wife who tried to leave her husband but couldn't was urged to stay with her husband because he needed someone to take care of him.
4. A woman who was often depressed was asked to set one hour aside each day to be depressed. The woman was told that if she was to be in control of her depression, she would have to learn to turn it on as well as turn it off.
5. A couple whose only contact occurred when they argued were told to increase their bickering so they would be closer to each other.
6. A teenage girl who was having trouble separating from her mother was told that she was noble and that her sacrifice, though very sad, did protect her mother from the realities of life.

7. A depressed girl was asked to pretend she was depressed and her parents were told to encourage her to give a better performance of her depression.
8. A mother who worried constantly about her son was asked to set aside one hour each day to worry so she could be more effective at it. She was to do nothing else during this hour.

### Positive labeling and connotation

Strategic family therapists generally attribute "positive motives to clients" (Stanton, 1981, p. 376). Problem behaviors are often relabeled to have more positive meaning. For example, a **positive label** for "jealousy" could be "caring," and "anger" could be relabeled as "desiring attention." New labels often provide family members with a new way of thinking about the problem, so that it can be resolved. For example, Madanes (1981) cites a case in which a woman's "hysterical paralysis" was relabeled as "muscular cramp" and another in which a man's "depression" was labeled as "irresponsibility." In both cases, the problem was relabeled to make it amenable to change.

DeShazer (1975) suggests that symptoms are adaptive and that families do what is necessary at the time. This idea is shared by Haley (1976), Minuchin and Fishman (1981), and Boszormenyi-Nagy and Spark (1973). Stanton (1981) labels this concept as "ascribing noble intention." Stanton and his co-workers found that in working with addict families they needed to attribute positive motives to extremely destructive behaviors exhibited by these families. Stanton credits Boszormenyi-Nagy for the idea that symptoms are adaptive across generations, but differs from Boszormenyi-Nagy in that he will use this approach to produce a desired effect.

Relabeling has also been used by Palazzoli-Selvini and associates (Palazzoli-Selvini, Boscolo, Cecchin, & Prata, 1978) in Milan. They refer to their technique as "positive connotation." They write that "all the observable behaviors of the group as a whole appeared to be inspired by the common goal of preserving the cohesion of the family group" (p. 56). For example, Palazzoli-Selvini et al. (1978) describe a 10-year-old boy who exhibited psychotic symptoms following the death of his grandfather. At the end of the first session, the therapist told the boy that he was "doing a good thing" (p. 81). The therapist further noted that the grandfather was a "central pillar of the family" and kept the family together. The boy was told that he had assumed his grandfather's role to maintain balance in the family and that he should continue this role until the next session. Here the therapist used "positive connotation" to maintain the homeostasis in the family. The boy had taken the grandfather's place to maintain a heterosexual balance in a family that, following the grandfather's death, had been dominated by women. The use of positive connotation allows the therapist to join with the family at a time of crisis and shift the problem to a systemic level.

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