5

Choosing the Right Strategy

A strategic therapist must have a strategy. The issue is choosing the strategy that is best suited to each different kind of problem. Traditional diagnostic categories are not helpful in making this choice. A therapist must develop the right thoughts so that he can not only come up with the right intervention but also elicit in himself the sympathy for and interest in the clients that will make it possible to influence them. What makes a therapist choose a particular strategy is how he conceptualizes a problem brought to therapy as well as the specific characteristics of the problem itself or of the people who present it. These characteristics are mostly in the head of the therapist. That is, the way a therapist thinks about a problem and the way that problem touches him is what determines what strategy will be used to solve it. For example, an adolescent who refuses to go to school may be thought of as being disobedient and out of the control of the parents; or he may be thought of as misunderstood and mistreated by rejecting parents; or he may be thought of as a pawn in a struggle between the parents, in which one parent takes revenge on the other by arranging that the son fail; or he may be thought of as being concerned about and protective of

the parents, sacrificing himself to keep the mother company and so replacing the father and freeing him for other endeavors; or he might be thought of as the victim of an oppressive school system that is not geared to his sensitivity and talents. All these hypotheses may fit the situation equally well. The hypothesis that is chosen from among the many different ways to think about a problem is the one that appeals most to the therapist at a particular time; it is the one that elicits his sympathy and interest in the family.

The many different ways of thinking about a problem tend to cluster around a set of concepts that are most frequently used in strategic therapy. These concepts are presented here, followed by a review of the various strategies based on these concepts. Each concept tends to encompass a range or continuum that goes from one extreme to another. For example, a therapist might think about relationships in a family in terms of hostility or love, with a range of mixed or ambivalent emotions between the two extremes. But whether a therapist thinks at all in terms of hostility and love instead of, for example, in terms of equality and hierarchy determines what strategy for therapy will be chosen.

In human relations, nothing is ever all black or all white; where there is love there is hate, power is always associated with dependence, behavior is never totally voluntary or involuntary. As soon as one seems to have defined a situation and understood it without ambiguities, the opposite definition comes to mind and appears equally feasible. It may be that what is characteristic of a good therapist's thought processes is a particular tolerance for ambiguity.

The following are eight dimensions for conceptualizing a problem brought to therapy.

Involuntary Versus Voluntary Behavior

Characteristically, the problems presented to therapy are introduced as involuntary behavior by the symptomatic person. The relatives sometimes share this view, or they may prefer to think of the problem as voluntary and under the control of the

patient. For example, headaches are often considered involuntary by everyone involved, while stealing cars tends to be considered deliberate, voluntary behavior. Of course, there are exceptions; husbands have been known to argue that their wives deliberately bring on a headache to reject them, and certain parents of delinquents have gone so far as to propose that there must be a specific brain damage associated with stealing mopeds.

A strategic therapist generally prefers to think of all symptoms (except for organic illness) as voluntary and under the control of the patient, although this thought may or may not be shared with the clients. Even with organic illness, often the extent of the handicap is related to this issue of voluntary or involuntary behavior. Sometimes a first step in resolving the presenting problem is to redefine it as voluntary rather than involuntary behavior. This may be the only intervention that is necessary, as the client may solve the problem once he accepts the idea that it is under his control. At other times, the request to deliberately produce involuntary behavior has a paradoxical effect and the behavior disappears. In some situations, a client may present a problem as involving voluntary behavior on his part, and the therapist may choose to redefine it as involuntary and out of the client's control.

The issue of whether a behavior is voluntary or involuntary is crucial to some cases and to some strategies and quite irrelevant to others. For example, defining drug addiction as voluntary rather than involuntary behavior is usually crucial to the therapy. However, whether a couple's bickering is voluntary or involuntary is not necessarily relevant to change.

Helplessness Versus Power

A symptomatic person tends to appear helpless in that he presents unfortunate and/or involuntary behavior that is out of his control; he cannot change even though he wants to. However, this very helplessness is a source of power in relation to significant others whose lives are often limited and dominated by the unreasonable demands, fears, and needs of the sympto-

matic person. The nonsymptomatic members of the family appear to be in a position of power in that their own behavior is under their control, but they are helpless to influence the symptomatic person, who, in fact, has a great deal of power over them. Those in power are always dependent on the powerless, and the helpless have power over the powerful. For example, a baby can be seen as being more powerful than his mother and a servant as more dominating than his master.

A therapist can think in different ways about the power and helplessness of various family members. He may choose to view the helpless symptomatic child as powerful or as victimized, and the parents may be seen as tyrannical or exploited. The therapist may or may not choose to share these thoughts with the family. A therapist thinking within the dimension of power and helplessness also may choose to redistribute power and the responsibility that goes with it. Children may become agents of change, or parents may become therapists to their children. How a therapist thinks about power and whether he thinks about power and helplessness at all will determine how he designs a strategy for change.

Hierarchy Versus Equality

Related to issues of power and helplessness are issues of hierarchy and equality. Some therapists think that a well-functioning family is an organization of equals, while others prefer to think that hierarchy is essential to the effectiveness of a family system. Whether a mother and daughter will be organized in a hierarchy in which one has power over the other or whether they will be thought of as roommates sharing equal responsibilities has to do with the way in which a therapist chooses to think about a problem. Deciding whether to shift from hierarchy to equality or vice versa and when to make that shift also may be at issue in the conceptualization of a problem. For instance, a therapist must decide whether he will consider a marriage to be a relationship of equals or whether he will take into consideration the hierarchical positions of the spouses in relation to their families of origin and their work situations. A focus on hierarchy is usually associated with a concern with power, status, money, and extended family. A focus on equality is usually associated with a concern with communication and a view of a couple as an entity separate from extended family and issues in the outside world.

Hostility Versus Love

People can be seen as being motivated mainly by hostility or by love; the same action can be interpreted or motivated by either emotion. A man may reject a woman because he does not like her or because he considers himself unworthy of her and fears that she will not be happy with him. Parents' disciplining of their children can be seen as acts of love or of punitiveness. Some therapists prefer to think in terms of rejection, revenge, punitiveness, aggression, envy, jealousy, hate, and other unsavory motivations. Others go to extreme lengths to see everyone as being concerned about others, benevolently motivated, and compassionate. The issue has to do with both the attribution of meaning and the question of redefinition as a therapeutic tool. Once a therapist understands a problem in a certain way, he has attributed meaning to the motivations of the people involved. This particular meaning constitutes an important consideration with respect to the therapist's choice of strategy. Even more important, however, is whether the therapist's conceptualization of the problem coincides with the view that is presented to him or whether he will choose to redefine and change this view. That is, a rebellious adolescent may present himself as being motivated by hostility and the desire for independence and the parents may see him in the same way. The therapist, however, may think that the young person is benevolently concerned about his parents and distracts them from their other difficulties by providing them with a focus for their concern. The issue then is whether the therapist will choose to explain this view to the family and will base a strategy on this redefinition of the situation or whether he will not explicitly address the issue at all. Strategic therapists tend to think of and redefine people as being benevolently motivated,

probably because this view is more conducive to sympathy and interest in the human dramas brought to therapy.

Personal Gain Versus Altruism

A symptomatic person may be motivated by personal gain or by altruism. If the symptomatic person is seen as being hostile, his motivation is always thought to be personal gain. However, if the symptomatic person is seen as being motivated by love, the therapist may view him as being concerned either with helping others or with receiving more affection himself. For example, a symptomatic child may be seen as being concerned about and loving toward parents and siblings. The symptom then may be seen as related to an attempt to receive more affection from them or as an effort to help them by becoming, for example, a communication vehicle between them. The two motivations are not necessarily exclusive. If the therapist accurately perceives whether the child is motivated by personal gain or by altruism, then the strategy of the therapy is laid out before him. All he has to do is to arrange for the same consequences of the symptom to take place without the symptom, and the problem behavior should disappear. For instance, if a child has fears because he wants demonstrations of love from his father, the therapist need only arrange for these demonstrations of love to take place without the fears and the fears will be gone.

Issues of personal gain and altruism are more important in relation to the symptomatic person than to other relatives because a correct understanding of the symptomatic person's wishes can lead quickly to a strategy for change. However, if one considers the possibility that other family members are involved in the problem and are instrumental to maintaining or resolving it, the issue of whether they are motivated by personal gain or by altruism is equally important. If, for example, disability payments for mental illness in one person contribute significantly to the support of other family members, these relatives may be motivated by personal gain to maintain the mental illness of the patient. The therapeutic approach to loving, altruistic parents of a hostile adolescent may be quite different from

the approach to parents who seek to arrange a hospitalization so that they can go off on vacation together. However, personal gain and altruism usually overlap and are difficult to distinguish, forcing the therapist simply to choose to think in the way he thinks is more conducive to change.

Metaphorical Versus Literal Sequences

A therapist can focus on concrete facts, observations, and information, or he can be interested in covert, implied, or indirect references. A child who refuses to go to school may be thought of as being a disobedient child and the problem understood as how to get him back in school. In contrast, the refusal to go to school may be considered an allusion to another situation in the family; the therapist may connect it, for example, to the mother's depression and difficulty in finding a job. The child's behavior in relation to the parents may be considered similar to the mother's behavior in relation to the father. The child's refusal to go to school in spite of the parents' efforts may be considered an allusion to and a metaphor for the mother's refusal to go to work in spite of the father's efforts to convince her. The parents' struggle with the child may have replaced the struggle between the mother and father in the family. A therapist may think in terms of the metaphor in a symptom or in a sequence of interaction, yet he still may choose to take a matter-of-fact approach to the therapy, disregarding metaphors. On the other hand, the idea that a symptom may be a metaphor for the problems of another person may lead a therapist to focus on resolving those problems instead of focusing directly on the symptomatic person. If the therapist thinks of the presenting problem as part of a sequence that is metaphorical for another sequence, he may think that a change introduced in one sequence of interaction may have repercussions in other relationships in the family.

Freedom Versus Dependence

A therapist's and client's concern about freedom and dependence may or may not coincide. A therapist may look at a

family and think that the members' lives are limited by extreme dependence on each other, or he may find them so unattached that there is minimum contact between family members. Characteristically, certain patients remain intensely attached to their families while the therapist attempts to give them more freedom. Others seem unable to hold on to their attachments and, even though unhappy with their situations, appear to convey that their freedom and independence are more important than any relationships. It is questionable whether it is up to a therapist to say what degree of dependence or freedom is most desirable. Therapists must consider the issue in the context of the goal of the therapy. Sometimes the issue can be considered and discarded. At other times, a redefinition of the problem or the incorporation of the issue into a general strategy is crucial to the success of the therapy. To a person who sees himself as being totally dependent on his family, the therapist may present the idea that he is actually completely alone in the world. A client who thinks of himself as free can be told that he is extremely dependent on his spouse or his children. These redefinitions are possible because freedom and dependence are mostly only illusions. We are dependent on others in extreme and complex ways, yet we are quite alone in the world. The issue of freedom versus dependence has to do with the intensity of human involvements and is usually an important consideration in marital problems and in the difficulties of young adults.

Resistance Versus Commitment to Change

The choice of strategy is often determined by whether client and relatives are seen as resistant or committed to resolving the problem. When family members are not sure whether they like the therapist, whether they will listen to any interpretation of their situation that is different from their own, or whether they want any therapy at all, it is best for the therapist to use indirect or paradoxical methods whose effectiveness is based on the idea that the therapist's influence will be resisted. A restraining technique may be used and the therapist may discuss with the family what the consequences would be if the presenting problem were resolved, implying that these consequences

might be negative and that the family is invested in maintaining the symptom (Haley, 1976).

A therapist can expect direct suggestions to be followed only by people who have a certain commitment to change and who are motivated to cooperate with the therapy. When this commitment does not exist, it is usually best for the therapist to plan to bring about change in indirect ways. Most often, people are partially resistant and partially committed to change, and the therapist needs to choose how to view them. Some therapists prefer not to consider the issue of resistance and instead choose to conduct therapy based on the assumption that client and family are committed to change.

Power Versus Weakness in the Therapist

Whether a therapist is in a position of power or weakness in relation to a client and his family determines to a great extent what strategy can be used. A therapist may be in a position of power because of his prestige. Sometimes just working in a well-known institution gives him important leverage. A client or a family may be respectful of a professional and attribute to him wisdom and power simply because he is supposed to be an expert. Other therapists may be too young to be looked upon as powerful. Their professional degrees, their sex, or their ethnic backgrounds may undermine their positions. A client or a family may think of themselves as being more educated or higher in social standing than the therapist. Family and client will usually let the therapist know in direct or indirect ways how much power they are attributing to him.

Generally, direct strategies should be used only when a therapist is in a position of power. It is useless to tell a family what to do if one knows that one's directives will not be followed. Direct strategies include: putting parents in charge of the children by having them enforce rules by following through on consequences if the rules are disobeyed; involving a marginal parent with a disturbed child; assigning tasks designed to improve communication, good feelings, and the organization of the family; prescribing an ordeal (for example, every time a person has an anxiety attack he has to do thirty push-ups); making

a contract (for instance, an anorectic will stop taking laxatives if the father stops smoking). These kinds of directives can be given to a family that is motivated to follow them. If the therapist is not in a position of power, he can make a plan to motivate the family to follow his directive before he gives it.

Even when a therapist starts off in a position of power, this power may quickly disappear. An analogy using large organizations may help clarify this issue. A consultant is hired by the owner of a large corporation to improve the efficiency of the organization. The consultant enters the system in a position of power, since he has been hired by the top echelon. Soon, however, he discovers that the problem in the organization is a conflict between the owner and his son, a second-level manager. The son is influenced by his mother, who uses him in her quarrel with her husband over the marketing expert, who allegedly is the husband's mistress. The consultant is faced with a situation in which, to achieve his goals, he must intervene indirectly and diplomatically, as if he had entered the organization from a position of weakness. A therapist's situation is often similar to that of such a business consultant in that he, too, may find himself divested of power when he has to intervene in the upper echelons of a family organization.

When the therapist is in a position of weakness, it is best to use indirect or paradoxical strategies. In playful cooperation with the therapist, family members may be asked to do what appears to be absurd and unrelated to the therapy, and they may become involved in discussions that appear absurd but are therapeutic. A *paradoxical intervention* is a directive or an extended message that is apparently inconsistent with itself or with the purpose of the therapy.* A *directive* is an instruction

*This definition is derived from the *Oxford English Dictionary* definition of paradoxical: "Apparently inconsistent with itself, or with reason, though in fact true; also, really inconsistent with reason, and so, absurd or irrational." This definition takes into account the issue of the veracity of "paradoxical." A paradoxical intervention is neither true nor false, but it can be effective or ineffective. If it is ineffective, it becomes "absurd or irrational." Otherwise, it becomes "consistent with reason" because, by solving the problem, it is consistent with the goals of the therapy.

to do something. An *extended message* is a conversation or discussion that may take a few minutes, a whole session, or several sessions.

Most people who come to therapy cannot follow good advice. Most therapists work from a position of weakness with patients who are not particularly eager to follow their suggestions. Usually, clients and families need to be influenced indirectly in order to change. Eight dimensions for thinking about therapy have been described; in what follows, a review of ten paradoxical strategies is presented with case examples and with an explanation of how these strategies relate to the therapist's conceptualization of the problem.* The list is by no means exhaustive and covers only the strategies that have been introduced by the author in this and previous works.

Strategy 1: Asking Parents to Prescribe the Presenting Problem or the Symbolic Representation of the Presenting Problem

In this strategy, the parents of a child with a presenting problem are asked to request that the child purposefully have the presenting problem. Then the parents are to supervise the child in performing the problem behavior and see that he does it correctly. In the case of a firesetter (see Chapter Three), the father was to see that the child set five different kinds of fires a day and that he put them out correctly and safely. The father was a busy man who often worked at night, so sometimes he had to awaken the son in the middle of the night to fulfill this task. The behavior that previously had represented the boy's rebellious destructiveness toward a distant father now came to represent his obedience to an overly involved father. Only after months of setting fires under supervision with no spontaneous firesetting was the task discontinued.

*The therapists in the case studies presented in this chapter were Marcha Ortiz, D.N.Sc.; Gerald Hunt, Ph.D.; Patricia Davidge, M.S.W.; Marvin Chelst, Ph.D.; Judy Birch, M.A.; Chip Olhaver, M.S.W.; Rochelle Herman, M.D.; June Kaufman, Ph.D.; Judith Mazza, Ph.D.; Bette Marcus, Ph.D.; Richard Belson, D.S.W.; and Patrick Fleming, M.A.

This kind of paradoxical intervention is similar to paradoxical intention as described by Frankl (1960), to prescribing the symptom as described by Jackson (1963), and to paradoxical techniques presented by M. Erickson (Haley, 1967) and by Haley (1973). However, these authors do not direct the parents to enforce the paradox.* Instead, the therapist gives the paradoxical directive to the child without the participation of the parents. For example, Erickson relates a case of a thumb sucker who was directed to "bug the hell" out of her parents by sucking her thumb. Haley describes the therapy of a boy who masturbated compulsively and who was asked by the therapist to masturbate more frequently on Sunday, the day he enjoyed it most. A schedule was made for masturbating, beginning early in the morning, and the manner of masturbating was determined by the therapist so that the process became an ordeal for the child. Both Erickson and Haley prescribe the paradox directly to the child and do not include the parents in these interventions. In such cases, the response of the parents is unpredictable.

In contrast, when the therapist requests of the parents that they prescribe the paradox to the child, the response of the parents is planned with the therapist, harmful reactions are blocked, the interaction between parents and child around the presenting problem can be controlled by the therapist, and the hierarchy is corrected with the parents, not the therapist, solving the child's problem. The hypothesis behind this kind of paradoxical intervention is that the symptomatic behavior has a certain function in relation to the parents: it is part of an interaction in which the child helplessly persists in his disturbing behavior while the parents helplessly insist that it should end but are unable to stop it. When the parents request the problem behavior instead of trying to prevent it and the child complies, the child is no longer helpless; he is deliberately following the parents' instructions instead of behaving in involuntary ways. The parents also are no longer helpless; they are successful in eliciting the behavior they want from the child. The symptomatic

*Haley (1963) has, however, reported cases where he requested that the husband of an agoraphobic ask the wife not to leave the house.

behavior no longer has a function in the family: it has been replaced by cooperation between parents and child.

After the symptom has been gone for some time, and at the same time as the paradoxical directive is discontinued, it is important to move parents and child to a benevolent interaction around other issues. In the case of the firesetter, for instance, after a few weeks of setting fires with his father, the boy complained that the two of them should spend time together doing more interesting and constructive activities. This was denied for a few weeks, but finally the father was allowed to teach his son how to play a musical instrument and to study history with him. In this case, the paradoxical directive was given to the father to enforce, and the mother was the log keeper who reported to the therapist. This was appropriate because the father was distant from the son, who was an only child and craved his father's attention. In other cases, it might be appropriate to have the paradox enforced by the parent who is more involved with the child or by both parents simultaneously.

In a similar approach, the parents are requested to ask the child to perform behavior that is a symbolic representation of the presenting problem. Symbolic representation refers to behavior that is similar to the symptom by vague suggestion rather than by exact resemblance and that could be taken by an observer to represent the symptom. Then the parents are to supervise the child performing correctly the symbolic representation of the problem behavior. If the actual symptomatic behavior occurs, more symbolic representation is prescribed.

A twelve-year-old girl masturbated compulsively at home as well as at school, in front of the whole classroom. The behavior consisted of sitting on the edge of her chair and rubbing her genitals against the corner of the chair with a movement that was very noticeable and that could be felt by the children sitting in adjacent chairs. The mother first noticed that the child was touching herself when she was five years old. Alarmed, the mother took her daughter to her gynecologist, who performed a pelvic examination, apparently for the purpose of determining whether there was an infection. The traumatic effect of this examination on the child is not known. By age nine she was

masturbating in the classroom. The teachers were concerned but sympathetic, and the child was in individual therapy for three years. When she entered seventh grade and a new school, her classmates became upset with her behavior. Their parents complained, the school psychologist intervened but was unable to produce any change, and the girl was expelled from the school. At the time she was referred by the school psychologist to family therapy, she was studying at home with a tutor. The girl's family consisted of the mother, who was a nurse, the father, who was an office manager, and an eleven-year-old brother.

In the first family session, the child was asked to perform the symptom as she did in school. Chairs were set up as make-believe school desks, the brother acted as a classmate, and the therapist played the role of teacher. The girl refused to perform in front of the parents; they had to turn around so she could demonstrate for the therapist. Then the therapist talked with the girl about her interests. She wanted to work with handicapped children when she grew up, and the therapist emphasized how nice it was to meet a young lady like her who wanted to be a helper. The therapist asked each parent to tell the girl that it was all right for her to masturbate in private, that it was only wrong to masturbate in public. The girl answered that she knew that. It was established that the goal for the therapy was that the child stop masturbating in public; however, the parents would not object to her masturbating in private. Then the therapist told the parents that she would embark on the treatment of this problem only if the parents promised in advance that they would follow all her instructions and continue to come to therapy for at least ten weeks, even if their daughter objected. The parents promised to do so, and the therapist explained that this problem was complex both in its origins and in its consequences for the girl and for the family. However, it was clear that the girl had not gone through the proper developmental stages, since she was behaving in ways that were more appropriate to a five-year-old than a twelve-year-old. Therefore, the parents had to take her back to an earlier stage until she was mature enough to move on to other things.

With this introduction, the following instructions were

given. The parents were immediately to buy a rocking horse of the old-fashioned kind that was made of some sturdy material. Three times each day—before going to school, when she came home from school, and in the evening—the girl was to sit on the rocking horse and rock for half an hour. The parents would take turns supervising her rocking and would make sure that she was not reading, watching television, or doing anything else but rocking. In this way, the girl would be practicing behavior that was appropriate to an earlier stage of development and would not need to practice those behaviors at school. The therapist would contact the school and arrange for the immediate reinstatement of the child, and the parents would send her to school from then on. The parents would enroll the girl in ballet, gymnastics, and horseback riding with teachers that were serious and exacting so that she would be involved in interesting activities every day after school and learn new ways of disciplining her body. If the school reported that the girl had masturbated, the time on the rocking horse would be increased to three one-hour sessions for that day; in addition, the girl would have to run around the yard for fifteen minutes on a broomstick rocking horse, supervised by her father. The parents agreed to all this, and the girl was amused by the idea of the rocking horse and delighted with the lessons she would be getting. She was a pixieish little blonde who had been excruciatingly shy during the interview and had only answered the most simple questions after looking at her mother for permission. The only time she had not been shy was when she had demonstrated the masturbation.

By the next interview one week later, the parents had carried out all the directives. For the next two or three weeks, the girl only masturbated in school for a few minutes the day before coming to the therapy interview. The therapist told the father to call the school and inform them that from now on he was in charge of his daughter and that he would call them every week for a report on whether she had masturbated. Also, a new consequence for masturbating in public was set up. For each time that she masturbated, the girl had to spend four hours of the weekend writing an essay under the supervision of one or

both parents. Also, if she squirmed in her chair while writing the essay in ways that were reminiscent of masturbation, she had to write another essay for another four hours. However, if the school reported that she had behaved well during the whole week, the father would take her and a girlfriend to a movie while the mother went out with the brother. (The child had been withdrawn and marginal during all her school years, and it was important to encourage social relations through these outings and with the private lessons, through which she could make new friends.)

After this, the girl masturbated in school only once, and the weekend consequence was enforced. She enjoyed rocking on her horse and did it without complaints. The therapist discussed with the family how, as the child became more normal, she might begin to misbehave in ways that normal girls misbehave; for example, she might begin to tease her younger brother. This could cause a problem, since she was now strong from so much ballet and gymnastics. It was suggested that the boy should take up some sport that he might enjoy and that would prepare him to defend himself against his sister. He chose karate and was very pleased with it. This intervention shifted some attention to the boy and prevented him from feeling neglected.

As the girl became more normal and no longer masturbated publicly at home or at school, the mother began to complain about her misbehavior. The child had shifted from being very shy, obedient, and extremely dependent on her mother to being impudent, disobedient, and belligerent. The parents asked to see the therapist alone and the mother, in tears, explained this situation. The therapist sympathized with the mother and said that the father should take charge of his daughter as he had done in relation to school. The mother would refrain from punishing her or arguing with her but would keep a chart on which she would draw an unhappy face every time the girl misbehaved. When the father came home in the evening, the mother would report to him. If there was one unhappy face on the chart, the father would supervise the girl in some household chore as a consequence of her misbehavior. If there were two or more unhappy faces, the father would punish himself instead of punishing his daughter. This punishment would consist either of doing some unpleasant household chore that the mother usually did, such as cleaning the bathrooms or the kitchen, or of taking the mother out to dinner to an expensive restaurant and leaving the children to prepare dinner for themselves. And, as the therapist explained to the father, since the girl loved him dearly, this would be the worst punishment for her: to see her father performing an unpleasant chore or spending money recklessly in a restaurant. From the father's sacrifice, the girl would learn self-discipline. The father agreed to follow the instructions, the mother was pleased, and the children were called into the room and informed of the plan. During the three years that the girl had masturbated in public, the mother had suffered the most pain and humiliation, because it was she who always dealt with the school. If the symptom served some function of hurting the mother or if the father were setting the child up to hurt the mother, then this function would be blocked by making the father the one to contact the school and later by making him be the one to suffer the consequences if the girl misbehaved—particularly if these consequences involved helping the mother with her chores or taking her out to dinner.

After this, the girl's misbehavior disappeared and she became very cooperative. Her appearance also improved and she looked more grown-up and feminine. In a final session, the children planned that the parents should do more together and go dancing, which the mother liked, and bowling, which the father preferred.

When prescribing the presenting problem itself is questionable because it may encourage the symptom rather than have a paradoxical effect, or when practical or ethical concerns are involved, prescribing the symbolic representation of the presenting problem is indicated. Once the symbolic representation of the symptom is accepted, the paradox works in the same way as directly prescribing the symptom: The response of the parents is planned, harmful reactions are blocked, parent-child interactions are controlled by the therapist, and the hierarchy is corrected by the parents as they solve the problem. Parents

and child first become involved in a struggle over the symbolic representation of the symptom, then the function of the real symptom disappears, as well as the real symptomatic behavior, and eventually the struggle over the symbolic representation gives way to other interests.

This type of paradoxical intervention is indicated particularly in cases in which the presenting problem is involuntary behavior—that is, in cases in which numerous attempts to change the child's behavior have been made and in which the child has said that he would like to stop but cannot. The intervention does away with both the involuntary nature of the behavior and the parents' helplessness to change it, both of which are essential ingredients in maintaining the symptom.

Another situation that calls for this kind of intervention is one in which the only benefit from the symptom seems to be an expression of hostility by the child and negative consequences for the parents. These interventions address the issue of the antagonism between parents and child. The function of the symptom is changed so that, instead of causing negative consequences for others, the symptom or its symbolic representation becomes an ordeal for the child herself.

This intervention bears some resemblance to an approach described by Erickson (Haley, 1973). He tells of the case of a boy who compulsively picked at a sore on his forehead. The father, angry because the boy persisted in this behavior, had broken the child's most treasured possessions, a bow and arrow. Erickson recommended that the boy practice penmanship for several hours a day. Because the child would be so busy with his writing, the father had to do all the son's chores. Erickson describes this approach as prescribing the character trait rather than the symptom. The boy compulsively picked at his sore; now he would compulsively write instead. The directive had negative consequences for the father and provided a way for the child to get back at him. In contrast to performing the symbolic representation of the symptom, practicing penmanship and picking at a sore are similar in that they can be considered compulsive behaviors, but one does not represent or appear to be similar to the other.

Strategy 2: Prescribing the Pretending of the Symptom

In this paradoxical intervention, the therapist asks the parents of a child with a presenting problem to request that the child pretend to have the presenting problem. The parents are to criticize the performance and make sure that the pretending is accurate, and then they are to behave as they usually do when the child presents the real problem behavior.

A young woman from a wealthy family had been a patient in mental hospitals for the ten years since her parents' separation and divorce. In the many hospitals in which she had resided, she had accumulated a variety of diagnoses, including epilepsy. She had arrived at the University Hospital in an ambulance, accompanied by her father, and she was being given antiepileptic medication intravenously because her seizures were so frequent and uncontrollable. It was arranged that the parents would come together on a weekly basis for family therapy sessions. A variety of strategies were used to solve this young woman's problems, but prescribing the pretending of the symptom solved the problem of the seizures. The parents were told to ask her to pretend to have a seizure in the session and then to reassure and comfort her. The staff of the ward where she was hospitalized were instructed to do the same. At first the young woman complied, but soon she refused to collaborate and was exasperated at the idea of pretending to have seizures. So, at any sign of irritability or impoliteness from her, parents and staff were instructed to say: "Oh, good! You are pretending to have a seizure!" and proceed to reassure and comfort her. The seizures disappeared within two weeks and recurred only once or twice a year during the next three years. The hypothesis behind the intervention in this case was that the seizures served the function of bringing the girl closer to her father, of bringing the divorced parents together in therapy, and of giving her special privileges in the hospital, since demands could not be made of her because she was so sensitive and any upset could bring on a seizure. If the girl could get special attention from the pretend seizures, then the real seizures would no longer be necessary. In such cases, it is important for the therapist to be

prepared to deal with other attempts the young person might make to remain in a privileged position after the presenting problem disappears. As new problems are presented, similar or different techniques can be used.

This kind of paradoxical intervention is appropriate when the presenting problem is involuntary behavior and when the therapist understands the interpersonal gain and the dependence on others derived from the symptomatic behavior. If this benefit is understood, then the therapist need only arrange for the same benefit to be accrued without the occurrence of the presenting problem. Pretending to have the symptom rather than actually having it accomplishes that objective. This approach is indicated when the interpersonal gain is benevolent and consists of receiving demonstrations of affection, togetherness, or special privileges that are not harmful to anyone. However, this intervention should not be used if the benefit involves hurting someone or expressing hostility. Arranging for such benefits to occur even if the symptom disappears could hardly be considered helpful. When the therapist understands the benefits from the symptom in terms of hostility, Strategy 1 should be used; when the benefit is understood in terms of an attempt by the symptomatic person to gain love and special consideration, Strategy 2 can be used.

Strategy 3: Prescribing the Pretending of the Function of the Symptom

In this approach, the family members perform, in a playful way, actions that represent what the therapist believes to be the function of the symptom. These actions do not literally represent the function of the symptom but are a condensed, abbreviated, somewhat symbolic, and somewhat humorous version of the family drama. A special characteristic of this type of paradox is that it reverses the positions of family members with respect to who needs help and who is helpful. For example, if a daughter is suicidal, the mother is asked to pretend to be depressed and the daughter to help the mother; if a child has fears, a parent may be asked to pretend to be afraid and the child to

protect the parent. The therapist conceptualizes the function of the symptom in terms of a parent covertly asking for help and a child covertly helping the parent through symptomatic behavior. In the playful prescription of the paradox, the parent overtly asks for help, and the child overtly helps the parent.

In the case of a boy with nightmares and night terrors, the mother had recently remarried; her new husband was an older man who was very reluctant to become involved with her children—to the point of actually saying in a session that he was not and did not want to be their father. He was kind to them and they found him appealing because he was an interesting man, but he insisted on keeping them at a certain distance. The biological father lived far away. The mother was struggling to develop a career and had a tendency to be obsessive in her doubts about the well being of her children and about the decisions she had made in her life. She described herself as an anxious and fearful person. The fears of the child were approached by asking the mother in the session to pretend that she was very afraid because she had seen a cockroach (the mother had previously expressed her fear of bugs). The stepfather was then to call the boy: "Jimmy, to the rescue!" Together, hand in hand, they would run to the mother and the boy would stomp on the cockroach. Then they would play another scene in which, instead of being afraid of a cockroach, the mother was afraid of a thief (played by a sister) who was breaking into the house. Once more the stepfather would call: "Jimmy, to the rescue! We must save your mother!" Together, they would repel the intruder. The family was asked to repeat these performances several times in the session and to act them out every evening at home. The idea behind the directive was that the child's fears were a metaphor for the mother's fears and that the mother was covertly asking the child to help her in integrating the stepfather into the family and in eliciting from the stepfather the kind of concern that she wanted. The child was covertly helping the mother by developing a symptom that brought the whole family to a therapy where these issues were discussed. In the dramatization that was prescribed, not only was the mother overtly requesting the child's help and the

child overtly helping her, but the child was doing so in collaboration with the stepfather, holding his hand and participating in an action that the stepfather initiated. This togetherness between the stepfather and son was what the mother wanted. Her fears centered around the distance between her son and her husband. In the next session, the stepfather told the therapist that he understood the intervention and that the dramatization was no longer necessary. He and the boy would find more interesting things to do together. The symptom did not recur.

Another example is the case of the suicidal sisters (see Chapter One), in which the father, by appearing extremely depressed, was covertly requesting his daughters' help in preventing his wife from leaving him and the girls, by attempting suicide so that the mother could not leave, were covertly helping the father—or so it was that the supervisor understood the function of the symptom. A playful dramatization made evident the father's depression and the daughters' concern and enabled the father to spontaneously correct his relationship both with his daughters and with his wife.

This kind of paradoxical intervention is appropriate when the presenting problem is either involuntary or voluntary behavior and when the therapist understands that the gain the child derives from the symptom is being helpful to someone else (usually one or both parents), even though this helpfulness is unfortunate. If the therapist understands not only the child's gain but also the covert request made by others for the child's help, then the strategy is simply to elicit an overt, rather than covert, request from those others and to have the child help overtly rather than through symptomatic behavior. Pretending to help the parents in other absurd ways (through dramatizations both in and outside of the sessions) rather than in the absurd way in which the symptomatic behavior is helpful serves this purpose and matches in playful ways the creativity of the symptom. This intervention is indicated when the therapist can see that the child is motivated mainly by love and concern, but it should not be used when all the therapist can see is rebelliousness and hostility (not because the intervention could cause harm, but because the family will refuse to collaborate). In

Strategy 2, the benefit for the child is understood as an attempt to gain love for himself; in this approach, the benefit is an attempt to gain a positive effect (reassurance, togetherness, love) for someone else.

The success of this kind of intervention depends in large measure on how accurately the therapist's understanding of the function of the symptom matches the child's reality. If the match is not good, chances are that the child will be reluctant to collaborate. For example, in the case of the suicidal sisters (Chapter One), when the supervisor at first misunderstood the situation as one in which the girls were helping the mother, the girls were very reluctant to perform the dramatization. However, as soon as the father was asked to pretend to be depressed and the girls to pretend to help him, they jumped out of their chairs, eager to perform the scene. A clear understanding of hierarchy and of metaphorical sequences is also crucial to this approach.

In another case, a little girl was afraid of taking shots (which she needed for her school immunizations). The family was from the Middle East and had suffered during a war in which the children had witnessed bombings and shooting. Ideas about the double meaning of the word "shot" were explored, and the parents' situation in a new country was discussed. It was found that the mother was Iranian and Jewish and so felt doubly persecuted. The father did not speak English and was facing the problem of having to revalidate his professional degree before he could begin to aspire to the same status he had enjoyed in his native country.

In spite of the father's difficult situation, the supervisor thought that the daughter's fears were a metaphor for the mother's fears and an attempt to help her by getting the father to be more involved with and more caring toward the family. So the mother was asked to pretend to be afraid of shots while the daughter pretended to give her a shot (a toy nurse's kit was brought into the session for this purpose) and the father consoled the mother. The daughter, however, refused to participate in this scene, persisting in her refusal even when the scene was performed several times anyway, with her sister playing the one

who gave the shots. The mother collaborated but did not like her part, and at the end of the session she told the therapist that it would be simpler to go ahead and force the child to take the shots that she needed for school, since it was too much for a mother to have to go through this kind of ordeal. The therapist responded only that he would like the family to perform this scene every evening at home for a week. (This child had been referred by the child psychiatrist at a clinic where a pediatrician and nurses had failed to give her the necessary shots because of the child's tantrums and screaming.) That week, after the one therapy interview, the parents took the little girl to the clinic and told her she must have her shots, which she took quietly and rather cheerfully—but, during the process, the father fainted. While he was recovering and the clinic staff was making sure that he had not had a heart attack, a nurse taught the girl how to give injections, and the girl even practiced on some oranges. The father's reaction at the clinic was an indication that the problem had been misunderstood and that the child's fears were most likely metaphorical of the father's situation and an attempt to help *him* and not the mother. Because of this misunderstanding, the child had refused to collaborate in the pretending and the mother had been reluctant to participate.

An intervention that is similar to prescribing the pretending of the function of the presenting problem is prescribing the symbolic representation of the solution to the presenting problem. This was the approach described in Chapter One in the case of the diabetic mother and daughter. In that case, the mother was neglectful of the child and did not give her the care she needed as a diabetic. The mother was asked in the session to pretend to be a nurse and, dressed as such, she went through all the motions of giving her child the care her medical condition required. She was instructed to do the same at home and, in representing a nurse, she was able to care for her daughter in ways in which she had failed as a mother.

The daughter had been covertly helping the mother by putting her in contact with physicians in the hospital. The daughter was asked to take care of her mother's diabetes while pretending to be a nurse and in this way to express her concern

overtly. In their dramatizations, both mother and daughter were symbolically representing the solution to the problem by taking care of each other in appropriate ways. Instead of expressing her love for her daughter by refusing to demand anything unpleasant of her (and thus neglecting to care for her diabetes), the mother, representing a nurse, took care of her child. The daughter, as a nurse, also took care of her mother instead of expressing her love by getting herself hospitalized.

This intervention is an indirect approach to therapy in that the mother was not asked directly to take care of her daughter; she was only asked indirectly to take care of her in a make-believe way. The daughter, by pretending to be a nurse, was asked to do in an overt way what she had been doing covertly by getting herself hospitalized—to take care of her mother. The mother responded to the situation by taking charge of her daughter and of herself, which was exactly what the therapist was after. This solution also points out another paradoxical aspect having to do with a hierarchical reversal: When the child was asked to be a nurse to the mother, the mother responded to this reversal of the hierarchy by correcting it and behaving responsibly.

This kind of intervention is indicated when family members fail to perform simple behaviors or to assume responsibility that could easily be assumed. It is appropriate when the benefit of the presenting problem appears to be related not to hostility but to love and concern. The intervention allows a solution to the presenting problem to develop and provides a way for this love and concern to be expressed.

Strategy 4: Prescribing a Reversal in the Family Hierarchy

This paradoxical intervention consists of putting the children in charge of the parents. All the children (or one particular child) are asked to take charge either of the parents' lives in general or of one aspect of their lives, such as their happiness (see Chapter Three). Sometimes the therapist gives the children authority by putting them in charge of each other, in this way re-

placing the parents. The children might be asked to discuss what they would direct a parent to do if they were in charge of the parent's happiness (see Chapter Three). This approach is appropriate when the parents present themselves as incompetent, helpless, and unable to take charge of their children while complaining that the children are out of control. It is also appropriate when a parent presents disturbing behavior, such as delinquency, alcoholism, or drug addiction, that disqualifies him from a parenting position. As the children are put in charge (in practice or in fantasy), the parent responds by becoming more caring and effective. The intervention is paradoxical because the parent typically complains that the children are "out of control," meaning out of the control of the parent, and the therapist responds by putting the children *in* control of the parent rather than *under* the control of the parent. The therapist prescribes a reversal of the hierarchy, which leads the parents to take charge and correct the hierarchy by taking more responsibility for themselves and for their children.

This approach is useful when a parent is ineffective, although it is not necessary to understand why the parent is ineffective. It is necessary, however, to give the family some rationale for putting the children in charge. The rationale might be, for example, that the parents are unhappy and need to be taught how to be happy or that a parent is tired and needs to be relieved of responsibilities. Whatever the rationale, the children need to be given concrete tasks and concrete topics to discuss in the sessions in relation to the parents. Most of the content of the therapy interviews must be centered on the children taking charge and on how they are going to do this. The approach is particularly useful when the parent does not provide appropriate caring behavior, when child abuse or neglect has occurred, or when the parent is the presenting problem. It is particularly indicated when the children are seen as being concerned about and caring for the parent but rejected in their affection. Whether the children are asked to take charge in realistic or fantasized ways, the tone of the sessions should be light, benevolent, and humorous.

As the children give love to the parents (by actually giving them directives, by taking care of them, or by fantasizing about how they would take care of them if they could), the parents not only become more responsible and caring toward the children but they also resolve their own problems. Children are often surprisingly wise in their directives and advice and, with the therapist's encouragement, they can be very helpful. When the children are put in a position of authority, it is important to allow them to make positive suggestions and to forbid all criticism of the parents. In this way, cross-generational coalitions that divide the parents and support their disturbing behavior are blocked, and a child cannot express overtly a parent's covert criticism of the other parent. At the same time, an alliance between the children is encouraged so that they can support each other and need not seek coalitions with the parents. This, in turn, gives the parents the satisfaction of seeing that their children are strong, united, and benevolently concerned about each other and about the parents, all factors that contribute to the improvement of the parents' situation. As the parents improve, the children are happy to see that their efforts have succeeded and they have helped their parents. With increased self-esteem and competence, the children, who characteristically have serious problems of their own, often spontaneously resolve their own problems.

This approach is appropriate both with shy, withdrawn children and with rebellious, misbehaving ones. It can be used with young children, adolescents, or young adults. No matter how withdrawn the child or how disruptive his behavior, the approach can succeed if the therapist is able to appeal to the child's sense of humor or to touch the chord of love that can always be found between parents and children. The strategy is especially useful when parents are very rejecting, because little or nothing is expected from them and all demonstrations of love and concern are initiated by the children.

The approach of prescribing that the children take charge of the parents is paradoxical when used in situations in which the parents are covertly encouraging the children to be in charge because of the parents' incompetence, symptomatic behavior, or neglect, or because one parent is siding with the children

against the other parent. The therapist encourages the children to take charge in an effective, benevolent way—quite differently from the way in which the parents were covertly requesting that the children take charge. As the therapist's prescription makes this covert request by the parents overt, the parents react against the therapist's prescription and take charge of themselves and of their children. The therapist appeals to the love between parents and children, to the children's altruism, and to their ability to communicate in metaphor.

Strategy 5: Paradoxical Contracts

This strategy consists of tying together two problem behaviors in two different family members so that if one person engages in symptomatic behavior the other is encouraged to do the same. The hypothesis is that the person with the presenting problem is trying to help another family member through the symptomatic behavior. If the situation is reversed so that the symptomatic behavior is harmful rather than helpful to the other person, and if it is nonsymptomatic behavior that actually helps the other person, the symptom will disappear.

A family consulted because their nineteen-year-old daughter was starving herself. During the previous year, she had eaten less and less, exercised violently, and abused laxatives; at present, she had locked herself in her room, too weak to move. She had refused to see a physician or a therapist, and the parents, in desperation, decided to consult a family therapist. The young woman refused to come with them, but they brought an older daughter, who had married and moved out of the home. They wanted to know how they could get treatment for their anorectic daughter.

Before the first interview each family member was seen individually in what was then a standard procedure at the Family Therapy Institute. Each was asked what was the problem about which they were consulting, and they all said it was Martha, the anorectic daughter. When asked if there was another problem about which they were concerned, the mother and sister said that they were extremely concerned about the father.

He had had bypass heart surgery, and he was an alcoholic who would not stop drinking. He drank large quantities of hard liquor every day, even though he knew that it would kill him, and he refused to admit that he was an alcoholic. In fact, the mother and the daughter, Susan, insisted that the subject not even be brought up in the session because the father became extremely hostile.

The therapist went into the first session prepared to engage the family to the point at which the father's alcoholism could be discussed openly without fear or hostility. After finding out the details of Martha's problem and learning something about the family's way of life, the therapist asked the parents and Susan the following question: If Martha were worried about someone in the family, about whom would she be worried? It was important to find out, said the therapist, because sometimes young girls express their concern in strange ways, and Martha might be acting so strangely because of her preoccupation about someone she loved. The father then said that he had had bypass surgery and that Martha might be worried about his drinking. A discussion followed about the father's stress at work, his illness, and his drinking. At the end of the session, the therapist obtained the parents' permission to visit Martha at home that afternoon shortly after the parents went back to their house. The therapist said that she was concerned that Martha's situation could be life threatening and that she wanted to see her and do her best to help her.

When the therapist arrived at the house, the father was coming in through the door with a big brown bag full of liquor bottles. Martha was locked up in her room. The therapist knocked on the door, and Martha refused to open it. The therapist explained through the door that she was concerned about the young woman's health and would like to speak with her. Martha answered with a barrage of insults and abuse. The therapist went back to the living room and told the father that she thought she knew what to do to get Martha to start eating again but that she needed the father's cooperation. The father agreed to cooperate. The therapist then said that she would like to make a contract between Martha and the father. If the father

drank even one glass of alcohol a day, Martha could starve herself; if the father did not drink a drop of alcohol, Martha had to eat. The father accepted this agreement, and the therapist went back and told Martha (through the closed door) that she had a deal that she thought would interest her. Then she proceeded to explain the contract and the fact that the father had agreed to it. Martha said, "Just a minute. I'm going to get dressed and come out." She came out, shockingly emaciated, and said to the therapist, "I still think you're a bitch, but I'll go along with the contract."

The father stopped drinking, and Martha started eating. The therapy took several months, during which the parents, with the support of the therapist, struggled to get Martha back to a normal way of life, involved in work and with friends. She never came to the therapy, but the father gave up the drinking and the daughter's weight returned to normal.

Contracts between family members can be used in a variety of ways, some straightforward and some paradoxical. To say that if the daughter eats then the father does not drink would be a straightforward contract; the daughter would be rewarded for eating in a direct way by helping her father stop drinking. This is quite different from saying that if the father drinks then the daughter can starve herself. Here the burden of the responsibility is placed on the father. If he drinks, he is sacrificing his daughter. If he does not drink, he is saving her life. If the father stops drinking but the daughter continues to starve herself, she is sacrificing her father, since she knows that drinking will cause his death. The contract is set up so that the drinking of the father has the power to destroy the daughter and the anorexia of the daughter has the power to destroy the father.

Straightforward contracts, in which good behavior is rewarded and interpersonal benefits are obtained, are frequently used in family therapy. Paradoxical contracts are more unusual. Another example of a paradoxical contract is the case of a young, single mother and her thirteen-year-old son. The mother brought the child to therapy because he was doing poorly in school, getting bad grades, and the school psychologist had recommended psychotherapy. The boy explained to the therapist that he had intellectual inhibitions and a learning disability, as

had been demonstrated by the psychological tests that he had taken at school. He had an anxiety that prevented him from doing his homework. The boy was very verbal and obviously intelligent. He seemed to take pride in his knowledge of his psychological difficulties. The mother was very young and attractive and led a lonely life. She worked all day and spent the evenings at home with her son, who kept house and cooked for her. She had had a boyfriend, of whom the child had been fond, but had broken up with him a year earlier. The therapist asked the mother what expectations she had for her son, and she explained that she wanted him to be a good student and to be successful. He asked the boy what kind of life he would want for his mother, and the boy said that he would like to see her happier, seeing friends and going out more. Then the therapist asked the mother if she would be willing to accept a contract that he would set up between her and her son that would ensure the child's success in school, even though it would require some sacrifice from the mother.

She said that she would do her best to help her son. The therapist said that she had to accept the contract before knowing what it was, and she agreed. The therapist explained the contract: Every time the boy brought home a B or an A on his homework, a test, a quiz, or whatever, the mother had to go out that evening with a man. It did not matter who the man was, where she went, or how long she stayed out, but she had to go out for a certain period with a male friend. If she failed to do so one day, then she had to do it the next day. The son would stay home and take care of the house. The mother said that she did not know whom she could call to go out, and the therapist told her that she should start thinking about it right away because the son might bring home a B any minute. The boy appeared to like the contract right away. It was written, signed, and witnessed by the therapist. The boy immediately began to bring home A's and B's, and his inhibitions and disabilities disappeared. The mother was too embarrassed to call a strange man and invite him on a date, so she decided that it would be less painful to call her old boyfriend, since at least she knew him. As a result, they got back together again.

This level of paradoxical intervention is appropriate when

the presenting problem is either voluntary or involuntary behavior and when the only gain the symptomatic person seems to derive from the symptom is being helpful to someone else by bringing him to therapy. The alcoholic father of the anorectic girl and the lonely mother of the boy with the school problem came to therapy because of the problem of the child. Apart from that, there was no evidence that the symptomatic behavior was helpful to anyone in any way. Before using this intervention, the therapist must ask himself the following questions: Is the symptomatic person trying to help someone else who has a problem? Does the symptomatic behavior help because it puts this other person in contact with a therapist? Does the therapist understand the problem of this someone else that the symptomatic person is trying to help? Is this someone else kindly motivated toward the symptomatic person and willing to make an effort to help him or her? If all the answers are affirmative, then the contract can be set up.

This type of intervention is best used where there are strong emotional ties and a serious commitment to one another. The success of the intervention largely depends on how accurately the therapist understands the emotional bond between the participants. The approach should not be used if all the therapist can see are hostility and unsavory motivations.

Special contracts between therapist and family members can also be of a devious nature. A working-class family consulted because of a suicide attempt by one of their ten-year-old twin boys. The father, a steel worker, who at the time was mostly laid off from work, customarily beat his children. He had threatened to whip the boy with a belt, and the child had taken a bottle of the mother's Valium. The boys were firesetters, misbehaved in school, and had been through years of therapy for their alleged hyperactivity. The father was uncooperative and said that he did not want to come to the sessions. The mother said that if her husband did not come, she would not come either, since previous therapy with only the children and her had failed. Both parents were very negative with respect to the children. They talked, for example, about the twins' stealing, but when questioned, what they considered stealing was taking

cake from the refrigerator. An important goal of the therapy was to control the father's violence toward the children; related to this was the issue of helping the parents discriminate between abnormal behavior and normal misbehavior of ten-year-old boys. A first step in curtailing the father's violence toward the children was to help him have a more positive view of them instead of indiscriminately interpreting their behavior as bad, delinquent, crazy, or out of control. Toward this end, several indirect techniques were used. At the end of the first interview, when the therapist was discussing the fee, which was on a sliding scale, the father said that he could not pay and that they could not come to the therapy. The therapist said that she would make a deal with him. If he followed her instructions (she had given him several directives for things to do with the children), but reported the following week that the children had misbehaved in abnormal ways, then *she* would pay for the session out of her own pocket. If the children had not misbehaved in abnormal ways, then the father would pay the lowest fee on the sliding scale according to the family's income. The therapy was taking place at a university hospital, where the therapist was a psychiatric resident. She said to the father that it was important for him to keep this contract secret because if anyone knew that she was paying for the sessions she would get into very serious trouble; in fact, she would have to give him the money every time so he could pretend that he was paying with his own money and no one would be aware of their arrangement. The father, who was a proud man, said that he could not accept such an arrangement and would not have her pay for the therapy. The therapist said that it was very important to her to be successful with his boys and that she was betting on the idea that she would never have to pay because their behavior would improve so quickly. The father accepted, and the parents never again talked of the boys' taking food, bickering with each other, and so on, as abnormal misbehavior. They followed the therapist's directives, and the firesetting and disturbed behavior disappeared. The therapy continued for seven months and shifted to a focus on marital problems. The therapist only had to pay for two sessions.

Strategy 6: Prescribing Who Will Have the Presenting Problem

This paradoxical intervention consists of prescribing the symptom but changing who will have it. Another family member is asked to take over the symptom for a time or various family members are asked to take turns in presenting the problem. The therapist makes the request with the rationale that if other family members were to take over the problem behavior (delinquency, hostility, depression, and so forth) the family member with the presenting problem would be free to engage in other pursuits. The idea is that not only is it fair to take turns but in this way old family habits will not be disturbed, since other family members will continue to be preoccupied with someone —but that person will be different from the identified patient. It is best for the therapist not to specify concretely which problem behaviors someone else must take over but to present them in a broad generalization, such as referring to being "the life ruiner" (see Chapter Two). In this way, the therapist equalizes different kinds of disturbing behavior and does not find himself in the questionable ethical position of prescribing antisocial acts. The therapist does not expect the family members to actually follow the paradoxical prescription; he expects them instead to rebel against the absurdity of such an assignment. This kind of paradox is similar to the first uses of paradox in the 1960s in that the family is expected to resist the therapist, but it is different in that this resistance is not thought to be related to the therapeutic effect. Rather, it is the interaction with the therapist and between family members that evolves from this prescription that brings out the conflicts in the family so that they can be resolved. Because the therapeutic effect lies in these discussions, it is important when using this approach that the whole focus of the sessions be centered on the issue of taking turns and who will have the problem, as illustrated in Chapter One with the case of The Life Ruiner. The therapist should be prepared with long monologues and discussion of why it is important to take turns, how it is helpful to various family members, who should have the problem, and so on. The fact that

family members refuse to follow the paradoxical instruction should lead to more discussion of whether they did or did not follow it, the importance of doing so, and so forth.

This kind of paradoxical intervention is appropriate in cases of severe problems, such as antisocial behavior, drug use, delinquency, bizarre communication, and depression. The hypothesis is that the person with the presenting problem is a metaphor for someone else in the family, distracting from the conflict with that person in a way that is unfortunately benevolent in that it prevents the resolution of that original conflict. As family members discuss the instruction to take turns, there is the implication that they replace each other and are interchangeable and that they collaborate with each other in causing distress. This disagreeable idea leads the individual members to assert their separate identities and insist on positive rather than negative collaboration. The therapist then takes the position that, although this would be desirable, it has not been their usual way. The conversation eventually leads to an eruption of the conflict for which the presenting problem was a metaphor and which it replaced. At this point, the therapist should focus the session on this conflict and attempt to resolve it so that it no longer will be dealt with in metaphorical ways.

Another important aspect of this type of intervention is that, as the family members agree to discuss the possibility of taking turns in having the problem, they also accept the idea that the symptomatic behavior is voluntary and therefore can be changed. Once this is accepted, the interaction around the problem is never the same, and improvement follows naturally.

Taking turns is a technique that seems easiest to use in a relationship between peers, such as siblings or spouses, but it also can be used across generations. Haley (1982) tells of a therapy, inspired by the case of The Life Ruiner, in which the father of a severely depressed young woman was asked to take over her depression for a week so that she could be free to pursue other interests. The father willingly sat in his daughter's chair and proceeded to become extremely depressed. It was then found that he had serious problems and that his depression was not make-believe. The daughter had been helpful to him in that

her depression had made him pull himself together in order to help her and had brought him to therapy. The depressed father, eager to help his daughter, offered no resistance to the idea of taking turns.

This level of paradoxical intervention is appropriate when the problem is severe and presented as either voluntary or involuntary and when the therapist understands that the gain for the symptomatic person consists of helping someone else or detracting from another conflict, even though who is being helped or what conflict is avoided may not be clear. This is a very verbal therapy, and the therapist must be prepared to talk at length in benevolent but absurd ways, matching with wit the creativity of the symptom. The approach should not be used if all the therapist can see are hostility and unsavory motivations. In Strategy 3, the benefit for the symptomatic person is understood as an attempt to gain a positive effect for someone else. Here the benefit is understood as an attempt to detract from conflicts with other family members or from the problem of another family member. The success of the intervention does not depend on an accurate understanding of the function of the symptom, but it does depend on a general understanding that the symptomatic person is a metaphor and that the symptomatic behavior is metaphorical for other conflicts. The approach results in transferring the family conflict back to its origin. In so doing, hierarchical problems are resolved and power is no longer derived from helplessness.

Strategy 7: Prescribing the Presenting Problem with a Small Modification of the Context

This paradoxical intervention consists of prescribing the presenting problem but changing when, where, and how it will occur. In this way, the therapist introduces a change that appears to be minor but that in fact alters so much the context in which the presenting problem takes place that it disappears. The approach originated in the work of Milton Erickson (Haley, 1967, 1973; Zeig, 1980). If the therapist wishes to give a rationale for this directive, he can say that it is an interesting experiment or that the presenting problem is so important that it is necessary to assign for it a special place, time, and rules for its manifestation. Family members are expected to follow the paradoxical prescription and to report their experience to the therapist. The therapeutic effect is related to the different interaction that evolves between family members as they follow the therapist's instructions. Since interactions with others are part of the context of symptomatic behavior and since the context makes possible the existence of the presenting problem, then changing the context can render the symptomatic behavior impracticable.

This kind of paradoxical intervention is particularly appropriate for marital problems in which husband and wife are stuck in a repetitive pattern of unfortunate interaction that does not seem to hold any benefit for either spouse. If the couple respond with humor at the absurdity of the directive (see Chapter Two), the therapist should respond with a deadpan attitude and only covertly imply that the directive is in fact humorous, so as not to disqualify it.

The hypothesis is that the nonsymptomatic spouse collaborates in the presenting problem and "sets up" the other spouse. Changing the when, where, and how of the problem behavior makes it impossible for it to occur as a response to some message of the other spouse; a specific time, place, and manner are prearranged so that one spouse can no longer set up the other. Changing the how of the presenting problem changes the response of the nonsymptomatic spouse so that he or she can no longer contribute to the persistence of the problem. The therapist's instructions about how the problem should take place should lead to blocking communication and discouraging interaction. As the couple carry out the instructions over a period of weeks, they strive for increased communication and positive interaction, which is exactly what the therapist is after.

In this approach, the benefit of the presenting problem for the symptomatic person is understood as being a leftover from the past, when the symptomatic behavior probably had a metaphorical function and sustained the other spouse or detracted from other conflicts. In the present, the problem is

understood as part of a habit-forming, repetitive sequence. The success of the intervention does not depend on an accurate understanding of the previous function of the symptom, but it does depend on a general understanding of the interaction around a presenting problem as a part of the problem. Issues of metaphorical communication, hierarchy versus equality, and hostility versus love are relevant to this approach.

A therapist can use this approach when he can understand the roots of the presenting problem but not its present function. As the interaction between the spouses changes, there is usually an eruption of the current conflict for which the presenting problem is a metaphor. For example: A couple in their sixties came to therapy because the wife could no longer tolerate her husband's constant recriminations and harassment for an affair she had had thirty years before. The husband said that he needed to express his pain for what she had done to him. The wife said that his expressions of pain were verbal abuse that on occasion had even become physical abuse. The therapist suggested that it was important for the husband to express his pain and for the wife to listen to him with sympathy. A special time, place, and manner in which this would happen would be set up. Every evening, the couple would sit together in the living room and the husband would express his pain for the terrible thing that the wife had done to him. The wife would listen sympathetically but would only answer, "I'm sorry, dear." This interaction would take place at 5:45 P.M., before the Walter Cronkite newscast, and would end when Walter Cronkite appeared on television. It would also occur in the morning from 7:45 to 8:00 A.M., before breakfast. In this way, the husband would be able to express his pain and the wife to give him her sympathy without interfering with breakfast or dinner or their favorite television program. While apparently favoring increased communication and the expression of old resentments, the directive was in fact blocking communication (since the wife could only say, "I'm sorry, dear") and reducing the expression of the husband's resentments to an absurd fifteen minutes before Walter Cronkite. The couple followed the directive successfully for two weeks, and then a conflict erupted.

The wife, instead of answering "I'm sorry, dear," bitterly recriminated the husband for a platonic affair that he allegedly was having. It became apparent that the wife was intensely jealous and that the couple's interaction around the wife's affair of thirty years ago was a metaphor for their conflict around the husband's relationships with other women. The therapy proceeded to another stage, in which rules were negotiated about relations outside the marriage and the husband wrote and signed a solemn promise to abstain from any relationships of which his wife was not a part.

Strategy 8: Paradoxical Ordeals

This intervention consists of making a deal between family members so that certain behaviors have unexpected consequences. The consequences of the symptom become that which the symptom was developed to avoid. An example is the directive given to the couple in the case of the compulsive cleaner (see Chapter Four). After getting the couple to agree that a cleaning woman, such as the wife, should have normal work hours, from nine to five o'clock, they were given the following instructions: If the wife was involved at all in cleaning after five in the afternoon, except for doing the dishes after dinner for half an hour, the husband would force her to lie in bed with him and watch television for the rest of the evening. If the cleaning occurred before dinner, he would take her out to a nice restaurant that evening. If the woman cleaned during the night, the consequence of either lying in bed or going out to dinner would be applied the next day. The hypothesis on which this strategy was based was that the woman cleaned to avoid being with her husband. By arranging that if she cleaned she had to be intimately involved with her husband, the consequences of the symptom became exactly what, through the symptom, she was trying to avoid.

The approach has its origin in Milton Erickson's case (mentioned earlier in this chapter) of the boy who picked at a sore on his forehead (Haley, 1973). In that case, the father, exasperated because the boy would not stop doing this, had

broken the child's favorite possessions, a bow and arrow, but the boy's behavior had not improved, and he had continued to pick at his sore. Erickson gave the child the task of practicing penmanship with the same obsessiveness and compulsion with which he picked at his sore. Also, since the child would be so busy practicing his handwriting, he told the father that he would have to replace the boy in doing all his chores. Erickson describes this case in terms of replacing one obsessive-compulsive trait—picking at the sore—with another—practicing handwriting. However, there is also the implication that if the child was engaging in this self-destructive behavior in order to punish his father, he could still do so by practicing handwriting, since the father would have to do the chores; but this new behavior would have no negative consequences for the child himself.

The case of the compulsive cleaner and the case of the boy who picked at his sore are similar in that both have to do with obsessive-compulsive behaviors. They differ, however, in that in Erickson's case one compulsive behavior is replaced with a more constructive one that has negative consequences for another person and in the case of the compulsive cleaner the compulsion is not replaced with another obsessive behavior. Instead, based on a hypothesis about the function of the symptom, it is arranged that the consequences of the obsessive behavior be what the obsessive behavior was designed to avoid—proximity to the husband.

An ordeal is not necessarily paradoxical. Arranging that the consequence of a symptom be the performance of a task or act that is more painful, difficult, or unpleasant than the symptom itself is a nonparadoxical ordeal. An example would be directing a patient who suffers anxiety attacks in the middle of the night to get up from bed and spend an hour writing a difficult report that then must be presented to a supervisor. An ordeal is paradoxical when, as in the case of the compulsive cleaner, a consequence for the occurrence of the symptom is arranged that is implied to be a punishment for the patient but that is actually harmless and benevolent and brings family members closer together. The elements of harmlessness and benevolence, however, are not sufficient for the success of the ordeal. The directive must be based on a correct hypothesis of the interaction the symptomatic person is trying to avoid (although he cannot admit to this avoidance). Going out to dinner or getting into bed with the husband can hardly be considered a fitting punishment for a compulsion as annoying as compulsive cleaning. Giving the directive, however, implies a punishment while never explicitly stating it as such. If the directive is enforced, the benevolent interaction that is aversive to the patient can only be avoided by not engaging in the symptomatic behavior. But the ordeal itself can hardly be thought of as aversive, and in this lies the paradox.

This kind of paradoxical intervention is particularly appropriate for marital problems in which one of the spouses presents fears, anxiety, or compulsive behavior. The benefit for the symptomatic person is understood as an avoidance of the spouse, and the success of the intervention depends on an accurate understanding of the function of the symptom. This intervention is not only useful when the symptomatic person is trying to avoid someone but also when the presenting problem is related to an attempt to get back at someone, to make someone suffer or pay, or to take advantage of others. The symptomatic person is sometimes a resentful burden rather than a benevolent helper of the family. In such cases, the therapist can set up an ordeal that appears to be designed as a deterrent for the symptomatic person but that in fact is designed to cause trouble and difficulties for the other family members. In this way, the therapist can indirectly arrange that other family members endure suffering because of the therapeutic directive and thus make it unnecessary for the symptomatic person to cause this suffering through the symptom.

A thirty-year-old woman had been a compulsive vomiter for fifteen years (she also had had periods of alcoholism and drug addiction). She had lost all her teeth from the acid brought up by the vomiting, and her health was not good. She did not work but was supported by her father, a physician, who gave her large sums of money to the detriment of his other seven children. The young woman, who said she vomited because of conflicts with her parents, played on her parents' guilt and took

advantage of them. Many interventions were used over the course of therapy, which lasted three years. A strategy that was particularly successful was the prescription of a paradoxical ordeal. The mother was instructed to keep in her house large amounts of the junk food the daughter liked to binge on (cheap ice cream, Oreo cookies, fried chicken, and so on). Every day, the young woman was to come to the mother's house, and the mother was to put all the junk food on the kitchen counter and supervise the daughter as she mushed up all the food with her hands. When the mother was satisfied that the food was properly mixed together and looked as if it had been digested, the daughter was to take the food to the guest bathroom and flush it down the toilet. While this task was being performed, one of the other family members always would be present, even if it meant having to leave work to do so. If the mother on occasion could not carry out the task, one of the siblings would replace her. If the toilet clogged after throwing the food in it, a plumber could not be called; the father had to unclog the toilet. The therapist gave this directive to the family with the rationale that what the daughter had been doing was throwing away food that had gone through her stomach first. Why not throw it away directly, which would be much less costly to her health? The family members were told that they had to participate because the daughter loved them and needed their help. In this way, under the guise of caring and togetherness, the family members were given an ordeal that replaced the pain that the vomiting had caused them. The incidence of vomiting decreased remarkably and eventually disappeared through the use of this and other similar interventions.

Paradoxical ordeals can be used, as described above, to maintain the interpersonal benefit derived from the symptom while making the symptom unnecessary. They also can be used to eliminate the interpersonal benefit so that the symptomatic behavior no longer achieves the same purpose. One way to arrange this is to reverse the sequence in which the symptomatic behavior takes place. For example, the husband of a compulsive vomiter (who binged secretly and then vomited) was told that every time his wife vomited he was to tenderly take her by the

hand to the kitchen and then, while always affectionately holding her hand, he was to force her to stuff herself. If she vomited again, the sequence had to be repeated (Madanes, 1981b). In this way, the sequence was reversed—instead of vomiting being the consequence of bingeing, bingeing became the consequence of vomiting—and the whole sequence came under the supervision of the husband.

Paradoxical ordeals work best in cases of compulsive behaviors and when client and family are clearly committed to resolving the problem. "We want to solve this problem but we cannot do it" is the kind of statement the therapist needs to hear before prescribing a paradoxical ordeal.

Strategy 9: The Illusion of No Alternatives

Generally, therapists like to broaden their clients' horizons, developing complexity so that the same sequences of behavior do not have to be rigidly repeated and introducing alternatives into otherwise limited lives. Paradoxically, however, broadening the horizons of some clients can best be accomplished by limiting their choices and presenting an illusion of no alternatives. Some people are talented, beautiful, intelligent, and well liked, and the apparently unlimited possibilities that loom in their future actually limit their possibilities by making them constantly unhappy with what they have in the present. It is not possible to have everything at the same time. For such a person, for example, choosing a spouse makes it immediately apparent that another possible spouse could have been chosen from among the myriad of men or women potentially available. If one career is followed, there is always the possibility that another career might have brought even more success. Sometimes such a person is paralyzed and does nothing but think about whether he made the right choice in the past and only broods about what choice to make in the future, without actually making one. This perspective is best broadened by limiting choices and presenting an illusion of no alternatives.

An ambitious young husband had a demanding job, and his beautiful, intelligent wife constantly nagged him for not

spending more time with her. She had had a successful career but had quit working when she married and at the time of therapy was only taking some crafts classes. The husband was a busy politician who could hardly cut down his work time. The wife was not happy with her situation, but she could not make up her mind about whether she wanted to lead a leisurely life, have children, devote herself to crafts, return to pursuing her old career, or start a new career. Therapist and supervisor decided to follow the strategy of the illusion of no alternatives. The couple was told that the wife had the problem of not being able to make up her mind about what career to follow—whether to be a professional woman and put all her energy into a career in her field or to have a career as a wife and devote all her energy and creativity to her husband. Both careers had their appeal and their advantages, but, because she could not decide between them, she did not follow either one and she was a failure in both. In terms of her professional career, she was doing nothing; and, although she pretended to be following a career as a wife, she was in fact ambivalent and undecided and was consequently also doing nothing in that respect. Other women who followed a career as a wife helped their husbands with their work. Why did she not go to her husband's office and volunteer to work? With her intelligence and experience she could be very helpful. Wouldn't the husband agree? The husband said yes, he would agree. Why did she not give dinner parties for important people to further her husband's career? All she needed was to learn to make three or four good dishes that she could then repeat. If she were serious about a career as a wife she would be doing that, and surely she could do it as intensely and successfully as other women. She was very attractive, and she was charming. She could use that charm in flirting with her husband's important business contacts so that they would be more interested in him and would help him. The therapist added that, of course, it could be that she was not seriously pursuing a career as a wife because she was thinking that it would be best for her to go back to her professional career; that might be best, the therapist said, although perhaps she thought that as a professional woman she would not be able to have children

and to be a good mother. That very well could be, although the therapist herself had three children and had raised them successfully while holding a job as a researcher. But the therapist really thought that the wife was more inclined toward a career as a wife because of her devotion to her husband. Because she was afraid of making that decision, and because she hesitated and was torn, she did not do anything well. However, the therapist thought that it was very important for the wife not to rush into any decision and to spend some time thinking and consulting with her husband about the problem of her career choice: a professional career or a career as a wife.

Two weeks later, the wife said that she had decided that she did not want to have a career as a wife; she wanted to have a professional career. The therapist restrained her, saying that she should not rush into a decision that might be too hurried. The therapist said she suspected that this was not her true choice because if it were she would have done something about it in all the time since she had quit work. Within two weeks of that session, the wife had a very good job and was working full blast. The couple were much happier together, but they wanted to consult the therapist about how they could reconcile the wife's work commitments with the husband's so that they could spend time together without sacrificing their work. The therapist said that they had resolved other problems in the past and so they could resolve this one. They were at least as intelligent as the therapist and did not need her help. The wife called a few months later to tell the therapist how happy she was and to thank her for "changing her life."

The two mutually exclusive alternative careers presented by the therapist were purposefully limited and not quite truthful. There are all kinds of life-styles, and many different combinations are possible in terms of being a wife, a mother, and a career woman. However, an illusion of no alternatives was presented to make it easier for the wife to make a choice. While she was in fact living as a not-very-devoted full-time wife, the implication that she could choose to be a devoted wife as a career provoked her into deciding what she wanted to be. As she became more involved in her profession, she stopped wondering

about her choice of husband and about how she could change him. She also became less demanding of him. As the wife became more involved in her work, the husband began to want to spend more time with her, and they achieved a better balance in which they were both equally interested in each other.

The illusion of no alternatives is an approach that is useful in dealing with life's difficulties, not necessarily with symptomatic behavior. It is useful in getting people unstuck from an illusion of freedom that makes choice impossible. Issues of personal gain versus altruism and freedom versus dependence are relevant to the approach.

Strategy 10: The Illusion of Being Alone in the World

Usually therapists like to be optimistic and hopeful and to bring people together with good feelings and expectations of increasing cooperation and love for each other. Sometimes, however, to encourage expectations of love, caring, and support not only may be unrealistic but may limit the options in a client's life, restrict opportunities, and increase bad feelings. Some severely disturbed people seem to have dedicated their lives to devious helpfulness toward their loved ones. For this sacrifice, they expect in later years to be unconditionally cared for and supported. However, those who elicit such devotion and self-destructive helpfulness tend not to retribute in kind, so the patients find themselves let down and rejected by those from whom they expected the most. Recriminations then lead to more rejection, which in turn leads to extreme behavior and further rejection. Usually, it is a disturbed child and his parents who are involved in such a chronic drama of resentment and rejection, although sometimes spouses can be caught in the same kind of interaction. A benevolent family therapist may unwittingly help the parties further entrench themselves in their respective positions. As the therapist requires responsible dedication from the parents and they refuse to provide it, their rejection becomes more apparent. The more the parents refuse to comply with the therapist's requests, the more the disturbed young person behaves in helpless and dependent ways. This

helplessness, however, only elicits more rejection on the part of the parents. The therapist is caught in a cycle in which the more he pushes the parents to behave responsibly and in caring ways toward their offspring, the more the youth behaves helplessly and incompetently and the more the parents become rejecting. The issue for therapy is how to break this escalating cycle of bad feeling, incompetence, and failure. One way is to present to the family the idea that the youth is alone in the world, that the parents have rejected and abandoned him, and that, for all practical purposes, he is an orphan.

A sixteen-year-old boy had been arrested for stealing a car. He was an alcoholic and had dropped out of school. His drinking was supported financially mainly by his grandmother, for whom he did odd jobs and who denied that he had any problems. His mother was a sad, obese woman, and his father, who appeared to be very much a ladies' man, was too busy to be involved with the family. During several family sessions, small, simple things were requested of the parents, particularly of the father, in an attempt to arrange that he provide some guidance for his son and some help in finding him a job and getting him into night school. The parents never complied with any requests or directives. The grandmother attended one session, during which she refused to collaborate with the family or the therapy in any way.

It was apparent that the boy provided some distraction to the mother while the father was out gallivanting around. He was not about to give up the boy as a means of keeping his wife off his back. Father and son came alone to the sixth session, and the father once more reported that he had not done anything for his son. The therapist said that, unfortunately, he was going to have to tell the boy the truth about the way he saw his situation. Looking at the boy and ignoring the father, the therapist proceeded to explain that he was shocked at the father's total lack of concern for his son, that the young man had to realize that he was alone in the world and that he could not count on his father for anything, including emotional support, financial support, and guidance. He, the therapist, had done everything possible to elicit some interest or concern on the

part of the father and had totally failed. In terms of the mother and grandmother, the youth had nothing to count on either; they were not interested in helping him. If the young man were to end his days in the gutter or make something of his life, it would depend entirely on him; nobody was going to help him, he was alone in the world, and it was up to him. The therapist was sad that this was the situation, but he felt he owed it to the young man to tell him the truth about what he saw. The therapist ended the session by saying that he would continue to see the boy alone if he wished but that he was no longer interested in the family. Through all this, the father did not say a word. The boy enrolled in night school, quit drinking, and found a job. The therapist continued to see him alone every two or three weeks for a few months. He brought his girlfriend, a very sweet, attractive girl, to the last session.

Another example of this approach is the therapy of a twenty-six-year-old woman from a well-to-do family who had been a patient in mental hospitals since she was sixteen years old. Among many other symptoms, she was severely suicidal and on several occasions had cut her wrists and hurt herself. The parents were divorced and involved in a struggle over money, with the father feeling that the mother was always extorting money from him. The mother was depressed and alcoholic. After a year of family therapy, during which various approaches were used for different problems, the young woman was out of the hospital and living with her mother. She could not find a job, however, they had little money, and the father kept making promises of the help that he would give his daughter, but this help never materialized. The therapist called a session with the mother, father, and daughter. Before this session, supervisor and therapist wrote a letter, which was addressed to the father and was intended for him to read aloud when he came to the interview. In the letter, the therapist said that the father had constantly disappointed both the therapist and the daughter by always promising that he would act as a responsible, caring father to the daughter and then refusing to do so. These promises that were not kept were very detrimental to the young woman's well being. The father sometimes talked as if she were his daughter, but then he refused to give her the things that a woman her age, in her social class, and with her family situation should have. The father did not give her money, would not buy her clothes, or offer her help or guidance. The therapist had decided that it was necessary once and for all to clarify the situation. The father had to decide either that he would be father to his daughter and give her the things that went with that relationship or that he would not be her father, which meant deciding that she was an orphan. If he decided not to be her father, from then on he would disappear from her life and she would go on by herself, as an orphan.

Father, mother, and daughter were shocked and could not quite believe that that was what the letter actually said. The father said that he certainly would be father to his daughter and that he was not dead. He would help her find a job and an apartment, pay for her education, buy her clothes, and do everything that was necessary. Mother and daughter were pleased, and a plan was made specifying how all this would take place. A month later, nothing had been accomplished and the father had managed to fail to provide anything. Another meeting was held and the father was confronted with the fact that, although he had chosen to be a father to his daughter rather than be dead in relation to her, he had failed to fulfill any of his promises. The father made excuses about the girl's misbehavior and attempts to obtain money for her mother through him. He ended by saying that he would not help her and she should consider him dead. The therapist said that now that he was dead and she was an orphan, she had to inherit from him. He needed to know what the estate consisted of, because he would get in touch with the other adult children to make it clear that the young woman was taking her part of the inheritance. The father immediately backed off and said that that was being too literal; he had not really meant that he was dead for his daughter, and she could count on him and he would help her. From then on, without the therapist's intervention, he provided some help and financial support, and, in contrast to the past when he had been inaccessible and most often refused to speak to her, he became always available to her on the telephone and in person when she wanted to see him. Most important of all, the daughter changed and began to expect very little or nothing from him. She

stopped hoping that her father would be more generous to her mother and began to see him more realistically for what he was. She found a job and a boyfriend, with whom she moved in. Two years later, she still had some hope that she could get some money out of her father, but she was independent and working and had not gone back to the mental hospital.

Just as freedom is an illusion, it is also an illusion to think that we are alone in the world. At some level, even the most rejecting of parents care for their children, and there is always someone one can turn to for help. However, to achieve the goals of therapy, it is sometimes better to insist that the client is on his own, alone in the world, and that he must rise or fall on his own merit rather than insist on improving relationships in futile attempts to make people act responsibly toward one another.

This approach should be used only in chronic cases in which all other approaches have failed and in which there is an ongoing intense relationship between therapist and family. The therapist needs to think about the problem in terms of helplessness and power, hostility and love, and freedom and dependence. A therapist should be wary of using this intervention simply out of sympathy for the offspring and irritation with the parents. It is an intervention that could be harmful and should be used only by the most experienced therapists.

Conclusion

When a therapist sees himself as being in a position of power, he can directly tell a client or a family what to do to solve the problem. When a therapist is not certain that his directives will be followed, he is better off using an indirect approach to influence people. This chapter presented eight dimensions or variables to consider in attempting to understand a dilemma brought to therapy and described ten paradoxical strategies, with indications for matching the therapist's mode of thinking to each particular strategy. The emphasis, however, is on the therapist's thoughts rather than on the strategies. When a therapist thinks clearly about a problem, he can develop the right strategy to solve it.