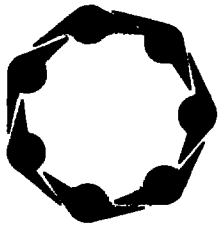

The Paradoxical Prescription in Individual Psychology

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Adler has been identified as the first person in Western civilization to use and write about paradoxical interventions in psychotherapy (Mozdzierz, Macchitelli, & Lisiecki, 1976). Mozdzierz et al. (1976) have provided the following description of a paradoxical intervention: "It consists of seemingly self-contradictory and sometimes even absurd therapeutic interventions which are always constructively rationalizable, although sometimes very challenging, and which join rather than oppose symptomatic behavior while containing qualities of empathy, encouragement and humor, leading to increased social interest" (p. 169). The paradoxical prescription is thought to place the client in a therapeutic bind, and Adler frequently employed "prescribing the symptom" as a means of defusing the client's resistance to the therapist's influence (Ansbacher & Ansbacher, 1978). While the content of the therapist's words recommends that the client continue with the problematic behavior, the nonverbal message challenges the client to behave in a "normal" manner and reflects concern as well as empathy for the client (Haley, 1976; Weeks & L'Abate, 1982).

From an Individual Psychology perspective, Mozdzierz et al. (1976) presented five essential principles of the therapeutic paradox:

1. The paradoxical technique is used to transform the client's symptomatic asocial behavior into cooperative behavior.
2. The paradoxical technique is used to prevent or remedy power struggles in therapy and thereby block the client's attempts to depreciate or oppose the therapist.

3. The client is often defending against external control and influence, and the paradoxical technique aids the therapist in joining with the client in an unconditional manner.
4. The paradoxical technique moves the client toward rather than away from the symptom, even to the point of the client's experiencing the original symptom more intensely than before.
5. The paradox may also be a context for humor; that is, the client sees the symptomatic complaint in a humorous and, therefore, more detached manner. Through this new perspective, the power of the symptom is lessened.

Authors not directly aligned with Individual Psychology have also studied paradoxical interventions. These include Bateson, Jackson, Haley, and Weakland (1956), Dunlap (1928, 1939, 1942), Frankl (1960, 1975), Erickson (1967), Haley (1963, 1976), Jacobson and Margolin (1979), Lankton and Lankton (1983), Raskin and Klein (1976), Newton (1968a, 1968b), Rossi (1980), Watzlawick, Weakland, and Fisch (1974), and West and Zarski (1983a, 1983b).

This article expands on the Adlerian perspective offered by Mozdzierz et al. (1976), integrating the ideas of those authors not directly aligned with Individual Psychology for implementing paradoxical prescriptions. The following discussion describes a method for implementing paradoxical prescriptions framed within an eight-step model developed by Haley (1976), whose model is elaborated on by reference to related studies. Ansbacher and Ansbacher (1978) point out that Haley's work ". . . blends very smoothly with Adlerian theory" (p. 320).

Initial Steps in Delivering a Paradoxical Prescription

The first three steps of the model (Haley, 1976) insure (1) that the client is committed to "change" as the goal of therapy, (2) that the presenting problem is clearly defined, and (3) that the objectives of therapy are clearly articulated. Individual Psychology (Dreikurs, 1956) has also suggested the importance of establishing a therapeutic contract. Being placed in a therapeutic paradox requires that the client believes she or he is moving against an expressed desire, that is, the desire to change. Furthermore, before the presenting problem can be prescribed, it needs to be explicitly defined.

Developing a Rationale for the Paradoxical Prescription

Haley's (1976) fourth step in providing a paradoxical prescription

includes developing a rationale or justification for the intervention. Rohrbaugh, Tennen, Press, and White (1981) describe two frameworks within which to utilize paradoxical prescriptions, each of which relies on Brehm's (1976) concepts of "psychological reactance" and "freedom of behavior." Rohrbaugh et al. (1981) define "psychological reactance" as the ". . . desire to avoid being subject to any directive that threatens to eliminate the individual's 'free behavior'. . . . Whenever a therapist offers suggestions, assigns tasks, or in other ways attempts directly to influence a client, the therapist runs the risk of threatening behavioral freedoms and arousing reactance, thus increasing the likelihood of noncompliance or rebellion" (p. 457). In turn, "freedom of behavior" refers to the client's perception that the target complaint is being voluntarily expressed.

Paradoxical prescriptions that are designed to *reduce* psychological reactance encourage cooperation (Rohrbaugh et al., 1981). With implementation of the directive, the client learns that the presenting complaint is under voluntary control and/or experiences the complaint as an ordeal. On the other hand, paradoxical prescriptions designed to *increase* psychological reactance stimulate the client to rebel against implementation, resulting in resolution of the complaint (Rohrbaugh et al., 1981).

In part, the effectiveness of the paradoxical prescription lies in its accompanying rationale. For example, Rohrbaugh et al. (1981) suggest that when a client demonstrates a low degree of psychological reactance and describes the problematic behavior as "unfree" or involuntary, an appropriate rationale may be ". . . that learning to turn the symptom off will be greatly facilitated if he [the client] can first learn to turn it on" (p. 462). A rationale used with the psychologically sophisticated client may consist of informing the individual of the necessity to practice the complaint in order to understand better his or her life-style and its fictional goal (Rohrbaugh et al., 1981). Illustrations such as these (low "reactance" combined with a reasonable rationale) suggest that the client will implement the paradoxical prescription. Implementing the prescription enables the client ultimately to view the symptom as a voluntary act and/or as an ordeal. Either of these outcomes may extinguish the behavior.

Rationales framed in a manner *congruent* with the client's own language or construct system are likely to reduce the reactance level and enhance the probability that the client will *comply*. Tennen, Rohrbaugh, Press, and White (1981) credit Fisch et al. (1975) for conveying a fundamental Ericksonian principle: Clients are more likely to accept and implement paradoxical directives that ". . . begin in and represent extensions or variations of their own views" (Tennen et al., 1981, p. 17). For example, when working with a client whose behavior characterizes a

"driver" life-style (Mosak, 1971), the rationale for the prescription may be stated as follows: "Because you are conscientious, you'll want to persist in understanding the basis of the compelling workaholic behavior. You will need to become a steadfast spectator of your own behavior in order to thoroughly understand how the workaholic behavior is perpetuated. Therefore, this week it might be important to (prescribe the symptomatic behavior)." The framework for this paradoxical prescription also incorporates a rationale described by Weeks and L'Abate (1982), that is, recommending that the client learn from observing her or his own symptomatic behavior.

When the client displays a high degree of reactance, the therapist may preface a paradoxical prescription with a rationale that is *incongruous* with the way the client would like to see herself or himself (Rohrbaugh et al., 1981) in order to increase the probability of a *noncompliant* response. Here, the therapist realizes that human movement consists of striving from a "felt-minus" toward a "felt-plus" position (Ansbacher & Ansbacher, 1956). By assuming a one-down subordinate position to the client, the therapist utilizes the client's desire to "overcome" and channels the client's behavior toward the useful side of life. By refusing to implement the prescription the client defeats the therapist and also resolves the presenting complaint. For example, an adolescent may respond to his younger brother with the mistaken goal of power (Dreikurs & Soltz, 1964) and the siblings may find themselves embroiled in conflict. The rationale for the paradoxical prescription to the adolescent may be stated as follows: "It appears that your brother is quite skillful at tricking you into quarrels or fights. Evidently, your brother discovered he can make you upset by simply entering your room, changing the television station, or accusing you of something that isn't true. He is so skillful that it would be very difficult to step out of these conflicts. Perhaps you need to realize that he can force you into becoming angry. Rather than experiencing failure in trying to change, you may need to learn to live with a clever brother. Therefore, this week consider (prescribe the symptomatic bahavior)." This rationale also incorporates the idea of the client's learning to live with the present situation (Rohrbaugh et al., 1981).

Disqualifying Significant Other and Prescribing the Paradox

Haley's (1976) next two steps consist of (1) disqualifying significant others who are involved in maintaining the client's presenting problem, and (2) prescribing the problematic behavior. Frequently, these steps can be interchanged and suggested within the same session.

Zeig (1980) suggests several issues to consider when prescribing a paradox: (1) the symptom's cognitive, affective, and/or behavioral components can be prescribed, (2) contextual factors of time and place can be incorporated, and (3) elements can be prescribed in ways that highlight the role of the symptom in the client's relationship with significant others. Weeks and L'Abate (1982) have illustrated a procedure that stimulates both intrapersonal and interpersonal insight for the client: "Whenever you feel, think of, hear, see, etc., I want you to (prescribe some concrete behavior)" (p. 143) or "The next time John does——, I want you to (prescribe the symptom)" (pp. 143-144). Both prescriptions foster the client's ability to make associations between feelings, thoughts, or behaviors, and the symptom. As a result, the client learns how his or her problematic behaviors are elicited or motivated, and learns to recognize that the behavior is a voluntary action.

In discussing guidelines for prescribing and scheduling symptomatic behavior, Newton (1968a) mentions that the schedule can be developed in a manner that produces stress for the client. Haley (1984) and Madanes (1984) describe a procedure for making implementation a therapeutic ordeal. These special ordeals expand on Milton Erickson's use of paradox and focus on making a seemingly involuntary act, or symptom, voluntary (Haley, 1984). For instance, the symptomatic behavior can be scheduled for a time when the client would rather be doing something else, or the prescription can direct the client to repeat the symptom deliberately each time it "involuntarily" occurs (Haley, 1984). The prescribed ordeal leads to the client's experiencing ". . . distress equal to or greater than that caused by the symptom" (Haley, 1984, p. 6). As a consequence, the client may give the symptom up in order to avoid the ordeal. When the severity of the ordeal is not rigorous enough to extinguish the symptom, the magnitude of the ordeal can be increased. Haley (1984) also emphasizes that the ordeal must be something the client can legitimately do without producing harm or violating moral standards.

When the level of psychological reactance is high and the symptomatic behavior is described as "unfree" or involuntary, the therapist may focus on prescribing a "free collateral" client behavior (Rohrbaugh et al., 1981). For example, the client who "needs to be right" (Mosak, 1971) may describe her or his *covert* evaluations of others as problematic but unavoidable, while accepting *overt* criticalness (a collateral complaint) as "free" or voluntary behavior. In such a situation, the therapist can prescribe the *collateral* behavior, for example: "You may not be right about wanting to change the nature of your relationship with others. When I provide clients with the opportunity to listen for the hidden meanings of their symptoms, they often realize that they've been

mistaken. You could be wrong about wanting to change. Consider giving up your effort to change. During the next week share your critical evaluations while working with colleagues, socializing with friends, and playing with family members." The rationale in this paradoxical prescription is, in part, based on comments by Rohrbaugh et al. (1981) and Weeks and L'Abate (1982). The rationale is framed *incongruently* with the client's self-image (needing to be right) and suggests that the client needs to listen for hidden messages contained in the problematic behavior. The prescription places the client in a position to defeat the therapist *and* to resolve the complaint by refusing to practice the "free collateral" behavior. Since the "free collateral" behavior (overt criticalness) can be influenced, it is hypothesized that the client's interactions with others will improve, in turn bringing about a change in the client's "unfree" or involuntary complaint (covert critical evaluations).

The need for therapeutically disqualifying significant others (Haley, 1976) is congruent with Adler's observation that human beings are social animals and, therefore, client complaints can be understood as problems of cooperation (Ansbacher & Ansbacher, 1956). Indeed, Adler asserted, "It is an irreparable mistake to tear symptoms from their natural context and to regard them in isolation" (Ansbacher & Ansbacher, 1978, p. 406). The therapist may find that significant others in the client's life are inadvertently maintaining or reinforcing the client's presenting complaint. For example, the therapist may ask a significant other, "If Ben's (the client's) procrastination were resolved, how would your relationship change and in what ways would you be required to change?"

At other times, the therapist may disqualify a significant other by relabeling the problem-maintaining behavior with a positive interpretation: "While completing and fulfilling Ben's obligations shows your concern and interest in his work, I wonder if this interaction between you encourages him to be more accountable?" The wife's "control" priority (Mosak, 1971) may complement and reinforce the husband's procrastination. Relabeling the wife's over-involvement with positive intent encourages her to realize that her style helps to maintain the husband's demonstrations of inadequacy. Palazzoli, Boscolo, Cecchin, and Prata (1978) note that positive relabeling decreases the danger of the therapist being disqualified by the client and poses a paradoxical question: "Why does such a good thing (e.g., display of concern and interest) produce difficulties in our relationship?"

Rohrbaugh et al. (1981) suggest utilizing *tandem* paradoxical prescriptions to disqualify significant others and state: "This paradoxical approach tends to be most effective when the spouse, parent, or friend to be influenced is bothered about the problem and 'sweating' as much or more than the person defined as the problem bearer" (p. 464). In the

previous illustration, a rationale for the tandem prescription may have benevolently described the husband-wife interactional pattern as preserving family stability (Papp, 1981): "Ben's (the husband's) failure to complete obligations and your willingness to finish his projects provides many topics for discussion and, thus, provides many opportunities for remaining close and involved with one another." A tandem prescription could direct the husband toward procrastinating during the week, while the wife could be directed to refine or complete those projects that the husband attempted: "During the week, in order to preserve your togetherness, you (the husband) need to continue failing at obligations while you (the wife) continue to complete the projects your husband initiates." If either the client or the significant other ". . . defies the prescription, some change in the usual pattern is inevitable" (Rohrbaugh et al., 1981, p. 464).

Prescribing the paradox at the end of the session prevents the client from commenting on the therapeutic directive and, as a consequence, the client is placed in a double bind (Weeks & L'Abate, 1982). A double bind is experienced as the client leaves the therapist's office and realizes she or he will be accountable for implementing a prescription or a set of behaviors that have previously been identified as problematic and counterproductive. As a result, the client is often forced to encounter her or his egocentricity and, perhaps, private logic. Hence, as Andolfi (1980) suggested, the paradoxical prescription can facilitate a personal and private confrontation without resulting in the client's "losing face."

Following up the Paradoxical Prescription

Steps seven and eight in Haley's (1976) model relate to following up the paradoxical prescription. Rohrbaugh et al. (1981) recommend having the client follow through on the ". . . prescription with more the same when the strategy seems to be taking hold" (p. 465). The general rule is when the client discontinues the problematic behavior, the therapist follows up by suggesting that the client is changing too soon or too fast (Weeks & L'Abate, 1982).

If during a follow-up the client reports that the symptomatic behavior has suddenly disappeared, a "paradoxical prediction" may be delivered in which the client is informed that the symptom is likely to reappear (Weeks & L'Abate, 1982). Weeks and L'Abate (1979) mention that the ". . . predictive paradox is designed to help maintain control over the symptom. It is set up so that if the symptom disappears, the client has control over the symptom; and if the symptom continues, then the therapist predicted it, and it is under his control. . . . One way

to increase the power of a predictive paradox is to make the prediction and discuss ways the client can make it come true or have the client think of ways to make it come true" (p. 65). If the symptom does reappear, the therapist may follow up with one of two procedures. He or she may provide another paradoxical prescription that incorporates the qualities of an ordeal. Or, clinical judgment may suggest that reappearance of the symptom has confirmed the therapist's predictive powers, which, in the client's eyes, may elevate the therapist to an "expert" position (Minuchin & Fishman, 1981). As a result of the therapist's increased level of influence, it may be possible for him or her to utilize "compliance-based" directives.

When following up a case in which the client has demonstrated a high level of psychological reactance, the therapist may decide to enumerate the protective or stabilizing properties of the symptom (Papp, 1981) and represcribe the original presenting complaint. Or, the therapist can follow up the prescription by actively searching for any part of the prescription that was overlooked or carelessly implemented and critique the client's efforts to exhibit or practice the presenting complaint (Rohrbaugh et al., 1981). Finally, before "prescribing a relapse," the therapist may provide an Ericksonian rationale (Haley, 1973): "I want you to go back and feel as badly as you did when you first came in with the problem, because I want you to see if there is anything from that time that you wish to recover and salvage" (p. 31).

When therapeutic progress is noticed, the therapist avoids accepting credit for client change and may express puzzlement relative to the progress (Haley, 1976). Not accepting credit for client change is an Adlerian device utilized to prevent a client relapse (Ansbacher & Ansbacher, 1956): "One of the most important devices in psychotherapy is to ascribe the work and success of the therapy to the patient at whose disposal one places oneself in a friendly way, as a coworker" (p. 338). Eventually, the presenting problem is dropped and, perhaps, the therapist and the client can decide to explore other issues.

Summary

Haley's (1976) eight-step model and the accompanying references provide a conceptual framework for expanding the Adlerian perspective on implementing paradoxical prescriptions. The primary purpose of the paradoxical prescription is to disrupt nonproductive behavioral patterns. Proficiency with paradoxical prescriptions is associated with skill development: Conceptual skills are developed with a theoretical understanding of Individual Psychology; conceptual skills are also developed

with a theoretical understanding of the paradoxical procedure (some pertinent reviews are listed in the reference section); and therapeutic skills are enhanced by receiving supervision in the delivery of paradoxical prescriptions. The reader should realize that paradoxical prescriptions are not panaceas in psychotherapy, but that therapeutic outcomes are dependent on interventions that precede and follow the paradoxical prescription (Zeig, 1980).

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We cannot put off living until we are ready. The most salient characteristic of life is its coerciveness; it is always urgent, "here and now," without any possible postponement. Life is fired at us point blank.

Ortega y Gasset
