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# The ethical use of paradoxical interventions in psychotherapy

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## Author's abstract

*The purpose of this paper is to establish ethical guidelines for the use of paradoxical interventions in psychotherapy. These are defined as interventions which are counterintuitive, coercive, and which require non-observance by the client. Arguments are developed to show that such interventions are associated with a psychology that understands individuals solely in terms of their relationship: a 'strong interactionist' position. Ethical principles consistent with such a position are considered, and from these it is derived that: paradox is an ethical technique with resistive patients; it requires consent; its content should be consistent with general ethical principles, especially those of beneficence and non-maleficence; non-paradoxical techniques should be preferred when possible; and it should not be used as an assessment procedure. It is concluded that research is needed to explore the effect of such ethical guidelines of effectiveness, though preliminary impressions are encouraging.*

## Introduction

Like many other therapeutic techniques, a simple paradoxical approach may be found among the skills used by a mother in managing her child. For example, a child who is fussy about food may be told about a new dish that the mother thinks is delicious, but which 'might not be suitable' for the child. Of course, the idea is to make the child want the food so much that he or she 'persuades' the mother to give him or her the food. Therapists have a wide range of such techniques available to them (1): they may prescribe the very symptom the client(s) have requested them to alleviate; they may recommend that things do not change when they want them to do so; perhaps they may even comment that any alternative to the current situation would be worse. However, the rather underhand nature of these techniques has led some authors (2,3,4) to question whether such techniques can be used by an

ethical therapist. The purpose of this paper is to identify a generally acceptable group of ethical principles that are relevant to paradoxical interventions, and from them derive guidelines for their ethical use.

## The Nature of the Problem

### DEFINING PARADOXICAL TECHNIQUE

Though paradox is easy to recognise, it is more difficult to define, as different therapists have presented widely different rationales for it. Thus Dunlap (5) saw it as establishing voluntary control over previously involuntary habits; Adler (6) and Kraupl Taylor (7) considered that it made positive use of the patient's resistance to the therapist; Erickson (8) saw it as being related to hypnotic suggestion; Frankl (9) saw it as establishing an existentially authentic distance between the symptoms and the sufferer; Haley and his followers (10,11) believed that one was correcting symptom-producing interactions between family members; while more recently (12) it has been proposed that such interventions disrupt existing family patterns, forcing the family to change in order to maintain its integrity. Whatever the theoretical background, the interventions described tend to have three qualities in common: they are counterintuitive; they require that the therapist's suggestion not be carried out ('non-observance'); and they are coercive (12,13). For example, consider the mother and her fussy child described above: suggesting to the child that the food might not be suitable is at first sight counterintuitive; the mother wants her child to challenge that statement; and the mother is making use of the child's oppositional behaviour to force the child in the direction she wants. The 'force' of the coercion comes from the mother making use of a characteristic of the child without the child having any say in the matter.

One model is not included in this; the behavioural approach of Dunlap (5). However, his approach, of repeatedly practising the behaviour (usually a tic) that one wishes to get rid of would now be seen as a form of orthodox behaviour therapy called flooding (14), where a behaviour may be repeatedly elicited till it ceases to occur (a process called extinction).

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## Key words

Psychotherapy; ethics of psychotherapy; paradox; family therapy.

## A FUNDAMENTAL ASSUMPTION IN PARADOXICAL PRACTICE

Despite the markedly different theoretical bases of different 'paradoxical' therapists, they all hold what I shall call the 'strong interactionist' position: that is, for the purposes of paradox they all assume that the individual can be completely and essentially described by the frame of relationships including him or her. In other words, the individual has no existence apart from his/her relationships. As a statement about individuality it is, at the very least, incomplete; however, it can be found as an assumption in all the models of paradoxical practice referred to above. It is regarded as being one of the implications of a 'systems' approach in family therapy (15), which group are the largest users of these techniques (1). Erickson (16) accepted a 'systemic' reformulation of his own work; and Adler (17) considered that all human behaviour derives from the configuration of power-relationships between people. Frankl's 'Paradoxical Intention' is a special case of his concern with those neuroses which he considers reflect the 'existential vacuum' common to all. The ontogeny of this vacuum has been discussed by Sartre under the heading of 'nothingness' (18). Starting with Husserl's contention that in order to be conscious, one must be conscious of something, he argues that the perceptually conscious entity has to be aware of its own consciousness in order to use it. This state he refers to as 'being for itself' as opposed to the unconscious 'being in itself'. In order to be conscious, consciousness must therefore distance itself from itself, and the sense of alienation resulting was characterised by existentialists as a gap; the 'existential vacuum' or 'nothingness'. Thus, the individual comes into being through a relationship – a Strong Interactionist position. Kraupl Taylor's overall approach to psychiatry, from an analytic and phenomenological background, accepted the existence of individual characteristics that could not be translated into relationships. However, he considered that those clients suitable for his 'paradoxical' approaches were those whose behaviour was completely at the mercy of their transference reactions, and who had thus lost individual autonomy apart from their relationships (7). He thus considered them to be in a situation that would make 'strong interactionist' assumptions valid.

### THE IMPACT OF THE 'STRONG INTERACTIONIST' POSITION UPON ETHICAL DECISIONS

The 'strong interactionist' position takes a view of the individual that is not typical or generally agreed. MacIntyre (19) has pointed out that one's world-view crucially affects one's ethical decisions. Thus, one may expect to find some 'paradoxical' therapists honestly espousing practices that would not be considered ethical by most people, or alternatively seeking new ethical systems that might better include their viewpoint. This is in fact the case. Haley (20) argues that the therapist is entitled to mislead the client if he

deems the outcome of this is beneficial ('the benevolent lie'). Other 'paradoxical' therapists insist that informed consent is in fact antitherapeutic in their paradigm, as it renders paradoxical approaches ineffective (21). Lakin (22) describes a training videotape which shows a boy having his mouth covered with adhesive tape as a response to his persistent refusal to speak in a family session. Arguments have also been presented by family therapists working within this perspective (23,24) for a re-definition of psychotherapeutic ethics to allow a more flexible interpretation of individual rights in therapy, especially specifically to include the idea of the individual as a locus of relationships. It can be demonstrated that these views represent the 'strong interactionist' position rather than a family therapy perspective by considering family therapists who do not take such a perspective. Hare-Mustin's (25,26) feminist approach is not 'strong interactionist' in that it assumes relationships are predicated by, and so secondary to, gender identity. Patterson's (27) social learning approach is not 'strong interactionist', as it does not ascribe to relationships a privileged role in the definition of the individual – they are simply another set of potential rewards for the right behaviours. Both of these workers emphasise the value and usefulness of informed consent. Additionally, Hare-Mustin sees a danger of covert paternalism in paradox (or other coercive interventions) while Patterson (28) suggests that client non-compliance, for which paradox is said to be most effective (13,29) may be a function of therapist style.

### Qualities that should characterise an ethical position for paradoxical therapists

Therapists are also people. Though their role might afford them some privileges as citizens, it is difficult to imagine that therapists could obtain, or be allowed to work if people knew therapists did not conform to the moral principles of their clientele. On the other hand, those principles should be sufficiently broad to allow the therapists scope to do good, otherwise such principles would themselves not be moral (30). Beauchamp and Childress (31) have presented four principles: respect for autonomy; beneficence; non-maleficence, and justice, which, they argue, have especial relevance to medical ethics. Gillon's further exploration of these principles (32) suggests that they maintain their integrity even when applied to situations in medicine where interpersonal relationships are paramount. Therefore, they are likely to be sensitive to the special needs of the 'strong interactionist' position, while at the same time conforming to the ethical requirements of ordinary moral society.

### Deriving guidelines from the principles

To be valuable, the ethical principles suggested above should both enable one to recognise the circumstances in which a paradoxical approach is ethical, and to

distinguish between ethical and unethical approaches of this type.

#### RESISTANCE AND THE ETHICAL USE OF 'NON-OBSERVANCE'

Of the three characteristics of paradox described above, the expectation that the client will resist – which I shall call the requirement of 'non-observance' – is the one that gives paradox its unique character (12). Essentially, one misleads clients by telling them, with apparent sincerity, something that you want them to disagree with. Intuitively, it seems ethical for the parent with an everyday problem with an awkward child, but the therapist's position is different in two ways. Firstly, the therapist is using deceit to promote change in a central part of the client's life. Secondly, the therapeutic relationship, unlike that of parenthood, involves a consenting agreement by both parties. It is much harder to justify deceit when the client has a right to evaluate the therapeutic relationship, and therefore has an entitlement to accurate information.

In therapy, the client places his trust in the therapist, in the belief that the therapist can help him. To do this safely, the client must assume that the therapist possesses two virtues (as well as professional competence). The therapist must have honesty, as the client must be able to assume that the therapist is not misleading the client in agreeing to help him. The therapist must also have dependability, as the client relies on the therapist to help him through the difficulty the client has brought.

In therapy, resistance may show itself in a number of ways. Clients may repeatedly fail to carry out tasks recommended by the therapist; or they may avoid the discussion of issues salient to their difficulties. The more the therapist perseveres, the more the client refuses, and therefore the client may become cut off from paths of improvement previously open to him or her. Thus, the client who responds in a resistive manner to the therapist places the therapist in an ethical quandary. If the therapist gives the client the 'right' advice, the therapist ceases to be dependable, as the client may deteriorate. If the 'wrong' advice is given, the therapist may remain dependable (resistance no longer closing the paths to improvement), but at the cost of his honesty. Doing nothing, once in therapy, deprives the therapist of both virtues. Not agreeing to treat the client in these circumstances also seems to be unethical if, as the 'paradoxical' therapists claim, an effective treatment exists and the clients would change if they could. It has been pointed out (33) that one owes a duty of non-abandonment to one's clients, by which is meant that, having begun a therapeutic relationship (and thereby implying that therapy is of benefit to the client), one may only terminate it at either the request of the client, the successful completion of the therapy, or by a transfer to another therapist (that term now being interpreted in its broadest sense). This is because by abandonment one deprives one's client of a benefit,

and so breaks the principle of beneficence to which as a carer one is committed.

In this situation, a choice must be made between honesty and dependability. It is not possible to argue convincingly that either is more important than the other. Foot (34) comments that such a choice of principles may be regarded as elective, it being morally correct to make such a choice a matter of personal preference. However, whose choice should it be? The therapist has no claim to expertise in such a choice: thus, the principle of 'respect for autonomy' would seem to require that this choice be made by the client. This implies that a 'paradoxical' therapeutic approach requires the consent of the client.

This analysis has further implications. The ethical justification of paradox is based on a situation where the therapist is being forced to choose between honesty and dependability. Where the choice is not forced, the client is entitled to expect both. Thus, when both paradoxical and non-paradoxical treatments are equally possible and effective, or the effectiveness of both is equally uncertain, one should choose the non-paradoxical approach. A corollary of this is that paradox should only be employed after a thorough assessment has been made, and may not be used as an assessment technique. It is not sufficient to obtain a 'blanket' consent for paradox at the outset. Where there is no resistance, to request such consent would be to invite the client voluntarily to give up the right to expect the virtue of honesty, which would deprive the client of his or her ability to evaluate the therapy accurately. When there is resistance the client, as we have seen, does not allow both honesty and dependability to coexist in the therapist, and the 'consent' is in fact an invitation for the client to choose which virtue he or she prefers.

It is inconsistent to insist that any insight into paradox will ablate its effect. All the authors on paradox agree that it is prescribed in circumstances where (for whatever reason) it is deemed that insight will have no impact upon the client. There seems to be no reason to presume that insight into paradoxical techniques is any different from insight in general, and so one can presume it will not change anything. Such has, in fact, been this author's experience in using paradoxical techniques with adolescents – they quickly catch on, but respond nonetheless.

#### THE LIMITS OF JUSTIFIABLE COERCION IN PARADOX

Though the problem of coercion is usually coupled with consent, it needs to be dealt with separately here. The problem is that, in paradox, coerciveness is closely related to effectiveness, as it will be used in situations where the client will be unable to make decisions freely. Such a limitation severely comprises the client's autonomy, and such coercion is not therefore incompatible with 'respect for autonomy' if it results in a greater range of options becoming available to the client – in the first example, the child ends up with a greater choice of foodstuffs than before. Such a

justification is, of course, a special case of 'the ends justifying the means', and therefore requires further qualification. Firstly, it assumes that non-coercive alternatives will not lead to the same result, which may only apply in the presence of resistance. Secondly, the means, as well as the ends, must be beneficent and non-maleficent. Thus, Madanes (35) considers that paradox is contraindicated in cases of intrafamilial sexual abuse, and Kraupl Taylor (7) warns against the use of paradox in depression; in both cases because non-observance might be difficult to ensure. The duty of non-abandonment also crops up here – one wishes to encourage resistance, but such encouragement may also unduly influence the client to terminate therapy before it is of benefit, or at least harmless, to do so. Finally, the adhesive tape incident described by Lakin (22) suggests that justice must be a major consideration in the choice of any coercive therapy.

#### HOW INCOMPREHENSIBLE SHOULD PARADOXICAL THERAPIES BE?

The counterintuitive nature of paradoxical approaches does not seem to warrant great ethical concern. In trusting experts to be expert, we must allow them the freedom to make use of their expertise in interpreting the problems they are asked to address, and it is not necessary (in the logical sense) that the expert's understanding will be immediately comprehensible without special training. However, the expert does have a duty (derivable from the principle of respect for autonomy) to make any explanation sufficiently comprehensible to the client to ensure that the client is able to make a real decision regarding a treatment option, and not simply have to agree in total ignorance with the therapists. Thus, as with any other procedure, both the advantages and the disadvantages of a paradoxical approach need to be conveyed to the client when consent is sought.

#### Paradoxing more than one

There seems to be no reason for regarding any of the guidelines derived so far as being inapplicable to the group or family setting. Paradoxical approaches tend not to be employed in group therapy, and so this setting will not be considered further; however, paradox is probably used most frequently of all in family therapy. The family setting especially poses an additional ethical problem: there may be only one member who is experiencing difficulties in living. What are the ethical grounds for applying techniques such as paradox to people who wish to help, but who may have no problems of their own?

To argue that they need to change because they have problems by virtue of there being an identified client is disingenuous. Even within a 'strong interactionist' perspective, it is possible for all of a person's relationships to be adaptive except those with the identified client, and the client to have equally maladaptive relationships to all. In that setting, it is hard to argue that anyone except the identified client

should be required to change.

The four principles of respect for autonomy, beneficence, non-maleficence and justice must apply equally to all. However, in a family not all are equal. Especially, the children may only achieve those rights at the behest of their caretakers. Therefore, in order to be just (following Rawls's interpretation of 'justice as fairness' (36)) the therapist must support the children against the caretakers in any conflict of interest. However, the therapist is limited by this same principle, in that the child has no greater entitlement than the caretakers, and so the caretakers' interests must also be served as far as equitability allows. This has the corollary that, despite recognising the interactions between family members, the therapist is required to give primacy to the individual needs of family members, and especially any children. These individual needs of course include ethical treatment for each individual.

The power relations in the family mean that any action consented to by the 'family as a whole' may be heavily weighted in favour of the most powerful members, the caretakers. To ensure ethical equitability for all the family members, such agreements should be confirmed individually for all the family members involved, taking into account their individual capacities (Cf Lo Cicero (37)). After this it is fair to use paradoxical techniques to improve the situation of the children, even if it does not improve that of the caretakers, as the caretakers are more able than the children to improve their lot. However, to be equitable, the lot of the caretakers should not be worsened by such an approach.

It is probably inadvisable to use paradox that involves the children to benefit the caretakers, unless the paradox is designed materially to benefit the children also. This is because children are more vulnerable to their caretakers than vice versa, and thus in the interest of fairness it is important to take positive steps to protect them from any potentially negative consequences of change, as they will be less able to take those steps themselves.

#### Conclusion: Does the adoption of ethical constraints impair the therapeutic effectiveness of paradoxical interventions?

One may conclude that:

1. Paradox is an ethical technique with resistive clients.
2. It should therefore be used only after an assessment and not as part of an assessment procedure.
3. Non-paradoxical techniques should be preferred where possible.
4. It requires consent.
5. Its means, as well as its ends, should embody generally accepted ethical principles.

However, as has already been observed (30) such guidelines would not themselves be ethical if they

crippled an effective technique.

To date, there is no research that has considered the impact of consent upon paradoxical interventions, nor is there a direct comparison of paradox when given as part of, or separate from, an assessment procedure.

However, the first and the last of the principles listed above both have a little support from the meta-analysis of outcome studies of paradox by Shoham-Salomon and Rosenthal (38). Their definition of a paradoxical intervention included 'symptom prescription' and/or 'positive connotation'. In the former, the therapist advises the client to do everything possible to bring on or worsen the symptoms. In the latter, the symptoms are identified as having some beneficial role, and the client praised for so using them. Both of these are consistent with my own criteria: they are clearly counterintuitive; both require the client either to fail in, or reject the injunction in order for them to be successful; and both rely on producing an effect independent of the patients' volition, ie are coercive.

The authors found a highly significant trend for paradox to become more effective with increasing severity of symptomatology, while non-paradoxical treatments became less so. It seems likely (though by no means certain) that highly resistive clients, and those who have failed simpler treatments, would be among the most symptomatic. These results are thus consistent with an assertion that restricting paradox to such a clientele will not prevent those who need paradox from having it. The second finding of relevance here was that paradoxical techniques that involved 'positive connotation' were superior to those techniques that did not. This technique, with its emphasis on personal competence and worth of the client, is in keeping with a principle of aiming at benefit for the client whenever possible (beneficence and non-maleficence). This last guideline, of ethical means, may thus be an important therapeutic, as well as ethical principle.

Further research to address these issues directly needs to be done. However, the suggestion is that the development/acceptance of ethical guidelines in paradoxical interventions may lead to more effective use of the technique, rather than the reverse.

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## References

- (1) L'Abate L, Weeks G. A bibliography of paradoxical methods in the psychotherapy of family systems. *Family process* 1978; 17: 95-98.
- (2) Whan M. Tricks of the trade: questionable theory and practice in family therapy. *British journal of social work* 1983; 13: 321-327.
- (3) Maranhao T. Family therapy and anthropology. *Culture, medicine and psychiatry* 1984; 8: 225-279.
- (4) Doherty W J. Values and ethics in family therapy. *Counselling and values* 1985; 30, 1: 3-8.
- (5) Dunlap K. A revision of the fundamental law of habit formation. *Science* 1928; 67: 360-362.
- (6) Adler A, cited in: Dinkmeyer D C, Pew W L, eds. *Adlerian counselling and psychotherapy*. Monterey: Brooks/Cole, 1979: 115-116.
- (7) Kraupl Taylor F. Prokaletic measures derived from psychoanalytic techniques. *British journal of psychiatry* 1969; 115: 407-409.
- (8) Haley J. *Uncommon therapy: the psychiatric techniques of Milton H Erickson M D*. New York: W W Norton, 1973: 21-32.
- (9) Frankl V E. *Psychotherapy and existentialism: selected papers on logotherapy*. UK: Pelican Books, 1973: 148-149.
- (10) Haley J. *Strategies of psychotherapy*. New York: Grune and Stratton, 1963: 17-19.
- (11) Watzlawick P, Weakland J, Fisch R. *Change: principles of problem formation and problem resolution*. New York: W W Norton, 1974: 113-114.
- (12) Papp P. The Greek chorus and other techniques of paradoxical therapy. *Family process* 1980; 19: 45-57.
- (13) Evans J. Ambivalence and how to turn it to your advantage: adolescence and paradoxical intervention. *Journal of adolescence* 1980; 3: 273-284.
- (14) Marks I M. Flooding (implosion and related treatments). In: Agras W S, ed. *Behaviour modification: principles and clinical application*. Boston: Little Brown, 1972: 179-180.
- (15) Holmes J. Family and individual therapy: comparisons and contrasts. *British journal of psychiatry* 1985; 147: 668-676.
- (16) Haley J. *Uncommon therapy: the psychiatric techniques of Milton H Erickson M D*. New York: W W Norton, 1973.
- (17) Adler A. New leading principles for the practice of individual psychology. In: *Individual psychology*. London: Routledge and Kegan Paul, 1955: 23-31.
- (18) Sartre P. Immediate structures of the for-itself. In: *Being and nothingness*. Northampton: John Dickens and Co, 1966: 73-79.
- (19) MacIntyre A. *A short history of ethics*. London: Routledge and Kegan Paul, 1987: 1.
- (20) Haley J. *Problem-solving therapy*. San Francisco: Jossey Bass, 1976: 199-206.
- (21) See reference (11): 77-91.
- (22) Lakin M. *Ethical issues in the psychotherapies*. New York: Oxford University Press, 1988: 97.
- (23) Wendorf D J, Wendorf R J. A systemic view of family therapy ethics. *Family process* 1985; 44: 443-460.
- (24) Boszormenyi-Nagy I, Krasner B R. Trust-based therapy: a contextual approach. *American journal of psychiatry* 1980; 137: 767-775.
- (25) Hare-Mustin R T. A feminist approach to family therapy. *Family process* 1978; 17: 181-194.
- (26) Hare-Mustin R T. Family therapy may be dangerous to your health. *Professional psychology* 1980; 11: 935-938.
- (27) Patterson G R, Reid J B, Jones R R, Conger R E. *A social learning approach to family intervention: families with aggressive children*. Eugene, Oregon: Castalia, 1975: 53-67.
- (28) Patterson G R, Forgatch M S. Therapist behaviour as a determinant for client non-compliance: a paradox for the behaviour modifier. *Journal of consulting and clinical psychology* 1985; 53: 846-851.
- (29) Weitzman J. Engaging the severely dysfunctional family in treatment: basic considerations. *Family process* 1985; 24: 473-485.

- (30) Hare R. The philosophical basis of medical ethics. In: Bloch S, Chodoff P, eds. *Psychiatric ethics*. Oxford: Oxford University Press, 1981: 31-45.
- (31) Beauchamp T L, Childress J F. *Principles of biomedical ethics*. New York: Oxford University Press, 1983: 59-220.
- (32) Gillon R. *Philosophical medical ethics*. Chichester: John Wiley and Sons, 1986.
- (33) Furrow R. The duty of non-abandonment. In: *Malpractice in psychotherapy*. Lexington: D C Heath and Co, 1980: 37.
- (34) Foot P. *Morality and art*. Henrietta Herz Lecture, Proceedings of the British Academy 1970: LVI.
- (35) Madanes C. *Strategies of family therapy*. San Francisco: Jossey Bass, 1981: 135.
- (36) Rawls J. *A theory of justice*. Oxford: Oxford University Press, 1985: 11-12.
- (37) Lo Cicero A. The right to know: telling children the results of clinical evaluations. In: Koocher R, ed. *Children's rights and the mental health profession*. New York: Wiley, 1976: 13-21.
- (38) Shoham-Salomon V, Rosenthal R. Paradoxical interventions: a meta-analysis. *Journal of consulting and clinical psychology* 1987; 55: 22-28.
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