Paradox as Epistemological Jump

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Recent articles on paradoxical interventions tend to view them as something given by a therapist to a patient, thus unintentionally adopting a unidirectional view of causality and an outmoded epistemology. It is postulated that change takes place in the context of a patient-therapist relationship and that when that relationship becomes paradoxical it becomes more difficult for the patient to view himself as a reified "thing." Paradox effects change, then, by altering the meaning of experience and modifying epistemological assumptions.

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WITH THE POPULARITY of paradox on the rise as a therapeutic technique, recent articles (5, 6, 10, 13, 16) in this journal have attempted to clarify some of the theoretical issues posed by the peculiar nature of the intervention. What tends to be missing from all the expositions, however, is an awareness that—paradoxically—practitioners of paradox are relying on an old epistemology to explain its effects.

That epistemology is perhaps most obvious in the current, much abused phrase, "The therapist paradoxed the patient." This is a clear example of thinking in a linear causality that should be almost blasphemous to proponents of the interactive assumptions on which systems theory is based. In every discussion of paradox in the March 1981 issue of *Family Process*, the notion was that paradox is something the therapist imposes on the patient. That is as inaccurate as the idea that the double bind is something a schizophrenogenic mother imposes on her innocent child, a notion that has haunted the literature for thirty years despite repeated attempts to abolish it (7). Communication is always a two-way street, if only because a message that is sent must be interpreted by the recipient, with the interpretation providing feedback for future messages by the sender. As Laing (11) noted some time ago, the data we are concerned with in interpersonal perception is not "what he thinks" but "what he thinks about what I think about what he thinks," and so on.

Thus a crucial aspect of paradoxical interventions involves formulating them as a transaction within a patient-therapist system. Too often a paradox is treated as a kind of bomb the therapist gives the patient to take back into the patient's family system. But for a paradox to function as a bomb in the family system, it must first acquire its explosive qualities in the interpersonal definitions of the therapist-patient system.

I believe the contributions of the therapist-patient interaction to the nature of paradox have been overlooked because most family therapists tend to have deeply ambivalent attitudes about the extent to which they function as live, active parts of the

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patient's family system. That may have partly a historical basis, as an attempt to distance family therapy from the psychodynamic treatments in which change was a function of the patient-therapist interaction and nothing else. In addition, any family therapist has experienced the tremendous pull a family exerts to bring the therapist into their view of the problem and to join in the familial interpersonal struggles along family-established rules of transaction. The prevailing attitude among family therapists seems to be that one must join the family to have any efficacy, while maintaining sufficient independence to be an effective change agent, ready to pull out at the first sign of fusion; then one must disengage once change occurs lest one's presence in the system lead to a long-term therapy in which adequate functioning is dependent upon the therapist's continued presence in the family system (8). Although this attitude is therapeutically useful, it tends to make us uneasy about examining too carefully the patient-therapist subsystem in its own right. We tend nervously to refer such issues back to the family proper, avoiding an identified-patient/therapist/rest-of-the-family triangle.

Whether we like it or not, however, such efforts are doomed to failure. When a therapist meets a patient or the patient's family, he is not excluded from the ordinary laws of interpersonal transactions: he cannot not communicate (2). That being so, it is quite impossible to be an outside observer acting on the system—a view inherent in many of the theories emphasizing paradox as a therapeutic technique. If there is one thing that developments in systems theory, modern physics, and communications theory have taught us, it is that we must pay attention not to things or techniques applied in unipolar directions, but rather to relationships, with all the interactive effects relationships always imply (2, 16, 19).

The therapist is forced into a relationship with the patient by virtue of being unable to avoid communicating. In addition, one does not have to subscribe to psychoanalytic notions of transference to acknowledge that patients bring expectations to therapy along with themselves. In describing paradoxes, Dell (5) asserts that the "typical" expectations are that the therapist will be a benign, helpful person. But these are the typical expectations that *therapists* have of one another. Patients' expectations are more variable: they may see the therapist as a benign, helpful person but also as a potentially vengeful or critical authority figure. It is also extremely common for patients to have some magical expectations of the therapist; I do not use this term pejoratively but simply to describe the vague hopes and fears of the patient that something wonderful or awful will be imposed on him by a masterful figure. Many strategic therapists in fact do aspire to be a kind of magician (1), and the interest in Ericksonian methods is in line with those aspirations. But beyond this, the very context of therapy is such that *all* therapies incorporate the role of therapist as magician to some extent. Therapy becomes a kind of drama taking place in the empty space of interpersonal transactions, and as in any theatrical empty space the trick becomes one of showing the audience you have nothing up your sleeve and then pulling rabbits and colored ribbons out of it (4).

But notice that this already has the germ of a paradox to it: "I have nothing up my sleeve"/"Here are some rabbits from my sleeve." With a magician, of course, this is more of a contradiction than a paradox because one of the premises is invalid: he does indeed have something "up his sleeve," namely some trick or sleight of hand. But in addition, the magician is always metacommunicating with his audience. The average magician metacommunicates: "You know this is a trick and I know this is a trick, but what a puzzle it is for you not to be able to figure it out." And that evokes pleasure. But the great magician

metacommunicates something else: he simultaneously implies: "Yes, this is a trick," and "No, this is *real magic.*" Such a magician provokes some rekindling of childhood awe and perhaps even a slight questioning of whether our assumptions about the structure of reality are really true. Gregory Bateson has described (3) how he experienced an epistemological revelation through what was, essentially, a perceptual magic trick.

The point of all this is that the therapist who prescribes a paradoxical intervention, like the magician, is simultaneously metacommunicating about what he is doing. He can't help it. But the metacommunication (about the paradoxical intervention) is *itself* paradoxical. For while the therapist is prescribing a symptom or enjoining the patient to give up all hope of a cure, the very frame of the therapeutic situation is that this is a place where cures are given. Watzlawick et al. (17) have come close to mentioning this factor when they include, as one of the criteria for paradox, that the patient see the therapeutic intervention that prescribes the symptom as the medium for alleviating the symptom. But this couches the intervention in terms of things—symptoms—rather than relationships. What is most crucial to the paradox is that the therapist is saying simultaneously: "I cannot cure your symptom," and "I am curing your symptom." Thus, *there is a paradoxical metacommunication about the therapist's relationship with the patient.* I propose that it is this *relationship* paradox that forms the first vehicle for change, in a way to be described below.

By placing the essence of paradox in the relationship, we are excluding certain kinds of interventions from being considered paradoxical. If a therapist asks a patient to escalate a symptom "so we can study it and understand it better," that involves no paradoxical communication in and of itself; the therapist is enlisting the patient's aid in a common undertaking, and preserving the therapist's role as a helpful healer. Similar comments can be applied to attempts to redefine a problem, another type of "paradox" listed by Fisher et al. (6). Both redefinition and instructions to display the symptom so that it can be studied are components of traditional psychotherapy (cf., the psychoanalytic instruction to allow even "symptomatic" thoughts to be expressed during free association), and no theories of paradox need be applied to them. *Techniques* are not paradoxical, only *relationships* can be. Any technique may become paradoxical if it involves defining the therapeutic relationship as simultaneously a vehicle for change and a vehicle for stasis, through the nature of the personal relationship that is offered.

By locating the change-producing nature of paradox in the contradictions of the therapeutic relationship, it becomes possible to extend the notion beyond specific techniques of symptom prescription to a general aspect of therapy, namely, the patient's coming to terms with the therapist being both powerful and impotent. Whitaker (18) has noted the importance to the family therapist of being impotent, and of course psychoanalysis has stressed that "resolving the transference" involves giving up fantasies of cure by the analyst—which, paradoxically, leads to cure. Neither of those formulations, however, has directly addressed the paradoxical nature of the double bind that confronts the patient: the problem of being in a treatment that promises to cure if only he recognize the inefficacy of the treatment as a source of a cure. Psychoanalysis has been much criticized by family therapists for not addressing that paradox, but now family therapists are being forced to ponder the issue themselves, as attempts to explain paradoxical interventions purely as a technique isolated from relationships become increasingly frustrated.

When we prescribe that a patient actively try to have a symptom and note the differ-

ence in the way family members and the patient then relate to the new, voluntarily produced symptoms, we are inclined to ascribe the change in the system to the change in voluntariness—i.e., to the technique of paradox. But we have not answered a more profound question: what impelled the patient to make the change in the first place? How did we help the patient decide to attempt voluntarily to produce symptoms? That is where the first change occurs, and it is a point that has stymied many therapies. Usually we try to "convince" the patient to undertake the paradoxical prescription. But what is the medium of such convincing?

The medium is the paradoxical relationship the therapist offers to the patient. By saying "I am a healer" (through the frame, "This is therapy; thus whatever I say in this frame is a healing statement"), and "I am not healing you" (by insisting the patient maintain or increase symptoms), the therapist is offering a highly charged mutative situation to the patient. The patient may have always had a sneaky suspicion that the therapist was a trickster out to manipulate, but at other times the patient may have had a basic expectation of the therapist's good will and ability to cure. Suddenly the patient is confronted with a person who says that both are true—he is healer and charlatan, omnipotent and helpless, manipulator and benignly passive.

At such times, the therapist presents a model of a new epistemology to the patient. He is in effect echoing Walt Whitman's song, "Do I contradict myself? Very well, then, I contradict myself!" That is why the therapist's manner is so crucial in the paradoxical intervention (6); it must be confident, even joyful. By showing the patient how the therapist can be more than one thing at a time, he is showing that a person is not a thing, some stable lump of unchanging essence. The central epistemological error patients tend to make is to treat themselves as things, with invariable contents. "I am the person-thing who has the symptom of being afraid of going outdoors." A patient's identity becomes reified in symptoms and set ways of interacting. That in turn is related to the kind of hubris that Selvini-Palazzoli et al. (14) talk of as crucial in pathological transactions: the assumption that one can arrange things to be totally in control. Symptoms then reflect a family's misguided efforts at maintaining an impossible consistency, even at the price of sacrificing a sense of aliveness. The playwright Tom Stoppard (15) has depicted the kind of paralysis that can overcome people when he has his characters chant the following litany:

> *Rosencrantz:* Consistency is all I ask!"
> *Guildenstern:* Give us this day our daily mask.
> [p. 39]

The therapist, by *being* paradoxical (rather than by giving the patient a "thing," a "paradoxical intervention") shows the patient that one can have two (or more) experiences simultaneously and *both can be correct.* The therapist can be consistently inconsistent. And the mutative effects of that are not limited to presenting a model to the patient; to the extent that the patient experiences the paradox himself, he too has consistently inconsistent reactions. The patient feels simultaneously toward the therapist whatever he might feel for both a charlatan and a sage, and both of his feelings are correct. The patient may feel confused, hopeful, angry, disappointed, and the very unexpectedness of the multiple experience may help the patient move out of his too-narrow definition of himself for one moment to embrace a wider range of experience. Because the situation is itself paradoxical, the patient cannot censure one reaction as "invalid" and maintain the other as the "consistently right one." Both reactions flip-flop between valid and invalid. And if one can feel angry and hopeful at one time, then perhaps one can also feel anxious but not-anxious at the same time—

one can have a symptom that is not a symptom, as everything becomes embraced simply as experience. In this way the meaning of experience, the way the patient and his family order experience, can be transformed. In this view, then, *the essential function of a paradoxical intervention is to de-reify the patient's (and the family's) conception of a situation, to provide an epistemological jump.*

By simultaneously offering himself to the patient as healer and helpless, the therapist in effect is echoing Epimenides of Crete saying, "All Cretans are liars." "I am therapist, one who heals; and all therapists fail to heal." Of course, the paradox works only if the patient experiences it; and there are many loopholes a patient may find (perhaps the most common loophole is to think, "Perhaps it is not true that *all* therapists are healers who can't heal; perhaps some other one could." Here is where the charisma of the therapist must come into play, to preclude this).

But when the relationship paradox is fully perceived, when one does not shut it off in one fashion or another, it is a gut-wrenching experience. Staring a paradox in the eye, experiencing both sides as valid and true, yet realizing one must preclude the other, the only solution is to give up an attempt at complete, unchanging consistency. In formal logic, this means that all systems of sufficient power to talk about themselves and claim completeness must necessarily be incomplete (9). But in the realm of personal experience, giving up the ideal of complete consistency means giving up the idea that there is some final, underlying core "essence" that somehow constitutes, through all situations, "me." It means that all attempts to draw a neat description of ourselves that ultimately defines us must fail. But to adopt that kind of epistemology, implied by systems theory, means experiencing the fact that there is no ultimate "core" to the self; it means that one must confront one's own emptiness. But it is this very emptiness of the self that allows emotional closeness to develop (12). We also see now that ultimately, to the extent that paradoxical interventions invoke an experience that allows patient to give up the hubris of having a reified, constant conception of himself and to permit himself to be consistently inconsistent, to that extent the patient can give up his symptoms. We are faced with a situation, then, in which it is the very experience of the self as empty, as lacking a solid core, that leads to a wider, stronger, healthier experience of the self. That is the paradox of paradox.

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