CHAPTER 31

PARADOX-BASED TREATMENTS

Howard Tennen
Glenn Affleck

Paradoxical interventions are therapeutic strategies that are in seeming opposition to the treatment goals they try to achieve. Case illustrations are provocative and have raised many questions regarding the efficacy and mechanisms of this treatment approach. The following examples from the literature, to which we will return later, convey the uncommon-sensical nature of these interventions as well as their range of application:

1. A patient complaining of panic attacks is asked to have such an attack deliberately so as to help bring the symptom under her control (Weakland, Fisch, Watzlawick, & Bodin, 1974).

2. A depressed stroke victim improves when his wife and children are told to stop trying to help him and to be ineffectual and helpless in his presence (Watzlawick & Coyle, 1980).

3. The father of a boy who regularly wets his bed at night is told that he must promise to follow the therapist’s instructions before hearing what they were. After he agrees, he is told to give his son a large glass of water every evening and demand that the son urinate on the bed and go to sleep on the wet bed (Madanes, 1980).

4. A patient with a long history of headaches is told by her therapist that her condition is probably irreversible and that therapy should concentrate on helping her live with the problem (Watzlawick, Beavin, & Jackson, 1967).

5. A young man diagnosed as schizophrenic is praised for acting crazy, since he is thus able to protect his father. By occupying mother’s time with fights and tantrums, he allows father more time for work and relaxation (Selvini-Palazzoli, Cecchin, Prata, & Boscolo, 1978).

Our purpose in this chapter is to review the experimental, conceptual, and clinical literature related to paradox-based therapeutic intervention. We begin with a review of the clinical outcome literature. We then describe and evaluate clinical and social psychological explanations for paradoxical interventions. We next differentiate the key components of paradoxical interventions and place them in the context of a brief strategic ther-
apy. Finally, we suggest implications for clinical and social psychological theory and research.

**CLINICAL EFFICACY OF PARADOXICAL INTERVENTIONS**

The most important question we can ask about any therapeutic technique is, Does it work? Any discussion of theory or technique must await an affirmative answer to this question. We therefore begin our review by examining three areas of the outcome literature: case studies, single case experimental designs, and randomized between-group designs. Together these investigations make a strong case for the efficacy of paradox-based treatments.

**Case Studies**

Case studies depict vividly the successful development of paradox-based interventions. The range of clinical problems to which they have been applied is impressive and includes tics (Yates, 1958), phobias (Malleson, 1959); depression (Johnston, Levis, & L’Abate, 1986), obsessive disorders (Frankl, 1960; Gertz, 1966; Gibson, 1985; Solyom, Garza-Perez, Ledwidge, & Solyom, 1972), urinary retention (Mozdzierz, 1985), sexual disorders (Frankl, 1966; Vandereycken, 1982), anorexia (Hsu & Liberman, 1982; Selvini-Palazzoli, 1974; Yapko, 1986), insomnia (Espie & Lindsay, 1987), anxiety-related somatic complaints (Greene & Sattin, 1985), problem prisoners (Chase, Shea, & Dougherty, 1984), transvestism (Cliffe, 1987), panic attacks (Datillo, 1987), alcoholism (Weinstein, 1985), temper tantrums (Hare-Mustin, 1975), stuttering (Frankl, 1966), schizophrenia (Bergman, 1982; Selvini-Palazzoli et al., 1978; Walker & McLeod, 1982), school problems (Williams & Weeks, 1984), migraine headaches (Gentry, 1973), hypertension refractory to treatment (Suzuki, 1985), and family problems (Mandana, 1980).

Despite the plethora of successful case examples, it has become commonplace to describe the clinical outcome of paradoxical interventions as “untested” (Schwartz & Perrotta, 1985). The inherent unreliability of the case study method makes it impossible to draw valid conclusions about the generality of paradox-based interventions despite the apparent success suggested by these reports (Kazdin, 1980). Threats to internal validity, such as patient selection, present another problem (Campbell & Stanley, 1963). Finally, therapist bias and the exclusion of experimental controls severely limit the usefulness of case studies (Wilson & Bornstein, 1984).

Empirically minded clinicians also have complained that published outcome data are sparse (Coyne & Biglan, 1984; Tennent, Eron, & Rohrbaugh, 1985), that most evidence about paradoxical techniques is impressionistic (Kolko & Milan, 1983; Soper & L’Abate, 1977), and that “there has been very little empirical work of any kind” (Weeks & L’Abate, 1982, p. 219). They have urged the publication of empirical research findings (Cade, 1984). We will demonstrate that there is now a sizable and consistent empirical literature supporting the therapeutic efficacy of paradoxical interventions. This literature consists of single-case experimental designs and comparative studies of paradoxical and nonparadoxical interventions.

**Single-Case Experimental Studies**

Single-case experimental designs or intrasubject-replication designs (Kazdin, 1980) are best applied to interventions that are targeted to a specific symptom or behavior, that produce rapid improvement, and that are flexible enough to allow the clinician to implement or withdraw treatment as necessary. Paradox-based interventions are thus well suited for this approach.

The most widely employed intrasubject-replication design is the ABAB design in which a baseline is established (A), followed by an intervention (B), subsequent withdrawal of the intervention (A), and finally its reimplementation (B). Symptom changes should parallel changes in implementation and withdrawal. ABAB designs have been employed successfully in the paradox-based treatment of constipation and encopresis (Bornstein, Sturm, Retzlaff, Kirby, & Chong, 1981) and sleep-onset insomnia (Ascher & Efran, 1978). Simpler AB designs have been used to treat agoraphobia (Kolko, 1984) and school truancy (Szykula & Morris, 1986). An ABC design was employed for obsessional flatulence ruminations (Milan & Kolko, 1982). After baseline (A) and an unsuccessful cognitive intervention (B), the authors successfully employed a paradoxical directive that resulted in the rapid and continued elimination of the rumination.

Several studies have employed multiple baseline designs, in which the length of the baseline is altered after each intervention (Kazdin, 1980;
Wilson & Bornstein, 1984). This design has been applied to the paradox-based treatment of agoraphobia (Ascher, 1981), insomnia (Relinger & Bornstein, 1979), and delinquent behavior (Kolko & Milan, 1983). Taken together, these studies provide consistent empirical support for the efficacy of paradoxical interventions.

Between-Group Studies

Studies comparing paradoxical and nonparadoxical treatments through randomized between-group designs are even more impressive (Katz, 1984; Strong, 1984). Two meta-analytic reviews (Hill, 1987; Shoham-Salomon & Rosenthal, 1987) document the effectiveness of paradoxical interventions in alleviating specific symptoms. The studies included in these reviews are summarized in Table 31.1.

Hill (1987) reviewed 15 published studies comparing paradoxical interventions and nonparadoxical treatments and computed the magnitude of the therapeutic effects. The effect size is computed by subtracting the mean of the control group from the mean of the treatment group and dividing by the standard deviation of the control group (cf. Smith, Glass, & Miller, 1980). The results make a strong case for the effectiveness of paradoxical interventions. The effect size for paradoxical interventions compared with no-treatment controls indicated that an individual at the mean of the intervention group would be at the 84th percentile of the control group. Even when compared with placebo treatments, individuals who received paradoxical interventions experienced significantly more symptom relief.

The effect size for nonparadoxical treatments (usually behavioral or cognitive-behavioral interventions) was not significantly different from the effect of paradoxical approaches. But several of the studies included in the meta-analysis contained numerous effect sizes, which could bias the results. To correct for this bias, Hill computed the mean effect size for paradox-based and alternative treatments. Paradox-based treatment proved superior.

Shoham-Salomon and Rosenthal (1987) reviewed 10 outcome studies, including many reviewed by Hill. Their findings support and extend Hill’s conclusions. They found that subjects receiving paradoxical interventions showed substantial symptom reduction compared with subjects receiving no treatment. Paradox-based treatments also showed a modest and nonsignificant advantage when compared with behavioral and cognitive-behavioral interventions. Moreover, their analysis of the durability of the treatment effect, its relation to the severity of the presenting symptom, and the differential impact of types of paradoxical interventions, provide an even more impressive picture of the efficacy of paradoxical treatments.

The effect of paradoxical treatments is durable and actually appears to increase with time. At 1 month follow-up, paradoxical interventions were superior to other treatments. This superiority is not due to the waning effects of the alternative modes, but rather to ongoing symptom reduction after the completion of paradoxical interventions. Shoham-Salomon and Rosenthal (1987) suggested that paradoxical interventions may require an incubation period before their full effect is obtained. But the enhanced effect over time is also consistent with a fundamental premise of those who employ these techniques: that change begets change (Watzlawick, Weakland, & Fisch, 1974).

It has been asserted (Watzlawick et al., 1967; Weeks & L’Abate, 1982) that paradoxical interventions are most helpful when the presenting symptom is severe. To test this assertion, Shoham-Salomon and Rosenthal (1987) computed the correlation between symptom severity and treatment effectiveness. Although the necessary data were


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available for only two studies, the findings are intriguing: greater symptom severity is associated with poorer outcome for nonparadoxical treatments, but greater severity is associated with better outcome for paradoxical interventions. The difference between these correlations is highly significant and, although tentative, suggests that paradoxical treatment approaches may be most effective where behavioral and cognitive-behavioral treatments fail.

In their landmark work on the benefits of psychotherapy, Smith et al. (1980) compared 17 types of therapy. Shoham-Salomon and Rosenthal (1987) rank ordered the effect size of these treatments and found that the paradox-based treatments evaluated in their meta-analysis ranked third following only cognitive therapies and hypnosis. They concluded that studies employing paradoxical interventions yield an effect size that is larger than the effect of 95% of the interventions reported by Smith et al. (1980).

One concern not yet addressed in our review is whether paradoxical interventions have an unacceptable proportion of iatrogenic outcomes. Might there be significant risk in asking a patient to exaggerate his or her symptom? Hill (1987) found that only 1 of 39 effect sizes was in a negative direction compared with no-treatment controls. The one negative effect was reversed by the time of follow-up, supporting Shoham-Salomon and Rosenthal's (1987) contention that paradoxical interventions may produce "sleeper effects." This rate of untoward effects (3%) compares favorably with the 12% rate for other modes of psychotherapy (Smith & Glass, 1977).

Since the publication of these meta-analyses, four controlled studies have appeared employing paradoxical interventions. One study (Westerman, Frankel, Tanaka, & Kahn, 1987) included individuals with a broad range of problems applying for treatment at a mental health clinic. The other three studies investigated the treatment of agoraphobia. Westerman et al. (1987) reported that behavior therapy and paradoxical interventions were equally effective. Ascher, Schotte, and Grayson (1986) and Schwartz and Michelson (1987) found that paradoxical intervention was as effective as behavioral techniques in the treatment of carefully diagnosed agoraphobic patients. Michelson, Mavissakalian, Marchione, Dancu, and Greenwald (1986) found that although effective, paradoxical intervention was not as effective as behavioral treatments of agoraphobics.

Overall, our review of the outcome literature indicates that the effectiveness of paradoxical interventions is substantial. Case studies and single-subject experimental designs support its efficacy. Controlled studies comparing paradoxical with other treatments reveal that paradoxical interventions are not only adequate, but may be superior. The studies reviewed include both carefully diagnosed patients and university students. The symptoms addressed are fairly wide ranging. The findings are compelling and demand an adequate explanation. We now examine the plethora of clinical and social psychological models proposed to explain the efficacy of paradoxical interventions.

**CLINICAL EXPLANATIONS OF PARADOXICAL INTERVENTIONS**

The relation between clinical theory and paradoxical interventions is akin to the fable of the blind men and the elephant: Every theory has attempted to take paradox out of context so that it is no longer contrary (parar) to common opinion (doxa). The explanations, however, are inchoate and have stimulated neither research nor innovative clinical application.

Examples of paradoxical clinical interventions appear as early as the 19th century (cf. Foucault, 1965). The first modern application is described by Dunlap (1932), who explained paradox in terms of learning theory and called the technique "negative practice." Dunlap hypothesized that when a symptom is prescribed by a therapist and practiced by a patient, two things happen. First, the symptom, which was uncontrolled, is now under voluntary control. Second, it is subject to extinction. Thus, by practicing the symptom, the patient will remove it.

Conditioned inhibition and satiation are related learning theory constructs that have been used to explain paradox-based treatment (Rabkin, 1977). Conditioned inhibition refers to the observation that the repetition of a habit leads to its extinction even if the habit is followed by a reward. Satiation, on the other hand, explains the success of paradoxical interventions by noting that with continued presentation, a reinforcer loses its rewarding properties. These learning theory explanations may have some heuristic value when the patient actually repeats the symptom on many occasions. Most reports indicate, however, that symptom prescription is successful after only one or a few tri-
als—an outcome that cannot be explained by conditioned inhibition or satiation. Nonetheless, behavior therapists continue to view paradoxical interventions as another tool in their armamentarium (cf. Michelson & Ascher, 1984).

Frankl (1960) explained the effects of paradoxical treatment with existential (logotherapy) concepts. He suggested that paradoxical interventions, specifically symptom prescription, produces change through “hyperintention” and humor. In theory, hyperintention means trying in an exaggerated way to produce a symptom. This very effort counteracts anticipatory anxiety or “fear of fear.” By trying to bring on his or her fear or obsession, the phobic or obsessional patient finds that he or she is less ruminative or fearful. Humor provides a context of detachment from the symptom. Hyperintention may explain why many patients lose their symptoms with little practice (see example 1 at the beginning of this chapter), but it cannot explain situations in which the therapist tells the patient to not get better (example 4) or those situations in which another family member is asked to change his or her behavior (examples 2 and 3). Moreover, we will demonstrate later that the interventions that are best explained by existential concepts are least likely to have an adequate clinical effect. Despite these limitations, the logotherapeutic literature is replete with suggestions for refining the application of hyperintention and humor (Fabry, 1982; Riveros, 1984; Shaughnessy, 1984).

Adlerian therapy (Corsini, 1982; Main & West, 1987; West, Main, & Zarski, 1986), gestalt therapy (Seltzer, 1984; Peterson & Melcher, 1981), reality therapy (Wubbolding, 1984, 1985), transactional analysis (Massey, 1986; Price, 1986; Watney, 1982), and psychoanalysis (Gurman, 1982) also have been used as conceptual bases for paradoxical interventions. The differences among these explanations is dramatic. Reality therapy explains paradox in terms of “conflict in need fulfillment” (Wubbolding, 1984); transactional analysis employs “duplex communication” and “stroking the client” (Massey, 1986); whereas psychoanalytic theory claims that paradoxical interventions are effective because they “express the most central and powerful psychodynamic themes . . . and . . . reveal both the positive and negative elements of intimate collusion” (Gurman, 1982, pp. 72–73).

We believe that the proliferation of these unsupported theories is more interesting than their heuristic value. This proliferation has two implications. The first is that behavior, whether patient’s or therapist’s, is easily absorbed into one’s existing worldview. Second, attempts to persuade people that their view is incorrect by presenting evidence or alternative explanations seems to have no impact on their position. This attempted solution may even exacerbate the problem by making people more entrenched in their position. These implications will form the basis for our eventual conceptualization of paradoxical interventions.

SOCIAL PSYCHOLOGICAL EXPLANATIONS

The mystique of paradoxical interventions and an increasing interest by social psychologists in clinical phenomena (Strong, 1987) have led to social psychological explanations for the effects of paradox, and to models of clinical technique. Like most schools of psychotherapy, each social psychological theory explains paradoxical interventions within its own framework, and each leaves many unanswered questions.

Cognitive Dissonance

Kercher and Smith (1985) and Bogdan (1982) have offered explanations based on cognitive dissonance theory (Festinger, 1957). They hypothesize that prior to treatment, patients possess a cognitive consonance: they view problematic behaviors as maladaptive and also are concerned about those behaviors. To have a problem and not be concerned would create dissonance. When clinicians invoke paradoxical interventions, they arouse dissonance, which patients then try to reduce. Dissonance may be aroused by prescribing the symptom (see example 1 in the beginning of this chapter) or by relabeling it as good instead of bad (example 5). A symptom prescription is dissonant with the view that the symptom is bad. To reduce the dissonance, the patient may change behavior associated with the symptom. For example, the phobic may stop avoiding fear-inducing situations. When dissonance is aroused by relabeling a symptom, it can be reduced by not trying to change the symptom. For example, a depressed individual may be told that her depression is not to be avoided because it helps her understand herself. She can reduce dissonance by not trying to change her depression.

Although intriguing, the dissonance explanation is based on an assumption that is beyond the domain of the theory. Specifically, it assumes that
people's attempts to solve problems can actually create larger problems. This can be seen in both of the examples presented to support the theory. The phobic's problem is not his or her fear, but the attempt to solve that problem by avoiding certain situations. Similarly, the depressed patient's problem is not her sadness per se, but her unsuccessful attempts to ward it off. As we hope to demonstrate, the concept of "problem-maintaining solutions" is central to an adequate conceptualization of paradoxical interventions. Nonetheless, it falls beyond the domain of dissonance theory.

Attribution Theory

L'Abate (1986) and Strong and associates (Beck & Strong, 1982; Hills, Gruszkos, & Strong, 1985; Strong & Claiborn, 1982) employ attribution theory to explain the effects of paradoxical interventions. Beck and Strong (1982) hypothesize that paradox-based treatments are successful because behavior change is attributed to internal stable sources. For example, when a therapist associates a patient's depression with sensitivity and caring, he or she is suggesting an internal stable attribution for any change in the symptom. An attributional explanation of paradoxical interventions faces two problems. First, it cannot account for those interventions in which someone other than the identified patient is the agent of change (see examples 2 and 3 at the beginning of this chapter). Moreover, the formulation does not stand up to empirical scrutiny. Strong is one of the few clinicians to test clinical hypotheses empirically, and he has not been able to provide support for his attributional formulation (Feldman, Strong, & Danser, 1982).

Reactance Theory

Another application of social psychological theory to paradoxical interventions appears in the work of Tennen, Rohrbaugh, and associates (Tennen, Rohrbaugh, Press, & White, 1981; Rohrbaugh, Tennen, Press, & White, 1981; Rohrbaugh, Tennen, & Eron, 1982; Tennen et al., 1985), who presented a model of therapeutic intervention based on reactance theory (J. W. Brehm, 1966; Brehm, 1976). Their model has generated both clinical (Ascher, 1986; Cade, 1984; Dowd & Swoboda, 1984; Kolko & Milan, 1986) and research (Westerman et al., 1987) interest.

Reactance theory is based on the assertion that people experience certain behaviors, thoughts, and attitudes as "free," meaning that they could engage in that behavior, thought, or attitude at any given time. The central premise of the theory is that a person will experience an aversive motivational state, psychological reactance, when any free behavior is threatened. In response to this threat, he or she will try to restore the free behavior, thought, or attitude. If someone's free behavior is threatened by a request or directive, the simplest way to restore freedom is to disobey or do other than what is requested. Drawing on this premise, we differentiated two types of paradoxical intervention: those in which therapeutic change derives from complying with the therapist's directive, and those in which change results from defying the directive.

Compliance-based interventions are effective because complying with the directive interrupts the process that maintains the symptoms. Symptom prescription is thought to be most effective with obsessions, anxiety, and insomnia because these problems are maintained by attempts to stave them off. When a patient complies with a symptom prescription and attempts to create the symptom, he or she is interrupting a usual tactic of trying to prevent it.

Defiance-based interventions are effective because people change by defying the therapeutic directive. Consider the example of disengaging an overprotective mother from a symptomatic child (Haley, 1976). The therapist encourages the mother to spend even more time with her child to warn him about all of life's dangers. As Haley (1976) noted, "If this approach is done well, the mother will react by rebelling against the therapist and hovering over the child less" (p. 71). The reader might notice that as was true of dissonance theory, reactance theory requires the additional assumption of a problem-maintaining solution. Both compliance- and defiance-based interventions imply that the therapist is trying to get the patient to do less of something. That something is often the patient's well-intended but misguided solution to a problem.

We reasoned that two factors, both derived from reactance theory, determine whether to use compliance- or defiance-based paradoxical strategies. One factor is the probability that the person to be influenced will experience psychological reactance in response to the planned intervention. The second factor concerns the behavior or attitude to be influenced: Does the individual believe that it is "free?" Defiance-based strategies are
most effective when the target behavior is free and reactance potential is high. Compliance-based paradox is most effective with "unfree" behaviors such as symptoms and when reactance potential is low. When reactance potential is low and the target behavior is free, paradoxical interventions are not necessary.

The most difficult clinical situations are encountered when reactance potential is high and the target behavior is unfree. In these cases, Tennen et al. (1981) recommend that the intervention be shifted to a collateral or supporting behavior. They offer the example of the depressed individual who believes that his or her depressive symptoms are unfree, but who could enumerate behaviors related to the depression that are free, such as calling an employment agency or walking to the neighborhood tavern. After having the defiant patient describe what he or she could do, the therapist might then suggest explicitly that he or she avoid doing these things.

The compliance-defiance model need not be applied to the problem-bearer. In fact, the behavior of others—usually family members—is usually a better prospect for defiance-based paradoxical interventions, because significant others usually define their behavior as free. Haley's (1976) case of the overprotective mother is a good example of this type of defiance-based intervention. But recall that while Haley endorsed this approach if it is done well, he did not specify the components of a well-presented intervention. Similarly, Tennen et al.'s model remains incomplete without an exposition on how to carry out effectively a compliance-or defiance-based paradoxical intervention. The model, like other social psychological models, also requires the concept of problem-maintaining solutions; that is, attempted solutions that exacerbate the problem. This concept is beyond the scope of the model. We now present a comprehensive model of behavior change, the strategic therapy approach, that we believe provides the best context from which to understand paradox-based treatment.

**THE STRATEGIC THERAPY APPROACH**

Most schools of psychotherapy require that the patient come to accept the therapist's definition of reality or at least comply with therapeutic directives or suggestions. But patients often resist our attempts to redefine their reality and only sometimes follow our suggestions. The "strategic" approach to therapy, most clearly described in the work of Jackson, Watzlawick, Weakland, Fisch, Coyne, and others at the Mental Research Institute in Palo Alto, California, advances the position that changing people's behavior does not require that we challenge their cherished assumptions about themselves and the world. Profound changes can occur with minimal interventions that merely extend existing assumptions. Consistent with Erickson's (Erickson & Rossi, 1975; Erickson, Rossi, & Rossi, 1976) principle of accepting and using what the patient offers in a manner analogous to psychological judo (Bandler & Grinder, 1975), strategic therapists propose to patients variations of their existing personal paradigms (Mahoney, 1980) or world images (Watzlawick, 1978).

We believe that the strategic therapist's application of paradox-based interventions turns on five central concepts: worldviews, reframing, problem-maintaining solutions, positive connotations, and behavioral prescription or restraint. We will attempt to elucidate these concepts and their relation to paradox-based treatment.

**WORLDVIEWS, REFRAMING, AND THERAPEUTIC CHANGE**

Our worldviews or world images are those cherished assumptions that we hold about the nature of things. Watzlawick (1978) referred to them as "second-order realities," as opposed to first-order reality, which is the world that exists independently of our appraisals. Drawing on the constructivist position (Dell, 1987; Efran, Lukens, & Lukens, 1988; Keeney, 1987; Maturana, 1975; von Glaserfeld, 1984), Watzlawick argued that the world "out there" is not accessible to us, and that our problems in life derive from our second-order realities.

In practice, a patient's worldview (which includes a view of oneself) is usually inferred. Consider the following example of a mother who brought her daughter for treatment of thumb-sucking. She had not complied with the therapist's request that she initiate a home-based program in which the girl was to be rewarded for not sucking her thumb and placed in her room for five minutes (time out) each time she sucked her thumb (Szykula & Morris, 1986):

Therapist: What has interfered with your using the suggestions for using incentives and time out?
Patient: Well, ... I don't know if it's going to help ... to reward and punish Nancy's behavior. I think Nancy has the problem because of her father's and my divorce. Do you think she's suffered emotional damages?

Therapist: ... Her emotionality ... and sulking are more a result of her feeling that the two secure people in her life have changed. And she is unaware whether they will really offer future security. ... The structure of a point program ... gives children a sense of security that they can both see and feel. It alleviates any thoughts that "mommy" can't take care of things because "daddy's not living at home any more."

Patient: Gee, I never thought of it that way. I just thought it ... so superficial ... 

Therapist: It seems superficial to us adults, but to a child's view of the world, it's security and stability. (pp. 176-177)

In keeping with this mother's definition of the problem, the therapist redefines reward and punishment as sources of security and stability. The redefinition presents a reality that is so plausible, we need to remind ourselves that it is, in fact, an invented reality that is congruent with the mother's views. Equally plausible realities can be constructed for this or any situation.

In some circumstances, rather than working directly with the patient's worldview, the therapist cultivates a frame by gently crafting a new way to view the presenting complaint (Jones, 1986; Snyder, Higgins, & Stucky, 1983). Consider the case of a wife who is critical of her husband, whom she views as not caring and indifferent to her needs (Fisch, Weakland, & Segal, 1982). The therapist meets alone with the husband to understand his "flaw," and then with the wife. To cultivate a new frame, he asks her some leading questions:

Would I be correct that his parents might be described as cold and overly controlled ... ? When you have pointed out to him his failure to be thoughtful to you, does he get angry, angrier than one would normally get ... ?

The stage has now been set to redefine the husband's behavior not as evidence of his lack of caring, but rather of his inability to do otherwise:

What you have confirmed and helped me to see clearly is that, in a sense, Bob is a person who has been crippled, most likely in his early rearing. But it's a particular kind of crippling. You see, he can be a bright person, but he lacks the ability to be normally perceptive of others' needs and sensibilities, and this is all the more so with people he is most close to. I myself do not understand it, but he can have less difficulty with people who are not important to him; yet the closer and more meaningful the relationship, the more this deficit will show up. What makes it a more sticky problem is that it's hard for him to be aware of it, and so he will get very angry when accused, even rightly, of being uncaring or thoughtless, since, as far as he knows, there is nothing he can perceive that needs taking care of. In a manner of speaking, it is almost as if he were retarded, not intellectually but perceptively. (Fisch et al., 1982, p. 106)

Jones (1986) pointed out that this kind of intervention makes intuitive use of what social psychologists have learned about schemas (Fiske & Linville, 1980), schema activation (Cohen & Ebbesen, 1979), and category accessibility (Weyer, 1980).

For both the mother of the emotional child and the wife of the uncaring husband, the reason that the reframe or redefinition is therapeutic is because it interdicts a problematic sequence of behavior. In the process of viewing the problem in a new light (yet one consistent with their own world image), these individuals behave differently. They no longer try to solve the problem by doing things to perpetuate it. As we mentioned in our discussion of social psychological perspectives on paradox, the idea that people engage in problem-maintaining solutions is central to nearly all explanations of paradoxical interventions.

**PROBLEM-MAINTAINING SOLUTIONS**

Problem-maintaining solutions are well-intended behaviors that are meant to alleviate a difficulty but instead change that difficulty into a problem. Tennen et al. (1985) describe three labels, premises, or expectations that appear to be tied repeatedly to problem maintenance: the expectation of mastery and control, utopian expectations, and labeling behavior as mad or bad. These views, when applied rigidly, lead to three kinds of problem-maintaining behavior: action where none is needed, no action where some is needed, and the wrong kind of action.

The expectation of control may be the most pervasive problem-maintaining premise. The problematic expectation is that people are masters of their fates and they should take responsibility for their own behavior. Problems maintained by the expectation of mastery include those where a per-
son tries to produce an outcome that by its very nature requires not trying. Action is thus taken where none is needed. Tennen et al. (1985) offered the example of a man who is having difficulty maintaining an erection. This difficulty becomes a problem when he tries to create an erection by willing one: “The problem-maintaining premise of course is that there is a correlation between effort expenditure and intensity of erection. The harder he tries, the softer he becomes, which is interpreted as evidence that he is not trying hard enough . . . ” (p. 193).

Utopian assertions (Watzlawick et al., 1974; Watzlawick, 1978) can also create a problem-maintaining solution. The assertion is that all is well in situations where some action is needed. Tennen et al. (1985) offered as an example the father of a delinquent adolescent referred by the courts, who talks about his son as if he were selected class valedictorian rather than someone who persists in making trouble. The therapist's task is to redefine the meaning of the boy's behavior in a way that produces appropriate action by the father. The details of this redefinition depend in part on the father’s worldview. In any event, the therapist would not challenge the father to “face the facts.”

A third group of problem-maintaining beliefs involves whether behavior is labeled as mad or bad. As labels have significant effects on those labeled (Berger & Luckmann, 1966), the therapist's task is to shift the meaning of the labeled behavior, which in turn influences how people behave. In the case of the frustrated wife whose husband was “not caring” (bad), the therapist redefined his behavior as inept and determined by deep-seated psychological forces (mad). This redefinition interdicted the wife's problem-maintaining pattern of accusations, which had led regularly to the husband's withdrawal, which, of course, the wife defined as more evidence that he is uncaring. There are other situations in which the problem-maintaining label is “mad” and the therapist reframes the behavior as “bad” so as to initiate new interaction patterns (e.g., Hoffman, 1976).

We can now identify problem-maintaining behaviors in each of the examples presented at the beginning of this chapter. In the first example of panic attacks, the problem-maintaining behavior is avoiding situations that may bring on an attack. The therapist therefore prescribes the symptom to interrupt the problem-maintaining cycle. In the second example, the children of the depressed stroke victim are taking the wrong kind of action. Their efforts are well intentioned, but it is not until they act in a helpless manner that their formerly “take charge” father begins to take charge again. In the third example, action is needed, but none is being taken. By extracting a promise in advance, the therapist gets the father to create an “ordeal” for his son in which bedwetting is no longer a viable alternative.

In the case of the patient with chronic headaches (example 4), the therapist attempts to interrupt the problem-maintaining solution of trying to eradicate the headaches. Finally, the young man in example 5 was diagnosed as schizophrenic. The therapist believes that this “mad” label plays a role in maintaining crazy behavior, and redefines the craziness to the family as the patient’s noble attempt to protect his father. In this last example, the therapist indicates that the patient’s symptoms are not only tolerable, but actually praiseworthy. This tactic of connoting a problem in a positive light plays a key role in the armamentarium of clinicians who employ paradoxical interventions. We now review the clinical and empirical evidence supporting this technique.

**POSITIVE CONNOTATION AS A PARADOXICAL THERAPEUTIC STRATEGY**

Despite the protestations of the constructivists, in our everyday activities we view reality as something “out there” that we perceive in a valid way. There are circumstances, however, that remind us of the fragility of that external reality. For example, in 1988 when massive forest fires swept through large sections of Yellowstone National Park, many people were horrified by what was to them without doubt massive destruction. But environmentalists were not at all concerned, nor did they view the fire as destructive. Rather, they viewed it as a natural phenomenon with many benefits, such as richer plant life, more nutrition for wildlife, and new information about the process of rejuvenation. These divergent views suggest very different actions. Those who witnessed destruction demanded that the fire be contained. Those who witnessed a positive and beneficial event suggested that nothing be done to protect the forest. This example demonstrates that a positive interpretation can be placed on almost any situation, and sets the stage for our discussion of
one particular subset of reframes—those in which a problem is given a positive meaning, which is critical to our discussion of paradoxical interventions.

Clinical examples highlight both the power and potential perils of positive connotation: A depressed 12-year-old withdraws from others frequently, particularly when he is encouraged to interact with his peers. After the therapy team reviewed a series of problem-maintaining solutions, "He was told that, after thinking about this issue, we supported his withdrawal, inasmuch as it most likely represented an attempt to get in touch with his sad feelings. We further observed that only after he had truly come to know himself well, could he begin to interact with others" (Jessee, Jurkovic, Wilkie, & Chiglinsky, 1982, p. 316).

Coyne (1987) described the use of similar tactics with couples:

With a couple, the therapist may ask the partners individually how they have been able to make it as long as they have, despite their problems. . . . If the client merely states that they have stayed together because of fear or the welfare of the children, the therapist may reply that for many that would not be enough, and that somehow the client had found the personal resources to endure. If the client expresses longstanding hostility toward the partner, the therapist may comment that this may represent a real loyalty. . . . and that remaining hostile, at least for now, may be a way of keeping enough distance to reduce the hurt. (p. 541)

As Coyne (1987) noted, such positive connotations are central to paradoxical interventions. Before implementing them, however, he advised the therapist to grasp the patient’s existing perspectives (worldviews) and actively accept them. He noted that it is preferable for the client to volunteer evidence of strength or resources. Even then, he urged the therapist to not confront people with their strengths in a way that may burden them or demonstrate the therapist’s lack of understanding.

Coyne’s concern is well founded in view of the perfunctory application of positive connotation in the clinical literature. For example, a couple with chronic relationship problems is told that they really love each other and that changing for the better would be a sign of rejection (Soper & L'Abate, 1977). Or consider the patient who is commended for his symptoms. The therapist expresses admiration for the patient's “extraordinary sensitivity,” “generosity,” and “willingness to suffer and make unparalleled sacrifices” for the family (Selvini-Palazzoli et al., 1978). We believe that the patient’s acceptance of this positive connotation depends on the parameters mentioned by Coyne: that the connotation fit well within an existing worldview and that it neither burden the patient nor demonstrate the therapist’s lack of understanding. Much has been made by family therapists of redefining symptomatic behavior as “heroic” (Sluzki, 1983). We fear, however, that the burden of superior qualities associated with hero status may turn some connoted heroes into tragic heroes.

The application of positive connotation in research studies is particularly troublesome, though understandable in view of the demands of randomized group designs. For example, Kraft, Claiborn, and Dowd (1985) offered six identical positive connotations to their mildly depressed subjects. Each connotation labeled the subject’s characteristics or behavior as a sign of strength or good fortune. The exigencies of well-designed research may require that each subject receive identical instructions. But by not tailoring positive connotations to subjects’ existing worldviews, outcome research underestimates the efficacy of paradox-based treatment.

Despite the constraints imposed by research design, there is now empirical evidence that positive connotations are a key ingredient in paradoxical interventions. In their meta-analytic review, Shoham-Salomon and Rosenthal (1987) investigated separately the effects of positive connotation and symptom prescription. The findings were provocative: Positive connotations were more effective than nonpositive connotations, increasing the mean therapeutic success rate from 14% to 85%. Moreover, positively connoted paradoxical interventions were significantly more effective than behavioral and cognitive-behavioral treatments. This is particularly impressive because systematic desensitization is considered the treatment of choice for the anxiety-based disorders investigated in these studies (Brehm & Brehm, 1981; Kazdin & Wilcoxon, 1976). Finally, Shoham-Salomon and Rosenthal found that in the absence of positive connotation, symptom prescriptions, the cornerstone of the logotherapeutic approach to paradoxical interventions, were less effective than other treatments.

We conclude this section with a reminder that positive connotations simply provide plausible and workable realities. Skyner (1981) suggested
that these connotations express "the most essential truth" (p. 76). We must disagree. There are many truths, some more helpful than others.

**PRESCRIBING AND RESTRAINING: THE FINAL INGREDIENTS**

We have described four key components of paradoxical intervention: assessing and endorsing the patient's worldview, identifying problem-maintaining solutions, reframing the problem in a manner consistent with the patient's worldview, and employing positive connotation as part of the reframing process. The final component of the process is either prescribing the symptom or some related behavior, or restraining the patient from change.

Throughout this chapter, we have stressed that the meaning one attributes to events influences behavior, and that by rearranging meaning we can make significant therapeutic changes. It would be incorrect, however, to assume that one must change meaning to change behavior. Changes in behavior can themselves lead to new worldviews, views that would never occur without the new behavior. Therefore, behavioral directives play an important role in paradox-based interventions.

Ironically, the best known case of a single small behavior leading to significant changes comes not from the literature on paradox, but from psychoanalysis. Balint (1968) described a young woman who complained of not being able to achieve anything because of an overwhelming fear whenever she had to take a risk or make a decision. In the course of psychoanalytic treatment, she mentioned that despite many efforts, she had never been able to do a somersault. When Balint inquired further, she got off the analytic couch and to her amazement performed a somersault. Balint documented many positive changes in her emotional, social, and professional life that followed this seemingly minor event. Her view of herself and her relation to the world had apparently changed because of one small behavior.

Watzlawick (1985) reminded us that sometimes people's worldviews do not allow them to engage in behavior that could have a lasting impact, no matter how effortless that behavior may be. This is why reframes and positive connotations are employed; not only to infuse new meaning into a symptom or interaction pattern, but also to provide a rationale for one of two behavioral directives—behavioral prescription or restraint. Prescribing means telling people what to do either by giving them tasks or making suggestions. Prescribing the symptom is a common paradoxical tactic, but the literature is unclear as to whether the therapist should provide a rationale or simply instruct the patient to have his or her symptoms. Thus, some investigators employ no rationale (Westerman et al., 1987). Others provide a straightforward rationale such as "this activity could vitiate therapy" (Turner & Asher, 1982, p. 36) or tell patients that engaging in the symptom can "be used as a coping procedure to reverse the vicious cycle of fearful responding" (Michelson et al., 1986, p. 96). Our concern with these rationales is that they neither take full advantage of the patient's worldview nor provide a positive connotation to the problem behavior. As we have seen, the empirical literature supports our concern. Paradoxical interventions in the absence of positive connotations are less effective clinically.

Some investigators, nonetheless, have found that negative connotation can have a positive therapeutic impact. Kolko and Milan (1983), following the reactance theory model, successfully maximized opposition to a paradoxical directive that a young school truant not attend school by suggesting to him that he may not be mature enough to handle the attendant responsibilities. We believe that negative connotations may be more difficult than positive connotations to implement, and their potential effectiveness awaits stronger empirical support.

Behavioral prescriptions are targeted to interrupt problem-maintaining solutions, as demonstrated by the first three examples at the beginning of the chapter. Example 1 is a symptom prescription designed to interrupt the attempted solution of avoiding panic attacks. Example 2 is a behavioral prescription directed to the problem-maintaining behavior of well-meaning family members. The third example captures well Watzlawick's (1985) contention that existing worldviews often restrict potentially helpful actions. The father is directed to create an ordeal for his son, but only after the therapist extracted a promise from him that he would follow whatever the therapist requested. The father would never have let his son sleep in a wet bed had a promise not been given in advance. Yet this very behavior eliminated his son's symptom and enhanced their relationship, the son's esteem, and the father's sense of competence. This intervention demonstrates both the power of behavioral directives and the fact that changes in behavior can precede or lead to changes in one's view of the self, others, and the world.
Restraint is another way of influencing behavior to interrupt problem-maintaining sequences. Tennent et al. (1985) distinguish among implicit restraint, soft restraint, and hard restraint. Implicit restraint allows the patient to do less of the same. In fact, the entire process of paradoxical-based treatment is directed toward restraining usual attempts to change the problem. Thus, the therapist sets minimum goals and suggests starting slowly (Coyne, 1987).

Soft restraint involves the suggestion or implication that the patient should not change the very behavior that brings him or her to treatment. The therapist might voice concern about the dangers of improvement or the unfavorable consequences of change. Examples of soft restraint are found in our earlier vignettes of the withdrawn 12-year-old and the hostile couple. The 12-year-old is told, in essence, to continue to withdraw. The couple is told to remain hostile toward each other. Although potentially powerful, restraining maneuvers are easily misused because the therapist is saying things that could be interpreted as insulting. Yet, benevolent concern (Haley, 1976), the use of the patient’s worldview, and positive connotation help assure that the intervention will succeed.

Hard restraint is the most extreme of the restraining strategies and we now believe that it may be unnecessary. It requires the therapist to suggest that the patient probably cannot change. Greenberg and Pies (1983) reported the following interaction between a patient diagnosed as having a borderline personality disorder and her therapist:

Ms. A.: I want you to know I’m very sick.

Th.: I realize that. I think it’s going to be very, very difficult for you to get well.

Ms. A.: I think it’s going to be very, very, very, very difficult.

Th.: I agree. In fact, I’d say the chances of your getting well are about 1 in 100. (p. 68)

The patient grew increasingly suicidal. Greenberg and Pies (1983) concluded that paradoxical techniques may produce adverse outcomes with borderline patients. They support this conclusion with the psychodynamic idea that in response to paradoxical interventions “the split object-relations unit may be projected onto the therapist” (p. 68). Another explanation is that the intervention failed because the therapist did not attempt to positively connote the patient’s symptoms, did not attempt soft restraint, and did not assess or attempt to interdict a problem-maintaining sequence. In short, the therapist did not apply the fundamental principles of paradox-based interventions. Nonetheless, in view of the potential abuse of hard restraint, we now recommend against its use.

In summary, we have delineated the central features of paradoxical interventions: (a) an appreciation of the patient’s or family’s “worldview”; (b) an assessment of problem-maintaining behaviors or interactions; (c) a positive connotation or re-definition of the problem behavior that is either consistent with the patient’s worldview or derives directly from the “cultivation” of a useful frame; and (d) behavioral prescription or restraint. The most important guidelines for the implementation of paradoxical interventions is that theory and technique should be inseparable. Before telling patients to change or not to change, the clinician must understand that attempted solutions turn difficulties into problems, that people are more willing to accept suggestions that simply extend their own point of view, and that certain constructions of reality are more useful than others.

**CHALLENGES TO CLINICAL AND SOCIAL PSYCHOLOGY**

We began this chapter with a review of clinical and social psychological explanations of paradoxical interventions. We will end with implications of these interventions and their constructivist underpinnings for clinical and social psychology. Attempts to “explain” paradox from other perspectives have not been productive. These interventions have their most heuristic explanation in the strategic-constructivist model of behavior change. Clinical and social psychology might profit from a change in perspective. Rather than attempt to explain paradoxical interventions within existing frameworks, existing frameworks might benefit from considering the challenge posed by the efficacy of paradoxical interventions. To this end, we offer some implications for theory, research, and practice.

**Clinical Theory and Practice**

*Discovering Truth*

There are several challenges for clinicians. The first has to do with truth and its relation to well-being. Schools of practice as diverse as cognitive behavior therapy and psychoanalysis agree that
there is a truth, which if discovered, will enhance emotional well-being. Psychoanalytic truth lies in repressed memories and transference manifestations. Cognitive behavioral truth lies in irrational beliefs. But which truth do we select? Consider the issue of guilt. Cognitive-behavioral truth regarding guilt was depicted by Beck, Rush, Shaw, and Emery (1979):

Some patients may feel guilty about their thoughts or wishes, rather than actions. A female patient experienced no feelings of guilt about having an affair with a married man, but she felt extremely guilty about wishing that the man’s sick wife would die. The therapist pointed out that thoughts are not actions and that since the patient wasn’t omnipotent, her wishes could not influence reality. The therapist also explained that her wish, although contrary to her value system, was understandable in view of the patient’s desire to marry her lover. (p. 177)

This sounds true enough. But now consider the psychoanalytic truth about guilt put forth by Freud (1955):

When there is a misalliance between . . . the intensity of the self-reproach and the occasion for it, the layman will say that the affect is too great for the occasion—that it is exaggerated—and . . . that consequently the inference that the person is guilty, is false. On the contrary, the affect is justified. The sense of guilt cannot itself be further criticized. But it belongs to another content, which is unknown and which requires to be looked for. (pp. 175-176)

These contradictory positions both claim to be true. But clinicians need not discover truth. They can construct workable points of view or plausible realities. In fact, one therapist’s discovered truth is another’s constructed reality. Consider the therapist who tells a patient that his or her guilt is justified. Is he or she a psychoanalyst following Freud’s (1955) dictum, or is this a positive connotation and implied restraint? We believe that clinical theory and practice have suffered by insisting that there is truth in a realm of interpersonal relationships. The constructivist underpinnings of paradoxical interventions offers a challenge to this point of view.

Insight Precedes Change

A second challenge to clinical theory derived from paradoxical interventions is that insight or understanding is not a necessary precursor of meaningful behavior change or emotional well-being. With few exceptions, schools of psycho-therapy dictate that for lasting change to occur, an individual must understand the nature of his or her problems. This position, of course, rests on the assumption that there is a reality to understand. Yet as we hope we have demonstrated, significant changes can occur without insight. In fact, insight into former problem-maintaining sequences may only emerge after new behavior. We are not saying simply that insight is unnecessary for behavior change. Behaviorists have known this for decades. We are suggesting that we understand our world in part through our behaviors, and that new and more helpful understandings can derive only from a change in behavior.

The practical implications of this position are significant. It suggests that we need not challenge people’s beliefs through interpretation (Strachey, 1934), cognitive restructuring (Meichenbaum, 1977), attribution retraining (Forsterling, 1985), and the like. Such challenges are difficult to enact, because people rightfully protect themselves from what they believe is an assault on their most cherished assumptions (Janoff-Bulman & Timko, 1987), and we interpret our failures to change these assumptions as proof that we must try harder. This may be a quintessential problem-maintaining solution.

Big Problems Require Big Interventions

Implicit in most approaches of psychotherapy is the idea that big problems require massive interventions. Thus, even clinicians who have witnessed the big effects of small interventions (Balint, 1968; Gurman, 1982) insist that the small intervention cannot replace interpretation, working through transference responses, and lifting repressions. At its core, the strategic-constructivist position is a minimalist position (Coyne, 1987) in which the therapist acts as a repairperson not an omnipotent healer (Watzlawick, 1985). Big problems become big because the wrong solution has been applied to one of life’s difficulties, and when this solution has been unsuccessful, it is applied even more. Thus, the original difficulty is amplified by a recursive process so that the current problem has little resemblance to the difficulty (Maruyama, 1963; Szykula & Morris, 1986). To intervene effectively, one helps interrupt the attempted solution. Big problems can thus be resolved with small interventions.

The Past Influences the Present

The final implication of paradoxical interventions for clinical theory is that we may be able to
change the past by redefining it in the present. Many schools of psychotherapy are based on the logical premise that since a cause must occur prior to an effect, events of the past create current problems. We maintain that current behaviors create current problems. If, however, those current behaviors are guided by premises about the past, we can more benignly redefine the past so as to interpret current problem-maintaining solutions. The vast literature on state-dependent memory (e.g., Singer & Salovey, 1988) documents just how our views of the past can be influenced by our current situation.

Social Psychological Theory and Research

The strategic-constructivist perspective that guides paradoxical interventions also has significant implications for social psychology. We will discuss briefly its implications for the definition of social support, for our understanding of responses to threatening events, and for our perspectives on well-being.

What Is Social Support?

The value of social support as a coping resource has been well documented. Social support appears to buffer individuals from stress (Cohen & Wills, 1985) by meeting a wide range of needs, including intimate interactions, advice, information, tangible aid, and social participation (Barrera, 1981; Cohen & McKay, 1984). Most functional theories define social support as perceived support (Cohen, 1988). Yet the strategic-constructivist perspective suggests that our current definitions of social support may be inadequate to explain certain adaptation-enhancing social interventions.

Consider, for example, an attempt to interrupt a cycle of problem maintenance by someone in a victim’s support network. Do we characterize this attempt as supportive only if the victim experiences it as meeting a need? If so, how do we conceptualize defiance-based suggestions by perceptive friends or family members in which a problem-maintaining sequence is successfully interrupted, but the victim believes that he or she is doing well despite, rather than because of, the suggestions?

The concept of worldview also has implications for support-providers. If problem cycles are to be effectively interrupted, comments, suggestions, and other supportive attempts must be framed in a way that is consistent with the victim’s worldview. Many well-intended support-providers offer to a victim interpretations of the victimizing event that are offensive because they are not in keeping with an existing worldview. We have found that encouraging a philosophical perspective is appraised as helpful by some victims, but as hurtful by others (Affleck, Tennen, Rowe, Walker, & Higgins, in press). Thus, people who, for example, do not already believe in “God’s will” are unlikely to benefit from well-intentioned interpretations that invoke the will of God.

An important reason why intimate support providers may not be helpful in their interactions with victims is that the potential support-provider may have an overriding interest in seeing the victim recover quickly from the crisis (Lehman, Ellard, & Wortman, 1986). In contrast, the strategic perspective suggests that the best start is a slow start and that trying to recover may itself maintain emotional distress. Rather than supplying victims with cognitive coping strategies, which try to place a positive frame on an aversive event, the strategic perspective suggests that a positive connotation be placed on the victim’s response to that event. We believe that the concepts of a problem-maintaining solution, worldview, and positive connotation might add a productive perspective to the social support literature.

Responses to Threatening Events and the Nature of Behavior Change

Recent advances in our understanding of how people respond to threatening events pose sobering implications for the process of recovery following victimization. Taylor (Taylor, 1983; Taylor & Brown, 1988) and Snyder (Snyder & Higgins, 1988) provide evidence to support their contention that in the face of threatening information about their physical health or self-esteem, individuals maintain a resilient set of illusions that ward off these threats. Janoff-Bulman (Janoff-Bulman & Timko, 1987) agreed that our assumptions about the nature of things are so robust that they can be shattered only by catastrophic events. Although the resilience of our “assumptive worlds” (Janoff-Bulman & Timko, 1987) or “adaptive illusions” (Taylor & Brown, 1988) have been framed as a protective mechanism, many victims (and non-victims) maintain assumptive worlds or beliefs that are problem maintaining rather than problem alleviating. If it is true that people effectively ward off threats to these assumptions, then attempts to
change maladaptive assumptions by direct challenge may be doomed to failure.

The strategic-constructivist approach to behavior change offers an intriguing alternative. Its minimalist perspective suggests that despite apparent evidence to the contrary, assumptive worlds can change without massive challenge by getting people to behave as if they held a more adaptive view. A change in the assumptive world will follow. Another suggestion is that attempts to directly challenge worldviews (Meichenbaum, 1977; Ellis & Harper, 1975) face a formidable task. Social psychological inquiry in this area has been based on the reasonable assumption that beliefs influence behavior. We might expand our perspective on adapting to threatening events by considering how behavior influences beliefs.

Defining Well-Being

Recent interest by social psychologists in adaptation to negative events raises the question of how to define emotional well-being. In a recent review of social psychological investigations of emotional well-being following threatening events, Tennen and Affleck (in press) found that every study assumed depression to signal maladaptation. A more positive connotation of depression in the face of threat is that the capacity to tolerate these feelings is not only nonpathological, but an emotionally mature response. The inability to experience or bear depression in the face of loss may signal a failure to mobilize available resources after accepting what cannot be controlled (Shur, 1953; Zetzel, 1965). Rather than something to be eliminated, depression becomes something to be experienced.

The Interational Nature of Emotional Disorders

As its core, the strategic approach focuses on interactional, problem-maintaining sequences. This poses a challenge to current social psychological theory, which, as Strong (1987) noted, has focused on intrapsychic events. There is a paucity of social psychological studies that view clinical disorders from an interactional perspective (Coyne, 1976; Forrest & Hokanson, 1975; Shaw, 1982), and even fewer consider symptom-maintaining sequences. The strategic-constructivist perspective guiding paradoxical interventions holds considerable promise as a framework from which to view the maintenance and alleviation of emotional disorders.

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