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The use of the paradox technique in family therapy with Iranian families: case report

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Summary

Aim. This study assessed the effect of the paradox in family therapy. The paradox, as a therapeutic tool, has been explored by a number of therapists, particularly Mara Selvini Palazzoli.

Cases. Two female clients were chosen for this study. Both girls were the only ones in their families with symptoms of depression and they had been on medication for more than 2 years.

Management and outcome. The therapist used the Milan Systems Approach to family therapy and both families participated in 16 therapy sessions. They were followed up for 2 years. All family members filled in the Family Assessment Device (FAD) and Beck Depression Inventory (BDI) questionnaires before the therapy, at the 10th session, when the therapy concluded and finally 3 months later. It was found that in appropriate cases the paradox had a satisfactory outcome. It reduced the symptomatic behaviour and affected the family system as a whole. The family system became more workable and functional. Case 1 after two years was functioning well and got married. Case 2 stopped taking her medication after the therapy, finished high school and entered university.

Conclusions. The paradox is a powerful tool for family therapy. It is a creative and critical solution for long-term illness. However, caution should be exercised and it should be the last option in the course of family therapy, when other techniques have failed.

the paradox/family therapy/Millan systems approach/positive connotation.

INTRODUCTION

Helm Stierlin states that the paradox is a potent therapeutic instrument that uses two main elements [1]. First, the therapist establishes a positive relationship with all family members. To do so, they accept and "connote positively" anything the family offers, avoiding taking the moralizing stance or using any word that may induce anxiety, shame or guilt. Second, the therapist encourages a radical change of family relations trying to give all members a new chance to pursue their own individuation and separation.

A number of family therapists contributed to developing the paradox technique, a powerful therapeutic tool in the field. First Batson and his team [2] worked in the Mental Research Institute and examined verbal and non-verbal communication of families with a family member who had schizophrenia. The team further developed the concept of paradoxical injunctions. They introduced some important concepts in therapy such as communication, meta-communication,

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double-bind, circular mode and paradox [2-5]. Paradox, like any other powerful therapeutic instrument, can harm while helping [1].

The Milan team was influenced by systemic thinkers such as Batson, Haley, Watzlawick and Shands [2, 6-10]. They used the paradox technique with families where one of the family members had anorexia [1]. They further developed the concept of paradox by working with families where there was schizophrenia. Crowe & Ridley [11] raised concerns about the value of the paradoxical message and whether it provides a creative solution to damaging long-term illness. They stated that the nature of the paradox is not clear and it does not show how it gives all members a new chance to pursue their own individuation and separation.

This study assessed the impact of the paradox in family therapy. The therapist benefitted the Milan systems approach to family therapy. Two clients (both female) were chosen for this study. These two girls were the symptomatic members of their families.

CASE PRESENTATION

Case 1

A., 19 years old, was referred for family therapy by her psychiatrist. She was diagnosed with depression and had been taking medication for the past 4 years. She left school at 15. A. and her family had been seen by a family therapist for a few months in the past. At the time of the study A. was living with her family: father (55 years old), mother (45 years) and brother (22 years). Her father was addicted to opium and worked as a vegetables' peddler. They lived in a basement flat. Her brother was unemployed. Their family were of a low social standing.

The immediate problem was presented by A.'s mother as A.'s sadness and crying during the night that disturbed the family's sleep. The mother described her crying and sleeping behaviour in detail. She cried every night and put paper tissue under her mattress, so that when her mother was moving the mattress, she would notice the tissues and become upset. She got up about noon. She did not do anything at home but listened to sad music. The mother was distressed and worried. The situation caused her a lot of suffering. The girl's father and brother were apparently disinterested – A. was in permanent conflict with her brother; they fought every day.

While examining the mother–daughter interaction, it seemed that the mother was extremely worried about family finances, her husband's addiction and her unemployed son. A.'s behaviour distracted her from all the other problems and was a reason for her to live on.

Case 2

J., 18 years old, was referred to family therapy by her psychotherapist with a recommendation that the whole family should be involved in therapy. The psychotherapist's note said that J. had been on medication (for depression) and individual as well as family therapy for 2 years. The previous therapy course seemed not to have alleviated her depression and family tension. For the past few months, J.'s mother and sister had been arguing with the psychotherapist and insulted her several times. They thought that she encouraged J.'s more disrupted behaviour and her leaving school. For this reason the therapist ceased J.'s therapy and referred her for family therapy.

J.'s family were well-off and consisted of father (56 years), mother (50 years) and sister (23 years). Her father ran a factory and they lived in a big house. Her sister was studying for a Master's degree. The family enjoyed a high social status. J.'s mother presented her immediate problems as her impolite and violent behaviour. She was constantly fighting not only with her family members but also with all her relatives. She failed to finish high school and refused to continue her education. Sometimes she physically attacked family members and in turn they beat her. She was angry with her family. The father had a gentle, calm character. J. relied on her father asking for help. Her mother and sister were furious with her.

J. was in daily conflict with her mother and her sister. They complained about how J. acted towards the father. They said that sometimes the father stayed quiet, saying nothing at home (perhaps he was on J.'s side), while some other times (rarely) he beat her. She did not sleep at night,

but stayed up playing on her computer till late and slept until noon. She did not do anything at home, but watched carefully her family members' every movement and listened to their conversations, looking for a reason to start fighting.

Examining the mother–daughter interaction, it seemed that the mother, a very controlling person, was controlling every movement and event in the family. She had a strong bond with J.'s older sister. She planned everything at home, even her husband's clothes. J.'s father did not like it but still left everything to his wife. It seemed that without J.'s problem the family could not stay together. The older sister played a role of J.'s second mother.

The mother had no problem with J.'s behaviour for years but now she could not control it outside their home. J. watched her mother and sister's every movement like a detective and argued with them. The mother decided to keep her at home but she confronted her, which usually led to fighting. The family was in social isolation. Close relatives and friends found out about the problem and were reluctant to have relations with them, seemingly avoiding the negative effects of this family.

In Iranian society, girls should get married at the age these two sisters were – they were tall, beautiful and intelligent. J.'s behaviour was irresponsible. The older sister was helping the mother control her. The sisters did not think of marriage. Other people understood the family situation and nobody proposed marriage.

MANAGEMENT AND OUTCOME

Case formulation

Using Crow's three-point plan [11], the cases are formulated below.

Case 1

(1) The symptom/s can be described as A,'s crying and her immature, irresponsible behaviour.
(2) The reciprocal behaviour can be described as mother's overprotectiveness directing all her attention to A.'s well-being. The mother did not want to consider that she is growing up and is going to leave her.
(3) The feared consequences of the removal of the symptom/s in this family were the mother's fear of losing A. For the mother it was impossible to live her life without A. In their socio-cultural context, girls get married early and A. was tall and beautiful. Since she was a teenager, the family had been receiving marriage proposals. It meant that she was mature enough and ready to leave her family in the near future. However, she understood her mother's fear and acted irresponsibly. People found out that she was not able to enter the next phase of her life. When she left high school, she stayed at home. She acted like a small girl and her mother took care of her. A.'s behaviour was tiring, however, and eventually the mother could not tolerate it.

Positive connotation

The therapist told the family that "you are obviously very close to each other. You are all upset by the family situation. You want to do everything for your family. Usually, a sad person cries. This behaviour is a buffer. A. is sad for her family. She shows this sadness in an extreme way. It means she has to cry to release her sadness."

Paradoxical message

The family was told that: "A. needs to cry every night. Let her do so. This is her task. She has to cry from 10 to 11 o'clock every night. The mother should put a box of tissues next to her mattress. You do not need to change now. A.'s behaviour shows that you love each other very much and that you are afraid of losing each other."

Case 2

(1) The symptom/s can be described as J.'s fighting, and her immature and irresponsible behaviour.
(2) The mother's controlling behaviour can be regarded as a reciprocal behaviour. The mother was not ready to see her daughter grow up and leave the family.

(3) The mother's fear of losing her whole family can be deemed the feared consequences of the removal of the symptom in this family. The father was not satisfied with his own marriage but he did not show it. J. understood her mother's fear of family separation and the deep disagreement between her parents. J.'s irresponsible behaviour seemed to distract them from other family problems. Also, leaving school and staying at home made people think she was unable to enter the next phase of her life. She acted like a small girl and relied on her mother to do everything for her. J.'s behaviour was no longer tolerated by her family, which resulted in seeking professional help and therapy.

Positive connotation

The family therapist told them that: "J. is a young person. Usually young people are stubborn. J. is a sad young person. Sad people cry and sad teenagers sometimes express their sadness with violence. J. is a stubborn, sad teenager. She loves her family too much, and she tries to cope with family problems in an extreme way. When she thinks there is a conflict in the family, she tries to attract your attention. This behaviour is a buffer for your family not to fall apart. It means she is fighting to feel better."

Paradoxical message

The family were also told by the therapist: "She needs to fight with family members. Doing this makes her feel better, so let her do this. From now on, her therapeutic homework is to fight every other day with her mother and sister from 5 to 6 o'clock in the evening and with her father at the same time every Friday evening."

Therapy sessions

The families participated in 16 sessions of therapy. The assessment showed that both clients and their families had been in full courses of family therapy in the past and received various therapeutic treatments with no success. In the first session, the therapist tried to get to know each family member and develop a good rapport with the family as a whole. Then she asked them to explain about the problem and how it affects them. In the next step, positive connotation was applied. At the end of the first session, the paradoxical massage was delivered by saying "do not change anything now and make a timetable for continuing the symptomatic behaviour". At least for 5 sessions, the therapist encouraged the symptomatic member to follow the timetable and asked other family members to help her to do so. During those sessions they were helped to negotiate more with each other. Then some ritual was introduced to change their behaviour. The timetable for activities was applied for the symptomatic member with support of the family. They were followed up for 2 years. All family members filled in the Family Assessment Device (FAD) [12] and Beck Depression Inventory (BDI) [13] questionnaires before the therapy, at the 10th session, immediately after the therapy and 3 months later.

Case 1, A. was depressed and had been on medication for 4 years before family therapy. The therapist asked her to cry every night to feel better. Apart from this paradoxical task, there were some other tasks to activate her behaviourally. She was asked to get up 15 minutes earlier every day. After breakfast she went out with her mother for half an hour or for a walk After 8 sessions, her task was to do something at home like cooking and cleaning. No symptoms were reported anymore. The family reported that she was doing well and the family were more in agreement. Her mother sold her gold necklace and rented a shop for her son, saving some money for A.'s future (for her marriage). After 2 years' follow-up A. was functioning quite well and finally got married. Her BDI scores were 31 before the first interview, 19 at the 10th session, 12 after the therapy and 7 at 3 months' follow-up. Her mother's BDI scores were, respectively, 24, 15, 10 and 8, whereas her father's and brother's BDI scores were between 9 and 13 during all assessment points. The family's mean FAD scores were 3.5 before the first interview, 2.9 ąt the 10th session, 2.08 after the therapy and 1.8 at 3 months' follow-up. This demonstrates that the family reported far less dysfunction at the end of the therapy and at follow-up.

Case 2 was also clearly depressed. After 5 sessions she had arguments once a week, not using

physical fighting. She returned to high school and found some friends. She could spend her pocket money without her mother controlling it. After ten sessions, the psychiatrist stopped her medication. She finished her high school and entered university. After one year, her sister came to see me. J. decided to continue her studies abroad. When visiting her family, she contacted her therapist. She seemed to be happy with her new life independent of her family. J.'s BDI scores were 27 before the first interview, 16 at the 10th session, 10 after the therapy and 9 at 3 months' follow-up. The other family members scored between 7 to 12 at all assessment points and the family mean FAD scores were 2.7, 2.8, 1.6 and 1.5 at all assessment points, which shows a considerable reduction in family dysfunction level.

CONCLUSION

The findings of the present report demonstrate that using the paradox in appropriate cases can produce a satisfactory outcome. This method reduces the symptomatic behaviour, and benefits the affected family system as a whole. Consequently, the family system becomes more workable and functioning. The impact of positively connoting the symptomatic or distressing behaviour patterns and describing them as a kind of buffer in their relationship may take much of the guilt and anxiety out of a fraught and emotionally draining situation.

The paradox is a powerful tool for family therapy. It is a creative solution for long-term illnesses [14]. However, we should keep in mind that it should be the last option in the course of family therapy. First, the therapist should focus on therapeutic interventions which are built on the observed interaction and stated desires of the family for change in their relationship. Then the family and the therapist have to enter into a joint contract to work together to facilitate the desired changes. If all therapeutic interventions fail, then the therapist can consider the paradox technique. This technique should be used with caution in family therapy.

Inexperienced therapists usually find both the delivering of paradoxes and the impact on the family quite difficult to manage. I believe that the therapists using the paradox in any society including Iranian society should meet necessary criteria such as having been involved in family therapy for at least 10 years, acting assertively, and being trustworthy. These will help clients to follow the therapeutic tasks and instructions and using the paradoxical message in rigid families will be more likely to be successful.

After Selvini-Palazzoli [1], who introduced the paradox as a strong therapeutic tool, we can find hardly any studies focused on this topic. As the literature search shows, the present report is the first research-based article addressing the usefulness of paradox in family therapy in Iranian society.

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