# Janusian Process and Creative Intervention: Paradox, Irony

Albert Rothenberg

*The Creative Process of Psychotherapy*

# Janusian Process and Creative Intervention: Paradox, Irony

**Albert Rothenberg, M.D.**

e-Book 2015 International Psychotherapy Institute



Created in the United States of America

www.freepsychotherapybooks.org
ebooks@theipi.org

**By the Same Author**

The Emerging Goddess:
The Creative Process in Art, Science and Other Fields (1979)

The Creativity Question (with Carl R. Hausman) (1976)

The Index to Scientific Writings on Creativity:
General, 1566-1974 (with Bette Greenberg) (1976)

The Index to Scientific Writings on Creativity:
Creative Men and Women (with Bette Greenberg) (1974)

# Table of Contents

# Janusian Process and Creative Intervention: Paradox, Irony

Although I have followed Schafer and applied the term "paradoxical actions" to psychological conflict, I have so far largely refrained from connecting paradox directly with the janusian process. Some commentators on my previous work have done so, and I am sure that many of my readers have considered similar ideas before reaching this point. I have abjured using the word "paradox" up to now for several reasons, the main one being that it is far too loose a term. Common usage has given it overtones of the mysterious and bizarre or even the absurd but, worse than that, there is a good deal of variation in its meaning. Its original, and most general usage is as, dictionary defined, "a tenet or proposition that is contrary to received opinion."[1] This meaning does not coincide with that of the janusian formulation of simultaneous antithesis, because a distinct feature of the latter is that it is *both contrary and confirmatory* of received opinion at the same time. The simultaneous antithesis contains more than one contrary aspect. Only in philosophical and other technical discourse do definitions of paradox emerge that resemble the definition of simultaneous antithesis. Such discourse, important as it is, and as it has been in the history of philosophy,[2] is often concerned with logic and with the possibility or nonpossibility of resolution of paradox, rather than —as we are concerned here—with ongoing psychological thought processes and their clinical function. Regardless of

purpose and use, the variability of meaning renders the term problematic in relation to the psychology of the creative process.

Nevertheless, there clearly are connections between the idea of paradox and the janusian process. Notably, in relation to psychotherapy, the idea of paradox has caught the attention of a large group of practitioners in both family and individual therapy. In many instances, their clinical applications reflect the operation of janusian process. Particular interventions described as paradoxical seem either to result from the janusian process or to constitute aspects of its development.

In addition to paradox, another type of clinical phenomenon, irony and ironic intervention, is often reflective of a creative janusian process. Both paradox and irony (under the general rubric of humor) have been advocated by various theorists and practitioners for use as therapeutic interventions. In the previous chapter, I discussed the therapist's use of the janusian process primarily as a means to insight and understanding. I labeled this use as a waystation in an overall creative process in which the exact content of the understanding might or might not be transmitted directly to the patient. In this chapter I shall consider direct manifestations and applications of janusian process in treatment interventions.

## PARADOX

An early use of the paradoxical type of therapeutic intervention was manifest in a famous case described by the psychoanalyst August Aichhorn. A 17-year-old delinquent boy had been in Aichhorn's institution for several months and no one had been able to develop a treatment relationship with him. Aichhorn thereupon induced the boy to *run away* on the supposition that he would find that the outside was no better than the inside of the institution. Although he became worried at first when the boy did not return after a week, ten days later he appeared and a positive alliance developed.[3]

The more recent interest of family therapists in the use of therapeutic paradox can be traced to the work of Bateson and other members of the so-called Palo Alto group on the double bind theory of schizophrenia.[4] These workers described a confusion in hierarchical levels —on the basis of Russell's theory of Logical Types —that was observed in families of schizophrenic patients. According to the double bind theory, a schizophrenic son or daughter was continually exposed to double binds from parents, such as verbal encouragement to express feelings together with nonverbal prohibition against such expression. Because of the apparent pervasiveness of this type of family interaction, the Palo Alto group recommended the use of what they called "therapeutic double binds" to reverse such patterns. This therapeutic tactic was later extended to other types of illness and referred to by Haley as paradoxical.[5]

Similar approaches of other therapists with both individuals and families, notably those of Milton Erickson, were also studied and adopted. The naming of a specific therapeutic technique with the word "paradox" seems to have originated with the existentialist therapist Frankl in his term "paradoxical intention."[6] As an intervention appropriate to family therapy, the paradoxical technique was further developed by Mara Selvini-Palazzoli and her Milan group.[7] Many other family therapists, including Haley, Watzlawick, Weakland, Fisch, Papp, Weeks, EAbate, Madanes, and Rohrbaugh, have written about varying forms of paradoxical interventions.[8]

In the hands of the Milan group, the use of paradoxical intervention has consisted primarily of "prescribing the symptom" and more recently has been extended in various ways. Prescribing a symptom consists of instructing a family group to continue or intensify such behavior as catering to a ritual, phobia, etc., of the member of the family designated as the patient (the so-called "identified patient'). At the same time, the patient may be told to continue or intensify performance of the ritual, augment the range of phobia, etc. Such prescriptions may also be extended to a broader pattern of family behavior and are then designated as "prescribing the system." In such a case a rigid father may be instructed to become even more rigid, a mother may be told to be more docile, and a patient shown how to become even more manipulative. Properly applied, such instructions are accompanied by comments introducing new alternatives for other members of the family.

Other types of paradoxical interventions have also been described and analyzed. Particular terms that have been used to denote these other approaches are the following: restraining change; reframing and positive framing; benevolent ordeals; positioning. Restraining change consists of a therapist telling a patient that he cannot change or, less strongly, worrying with the patient about the dangers of improvement. Reframing involves redefining behavior from the point of view of another person, such as telling parents that a supposedly weak and mentally ill child is winning a power struggle over them. Positive reframing consists of redefining negative behavior in positive terms. For example, in a case described by Papp, a wife who complained about the overinvolvement between her husband and his mother was instructed to find ways to praise the "beauty" of the rare mother-son devotion; she was also advised to suggest that her husband spend even more time with his mother.[9] Prescribing benevolent ordeals, such as suggesting to an insomniac that he deliberately think of all the horrible things he could while lying in bed awake at night, or devising other tasks that are worse than a symptom, is a principle derived by Haley from his observation of the work of Milton Erickson.[10] Positioning involves the acceptance and exaggeration of a patient's problematic "position," i.e., an assertion that an individual is making about himself or his problem. As described by Rohrbaugh *et al*., "when a patient's pessimism is reinforced or maintained by an optimistic or encouraging response from significant others, the therapist

may ‘outdo’ the patient’s pessimism by defining the situation as even more dismal than the patient had originally held it to be.”[11]

All of these techniques of paradoxical intervention do involve opposites and opposition of some type, whether or not they would be logically considered to be paradoxes. All have been claimed to have successful therapeutic effects. In each case, their advocates have provided detailed specifications and injunctions for their proper use. Paying attention to such factors as tone of voice, patient susceptibility, and other more specific factors that I shall discuss presently has been considered critical in the successful application of such techniques. Recently, Haley advised that they be used with caution and advocated applying them in stages and paying attention to follow-through.[12] Many theoretical formulations about the reasons for success have been proposed, most of which emphasize the instilling or instigating of change in an individual patient or family system.

From the point of view of the therapeutic creative process, all of these approaches run the risk of becoming routinized techniques in which a certain formula is applied over and over in differing situations with little regard for freshness or appropriateness. As I pointed out in the previous chapter, such risk is also constantly present with routinely applying Freud’s creatively discovered principles; each new application of the janusian process must be attuned to a specific context. Because these paradoxical techniques involve a

series of particular actions rather than understanding alone, there may be even greater risk of stagnation. This may in part explain why it is that many family therapists today seem to find the work of the Milan group to be somewhat repetitious, and the group itself seems to be moving away from techniques described in their earlier works.

Although direct testimonial evidence is lacking, I believe that it is reasonable to assume that the janusian process played a role at the discovery phase of each type of paradoxical intervention approach and, beyond that, particular clinical applications in treatment frequently result from the therapist's use of the janusian process. In many cases described in the literature, and in ongoing clinical observations, there seems to be little doubt that the therapist formulating particular interventions is actively conceiving two or more opposites or antitheses operating simultaneously. A therapist developing paradoxical interventions in this way is similar to one who develops creative insights about a patient's specific conflicts. He is aware of principles of psychodynamics or system organization and operates creatively in the particular therapeutic context.

Such creative development and use of paradoxical intervention is illustrated in a case example presented by Wynne.[13] A 34-year-old woman suffering from severe anorexia nervosa with bulimia, her 34-year-old husband, and their 13-year-old daughter came for treatment and, as Wynne

describes it, they were all “enmeshed in turmoil” over the mother’s symptoms. In the initial consultation, Wynne was particularly impressed with the husband’s involvement. The wife gorged food massively three times a day that she subsequently vomited; the husband both purchased the food and supervised the vomiting. Their lives were consumed by this cycle because of the time spent obtaining the food and cleaning both kitchen and bathroom where she would seclude herself. No ordinary relationships with friends had taken place for years.

In discussing the background of the problem, both marital partners spoke of a conflict between the wife and her mother, a problem the husband said he had “inherited.” Both recognized the vomiting to be an aggressive, upsetting act and spoke of her “throwing money down the toilet” and of the enormous amount of food that was being “wasted.” Her father, the husband emphasized, was a banker who was concerned about saving money. Although the wife spoke of feeling extremely guilty about the hurtfulness of this “waste,” she cyclically experienced both remorse and anger followed by gorging and vomiting.

Wynne says: “At a point in the consultation when I felt able to identify the cyclical impasse of the family system, I decided to introduce a paradoxical family intervention.” This intervention involved prescribing the symptom but, he emphasizes, he made a thoughtful choice of the particular symptom to be

prescribed. He describes his intervention as follows: "I had her give me a list of the food she had prepared the previous day. Some thirty dollars worth of food had been vomited on that day. I stressed that she continue to prepare such food exactly the same except that she was now to put the food *directly* into the toilet, and skip the step of putting it into her mouth and stomach. . . . We worked out a plan in which the husband . . . was to make sure that she continue to prepare the same amount as previously. . . . He was also to supervise her putting this food in the toilet. . . ."[14]

Wynne goes on to describe further interaction and working out of this intervention with the family, the fact that at the next visit to him ten days later the vomiting had stopped, and his later use of other types of nonparadoxical interventions to ensure a lasting improvement. Up to this point, the elements of the janusian process sequence have been demonstrated in Wynne's approach. First, there was an early identification of the husband's involvement. The themes of aggressiveness and of wastefulness next emerged as the context became further defined and both partners focused on the financial loss caused by the wife's illness. The husband, Wynne observed, made a point of saying that the banker father was concerned with money. Instead of worrying about her self-destructiveness and precarious physical state, waste and money seemed a focus for them both. Because of Wynne's careful attention to interpersonal interaction and to understanding the background and psychodynamics, a particular context had been developed

and salient themes identified that would be the basis for specific opposites and antitheses.

Although Wynne does not describe the detailed steps in his thinking, he makes it clear that he had decided to shift to an intervention involving the opposite of a particular theme. Instead of the symptom of vomiting, the aggressiveness *per se*, or even the husband's involvement, he focused on *waste* and *destructiveness* and the throwing of costly food down the toilet. In formulating this particular intervention, he had recognized the concrete importance of the toilet and had, therefore, very likely conceived of the patient's engaging in *both purging and not purging at the same time*. By throwing food directly into the toilet, the patient bypasses her own body but has the experience of discarding and purging nutriments nevertheless. The conception for this paradoxical intervention, therefore, appears to have been a janusian formulation and was, I would propose, a creative step.

It is important to emphasize that such a formulation is an aspect of an unfolding creative process. This means that additional factors need to come into play and that the particular paradoxical intervention used may or may not lead to a creative effect. This point shall warrant a good deal of our attention presently but first let us look further at the detailed outcome of the Wynne intervention to assess its nature.

After reporting the absence of the patient's vomiting, Wynne poses both an important question and its answer: "What was the mechanism of change? Let me look for clues in the next session. The wife said that this had been the most 'dynamic experience' the most 'eye opening experience' she ever had in her life. . . . When she saw all that food going down the toilet, food that she had deliberately placed there and had not 'involuntarily' vomited, she realized for the first time what she had been doing. I did not need to make any interpretations whatsoever; *she* made them."[15]

There is evidence, therefore, that the paradoxical intervention produced some insight for the patient, an effect that was somewhat similar to the creation of insight I have discussed in previous chapters. Notably, Wynne emphasizes that the patient made interpretations and presented the insights on her own. In this way she developed his janusian formulation into a creative effect. Going on to describe a problem that developed in the interim between their sessions, he designates another type of creative outcome as well.

The couple reported that the husband, whose tendency to withdraw had consistently been a problem, had decided to spend both an afternoon and evening watching television and had inexplicably refused to talk with her. The patient responded, according to Wynne, as follows: "She felt rejected and, as in the past, she felt a great surge of motivation to gorge herself. She also, as in the past, felt physically chilled. Now, however, she suddenly realized that if

she did gorge herself, the food and vomiting would make her feel 'warm.' Her husband insisted that she not gorge but, rather, throw the food down the toilet directly. It was then that she had a creative 'solution.' Instead of gorging herself, she went and cuddled up on her husband's lap and became warm in a new way. The husband, who had been hoping for such physical advances from her for years, now was nonplussed. He discovered, to his dismay, that he did not know how to respond to her. At this point we could move on to a new stage of therapy; the structure of the family system had changed."[16]

Wynne's designation of a creative effect seems quite justified. Although this was not as yet a final outcome, the wife's behavior was creative in that it was both new and positive in the family context. As is often the case with creative effects, it was also initially disruptive to someone. This is not a necessary result, but such a disruptive impact —creative or not —is often cited by family therapists as a desirable outcome of the use of paradoxical interventions. Emphasizing that the family is a system, and that any intervention in family therapy must take that into consideration, they argue that paradoxical interventions disrupt system homeostasis and initiate change.

I believe this claim to be correct, as far as it goes. In the family therapy situation, unlike individual therapy, active suggestions and directions are often necessary in order to ensure coordination and promote change in a

pattern of relationships. Exclusive attention to resistance, which may be appropriate in individual therapy, may at times serve different family members in different ways. Exploring a child's resistances in front of a parent may serve to enhance or reinforce a parent's resistance, and vice versa. Insofar as a family manifests a "system" of fixed patterns of relationship and behavior, it seems necessary to disrupt these patterns actively to facilitate change. Notwithstanding, all disruptions are not equally appropriate and all change is not necessarily beneficial.

Many interesting extensions of this principle of inducing change have been developed that relate the effect of paradoxical interventions to the following: the larger framework of Taoism;[17] epistemological assumptions and the interpersonal context;[18] therapeutic "compression" involving the enhancement of proximity in the family system.[19] Also, broad theories of psychopathology and structural change have been explored with both implicit and explicit connections to paradoxical interventions. These have included extensions of the initial double bind theory of schizophrenia to other types of psychopathology,[20] the effect of "dissonance" in structure,[21] and an alternative focus on problematic and nonproblematic reflexive loops.[22] Clinical analyses of the effect of the prescribing-the-symptom type of paradoxical intervention have emphasized that such prescribing involves accepting the system at its current level of operation as well as getting on the patient's side before initiating change.[23] Others have focused on how

paradoxical interventions provoke defiance in members of the family and thereby produce change.[24] However, all discussions, even those that focus on getting on the patient's side, emphasize the startling and disruptive effect of the paradoxical intervention and, like Wynne, posit that the disruption is a force for change. The presumption of disruption is, in turn, directly dependent on the core notion of paradox in all the prescriptions described.

Paradox is disrupting and disruption stimulates change. Although this proposition seems quite acceptable and applicable to the Wynne example just presented, as well as to many others, it deserves further assessment on a clinical basis. The logically paradoxical nature of interventions involving prescribing the symptom depends, as Rosenbaum has stated it, on the principle that the therapist offers two contradictory statements at once: (1) "This is therapy; thus whatever I say in this frame is a healing statement." (2) "I am not healing you (by insisting that the patient maintain or increase symptoms)."[25] To the extent that this formulation describes the therapeutic circumstance, it conforms to the philosophical definition of paradox given earlier. Also it suggests the presence of a janusian conception. It is critical to note, however, that the first of the two contradictory statements is never stated explicitly to the patient. Moreover, no indication is ever given that the therapist makes any effort at all to establish that the patient has actually adopted the healing view of the therapist and the therapy situation.

Patients do not necessarily believe, either consciously or unconsciously, that everything they hear in therapy is a healing statement, nor do they necessarily come to the therapy in the first place with the expectation that they will be healed. All we have learned about resistance and about patients' coming to therapy merely to be supported or agreed with —even when they know they are behaving in problematic or pathological ways —indicates that we cannot take the first statement for granted. Despite the therapist's good intentions, and despite all surface appearances and traditional beliefs about seeking treatment, a patient may be neither motivated nor convinced about being healed. At least, the patient may not be convinced enough for one to assert that a true logical paradox is engendered. In practical clinical terms, an individual or family may not experience a suggestion to continue or intensify a symptom —depending on which symptom it is, of course —as extremely discrepant and paradoxical, or even, in some cases, as different from expected.

With respect to the second and assumedly contradictory statement of a non-healing effect, much of what is done in practice serves to modify or otherwise reduce this aspect of the paradox. Therapists usually introduce an intervention together with an explanation about the need to go slow or with some other justification about a healing effect. Such proffered explanations cast the intervention as a positive therapeutic action and, more important, they tend to prevent feedback from the patient and family as to how the

instruction is actually perceived. Adding an aversive element to the symptom prescription, as is advocated by Haley and sometimes done by Erickson, also very likely conveys to the patient that the therapist is primarily healing in his purpose.[26] For example, the purpose of Haley's directive to another insomniac patient that she stay up all night, but carry out strenuous and unpleasant housework during the night, was very likely not lost on the patient. She must have clearly inferred that Haley was introducing factors that would directly stop her from being insomniac.

Paradox, in the sense of self-contradictory propositions, is in the mind of the therapist, but not necessarily in the minds of patients. The therapist perceives himself as being self-contradictory whenever he prescribes a symptom or a negative behavior. In order for the patient or family to experience an impetus to therapeutic change and participate in producing a creative effect, however, additional factors must be considered. Critically important are the means of transmittal and the nature of the specific content of the paradoxical intervention, as well as the patient's or family's psychological set and ability to apprehend. Simply formulating what the therapist considers paradoxical does not ensure the patient's engagement in a creative process.

In the Wynne example, on the other hand, meaningful paradox was experienced and engagement in the creative process occurred. In reporting

her feeling of having achieved new insight, the patient indicated that she had taken over and apprehended the purging/not-purging reference of the therapist's paradoxical intervention. She stated that she realized what her "involuntary" vomiting had been doing. Wynne points out emphatically that he made no interpretations but the patient made them all.

Also demonstrated in the Wynne example is a principle regarding the transmission and content of a paradoxical intervention. The principle is that such interventions are creatively formulated and transmitted to the patient and family when, as discussed in Chapter V, they concern specific salient conflicts. Symptoms represent embedded conflicts. A choice to represent a symptom in a simultaneously antithetical way is a choice to unearth or clarify a conflict. The particular injunction to throw the food down the toilet focused Wynne's patient on purging and not purging. This focus very likely also included her conflicted concerns with control and with anal functions. Patients with anorexia nervosa and bulimia are, as I have attempted to show elsewhere, beset with conflicts about anality and control[27] and Wynne's example throws these factors into sharp relief. The paradoxical intervention therefore functions as a dramatic enacted form of interpretation at the same time as it serves to disrupt ingrained patterns of the family system.

The janusian process leads to formulation of specific conflicts in context, and these formulations are incorporated into creative paradoxical

interventions. In order to transmit the janusian formulation effectively, it is necessary to be sure about the patient's apprehension of the apparent self-contradiction. At the moment of transmitting the paradoxical intervention, it is important to ascertain that enough groundwork has been laid so that the patient and family will intrinsically accept the therapist as a healer. This groundwork cannot derive from the mere fact of seeking therapy, or solely from the benevolence of the therapist, or even from transference alone, as transference can be quite negative right at the start. On another level, the care and thoughtfulness with which the therapist chooses a particular symptom or identifies a conflict will have an impact on whether, and how much, the family apprehends the therapist as a healer.

So far, I have primarily discussed a particular prescribing-the-symptom type of paradoxical intervention. Other types of interventions also labeled as paradoxical may share similar strengths and pitfalls with respect to creativity and therapeutic effectiveness. They may: effectively disrupt routinized patterns and instigate change; identify specific conflict; facilitate the mutual creative process involving the therapist together with the patient and family. On the pitfall side, all may become too routinized and formulaic to be creative or therapeutically effective. All may not be apprehended or taken over by the patient as simultaneous antitheses.

The pitfall of lack of apprehension of simultaneous antitheses may loom

even larger than with the symptom prescription in such paradoxical interventions as restraining change, reframing, positioning, and benevolent ordeals. These interventions often have the difficulty, to start with, of being paradoxical only in the limited sense of the common understanding of this term. They frequently involve only the contrary of what is expected instead of consisting of explicit or implicit self-contradictions. Rather than a set of simultaneous opposites or antitheses, they are simply reversals and opposing positions. For example, when a therapist suggests that a patient cannot change or may encounter dangers with improvement, this may be surprising only because it is not what was expected. It may instill defiance (or pessimism when it fails completely), but it would not very likely be experienced as dissonant with the therapist's task. After all, one of a therapist's time-honored functions is to give the patient a realistic appraisal of the chances for success and therefore such remarks often would be heard as serious appraisals. In similar fashion, the reframing of negative behavior as positive, or vice versa, may also be experienced as surprising and contrary to a previous belief. However, it is then only an opposite rather than a simultaneous antithesis or a set of simultaneous opposites.

In the examples I have discussed up to this point I have focused on family therapy because the term paradox is frequently used there. However, I have indicated at several points that some of the same considerations apply to work with individuals as with families. To focus on this more general use of

paradox in treatment, I will turn to the work of the creative therapist, Milton Erickson.

## MILTON ERICKSON AND PARADOX

Innovation and the unusual were characteristic of the work of Milton Erickson. Although many of his approaches, such as the use of metaphors and storytelling discussed earlier, his use of hypnosis and his focus on unconscious processes and unconscious learning, are derived from, or share features of, other disciplines and fields such as Zen Buddhism, Judaic teaching, Sufi poetry and storytelling, psychoanalysis, and subliminal perception, his investigative and clinical work is constantly shifting and exploratory with an emphasis on new tactics and ideas. Although such a focus on the new and different is sometimes thought to be synonymous with creativity, such is not the case. We have required that newness be accompanied by value in our definitions of creativity, and all judgments on the value and outcome of Erickson's new ideas and tactics have not yet come in. Erickson's work is, however, highly focused on the use of paradox and, in many cases, his paradoxical formulations seem to result from the operation of a janusian process. Overall, unlike Freud, he did not develop any systematic theory of his clinical approach or of the nature of human functioning, and his creativity has been manifest primarily in his formulations and interventions.

Although systematic theory is lacking and some, such as Hoffman,[28] maintain it is impossible to replicate his work, others have attempted to describe distinct principles and clinical procedures, both with Erickson's help and on their own. Haley has used the term "strategic therapy" for the type of treatment done by Erickson and has called him "the master" of this approach.[29] Many of the particular strategies and precepts that Haley defines as part of this therapy appear to have involved a janusian process at some point in their development. For instance, "encouraging resistance," "providing a worse alternative," "encouraging a relapse," "encouraging a response by frustrating it," and "amplifying a deviation" all bear the stamp of self-contradiction and simultaneous antithesis.[30] Although we do not know the actual way these principles were developed, Erickson's own statement on his thinking and orientation is highly suggestive of the process I have described. In his preface to Watzlawick, Weakland, and Fisch's book entitled *Change*, Erickson says: "I have viewed much of what I have done as expediting the currents of change already seething within the person and the family-but currents that need the 'unexpected,' the 'illogical' and the 'sudden' to lead them into tangible fruition."[31]

The precepts described by Haley are now all familiar components of paradoxical techniques used in family therapy; this is one reason Erickson has been called "the grandfather of family therapy."[32] With regard to his landmark work with hypnotic induction, which he used both with families

and with individual patients, he developed a principle of indirect suggestion and elaborated it throughout his life. This principle implicitly involves a distinct janusian formulation. The idea of suggestion in relation to hypnotic states is clearly much stronger than its conception in everyday common usage. In the latter it is a proposal, but in hypnosis it is a form of directiveness or direction. The idea of indirect suggestion in hypnosis, therefore, is more appropriately considered as *indirect direction* —a simultaneous antithesis.

As a concrete example of this idea in practice, here is the verbatim beginning of one of Erickson's trance inductions:

> Look at the far upper corner of that picture. Now you [speaking an aside to an observer] watch her face. [To the patient again] The far upper corner of that picture. Now I'm going to talk to you. When you first went to kindergarten, grade school, this matter of learning letters and numerals seemed to be a big insurmountable task. To recognize the letter A, to tell a Q from an O was very, very difficult. And then, too, script and print were so different. But you learned to form a mental image of some kind. You didn't know it at the time, but it was a permanent mental image. And later on in grammar school you formed other mental images of words, or pictures of sentences. You developed more and more mental images without knowing you were developing mental images. And you can recall all those images. Now you can go anywhere you wish, and transport yourself to any situation. You can do anything you want. You don't even have to listen to my voice because your unconscious will hear it. Your unconscious can try anything it wishes. But your conscious mind isn't going to do anything of importance. . .[33]

This monologue induction was spoken, as Erickson's inductions always were, very slowly and regularly. The feature of indirect direction is, I believe,

readily apparent in his shifting away from commands to enter a trance or fall asleep while at the same time directing the subject to believe in, and focus on, mental imagery. Furthermore, by using the idea of the unconscious mind, he both directs her to listen to his voice and permits her not to do so at once.

Other particular types of hypnotic induction developed by Erickson also reflect his tendency to formulate simultaneous antitheses. For instance, he slowly proclaims a series of opposite and contradictory statements which, he says, require the patient to seek understanding or meaning at another level. Frequently, he uses a type of contrary directive that, he believes, instigates the opposite at the same time, such as giving an example of a forgotten experience of childhood to facilitate both forgetting and recall, and emphatically admonishing withholding patients to withhold vital information "until the latter part of next week" as a procedure inducing them both to resist and to yield at once.[34]

Much has been written by both Erickson and his associates attempting to explain the effectiveness of his approach to hypnotic induction. In distinction to dramatic, commanding approaches, there may possibly be less instigation of a patient's dependency on the therapist. Erickson, Rossi and Rossi, Lankton and Lankton, all claim that it facilitates the patient's own capacities for change.[35] Erickson says, "the less the operator does and *the more he confidently and expectantly allows the subject to do*, the easier and

more effective will the hypnotic state and hypnotic phenomena be elicited in accord with the subject's own capabilities and uncolored by efforts to please the operator."[36] Also, the claim is made that these procedures encourage the patient's creativity and that some aspects of it give "free reign to the creative process."[37] Leveton draws analogies between Erickson's later work involving induction of light trance, Bachelard's focus on reverie, and Winni- cott's designation of transitional phenomena and emphasizes the therapeutic importance of eliciting what he calls the "between" realm of experience.[38]

Whether or not the indirect direction of Erickson's hypnotic induction stimulates further creative elaboration on the patient's part is hard to ascertain. If the technique is applied to everyone without regard to the principles of application of the janusian process I have outlined, it is unlikely to have a creative effect. For instance, the oppositions compliance and defiance are implicitly addressed in this approach. If these specific opposites are not important for a particular patient, a creative janusian process will not likely ensue.

Several of Erickson's own interventions in his ongoing relationships with his patients, however, are decidedly directed toward salient features of their difficulties. In the examples to follow we see a phenomenon similar to the clinical use of the janusian process by Freud described in the last chapter. With the vomiting mother, Freud's use of hypnosis seemed less important

than his identification of a central conflict. Erickson's identification of conflict also seems to be a primary factor in his therapeutic effect.

In the case of a young adult male with a history of enuresis since puberty,[39] a case that has also been discussed by Hoffman,[40] Erickson reports that he first determined that the patient had been cystoscoped and had taken "barrels of medicine" for his difficulty. Also, he gathered the particular information that the patient lived at home and it was his mother who found his bed wet every morning. Then, assuring the patient that his problem was psychological in origin, Erickson told him to carry out a particular series of actions. First, he was to go to a neighboring city and engage a hotel room. While there, and preparing to sleep in the bed, he was to consider how frightened and distressed he would be when the maid, like his mother, discovered a wet bed the next morning. Then, thinking constantly of how humiliating and anxious he would feel, he would begin to think of what an amazing but bitter joke on himself it would be if, after all his worrying, the maid were surprised by a *dry* bed. He would focus on this latter idea and begin to feel shame, anxiety, and embarrassment when thinking about the maid discovering a dry bed rather than a wet one. If this program were successful, he was to remain in the room another day and again to worry about the maid's discovering the bed to be dry.

Erickson reports that this intervention was indeed successful in

interrupting the enuretic symptom. Although the suggestion was carried out under hypnosis, and some other directives regarding the patient's grandparents were also included,[41] the presentation illustrates an identification of a central conflict. Erickson structures the situation to convey a circumstance in which the patient simultaneously wishes to wet the bed and not to wet the bed. Also, he experiences anxiety about both wishes. In either case, he is in the position of defying the maid who is represented as a displaced substitute for the mother. Therefore, it is a conflict about the desire to defy the mother that causes the patient anxiety. The patient is presented with a janusian formulation which serves as a nonverbalized or action-embedded interpretation of conflict.[42]

In another case of a man suffering from phantom pain in his legs, Erickson began the treatment by telling the patient stories about his own life. Two circumstances were described in which he experienced uncomfortable physical sensations as nonexistent or even comforting. Watching the man's reactions carefully while he talked, Erickson asked him directly where he felt the pain. The man replied that he felt it in his foot and (reminded by his wife) added "where there is no foot." Thereupon, Erickson told the man about a psychiatrist friend of his with a wooden leg. One day, while this friend and he were talking, the friend reached down to scratch his ankle. Then Erickson, referring to the itch as though it were real, asked the friend how the limb felt after the scratching. He replied, "good." Addressing the patient directly,

Erickson said: “You can have good feelings in the foot, not just painful ones. ... If you have phantom pain in a limb, you may also have phantom good feelings.”[43]

Again, although couched in terms of storytelling, Erickson’s central intervention constructed the simultaneous opposites of pain and pleasure together in the symptom. This was therefore a dramatized type of interpretation focusing on conflict either about masochistic gratification or else the secondary gain aspects of the symptom, or both. That secondary gain was likely a factor in the case is suggested by the fact that the patient next began to protest gratuitously that he did *not* want his wife to spend so much time taking care of him.[44] Erickson used a similar type of interpretation in the case of a young bridegroom who sought help because he was unable to achieve erection during a two-week honeymoon.[45] Instructing the man to experience both his sense of shame and humiliation over the events and a wish to do “anything, *just anything*, to escape from that completely wretched feeling,” he then suggested that the patient imagine himself and his wife in the nude. At the same time, however, he would feel that he had no control over his entire body. This would lead to the discovery that he sensed physical contact with his bride that was intimate and exciting him to action but there was “nothing he could do to control his physical responses.” From Erickson’s report that this intervention led to successful intercourse the same night, it appears that the simultaneously antithetical prescription to want to do

something and nothing was successful. Very likely, this dramatized type of interpretation focused the young man on his conflicts about control, i.e., whether to be in control or to be controlled in the sexual relationship.

Conflicts about control are, of course, found routinely in obsessive-compulsive disorders, and conflicts about masochistic gratifications or secondary gain are found in a range of different conditions. Neither Erickson nor his associates discuss diagnostic factors or principles of psychopathology in describing his approach. However, verbatim transcripts of his work, his own commentary, plus the testimony of those who have worked directly with him,[46] indicate his continual and penetrating observation of his patients' verbal and nonverbal reactions. While delivering a monologue, either story or other type of trance induction, he modified, shifted, or honed in on a particular area touched upon, after noting nuances of reaction or response. It may be remembered, in the verbatim hypnotic induction I quoted above, that Erickson told the observer to watch the patient's face. In this way, his approach is exquisitely responsive to a particular person's psychological makeup.

His skill in observation is, I believe, the factor that gives specific creative impact to his work. The examples of janusian formulations I gave are only a small sampling of the numerous interventions of this type found throughout his and others' writings about his cases. Those used seem to demonstrate the

choice of salient opposites despite the relative absence of information about how Erickson went about selecting them. In numerous other cases, his persistent use of reversals and paradox —in the commonly understood sense of contrary to the expected —seems also to have resulted in creative effects. In these, a mutual janusian formulation may have been developed in which the patient's understanding provided an aspect of the simultaneous antithesis. In such cases, and in those I have discussed, it seems fair to presume that Erickson's observations, though not described, functioned to determine important thematic factors and salient opposites.

The janusian process requires, for its creative effect, such specificity of themes, antitheses, and opposites. Use of techniques involving routine reversals, contraries of expected actions or behaviors, or even a routine introduction of the unusual would not be applications of janusian process and would not have creative effects. It is often said that Erickson's work cannot be replicated. One reason for this may be that those who attempt to use his approaches do not also possess, or work to learn, his sensitivity to and observation of conflict.

## IRONY

Another type of intervention manifesting a simultaneously antithetical structure is irony. Unlike paradox, irony has not received much attention in

psychotherapy literature and has not been incorporated into a defined technique.[47] It does share common features with some of the paradoxical interventions described here, in that its structure and effect are highly dependent on context. Irony consists of a verbal construction in which the opposite of what is literally stated is implied.[48] Consequently, an ironic statement cannot be understood to be one unless the implication is conveyed by the context. In psychotherapy, if a patient does not apprehend that the therapist is implying the opposite or intending a comment to be ironic, it will be taken literally. For instance, after having delivered a flood of hostile invective at the therapist and getting no response, a patient says, "You're really all right, doctor." The therapist then ironically says, "Whew, what a relief!" If this therapist response is not given with the right tone of voice, or if the patient has reason to believe that the therapist has been truly intimidated, the irony will be lost.

Irony is often considered to be a type of wit or humor, but many types of irony are not at all evocative of laughter. These are usually found in an and literature and range from serious to skeptical to tragic. Such irony usually is presented in the artistic context in a complicated unfolding way and is used to connote and express both superficial and profound truths. Considered the fundamental basis of poetry and drama by many critics, much has been written about its aesthetic and philosophical importance.[49] In art and literature, irony serves to exemplify, instruct, charm, humor, provoke, enrage,

and otherwise deeply move both readers and viewers. In the therapeutic context, irony used by the therapist as interpretation is most commonly associated with humor. This is partly because ironies contained in relatively short constructions involve an apposition of opposites and, as Freud has shown, opposites brought together are often experienced as humorous.[50] More important to the therapeutic use, however, humor serves as a cue to the patient that something other than a literal meaning is intended.[51]

The use of any type of humor in therapy has been a topic of some controversy.[52] A therapist's display of wit or humor is considered by some to be, at a minimum, either seductive or competitive or self-aggrandizing and, at a maximum, a way of shortcutting and suppressing the exploration of a patient's dynamic concerns. This latter effect allegedly results because humor functions to release and alleviate anxiety about a particular issue or topic, and so the issue or topic is dismissed before the roots of the anxiety are explored. In such circumstances, the criticism goes, the therapist using humor is acting out his own countertransference conflicts and suppressing patient issues that are anxiety-provoking to him.

With each of the former effects, some countertransference factor is acted out as well. With seductiveness, the therapist exploits the capacity of humor to generate warmth, friendliness, and even sexual feelings in circumstances where he either cannot tolerate hostility or a feeling of

distance from the patient or also needs the patient's love. With competitiveness, both the aggressive factor in humor and the humorist's demonstration of skill are seen to play a role. Aggressiveness, as Freud succinctly demonstrated, is an almost invariant component of jokes and other forms of humor.[53] Any type of therapist joking or casting of comments in a humorous way may be at the patient's expense and may also often be an indirect vehicle for the therapist to discharge hostile feelings. Demonstration of skill in a competitive way enters the picture because humor often involves cleverness, perceptiveness, wit, and other valued social capacities. Putting the patient down may be the therapist's purpose, without his realizing or knowing it. Also related to this factor of demonstration of skill is the self-aggrandizing and "show-off' function of displaying virtuosity and seemingly superior capacities to the patient. This serves only to reassure the therapist about himself and has little value for the patient. Particular types of highly fragile or paranoid patients may invariably misunderstand and be damaged by humor.

All of these criticisms are potentially valid but they need not deter the proper use of humor in therapy. They serve both to emphasize the potentially useful functions of therapeutic humor and as cautions or limits regarding improper use. First, although it can be used seductively by the therapist, humor does have the function of facilitating intimacy and warm relationships. It can be used to help the patient to feel intimate with the therapist without

an accompanying feeling of guilt and fear. It can demonstrate a therapist's genuine positive feelings toward the patient and his willingness to relax and be friendly, and it can allow the patient to experience similar feelings in return. With some patients, relaxed or positive feelings are far more risky and guilt-ridden than are negative hostile ones.

Second, although humor can be used to obscure and bury issues that are anxiety-provoking both to patients and therapists, it also serves as a valuable release of anxiety in circumstances where therapy has become bogged down or where anxiety has reached an insupportable level. Each and every conflict that a patient brings to therapy is not necessarily explorable and, especially in working with seriously disturbed patients, use of humor to modulate anxiety may be the only way therapy can proceed. Done with care, this can be true for paranoid patients as well.

Third, although humor can be used just to display the cleverness and wit of the therapist, it nevertheless does derive from positive skills. It requires a certain degree of flexibility and freedom on the therapist's part and usually the same type of skill with words that is required in every psychotherapy. Also, it often requires a certain degree of perceptiveness and insight and, as I shall discuss presently, in the case of irony, a creative capacity. To expose these skills to the patient is not a detriment and can serve to facilitate the therapeutic alliance. Moreover, as some identification with the

therapist always occurs, exposing these skills and attributes may serve as a positive model for patient development.

Finally, although humor often has an aggressive component, it is not therefore necessarily hostile to the patient. Aggressiveness in humor may not be at all greater than that in literal admonitions, confrontations, or even direct interpretations. As a positive feature, the therapist's ability to express aggressiveness in a socially acceptable way may also have a modeling function. The tendency of humor to be conveyed through exaggeration and dramatization, with the use of alterations in tone of voice and manner, additionally serves as a special check on aggressiveness. It is relatively easy for the therapist himself to recognize when his aggressiveness has changed to hostility in any particular humorous remark. This allows him to monitor his countertransference hostility and to correct it and, as with other types of errors I shall discuss in Chapter VIII, to use it therapeutically.

When humor and humorously stated irony become charged with hostility, there is a shift into *sarcasm*. Although technically sarcasm is considered to be a form of humor, it does not share any of the positive characteristics I have just outlined. Seldom, if ever, does sarcasm or a sarcastic intervention have a use or valuable function in therapy. Although sarcastic interchanges between two individuals may seem humorous to a third party, they are always hostile attacks at the expense of one or the other

individual. It is just at the point that a remark intended to be friendly and ironically humorous becomes tinged with sarcasm that a therapist must become aware of the influence of countertransference hostility.

The dividing line between friendly humor and sarcasm is sometimes rather thin and for this reason humor must be used with care in the therapeutic situation. Only elements of context, such as the exact shading of the tone of voice, expression on the therapist's face, and other shared vehicles of meaning between patient and therapist, can determine the difference. With an ironic remark such as "What a relief!" any defensive quality to the tone on the therapist's part or any indication that he may not be as amused as he pretends to be will be properly experienced as a hostile rebuff by the patient. Also, if either the literal aspect of the remark or the implied opposite meaning receives undue emphasis, then the intervention will shade into sarcasm.

The simultaneously antithetical character of an ironic remark is critical both for its nonhostile effect and for its operation as a therapeutic intervention. When both the literal aspect and its implied opposite are conveyed and experienced as meaningful and applicable, the ironic remark then functions as an interpretation of conflict. When the therapist says, "What a relief!" after a hostile barrage followed by a compliment, he conveys his understanding that the patient wished to injure him but was also feeling guilty about that wish. The literal aspect regarding relief acknowledges the

wish to injure and the implied opposite conveys that the therapist is perfectly all right. Beyond a simply literal interpretation, moreover, the humorous ironic intervention provides an affective acceptance of the patient's hostile wish. Rather than literally telling the patient that he is all right and uninjured, he enacts and demonstrates his comfortable state of being with his good humor.

An ironic intervention is a janusian formulation identifying both sides of specific patient conflict. Because one of the opposites in an irony is implied, there is often a more telling sense of simultaneity than with more explicit types of janusian formulations. This is because making each opposite explicit technically requires stating the substance sequentially. Even if that were not the case, however, the ironic intervention can convey a greater degree of acceptance by the therapist than other types of interpretations. A moderately depressed person, for example, may pour out a series of complaints about himself, such as: "I try to be nice to people but it never seems to work. Everybody acts as though I'm antagonistic, or lazy, or a bother. I used to be able to make friends; I used to have a lot of energy. I don't know why I try; I feel like giving up." To these, the therapist may ironically reply: "So, I guess you're just a worthless, nasty bum." Such a comment conveys the therapist's implied formulation of the opposite, i.e., "you're not worthless," and it also conveys an understanding that the patient actually does feel worthless. Moreover, instead of simply reassuring the patient, it acknowledges both

sides of the conflict. On the one side, there is the element of truth in the self-deprecatory content of the complaint that commonly appears in depressed states. The patient is, and wishes to be, passive and nasty. On the other side, there is the wish to be active, make friends, and feel a sense of self-esteem and worth. Both sides are interpreted and, because of the friendly, humorous tone, acceptance of both sides is conveyed.

On another level, Stein, in an article on irony in psychoanalysis,[54] has pointed out that the entire analytic situation is an ironic one. Patients are expected to develop a transference but transference must be analyzed and hopefully renounced; the more intense and florid the erotic attachment in the transference, the more likely is it to be accompanied by, or be a defense against, hostility; the more the analyst feels himself responding, the more he has to understand his feelings; the patient sees the analyst as an omniscient and loving parent and is also aware that he is being charged a substantial fee; the procedure is conducted on the basis of psychic determinism as well as the implicit assumption of purposeful and moral choice. Although many attempts have been made in psychoanalytic literature to reduce and explain these ironies, Stein recommends that the analyst adopt an ironic but not cynical stance. This must involve some degree of detachment in conjunction with a deep commitment. Schafer also advocates what he calls an "ironic vision" for the psychoanalyst, and he quotes Freud as having said that psychoanalysis shows man to be more moral as well as less moral than he thought.[55]

With regard to the creative effect of irony, whether general stance or vision as Stein and Schafer describe or as a particular ironic intervention, it is necessary that the patient both apprehend the irony and apply it in the ongoing therapeutic process. Usually, this is manifested by a development of insight which may or may not be expressed by the patient as a prepositional or intellectual formulation. For example, a patient was considering terminating therapy but the therapist knew that he was deeply ambivalent about doing so. Beginning a therapy hour with the description of a highly problematic situation at his office, his rendition of the details made it clear that he had become entangled in, for him, a repeated constellation of difficulties. He was being downgraded by his co-workers and his boss, a circumstance in which he characteristically responded with passive withdrawal. As he recounted the story, he began to talk about his growing awareness of the constellation and of his own tendency to withdraw. Reporting that he had this awareness in mind while working in the office the previous day, he described himself taking an active stance. He told his coworkers how much he resented their scapegoating and, in addition, took on a job for the boss that he completed successfully. Although he told all this to the therapist with some hesitation and discomfort, a distinct tone of pleasure also crept into his voice as he reported his effectiveness and success.

The therapist at that moment became aware of the patient's simultaneous wishes for both success and failure conveyed by the content of

the tale and the manner of presentation. Thus, in a friendly tone of voice, he said: “Well, now, we can’t have that kind of behavior! For all we know, you’re going to continue doing this kind of thing; you’re going to keep on understanding the source of your difficulties and correcting them. You’re going to begin to be able to handle yourself in all kinds of difficult situations. The next thing we know you’ll feel that you’re better and will want to terminate therapy. Then, you may even feel cured. We can’t have that! What are we going to do then?”

The tone, as I said, was friendly. The patient, who had heard ironic comments from the therapist before, smiled and immediately replied, “Yes, we can’t have that. What am I going to say to my friends and my wife if I’m better?” Following this, he started tentatively exploring some specific goals in that session that might lead to termination of therapy. He continued to work on these goals in subsequent weeks.

In this ironic janusian formulation, the therapist conveyed that he was aware of the patient’s conflict about success and failure and interpreted both sides at once. He spoke literally of the sequence of the desired events that might follow the therapeutic movement and also acknowledged the patient’s desired opposite in his negating and humorous phrasing. He indicated uncritically that the patient might wish to fail in order not to leave therapy and still be perceived as being ill —an aspect of the interpretation verified by

the patient's own ironically stated and insight-containing response. Also, he showed support and friendly pleasure for the patient's genuine wishes to improve and be on his own.

As with paradoxical interventions, it is important that an ironic intervention be related to the patient's specific conflicts and that the opposites involved develop from the particular context. Routine types of interventions will not be janusian formulations developed from the therapeutic interaction and will not lead to creative effects. Using humor for its own sake also will not necessarily touch on a patient's concerns and may have all the negative features discussed as cautions above. Using humor in the form of jokes told to the patient, or in the form of witty aphorisms, is similar to other types of storytelling or to the Erickson "embedded metaphor" technique. It will be effective if it derives from careful observation and understanding of a patient's specific concerns. To know that this is so requires confirmatory responses from the patient. All humor is not ironic and even ironic humor requires patient confirmation that it has been apprehended.

A 22-year-old schizophrenic female was acutely sensitized to being abandoned because her parents had traveled all over the world and often left her behind in a punitive way. Extremely wealthy and given to taking frequent vacations, they would invite the patient to accompany them when she

behaved as they had wanted and not offer, or withdraw, an invitation when she did not measure up. After several months in psychotherapy, she had benefitted a fair amount and had fewer and fewer psychotic episodes. Although often manifesting massive denial, she displayed some capacity for humor. At a point when the therapist announced that he would be away for a month's vacation, the following interchange occurred at the beginning of a therapy session.

P: I'm really glad you're going away and I won't have to come to therapy. My mother wants me to ask you where you are going.

TH: Your *mother* wants to know?

P: OK, where are you going on vacation?

TH: (smiling) As *far* away from you as I can get!

P: Vermont? (N.B. the treatment took place in Massachusetts)

TH: Not far enough.

P: Florida?

TH: Much too close.

P: Europe?

TH: Right around the corner.

P: South America?

TH: Not far enough, thousands more miles away.

P: Maybe I can go with you.

TH: (still smiling) Ugh!!

In the remainder of the session the patient continued to focus on the therapist's vacation and, becoming more and more serious, she acknowledged feelings of jealousy and resentment about his going away. She also touched on some of her feelings about her parents' controlling behavior in connection with their vacations and other facets of their relationship with her. In this case it was clear that the apprehension of irony depended both on the therapist's ability to convey his genuinely genial feelings and on the patient's capacity for humor. Despite the extremity of her illness, however, there is no question, from a consideration of the verbatim interchange, that she fully understood and reacted to the therapist's creative interpretation. In stating that he wanted to get far away from her, he acknowledged her literal wish that she not be tied to therapy and, at the same time, he implicitly interpreted her fear that she was driving him away. Moreover, his affect indicated that she wasn't driving him away at all. This was further demonstrated by the continuing irony of the interchange. Each time the patient half jokingly and half seriously tested the therapist's interpretation of her conflict and fear, he increased the polarity of the oppositions and conveyed the feeling that he did not wish to get rid of her at all. At the same time, the patient designated locations to which her parents had gone, both with and without her. Thus, the

interchange in this case represented a compressed reenactment, together with some working-through, of experiences she had had with her parents.

That some degree of working-through occurred is indicated by her revealing openly her wish to go with the therapist on his vacation. At that point, the therapist again reacted with irony and, compressed as it was, a telling interpretation. The use of the sham grunt of "Ugh" conveyed to the patient both an understanding of her fear that he would be repelled by her and her request, and an assurance he did not feel that way at all.

In addition to particular short interchanges, ironic interventions can be developed over longer periods of time and can also be quite serious in tone. For instance, a therapist developed the idea with a schizoid patient that at the end of therapy he would become more independent and then his loneliness would change to a feeling of really being alone. In another case, a therapist brought home to an idealizing patient who was seeking to attain physical prowess that, after consulting with many therapists, he had ironically chosen one who was far shorter than he as well as appearing to be physically inept. And then, of course, there are the myriad instances in therapy when one points out that a patient is carrying out the very behavior he abhors in others, that he has become identified with an aggressor, that he has difficulty functioning heterosexually because he cannot accept latent homosexual wishes, and that he cannot become truly independent because he has not

accepted his feelings of dependency. Sometimes such formulations are constructed and used creatively by the therapist and patient together in a particular context, and sometimes they derive from other types of useful but not manifestly creative processes.

It is important to emphasize, however, that all life experience is perfused with irony and paradox. Life ends in death; wars are waged for moral reasons; evil is banal. Beyond any particular creative derivation or effect, it is probably safe to say that many of the formulations I have discussed ultimately derive their validity from the intrinsically paradoxical and ironic nature of life itself.

# Notes

1. *Webster's, op. cit.*

2. Zeno's paradox (discussed by Plato and Parmenides) and Russell's and Cantor's paradoxes have been important milestones in the development of modern philosophical perspectives.

3. August Aichhorn, *Wayward Youth,* London: Imago Publishing Co., 1951, pp. 139-142.

4. Gregory Bateson, Don D. Jackson, Jay Haley, and John H. Weakland, "Toward a Theory of Schizophrenia," *Behavioral Science,* 1( 1956):251-264.

5. Jay Haley, "Development of a Theory: A History of a Research Project," in Carlos E. Sluzki and Donald C. Ransom (eds.), *Double Bind: The Foundation of the Communicational Approach to the Family*, New York: Grune and Stratton, 1976, pp. 59-104.

6. Viktor E. Frankl, "Paradoxical Intention: A Logotherapeutic Technique," *American Journal of Psychotherapy,* 14( 19 60): 520—535.

7. Mara Selvini-Palazzoli, Luigi Boscolo, Gianfranco Cecchin, Giuliana Prata, *Paradox and Counter-paradox. A New Model in the Therapy of the Family in Schizophrenic Transaction,* Elisabeth V. Burt (trans), New York: Jason Aronson, 1978.

8. Jay Haley, "Whither Family Therapy?" *Family Process,* 1(1962):69—100; *Problem-Solving Therapy*, San Francisco: Jossey-Bass Publishers, 1976; *Leaving Home: The Therapy of Disturbed Young People,* New York: McGraw-Hill Book Co., 1980; Paul Watzlawick, John H. Weakland, Richard Fisch, *Change. Principles of Problem Formation and Problem Resolution,* New York: W. W. Norton, 1974; Gerald R. Weeks and Luciano LAbate, "A Compilation of Paradoxical Methods," *American Journal of Family Therapy,* 7(1979):61-76; Peggy Papp, "The Greek Chorus and Other Techniques of Paradoxical Therapy," *Family Process,* 19(1980):45-57; Cloe Madanes, "Protection, Paradox, and Pretending," *Family Process,* 19(1980):73—85; Michael Rohrbaugh, Howard Tennen, Samuel Press, Larry White, "Compliance, Defiance, and Therapeutic Paradox," *American Journal of Orthopsychiatry,* 51(1981 ):454—467.

9. Papp, *op. cit.*

10. Jay Haley, *Ordeal Therapy,* San Francisco: Jossey-Bass Publishers, 1984.

11. Rohrbaugh *et al., op. cit.,* p. 456.

12. Haley, *op. cit.,* 1980, pp. 244-253.

13. Lyman C. Wynne, "Paradoxical Interventions. Leverage for Change in Individual and Family Systems," in John S. Strauss, Malcolm Bowers, T. Wayne Downey, Stephen Fleck, Stanley Jackson, Ira Levine (eds.), *The Psychotherapy of Schizophrenia,* New York: Plenum, 1980, pp. 191-202.

14. *Ibid.,* pp. 199-200.

15. *Ibid.,* p 200

16. *Ibid.,* p. 201.

17. John R. Jordan, "Paradox and Polarity: The Tao of Family Therapy," *Family Process,* 24(1985): 165-174.

18. Robert L. Rosenbaum, "Paradox as Epistemological Jump," *Family Process,* 21(1982):85—90.

19. M. Duncan Stanton, "Fusion, Compression, Diversion, and the Workings of Paradox: A Theory of Therapeutic/Systemic Change," *Family Process,* 2 3(1984): 1 35-167.

20. Carlos E. Sluzki and Eliseo Veron, "The Double Bind as a Universal Pathogenic Situation," *Family Process,* 10( 1971):397-410.

21. John Schwartzman, "Creativity, Pathology and Family Structure: A Cybernetic Metaphor," *Family Process,* 21(1982): 1 1 3-127.

22. Vernon E. Cronen, Kenneth M. Johnson, and John W. Lannaman, "Paradoxes, Double Binds, and Reflexive Loops: An Alternative Theoretical Perspective," *Family Process, 2*1(1982):91 — 1 12.

23. Jeffrey L. Bogdan, "Paradoxical Communication as Interpersonal Influence," *Family Process*, 2

1(1982)443-452.

24. Haley, *op. cit.*, 1976, Rohrbaugh, *op. cit.;* Bogdan, *op. cit.*

25. Rosenbaum, *op. cit.,* p. 88.

26. See Haley, *op. cit.,* 1984, for systematic use of aversive procedures and for descriptions of Erickson's use of this type of intervention. For an earlier description of Erickson's approach, including aversive procedures, see: Jay Haley, *Uncommon Therapy. The Psychiatric Techniques of Milton H. Erickson, M.D.,* New York: W. W. Norton, 1973.

27. Albert Rothenberg, "Eating Disorder as a Modern Obsessive-Compulsive Syndrome," *Psychiatry*, 49(1986) 45-53.

28. Lynn Hoffman, *Foundations of Family Therapy,* New York: Basic Books, Inc., 1981, pp. 232-235.

29. Haley, *op. cit.,* 1973, p. 18.

30. *Ibid.,* pp. 17-40.

31. Watzlawick *et al., op. cit.,* p. ix.

32. Sidney Rosen, "The Psychotherapeutic and Hypnotherapeutic Approaches of Milton H. Erickson, M.D.," *The American Journal of Psychoanalysis,* 44( 1984): 13 3-145.

33. Milton H. Erickson, Ernest L. Rossi, Sheila I. Rossi, *Hypnotic Realities. The Induction of Clinical Hypnosis and Forms of Indirect Suggestion,* New York: Irvington Publishers, 1976, pp. 6-9.

34. *Ibid.,*p. 72.

35. *Ibid.-,* Lankton and Lankton, *op. cit.*

36. Jay Haley (ed), *Advanced Techniques of Hypnosis and Therapy. Selected Papers of Milton H. Erickson, M.D.,* New York: Grune and Stratton, 1967, p. 128.

37. Milton H. Erickson and Ernest L. Rossi, "Two Level Communication and the Microdynamics of

Trance and Suggestion," *American Journal of Clinical Hypnosis,* 18(1976): 153-171, p. 160.

38. Alan Leveton, "Between: A Study Showing the Relationships Between Erickson, Winnicott, and Bachelard," in J. Zeig (ed ), *Ericksonian Psychotherapy. Volume II. Clinical Applications,* New York: Brunner/Mazel, 1985, pp. 515-553.

39. This case was reported by Erickson to Haley and described by the latter in Haley, *op. cit.,* 1973, pp. 86-88.

40. Hoffman, *op. cit.,* pp. 233-234.

41. Hoffman, *op. cit.,* points out that the suggestions to the patient to visit both his paternal and maternal grandparents played a role by focusing on a conflict of loyalties the patient may have been experiencing. This supposition is completely in accord with the point I am making here but I have omitted the material regarding the grandparents to avoid unnecessary detail and complexity.

42. The term "action-embedded," as well as other terms applied here to interpretations such as "enacted" or "dramatic" are not formal ones but they are consistent with the concept of "presented knowledge" explained in Chapter IV.

43. Milton H. Erickson and Ernest L. Rossi, *Hypnotherapy. An Exploratory Casebook,* New York: Irvington Publishers, 1979, pp. 102-123, especially pp. 106-107. This case is also reported and discussed in Lankton and Lankton, *op. cit.,* pp. 69-72.

44. Erickson and Rossi, *op. cit.,* 1979, p. 109.

45. Haley, *op. cit.,* 1973, p. 158.

46. Personal communication, Alan and Eva Leveton.

47. See Martin H. Stein, "Irony in Psychoanalysis," *Journal of the American Psychoanalytic Association*, 3 3(1985): 3 5-57; see also discussion of the ironic vision in Roy Schafer, "The Psychoanalytic Vision of Reality," *International Journal of Psycho-Analysis,* 51(1970):279—297.

48. *Webster's, op. cit.*

49. Wayne C. Booth, *A Rhetoric of Irony,* Chicago: University of Chicago Press, 1974; J. A. K. Thomson, *Irony, An Historical Introduction,* Cambridge: Harvard University Press, 1927; S0ren Kierkegaard, *The Concept of Irony: With Constant Reference to Socrates,* M. Lee Capel (trans ), Bloomington: Indiana University Press, 1968.

50. Freud, *op. cit.,* 1905.

51. Personal acknowledgment to Dr. Jules V. Coleman for stimulating my early interest in this topic.

52. See especially: Lawrence S. Kubie, "The Destructive Potential of Humor in Psychotherapy," *American Journal of Psychiatry,* 127(1971):3 7-42; "Letters to the Editor," by Henry J. Friedman, Richard Schaengold, Morton S. Rapp, Robert Silbert, Richard A. Kunin, Jules V. Coleman, Norman R. Schakne, Francis H. Hoffman, Leon Salzman, and "Reply," by Lawrence Kubie, *American Journal of Psychiatry,* 128( 1971): 1 18-121; Warren S. Poland, "The Place of Humor in Psychotherapy," *American Journal of Psychiatry,* 128(1971 ):63 5—637; John L. Schimel, "The Function of Wit and Humor in Psychoanalysis," *Journal of the American Academy of Psychoanalysis,* 6(1978): 3 69-3 79. Kubie takes a broadly negative position about the use of humor in psychotherapy and this is countered to some degree by the other authors listed.

See also, for different types of positions about humor in psychotherapy, the following: Martin Grotjahn, *Beyond Laughter,* New York: Blakiston Division, McGraw-Hill Book Co., 1957; Gilbert J. Rose, *"King Lear* and the Use of Humor in Treatment," *Journal of the American Psychoanalytic Association*, 17(1969). 927-940; Eliyahu Rosenheim, "Humor in Psychotherapy," *American Journal of Psychotherapy*, 28(1974): 584—591; Irene Bloomfield, "Humor in Psychotherapy and Analysis," *International Journal of Social Psychiatry,* 26(1980): 1 35-141; Steven Sands, "The Use of Humor in Psychotherapy," *Psycboanalytic Review,* 71(1984):441-460.

53. Freud, *op. cit.,* 1905.

54. Stein, *op. cit.,* pp. 48-49.

55. Schafer, *op. cit.,* 1970, p. 294.