

Paradoxical Interventions with People Who Insist on Acting Crazy

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This article describes the use of paradoxical interventions with patients who have had an impressive history of prior treatment failure. Six brief case studies are presented which illustrate different interventions such as: prescribing the symptom; restraining change; and using counterrituals. These interventions are explained on the basis of general systems theory.

I would like to describe some interventions that seem to be effective with people whose behaviors historically have been resistant to change. This population of people is usually labeled "schizophrenic" or "psychotic" when first admitted, and in time generate a revolving-door pattern of being in and out of mental hospitals. By the time these people get into a community home program, some of these behaviors appear quite entrenched and resistant to most therapeutic interventions.

Most community home programs in the United States are an outgrowth of a nationwide effort to close the institutions and place as many people as possible into the community. In theory, community homes often function as a transitional living situation established to teach these people the necessary skills in order to live independent and productive lives in the community. The community-home programs for which I have served as consultant usually consist of eight residents who had been institutionalized in state hospitals anywhere from 6 to 35 years before being placed in the home. During the twice-a-month meetings the staff of each home and I discuss various behavioral programs and interventions. The staff subsequently implements these programs and monitors progress.

The symptoms or behaviors discussed in this article are viewed as functional for the resident and maintained by the emotional system in the community home. Context replication may also occur, namely, a particular symptom served a similar function when the resident was living in the institution and, prior to that, when the resident was living with his family of origin.

Usually, behavioral approaches seem most effective in changing the

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behaviors of this population.¹ Some of these behavioral approaches include: variations of positive reinforcement schedules; extinction schedules; and time-out. *Only* when these traditional approaches fail to change behaviors are paradoxical interventions considered.

Many of the following case studies illustrate interventions in which the symptom or behavior to be eliminated is prescribed.²⁻⁴ Often, when a behavior is prescribed, a rationale is given to the person for the reason the behavior is being encouraged. This rationale is called reframing.³ Sometimes the reframing is positive and has been referred to in the family therapy literature as positive connotation.⁴ Other times, the reframing is neutral or negative.⁵ Reframing is probably the most important and difficult aspect of a paradoxical intervention and requires considerable ingenuity, creativity, and understanding of resistance and systems theory. Milton Erickson's work illustrates the art of reframing.⁶

In this paper each case study is followed by an attempt to explain why a particular intervention was effective. These explanations are at best *post hoc* and do not discount other possible interpretations of the interventions. What is important is that the intervention was effective following prior failure using traditional behavior modification approaches.

CASE STUDIES

Case 1

Melvin is a 28-year-old male whose hospitalizations go back to the time he was in the third grade. He has spent over 15 years in prison, state schools for the retarded, and state mental hospitals. He has had three charges of arson and recurrent paranoid episodes involving the Puerto Rican Mafia.

One problem with Melvin had to do with his refusal to participate in any of the day activities programs of the community care center. Instead, he would sit on top of an oil drum all day outside the center. All efforts to get Melvin to participate in activities failed. It was important to get Melvin to participate in these activities since residents are not permitted to live in community homes unless they are working or are involved at the center.

The following intervention was used: We told Melvin that the community care center was having a fund-raising campaign and needed a model idiot to sit outside the care center to elicit sympathy. We also told Melvin that when he was outside sitting on the oil drum, he should slowly rotate 360 degrees in order to maximize the sympathetic responses of the community at large.

Upon hearing the intervention, Melvin immediately returned to the day activities program, and has become involved in all aspects of the program.

The intervention was effective for a host of possible reasons. The possibility that the community care center was benefiting more from Melvin's behavior than Melvin himself was intolerable. In addition, when

working with institutionalized populations of people, it is well known that mental patients are snobbish toward retarded people, and retarded people see mental patients as unstable. Calling Melvin a model idiot may have mobilized him off the oil drum because he took more pride in his intelligence than his mental stability.

Case 2

Margaret, a 25-year-old female, was placed in a community home after nine years in a state hospital. The most recent problem with Margaret was her incessant complaining to everyone in the house. She would complain in a loud and whiny way that she was ugly, stupid, crazy, worthless, unlovable, and confused most of her life. Prior attempted solutions to change this behavior, such as reassurances, extinction programs, and positive reinforcement for noncomplaining time, were not successful.

The following intervention was then implemented: Margaret was told that when she complained, it was a signal to the staff that Margaret needed to "de-complain her brain." Whenever she complained, she was to go into a "de-complain your brain" room and complain into a cassette tape recorder until she felt her brain was completely de-complained. For a period of one week, Margaret went into this room and complained into the tape recorder. However, when she complained *outside* of this special room, we now used a confusion technique⁷ by reinterpreting her complaining out of this room as a signal that her brain was in need of confusion. When this happened, we would have Margaret walk around with an earphone in her ear, listening to her recorded complaints until she felt that her brain was sated with confusion.

One week later, Margaret said that she was much less confused, and did, indeed, sound less confused. There has also been a 95 percent decrease in the frequency of complaining. In addition, she is doing much better on her previous behavioral contract, has improved her grooming, and has become more assertive.

Margaret's complaining behaviors were probably reinforced by the anxiety and anger it produced in the other residents and staff. Teaching the other residents and staff not to respond to Margaret's complaining failed because Margaret was better at provoking others than others were in not responding to the complaints.

Directing Margaret to go into a different room and to complain into a tape recorder initially worked. She found complaining into the recorder engaging since it was new, and her complaints were being listened to, albeit by mechanical rather than human sources. After a week of complaining into the recorder, she began complaining outside of this room, probably because she needed more human responses to her complaints. Reframing her complaining outside of the room as her brain being in need of confusion produced several consequences: the confusion technique produced more confusion than the confusion she was complaining about; since complaining outside the room now was reframed as her brain being in *need* of confusion,

this contradicted her initial complaints that she was too confused; and, finally, the consequences of her "brain being in need of confusion" resulted in Margaret listening to her own recorded complaints which both bored and irritated Margaret. Margaret was placed in a dilemma: she now could complain all she wished, but on our terms (a different room and into a tape recorder) rather than her own terms. If she now complained on her terms (outside this room), the end result was the "need for more confusion" (which she wanted to reduce) and listening to her recorded complaints (clearly a boring and toxic experience). Margaret chose to complain less and be less confused.

The intervention also shifted onto a different line of resolution. Margaret approached the staff with her illogical problems and defeated the staff when logical solutions were tried. Once the staff's solution became more illogical than Margaret's problems, Margaret was forced to be more logical and drop her complaints about complaining as well as confusion.

Case 3

Ed is a 48-year-old male who was institutionalized for 25 years before being placed in the community home. Our most recent problem was Ed's urination and defecation all over the bathroom except into the toilet bowl. Members of the house and staff became furious with him, and he became the scapegoat in the house.

Prior attempted solutions to his problem included: rewarding Ed for having good aim; when that failed, we had Ed over-clean the entire bathroom even in places which were not his responsibility. Ed took about three hours to clean the bathroom, which kept others out of the bathroom and infuriated them even more.

The following intervention was then used: We apologized to Ed for trying to help him learn how to eliminate properly in the bathroom, since we did not realize until recently that Ed was actually a dog trapped in the body of a human being. We therefore no longer expected him to use the bathroom in the house since it would be cruel to expect a dog to eliminate like a human. We told Ed that he was now to eliminate on top of a compost pile which was located in the corner of the backyard. He was not to use toilet paper since that was too complicated for animals, but he was to try and cover his droppings by scratching the earth with his "hind" feet. He was to urinate by lifting his left leg, and if he wasn't sure about his gender, he was to squat.

In addition, we had two other residents walk him in the morning and evening to the compost pile, and had members of the house go up to Ed and pet him affectionately.

Needless to say, within a period of one day, Ed's aiming problem was mysteriously transformed into precision accuracy, the quality of which would interest defense workers in the field of guided missiles.

This intervention involved reframing deliberate toilet accidents as the behavior of a dog. The reframing permitted two operations to occur. First,

we prescribed the behaviors to be eliminated on our terms, which involved an ordeal which took more time and energy than would be necessary to eliminate properly. Second, calling Ed a dog trapped in the body of a man activated his *hubris* or pride, and mobilized him to prove to us and to the world that we were wrong, and that he was indeed a human being.

Case 4

Luigi, a 30-year-old male, was placed in the community after six years in a state hospital. Since his arrival in the home, Luigi would speak nothing but gibberish and Italian. One day while talking to his mother in Italian and trying to give her directions to the home, he slipped and asked a staff member for directions in perfect English. In addition to the gibberish, he would pace for hours in the living room, and also would pace quite loudly in his room in the middle of the night, waking up many people. Finally, he would whine incessantly throughout the day.

The following ritual was then implemented: We apologized to Luigi for trying to change him, and for not realizing until recently that he was actually a spy from the state hospital. He was encouraged to speak gibberish, which was actually a code, needed to safeguard his cover as a spy. Whenever he began speaking English, we reminded him to go back to code so his cover wouldn't be blown.

We also encouraged the pacing by constructing a pacing tract on the front lawn. We told Luigi that we knew he picked up radio signals through his feet which were transmitted by the state hospital, and that pacing on the pacing tract would give him the best reception for the signals. Therefore, he could pace outside as much as possible; but if he paced in the house, even in the middle of the night, he was escorted outside to pick up the stronger signals. We reframed the whining as Luigi's signal back to the hospital that he clearly received their transmissions.

Luigi immediately insisted, in perfect English, that he was not a spy from the state hospital. The staff was not convinced. Within a two-day period Luigi ceased pacing, and within a two-week period he stopped the gibberish and the whining. The staff warned him that he might blow his cover, but for some reason he did not seem to care. Every once in a while he does something crazy, which is immediately stopped by having him face the direction of the state hospital for signals.

The gibberish, pacing behavior, and incessant whining all were reframed with the interpretation that Luigi was a spy from the state hospital. The reframing was toxic to Luigi for at least two reasons: (a) he hated the state hospital as any mortal would after residing there for six years; (b) the other residents in the house avoided Luigi because not only did he now represent the state hospital, but he was also something other than what he appeared to be. Now, instead of avoiding Luigi because he was crazy (Luigi had control over the gibberish, pacing, and whining), they were avoiding Luigi for other reasons (which Luigi had no control over).

Luigi tried to disqualify the reframing by verbally disagreeing with the interpretation. However, he was unable to do so, because this interpretation

was possible, and because the staff insisted that it was so. In addition, by definition, a spy will always deny he is a spy. The only way to disqualify this interpretation was to stop the behaviors, which Luigi did, and which consequently placed him back in control.

Case 5

Dotty, a 73-year-old female, was institutionalized for 35 years in a state hospital before she was placed in a community home. Five months ago, she broke her leg, which was then put in a cast. Because it was difficult for her to walk with the cast, she was given a walker, and her bed was placed on the first floor since she could not walk upstairs to her bedroom. However, since there was no bathroom on the first floor, she was given a commode to use until she could get around better.

Two months after the cast was removed, Dotty refused to return to the second floor and she continued to use the commode which she refused to clean or empty. The stench from the commode was getting quite annoying to other members of the house. All efforts to get Dotty to empty the commode failed.

The following intervention was then used: The staff was told to tell Dotty that they brought her case up for review, and that a doctor told the staff that Dotty was well enough to go upstairs. The staff, however, wasn't sure whether Dotty was ready, but decided to provide a commode service for Dotty at a reasonable rate. The service consisted of the staff removing and cleaning the commode at the rate of five dollars a day for all the urine she could pass, plus three dollars per piece of feces, and eight-dollars if her feces were not countable.

Within 20 minutes of hearing this intervention, Dotty started telling people she couldn't afford to have diarrhea, demanded that her bed be placed back on the second floor, threw away her walker, and moved back up to her second-floor bedroom. In addition, she started attending a day activities program for the first time in eight months, and told everyone in the house that she was a healthy woman with a born-again enthusiasm for life.

For whatever reasons, Dotty had chosen to remain living on the first floor as an invalid, and not to clean or remove the commode. The intervention probably mobilized Dotty because some control was taken away from her by the intervention. She could now continue what she was doing, but there would be an added penalty involved if she had diarrhea (which she could not control). Rather than run the risk of not being in control of something uncontrollable, Dotty chose to remain in charge by deciding to move upstairs and retire from being an invalid.

Case 6

Eddie, a 39-year-old male, was institutionalized in a state hospital for 19 years before he was placed in a community home. He is a professional at being helpless and in getting people to do nearly everything for him. He normally stays in bed 23 hours a day, reserving his only remaining hour to whining, crying, walking in circles,

and harassing others to do everything for him. When it is his turn to cook dinner, he invariably burns the food, serves frozen french fries, and tells astonished onlookers that the food tastes better that way. Recently he was quoted as saying, "I've done everything in life there is to do."

The following intervention was used: We agreed with Eddie that he probably had done everything in life there was to do, and therefore the only thing left to do was to prepare to die. We took Eddie's bedroom door off the hinges, brought it down to the living room, where it was covered with a blanket and elevated with cinderblocks. We centered the door in the middle of the living room, and converted the entire room into a funeral parlor. Now, Eddie was to lie in state, dressed in his best suit, and holding rosary beads. Candles were lit and fresh flowers placed daily next to the deceased.

We informed everyone in the house that Eddie was "basically dead," and that we were waiting for his soul to leave his body. Every evening, twenty minutes before dinner, there was a formal viewing by all members of the house, now wearing black armbands, to say their last farewells to Eddie. Some of the women residents wept. Throughout the day, Eddie was referred to in the past tense and people directed their voices toward heaven.

The moment the intervention was introduced, Eddie started jumping up and down, screaming that he was not dead. We reframed this reaction as a death cackle. Eddie then lay in state for three successive days. On the fourth morning, a miracle happened. Eddie started going to the day program, refused to sleep or stay in his room for more than seven hours, began dating women, refused to let anyone help him with the cooking, and started doing his own laundry. Two years later, he remains more alive than ever before.

This intervention was based upon prescribing the resistance inherent in the statement that Eddie had done everything in life there was to do. We agreed with the statement and added the next logical step to an extreme degree, namely, that Eddie was to prepare for death.

Reframing the sleeping behavior as premonitory, and converting the living room into a funeral parlor, was an attempt to make the reframing more dramatic and therefore powerful. Prior to this intervention, Eddie was getting attention for his absence in the house by staying (sleeping) in his bedroom. Now he was getting more direct attention from everyone in the house for the *same behavior*, but with a reframing of the motivation for the behavior which was intolerable to Eddie. The only way Eddie could disqualify the reframing of the motivation for his behavior, and defeat the staff, was to demonstrate that he indeed was not dead.

DISCUSSION

Before an explanation is given as to why these particular interventions were effective, a few points should be made about the interventions themselves.

First, it is important to underscore that these interventions were effective

when traditional behavioral approaches failed, and that they were devised only after more traditional approaches failed.

Second, these interventions may be more time saving than traditional behavioral approaches since they are quite powerful and have a "one-shot" quality to them. That is, the ritualistic and dramatic quality of the interventions should be implemented just for a short period of time (versus more traditional extinction programs) and perhaps only for the time needed for a patient to disqualify the paradoxical interpretation. The parsimony of these interventions is important when one considers that in a community-home program, the staff might be trying to alter the behaviors of eight people at the same time.

Third, these interventions can only be successfully implemented by a cooperative staff, convinced that traditional approaches are not effective with these behaviors, and who are able to implement these interventions with rigor and enthusiasm.

There are many possible explanations for why these interventions were successful. Paradoxical intervention, where a patient is encouraged to do or wish to happen, the very thing he fears, is viewed by Frankl as effective because the intervention interrupts a vicious cycle of anticipatory anxiety.² The theoretical basis of this article is rooted in systems theory and has been explained in detail elsewhere in connection with my work with formerly institutionalized mental patients and the retarded.⁵ The effectiveness of these interventions depends on the nature of the paradoxical intervention itself. Usually a resident defeats the staff by placing himself in a one-up position when a behavior cannot be changed by the staff. The resident maintains this one-up position when his behavior, more often than not, elicits fear, anxiety, or rage in the staff. By prescribing the behavior, the staff obtains a one-up position by telling the resident that he *must* do what the resident is already doing, with a reframing that is likely to produce fear, anxiety, or rage in the resident.

In addition, the reframing of the *motivation* for the behavior places the resident in a dilemma. When the staff prescribes a behavior with a reframing of the motivation that is toxic to the resident, the resident can do one of two things: (1) Continue to display the behavior, but then he must tacitly agree with the reframing of the motivation for the behavior, an intolerable position for the resident. Although residents immediately try *verbally* to disqualify the reframing when the intervention is introduced, they can never do so because (a) one can never verbally disprove an alternative explanation of a behavior, (b) the staff remains convinced that *their* explanation is the *real* motivation for the behavior. (2) Stop the behavior, because this is the only way the resident can disqualify the staff's reframing of the motivation for the behavior and also "defeat" the housemanagers.

Perhaps ten percent of the time, the interventions do not work. The unsuccessful intervention might be caused by the failure to understand the function that the symptom or behavior serves in the interpersonal system (resident and staff), or by improperly framing the language of the intervention. After such unsuccessful intervention the symptom should be re-evaluated in a new context, using a different language.

SUMMARY

This article describes the use of paradoxical interventions to change the resistant behaviors of community home residents who were formerly institutionalized in state hospitals for periods ranging from 6 to 35 years. One of the goals of these community home programs was to quickly eliminate the existing maladaptive and bizarre behaviors cultivated in the hospitals so that these people could remain in the community. Quite often, community-home staff do not have sufficient time to teach patients new behaviors since patients become rehospitalized because their behaviors are so unacceptable to the community.

The paradoxical interventions used in this program followed prior therapeutic failures using more traditional behavioral approaches. Six brief case studies describe the problem, the paradoxical intervention used, reactions to the intervention, follow-up information, and an explanation of the intervention. Some of the paradoxical interventions used include: prescribing the resistance, symptom, or system; restraining change; and using counterrituals. Explanations of these interventions are given based upon general systems theory.

REFERENCES

1. Ullmann, L. and Krasner, L. *Case Studies in Behavior Modification*. Holt, Rinehart and Winston, New York, 1965.
2. Frankl, V. E. Paradoxical Intention. A Logotherapeutic Technique. *Am. J. Psychother.* 14:520, 1960.
3. Watzlawick, P., Weakland, J. H., and Fisch, R. *Change: Principles of Problem Formation and Problem Resolution*. W. W. Norton, New York, 1974.
4. Selvini Palazzoli, M., Boscolo, L., Cecchin, G., and Prata, G. *Paradox and Counterparadox*. Jason Aronson, New York, 1978.
5. Bergman, J. S. The Use of Paradox in a Community Home for the Chronically Disturbed and Retarded. *Family Process* 19:65, 1980
6. Haley, J. *Uncommon Therapy*. W. W. Norton, New York, 1975.
7. Erickson, M. H. The Confusion Technique in Hypnosis. *Am. J. Clin. Hypnosis* 6:183, 1964.