doxical treatment the doctor must be able to think paradoxically. He must therefore see the symptom as a vehicle of change, see the symptom in functionally positive terms—for example, as a sign of caring, protection, and closeness, and must understand how the family and professionals are reacting.

Paradoxical treatment seems to be most efficient and effective when the child has resisted any changes in the past. The use of these methods with an easy and cooperative case may be no more effective than other techniques.[13] The methods are undoubtedly effective in reducing the soiling quickly, but it is always difficult to measure the true effectiveness of any treatment in a self limiting condition.

There is, however, no doubt in our mind that relationships in the family improve rapidly as the child shows his mother and the doctor that he really does love her and does not want to live in 'Poohland'. The theory is simple to understand but at times difficult to execute. The doctor must, as in all work with children, be comfortable with the style of work or it is likely to fail.

We have outlined a method that can be quickly effective in producing a change in children who continue soiling despite all other efforts. This is a technique that some may find interesting and challenging and its future lies in improving the selective criteria more scientifically and at the same time refining the interventions.

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Commentary

Paradoxical techniques have been around long before psychiatrists and allied workers discovered them for therapeutic purposes. We have always known that under certain circumstances people are inclined to do quite the reverse of what we want them to do. We might then deliberately instruct them to do the opposite in the hope that they will resist this injunction as well and thereby behave in the way which we desire: surely, parents of adolescent children are more than familiar with that strategy.

Clinicians have used paradoxical methods for many decades,[1] but their arrival in the field of family therapy is fairly recent.[2 3] In Europe the work of the Milan team has been particularly influential.[4] Their treatment sessions of anorectic and psychotic patients and their families culminated in the whole family being 'paradoxed' with a prescription telling them to continue with the symptom and related behaviours because it benefited the whole family. The patient's symptoms were viewed as a (failed) solution to problems involving the whole family. The patient's efforts to resolve the family problem were therefore positively connoted as this apparently being the only thing that he or she could do 'in the service of the family'. This 'sacrifice intervention' often resulted in the symptoms vanishing, but families frequently vanished from the treatment too.[5] Some parents subsequently complained that they had been told by experts that self starvation or hearing voices were a 'good thing' and that their offspring had been encouraged to remain ill or even get worse. This not infrequently led to considerable acrimony between referring doctors and paradoxical therapists. The latter thus had to modify their approach and make a shift away from implying that a family 'needed' a symptom. Nowadays symptoms are seen as something that people have got used to, habits which are hard to break. In this way it has been possible to avoid seeming to approve of some terrible symptom.

What then is paradoxical about such an approach? If a patient wants to be cured of a symptom but appears to resist any therapeutic efforts, he can be released from this apparently paradoxical situation by means of a 'counter-paradox'. The patient is thus put in a bind: he can only resist treatment by giving up the symptom, or else he can only maintain the symptom by giving up the resistance. With treatment resistant patients or families this intervention creates a bind: the patient can only 'win' (or defeat the doctor) by not following the prescription of 'no change': he therefore has to relinquish the symptomatic behaviour. If, however, he follows the prescription of doing more of the same, the patient accepts what the doctor is asking him to do, namely to produce his problems deliberately. Learning to produce the symptomatic behaviour at will can teach one a lot about how to prevent it at will. It is therefore a first step to attaining control over a problem.

There are other paradoxical techniques apart from symptom prescription.[6] By using restraining strategies the therapist apparently attempts to slow down the patient's efforts to overcome his problems. Therapists can do this by discouraging or even denying the possibility of change, so that sometimes the patient may get better to prove him wrong.

Other paradoxical methods include positioning techniques, which are at times used by apparently accepting and exaggerating the

patient's illness position: the therapist may for instance 'outdo' the patient's pessimism by defining the situation as even more dismal than he (the patient) had held it to be. This may force a patient or family to assume a counter position, namely encouraging the therapist not to give up and showing some positive changes so as to keep the therapist engaged in the treatment process.

In the field of paediatrics paradoxical approaches have been successfully used for the treatment of persistent enuresis and encopresis, tics, sleeping and eating disorders, chronic abdominal pain, speech disorders, and other conditions. To date there are, however, no systematic studies evaluating the long term effect of this work.

As can be seen, this approach is far from straightforward and it is hardly a first treatment choice, as one may risk alienating patients as well as colleagues and losing therapeutic credibility.[7] It is therefore important to place paradoxical techniques in context: they are only one of many different family therapy techniques,[8] and are best only used as a last resort, once the more straightforward approaches have failed.

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