Paradoxical Treatment of Severe Depression: An Unconventional Therapy

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Abstract

This paper describes the use of a paradoxical technique called prescribing the symptom with patients who are depressed and potentially suicidal. Nicholas Cummings has published cases where he provided suicidal patients with cyanide and challenged them to kill themselves. Several other paradoxical interventions are also described as a way to highlight ethical issues related to the use of such techniques with depressed clients. The literature on using paradoxical techniques in psychotherapy is reviewed. No empirical support for the use of such techniques with suicidal patients was found.
Paradoxical Treatment of Severe Depression:
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Could it ever be considered ethical for a psychologist to give a suicidal patient a cyanide capsule and challenge her to take it? This is one of the paradoxical interventions used several times by prominent psychologist Nicholas A. Cummings. While some therapists have reported success with paradoxical techniques for insomnia and agoraphobia, only Cummings is known to have treated severely depressed and suicidal patients by prescribing the symptom. Cummings is well known for his efforts promoting the integration of psychotherapy into managed care, but his controversial therapeutic techniques are less familiar. This paper provides a description of Cumming’s extreme approach to working with depressed and suicidal patients, a summary and critique of some cases he has published, and an overview of the ethical issues regarding the use of paradoxical interventions.

The Cummings Model: Focused Psychotherapy

Nicholas A. Cummings has been called “psychotherapy’s most quotable soothsayer and, arguably, one of the prime architects of modern mental health practice” (Simon, 2001). His numerous awards attest to his high regard in the psychological community. According to his daughter, he “has received every honor and award the profession has to bestow” (Thomas & Cummings, 2000. p. xviii). Cummings launched the professional school movement by founding the California School of Professional Psychology in 1969. He was president of the American Psychological Association (APA) in 1979 and was also a Director of the Mental Research Institute (Awards, 1985). He wrote the first prepaid psychotherapy insurance benefit, conducted research on the
medical cost offset effect of psychotherapy, and founded American Biodyne, the first psychology-driven managed behavioral health organization. Biodyne grew to 14.5 million covered lives in thirty-nine states before Cummings sold it in 1992. He has authored several books and has received the APA Award for Distinguished Professional Contributions in 1984 and the Gold Medal Award for Life Achievement in Practice of Psychology from the American Psychological Foundation (Gold Medal, 2003).

Cummings is recognized more for his medical cost offset research than for the model of psychotherapy he developed and taught Biodyne psychologists to use. According to Cummings, throughout his career he has practiced psychotherapy, seeing forty to fifty patients a week along with his other activities (Wright & Cummings, 2005). His approach to psychotherapy is his own unique blend of psychodynamic psychology and strategic therapy that he called Focused Psychotherapy. He has described his approach as “psychojudo” and “psychological surgery” (Cummings & Sayama, 1995, p. 41). He described many cases to show how psychojudo works in the book *Focused Psychotherapy* (Cummings & Sayama, 1995).

Cummings received his psychoanalytic training at the William Alanson White Institute in New York and began a training analysis with Erik H. Erickson, but Erickson terminated the analysis after a few months, so Cummings was never fully analyzed. Nevertheless, Cummings became a practicing orthodox psychoanalyst (Sayama, 1986). Later he was briefly a director of the Mental Research Institute, where strategic therapy and many paradoxical interventions were developed (Fisch, Weakland, & Segal, 1982). His unconventional therapeutic techniques are based on psychodynamic assumptions, leading him to use tactics such as “entering the delusion” and “mobilizing rage,” (which
are described below) but often he utilizes strategic tactics such as prescribing the symptom, overwhelming resistance, and denying treatment (Cummings & Sayama, 1995). Cummings said “Although some people call me a ‘strategic therapist,’ . . . I stress that psychodynamics are the road map of the treatment plan. That is the way I formulate the case” (Cummings, 2000, p. 402). Thus, his approach might be seen as founded in psychodynamic assumptions but applied using strategic techniques in brief therapy.

The Technique of Mobilizing Rage

Cummings accepted the psychoanalytic idea that depression is anger turned inward. The theory was that anger toward a loved one becomes guilt, resulting in depression, self-directed hostility, and possibly suicide. However, this theory has been disproven (Tavris, 1989). There is no simple relationship between anger and depression, and there is no more reason to think that depression is anger turned inward than that anger is depression turned outward. Simple equations between depression and the “direction” of anger have not been supported (Klein & Wender, 2005). Cummings stated “It is a well-known axiom that every suicide is really a homicide turned inward” (Cummings, 1984, p. 207).

If one believes that a patient’s depression is really rage directed inward, then one solution is to externalize the rage; Cummings technique was to make the patient angry toward the therapist. He wrote that since reactive depression is introjected rage, he used Frieda Fromm-Reichman’s technique of mobilizing rage in the service of health; the patient is meant to displace anger toward oneself or a loved one onto the therapist (Cummings & Cummings, 2000). Supposedly the result would be relief from the depression. Cummings recognized that this technique was risky; he said “an intervention
that might be termed psychological surgery” could result in “psychic blood” or even be deadly (Cummings & Sayama, 1995, p. 54). According to Havens (1986), provocative statements by the therapist encourage the patient to externalize their blame and rage onto whoever is convenient. If the patient acts out violently due to the therapist’s instigation, real damage could result. It is unclear how the therapist is supposed to channel the patient’s rage precisely in a certain direction. Although it is rare, patients do sometimes attack their therapists. Given the lack of evidence for the depression/anger hypothesis, and the existence of well established treatments for depression, Cummings’ use of the “mobilizing rage” technique with suicidal patients would seem to be reckless and unnecessary.

The Technique of Overwhelming Resistance

Cummings and Sayama (1995) called their model “psychojudo” to highlight their assumption that clients resist change, and the term psychojudo suggests using the resistance and converting it into momentum for change (p. 41). The strategy is to design a treatment plan utilizing, deflecting, or overwhelming the patient’s resistance in the service of growth. Cummings (2006a) wrote “Think of it as turning around an ocean liner . . . . the pilot must go in the direction the ship is going and turn it around slowly until it is going in the opposite direction . . . . By going with the resistance, the patient eventually turns around and then therapy moves rapidly without the fear of change. Paradoxical intention is a useful technique in psychojudo” (p. 132).

In the Focused Psychotherapy model, as described by Cummings & Sayama (1995), anxiety is considered the basic psychological problem; when defenses are breached, anxiety results, and the patient regresses to strategies that were developed in
childhood to respond to trauma. These strategies may have worked then, but are maladaptive when applied to current problems, and anxiety results. The anxiety increases the regression and the resistance to change. Cummings’ therapy techniques are meant to utilize resistance in the service of healing. The therapist should “employ creative interventions” and “enter into unconscious realities hidden from the patient himself or herself” (Cummings & Sayama, 1995, p. 7). It is unclear exactly how therapists are to enter the unconscious reality of the patient; for one thing, how can the therapist know for sure what the patient’s unconscious reality is?

“Prescribing the resistance is a variation of psychojudo. By directing the patient to continue behavior that seems anti-therapeutic, the therapist surprises the patient’s defenses, [and] forces oppositional patients to adopt the position of the therapist” (Cummings, 2006a, p. 132). Cummings (2006b) advised therapists to raise the intensity of therapy: “Doing something therapeutic that is both unexpected and novel often catapults a wishy-washy patient into intensity” (p. 297). While almost all theories of psychotherapy agree on the existence of patient resistance, theories differ widely regarding the causes of resistance and the best methods for dealing with resistant patients (Beutler, Molerio, & Talebi, 2002).

Cummings believed that some resistant patients require that the therapist take drastic risks; the intensity of the therapeutic technique must equal the intensity of the patient’s resistance (Cummings & Sayama, 1995). An example of Cummings’ technique of prescribing the resistance is found in his work at American Biodyne with patients diagnosed with borderline personality disorder. He put eight “borderline women” into a treatment group and called it “The Losers Group;” he told them “I have a side bet that
you’re all going to flunk” (Yalom, 2009). This was meant to motivate the patients to change by prescribing their resistance and mobilizing their anger at him (they would overcome their condition simply to prove him wrong). It is difficult to understand why patients with a lifelong personality disorder would suddenly become motivated to overcome it simply because a therapist called them losers and expressed doubt about their ability to change. Cummings said the technique worked, but no documentation of the effectiveness of these interventions has been found in the literature.

Cummings appears to assume that most patients are oppositional and resist change. While this idea has a long pedigree in the psychoanalytic literature, there is no actual evidence to support it. Some therapists have re-conceptualized resistance and see it as a message regarding how the patient can best be helped (de Shazer, 1985). A patient who “resists” the intervention of one therapist may be very cooperative with the intervention of another therapist. Presumably all patients who seek psychotherapy are open to change (at least to some degree) or they would not be there. Other therapists have conducted research that established the stages of change model (Connors, Donovan, & DiClemente, 2001; Miller & Rollnick, 2002). In this model patients are seen on a spectrum of readiness for change, rather than as resistant or cooperative.

The Technique of Entering the Delusion

Cummings accepted Frieda Fromm-Reichman’s ideas about how to treat patients diagnosed as schizophrenic by joining them in their delusions. She taught him that because delusions occupy time and space, there is only room for one person in each delusion. So the therapeutic technique is for the therapist to enter the patient’s delusion; that is, act just as delusional as the patient. If the patient is playing with feces on the
floor, the therapist should put on rubber gloves and get down on the floor and play with the feces too. Supposedly this would make the patient give up the delusion (Cummings & Sayama, 1995). As with many psychoanalytic techniques, this idea has not been subjected to rigorous research, so there is little reason to think that “entering the delusion” is an effective way of treating delusional patients.

The Technique of Doing Something Novel

Novelty has been utilized by many influential psychotherapists, particularly Milton H. Erickson, Jay Haley, John Weakland, and Richard Fisch. The idea is to introduce to the client a new way to view the problem or react to the problem. While all therapists endeavor to help the client act, think, and/or feel differently than before therapy began, in the Focused Psychotherapy model the novelty is introduced in the first session. Other brief therapists have suggested that while novelty can be useful when applied skillfully, novel interventions should not be so novel that the client rejects them as shocking, impossible, or undesirable, unless the therapist is using a paradoxical intervention, in which case the client is expected to reject the intervention (Budman, Friedman, & Hoyt, 1992).

An Example of doing Something Novel and Prescribing the Symptom

As an example of doing something novel in the first session, Cummings described the case of Grace, a schizophrenic and alcoholic woman who was referred by a colleague. Grace sometimes fell to the floor and “stopped breathing, turning blue and becoming cyanotic, at which point the therapist was obliged to call the paramedics to resuscitate her, literally saving her life” (Cummings & Sayama, 1995, p. 44). Cummings prepared a paradoxical intervention for Grace. When she fell to the floor in the first session with
him, he picked up a camera to take her picture, searched for the film, fumbled with it, and “talked excitedly to Grace, encouraging her to keep up the performance so it could be recorded for medical history” (Cummings & Sayama, 1995, p. 45). Cummings said she soon got up and sat back down in her chair.

Cummings described his technique with Grace as doing the unexpected. He was also prescribing the symptom by telling her to continue to hold her breath. This technique was fairly safe, since it is not actually possible to die by voluntarily holding your breath. It is unclear why previous therapists had treated her holding her breath as a medical emergency. At some point Grace would lose consciousness and normal breathing would automatically resume. At any rate, prescribing the symptom meant that Grace would have to find a different way to express her distress. Whether the technique produced any real improvement in her condition is unknown.

Controversial Ideas and Methods

As stated in the biography on his website, Cummings has been controversial all his life (Cummings Foundation, 2011). His work has been criticized on several fronts. One line of criticism has focused on Cummings’ role in facilitating the incorporation of the practice of psychotherapy into managed care. Rainville (2011) noted that Cummings now laments the decline of clinical psychology, even though it was his promotion of managed care that “brought psychotherapy to its current poor state” (p. 20). Cummings is emphatic that psychological practitioners are not in the mental health business or the psychotherapy business; they are in the health care business (Cummings, 2005). He attributed the decline of the profession of psychotherapy to their lack of business skills,
rather than the corporatization of the profession, which resulted in greatly reduced fees for psychotherapy.

Shulman (1988) made the case that in the Biodyne model the interests of patients were secondary in importance to organizational demands for cost savings. Clear evidence for Cummings’ claim that insight into clients’ dynamics underlying the presenting problem could be achieved in one or two sessions was never provided. The Biodyne model of therapy promoted the corporatization of health care (Shulman, 1988). Similarly, Kuttner (1991) wrote that Biodyne specialized in an aggressive brand of managed care; Biodyne’s earnings depended on minimizing treatment costs (such as hospitalization) rather than providing needed care. Biodyne was sued for gross negligence after a suicidal patient killed himself shortly after Biodyne psychologists overruled emergency room doctors who wanted to hospitalize the patient; the defendants denied any wrongdoing (Kuttner, 1991). Eventually the lawsuit was settled for an undisclosed sum, thought to be in excess of a million dollars (Kuttner, 1999).

Little criticism has been directed toward Cumming’s psychotherapy techniques. This is surprising, given how unconventional many of his methods are, but it may be that most psychologists are simply not aware of them. A few psychologists noted his extreme techniques after *Focused Psychotherapy*, Cumming’s book on his therapy model, was published. Vaillant (1996) called the book “exciting and controversial” with “creative suggestions” and “sometimes shocking approaches” (p. 1131). Hoyt (2002) described the cases in the book as “thought provoking and at times controversial” (p. 127). MacFarquhar (1996) described one of the cases in *Focused Psychotherapy* as “the kind of story that sends more conventional therapists into a panic” (n.p.). Cummings has written
that “It really doesn’t matter how many mistakes you make in a session. It really doesn’t. Good therapists make a lot of mistakes” (Sayama, 1984, p. 172).

Perhaps the most controversial cases that Cummings has published describe how he sometimes works with depressed and suicidal clients. His approach is based on the assumption that the dynamic of depression is anger turned inward to an introject of the hated object; the patient’s rage can be mobilized to expel the introject. A convenient object for the redirected rage is the psychotherapist. Cummings reported that patients often become quite angry at him and at other therapists who follow the Biodyne model. Cummings reported that in one research project, at follow-up many Biodyne clients said “He [the therapist] made me so mad I realized I had to solve this myself” (Cummings & Follette, 1976, p. 172).

The Cyanide Intervention

Cummings first described the case of Beth in an interview with Sayama (1984, p. 175-177), parts of which were published in the book *Samadhi* (Sayama, 1986, 116-118). He also described the case in training workshops for Biodyne psychologists (Cummings, 1985). This author attended the workshops and worked at one of the Biodyne centers in Phoenix in 1985-87. Cummings also described the case of Beth and similar cases in his book *Focused Psychotherapy* (1995, p. 71-75); apparently he felt these cases illustrated important principles of his model. These sources can provide more context for the cases than space allows here.

According to Cummings, Beth was a schizophrenic woman who had painful sores all over her body due to neurodermatitis. She had the sores for 11 years and had been seen by 60 psychiatrists and psychologists and scores of physicians, was taking 23
medications, and had exceeded $750,000 in health care (Cummings, 1985). Cummings decided that she was slowly killing herself in an unconscious effort to punish her husband, who had an affair. According to Cummings, the family had been told that if the skin condition got worse it would threaten her life if sores developed in her trachea. His diagnosis was rage depression (major depression), and he said her schizophrenia was being acted out somatically. Beth admitted she was determined to die, but not anytime soon; Cummings saw her skin condition as slow suicide. After other strategic interventions failed, Cummings developed what he called a “drastic strategy” (Cummings & Sayama, 1995).

Apparently Cummings believed that Beth was suicidal, but that she was only interested in killing herself slowly rather than quickly. She was expressing her anger toward her husband by having eczema (somaticizing her rage). Cummings’ treatment plan was to mobilize her rage by making her angry at himself rather than her husband; hopefully this would relieve her depression and her skin condition. Cummings would call Beth’s bluff, and prove that she was not immediately suicidal; he would prescribe the symptom by inviting her to kill herself, and offering her an easy way to do it. Cummings said “I explained to her that she was killing herself . . . . Your [sic] acting out of your psychoses is so massive you’re going to kill yourself” (Sayama, 1986, p. 117).

Cummings was well aware that he was about to make a very risky intervention; he wrote “I don’t know if the world is ready for this. I think a lot of people will accuse me of godplaying. . . . You have to take the risk that they might kill themselves” (Sayama, 1984, p. 176). Cummings had a cyanide capsule that he had taken from a German officer in World War II and kept as a souvenir. He met with Beth, put the capsule on her bedside
table, and told her “He would then leave the room for 15 minutes, during which time the patient had the option of ending it all. He then added that this might be a relief for all concerned, but he doubted that she had the courage” (Cummings & Sayama, 1995, p. 74). “I would say ‘I’m tired of this bullshit. This thing of dying slowly, of committing suicide slowly is a lot of bullshit. This is cyanide. I’m going to walk out of here. You have fifteen minutes to swallow that cyanide . . . . I challenge you to take it’” (Sayama, 1986, p. 117).

When he returned to the room Cummings found Beth alive and defiant; he took back the cyanide, and “spent 15 minutes telling Beth she was indeed a coward, and a fraud as well” (Cummings & Sayama, 1995, p. 74). “You’re a goddamn fraud. You don’t have the guts to kill yourself so you’re killing yourself the slow way and punishing your family and everybody around you” (Sayama, 1986, p. 117). Beth said “I’m mad at you. You have no right to talk to me this way” (Sayama, 1984, p. 177).

The procedure with the cyanide capsule was repeated four times over the next four weeks. “Every Friday I’d talk to her for fifteen minutes. Then I would walk out, and she would have fifteen minutes alone with the cyanide. Then fifteen minutes afterwards I would berate her for being a goddamn phoney” (Sayama, 1984, p. 177). Cummings reported that by the sixth week Beth’s neurodermatitis had begun to subside; she berated Cummings angrily, which he took to mean that “she was beginning to expel the introject” (Cummings & Sayama, 1995, p. 75); later she divorced her husband and rebuilt her life, according to the case description. Cummings fails to note any other possible reasons for Beth’s improvement, such as the medical treatment she was receiving at the same time or other events in her life outside therapy.
Cummings described his techniques in this case as mobilization of rage and overwhelming the resistance; the homework he gave her was to “commit suicide rapidly.” Cummings believed that Beth wanted to kill herself slowly, but not quickly, and that if he offered her cyanide she would probably not take it. The paradoxical prescription seems to be based on the formulation: You seem to want to die, so take this capsule of poison and you will die. If you do not take the capsule, it proves you do not really want to die, so you may as well stop killing yourself slowly by having the skin condition.

A reasonable question would be, if one were determined to try this this kind of technique, why not use a fake cyanide capsule? The patient would have no way to know about the deception and there would be no risk of her dying. Cummings said “Had the psychologist chosen to use a harmless capsule, claiming it was cyanide, Beth would have seen through the ruse. The therapist’s emotions left no doubt but that the game was real and deadly” (Cummings & Sayama, 1995, p. 74-5). This makes clear that what was a “game” to Cummings was deadly serious for the patient.

This case raises several other interesting questions. First of all, there seems to be some confusion regarding the patient’s diagnosis. Cummings titled the case description “Beth – Death by Neurodermatitis” and he also referred to her condition as “nervous sores” (Cummings, 1985) and as “hives” (Cummings & Sayama, 1995, p. 72). Clearly, he thought she had a psychosomatic condition (called a somatoform disorder in DSM-IV). However, neurodermatitis is eczema typically created by scratching, and it is not usually considered particularly serious, let alone life threatening (Merck, 2008). It is possible that Beth’s skin condition was psychosomatic, but it is unclear whether prior treatment
had included preventing Beth from scratching. Cummings describes the skin sores as if they simply appeared without any apparent cause, due to Beth’s desire to harm herself.

Regarding her diagnosis, Beth is described as having “Rage Depression (Major Depression)” and was “determined to die” (Cummings & Sayama, 1995, p. 75). Beth was also diagnosed as “psychotic” and “schizophrenic” (Sayama, 1986, p. 116). So Beth had schizophrenia, major depression, a somatoform disorder, and had suicidal intent. Cummings’ paradoxical technique was based on the idea that her eczema was due to her somatizing her rage toward her husband. Cummings thought that Beth was killing herself slowly with neurodermatitis but that she was not suicidal in terms of wanting to die rapidly. What is unclear is why making Beth get angry at Cummings (for calling her “bluff” about being suicidal) would have any effect on her skin condition, her depression, or her schizophrenia. Apparently Beth never said she wanted to die anytime soon, or directly by her own hand, so why would refusing to take the cyanide be significant? And why would getting angry at Cummings change the anger she felt toward her husband? According to Cummings, as Beth’s anger toward him increased, her neurodermatitis subsided. In Cumming’s model, apparently just mobilizing the patient’s rage toward the therapist somehow negates the patient’s original rage toward her husband. Another question is how this paradoxical intervention cured Beth’s schizophrenia. According to the case description, “Today she’s living a normal life” (Sayama, 1986, p. 118).

The case of Beth also raises ethical issues. Was it ethical for a psychologist to give a schizophrenic, severely depressed and possibly suicidal patient an easy means to kill herself? Would such an intervention have been justified if Beth had really had a life-threatening condition? Was it legal for Cummings to give Beth a cyanide capsule and
leave the room, or would this be considered assisted suicide if Beth had killed herself? If Beth had taken the cyanide and died, would Cummings have published the case study? Should paradoxical prescription be used with suicidal patients? And finally, what are psychologists meant to learn from this case study? Cumming’s purported successful use of paradoxical prescription in this case implies that psychologists who have clients who are engaged in some form of “slow suicide” should be challenged to commit suicide quickly rather than draw it out.

Cummings said he offered cyanide capsules to three different patients, because “These people were going to die of psychosomaticizing . . . . you have to bring them face to face with death the fast way in order to get them to want to live. You have to take the risk that they might kill themselves” (Sayama, 1986, p. 117). It is unclear why the therapist has to take the risk that the patient will die. Was there any research or evidence of any kind that informed Cummings’ decision to use the cyanide intervention? Why did he (apparently) not try safer and more established psychotherapy methods first? If Cummings thought it was highly unlikely that Beth would take the cyanide, he would probably not have been too concerned, but he makes it clear that he really did think Beth might take the cyanide and die: he “sweated clear through his suit as he experienced strong chest pains” and he “slept poorly and ate little. He lost several pounds;” he felt “constant terror;” his “emotions left no doubt but that the game was real and deadly” (Cummings & Sayama, 1995, p. 74-75). This seems to indicate that Cummings knew there was a real risk of Beth killing herself with his cyanide capsule; she was not simply pretending to be suicidal. Cummings must have known that if Beth killed herself he would be held responsible for her death.
Another difficulty with this approach is that one never really knows that a patient will die from a psychosomatic illness. For example, in the case of Beth, was there really any certainty that she would die from a skin condition she had had for 11 years? Should individual psychologists be given the authority and responsibility to offer patients cyanide if they might have a terminal condition? Was Beth really suicidal? She may have had a psychosomatic skin condition or she may have been scratching herself so that her sores would draw attention to her and cause her husband distress.

Cummings was convinced that Beth had unconsciously created her skin condition as a way to commit slow suicide. This would seem to be a very unusual and not very efficient way to die. Smoking and anorexia have also been considered methods of slow suicide by some psychologists, but this idea has been debunked, as has the idea that suicide is a manifestation of suppressed rage (Joiner, 2010). This provides further evidence that a paradoxical approach to treating a severely depressed and potentially suicidal patient is misguided. A review of 14 recent texts on the treatment of depression and the prevention of suicide revealed no mention of paradoxical treatment methods. Chiles (1995) stated that the first rule when treating a suicidal patient is to do no harm, and the second rule is to use only treatment approaches with evidence of their effectiveness.

Cummings has apparently not published case studies of the other two patients to whom he gave cyanide. We do not know their diagnoses, treatment histories, or whether they actually had terminal illnesses. We do not know if they were really suicidal of if Cummings just thought they were, and we do not know the outcome of the cases.

Paradoxical Treatment of Suicidal Patients
In describing how to work with suicidal patients, Cummings and Sayama (1995, p. 225) wrote that “therapists tend to err on the side of too much caution” and that overly cautious therapists may miss the lethality of depressed clients and escalate the nonlethal suicidal activity of borderline patients. He advised therapists not to be overly kind to suicidal patients, and to never take responsibility for their lives. “Successful interventions might require tough love, or what we term the spilling of some ‘psychic blood’” (Cummings & Sayama, 1995, p. 229). “Traditional and wimpy do-gooders often just increase the patient’s sick resolve” (Cummings & Sayama, 1995, p. 72).

In discussing treatment for borderline patients, Cummings and Cummings (2006) wrote “The therapist must never be intimidated by the patient’s threats of suicide . . . . Once the therapist buckles under the threat of suicide or psychosis, he [sic] becomes fair game for a disdainful patient that will thereafter unceasingly hold the threat over his [sic] head.” (p. 161). Cummings particularly recommended the use of paradox with borderline patients who are suicidal. For example, he described a case where he told a borderline patient “you could be Nick Cumming’s first suicide. . . . I’m going to ask you a favor . . . . Come up with a suicide that will at least make the headlines.” When the patient said he decided to jump off the Golden Gate bridge, Cummings said “Is that the best you can do? Kill yourself any way you want to, but you’re not worthy of being my first suicide. The hell with you” (Cummings & Sayama, 1995, p. 231-232). Cummings maintained that if this is said mischievously with a smile or an eye blink then the borderline client will love you. The outcome of this case was not reported; did the patient eventually take Cummings’ advice to commit suicide?
Interestingly, Cummings’ daughter, Janet, used the very same paradoxical intervention with a female borderline patient. She told the patient she was writing a book chapter on suicide, and “If you are going to be my first suicide the least you can do is come up with something dramatic enough to make my chapter incredibly interesting;” when the client said she planned to jump off a high bridge, Cummings said “I’m disappointed. That’s been done and overdone . . . . You need to come up with something better than that” (Cummings, J. L., 1996). She concluded “As with most interventions for nonlethal patients, the therapist is free to be creative and innovative” (Cummings, J. L., 1996). This raises some questions. How could she have been 100% sure that this borderline client was not suicidal? According to her father, “Borderlines will kill themselves in despair” (Cummings & Sayama, 1995, p. 231). How does her statement that therapists are free to be creative with nonlethal patients relate to her father’s case with Beth, in which he was certain that Beth was suicidal, and he tried to convince Beth that she was suicidal, but then he hoped that she would not take the cyanide he gave her?

Cummings described the case of a woman who had gone to the hospital emergency room seven times with her wrists slashed; each time it took hours to sew her up (Cummings, 1985). Cummings met with her and gave her a 20 minute lecture on how to successfully commit suicide by slashing her wrists. “I showed her what direction to cut in, how deeply she would have to go, where the arteries were that you wanted to sever, and I said ‘If you follow my instructions there will be no way anybody will be able to rescue you’. . . . I left and went home to bed.” Cummings considered this a successful intervention because the patient stopped trying to cut her wrists; her next suicide attempt
was by an overdose of aspirin (Cummings, 1985). No diagnosis or follow-up information was provided for this case.

In another case that Cummings described, Elaine was a mother of three children who intended to kill herself by taking a bottle of Valium and walking into the ocean. Cummings “agreed with her that, sadly, she was right: committing suicide would be the best assurance her children would be properly cared for” (Cummings & Sayama, 1995, p. 56). Cummings told her she did not have enough Valium and pointed out that she could obtain more by getting small amounts from each of several physicians. He then asked if he could cancel her next appointment, since she would be dead anyway. The reported outcome was that the patient never again threatened suicide. Of course it is possible that Elaine remained suicidal but did not mention it because she felt rejected by Cummings. He described the technique he used with Elaine as mobilization of rage and prescribing the symptom through paradoxical intention (Cummings & Sayama, 1995). As with all of these cases, the long-term outcome is unknown; did any of the patients eventually commit suicide? No follow-up information is provided.

Linda was a patient Cummings diagnosed as a depressed hysterical; she was suicidal and her therapist had taken away the prescription pills she planned to use to kill herself. Cummings, acting as supervising psychologist, suspected she was infatuated with her therapist. He told her that he was convinced she would kill herself. “He [Cummings] said he would be returning her pills and he wanted to be notified as soon as she had committed suicide. He would then fire her therapist for incompetence” (Cummings & Sayama, 1995, p. 59). Linda promised not to commit suicide and said she would continue therapy if her therapist were not fired. Cummings called this technique to treat reactive
depression the mobilization of rage. He commented “Since the dynamic of reactive depression is anger turned inward to an introject of the hated object, mobilizing rage can be particularly useful in expelling the introject (Cummings & Sayama, 1995, p. 59).

These cases raise some of the same ethical issues described above regarding the case of Beth. Is the technique of challenging a borderline patient to commit suicide in a creative way ethical? Is it ethical to encourage a client to obtain enough prescription drugs to kill herself? It would appear that these are extremely risky methods, and Cummings provided no citations to any research that would support their use. Just by describing them, and their positive outcomes, he appears to recommend them. It would not make much sense to say, in effect, I used these techniques, and they worked very well, but no one else should use them. If they are ethical and effective, why not?

Cummings has said that successful therapy may require taking risks. He criticized the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2002) as being outmoded and too restrictive. The “guidelines are taken too far and become transformed into artificial boundaries that serve as destructive prohibitions that undermine clinical effectiveness” (Cummings, 2003, p. 119); and effective therapy may “require the undertaking of spontaneity within the context of prudent, well-designed therapeutic risk” (p. 122). “I believe strongly that if we were not so bound by our sacred cows, we could discover far more effective techniques than we have” (Cummings, 1988, p. 310). The question is whether therapists should ignore ethical principles in the search for creative psychotherapeutic techniques.

The Ethics and Effectiveness of Paradoxical Techniques
Adler (1956) was the first theorist to write about using paradoxical strategies in psychotherapy, including paradoxical prescription (telling clients to engage in their symptomatic behavior). Victor Frankl (1967) said he had used paradoxical intention since 1925, and Rosen (1953) described his use of several paradoxical techniques. However, the theorists and psychotherapists at the Mental Research Institute wrote the first book to formalize the practice of paradoxical psychotherapy (Watzlawick, Beavin, & Jackson, 1967). Prescribing the symptom is a paradoxical technique with a long history; it was developed as one of several paradoxical interventions by therapists at the Mental Research Institute (MRI), and was based on the work of Milton H. Erickson. Jay Haley’s *Uncommon Therapy* (1973) was an influential book about the unusual and often paradoxical techniques used by Milton H. Erickson. Haley (1963) wrote that paradoxical strategies utilize defiant clients’ resistance to promote change. Cummings was director of the MRI for a while and was evidently heavily influenced by Haley, Erickson, and the staff of the institute.

The use of paradoxical psychotherapy has always been somewhat controversial (Brown, 1986). Some critics have called it dishonest and unethical. “No therapeutic procedure has been or is so attacked from an ethical point of view as the so-called paradoxical procedures” (Deissler, 1985, p. 88). One danger of paradox is that it can be applied unethically by a therapist who wishes to enhance his or her own sense of personal power at the client’s expense (Deschenes & Shepperson, 1983). Fraser (1984) wrote that paradox should not be used even as a last resort, because to do so might mean withholding a more effective kind of treatment.
Most of the research on the effectiveness of paradoxical interventions is based on case studies and anecdotal reports. Although there are clinical reports that attest to the efficacy of all types of paradoxical interventions, empirical evidence from controlled studies indicates that some are not supported (Shoham-Saloman, Avner, & Neeman, 1989). Paradoxical psychotherapy has not gained widespread acceptance and has no underlying theory to guide its development or practice (Weeks & L’Abate, 1982). It may eventually become more accepted, but the proponents of paradoxical therapy must provide more data on its safety and effectiveness (Hunsley, 1988). Fabry (2010) examined the evidence base specifically for paradoxical intention and found 19 outcome studies, all but two of which were more than ten years old. For purposes of the review, paradoxical intention was defined as inviting the patient to intend, even if only briefly, that which he or she feared, with the aim of countering anxiety. Most of the outcome studies focused on patients with insomnia or agoraphobia. Most of the studies were small, and not all included control groups, but all but one of the studies yielded positive results. Fabry (2010) noted that paradoxical intention was incorporated into Cognitive Behavior Therapy (CBT) over 20 years ago, and is sometimes used today as part of a CBT treatment program.

According to Ghadban (1995), “The ethical and legal implications of using these techniques need to be examined closely” (p. 17) and prescribing the symptom “should be used cautiously by highly skilled therapists” (p. 18), but no criteria for defining “highly skilled therapists” are provided. Based on his research, Foreman (1990) concluded that the use of paradoxical interventions requires that the means, as well as the ends, should embody generally accepted ethical principles. Some critics have commented that
paradoxical strategies are unlikely to be ethical since they involve manipulation and deception (Ridley & Tan, 1986) and they do not comply with most psychologists’ ethical principles and standards of practice (Schmidt, 1986).

According to Dowd and Milne (1986), paradoxical techniques should not be used with borderline, suicidal, impulsive clients, or clients with severe mental illness or affective disorders. They also state that paradoxical strategies have been shown to be ineffective with clients in crisis. Encouraging a suicidal client to commit suicide can be disastrous if done sarcastically (“There’s the window – go ahead and jump!”) (Tennen, Eron, & Rohrbaugh, 1985). Apparently unaware of Cummings, Hunsley (1988) wrote that no therapist would ever advocate that suicidal clients be encouraged to experiment with various methods of self-destruction.

There is no research to support the use of prescribing the symptom with suicidal clients. What if the intervention backfires? Writing about paradoxical interventions, Weeks and L’Abate (1982) said “the clearest contraindication is for destructive behavior, especially homicidal and suicidal behavior. Needless to say, a therapist would not prescribe suicidal behavior” (p. 65). Paradoxical intervention with suicidal clients would most likely be unhelpful, and thus irresponsible. Foreman (1990) emphasized that paradoxical interventions require the client’s consent; should not be used with depressed clients; and non-paradoxical techniques should be preferred where possible. According to Ascher (1989), paradoxical strategies are contraindicated in cases where there is potential for destructive behavior, including suicidal ideation and intentions. He advised therapists to resolve therapeutic stalemates through listening, negotiating, and collaborating with the patient rather than using a paradoxical intervention.
Some of the current APA Ethical Principles that might be relevant to the use of paradoxical prescription with suicidal patients include Principle A (psychologists take care to do no harm) and Principle C (psychologists do not engage in fraud, subterfuge, or intentional misrepresentation). Relevant standards include Standard 3.04 (psychologists take reasonable steps to avoid harming their clients/patients) and Standard 10.01 (psychologists obtain informed consent to therapy and inform clients of the potential risks involved) (American Psychological Association, 2002). Textbooks on ethical issues in counseling and psychotherapy emphasize the risk that paradoxical approaches may be harmful. Nontraditional approaches that have limited evidence of effectiveness may be used only if more proven approaches are unsuccessful (Welfel, 2010). A psychologist who prescribes behavior (e.g., prescribing the symptom) has a responsibility to make sure that no one is harmed as a result of the directive. Some paradoxical interventions are thought to have a high risk of negative outcomes (Remley & Herlihy, 2005).

One of the problems with case histories such as those described by Cummings and Sayama (1995) is that it is difficult or impossible to substantiate their claims. Usually only cases with successful outcomes are reported, and there may be no way to independently verify the outcome of the cases. The reader must take the case reports on faith, trusting the writer not to embellish or exaggerate (this is one reason case studies are not considered particularly good evidence). MacFarquhar (1996) said Cummings’ “too-tidy, whiz-bang case histories . . . . often sound too neat to be trustworthy” (n.p.). Paradoxical techniques may not become popular until much more good quality research supporting them is conducted. Paradoxical psychotherapy must demonstrate its
effectiveness empirically before it could be seen as the treatment of choice for a difficult case, and the clearest contraindication is for suicidal behavior (Weeks & L’Abate, 1982).

Conclusion

Some psychotherapists have reported the successful use of highly risky and remarkable techniques that have the potential for disastrous results. One such therapist was Milton H. Erickson. Lynn Hoffman (1981) wrote “One can read through Haley’s book on Erickson, or peruse Erickson’s own articles, and appreciate the amazing ideas and the incredible outcomes but be no wiser as to how one might replicate such work . . . these things are simply not replicable” (p. 338). Nicholas Cummings visited Erickson and admired him as a therapist, saying he was “iconoclastic, and wasn’t afraid to take risks” (Sayama, 1984, p. 171). Cummings’ Focused Psychotherapy model might be another example of an approach that makes for interesting reading, but raises significant ethical issues, and should not be practiced by any psychotherapists. Cummings himself used the cyanide intervention with three patients, but he stated “Unequivocally it is not something that should ever be done by any therapist” (Cummings & Sayama, 1995, p. 71). This raises several questions. If the cyanide intervention should never be done, why did he do it? If it worked so well with three patients, why did he stop doing it? Does he really believe it is ethical to give a severely depressed, suicidal patient the means to commit suicide? To his credit, Cummings recognized that he would be liable if he made a mistake: “If I do a technique by the seat of my pants and my patient does suicide, maybe I deserve to be sued or whatever” (Cummings, 1985). One concern is that “seat of the pants therapy” is probably inherently dangerous and not particularly likely to be effective.
Until clinical and empirical research is conducted to support the use of paradoxical interventions with suicidal patients, they are best avoided. But it is hard to imagine how it would be ethical even to conduct such research; the extremely high risk of a patient’s death would seem to make such research impossible. What institutional review board would approve such a study? Plenty of well-researched models for the prevention of suicide and the treatment of depressed clients exist, and these should be considered the treatments of choice (Society of Clinical Psychology, 2011). Perhaps psychologists would be wise to follow Cummings’ advice not to do what he did.
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