The Paradoxical Theory of Change

The Paradoxical Theory of Change states that 'change occurs when one becomes what he is, not when he tries to become what he is not' (Beisser, 1970: 77) and goes on to state that 'one must first fully experience what one is before recognizing all the alternatives of what may be' (ibid). Gestalt therapists do not believe that fundamental change can occur until there is a complete acceptance of the individual’s whole personhood, including embracing aspects that the client may wish to amputate from their being. This simple yet profound theory has become a guiding principle for gestalt therapists.

The profundity of this theory is multiplied when considered in the light of its founder Arnold Beisser’s life story from which it developed in true ‘gestalt style’ – experientially. I am grateful to Lynne Jacobs (personal communication) for clarifying aspects of his life story.

Beisser was an intelligent, athletic, attractive man, a US-ranked tennis player, who despite his many attributes was apparently ill at ease with himself. At the age of thirty-two he was struck by polio resulting in paralysis from the neck downwards. Having been an active, virile young man the only things he was then able to do for himself were to eat and breathe, and he could only do the latter with the aid of an iron lung which he needed for the first three years following his paralysis. Following an initial depression Beisser grew to accept his new life and developed The Paradoxical Theory of Change, which in essence had emerged from his personal journey. He was a sociable man, popular with others following his paralysis, his field of relationships reflecting his own self-acceptance. Even with his profound disability he was willing to support friends in any way he could. Towards the end of his life he said that even if it were possible to be given the choice of returning to being the athletic young man he was prior to his paralysis he would not take that option – he had truly become what he was and accepted what was. Apparently, prior to his

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paralysis, Beisser did not consider himself to be a particularly likeable man. His self-perception probably wasn’t shared by those around him judging from the number of people that maintained close contact with him.

If we concentrate on restoring what we decide to be health, we run the risk of depriving the client of the opportunity to live out the life change that is happening and to adapt to that life change creatively. If we attempt to rescue, we can rob the other of the journey to discovering the best creative adjustment to their situation. It is in taking that journey that the client has the opportunity to experience a far more profound learning than we could ever give, as in gestalt theory we firmly believe that there is wisdom in the organism (PHG, 1951). Having said that, most clients who come for therapy want to change something about themselves and their situation in accordance with some preconfigured picture that often involves ridding themselves of some behaviour, thought, disturbing emotion or attitude. If we collude with this impossible task, a counter-force can be co-created with the client who subsequently invests his/her energies in maintaining the status quo through outlining why that change is not possible. We need to notice what is obvious before us. The client wants change, they want something different, but they are sitting before us in their situation fighting to remain the same. If we invest in only one aspect of the client – their desire to rid themselves of the perceived unpleasant quality – whilst this may provide a short-term panacea we miss the aspect of the client that invests in being as they are. Consequently, we miss the complete personhood of the client – what dilemmas they are struggling with, what the change will cost them, the loss involved in the change and the value of that quality. Rather than exploring how to change or what coping methods may be useful, the gestalt therapist and the client co-explore what is.

During the years I spent working in psychiatry, I worked with many clients who experienced auditory hallucinations. Some were distressed by what they described as ‘the voices’ or ‘their voices’ but many were not. Irrespective of the level of distress all were

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6 I would like to be clear that for some of these individuals their auditory hallucinations were so terrifying, threatening or deprecating that for
prescribed powerful anti-psychotic medication. The cost to the client of dulling down their auditory hallucinations was often a host of unpleasant and debilitating side effects. Not surprisingly many of these people tired of suffering dry mouths, constant tremor, drug-induced Parkinsonism, to name a few of these complaints, and discontinued taking the medication. Some sought different supports to discover ways of living with their 'symptoms' rather than fighting against them. Self-help groups formed and a National 'Hearing Voices' network grew. In essence these 'sufferers' accepted this part of themselves rather than treating it as separate from themselves and proceeded to creatively adjust to their situation.

According to Lichtenberg (2008) we cannot coercively change the other in some productive way. Such coercive change can only occur destructively through such examples as oppression, exploitation and domination. One must become who one truly is before constructive, true change is possible.

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