

PROVOCATIVE THERAPY

by FRANK FARRELLY and JEFF BRANDSMA



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Preface 1

I never used to believe in prefaces, they seemed such unbelievable stodgy affairs. But after writing this book with Jeff, I feel like paraphrasing the cowardly lion in the Wizard of Oz and exclaiming, "I do believe in prefaces, I do believe in prefaces."

There are a variety of ways in which this particular preface could be written, but I will simply confine myself to some notes on how the book began.

Several years after the beginning of provocative therapy, Randy Parker, a friend and colleague at Mendota, began urging me to "write a book on your system of therapy", and offered to help me transcribe samples from the hundreds of interview tapes I had. Since at the time I felt dismayed and discourage at the enormity of the task, I accepted his help and we met each week at my house. With June and Donna Goher (Randy's fiancé), we had, within a year's time, a stack of verbatim samples which adequately illustrated the system, but still no book.

Randy and Donna left the city and I felt left behind; however, I continued to keep notes on my therapy, in an attempt to conceptualize further the process. Slowly, the growing stack of notes began to fall almost by themselves into different categories, which became rough chapters and it? was at this time that I met Jeff Brandsma.

He came with two other psychology interns, Gary Emmanuel and Brent Davis, to Mendota in the summer of 1969. In short order we had a seminar in provocative therapy going, and worked on some cases together. The drive and enthusiasm of the "three musketeers" were a real help to me at this time, and in May of 1971 Jeff wrote from the University of Kentucky about finishing the book with

me. He was committed to the idea, wanted co-authorship, and immediately provoked in me a welter of conflicting feelings: I was delighted with his offer of help, and dismayed at sharing my "baby", felt excited about the imminent emergence of the book and fearful I of the book somehow not really capturing in final print what provocative therapy was. But my strongest feeling was one of possessiveness; provocative therapy was mine, mine, MINE.

The reassurances, however, of both June and Jeff around the point quickly settled it for me; I sent him six and one-half pounds of manuscript and notes, and the task began of writing and rewriting. My aim was threefold: clarity, clarity, and clarity. And in that I think we have succeeded.

As our working relationship progressed, It became clear that I had placed myself in the hands of a highly intelligent Simon Legree. I remember fourteen hour days when I wrote and wrote and wrote and Jeff mercilessly saying, "O.K., now I'll give this to Mary Gilberts and you start on ...". But his unflagging interest, his enthusiasm, and drive to completion buoyed me up. His humor, his perceptive contributions, and ability to adapt to my pace, style, and mood rapidly demonstrated that he was not only a co-author, but a brother and a friend.

Now the book is finished, and I think we have, after all, adequately explained provocative therapy in print. And yet I wonder. Just the other day a student indicated her interest in learning provocative therapy, saying, "I've been working with some 'hopeless clients' and I've felt like shaking them to pieces." I cringed, held my head in my hands, saying, 'Hold it! Wait a minute. Provocative therapy is not 'shaking clients to pieces'."

The task of explaining the explanation lies ahead.

Frank Farrelly
August 26, 1973

Preface 2

It is my hope that this book will live up to its title. It was our intention for it to be provocative and at times disturbing, but above all, hopeful. We know that this approach can benefit those who have taught us the lessons contained therein (i.e., patients and clients).

These pages attempt to capture an amazing human being. In the art form which psychotherapy still largely is, there are few artists, but Frank Farrelly is one of them. Out of his history, ambition, behavior, and fallibility has come this effort to make available a different philosophy and a wide range of behaviors to clinicians who haven't quite found "the truth" for all clients or their personal truth as yet. Provocative therapy brings out and emphasizes a more sociological, interpersonal perspective of man, a perspective more attuned to individuals enmeshed in our society's current problems and realities.

My greatest single contribution was to provide structure for this man and his ideas. I was at various times an organizer, monitor, critic, respondent, and contributor; together we labored to discipline and shape these conceptions as much as possible. We decided not to burden the reader with authoritative and research references in this text, but we believe that our statements can or will be backed up by extant or future research.

Reading the book may be a little like experiencing provocative therapy, i.e., with shifts in style and content but so it is. Hopefully it will be productive and enjoyable.

Jeffrey M. Brandsma
August 26, 1973

Acknowledgments

To attempt in several pages to thank the people who over the past twenty years have been "significant others" for me in my professional growth seems an impossible task. To list their names simply does not do them justice. Their support, their kindness, their understanding - it was always there from somebody when I needed it. And need it I did - in carload lots over the years.

When listing these names, I recall the specific things they said to me, and can see the time, the place, the tone of voice - but space does not allow for me to amplify all this.

So here goes, a mere listing of names: it is a list, however, not only of colleagues but of friends: Dom Jerome ("Jim") Hayden, O.S.B.; Kathleen Cole; the late John Palacios; the late Charlie True; Carl Rogers; Jack Riley; Charlotte Hubbard; Forest Orr; Joe Billed; Gene Gedling; Alyn Roberts; Velma Ginsberg; Lee Leasers; the late Virginia Franks; Bill! Jackson; John Thomas; Eve Owens; Randy and Donna Parker; Dick Crossman; Am Ludwig; Carl Whitaker; Lenny Stein; Sal Gambaro; and Lee Elkland.

And I must include my students, trainees and residents in social work, psychiatry, psychology, nursing and vocational rehabilitation - over the past decade and more they have asked the tough questions, confronted and challenged me, and have helped clarify my thinking in innumerable ways.

I also want to thank the rest of the staff .at Mendota State Hospital- recently renamed Mendota Mental Health Institute - over the past fifteen years. Many of them functioned as co-therapists with me and provided much stimulation in our talks after interviews with patients and their

families.

And in addition to all the foregoing persons, I would like to thank God. It's more than a little embarrassing to do this in a book of this sort, and I don't want Him to get any statue for the content or style. I'll take full responsibility for that. Conversely, I don't want Him to get any of the glory - He gets plenty, and I need some. I should add further that His consultation was a little slow in forthcoming at times.

We also wish to acknowledge our secretaries for their patience with our hieroglyphics and their sheer endurance with a great amount of work: Mary Gilberts, Sonja Johansen and Jan Douglas.

And finally we want to thank our wives, June and Anne, for their patience, unflagging support, food and ... but we'll thank them ourselves when we get home.

Frank Farrelly
Jeff Brandsma

Mendota Mental Health Institute
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Throughout the book, the dash (-) indicates, in dialogue or sessions with clients, an abrupt shift in thought or an interruption.

The Beginnings of Provocative Therapy



THERE ARE A VARIETY OF PATTERNS AND rates of learning among students of psychotherapy. Some learn best and are more comfortable with reading books about theoretical systems of psychotherapy, thereby achieving at least a rudimentary cognitive framework within which they can organize clinical phenomena, and then attempt to apply it in interviews with clients or patients. Others seem to exemplify the dictum that "imitation is the quickest mode of learning for the human animal and opt for observing advanced practitioners of psychotherapy in interviews with patients or clients: still others favor audio stimuli such as listening to tapes of therapy interviews. Others prefer watching video tapes of therapy. Finally, others appear to progress faster in "learning by doing" by actually doing therapy with clients and then holding "post mortems" on the interviews with a qualified supervisor or consultant.

I (F.F.) have learned about therapy from all of these methods, including being a client in therapy myself, but the most meaningful mode of learning for me has been doing therapy with clients. Over the years in thousands of interviews with widely differing cases, patients have been my professors; if I have grown and developed as a therapist, it is because of the lessons they have taught me.

This chapter, then, will be a chronological and highly personalistic account of the clinical experiences that I have had and the lesson I derived from them. I cannot stress enough that these experiences did not proceed in lockstep, logical fashion, week after week; I mean to attempt to trace an accumulation of experiences, some of which may have been omitted in this "saga". For a long time the experiences were disparate, broken, odd-shaped pieces of a puzzle that seemed to defy integration.

The names and identifying characteristics of patients have been changed to preserve confidentiality; but the

names of fellow students, supervisors, and colleagues have been included because it was they who helped me formulate and clarify my ideas throughout these experiences. I may have difficulty in remembering five items that my wife asks me to pick up at the grocery store on my way home from work, but I have little or no difficulty in recalling the exact details of time, place, situation, facial expression, tone and inflection of voice, and specific verbatim sentences that clients have said to me in the interviews which I have regarded as embodying significant learnings for me as a therapist. I should also add that my memory has been helped by tape recording approximately 90% of my interviews over the years.

My Very First client

When I began my clinical training at Catholic University in 1956 in the School of Social Work, my field placement was at the District of Columbia Children's Center at Laurel, Maryland. I was one of a group of six or eight students who went there three days a week under the supervision of Mrs. Kathleen Cole. I was very excited to get going and couldn't wait to get my first client. After orientation my supervisor assigned me a case, and she had a conference with me prior to my very first interview. When I asked her what I should talk about she urged me to "explore the familial constellation". I drew a blank at that so she listed some questions "I might ask. With fear and trembling I entered the first interview with a tough looking, 15 year-old white boy from the slums of Washington, O.C. I introduced myself, we sat down, and I told him that I wanted to talk about his "familial constellation".

(Sample #1: S.1)

C. (With a blank look on his face): Huh?

T. (Very tense, but attempting to appear calm): Well, what that means is that I would like to talk to you about your

family.

C. (Nodding): Oh, yeah, sure, why didn't you say so?

T. (Glancing surreptitiously at a 3x5 card with notes on it):
How do you get along with your father?

C. (Abruptly): Okay.

T. (Taken aback): Well, how do you get along with your
mother?

C. Fine.

T. (Sweating profusely): Well, I understand you have an
older sister - how do you get along with her?

c. (Shrugging his shoulders and glancing out the window):
Oh, her and me light, but she's okay.

T. (Nodding "professionally"): I see.

T. (Pause): How do you get along with your younger
brother?

C. (Sharply): Good.

This interchange took about 60 to 90 seconds; I was in a panic because I'd blown all of my questions. The client, loudly smacking his gum, stared out the window, and the rest of the hour passed in dead silence. The interview, in short, was a unmitigated disaster as far as I was concerned, but I did learn one thing - I had to learn, and learn a lot about how to talk with clients and how to develop a broad repertoire of responses. I was determined never to let that type of interview occur again.

The Case of Joey

Another young boy approximately the same age as that of my first client was named Joey. He was a young black boy from the slums of Washington who had been brought out to the Center because he wouldn't go to school. The trouble I rapidly found out in the interview was that he had come from the deep rural South and had never seen so many neon signs, streetcars, and bustling activity in his life. He would start to school but then get lost in wonderment of it all and thus was labelled truant. His parents couldn't see what all the fuss was about, since they had

only gone to the fourth grade, and Joey had already had twice as much school as they - he already knew how to "read, write, and figger".

In our very first interview Joey talked. And he talked. And he talked. I was so grateful to him, I got choked up, tears in my eyes, and wanted to hug him - but that would not be professional ("Sweet Jesus! I've got me a live one!"). He was so much fun to work with that I had interviews with him three times a week. Joey obviously didn't need any help, but I sure as hell did - and he helped me by becoming the "model boy in his cottage". He was so flattered that I took so much interest in him, and I was so flattered that he was helping me feel like I was helping somebody, that he rapidly improved his behavior (mainly going to school, not being tardy, and doing his homework) and was discharged. I learned from him that I could help somebody, that I had very real needs that could be met in this kind of work - not at the expense of somebody else - and that there were certain kinds of clients that it was much more easy for me to work with than others.

The Case of Rachel Slein

My second year field placement was at St. Elizabeth's Hospital in Washington, O.C. where I began to work with a patient I will call Rachel Stein. She had had every type of treatment that a well staffed mental hospital could provide: electric shock therapy, insulin coma therapy, recreational therapy, occupational therapy, dance therapy, art therapy, family therapy, discharge planning, etc., etc., etc. - and the net results of all this treatment had been pretty much "zilch".

I read her thick record before I initially saw her (it came to approximately five pounds of typescript) and rapidly came to the conclusion that I had been assigned her because, as another student put it, "They feel we can't do

these types any harm, and we just might possibly do them some good." I was rather frightened of her because I had read in the record that she had a bad habit of taking all her clothes off from time to time. I remember interview after interview as we went on through the fall and the winter months, constantly afraid that this very large, obese, swarthy gal was going to pull a Lily St. Cyr routine on me. I always interviewed her with her sitting next to the window and my sitting closer to the door so that I could rush out to the nurses' station if she began her strip tease. After seeing her for seven months on a twice-a-week basis and getting absolutely nowhere with her, I was to present her at a staff meeting. Everybody congratulated me on how well organized I was on my presentation, sympathized with me on my lack of progress, offered support and encouragement about "how tough it was to work with the mentally diseased", and suggested that I begin working with the family to accept her "bleak prognosis" while she was being transferred to one of the back wards. To state that I was depressed about all this would be to put it mildly; my supervisor warned me not to let my "Counter transference feelings get the best of me," and told me to begin terminating "the case." Two fellow students of mine who listened to my feelings about Rachel and my interviews with her, excitedly told me to read Carl Rogers' Client-Centered Therapy; they (Frank Hughes and Magnus Seng) had been reading it avidly, talking it over with each other, and had been getting excellent results with some patients with whom they had been working. They reported the patients were talking now about much more meaningful things since they began using the client entered approach, that their patients had shown marked increase in their sociability with 'Other patients on the ward, had measurably improved in terms of task performance areas (ward work assignments, etc.), and that all of

these improvements had also been noted by a number of the ward staff. As a matter of tact, one of Frank's patients had been elected "patient of the month" by his fellow patients on the ward - a title that was given on each ward to the patient who had shown the most marked improvement for the month. Mag and Frank didn't let up on me:

"Read Rogers, read Rogers" was the constant chant.

Finally, to get them off my back, I agreed to read a chapter or two of their new Bible.

I was singularly unimpressed. It seemed terribly superficial and as far removed from the straight Freudian gospel that I had been taught in my training that there seemed little "depth" to it at all. But then I ran across some of the verbatim interview samples in the book, and it struck me, "This is the way it really is, with the broken sentence structure, the 'hub's' , the fractured grammar, the misunderstandings

and efforts to correct them, and allow" The book then became alive for me, and when I went in for my "last" interview with Rachel, I told Frank and Mag: "I'll be Garl Rogers himself in this interview."

I was determined to make every effort to understand Rachel from her internal frame of reference, to start where she was and to stay with her step by step in an effort to achieve "empathic understanding." I began the interview and immediately it felt different to me - and two hours later I staggered out of the interview thinking, "What the hell ... ?" It was a whole different way of looking at people and talking to patients and clients. For the first time in seven months I began to see how things were for her, not just from the hospital staff's standpoint or my standpoint or that of her family and the community at large. From her perspective it made sense for her to act the way she did. It was a very frightening experience, but exhilarating to go into another person's world, into

whatever limbo or "corner or the universe" she inhabited (as I told Frank and Mag soon after), and to see people, places, things, feelings, ideas, attitudes, etc. from her viewpoint. Then her behavior made sense, it all hung together, it was eminently "rational."

I'll never target the excitement of those days; much of my training I jettisoned, many of the lectures and seminars I thought were simply ineffective or beside the point. Frank, Mag, and I had long, long talks and through these I began to reinterpret a number of other things that I was taught in a completely different light and tried to implement these in a very different way. Client-centered therapy for me was a new way of integrating what I had been taught and a way of interacting with clients. My interviews with Rachel, instead of being dreaded experiences, were meetings to look forward to now. I remember distinctly keeping my poor wife, June, up until 2:30 a.m. after this interview, excitedly telling her how I was rearranging all my training and ideas and only stopped talking to her when I finally realized that she had already fallen asleep. I was somewhat hurt, but realized that, try as she might, she could not share fully my excitement at my new "discovery". Within two weeks and six interviews the nurse on the ward received a message from the art therapist (the only activity that Rachel was now in) asking her if anything "new was happening with this patient" - she was drawing markedly different types of pictures in art therapy at this point. The nurse responded that she did not know but that the patient was acting very different on the ward: she was taking far better care of her personal appearance (she had previously only used make-up grotesquely), had spontaneously offered to do ward work, did not need to be dragged out of bed in the morning, but was getting up with the rest of the patients, was attending synagogue on her own, and in general was much less withdrawn and more sociable. In

short, it looked like a "resurrection." The nurse then called me and asked me if there was anything new happening in the interviews with the patient. I enthusiastically told her about "the new me and the new Rachel."

The Rachel Stein case was one of the most significant clinical cases I have ever experienced in my professional career. Looking back at it now from the vantage point of almost a decade and a half later, I wonder whether I am deriving the appropriate meanings from the experiences or simply imposing meanings on them, am I reading them accurately or indulging in a type of need oriented perception? But as I reflect on them I think, no, this is the way it really did happen, this is what those experiences meant to me at that time, and the lessons I derived then still hold true for me today.

The first and most clearly overwhelming realization was that well experienced, highly trained, intelligent, socially recognized "experts" could be wrong - and I, an inexperienced, not yet fully trained, and somewhat confused student could be "right." I realized also that repeated therapies and helping procedures with a given patient could simply be repeating the same errors - and hence be ineffective. I also realized that if the patient had not changed, it was not necessarily something residing in the patient (such as "unconscious resistance"), but that it very well might be that it was the therapies which were at fault, and lacking in some way. It was also suddenly clear to me that no matter how long the patient had been disturbed and no matter how severely, he could change - and change drastically and in an easily observable and measurable way - if only the effective conditions were present. I also felt I had been massively rewarded - that I had been given a gift for having experimented and determined in my future work that if the patient did not respond to one type of approach.¹ I used, I would "go back to the drawing board" and devise

another approach to which they very well might respond. Whether or not he intended to do so, the late John Palacios, who was my supervisor at that time, reinforced my idea that even though you had no business being "right" or effective, you could be. He recounted an incident involving a young, female, graduate student who had presented a case of an old, chronic, male patient that she had been working with in a staff discussion. The general consensus of the professional staff was to terminate working with the patient, that he would never get better. The student was furious and upset at this, and recounted this to the patient, crying openly as she did so. The patient was so thunderstruck at somebody caring this much for him he had never had anybody cry for and with him in this open manner - that he comforted the student and promised that he would get out of the hospital and never come back. He ran away, got a job, and remained out of the hospital!. It was obviously a weird kind of logic operating here, both in my working with Rachel and this student's work with the old chronic patient: she did everything "wrong" and it had turned out to be effective; and when I went to Rachel's "limbo," she began to come into the real world. It is very difficult to convey on paper the extent of my excitement and sense of discovery at this time. I felt a tremendous "freeing up" inside of me, an almost scary surge of energy (I was able rapidly to complete my dissertation and other papers for my courses), and felt things were "falling into place" for me. The richness of the experience for me is perhaps best summarized in a line from a letter I wrote to Garl Rogers at the time: "I feel like I am wading knee-deep in diamonds." I felt a tangible thirst for more clinical experience and especially for work with patients in mental hospitals. Previously I had fought hard not to be placed at the mental hospital where I took my second year field work; now I had

to work with the "sickest of the sick" as I told Mag and Frank at that time. Accordingly, I obtained a job at Mendota State Hospital in Madison, Wisconsin for a variety of reasons - to be nearer my family in the Midwest, to work with hospitalized psychotics, and to be in close touch with Garl Rogers and his client-centered group who were engaged in a large research project at Mendota at that time. Entering this context and group of professional colleagues was probably crucial in many ways. The therapy listening sessions, for example, were particularly helpful. In these sessions, held once per week from 1958 to 1960, we clinicians would present to each other our own taped interviews. These sensitized me to the many different ways clients could feel, the different possible responses (albeit within the client-centered framework), but mainly to continual feedback on my professional work. I learned that to demonstrate one's professional work openly was to invite many "slings and arrows" but also to effectively "program in" a never-ending source of professional development.

The Case of the Malingerer Nut

Not long after I came to Mendota I was working on a male admission ward and began seeing a patient with a history of repeated hospitalizations. He was receiving veteran's compensation because he had convinced the VA that somehow having been in the Army for six months had "driven him insane". He had not had a job since then, and his life had become a routine pattern of going into mental hospitals, accumulating several thousand dollars in VA benefits, and then going out and spending it on a variety of things, including week-long binges of drinking. I had been using a client-centered approach with him, although it was becoming increasingly difficult for me to be warmly empathic with him as he chortled about "beating the system." At one point when I was seeing him, he wrote several

frighteningly obscene letters to a young secretary at the hospital. I found out that he was the author, and "throwing therapy out the window" (as I put it to myself at the time), I became furiously angry at him, telling him that "if you write one more line to her Like that, I will personally see to it that you are locked up in seclusion and the key thrown away." He angrily and spontaneously replied, "You can't hold me responsible - I'm mentally ill!" I was stunned at this reply - I had never heard any patient so blatantly hiding behind what to me was obviously an excuse for his behavior. I realized that by "blowing up" I had bypassed his censors and inhibitions and had reached a very spontaneous, central assumption of his, i.e. that he would do whatever he liked the way he Liked whenever he liked because he was "mentally ill". It also became clear to me that here was a "certified, mentally diseased" patient who supposedly had "lost touch with reality", a patient who had very accurately interpreted the central, core message of my training (and virtually that of the entire field) - that the emotionally and mentally disturbed "can't help it" and were not to be held responsible for their actions, but instead were immune to the usual social consequences for their behaviors.

In my reply to him, however, I bypassed my training, the general tenor of clinical literature at that time (and what largely still obtains in the clinical literature of today), and instead replied: "I can't hold you responsible, huh? Well, you just try me, buddy, and see how far it gets you." And I went on to tell him that I was pissed off at him, that whether he thought it was "fair for me to hold you responsible or not, I'm going to do it." When in the remaining weeks and months of his hospitalization he no longer wrote any such letters to any female at the hospital, I came to the conclusion that the "mentally ill" have not at all lost "contact with reality," but that they knew perfectly well

what they were doing in most instances and were, in a sense, clever social systems analysts. But I did not feel comfortable with these conclusions at the time and so I shelved them for the time being - a reaction that I had with several other of my clinical experiences.

Tragedy Revisited

In 1959 I began consulting out of the hospital one day per week; one of my very first cases that I had transferred to me from another worker was that of the wife of one of our patients. The staff thought that the patient was paranoid regarding his wife's fidelity; the task was to try to get some data on this and to clarify the case. After an initial transfer interview (the worker stated, "I suspect she has been unfaithful to him, but in interviews over the past year she has constantly denied it."), I went to see her as a consultant. The very first day - it was a Monday - that I was to see her, lover slept. June woke me hurriedly, explaining that she had not pulled the alarm clock button out all the way, and in a flurry I dressed, gulped a cup of coffee near the front door, jumped into my car and drove quickly out to the isolated farm house where she lived. I remember feeling very anxious, thinking, "This is it. Now I am a consultant." I also remember talking to myself as I drove, telling myself that I must make the interview helpful on my own budding professional skill alone, because I did not have any professional office accoutrements to help me. In the interview the wife sat on a couch across the living room from me. I leaned forward with my elbows on my knees, my legs spread apart, intently trying to get across to her that we really needed to know about this matter: if she had not been engaged in this kind of behavior, then her husband was paranoid; on the other hand, if she had been, then we were holding her husband in the hospital under false pretences. Throughout the interview she avoided eye

contact with me and seemed to be staring at my nondescript tie with a vague, preoccupied look on her face. To my surprise she openly admitted the whole thing and went into great length about whom she had had sexual relations with while her husband was at the hospital and prior to his admission.

I drove away from that interview with my chest puffed out, feeling elated, very skilful, and a real "pro". I also gloated over the fact that my colleague had worked unsuccessfully on precisely this point for a year, whereas I had been able to elicit the information in a single interview. And I thought, "Man, real skill will win out."

My elation lasted until I arrived at the county courthouse. I went to the toilet to urinate, found that my fly had been open during the entire interview, became beet red in the face from acute embarrassment, and stayed in the room for five minutes because I was so rattled. Upon returning to the hospital I told the ward staff exactly what happened. They guffawed uproariously at my whole "new approach to treatment": "Open Fly Therapy," was the appellation they gave it. Psychologist friends stated ponderously that this proved the dictum, "Change the stimulus, and you change the response." (The patient, it should be added, was rapidly discharged with recommendations for outpatient therapy for him and his wife.)

There were several lessons to be learned from my chagrin. I realized that alongside of the pain and tragedy in this field are some of the funniest things I've ever heard, and that the comic as well as the tragic mask seem to embody the main themes in the clinical field. I learned to laugh at myself, at my mistakes, to share my "bloopers," and that other clinicians could often be sympathetic or supportive if I were open about my professional work.

The Congruence Experiment on the

Clem Kadiddlehopper Case

That same year (1959) I talked the ward psychologist into running an "experiment" with me. I told him that I knew that empathy, warmth towards, and caring about patients were helpful. But I had recently read Carl Rogers' "Necessary and Sufficient Conditions of Psychotherapeutic Personality Change" (1957) and wanted to experiment with maximizing therapist congruence and genuineness in an interview and to evaluate the effects. My ideas were that we would choose a patient nobody else wanted to work with, that we would tape record every interview (to include a half-hour interview and a half-hour "post mortem" on the tape), and that during the interview we would make available to the patient any thought, feeling, reaction, or bit of feedback we had about him. And not only were we to be congruent in general with the patient but also with each other; if either of us said something to the patient that the other did not like or felt uncomfortable with, we would immediately "call each other on it", ask the patient to wait right there in the room with us, and "thrash it out" then and there with each of her.

After I set things up, the patient came into my office and immediately asked, "Are we tape recording this?" The patient presented an inimitable sight: he was without his false teeth, he had a shock of red hair standing four inches straight off his head - looking as though he were holding an electric fence. He had two squinty little pig eyes, a bulbous tomato nose, and talked Like Red Skelton's Clem Kadiddlehopper.

I promptly went into hysterics, holding my aching sides and laughing until tears streamed down my face. The psychologist froze, cringed away from me, frowned, and stated, "Frank, that's no way to - what are you doing?" I gasped out through gales and guffaws of unstoppable laughter, "I can't help it - he's so screamingly funny!"

"Clem" looked from me to the other of us and stated, "No, it's okay, that's been the trouble. I try to make people laugh, then they laugh sometimes when I don't want them to, and I get hurt and mad and into trouble." Bingo! (Our experiments continued on a weekly basis, the patient was much improved, and was discharged a month or two later.) One thing in my mind was very clear: that radical congruence, if held constant, was very helpful to patients in interviews; that I could not only laugh at patients without detriment to them but even with help to them; that laughter towards patients was not inevitably "demeaning their dignity". I also felt very freed up in interviews. I wasn't "grinding my gears" and my responses towards clients weren't going in one direction while my thoughts, reactions and feelings were going in another.

The Case of the Dangerous Psychopath

In 1959 I had occasion to work with a patient who was in on criminal observation and was considered dangerous. I had taken an extensive social history from his family; he knew that I had seen his wife and mother and would be presenting my findings at diagnostic staff that week. He had talked to the psychiatrist and psychologist, and now wanted to see me. In a well thought out, organized manner, and with great sincerity he spoke for twenty minutes on how he had certainly had time to think since he had been in the hospital, had seen what a mess he had made of his life, realized that he and his wife needed marital counseling and wanted to obtain this when he left the hospital, recognized that he needed vocational training to learn some marketable job skills, etc., etc.

Throughout this recitation of his I sat and listened; at the end he asked me, "Well, Mr. Farrelly, what do you think of my case?" At this point I saw in my mind's eye as though written on a blackboard the sentence, "Since I'm

not going to be doing therapy with this patient, I can afford to be honest with him." I cringed as soon as I "saw" the sentence, but, stalling for time, I asked the patient, "Do you really want to know what I think?" The patient nodded seriously and sincerely and remarked, "Yes, sir, that's why I asked." I drew a deep breath and said, "Well, I think it's the slickest con job I've ever had pulled on me." Leaning forward, with an enraged expression on his face, he hissed, "I feel Like telling you, 'fuck you' and getting up and walking out of here." To which I replied, "Well, then, why don't you?" "Because I want to get through to you," he exploded, and then he became, before my eyes, a changed person. For over a half hour he spoke in broken sentences, jumped about from topic to topic, demonstrated primitive expressions of rage that were barely controlled, showed marked variations in voice tone, rapidity of speed, and choice of words, exhibited fright at "losing his mind." In a word, there was a marked contrast between the first and second part of the interview, and the latter part had the unmistakable ring of authenticity.

I explained to him that I needed to go to another building on the hospital grounds. While driving over to another building in the car, he asked me, "Am I going to be committed or released?" I replied, "I don't know, but as soon as I find out after the diagnostic staff, you'll be the first to know." He continued, "If I do get out, can I come back and see you for therapy?" "Why?", I questioned. He meditatively rubbed the car seat next to his leg and replied smoothly, "Well, I'm interested in psychology ... " Irritated, I rejoined, "Cut the crap - why me?" He paused and then stated in a subdued tone, "I'll give it to you in my own words." "Shoot", I replied. "Cause you don't give me no shit off the wall."

By confronting and being "emotionally honest" with this patient, I found I could build a relationship of trust in one

hour better than I had with some patients in months of interviews.

The Case of the Slutty Virgin

In 1960 I was leading an in-hospital therapy group in which there were ten women patients. The one I remember was a young, borderline mentally defective woman, age 20, who spoke mainly about how much she enjoyed being at Mendota State Hospital, that she enjoyed going to the movies and to dances and Canteen, that she liked bowling, swimming, baseball, volleyball, horseshoes, basketball, and tennis in recreational therapy, but wondered when "we were going to get horseback riding here." The rest of the group of women burst out laughing at her, but I got annoyed and accused her of "having a country club syndrome." I had seen the beneficial results that our extensive activity therapies program had had with our patients, especially those of the lower educational class who were not particularly oriented towards the "talking therapies." It became clear to me, however, that we were, with some patients, furthering and reinforcing dependency and "hospitalities" in an effort to make up for their "deprivation." The result was what I termed with this patient a "country club syndrome".

I further told her that she was not in therapy for this type of thing but instead to find out why she came to the hospital and what kinds of problems she was having here that were keeping her in the hospital, and how to get out of it and stay out of it. She burst into tears and stated that she was upset because "the boys around here say I'm a slut, but I'm not - I'm really a virgin." I was just irritated enough at this point to "throw therapy out the window" again and tell her, "Well, you talk like a slut, you dress like a slut, you walk like a slut, and you look like a slut. And you say you've been telling "dirty jokes" in the Food

Service cafeteria, so the guys over there are going to think, 'Well hell, if she's openly like this, what's she doing in secret?' It's not what you are objectively, kid; it's the image you create in of her peoples' minds - they're going to treat you in terms of that subjective image they have of you."

The patient tearfully remarked, "But I'm not that kind of girl." The other women in the group then told her, "Georgie, you know Frank's right. We know you're not that kind of a girl, but those boys over in Food Service don't .. Some of them pointed out that she was wearing a blouse at least several sizes too small for her (and since she carried a pair of 44's on her chest, the effect was eye- and button-popping), that she was poured into a tight skirt that was at least 6 inches too short for her (this was years before miniskirts came into style), and, in general, "acted like that kind of girl."

By this time she was sniffing and asked the women what she should do, because "she really wasn't that kind of girl." They offered to help her with her dress, manners, and way of talking, and she eagerly accepted their help. Within a matter of a week or ten days, she was dressed in a blouse that fit her (the effect was still devastating, but somewhat more demure), had her hair fixed in an attractive way, was using makeup sparingly, was wearing (according to the styles of that year) an appropriate knee-length skirt, was walking in such a way that no longer suggested that her rear end was a semaphore flag attached to ball-bearing hips, was no longer telling "dirty jokes," and in general appeared like a very attractive "young lady," as the other women in the group told her.

She was given massive support from the group for her changes, her depression lifted, her behavior changed dramatically, and the rumors suddenly ground to a halt. She was developing new friendships, was learning the

difference between being warm and friendly versus being blatantly seductive, felt that now "I got my self-respect, and I get respect from others." Her family was delighted with the changes, wanted her back home, and within a matter of two weeks she obtained a job in her home community and was discharged. She has remained out of the hospital ever since.

I was euphoric, walking on air. Georgia had effected a transfiguration. And it was all so easy to see, it made so much sense, it wasn't some mysterious "spontaneous remission," but instead, something tangible, measurable, and easily observable, with at least several dozen people (staff, fellow patients, and family members) agreeing on the changes that she had made.

I learned several basic lessons from the case of the "slutty virgin." First of all it became even more clear to me that people could change drastically and maintain these changes. Secondly, it was obvious they could change in a relatively short period of time. Thirdly, a vicious circle of feelings, attitudes and behaviors that was working to the detriment of the patient could be changed into a beneficent chain reaction of (1) changed behavior, (2) praise and positive feedback, (3) changed feelings and attitudes - leading to more changed behavior which in turn led to more praise and positive feedback from the social reward system. Still further, I learned that a group had power to change a person. I had thought that group therapy was simply a superficial, although economical substitution for individual therapy; my experience with this group effectively counter conditioned that idea for me. It was obvious that if you could get patients "tuned in" toward how other people felt and thought about them, and if you could show them how they could change those negative evaluations on the part of others, they could bring about changes in themselves relatively quickly. And finally it was proved to me that

people will treat you according to the image they have of you in their head and guts - how they subjectively perceive you, not how you are "objectively," whatever that was. So the therapist's task is to get the patient in touch with this feedback either by (1) the therapist himself telling the patient, or (2) by getting the patient to listen to what others tell him spontaneously (and this feedback, one of the most potent sources of change, is available every hour of every day); (3) and finally getting the patient to ACT on this information.

Counter transference Revisited

In the early 60's one of the biggest bugaboos in the clinical field was "watch out for your counter transference feelings towards clients." At this time I had several experiences which radically altered my ideas and clinical behaviors in this regard.

I was working with a male patient who had broken every rule in the book and was continuing to reiterate his innocence because "he was mentally ill." I recall the setting exactly. He was standing above me on a stairway and I was giving him some feedback regarding his breaking the rules and people getting "fed up with him." At this point he shouted, "You sound just like my father!" (In previous interviews he had said that it was his father who "caused" his "mental illness.") Therapist: (feeling taken aback, thinking, "Oh my God, now I've blown it!", to my own astonishment almost looking back over my shoulder to see who had said this and blurting out) "Then your father and I would get along famously, buddy!" .

I've had repeated experiences Like this in the clinical field and in my own personal life of going along on one tack with a person and thinking one thing while blurting out another, frequently the exact opposite. The "staircase interview" began a slow, dawning realization that my "blurt

outs" frequently hit the nail on the head and were more helpful than my measured, professional compositions. About this time I was talking to another social worker over lunch regarding my "blurt outs", my "counter transference" feelings, and my dawning suspicions that these frequently, if communicated to the patient, were proving most helpful. I can recall his stating: "I always try to keep my irritational feelings out of the interviews." I rejoined, "Well,- you know what I'm learning? I'm trying to put them in it. They seem to be better than my trained, professional responses. "

I then told him about my almost physical, tangible sensation of putting my hands to my head and lifting it off my shoulders and putting it in a chair next to me while I used more and more of my "counter transference" feelings in interviews with clients. Rather than laboriously composing responses, I now seemed to have a wealth of responses, a reservoir (hitherto untapped) of reactions and responses I could give clients. Although in some ways I was concerned about these responses of mine towards the clients, nonetheless they did seem to be consistently helpful.

Part of the explanation I formulated at that time (through talking with colleagues) was that it seemed as though people became frightened, suspicious, scared of others, and paranoid because they did not have access to an ongoing feedback system about others' feelings and reactions to them. In working with families of patients, they would tell me their feelings about their hospitalized family member. I remember one case distinctly where the wife came in and wept, was angry at her husband, recounted at length the problems she had had with him and their marriage, was frightened of his response to her when she would see him for the first time on the ward, felt very badly about his being in the hospital, and genuinely

missed his not being home.

After I took the social history she asked me, "What do you think I should tell him when I see him?" I pointed at all my notes and stated, "Why don't you tell him all this, how you miss him, how you're angry and annoyed at him, how you feel guilty about putting him in the hospital, how you couldn't put up with his behavior any more, how you want him back very quickly, and so forth?" The wife was aghast, and it suddenly struck me forcibly that no wonder our patient was suspicious, fearful, confused. He had every damn right to be, If he felt that something was "going on behind his back," that was the long and the short of it.

There was!

In speaking about the "staircase interview" to some of my friends on the project, they referred me to Standal and Corsini's book, *Critical Incidents in Psychotherapy*. When I read it, the whole book seemed to echo my experiences: in case after case the therapist finally "threw therapy out the window," vented some long pent-up feelings toward the patient, and the patient got better. The only explanation could be that the feelings instead of being "counter transference feelings" were very appropriate and needed information for that patient to work on.

I was also referred to Whitehorn's research regarding the "A and B styles" of relating to patients. This, too, gave me support to continue expressing my attitudes, ideas, and feelings about patients' behaviors. I also became increasingly convinced that my own experience, even though I was an unknown, relatively inexperienced social worker, did have validity for me. It could be used as added "pieces to the clinical puzzle."

The Therapist as a Horticulturist, a Midwife, or a ... ?

In 1961-63 when I was a therapist on Rogers' project at Mendota State Hospital, we used to have weekly administrative

meetings as well as weekly clinical meetings. It was in one of the latter that I began to confirm myself in a new role with patients and clients.

Two images that seemed to have real meaning for Carl at this time when speaking of the role of the therapist, were the roles of midwife and horticulturist. The horticulturist, I remember his saying a number of times, merely provided the appropriate conditions for the seed's growth. In the same way he felt this was what the therapist did to provide growth for the client. (Cf. "Necessary and Sufficient Conditions of Psychotherapeutic Personality Change," 1957)

And the midwife, another analogy he used a number of times, did not create the person but merely assisted in his birth.

I was becoming increasingly frustrated in my work with patients and clients using the client centered approach and waiting for the client to initiate most if not all actions and behaviors. And I remember distinctly the meeting in which finally I vented my frustration and told the project clinical meeting, "I'm sick and tired of trying to be a horticulturist or a midwife. I'm not any good in either role. What I want to do is to pry apart these people's shells, penetrate through to their core, and inject some LIFE into them." (In saying this I was pulling my hands apart, throwing my fist forward, and suddenly opening my hand with splayed fingers to indicate "injecting some life in them") Allyn Roberts, who was listening, chuckled and stated, "Frank you're so phallic!"

It is obvious that I was learning that the more passive, receptive, traditional role of the therapist was not for me. was increasingly unable to listen solely to the patient while ignoring the loud and clear signals from my own viscera, and the feedback I was getting about these patients from families, staff, and other patients. And I remember telling people at the time that I "want the whole ball of wax." I

wanted to put into the interview not simply a sensitively empathic understanding of the patient's experiencing, but also to program in the way other people experienced him to give him feedback from whatever *soirée* I derived it.

Patients Can Change if They Choose - and How

In 1963 I was working on an adult female ward and was having a last interview with a patient who was to be discharged that day. I was speaking of what she could anticipate when she returned home. She anxiously stated, "My family is going to be watching my every move." I responded supportingly: "No, they won't." Suddenly the "light turned on" again and I said, "Yes, you're right, they will be watching you Like a hawk. They're going to be wondering if you're going to be like you were when you had to come to the hospital!. During the first week they're going to be 'charting' your behavior every hour in all of your roles as wife, housekeeping, mother and cook - and your husband's going to be checking you out as a sexual partner, too, and watching your expression of feeling and anger. During the second week they're going to 'continue the observation' but will probably remark to themselves, if you're maintaining an even keel, that 'she seems to be in good control as long as we closely supervise her.' In the third week they're going to be saying to themselves, 'It's too good to be true, could it be possible that she's changed?' During the fourth week they're going to be saying to each other behind your back, 'She has changed - but will it hold up?' And during the fifth week they're going to be saying directly to you, 'You have changed, thank God!' During the sixth week they will drop their 'charting', and from there on out, if you maintain a basically even keel, you're just going to be treated like everybody else. The point is, you can change the picture that your family has of you in their heads by engaging in the exactly

opposite behaviors on your part and holding them all the time, and it won't take you anywhere near as long to change your 'rep,' your reputation as you did in getting it. And it won't take any more effort, maybe even less, to act sane than it did to act Like a nut."

What became clear to me was that patients' formulations were frequently more accurate than ours. I also learned (in follow-up with the patient who did exactly what I told her to do and felt support from my predictions which turned out to be true) that she'd changed drastically. The family was talking of a "miracle". From these and some other experiences I learned that patients could change drastically if they choose to do so.

I can still see the patient's face as I explained this to her - her initial aghast expression when I agreed that people "would be watching her Like hawks," and then her interested and alive expression as I explained to her how people would act towards her if she were "on an even keel" and held these adaptive behaviors over a relatively short period of time. And again in my head there was a "click" phenomenon. It made sense. What I told her was in some ways just plain, common sense. It was a very low level inferential explanation. There was no necessity for abstruse literary referents or dipping back into 2000 year old Grecian mythology to explain to her herself, her family, and the near future. It was all basically so simple, so easy to understand how people got nutty, and easy to understand and predict how they could get "un-nutty." I sensed a lawful, interactional progression that patients and their families went through. Instead of this being an abstruse, so-profound-you-can-hardly-understand-it experience, it was easy to understand, easy to reduce to the practical level and explain it to patients so that they could see it and how it worked or could work in their lives.

The lesson that came out of this experience was that

people did not have to be seen "for five days a week for seven years," as some clinicians at the time were saying was necessary for some of these disturbed patients with whom I was working. It struck me that that was clearly impossible and it occurred to me that "if it's impossible, it's not necessary." We would simply have to find better and shorter ways of reaching and helping these people.

The Demise of a Client Centered Therapist

From 1961 to 1963 on a regular weekly basis I saw a young patient who had had 36 different admissions to six different county and state institutions. For the first 25 to 30 interviews I had been employing a client centered approach with her. In approximately the 30th interview the client used the "answer" technique to drive me out of my receptive, reflective role. (I later came to adapt this technique for my own use in interviews. When clients avoided an important area of discussion, I learned to "go for broke" - reasoning to myself, "Some you win, some you lose, and on some you get rained out" - and to focus on that topic until they either ceased avoiding it and openly discussed it, or left therapy. Ninety-nine percent have chosen in this struggle of wills to discuss the anxiety laden topic.)

C. (Looking steadily at therapist with half-closed eyes; in a flat tone of voice.): What do you really think of me? I want to know.

T. (Nodding): Mhm, it's important to you.

C. (Flatly): Answer.

T. (Pauses briefly; warmly): There is an edge in your voice - sounds like you're irritated.

C. (Flatly; louder): Answer.

T. (Nodding his head.): Mhm, kind of, "come on, damn it!" Is that it?

C. (Even more firmly): Answer.

T. (Still forging ahead): You really want some outside person's opinion of you, that kind of feeling?

C. (With robot-Like sameness of tone.): Answer.
T. (Chuckling): And I guess you're saying, "I'm gonna make you tell me," is that it?
C. (In a flat tone): Answer.
T. (Thinking to himself, "Okay, damn it - I'm gonna wind up and let you have it right between the eyes"; in a slightly irritated tone.): You really want to know?
C. (With a faint smile; using the same tone of voice): Answer. (5.2)

I then gave her a 10 to 15 minute dissertation about herself, the main theme of which was that she was a pain in the ass to all and sundry. I didn't choose my words carefully or try to have any type of warmly empathetic tone of voice. I was angry and I let her see it. At the end of my tirade, the client smiled and said with self-assurance, "I thought so." The lesson from this for me was very clear that genuine anger could be very helpful to clients. She had thought for some time that people (not only me) were irritated, annoyed, and put out with her; demanding and getting free access to my experiencing of her and knowledge about her put the therapeutic relationship on a new basis of trust.

Some months later I left on vacation out of state. When I returned, I learned in the first interview with her (by this time she was out of the hospital and I was seeing her on outpatient basis) that she was rapidly returning to the identical types of behavior that led to her recent hospitalization. I "blew up" at her and shouted angrily, "God damn it! I go out of town for two weeks, and here you are, wallowing around in the same old shit! Here you were, coming along fine, and now what the hell's gotten into you?" In response to this angry tongue lashing, the client smiled and nodded to herself. She then told me that all her previous therapists, as soon as she began getting better, began to cut down on the number of interviews, explaining to her that they did not want her to become "overly dependent"

on them. Still angry, I told her in no uncertain terms that she did not have to engage in this kind of behavior to continue seeing me, and that I would see her "every week until I'm 94 and you're 82, and we're both in the nursing home together and I'm muttering at you through toothless gums." She chuckled at this remark, and immediately became "her new, improving self" again. The lesson I learned from this was never to give up on a client, and to stick with them as long as they needed me. I also learned that they could turn on and oft "crazy behaviors" for purposes of their own.

Over the ensuing months the client made and established a number of long overdue, easily discernible changes. Once her newfound behavioral changes were well established and the repetitive cycle of hospitalization seemed definitely ended, she decided that she no longer needed to see me in therapy. During the last interview asked her if she remembered how I was with her when was first seeing her and how I had "switched" after the "answer" interview. And I asked her of the two ways I had been with her, which seemed more helpful to her. She paused for a moment, looked at me directly, and stated, "Let me put it this way. I don't drive 300 miles round trip each week to be by myself."

Bart Starr, the Green Bay Packer quarterback at that time (in the early 60's), observed that once, after several years in the NFL, when he was over center, he felt as though "scales fell from his eyes" and he could suddenly "read" the opposition's defences. It struck me that this description exactly described my own significant professional (and personal) learning experiences with patients and clients. There was a suddenness to these experiences, as though "scales had fallen" from my eyes, as though somebody had turned a light on, as though the clinical phenomena I had been looking at for so long and so

intently had suddenly come into focus.

I would feel excited and exhilarated with each new discovery of mine; but at other times my feelings were almost those of despair, of giving up, of feeling that few people (other than some psychologist friends - such as Forest Orr, Charlie Truax, Allyn Roberts, Gene Gendlin, Joe Biledo, and some others) talked "my language", let alone understood what the hell I was talking about.

Thoreau's statement, "If a man does not keep pace with" his companions, perhaps it is because he hears a different drummer. Let him step to the music that he hears, however measured or far away", at times was supportive. At other times it seemed the height of poetical stupidity. It sounded beautiful, but in my mind's eye I would frequently and literally see the picture of my marching down one road while the whole world seemed to be marching off in the other direction, and it made my "music" seem like a cacophony of dissident, discordant, sour notes which made me feel like running after them, yelling, "Hey, fellas, wait for me!" To say that I felt very isolated at times. simply doesn't catch it. I didn't feel abandoned, because I knew I had chosen to march down this "road," but at other times it felt like I had to, that I had a "monkey on my back" as I told June repeatedly (yelled at, would be more accurate). I seemed driven at times, not really free, and it was hell. But with each discovery of a new piece of the "puzzle", my feelings and behaviors were identical. I would feel tinglingly alive and exhilarated, unbelievably "lucky" and fortunate, while simultaneously having a strong sense of deserving, of justification, of "I knew it, the missing piece had to be there." Then I would share my "finding" with June, and next my colleagues, demonstrating to the latter in interviews with patients how the "piece fit". We would discuss and argue at length, at great and at times (to them) boring length. And then it was back to the "laboratory" of

the interviewing room, testing it out with as wide a variety of clients as I could - with groups, families, and individual patients - until I would reach the point that it would become obvious that even though the piece was valid, and had obvious application to a number of cases, it wasn't enough. I was a perhaps necessary but not sufficient condition of change.

My colleagues' reactions to my "discoveries" were varied. Some were supportively encouraging. Some were intellectually curious and puzzled. Others shared my excitement. Still of hers were justifiably annoyed with my dogmatic and, at times, arrogant assertions of having discovered "THE Truth". Jack Teplinsky, a young psychiatrist with the Rogers project once asked in an annoyed tone "when in hell I was going to develop a Little professional humility". My response was, "I can't afford it yet. If I were in my 60's, had my books translated into umpteen different languages, and had gobs of honors given me like earl, then I, too, could be warmly soft, humble and scientifically tentative." His guffaw of laughter seemed friendly and supportive. His chuckling remark that "when you're 60, Frank, your attitude isn't the only thing about you that's going to be warmly soft" seemed uncalled for. But I realized that I was learning as much, if not more, from people who disagreed with me (because they provoked and stimulated my thinking) as I was from those who supported and agreed with me. And I had a growing feeling that I was on the "right track", that I was collecting pieces of experiences that were real, that I was not simply reading in meanings to these that were not there, that the puzzle was slowly, gradually beginning to tit together into what we now present as "Provocative Therapy."

The Beginning of Provocative Therapy

In July of 1963 I was continuing participation in Carl Rogers' project with chronic schizophrenics at Mendot,

State Hospital!. While in the 91st interview with the patient whom I'll call "Bili", I "stumbled" onto what felt like , crystallization of these previous experiences. Because I had not yet integrated my learning experiences and was G member of the project, I felt somewhat constrained to use a client centered approach with this patient. I had been essentially communicating three basic ideas to him: 1) You are worthwhile and of value; 2) You can change; and 3) Your whole life can be different. He, in turn, had been persistently communicating back to me three complementary responses: 1) I am worthless; 2) I'm hopeless and can never change) and 3) My life will always be one long psychotic episode and hospitalization. It was becoming increasingly clear that empathic understanding, feedback, warm caring, and genuine congruence were simply not enough and were getting us nowhere. At this point I "gave up" and said to him, "Okay, I agree. You're hopeless. Now let's try this for 91 interviews. Let's try agreeing with YOL about yourself from here on out."

Almost immediately (within a matter of seconds and minutes, not weeks and months), he began to protest that he was not that bad, nor that hopeless. Easily observable and measurable characteristics of his in-therapy behavior started changing. For example, his rate of speech markedly increased, his voice quality changed from a dull, slow motion, soporific monotone to a more normal tone of voice with inflections and easily noticeable affect. He became less over-controlled and showed humor, embarrassment, irritation, and far more spontaneity. In a very embarrassed tone, he spoke about his "regressing" (a favourite, central term in his emotional lexicon) but felt that I had been of great help to him. I replied, "Help? Hell, I started seeing you a year and a half ago on a locked, closed ward, then you moved out to an open ward, then you got discharged from the hospital, and now here you are, back again on a

closed, locked ward. Well, if I've been of any help to you and you're showing any kind of progress, you're moving with all the speed of a turtle encased in concrete."

He became red in the face and stated that I shouldn't expect too much too soon from him: "it'll probably take me two or three years of resting up here before I get out of the hospital!". My heart sank down to my liver, but I disregarded my affective response and blandly replied, "Yeah, I can see you now, as we go on and on towards the second 91st interview. You'll probably 'regress' more and more as you keep saying, until I'll be feeding you your Pabulum like a tiny baby." Then in a coaxing voice I added, "Come on, Billy, take your Pabulum." He blushed beet red and burst out laughing; I continued, "Then you'll probably lose control over your bowels and bladder (he again blushed furiously and laughed explosively), and I'll have to change your diapers, which we'll have to make up out of bed sheets because you've got such a fat ass, until finally by the time we reach the next 91st interview you will have made medical history." The patient looked puzzled and asked cautiously, "What do you mean?" I answered, "Well, hell, Bill, if you can continue this 'regression' like you keep saying, by that time you'll be the first neonate on record with pubic hair."

I further implied wearily that he probably was right, that he probably would spend the rest of his life in a mental hospital!. Six interviews later he got himself discharged. When he returned a year later, I immediately went over to his ward, walked into the dayroom where he was seated, and with an expansive, open-armed gesture, chortled loudly that my prophecy had come true: "Just call me Frank Isaiah Farrelly." In two weeks he fled, and has not returned since.

It was after the 91st interview with Bill that I sensed the basic pieces of the clinical puzzle fitting together for me. I

felt a very real sense of power in discovering what I then thought and still think is a central if-then proposition regarding therapist-client interaction. (See Assumptions and Hypotheses Chapter). I had discovered me in the therapeutic relationship, and all parts of me seemed freely available to me for use in helping patients.

The Case of the Disgusting Housewife

Shortly after the 91st interview with Bill, I became intrigued with the possibilities of using this approach with a new patient in an initial interview. Some of my colleagues with whom I consulted at this time suggested that if I were getting changes in the interviews with Bill, it might be because "a latent relationship was finally becoming manifest," or that he was undergoing "a spontaneous remission period" of his psychotic symptomatology. I was unsatisfied with these explanations and attempted to find out if I could elicit some of the same types of responses with a brand new client.

At this time I was asked to consult in a county welfare department on a case involving a young, married housewife who was convinced that she needed hospitalization. Her actual statement, which she reiterated over and over again was, "I should be locked up in a mental hospital and the key thrown away." The staff was puzzled with her because she seemed to be functioning fairly well in her social roles as wife, housekeeper, and mother. It seemed Like a golden opportunity to try out my new approach with an outpatient; consequently, I agreed to see her and, after carefully removing the ashtray from the table that was between us, I interviewed her for approximately an hour. I had serious difficulty keeping a straight face, hiding my astonishment, and swallowing my laughter at my own "lies" while agreeing with her markedly negative self concept.

I felt that I had been highly insulting and confronting

with her during the interview, and at the end of our talk I asked her if I could take five minutes of her time to question her about how I came across to her, how she perceived me in this interview. The reason I did this was that although it is important how I perceive myself in the therapeutic relationship or how others (raters, fellow therapists, etc.) might perceive me, the crucial factor in bringing help to a disturbed person is the client's own subjective perception, because that is what he or she is going to act upon. For this reason, I questioned her, and she stated something which I'll never forget: "You're the most understanding person I've ever met. You really understand just how bad I am." I remember my reaction very clearly to her statement. It was one of stunned disbelief, because, although she obviously believed what I said, I didn't believe one-tenth of the things that I had said to her during the interview.

In the years since my experiences with the "slutty virgin," the "staircase" client, the case of the dangerous psychopath, and other patients, I had been trying to give my own reactions of genuineness and caring to patients in what I termed an "emotionally honest" type of therapy. It had helped many patients, although quite a few, from time to time, had told me my caring for (hem was "too good to be true," or "Well, you're trained to care for us types, Frank," or "You're paid to care," or "you feel that way towards everybody." In short, I was at times rather unbelievable to clients even though I genuinely felt this way towards them.

With this client, as I had with Bill, I agreed with the "doom and gloom" attitude she had towards herself and even went a step further in suggesting that since she "really knew she was rather disgusting overall," she probably found it hard to believe her husband's words of affection and love. The frequent result of my having been

genuinely honest with clients had been disbelief on their part; the result of my "lying" was belief. Clinical work can be a crazy, upside-down, Alice in Wonderland type of world.

To say that I was intrigued and excited with the possibilities of my newfound approach to the helping relationship would be putting it mildly indeed. That evening I strode about the house, telling June that "I knew what Columbus felt like when he discovered America," enthusiastically comparing and contrasting the way I had dealt with clients in previous interviews and how I was going to deal with them now. I felt that I had "conquered" something. Victory was sweet, the payoff I was feeling was in sharp contrast to the price I had paid so often before: tears, gagging, vomiting, fitful sleep, wrestling and frustration with my work.

I began to experiment with group therapy, family therapy, therapeutic community ward meetings (large ward meetings at the hospital in which all the staff and all the patients on a given service get together and have "group think"), with every different diagnostic category (schizophrenic reactions, psychoneurotic reactions, and character disorders), with both inpatient and outpatients, and with widely differing age ranges of clients from pre-school to geriatrics. And finally, approximately four months after the 91st interview with Bill, I switched over to this approach in my private practice. I had visions of all my clients leaving, threatening malpractice suits while muttering through their clenched teeth, "Why the hell should I stay here and listen to you insult me when I can go home and get my spouse to do it as well? And I don't have to pay to have it done." My predictions did not come true. The reasons for this will be dealt with later in Chapter VI.

As I gained further experience in using my newfound approach, it became clear to me that it was not simply my

personality that was crucial in it, but that there were also techniques and assumptions inherent in this system apart from me as the originating therapist. In the literature on psychotherapy there are a number of descriptions of crucial interviews in which various therapists discovered their techniques or theoretical systems. For example, Freud "stumbled onto" his "chimney sweeping" techniques while working with hysterics; Albert Ellis (1962) talks about the particular interview in which he discovered rationale motive psychotherapy; Carl Rogers (1961), in his paper "This is Me", talks about the crucial interview he had with the mother of a failure case; and finally, I had my 91st interview with Bill. As Blanchard (1970) has stated so well:

It is a convention in the scientific world to report the emergence of a new theory as though it emerged slowly and inevitably from the analytical throttling of data. The scientist is pictured as plodding through his method, discovering some discrepancy in experiment results and myopically tracking this discrepancy until he stumbles over the doorstep of theory. Actually, far more often than not the theory springs into the scientist's vision as a wild surmise, and he spends most of his time searching for facts to fit it.

Two points need to be emphasized here: (1) New systems of psychotherapy are not usually formulated by therapists apart from a constant immersion in experiences of the psychotherapeutic process. In sharp contrast to the mythical behavioral scientist who supposedly sits down in his ivory tower, outlines his assumptions regarding human behavior, and then deductively proceeds to delineate those behaviors that would be therapeutic, it has been my experience that therapeutic systems develop inductively out of the cumulative and immediate experience of therapy as the therapist struggles to make sense out of his experiencing. (2) Therapists, apart from the originator of a psychotherapeutic system can - and do - employ these

systems effectively in their own work with clients even though they put their own individualistic stamp on their dealings with clients.

Naming the Baby

Randy Parker, a Vocational Rehabilitation Counselor at Mendota State Hospital in 1966, was a great help to me in attempting to formulate what it was in provocative therapy that was bringing about changes in clients and also in helping me glean samples from my large library of recorded interviews. One day he urged me to begin thinking about naming my new therapy: "If you name it, it then comes to have a life of its own. It's your baby, Frank, and every baby deserves a name." Whereupon we began thinking of various names, composing a list that included Protest Therapy, Banter Therapy, Provocation Therapy, Provocative Therapy, Humor Therapy, etc. Eventually we began to get slap-happy, increasing the list of names: Filthy Therapy, Sin Therapy, Attack Therapy, Giggles Therapy, etc. But we were satisfied with none of these because no one name seemed sufficient.

It was shortly after this that Am Ludwig suggested to me to "name your system." I told him disconsolately that we had attempted to do so but were unsuccessful. The next day he came to my office while Randy and I were working, reporting excitedly that he had found the name - "Provocative Therapy". We told him that we had already thought of that and had rejected it. I added, "I didn't like it. People will think it means sexually provocative and that all we talk about is sex." To which Am replied, "Well? ... Hell, that's what you do talk about a lot, and it fits." Although I could see how it fit, because the therapist did in this system attempt to provoke the client into certain kinds of responses, I was still reluctant. Am argued persuasively that no therapeutic system's techniques, goals, and

philosophy were completely contained in its two or three word name. When Randy agreed with Am, I decided to make it unanimous. Provocative Therapy. The baby had a name.

Assumptions and Hypotheses



PRESIDENT KENNEDY ONCE ASKED HIS

Scientific advisor why scientists (who were supposed to "know") with disturbing frequency arrived at remarkably divergent conclusions regarding the same problem, question, or phenomenon. The answer was that although scientists may study the same phenomenon, they approach it with different kinds of assumptions. It is for the same reason that each journalist or congressman returning from exposure to a crazy quilt of stimuli and experience organizes his report in line with his pre-existing biases and values.

These examples go a long way to explain why therapists who have, by and large, the same types of human behavior to deal with, come up with such widely diverging approaches, because they are holding different sets of assumptions about man, society, the meaning of language and behavior. Harper (1959) has described thirty-six of these therapeutic systems, each with at least slightly different assumptions. Thus different therapists will "see", organize, and respond to the clinical data their patients present to them in markedly divergent ways. For example, those therapists who are especially impressed with the fragility of patients and clients probably tend to espouse a "gospel of gradualism" in therapy. On the other hand, those therapists who are impressed with the strengths and resources of people will tend to engage issues more quickly and rely far more on the client's internal resources and ability to mobilize external resources within his own environment.

There is in the final analysis a welter of conflicting theories regarding human behavior, psychosocial development, motivation, and the meaning of life. The provocative therapist pledges allegiance to no one theoretical formulation regarding these areas of inquiry. The truth of the matter is that there is not as yet (and in all likelihood never

will be) an integrated field theory regarding human behavior. Nonetheless we are well aware that we too are making a variety of assumptions in provocative therapy which should be made explicit. We assert that any person in dealing with others has willy-nilly made implicit assumptions about how to interact with them to bring about changes in their ideation, affect, or behavior. You cannot not make assumptions in people work. How aware we are of these assumptions, however, is another question. In any event these are our positions on various issues as explicitly as we at present understand them. We believe that these assumptions guide the perception and organization of the clinical data, the responses of the provocative therapist, and the responses he is endeavouring to provoke from the client.

People change and grow in response to a challenge

There are a variety of ways people can adapt, learn, or change. One important mode is for a person to be faced with a challenge with which he is forced to cope and unable to avoid. When constructive anger at himself is added, changes can be rapid indeed. In a context of high expectation (even if implicit or denied by the provocative therapist) constructive anger at one's self (or the therapist's portrayal of the client's self) is a powerful motivator for change. The therapist's task is to challenge the client sufficiently but, not overwhelmingly (and this is a matter of clinical judgment) in order to provoke him to use new coping behavior. "Fight" reactions to problems are almost invariably preferable to "flight" reactions. One of the unique features of provocative therapy is the degree to which the therapist will not tolerate the client's avoidance, even from the initial contact.

We try to provoke a certain specific type of self anger. Large numbers of people get angry at themselves and

commit suicide or get into other less life threatening but severely intrapunitive and non-functional behavioral patterns; obviously these are not the types of self anger we attempt to provoke. Often this desirable type of anger is characterized by an intense and generalized attitude expressed verbally as "Enough's enough!" or "I can't go on this way any longer", or "I'm getting fed up with myself, and I've got to change". This annoyance at self tends to lead to a decision to cope, to "get my rear in gear". In a recent first interview a bright college student said, "You're objectifying my inner thoughts, and it's ridiculous! I've got to change. That's all there is to it!" We believe that this is a common, everyday, central human experience which elicits some of our best coping responses.

Many therapists give us the distinct impression of trying to keep the client calm, cool, and collected as they attempt to talk in soothing, even, well-modulated tones. In a certain sense, we want to do almost the exact opposite with clients in provocative therapy; that is, we want to impinge on their perceptual field in a way in which they are forced to cope and unable to avoid the therapist. One colleague (Dick Rossman) after witnessing a provocative group therapy session stated, "You speculated on a lot of different reasons as to why provocative therapy works with clients. You know, after listening to you with those patients, I get the impression that with some patients at least it may be far more simple. You get through to them because you have such a goddamn loud voice, Frank."

To summarize, it has been our experience that the client will move towards positive psychosocial behavior if presented with a non-overwhelming challenge with which he is forced to cope and unable to avoid. If the challenge provokes a self annoyance that leads to a decision to change, therapeutic progress can begin and be rapid indeed.

Clients can change if they choose

We assume that clients have not changed because they will not, and that clients can change if they choose. Individuals are responsible for their own feelings and behaviors and can at least change behavior (reorganized perceptions and feelings will follow) by an act of choice or "will" - if they want to. The concept of will is currently out of style in psychology and philosophy, and we do not intend an excessive, unrealistic, voluntaristic position. Nor do we mean that everything is up to "willpower" (tell this to an illiterate person from Appalachia or to a minority group member who has been systematically exploited). However, the idea of will is still crucial and useful in psychotherapy because on the practical level for the purpose of change it is necessary for people to take responsibility for their existence. The majority of our clients can change in significant ways if they choose.

Many other therapists, embracing psychological determinism, have sought to absolve clients from excessive guilt feelings at the price of saying that man is not free, that he is a victim. However therapists intend this message to be received, it unfortunately is all too frequently decoded by clients as a message of despair; "You can't help it," or "If you couldn't help yourself in the past, you cannot now or in the future. You may not be blameworthy but you are helpless."

T. (Wearily): Well, huh! You ... Well what's it that makes you different from other people? There's no question about the fact, you know, that you are different ... Now, have your sisters had six hospitalizations?

C. (Pause; quietly): No.

T. (Quickly): Well, why not? And why have you had them?

C. (Reflectively): My brother has, though.

T. (Pushing): He's had how many hospitalizations?

C. (Quietly): I never counted them, but quite a few.

T. ("Explaining"): Oh yeah? Well maybe you're like your

brother and your two sisters are like each other ... and you know, you two ... were the weak ones of the litter ... and those two were the strong ones.

C. (Agreeably): Well, they weren't as young when my mother got sick. [i.e., "mentally sick"].

T. ("Supportively"): See there, there ya go, I knew we could find it ... it we just searched for it ...

C. (Continuing): and I -

T. (Ignoring her): It was your mother who blighted your life! You didn't have a stable mother figure. How can you provide one for your children, see what I mean? Psychological determinism ... It's in the cards; they were stacked wrong at the outset.

C. (In a depressed tone): Ohhh ...

T. (Ignoring her): Your destiny is - well what? (mimicking the patient's tone) Ohhh, what?

C. (Her tone rises): It's ... awful to hear it.

T. (Leaning toward her): But haven't you thought it?

C. (Protestingly): Well I've thought it -

T. ("Reasonably"): Well -

C. (Protestingly): But I, I, you agree I'm not ...

T. (Interjecting): I shouldn't say -

C. (Protestingly): I'm not as healthy as you, and I have these ... morbid, unhealthy, discouraging, despondent thoughts ...

T. (Forcefully): Right!

C. (Plaintively): But can't you look at me with some hope, Mr. Farrelly?

T. (Laughs): Well you can think it, but I'm not supposed to say it out loud. Is that what we're supposed to go on?

C. (Puzzled): Hmm?

T. (Quickly explaining): You say ... I say, haven't you thought all this stuff? You say, "Well, yah." But, do - you don't like me to say it out loud? Is that what you mean?

C. (Less plaintively): I don't like you to agree with me.

T. (interjecting): Well -

C. (Finishing): That there's no hope. (5.3)

Few people other than therapists really believe that man is not responsible for what he does, that he does not choose but is driven. And even these therapists outside of

the interview hour cannot, and in fact do not, operate on this premise in their day to day interactions with people who are not clients. Human beings have only so many ways to organize themselves in groups, and no group that ever was, is now, or in all probability ever will be formed can operate or exist without presupposing choice, responsibility, and accountability on the part of its members.

Therapists have chosen to emphasize clients' rights and needs. Well and good, as long as the therapist limits himself to the one-to-one therapeutic relationship. However, even here this emphasis is myopic, and is presenting the client with a highly distorted view of social reality. For as soon as therapists begin using marital couple therapy, group therapy, and family therapy - something which Freud never did (Cf. Brody's 1970 article on Freud's limited and skewed case load) - then therapists are also faced with the problem of dealing with other people's rights and needs also.

No human group ever existed where a right was given without a corresponding obligation. Clients, aided and abetted by therapists, all too frequently think of their needs first and their obligations to others last. In contrast, the provocative therapist will typically say, "Look DumbDumb, I know this is not your style, but did anybody ever suggest to you that occasionally you are going to have to meet somebody else's needs first -and second and third - and that then they might meet your needs?"

The provocative therapist takes the operational stance, whatever the ultimate outcome of the centuries-long debate on determinism versus free will, that to hold people responsible for their actions gives them hope and dignity, and says in effect to them, "You may be guilty, but you can choose and change and your whole life can be different. You are not a blindly helpless, completely determined 'victim' of an UNCONSCIOUS" (the twentieth century

psychologically sophisticated term for devil). While we laugh at Flip Wilson's now classic comedy routine of "The Devil Made Me Do It", therapists often glumly nod when clients say in effect, "My UNCONSCIOUS made me do it." A word is in order here about guilt, shame, and fear. Fear is the felt experiencing of, "I have done something wrong, and I am afraid you're going to punish me." Shame is felt as, "I've done something wrong, and I'm afraid of your disapproval." Guilt is experienced as, "What I've done, I regret, for it is not consonant with the type of person I am and want to become." In my experience most clients feel fear and shame, not guilt.

All psychological defence mechanisms are statements to the effect that "It's not me. It's MOTHER, or FATHER, or SOCIETY", or "I didn't do it", or some of her version of denial made in an effort to save face and avoid shame. And each denial is also a choice. (it is not without significance that the vast bulk of clinical literature on mother-child relationships has been written by male theoreticians, with the not surprising result that mothers have been blamed for much of the clients' dysfunctional behaviors).

If a client is going to change at a practical level, then sooner or later the therapist, no matter what theory he holds, has to transmit the message, "Get your rear in gear". Some therapists attempt to do this subtly, but finally have to say, "I think we have discussed this enough, and interpreted and reinterpreted your unconscious dynamisms sufficiently. It is now time for you to begin using some of the insights you have gained." Translation: "Get your rear in gear."

Even B. F. Skinner's followers and disciples have to rely on choice and free will (despite Skinner's statements to the contrary - Cf. *Beyond Freedom and Dignity*, 1971). For example, if the client repeatedly fails to attend the sessions and claims that "reinforcement contingencies

prevented me", he would either choose to change his reinforcement contingencies or be dropped from therapy. If the client claims and maintains steadfastly that he "can't help it", then we either lock him up in a mental hospital or jail, or ostracize him in the community. He will not be released or be treated as anything else but as an irresponsible nut until he decides that he can "help it." Again, despite some therapists' rhetoric on the subject, the way society at large operates is, "if you can't pay the rent, get out". The following simple paradigm is central to what we have been saying:

- I. I do not function
- II. because
- III. I cannot
- IV. I will not

The client stresses the "I cannot". The provocative therapist firmly believing that the client will not, humorously agrees and echoes the doom and gloom messages of psychological determinism in an attempt to provoke the client into admitting that he is not functioning because he will not. Given that the client accepts I., he wants to explain his behavior to himself, to find a reason, a "because" (II.), which leads him almost invariably to III. The task of the therapist is to get him to admit IV., to then choose and assert his freedom. Nobody will give it to him. Granted that we are products of our heredity to a large degree (environment, after all, does not give us our genitalia); granted that there are a large variety of determinants for human behavior - economic, social, psychological, and cultural; granted we risk seeming simplistic; nonetheless, in provocative therapy we operate radically on the assumption that the client is responsible for his behavior. One of the most difficult admissions for any

human being is exemplified by "I did it with my little hatchet". To assume responsibility for behavior and not project it onto various other people, "systems", etc. is difficult but crucial. To many it would seem naive and terribly unsophisticated to maintain the position that people get themselves into difficulty because they choose to, but for therapeutic purposes and for the purposes of changing attitudes, perceptions, and behaviors on the part of clients, we make this assumption. Whether or not this is "true", clinical experience strongly suggests that it is the most functional assumption for bringing about change in clients and enabling them to most nearly actualize their potential.

Clients have far more potential for achieving adaptive, productive, and socialized modes of living than I, he or most clinicians assume.

Doom and gloom prognostic statements regarding clients' lack of ability are rampant in the clinical field and are probably much more a reflection of the individual clinician's subjective reaction of helplessness and hopelessness than any objective statement regarding the client.

Therapists, like most people, do not like to admit failure, and the temptation to practice that alchemy whereby our frustrations and sense of inadequacy is magically transformed into a scientific fact residing in the client is great "I failed, therefore you're hopeless." Or, "If I didn't help you, you can't be helped by anyone." Most of us who have worked for any time in people work, have found some respected, intelligent, well-trained, highly experienced person who has made or implied the statement about a particular client, "This person can't change". And then some student or novice therapist who doesn't know any better arrives and helps the client to make some significant changes. We suggest that this phenomena is best explained by the following: prognostic statements become

self-fulfilling prophecies. After all, who wants to work with a client with a "bleak prognosis" unless they don't "know" any better?

Perhaps we need the professional humility to admit that even though we are unable to help a particular client, somebody else, even a novice therapist, may very well be able to do so. I once consulted on a difficult case" on an adolescent ward; the patient was 17 years old, had ten years of hospitalization, and assorted other problems. One of the aides exclaimed, "Well, if Frank Farrelly can't cure her, nobody can." My response was, "Oh no, I don't buy that." Although I thanked her for her warm support, I told her that no therapist belongs in the category of infallible healer with every client. Research is gradually delineating the wide variety of reasons why this is so. However, if "one man's meat is another man's poison", then it seems from our experience that "One man's nemesis is another man's opportunity" as far as clients are concerned - and it is very well for clients that this is so. This strikes a hopeful note and gives young therapists reason to tread where "experts" fear.

The psychological fragility of patients is vastly overrated both by themselves and others.

Most patients walk around with the label "Fragile Handle with Care" pasted all over them. Unfortunately all too often clinicians believe the label and react accordingly: "Hands Off". For example, it is not infrequently heard that, "She's not ready for this interpretation", or "It would be too damaging to suggest ... " Most teachers of therapists who are giving seminars or lectures regarding human growth and development tend to be highly impressed by what's wrong with people. Not infrequently they are so impressed with psychopathology that they will express attitudes such as "It's a wonder people ever grow up halfway normal."

This training has much to, do in determining the therapist's assumptive set toward a given client and to what and how the therapist will respond: the strength and health of the patient, or his psychopathology and social deviancy. The provocative therapist in a travesty of traditional approaches over-focuses on what is wrong with the patient in an effort to provoke the patient's affirming what is right with him. It is not being Pollyannaish but simply more intellectually rigorous to assert that it is crucial to keep in mind that therapists are viewing that patient functioning at his worst (For example, Jacobson et al, 1965, documented that 75% of their clients were in a state of extreme crisis when they began seeing them). If the therapist only focuses upon this data (Le., dysfunctional, crisis behavior), he is getting a very skewed picture indeed and quite inaccurate measurement of the client's real strengths and coping abilities. While we must be sensitive to the psychological and physical limits of this proposition, in general we must demand more of our clients; in large measure they will! behave as they are expected to and are not the psychological equivalent of Dresden china.

The Client's maladaptive, unproductive, antisocial attitudes and behaviors can be drastically altered whatever the degree of severity or chronicity.

It is a truism in the clinical field that staff's expectations of hospitalized patients tend to be enacted by the patients. If the staff expects patients to get better, they tend to; if the staff expects patients to get worse, they tend to; and if the staff expects the patients to do nothing, they tend to do exactly that. Why is this so? The answer is not hard to find: the staff will act upon their belief system and assumptive set. For example, if they expect the patient to get better, they will! use reinforcements, coercion, etc. to make something happen with that patient.

This assumption is not an unfounded Pollyanna-like belief, but a recurring clinical fact in our judgment. There are too many instances of this type on record for this assumption not to have useful validity. Needless to say, the pseudo-scientific, intellectually slothful label "spontaneous remission" does not explain the drastic behavioral and attitudinal changes seen in changed patients once considered "chronic". It is somewhat amazing that we have not examined at length these types of cases. We have studied far more extensively how people break down or how they become socially deviant, but the "hopeless" cases who somehow get better (patients who demand the same degree of effort from the therapist as he would expend in trying to chip through the permafrost with a teaspoon) do not command this extensive study. We suspect that there is a definable measurable process they go through that is discernible, and one of the significant phases in this process has to do with their finally choosing to get better.

Adult or current experiences are as at least if not more significant than childhood or previous experiences in shaping client values, operational attitudes, and behaviors.

E. E. Le Masters, former dean of the School of Social Work at the University of Wisconsin, (Personal Communication, 1966), has pointed out that in contradistinction to the familial constellation prevailing in our largely rural culture of several generations ago, increasingly parents today are merely the custodians and not the shapers of their child's personality. The peer group, mass media, our pluralistic societal value and reward system, and the individual's own choices shape adult personality at least as much as Momma and Daddy. Further, Le Masters (1970:37) writes:

Social environment has been equated with parental influence.
It is one thing to assume (or conclude) that personality

is the net result of social interaction and exposure to cultural patterns, but it is quite another thing to assume that the social world of the child is the net result of the interaction with parents. It is true that in the early years the outside world is mediated by and through the family. but as Clinard has pointed out, there are forces such as the youth peer group. siblings. and mass media. Parental influence is not even synonymous with family influence, let alone social environment.

The net result of this sort of approach is to saddle fathers and mothers with complete responsibility for the molding and shaping of their children.

Perhaps behavioral scientists have inadvertently made parents feel more guilty and allow clients to engage in more irresponsibility.

Kinsey (1948:643) also has noted the over-emphasis on early childhood experiences as determinants of adult behaviors:

Learning and conditioning are, of course, familiar parts of the everyday experience of the human animal. Other things being equal, the first experiences, the most intense experiences, and the latest experiences may have the maximum effect on the individual's subsequent behavior. Freud and the psychiatrists, and psychologists in general have correctly emphasized the importance of one's early experience, but it should not be forgotten that one may continue to learn and continue to be conditioned by new types of situations at any time during one's life. It is incorrect to minimize the importance of all except childhood experiences in the development of adult patterns of behavior.

We are often impressed with the completely unrealistic expectations that some therapists have toward parents and especially mothers. In this regard several remarks will be made to redress the balance on the subject of parental responsibility. Consider: If scientists qua scientists had to raise children, they would throw up their hands. There are a mind-boggling number of variables that cannot be controlled

or predicted. Snarls in communications occur between even well-functioning adults. How much more, then, are these to be expected between parent and child who have markedly discrepant amounts and kinds of experience, as well as divergent needs and communication skills? Not only are sets of expectations different, they are often non-negotiable. Statesmen, scholars, and people in general over-generalize from insufficient data (this is perhaps a central human failing or limitation). Children, in addition to drawing conclusions from highly limited samplings of experience also tend, like adults, to draw unwarranted and over generalized conclusions. Naturally they start acting in line with these three sets of conclusions: 1) conclusions based on inadequate sampling, 2) unwarranted conclusions drawn from a distorted perception of these inadequate samples, and 3) overgeneralizations based on both inadequate sampling and distorted perception. (Example: "Mother didn't give me a sandwich, so she doesn't love me anymore. I must be worthless.") Labor mediators would throw up their hands if they shared no common language, set of experiences and expectations, and had as few ways of dealing with communication problems. Given these difficult circumstances, we commend parents for adhering to an extremely difficult task. The overwhelming majority of parents have excellent intentions and want good things for their children. Even when personal stress or a hostile environment intrude, the fairest assessment is often that both are caught in what is a generally impossible situation. Several writers have made reference to the "sick" messages parents send to children. Our position is that parents send millions of messages to their child. These messages are largely determined by the child's behavior. Simultaneously the child chooses to perceive selectively and respond only to certain messages and later, as an adult, chooses to

continue to respond to the ones he has selected. My Irish Daddy in speaking of his twelve children expressed the ambivalence that many parents experience, "I wouldn't take a million for any one of them, but I wouldn't give a nickel for another one." As a child I did not give equal valence to both parts of this quip. When I became a parent myself, I could weigh both parts equally and understand the experiences to which he was referring.

Speaking of mothers we only half facetiously suggest that all that can be reasonably expected of them is the following: she should conceive, bear, and deliver the child, see to his feeding and toilet training, teach him to use the appropriate utensils for eating within his given culture, teach him also how to engage in intelligible conversation to obtain reasonable need satisfaction, and see to the setting of any broken bones. If the kid is an Eskimo, the mother should inculcate one further important life lesson: Don't eat yellow snow.

In summary we point to the facts that adults have more information processing ability, more experience to generalize from, and the potential for a less egocentric approach to the world. If the therapist can get through to the client and use all the conceptual, attitudinal, and affective skills the adult has learned, then the client's potential for change is great.

The client's behavior with the therapist is a relatively accurate reflection of his habitual patterns of social and interpersonal relationship.

This is a well-established principle in the microcosm of group therapy and contributes greatly to the impact of that treatment modality. The provocative therapist helps create a social microcosm in several ways: 1) By frequently presenting the client with the evaluations of him by significant others, 2) by role playing social situations which humorously demonstrate that negative social consequences

follow from the client's attitudes and behaviors, and 3) by referring to the behavior-shaping feedback available to the client from the matrix of his social relationships.

("Screw what you think of yourself, Nutsy, it's the picture that other people have of you in their heads and guts that's important. There's a whole reservoir of feedback there for you, but if I were you, I'd avoid it, 'cause if you ever found out how people really think and feel about you, you'd go into a depression that you'd probably never get out of.") }

In reaction to these strong stimuli, the client soon produces his hierarchy of defensive manoeuvres or behaviors that he habitually uses in his everyday life. In their initial encounters as well as in their important ongoing affective relationships, people demonstrate their "best techniques (i.e., habitually employed but often unadaptive) for dealing with anxiety-laden interpersonal feedback. In the interview their social dysfunctioning rapidly becomes apparent, and the therapist can choose particular self-defeating strategies of the client on which to focus.

Clients bring their stereotypical "routines" to the interview, but after efficient counter-conditioning they can generalize their new affective learning and coping behaviors to other situations. A colleague once stated, "It she learns to cope with you, she sure as hell ought to be able to cope with her husband and family!" Our thrust is not to "make up" for clients' emotional deprivations, but instead to inure them to manure, to the "slings and arrows of outrageous fortune", and to help them develop more adaptive ways of coping in social relationships.

People make sense; the human animal is exquisitely logical and understandable.

Every person I have ever talked to who was communicating about himself has made sense to me; what he was conveying resonated in me and elicited ideational and

affective referents from my own experiences. This holds true from people at parties to psychotics. They were all understandable. Harry Stack Sullivan suggested that we are all more human than anything else; we suggest that we have far more similarities in common which can unite us than dissimilarities which separate us. It is relatively easy to understand another human being if he is laying out all the pieces of his puzzle. It has been my experience over the years that if any person over stresses the difficulty in understanding another human being, he does so for several possible reasons: (1) he has something to gain from not being completely understood (if he controls the informational input, he controls the behavioral output); (2) he has political, economic, or professional reasons for stressing the difficulty in understanding others. People (even seriously disturbed patients)-simply are not uniquely mysterious or alien. If such is our reaction, we just do not have all the data necessary to understand them. Thus in provocative therapy clients are at times "grilled" and given a classical "third degree" to obtain this information so that they will be understood.

The expression of therapeutic hate and joyful sadism toward clients can markedly benefit the client.

Long before the first provocative therapy interview it had become clear that one of the salient reasons the "mentally ill" feel as rejected and unloved is that they are rejected and unloved frequently. It was also clear that if they feel hated both by themselves and others, this is at least **partially** due to the fact that many of their behaviors are hateable. It also became clear that genuine rejection expressed by the therapist was far more helpful to the client than a phony, constrained acceptance. But before we elaborate on this, consider the following examples which we trust will

make some inductive sense in this context.

1) August Aichhorn (1935) writes of hiring a talented young therapist who soon experienced a marked decline in his effectiveness. The therapist was called in and admitted that he was attempting to model the rotund, grandfatherly Aichhorn who melted the children with love. Aichhorn asked him how he would have dealt with these problems in his previous work. The young therapist reported that he would have "boxed him on the head." Aichhorn, realizing his commitment to his patients, instructed him to do it, simply giving him permission to be congruent with his previous attitude for the time being.

2) A group of patients are exercising on a chronic ward. The pants of one male patient fall to his ankles (exposing his state owned underwear). Aide (Loudly): "Hey, let's get the pants up, OK? (Pause forcibly) Come on!" The patient does not respond; he looks off distantly. Another patient turns around and bounced the heel of his hand off the panties patient's shoulder (Exclaiming harshly): "Goddamn it, pull your pants up!" The "out-of-contact" patient promptly pulls his pants up and fastens them.

3) The scene is after the evening meal. Father is under time pressure to pick up Mother. Daughter, age four, has suddenly decided to engage in yet another battle of wills.

Father (Sottly): Come on honey, finish your milk.

Daughter (Emphatically): No!!

Father: Come on, honey.

Daughter (Sneering): No!

Father (Reasonably): Look, honey, milk's good for you. You ought to drink your milk.

Daughter: No, I don't want it!

Father (Voice starting to gain intensity): I want you to drink that milk. (Attempting to remain reasonable) How are you going to grow up to be big and strong Like Mommy?

Daughter: I don't want to be Like Mommy!

Father (Teeth clenched, voice intense): You better start

drinking that goddamn milk!
 Daughter (Adamantly): No!
 Father (Evenly): I'm going to count to three and if you don't start drinking, I'm going to slap your hand.
 Daughter: No!
 Father (Engaging in self talk): Forget it ... I've got to get moving ... It isn't worth it ... No, the hell with that - if I have to sit here until morning, this kid is going to drink this milk ... But parents can really traumatize and twist the personalities of Little children and make them irredeemable and non straightenable. (Then out loud in response to her crying and his slapping her hand for the third time): Work it out with a therapist when you're 21, kid!
 1-2-3- - No! - Slap - 1-2-3- - No! - Slap
 Father (More self talk): I thought you wanted to be a good fat her ... Your father made plenty of mistakes now you are repeating them.
 Of ten seven trials he is calling himself a brute, a sadist, too pressuring, coercive, not accepting of his child's perceptions, autonomy, etc. Meanwhile Daughter is crying, Father is wiping her face, counting and letting her have it. Finally, choking and sobbing, she drinks the milk. As they drive from the house, Daughter sniffles from the back seat, "Daddy, if I drink my milk, I don't get spanked."
 Father (Stopping the car, reaching back and hugging her): That's it, you got the message, sweetheart.

4) An eighteen year old functional illiterate was very assaultive, stabbing people with pencils, throwing a TV at a pregnant woman. In the first provocative interview:

I'm going to kick your goddamn teeth down your fucking throat!
 Therapist (Looking levelly at the patient): Yeah? And what do you think I'm going to be doing while you're 'kicking my goddamn teeth down my fucking throat'?
 Patient (Sulkily): You'll bite my foot off at the ankle.
 Therapist (Nodding and smiling): You got it, you biter!
 (S.4)

5) Ivar Lovass decided to apply learning principles to an autistic child who had to be tied in bed for seven of his eleven years so that he would not bite himself or bang his head. Armed only with a cattie prod (euphemistically termed a taradic stimulator) which does not harm tissue but hurts like hell, he allowed the child to be set free. The child looked around and began gnawing at himself. Lovass said, "No Billy!" and zapped him. The child was bewildered - no attention or affection. He started gnawing again and promptly was zapped. Within a minute and two more bite-jolt pairings, his behavior was counter-conditioned, extinguished (at least in Lovass' presence, generalization training could then proceed).

6) For years a nine year old child had been dumping a fecal load on the living room rug whenever he became angry at his parents. He had been taken to child guidance clinics, private therapists, and school consultations. He had been in play therapy making dolls and manipulating clay to no avail. A friend of the mother suggested rubbing his nose in it. The next time it happened shortly thereafter the desperate mother did what was suggested. The shitfaced child came up for air looking astonished. (This was not according to the script - What treatment is this?) Living room rug fecal-dumping behavior never occurred again.

7) A large family came in for therapy. The house was in a constant state of chaos and the educationally sophisticated mother felt very angry, guilty, and ready for a breakdown. She was asked for one concrete example of how she could be helped by the children in this situation. She decided that things would be measurably easier for her if the children would pack away their own clothes after being laundered.

Therapist: I'm going to teach you how to be joyfully sadistic.

Mother: What's that?

Therapist: How to inflict pain on others and get to love it.

In front of all the children and with much humor and persuasion the therapist convinced her to give the children no food until their clothes were put away: "If you don't work, you don't eat." With only five meal deprivations scattered among ten children in two days time, each and every child was cooperating beautifully.

To sum up, then, frequently in clinical practice as in life, a distinction must be made between short term "cruelty" with long term kindness on the one hand versus short term "kindness" and long term detriment on the other. There is a strongly prevalent myth in the field of child rearing (where the half-life of "truth" has been estimated at 10 years) that punishment or negative reinforcement or irritation toward another whose behavior the helper is supposed to be shaping will have an infallibly negative effect.

Vet the socialization of children in any culture is invariably implemented with love, tenderness, and massive counterforce, violence, punishment, withholding of food, forced social isolation, and similar "dog obedience training" methods. (Cf. Azrin and Holz, 1966; Aronfreed, 1971; Johnston, 1972; for further views on effective punishment.) In our opinion (Cf. Ludwig and Farrelly, 1967) punishments will always be used; the question is whether they will be effective and explicit or ineffective and apologetic. In all probability there will always be sadists in many walks of life including the mental health professions, but a distinction has to be made between sadism and taking pleasure in venting long overdue, justifiable anger towards the client or patient and enjoying the consequent changed, prosocial behavior in the "subject". If love is not enough, neither is punishment; the two together can be remarkably effective in changing behavior.

The more important messages between people are nonverbal

There is a piece of folk wisdom which states that it's not what is said, but how it is said. Group therapists interested in ascertaining the client's immediate experiencing and real feelings check the body language their clients speak. Facial expressions, intonation and inflection of voice, rate and pauses in speech flow, eye contact, hand gestures, foot tapping, etc. I've long been used by experienced therapists to decode communication and extend understanding. Not only is the client's nonverbal language crucial, in a paradoxical and sometimes harsh verbal context, the provocative therapist must depend on and utilize extensively his own nonverbal messages to qualify his words. We often tell students that an essential ingredient for provocative therapy is to learn to smile with your eyes and to practice sending humorously incongruent "vibrations".

Two Central Hypotheses

In addition to the foregoing ten assumptions there are also two central hypotheses of provocative therapy. These are phrased as hypotheses which are open to proof or disproof by each new client and by scientific methods.

The first hypothesis addresses itself to the client's attitudes towards himself, his self-concept: If provoked by the therapist (humorously, perceptively, and within the client's own internal frame of reference), the client will tend to move in the opposite direction from the therapist's definition of the client as a person.

The second hypothesis focuses on the client's overt behaviors: If urged provocatively (humorously and perceptively) by the therapist to continue his self-defeating, deviant behaviors, the client will tend to engage in self and other-enhancing behaviors which more closely approximate the societal norm.

There are a number of variants on these hypotheses: if the therapist excuses the client, the client will tend not to excuse himself and tend to adopt more responsibility for his behavior, his values, and his attitudes; if the therapist offers sufficiently inane rationalizations for the client's pathological behaviors, the client will tend to offer explanations of low level inference and to employ scientific principles of thought, especially the law of parsimony, Occam's razor. Examples of these hypotheses will be readily noticed in the clinical examples throughout this book.

A variety of speculations on the intervening mechanisms between the "it" and the "then" can be adduced from various theories; however, no effort will be made here to offer explanatory mechanism for these it-then propositions.

The Role of the Provocative Therapist

Anyone can become angry - that is easy, but
to be angry with the right person, to the right
degree, at the right time, for the right purpose,
and in the right way - this is not easy.

Aristotle



PROVOCATIVE THERAPY IS A BROADLY

based procedure employing many techniques and allowing a wide range of freedom in responding for the therapist. This fact in itself has dangers and advantages that will be dealt with in other contexts. This chapter will begin with more generalized descriptions and rationales for various aspects of the provocative therapist's role. As the discussion progresses, the techniques and examples will become more specific and operational. The highly significant and important aspects concerning the usage of language and humor in the role of the provocative therapist will be largely omitted here and covered extensively in separate chapters.

It should be noted that despite the name of "provocative therapy" not every single response of the therapist in the system can really be termed "provocative." As a graduate student pointed out after listening to a variety of therapy tapes from a number of different theoretical orientations, in provocative therapy a number of other techniques are used: confrontation, open ended questions, information giving, etc. (Even in client-centered therapy, not every therapist response is really a "reflection of feeling," although the preponderance and majority of the therapists' responses can fall into that category.) But psychotherapeutic systems are usually named after the major type of therapist response or after the therapist's basic theoretical or attitudinal set - hence the name, provocative therapy. A wide range of techniques are employed to provoke an immediate, effective experience in therapy. The therapist aims to provoke both positive and negative responses and to integrate them with their social and interpersonal consequences. Most commonly the negative responses in the client are anger or disgust and the positive responses are humor (laughter) and warmth. Thus the provocative therapist both sensitizes and desensitizes in the interpersonal

context; both anger and laughter become antidotes to anxiety and flight responses. In terms of therapist behaviors what distinguishes provocative therapy from other approaches is its degree of directness and use of confrontation, its contradictory and equivocal communicational style, its systematic use of both verbal and nonverbal cues, and the eschewing of professional dignity and deliberate use of humor and clowning.

Goals

Although each client provides a new and unique opportunity to test one's hypotheses, and although each will have different problems and goals, we think that some generalized statements about therapeutic goals are in order at this point. These considerations guide the use of various techniques in the therapeutic relationship. The provocative therapist attempts to create both positive and negative affective experiences in an effort to provoke the client to engage in five different types of behavior:

1. To affirm his self-worth, both verbally and behaviorally.
2. To assert himself appropriately both in task performances and relationships.
3. To defend himself realistically.
4. To engage in psycho-social reality testing and learn the necessary discriminations to respond adaptively. Global perceptions lead to global, stereotyped responses; differentiated perceptions lead to adaptive responses.
5. To engage in risk-taking behaviors in personal relationships, especially communicating affection and vulnerability to significant others with immediacy as they are authentically experienced by the client. The most difficult words in relationships are often "I want you, I miss you, I care about you" - to commit oneself to others.

It should be noted that, by the use of a variety of techniques on the part of the therapist, these five goals are successively approximated by the client over the course of

therapy. Acquisition of behaviors consonant with these goals seem to be ordered in the following pattern: 1) Clients are provoked into verbal responses to the therapist; 2) Clients respond in therapy both verbally and affectively, the latter at times inappropriate; 3) Clients respond to the therapist in an integrated fashion, with affect consonant with verbalized content; 4) Clients marshal for the therapist extra-therapy behavioral coping evidence to substantiate their now integrated responses; 5) Clients now engage in self-affirmatory, assertive, realistically defensive, socially adaptive, and risk-taking behaviors in relationships outside the therapeutic relationship.

Anything Goes

In order to have a fighting chance in this kind of therapy, most of the manoeuvres of patients must be available to the therapist to be used in the service of therapeutic change and strategy. Thus the therapist may engage in obvious Lying, denial, rationalization, invention (e.g. of "instant research"), crying and zany thinking. The client's behavior is frequently seen as a ploy to control the relationship, and occasionally the therapist must counter it on a quite primitive level. Figuratively therapists are often bound by Marquis of Queensbury type rules while patients use the psychological equivalent of knee in the groin and thumb in the eye. The outcome of such a contest is not often in doubt - to the ultimate detriment of the patient.

Provocative Communication

The single most succinct label for the role of the provocative therapist is that of Devil's Advocate. The therapist sides with and (if successful) becomes the negative half of the client's ambivalence toward himself, significant others, and his life's goals and values. The therapist plays the Satanic role by tempting and urging the

client to continue his "sinning", his deviant and pathological behavior patterns for "good" and plausible reasons. He takes the "crooked" portion of the script in the therapeutic interview, thereby provoking the client to take the more rational, "straight", and psychologically adaptive portion of the script. As an example, an attractive female call girl and drug addict was referred (to F.F.) for discharge planning from the hospital.

T. (Incredulously.): Discharge planning?! (laughs) Hell, with your internal, personal resources I think it's quite clear how you can make the scene in the community.

C. (Protesting.): Well, just a minute - I'm getting a job as a waitress.

T. (Reasonably): Well, what the hell do you want to stand on your feet eight hours a day when you can make the same amount of money Lying on your back for 20 minutes?

C. (Laughing but serious.): Will you quit talking like that?! (S.5)

This girl had made up to \$500.00 a night as a call girl and certainly the temptation was for her to return to the "life." However, she was determined not to (even though the therapist attempted to convince her to become a "community resource."). Instead she chose the more long-term satisfying job of waitress or secretary and endured because of her own conclusions about the self-defeating nature of her previous behavior patterns.

Another example of the provocative therapist "echoing the client's worst thoughts and fears about himself" might be cited. I (F.F.) was working with a chronic patient and suggesting to her that she become a "key worker" in the mental hospital; that is, I was urging her to give up getting discharged, to "settle down" in the hospital, and live out her life while working at some task. I role played how her life at the hospital would be, how other people would react to her as the decades rolled by, how eventually she would

become a geriatric and be unable to do her assigned task and how this would be a better life for her since we would organize and control it for her. She was horror-struck and frightened at the prospect but admitted that she had actually been thinking of something like this, and then voiced her increased determination to leave the hospital and never return.

In provocative therapy the therapist points out in a variety of ways either implicitly or explicitly the social consequences of the client's attitudes and behaviors. The therapist attempts to verbalize all the taboo things that people cannot say in our culture to one another; he endeavours to express the unutterable, feel the untellable and think the unthinkable with the client, verbalizing a the client's implicit doubts, echoing the client's own thoughts and fears about himself and about the reaction of other people toward him. The client invariably finds this he is not "destroyed or annihilated" and can deal with these conflict areas on a more conscious, realistic, and adaptive basis.

The provocative therapist very often goes beyond simple urging and tempting. Indeed, in the absurd encouragement of symptoms (to the point where they become ludicrous there are few limits. The therapist marshals idiotic data from any source in support of and to "prove" the client irrational contentions. He "takes over" rationalization: excuses, and cop outs by expanding them ironically and "plausibly" (a *reductio ad absurdum*). Attitudes are lampooned and burlesqued - while continually agreeing with them and presenting them in a "positive" context. Example: T. (To a coolly aloof, cynical female patient in a "sincere" tone.): "Why you're much too honest and perceptive to be affectionate." Two content areas that are especially frequent in this regard are the themes of the client's lack of responsibility and his incapacity to change.

Clients tend to perceive, relate to, and act only in terms of the bad, negative, hurting things in their life. There are two propositions toward life, i.e., Life is bad or Life is good, and there is much evidence on both sides. Clients tend to cling to a set of highly skewed data, seeing life as lousy, cruel, brutish, and too long, while actively neglecting to evaluate accurately the of her more positive, contradictory evidence. The therapist by leaning heavily on the "doom and gloom" side of life, attempts to provoke the client to marshal concrete, specific evidence and experiences (not contrived, Pollyanna platitudes) and give at least equal time to the myriad of positive, happy, growth producing experiences in their lives. Most patients can acknowledge finally that they have had successes, coped with problems, that others have extended themselves and given love and affection with a far higher degree of frequency than they were at first willing to admit. In an ironic way the therapist and the client thus relate to the client's strengths by having the therapist take over the weaknesses.

Another specific technique is that of disowning the communication.

This is often employed when the therapist wants to communicate something "straight" to the client but does not want the responsibility for the assertion or the client's use of it. This is often accomplished by starting statements with "Some therapists would say that ... " (and no matter what the statement, it will probably have been made by some therapist at some time) or "Did you hear about the research study that showed ... "

Direct Provocation

The provocative therapist approaches quickly those areas about which the client sends messages telling the therapist to avoid. (This has more picturesquely been termed by one client as "going for the jugular.") However,

the therapist feels no necessary responsibility for theme development once there. The therapist's job is to stay with the client on a moment to moment basis in terms of affective level and avoidance behaviors. The client will! bring order to this experience, develop the themes that he feels are important, and handle his own feelings. The therapist can deal with anger, chaos, shouting and a disorganized interview; these events do not signal the termination of a therapeutic encounter because the provocative therapist's comfort range is quite broad in regard to client's interview behaviors. The vast majority of interviews do not turn out as labile as this may sound for the provocative therapy client typically and quickly addresses himself to the work of therapy. Even for the openly hostile client, provoking his anger can be helpful in his learning control and limits. Example:

C. (Loudly and furiously.): Goddamn you! If you don't stop talking in that snotty, sarcastic way of yours, I'm going quit therapy and not pay your bill!

T. (With an alarmed, anxious, pleading expression.): Please, don't I need the money! (Slumps dejectedly in chair, holding forehead in hand, in a depressed, choked tone of voice.) Oh well, I'll just have to tell June and the kids no Christmas again this year.

C. (A kaleidoscope of emotions crossing his face: anger, laughter, suddenly placating): O.K., O.K., damn you, I know I need you more than you need 'me, but damn it, Frank, won't you please just ... (5.6)

Another example:

C. (Angrily, loudly.): You'd better quit talking like that or I'll ...

T. (interrupting, evenly, staring steadfastly at client.): If you want to throw a temper tantrum, why, go ahead, be my guest.

(Changing his voice tone to enthusiasm.) Why, hell, here at this hospital we have what I call a temper-tantrum

room for people like you who need to have temper tantrums. Actually, the rest of the staff! call it the seclusion room, but I think temper-tantrum room sounds better, don't you? (5.7)

The patient quickly controlled her anger in the interview. In provoking the client's anger towards him in the therapeutic relationship, one of the goals of the therapist is to teach the client appropriate assertive behaviors. This is especially true for anxious-acceptant clients who are always frightened about "But what will other people think of me?"

Communicational Pattern

Clients differ initially in their communicational patterns with the therapist. However, to the extent that the therapist has control over the variance, he tries persistently for a high responsivity rate, for much "give and take," i.e., a fast moving, short, clipped, emotive interaction sequence in an effort to provoke the client into reacting spontaneously in order to bypass the client's censoring and "canned", set responses. Many clients frequently communicate the message, "You must listen to me on my terms and don't interrupt until I finish." The provocative therapist from the outset confronts this hyper-controlling stance and demands at least equal time, and that the client expend as much effort to understand him as he invests to understand the client. The extensive use of confronting and provoking techniques throughout therapy is designed to lessen the chances of dependent relationships which seem to plague other forms of therapy. And finally the provocative therapist does not believe in silences (Jonathan Winters type monologues are preferable) and usually the stimuli presented will cause the client to respond overtly.

Feedback

Although the techniques may vary, provocative therapy considers immediate feedback a virtue. Example:

An obese patient enters office.

C.: May I speak with you Mr. Farrelly?

T.: My God, the Goodyear blimp has slipped its moorings!
(5.8)

Another example of feedback about personal appearance follows:

Client enters office looking harried and anxious; she sits down.

T. (Puzzled tone.): You look anxious tonight Gorgeous. But never mind that, I'm noticing that hairdo of yours, and I can't figure out what it looks like - an abandoned rat's nest or an explosion in a bed-spring factory.

C. (Grimacing, laughs.): It's windy out tonight, and I know I look a mess - but I want to talk about some of the things that have happened this week if you can stop being snotty. Now the other day ... (5.9)

Too many therapists feel that, as one trainee put it, "You can't just come right out and tell the client your reactions to him or your hypotheses or judgments about his behavior." They usually predict dire results if they were to do so - "Well, the client would get upset!" In various situations responses to that have been, "Hell, he's unsettling me, his family, the court, his employer, the rest of the world, so why not upset him for a change?" or "This is the client's third illegitimate pregnancy, so let's try something different; instead of understanding her needs, her conflicts, etc., get her to understand how everybody around her is upset and the community doesn't like it. If she would start meeting someone else's needs, some of hers would get met in the process." Many therapists prefer to eternally hint to the client rather than tell him bluntly and quickly.

It seems to us causal that because therapists many

times do not communicate their responses to clients, the') tell their colleagues, supervisors, and consultants. P trainee in supervision complained about "that irritating passive-aggressive Mr. X who, instead of coping directly) with his rather domineering mother, goes home and verbally kicks his wife." When asked, "Did you tell the client this in the interview?", he replied, "No ... " "Their where do you get off expecting him to risk in relationships with you and others when you are continually role-model· ing 'nothing ventured, nothing lost' in your interviews win him?" Many therapists seem to model this operational attitude for patients who have the same attitude and problem. We feel it is better to tell the client than colleagues in the coffee room - put all of the cards on the table, face up. More specifically, in order to make the therapist's response known (or to make a point or provoke a response) he will use whatever props are available, role play, joke, make up "instant research", and fictitious clients, or speak of previous clients and situations similar to the present client. He will also constantly, implicitly and explicitly check for feedback from the client to ascertain if he is on the right track.

Feedback is not necessarily a grim "telling it how it is in an externally objective, absolute kind of way, but rather "for me, here and now, in this relationship with you, this is how I feel about you." And this can be done with humor The client has the right to the therapist's reactions and ideas about him and to feedback from other sources that the therapist might know about. What the client's "best friends" won't tell, the therapist must provide, i.e. accurate, immediate feedback, both positive and negative. We have found that genuine rejection (of certain behaviors: is definitely more therapeutic than phony acceptance or é non-engaged indifference. The human mind needs truth just as human lungs needs air, and my reaction to you at

this moment in this interview is a social truth or reality which, if conveyed, is almost invariably helpful over the long run.

The provocative therapist not only gives feedback to the client, but also attempts to train the client into becoming aware of the sources and types of feedback that are potentially available to him, and which can prove to be a life-long reservoir of data for adaptational change. As an example, a client was asked to predict the therapist probable response to observing her "being washed ashore on a deserted island."

C. (Grinning.): You'd probably stand on the shore and say, "Oh no, not you! Why couldn't they have sent food instead!?" (5.10)

Nonverbal acceptance of the Client

The issue of accepting the client is crucial to all psychotherapeutic approaches. Somehow the client has to have a basic feel that the therapist is "on his side" and not out to lessen him. The client-centered school has defined one of the crucial variables in its approach as "unconditional positive regard," and most systems deal with this aspect of a therapeutic relationship in some way. However, it seems to us that the means of expression are much more variable than other approaches have emphasized. In our experience the non-verbal cues of caring are at least as crucial if not more crucial as the verbal I cues in this regard. Since the provocative therapist often urges deviance verbally and is sometimes harsh and confronting, the non-verbal qualities of his communication become very important. Humor, of course, is one of the main vehicles of positive regard (and will be covered in a separate chapter) as well as touching, the twinkle in the therapist's eye, and the high level of activity indicative of involvement (One patient labelled it the "intensity of attention"). Example:

Private client is leaving therapist's office at the end of an interview in which he discussed his homosexual problems. The therapist claps his hand on client's shoulder. T. (Sighing dejectedly.): Well, see ya next week, Hopeless. (Suddenly "noticing" his hand on client's shoulder, pointing with other hand at it.) Do you see that hand? Now that is trained acceptance! (Therapist leans forward, placing his forehead close to client's forehead, grimaces disgustedly, in a tone of Revulsion. Actually I can't stand you tutti-frutti, closet queen pansies, but - C. (Laughingly snorts, Shakes his head, punches therapist gently in ribs.): Boy, you just don't quit, do you, Frank? O.K., next week. (Leaves waving, shaking his head, and laughing.) (5.11)

The expression of concerned anger is also a vehicle which indicates caring for the of her person; many patients experience it this way, and it quickly increases their level of involvement in the relationship. Thus the provocative therapist sees his whole body as a communicational instrument and has to use the non-verbal components of his communication skilfully to obtain the desired results. This has implications for training which will I be discussed in other contexts.

Incidental Learnings

Although for a specific client the following may not be central issues in therapy for him, he can derive a number of incidental learnings from the provocative therapist's modelling: verbal, attitudinal, and behavioral sensitization and desensitization, appropriately assertive behavior, impulse control, communicational analysis and decoding nonverbal communication. Often these particular aspects may not be focused on for a given client because they are not problematic.

Style of Therapy

We have described in general terms the role of the

provocative therapist. Before discussing specific techniques, a key issue must be raised at this point. A rather typical reaction when first hearing of provocative therapy is, "Well, you can do that kind of therapy because you are that type of person; I couldn't come right out and confront patients like that or attack - even humorously - their pathological or deviant behaviors, or make fun of them. I'm just not that kind of person."

Perhaps it is true that, to some degree, every different therapeutic orientation is offering a different style or role within which therapists can be both comfortable and effective. All therapists are, after all, not exactly alike either in theoretical assumptions or in their mode of relating to others, and it is reasonable that some would tend to find a certain approach fits their personality characteristics, their view of man, and their life style more comfortably. They probably also feel that they can be more effective in helping clients using a particular approach which suits them more closely.

Although some may disagree with the following views and consider them oversimplifications, it seems to us quite clear that to be both comfortable and effective as a client entered therapist, one has to be a very receptive person, willing to suspect his judgment about the client, enter into his internal frame of reference and become another self for that client. To be comfortable in employing the rationale motive approach of Ellis, a therapist must be impressed with the change producing capabilities of information and logic when given to the client. It is also helpful to be dominant and highly skilled at argumentation in this approach. A psychoanalytic therapist must be intellectual, comfortable with high level abstractions, patient, and committed to the proposition that all subjective and behavioral data will ultimately make sense and thereby enable the client to grow and change.

To be an effective and comfortable provocative therapist, it helps to be a bit of a ham and actor, and to be able both to dish out verbal attacks on the client's self-defeating, deviant behaviors and attitudes, as well as to receive comfortably and with humor the verbal attacks of the client toward him. The attitude that "I'm not that kind of a person, I couldn't tell clients those things" which we've heard from trainees and colleagues alike provokes the response, "Oh yeah? Try it!" Inside many passive therapists there is a provocative therapist just screaming to be let out! Many therapists allow themselves an incredibly narrow range of affective and verbal behaviors in interviews with clients. In both clinical and teaching experiences we have found that they can profitably widen their range of responses not only without damage to the client but often with considerable help to him and comfort and fun for the therapist. We feel this to be a central thrust of the book, *Critical Incidents in Psychotherapy* (Standal and Corsini, 1959) and suggest from our experience that provocative therapy can be a liberating as well as effective experience for client and therapist alike.

Specific Techniques

Most of the specific techniques of provocative therapy are, if taken individually, probably not "new" but have been in use in other forms of therapy. However, the combination, style, and intensity of their use in this system is quite different.

Provocative therapy is not simply all "fun and games" at the client's expense. The message of the therapist has to be sensitive, perceptive and addressed to the client's own value system, his frame of reference, his ongoing, here-and-now experiencing, his self-attitudes, and his specific behaviors. In psychotherapy there is as yet no known substitute for clinical judgment and sensitivity.

In most responses the provocative therapist does everything in "larger than life" style. Voice intensity is louder than normal conversation, and everything is amplified. There is a strong element of drama and hyperbole throughout therapy. As an example of extravagant exaggeration, a client who had many questions regarding her adequacies as a mother was repeatedly and humorously defined by the therapist, using many of her own words and behaviors to "prove" this, as the psychological equivalent of the "plague" towards her child. She rather readily defended herself "as not that bad" - and reported a series of specific behaviors to support her new content ion that she was, in some significant ways, an attentive, considerate mot her who truly cared for her child. The therapist then "over-reacted" and began sarcastically lauding her as the "Mother of the Year", etc. She in turn realistically rejected his "overcorrection" and, pointing out that she did have some characteristic ways of interacting with her child that were not very nurturing, and rapidly got to work on changing her inconsistent behaviors.

The amplification of the therapist's subjective response to the client is an important facet of provocative therapy and allows the therapist to use a more complete repertoire of his affective behaviors. To implement a variety of therapeutic sub-goals (to point out negative social consequences, to sensitize and desensitize the client) the therapist will not only elaborate on the client's responses but will also use his own subjective reactions, his intuitive fantasies, and internal, idiosyncratic associations as building material for his responses. The therapist can elaborate humorously only so far if he adheres rigidly to just the client's content. It goes without saying that in the use of this material the therapist constantly attempts to focus and direct it to the client's conflict areas in a disciplined, sensitive manner.

When I first began provocative therapy, I played a taped interview to earl Rogers. He cringed somewhat and stated, "Boy, I wouldn't put those thoughts and ideas in her head." I replied, "Look earl, she's either thought these things or she's thought things first cousin to them, or other people have given her this kind of feedback." We have often been surprised in work with clients at how close we were to their thinking, especially when what we offered would be considered by some to be "far out." Many times the client will rejoin, "How did you know?" A number of them have told us, when the therapist offers some screwball mode of thinking or acting, "It's almost as though you can read my mind." Some have even insisted that I had "read their record or talked to a family member." It is relatively simple many times to "read their minds," as has been pointed out (Nizer, 1961): "Through cumulative experience we can anticipate with reasonable certainty how people will react to certain stimuli." And we would add how, with a high degree of probability, they must 'have thought, felt, and acted in the past given certain stimulus configurations. Or more simply just think of the lousiest types of thought patterns you can think of, and frequently you'll be close to the mark.

An example will now be cited of what is meant by reading the client's mind. As an introduction let it be stated that a person's body image (how one thinks and feels about his body, his satisfactions or dissatisfactions about it, how one feels it can perform in a variety of tasks) is very closely related to or is the most intimate personal dimension of his self concept.

A young woman was referred for therapy who had a variety of problems in both task performance and relationship areas. She was gradually able to achieve much better in her work but still continued not to date. She finally confessed with some embarrassment that when she was a

young girl and her breasts began to develop, she went to her mother and told her about her problem. The problem was that, though her right breast fitted her bra, her left breast "rattled around like a goober pea in a fuel oil barrel" Her mother took her to her family physician who took the bra off the frightened young adolescent, looked first at one breast and then at the other and issued this dictum, "This is not an uncommon phenomenon." She then was told to dress and return home. Horror stuck, she felt that she had a combination of leprosy, polio, and various venereal diseases. When she began to date boys, she immediately ran into the problem about their wanting to pet; her response was simply to avoid the situation and, as a result, she usually had only one or two dates with each boy.

T.: You mean you're embarrassed and ashamed for them to find out that you've got that weird felt tit?

C. (Embarrassed, hanging her head.): I don't like the way you put it but, yeah, that's about it.

T.: So that's why you've been avoiding half the human race! (He pauses for a moment.) Well, hell, now that I think of it, your behavior makes sense. Because you were to go out on dates with guys - guys, being guys, would naturally want to pet and get all they could off of you (the client nods), and once they got your blouse open, there could only be three possible reactions that a fellow could have toward you.

C. (Curiously but simultaneously embarrassed.): What are they?

T. (Very seriously.): Well, one reaction would be that he would hastily button up your blouse and say in an embarrassed manner, "I'm sorry, I didn't know you were a crip."

A second reaction might be that he would get all heated up and say, "Whoopee, I've always wanted to do it to a crip!" And the only other possible reaction that a guy could have would be that, once he had unbuttoned your blouse, he would stare at your weird felt tit and exclaim, "Hold it right there, will ya? Let me get my polaroid swinger ----:the guys back at the Irat house will never

believe it when I tell them." (5.12)

The patient stared at me throughout this and finally with a weak grin stated, "Yeah, that's what I feel would happen, but I'll never really find out if I just sit here and talk and talk about it with you." I got anxious at this point but told her that time was up and that we'd have to discuss it further the next time. As she was about to leave I remarked, "I like to name my interviews, so I thought I would call this "The Weird Left Tit Interview." She laughed and said, "That sounds like an appropriate title for it." The next interview she came in looking like the cat that had swallowed the 400 pound canary. I greet her with, "Well, Gorgeous, what the hell have you been up to since I saw you last?" Quite briefly, she explained that she had gone out and, with much tear and trepidation, had "hustled" a guy and had gone up to his apartment with him. They had shed their clothes and, while in their birthday suits, were having fun and games. Right in the middle of the proceedings she called his attention to the fact that her left breast was smaller than her right one. His response was to look at one and then the other and give a client entered response: "Oh, yeah, you feel it is, huh?" and immediately resumed his activities. She felt like an immense, eight year old lead weight had suddenly been lifted from her shoulders and she experienced a marked sense of relief at his acceptance of her.

T. (Disgustedly): So you went out and lost your virginity, huh?

C. (Grinning.): I lost everything but my technical virginity, but it was worth it because of what I learned about myself.

T. (Protesting.): Well, hell, Dum-Dum, you just ran into a sex maniac. You can't predict of her guys' responses from his response to you about your weird left tit. You just wait and see - the next guy will run screaming from the

car or bedroom when he sees it.

C. (Looking at the therapist patiently and with assurance.):
Well, then, I'll just tell him as he runs away, "Lots of
luck, fellow, on your truitiess quest for bodily symmetry."

And that, we submit, is a beautiful, integrated response.

Reality Testing

The therapist will likewise selectively amplify the client's responses in order to become a reality testing device for the client. This may be done by running various future and fantasized scenarios past the client based on the client's present attitudinal and behavior patterns. Negative statements that a client makes about himself can be quickly carried to their logical extremes until the client rejects them. This *reductio ad absurdum* (reduction to absurdity) is a frequent technique to help the client define, affirm, defend, and learn to laugh at himself. In the seventh interview a chronic patient said (laughing), "Oh, I just ... think you go a little to extremes sometimes. Even I can't believe that I'm that bad." The therapist attempts to provoke the client to affirm his own self-worth to himself and others and to assert himself behaviorally in his work and relationships; he attempts to provoke the client to defend himself against the unrealistic and excessively negative evaluation from himself and others; and by provoking the client, attempts to counter condition the self-defeating ideas of the client that simply are not working out in his life.

If the therapist is concentrating on the maladaptive, self-defeating patterns of the client by reducing them to absurdity, the client is provoked to put his statements and perceptions into more appropriate social and psychological perspective. We've often been amused in working with clients at how they will believe the "truth" of their assumptions and perceptions and attitudes, and what

kinds of evidence they will accept as "proof" for their belief systems and operational attitudes. The provocative therapist will frequently marshal idiotic "proofs" in support of clients' contentions, or, in a bumbling, Clem Kadiddlehopper fashion, accept their contentions as "self-evident" and needed no substantiating evidence to support them. The provocative therapist often "hurries to judgment" exclaiming, "What further need have we of evidence?" Furthermore, he takes the client's construing of his experience as tact, not his interpretation of his experience, and burlesques the client's assumptions in order to provoke psychosocial reality testing. As one client put it: "Well I'll see - yeah, you don't believe that, but you're sure as hell saying how I feel. And you make it sound stupid when you put it that way, but I guess ... I really do feel that. I've always just taken it for granted." The "reality" that the provocative therapist implicitly and explicitly points out is predominantly external, social and interpersonal and not simply intrapsychic. The therapist persistently and insistently calls attention (either directly or by provoking the client to state them) to the probable and plausible (past, present, and future) social consequences of certain attitudes and behaviors, and thereby points out that consequences are dependent upon and connected to his behavior. By frequently challenging statements the therapist attempts to get the client emotionally involved in defending himself appropriately by marshalling evidence (behavioral, coping evidence, that is easily observable and measurable) in support of his positive statements about himself and his socialized verbalizations. In effect, a constant theme of the provocative therapist is "That's nonsense. Show me. Prove it or shut up. If you have to protest it, it probably isn't true." Very quickly this places the responsibility for proof where in the final analysis it must be - squarely on the client.

Verbal Confrontation

Confrontation is an important technique in provocative therapy and in many ways permeates the whole experience. The provocative therapist is often verbally hard and challenging, not for the sake of being gratuitously harsh on the client, but in order to say in effect, "Look, Nutsy, I didn't make up the rules out there in society, but I know how they work, and I'm simply telling you the way it is. There are same hard Life lessons that each and every one of us have to learn it we are to function effectively, and the sooner you learn them and begin operating in terms of these, the better off you'll be." This is not to say the provocative therapist wants to promote mere "adjustment." It is to say that to the degree the client can relinquish his need oriented perceptions and over determined behaviors and begin living in terms of what is (rather than in terms of what has to be, ought to be, got to be, should be), to that degree will he develop the objectivity and reality contact enabling him to more easily and effectively satisfy his needs.

If the therapist understands only the external world of the client (with its expectations, regulations, etc.) and tries to convey this understanding to the client without an equally accurate understanding of how it is for the client, then the client will tend to feel "You don't understand me at all" and simply refuse to receive the messages - even valuable ones the therapist is transmitting. On the other hand, empathies understanding from the therapist, however precisely accurate, is simply not enough for the client to function in the world of social reality. There is an adequate substitute for the therapist's empathies understanding of the client; but for most if not all clients it is equally important for the client not simply to be understood accurately by somebody else, but also for him, the client,

to learn to understand the viewpoint, needs, and values of others and the messages they are sending to him.

Example:

T. (Laconically.): Look, stupid, what we have here is a failure to communicate. You're demanding that your family and the staff - and police and court - understand your feelings. O.K. But unless you get your rear in gear and start understanding their viewpoint and meeting their needs, you're gonna find you're starting a career in mental disease, and that they're gonna get on you like ugly on an ape and chew your ass out like it's hamburger. Get it?

C. (Pauses; head bowed, almost inaudibly.): Yeah.

T. (Mimicking his sulky tone.): Yeahhhhh ... (Laughs)
"Yeah" what? What do you get out of that?

C. (With an air of reluctant resignation.): You mean unless I start paying attention to what they want from me, I ain't gonna get what I want from them.

T. (Forcefully.): Right, dumb-dumb! And that's the way the world turns, kid. First you start meeting some other people's needs, and then they start understanding you and maybe meeting some of your needs. (S.13)

To "know thyself" is important and useful; to "know thy enemy", to know how to survive in the external world of social reality, is crucial.

We are often impressed with the gap between the client's words and actions, with the chasm between his verbalized descriptions and his actual behavior with its effects. One therapeutic task, therefore, is for the therapist to use terminology that is congruent with the client's behavior, to highlight persistently the actual operational assumptions that the client employs in guiding his life. This confrontation can be accomplished verbally either in a "straight" or provocative mode with the latter predominating.

Negative Modelling

Another way that provocative therapy confronts the

client is quite different from most of her systems. This we have come to call "negative modelling confrontation". In brief the therapist acts like the client, matching especially his communicational style and burlesquing those aspects of his functioning that are probably causing him trouble. It is a more informal and flexible way of playing a video-tape for the client. One client stated, "It's like you're holding up a mirror to me to show how I come across. It's a little distorted like a carnival hall of mirrors, but I get the point." In effect the therapist is saying, "This is how I perceive you (perhaps a little exaggerated). How do you like it? Want to do anything about it?"

The therapist also communicates that he perceives much of the client's behavior as acting, i.e., under voluntary control and subject to change. Thus, for example, if a female with conversion hysteria enters therapy with a "paralyzed" arm, she will soon find that her therapist has a paralyzed arm also. Of course, he has the advantage of being able to talk about and make sense out of his "paralysis" and abruptly use his arm should it become necessary, immediately reverting to a "paralyzed state" as it suits his needs. This technique often produces immediate behavioral changes in the client. It is as if the therapist has "beaten them at their own game" or "gotten into the delusion and pushed them out." The same principles apply to verbal interchanges and delusions as well - "O.K. I'll play with you, like you. I may not win, but neither will you (and I'll have fun). How well do you like zero sum games with small or self-defeating payoffs?"

As with many techniques endurance is a necessary corollary to confrontation. Many problems of the client are not susceptible to change by a one trial learning experience. Implicitly the therapist says, "I've got freedom, society, family, peers, and part of you on my side. It's an unequal fight, and I'm going to win. I'm not going to be

driven from my role. So how long do you want to keep this crap up?"

"Explanations"

In provocative therapy the therapist through his behavior (i.e., role modelling, humor, zany alternatives, etc.) demonstrates that there are many different ways for the client to conceptualize (and thus feel and act toward) his problems. This soon gives the client many different perspectives on his problem. Beyond this, however, is the fact that the human animal has an abiding need as well as the ability to make sense out of what he experiences. It is also probably quicker and more meaningful, although perhaps not as useful, for the client to explain his therapeutic learnings in his own terms. The provocative therapist may operate out of a consistent theoretical framework but is not basically in the business of giving his clients a coherent philosophy (or religion) for life. He does want the client to become aware of certain areas of his functioning, how they are hurting him, and give him the choice of change, but the why questions that clients ask very often are simply lampooned. Example:

C. (Tearfully): But why am I like this?

T. (Slumps in chair, eyebrows raised in wonderment, shakes head, raises hands and lets them fall helplessly on chair arms, letting out long, low whistle of puzzlement.)

C. (Pause, irritated.): Is that all you have to say?

T. (Again whistling helplessly.)

C. (Still irritated but now laughing and wiping tears.): Aw, come on Frank.

T. (Leaning) forward "supportively"; in a slow, sincere, and "profound" tone.): There are some mysteries in LIFE which will never be revealed.

C. (Laughing, exasperatedly shaking his head.): Aw, shit! (S.14)

The inferences and constructs used to provide answers

are not important in themselves, only to the extent that they take important aspects of behavioral and social reality into account. The provocative therapist, therefore, will offer and of ten burlesque explanations of all types. The burlesque will clearly indicate that behavior is more important than explanations. Another patient asked, "Well, why am I this way?"

T. (With professional profundity): Well, it's very clear. Obviously you had crooked chromosomes to start off with, your mother blighted your life, and your environment chewed up what was left! So what the hell chance do we have of changing you?" (S.15)

The main goal here is not to provide cognitive insights or explanations regarding the psychogenesis of their conflicts but to counter condition this fruitless quest for the golden fleece. Ironically, however, in the process of playing with the why question (especially if the client is persistent) the therapist may give the client as many differing explanations as anyone could hope for in one of three ways; (1) Choosing those that indicate that everything is out of his control and he is a creature of fate, (2) Giving a wide range of possible theories and in effect saying, "Pick a theory, any theory." (3) Contrasting high level of inference explanations with low level ones and again giving the client a choice. Parenthetically it is often in this regard that certain theoretical notions are favorite targets for satirization since they have the dubious "value" of being able to explain anything at any time at any level of inference with no behavioral referents. An example of the third type of explanation is as follows:

T. (Puzzled.): I can't figure out whether you are (1) immoral or whether you have learned self-defeating, acting-out, anti-social behavioral patterns of promiscuity; or (2) whether you are weak or whether you have a highly impaired ego functioning related to your significant early

emotional deprivation; or (3) whether you are lazy or simply are chronically dependent and overwhelmed by feelings of inadequacy in task performance areas.

C. (Pauses, somewhat embarrassed.): I think I'm immoral, weak, and lazy.

T. (Bluntly.): Oh yeah? Well, I don't think, I know you are sister. (5.16)

As an example of the "Pick a theory, any theory" type of explanation, the following case may be cited. (5.17) An adult male had used up six therapists and had had a number of hospitalizations. Besides having become a professional client by this time, he was overtly homosexual and often suicidal. He was referred to me by a person who stated, "Try Farrelly - he's rough as a cob, but he might help you."

In the initial interview it became clear that he wanted me to delve into the psychogenesis of his conflicts, elucidate their psychodynamics, and finally give him some insight, in 25 words or less, that would waft him effortlessly and gently into the realms of mental health, transform him into a flaming heterosexual, extinguish his suicidal tendencies, and enable him to live happily ever after.

T. (In a whining tone of voice.): Why, I can't do that, I'm only a social worker.

I further stated that I wasn't sure things worked that way and asked him what his problem was. He answered, "I'm queer!" He then launched into how bad he was and recounted at length all the people with whom he had engaged in fellatio. Throughout this I was sitting with my legs spread out and my hands behind my head listening as patiently as I could to his list of "sins." Finally I stated, "I don't know ... I don't think your main problem is your homosexuality."

C. (immediately protesting.): It's too I walk down the street and I look at guys' crotches all the time.

T. (Raising his eyebrows anxiously): Oh yeah? (Hurriedly

crossing his legs and putting his hands demurely and securely on his lap.)

C. (Laughing.): You son of a bitch; I don't like this!

T. What don't you like about it?

C. I don't know what you're going to do or say next, but worse than that, I don't know what I'm going to say next.

T. (Thinking to himself.): O.K., mission accomplished I've torn up his expectational script. Now let's try it my way.

Over the next ten interviews I expostulated about, while making a travesty of the various theoretical reasons for his becoming a homosexual and offered reasons why he should continue in this manner. Samples:

(1) T. You've probably got an unresolved oedipal complex - your mother try to seduce you?

C. Well, it making cookies for my boy scout troop has some symbolic seductive significance ...

T. I guess I could agree that cookies and intercourse are somehow different. (Brightening up.) Maybe your father frightened the living hell out of you?

It turned out that his father had been warm and affectionate toward him, took his son fishing and hunting and at the same time didn't act like a pal. There was no evidence for a messy, pathological familial constellation to explain his problems.

(2) T. (Defensively, using the "anthropological approach".): Well, the ancient Greeks did it!

C. The hell with the Greeks! What about me here and now?

(3) In another interview I appealed to the notion that everybody was a latent homosexual, an argument which he simply rejected. I then suggested that homosexuals are exquisite members of the third sex, that they are a race apart, that they are especially creative and attuned to many things that we average, insensitive clods simply don't perceive. He didn't accept this either.

(4) I explored the hypothesis with him that maybe he was just simply more emotionally honest than the rest of us

Liars and highly defensive people. He not only did not accept this, in fact, he went on to tell me at great length what a total liar he was, deliberately misleading people from the truth, people who, like his former wife, might be entitled to some honesty.

(5) T. Well, perhaps there are other factors - like maybe you were seduced by an older man.

C. No, I started it and did my own seducing.

One hypothesis after another fell in this fashion. Later he repeated that he was engaged again.

T. ("Alarmed. "): My God, what's wrong with her. She must be desperate or sick if she wants to marry a fruit like you!

C. That's what I thought!

T. For God's sake, you better tell her. (Pause.) Course, that's sort of a bind. You better tell her 'cause why inflict a person like you on her? On the one hand, if you do tell her, she'll dump you fast!

C. Well, that's what I thought too, but I had to find out for sure, so I told her.

T. (Triumphantly.): She dumped you!

C. No.

T. (Nonplussed.): She's sick!

C. (Laughing.): That's what I thought, but she still wants to marry me.

T. That proves it - she needs help.

A humorous aspect was that this man had very many likeable and even admirable qualities to which he seemed blind. (This points out the error in the therapeutic dictum that the client knows himself the best.) However, his fiancé obviously could appreciate his good qualities and loved him.

We had finally examined every hypothesis for fellatio.

T. (Muttering to himself.): We've explored every possibility. There could only be one possible reason left why he turned to homosexuality and committed fellatio with so many guys.

C. What? What? Tell me!

T. (Oblivious to client, continuing to muffer to himself.): Well, it couldn't be anything else, we've ruled out everything else.

C. (Angrily protesting.): Damn it, Frank, will you tell me?

T. (With a "scientifically speculative", puzzled frown): Have you ever considered the possibility that you might have a nutritional deficiency?

C. (Completely taken aback.): Huh?

T. (Enthusiastically warming to the answer.): Well, outside of the prostatic fluid, it's pure protein!

This patient finally got the point, (i.e., the hell with psychogenesis, deal with the fact) and proceeded to make a number of changes. He stood up to his boss and demanded a well deserved raise. His boss told him, "You were worth it for months but I figured, damn it to hell, you were going to ask for it yourself or you weren't going to get it." His salary was almost doubled, he gave up his homosexual liaison in a very appropriate and non-destructive way, and comfortably went ahead with his plans to marry his fiancé.

In the twelfth and last interview, he talked about the nutritional deficiency statement and laughed while shaking his head, stating that it was "seared onto his cortex." He felt that he was ready to quit therapy because of all the obvious gains he had made. His final statement: "You hit hard, and you hit below the belt, but if you had been a weak sister, we could have gone on and on and on for years. But I'll never forget what you said, you son of a bitch (shaking his head and laughing): 'Nutritional deficiency'!"

Contradictory Messages

The concept of contradictory messages and more especially the double bind has many negative connotations attached to it. This is not without cause as Bateson (1956), Lidz (1960), and their co-workers have shown that these may be important mechanisms in the schizophrenogenic family. However, it seems to us that much more conceptual

work must be done here, for it this communicational pattern is powerful enough to drive people crazy, perhaps it can be reversed to drive people sane. Furthermore, unlike the schizophrenogenic family the provocative therapist is nonverbally "rooting" for the patient, is cheering him on, and has as the goal of therapy to help the patient break out of binds (one rarely "resolves" them), assert and affirm himself in relationships, and achieve psychological autonomy and mature independence.

We strongly encourage the use of contradictory messages in provocative therapy. Besides the verbal and non-verbal differences, verbal messages can be both true and not true simultaneously. That is, it is true about you, the client, it you continue to feel and think, and therefore act, the way you have, and it is possible to be not true about you if you are willing and determined to change, and give concrete, specific behavioral evidence that you are doing so. As an illustration of the client's sensing this "true and not true simultaneously" style of communication on the part of the provocative therapist, one patient said, "I don't know whether to believe you or not." And another, "Are you serious? I mean, I've been thinking this way anyway ... "

Another important reason for using contradictory messages is that it gives the client practice in decoding communications and in dealing with the reality of mixed messages in most interpersonal relationships outside the therapeutic relationship. And further, if framed properly, contradictory messages can influence a client into more personally responsible, autonomous functioning. At a more simple level of conceptualization "contradictory messages" may turn out to be important and necessary discriminations that must be made by the client in order, for him to function more efficiently.

A final note is in order here. The provocative therapist, in

his contradictory messages to the client, frequently mirrors the world in which the client moves with its highly contradictory messages, pluralistic value systems, agonizing choices, and conflicting life styles. The client must choose from among all these, and adopt his own operational value system with its own internal consistency; the provocative therapist does not necessarily try to give it to him or to be consistent with him. In effect the provocative therapist is saying, "It doesn't matter that I said this one interview, and am now contradicting myself." He will even at times lampoon the client's excessive need for consistency. Example:

C. (Protesting.): But you said last week -

T. (Apologetically.): Well, I'm sorry, I want to rescind that statement unequivocally for the record that -

The client's response is usually to attempt to force the therapist to choose for him: "Well, which one is it?" And the therapist, by his responses, is saying in effect, "Which one do you want it to be, dangling? Choose and create from the welter of your experiencing your own consistency." Example:

C. (plaintively.): Come on, Frank, should I see _ about a change in jobs?

T. (Forcefully.): Yes, definitely! (Pauses, looks uncertain.) No wait , .. uh ... on the other hand ... well ... (T's face "lights up" as though, arriving at a decision; then hesitates.). no ... better wait on that until I figure it out for you ... And I should have it completely clarified for you in about two years.

C. (Leaving office, laughing.): Shit, you'll never tell me. (S.18)

Listing

Another commonly used technique in provocative therapy's "Listing". The therapist not only forces the client to list reasons and behavioral data to substantiate his selfaffirmatory

and assertive responses, but the therapist also engages in "Listing".

An example of the former is the following:

C. (Settling in chair, smiling.): Well, things are really looking up for me this week.

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T. (Suspiciously.): Oh yeah? Name three ways. Number one? (Holds up thumb.)

An example of the therapist "Listing" for the client follows: The client was a young female who had two dozen hospitalizations over a five year period. Virtually all of them have been for psychological reasons including suicide attempts (she was in intensive care unit for two weeks in a coma after ingesting 300 pills), and repeatedly mutilating herself. Although she has made many gains and changed her behavior drastically in work areas, she is still thinking longingly of suicide.

T. (He has his feet up on the table, puts a cigarette while sipping coffee; speaks throughout in a laconic, almost droning, soul-weary voice.): Wouldn't it be beautiful? With just a little effort, with just a little bit of pain, with just putting 300 more pills in your mouth, or just one pull of the trigger, or just that quick snap of the rope around your neck and a few minutes of choking, or just that one more leap from the fifth story window - and make sure this time you don't land in the bush, but on concrete wouldn't it be easy? And then, no more wondering whether or not you're pregnant for the fourth time and have to give yourself an abortion with knitting needles; no more calling yourself sexually rotten because you fucked five guys last week and that brings that actual total up to 1005; no more having to cut yourself to prove God knows what; no more having to go through your elaborate mental gymnastics to get them to screw you and hurt you so that you can feel almost elated though sore down there (he points at her crotch) the next morning; no more feeling depressed on gray, chilly, rainy mornings like today (He points over his shoulder out the window at the windswept rainy landscape.); no more

wondering if you can pass your courses in this new training program you're going into; no more anxiety about what will I my Mamma and Daddy think of me; no more being bothered by your weird so-called friends at all hours of the day and night; it would all just be beautiful, wouldn't it? To have the deep, long sleep. Isn't that a real, constant temptation? (The patient glances up and nods almost imperceptively.)

And you know, once they lay you to rest down deep in that warm, soft earth, there's no more hassles from the finance company; no more wondering how you're going to finance your new training program; no more wondering about whether to screw or not; no more of these interviews which you say you hate but you've been coming to with clockwork regularity for the past two years; no more getting your feet wet (Therapist points at client's wet shoes.) on raining chilly mornings; no more having a sore twat for having screwed five guys 17 times in one week; no more having to make up lies to your parents about how things are going down here in the city; no more decisions, no more worries. Corpses and cadavers don't worry about the scars on their body (T. points at her scars.) or what other people think of them, or how they will I pay their bills, or are they knocked up corpses don't get pregnant, research has proved that conclusively; corpses don't worry about having crotch rot - their whole body is rotting out; and corpses don't have to answer question that therapists pose that make them anxious. Corpses, Sweetheart, (therapist bends over and gently pats her knee.) corpses don't get anxious at all. They're just calm, peaceful, and it's sleep, sleep, sleep.

C. (Has sat throughout this, looking at the floor, her lips in a light grimace, her elbow resting on the arm of the chair and a hand to her forehead. She finally looks up and mutters something.)

T. (In the same quiet, almost droning tone of voice.): What was your response, Gorgeous?

C. (In a slightly louder tone, but still almost inaudible.): I said, Shut up, I don't want to hear all that!

T. (Smiling warmly; in the same soft tone.): But you thought it and felt it all, haven't you? Many times over?

C. (Looking steadily at therapist, in a level tone.): You

know goddamn good and well I have; but do you have to keep listing, listing, and Listing them?

T. (In a "sweetly reasonable" tone; leaning forward.): Well, Sweetheart, you think them, you feel them, so why the hell not say them out loud?

C. (In a much louder tone; forcibly.): Goddamn it, I'm not going to commit suicide. That's enough of that shit!

T. (Leaning forward, stroking the patient's knee almost seductively; very "supportively").: But, Honey, Sweetheart, Baby, you could always do it, just remember that.

It's sort of your trump card, isn't it? It's always your way out, isn't it?

C. (A Kaleidoscope of feelings crossing her face; she smiles, grimaces, and bursts out laughing.): Yes! Yes! God! What the fuck is the matter with me? (She puts her hand on her forehead, leans back in the chair and stretches for a number of seconds while saying.):

Noooooooooo, I'm not going to do it, not really. I've developed too many inhibitions.

T. (Leaning back in his chair, guffawing.): You?! Inhibitions?! Aw, come on. Now I'm told that you fucked 15 guys in the last 10 days, is that right?

C. (Leaning forward, grinning embarrassedly, pounding her fist on the desk.): I did not! It was only five!

Therapist and patient laugh together. **(5.19)**

As a close to this chapter the following verbatim sample is included to illustrate several of the techniques referred to previously (i.e., listing, "explanation", non-verbal acceptance, use of hyperbole, confrontation, etc.).

C. Uh, I just don't think it's helpful to tell a person that .

T. (Interjecting): The truth.

C. (Ignoring T.): ... that they're no good.

T. (Remonstrating): Well! I (T. hits desk with hand.) - You think it's more - what? I should lie, or something?

C. (Protesting): Well, don't you believe there's any good in me at all?

T. (Objecting): Well, - Oh, I thought you said "in people". I was going to say, "Well, of course I believe there's good in people, I wouldn't be in the field, (i.e., if J didn't) but then, there's you, you know what I mean?"

C. (Somewhat wearily): Mr. Farrelly, I don't -

T. (Interjecting.): Well, name three things good about ya. asked you that the other day.

C. (Pause): Well, I'm alive.

T. (Sighs disgustedly)

C. (Laughs quietly)

T. Well, I don't know if that's a - you know ... do you feel like is a blessing or a curse?

C. (Tonelessly.): It's a blessing.

T. (Pause.): Your life?

C. Not my life.

T. Well, there you go, see what I mean? ... See there? (Pause; T. Jeans back in chair.) Now for some people, you know, it's a real tragedy when they die, 'cause people miss them, and they need 'em and they want them around, you know, ... and it was a real gift knowing them. See what I mean? ... But then there's you.

C. You're saying I'd be better off dead.

T. (Laughing.): Well, haven't you thought that? Well, of course you did, don't you remember when you took all those pills and went in the ... garage and started the c - See what I mean? ... Well you did think that, now didn't you?

C. Yes, I did.

T. Didn't you think other people would be better off without you?

C. (Quietly.): Yes, I did.

T. See what I mean? (T. leans back in chair, snapping his knee off handedly with a rubber band.)

C. (Pause.): But I don't think my children would be better off without me dead right now.

T. (Lights cigarette; pause.): Well, they're just kinda better off without you, period, or - you don't necessarily, you don't want to just don't ... have to ... necessarily be ... dead, but uh you mean they're just better off without you. Is that what you mean?

C. Well, this is a decision I have to make.

T. (Pause): A decision you have to make? ... They are without you.

C. They are without me, but this is just a temporary arrangement.

T. (Pause; tries another tack.): Well, ... do you think you're a good mot her?

C. (Quietly.): I haven't been ... I've been a very poor mother.

T. See - see there? (Pause; T. coughs.) I asked you the other day, and I just got finished asked you, "Name three good things, worthwhile things about you." You're alive' Now we've already settled ... you know, well that's kinda dubious, try something else.

C. (Grins): Well -

T. ("Surprised".): Well you smile! What?

C. (Laughing and smiling.): Well, you just strike me funny sometimes.

T. (Smiling): How do you mean, I strike you funny? ... You strike me as hilarious, if you want (laughing) to know the truth.

C. (Interjecting): As a what?

T. As just hilarious ... You know.

C. (Disbelievingly): Yeah, I'm sure.

T. (Laughing.): Well, yeah.

C. (Sighs)

T. (Smiling): Yeah.

C. All right, I've got my physical health.

T. (Sighs disgustedly.): Well, alright, but what good is that, if, you know, you don't have your mental health?

C. (Speaking simultaneously.): Well I ah ... I don't have to ... undergo extensive medical treatment, I'm ...

T. (Wearily agreeing.): Yeahhh. You're physically healthy, O.K., your bowels move, and

C. (Several words unintelligible; sounds like "O.K., I GOULD -".)

T. (Ignoring her.): you know, and you don't have urinary difficulties and you ... (sighs) O.K., you - (Gesturing toward G.) there's a body. A live body ... that doesn't demand a lot of attention. Big deal!' What else?

C. Well-

T. (incredulous): You wan to count that one? As something real, really worthwhile, valuable about you? .. You wan to count that one?

C. That I'm physically healthy, yes.

T. (Resignedly): Alright, we'll c - we'll count that. Hell, you're gonna have such a hard time coming up with three good ones anyhow, might as well count that one. Go ahead.

C. (Weakly protesting.): Well I have two very, very, very ...

beautiful children.

T. Well you certainly do, I'll agree with you, I saw their picture, you showed them to me, but you know, ... huh!

What's that about you? That's probably your husband!

He's probably a ... functioning kind of guy, is he?

C. (Shakes head)

T. (Surprised): He's not either!

C. (Quietly): He hasn't worked for a year and a half.

T. (Quickly): Well, he doesn't have to, with all that money he's got.

C. (Cynically to herself.): Yeah.

T. How much money did he inherit?

C. (Pause. Sighs.): I don't know, he never told me his financial ..

T. Well you don't want an irresponsible, immature kid in on the, you know, family finances, do ya?

C. (Pause.): But he spent a great deal of what he's inherited, I know that.

T. Well, maybe one of these years he'll have to go back to work.

C. If he can. ,

T. (Yawning.): Yeah, maybe - I don't know, he may end up in a mental hospital or something. Well, he did once, didn't he? Wasn't he hospitalized -

C. He went to [Names hospital] for a month.

T. (Not very interested.): Oh, here in ? They buzz him up' there, or something, or what? ... Live better electrically?

C. No, they didn't give him shock.

T. They didn't? (Pause) Well, come on now, you were gonna try to name three good things [about yourself]. You say you have two children; I mean about you as a person.

C. (Pause)

T. Well, are you grinning, or what?

C. (Quietly): No, I'm thinking.

T. You're thinking.

C. (pause): Well, I have the desire to get well, Mr. Farrelly.

T. (Coughs; pause; disgustedly.): I wish, I wish. "11 wishes were horses, beggars would ride." Didn't you ever hear of that one?

C. Yes.

T. (Wearily): It's a Mother Goose rhyme.

C. (Quietly): Yeah.

T. (Mimicking her tone): I wish I could get well, or I wish to be well. Well,

C. (Loudly and emphatically): I want to be well!

T. (Just as loud and emphatic): Well, all right, you want. (Pause) So? . Well, all you're saying is, I'm sort of an impotent wisher .. Didn't you want to be well the first time you were hospitalized?

C. (Quietly): Of course.

T. (Continuing quickly.): Didn't you want to be well the second time you were hospitalized?

C. (Evenly): Yes.

T. Did you want to be well the third time you were hospitalized?

C. (pause)

T. (Aggressively): I didn't hear you.

C. (Annoyed): Yes.

T. (Pounding): Didn't you want to be well the fourth time you were hospitalized?

C. (In a "beaten" tone.): Yes.

T. Didn't you want to be well the fifth time you were hospitalized?

C. (Not responding.)

T. (Bluntly): I didn't hear ya.

C. (Angrily): Yes!

T. And now! here's the sixth hospitalization, 'n' I ask you to name something worthwhile and of value and good about you, and you say, "Well, I want to be well!." Well apparently your wishes and wants, you know, they don't, just don't, kinda .. produce anything ... Now that, so that - you wan to count that one? ... I'm physically healthy and I've impotently wished for six times to be well ... You wan to count that?

C. (Limply): Well If I didn't want to get well, I don't think I would. (Sighs)

T. (Loudly): Well, you haven't ... Oh, (In a mocking tone.) some amelioration of the symptomatology, but obviously the, you know, central problems have been there all along and never have been resolved .. (Bluntly) Well, you look so blank every time I make a statement. Kind of like a lifeless kewpie doll, or something ...

C. (Pause; evenly): I'm starting to get angry at you.

T. ("Innocently"): What are you getting - what do you mean, angry at me?

C. (Very annoyed.): Because you dislike me so intently and how can I like anybody (T. laughs shortly.) who dislikes me?

T. (Protestingly): Well! We don't have to like each other, all I'm saying is, "Be reasonable."

C. (Protestingly): O.K.! So I lace ... the horrible fact that I'm a mess!

T. Well-

C. Now .. Irom . I don't want to leave it at there, I don't want to leave it ... there!

T. (Wearily): Well is there any changing of you?

C. (Sighs deeply.): Yesss!

T. (Laughs)

C. There has to be, Mr. Farrelly.

T. You mean -

C. There has to be, I can't let my life stop right now.

T. (Reasonably): Well you could too, there's all kinds of people who do.

C. 1,1-

T. ("Supportively"): Well you could! Now, now, that - first 011, see there, you've gotta get things straight there. You certainly could let your life stop. See what I mean? As a matter of fact, you al most stopped it yourself ... at one point.

C. (Quietly): Yes.

T. And how old were you when you made that suicide attempt?

C. Oh it was just a couple, about ... three years ago.

T. Three years ago! You were thirty-Four! It almost stopped at age thirty-four and then here you come along and say,

"I can't let my life stop at age thirty-seven." Well that doesn't stand to reason. (Pause. A knock sounds at the door.) Course you could stop right now ... See there?

(T. goes to door and opens it. Other C. at door, says rapidly, 'They didn't have room for me, did you talk to 'em?' T. says shortly, "No, I didn't eat them." Other C.,

"See, they were taking .. her home and I didn't know that." T., "Sa you'll have to wait for the bus ticket and the five dollars." Other C., "Well did ... did it some

yet?" T., "No." C., "Oh." T., "Sa if I get it, I'll let you know, you'll be the first one to know." C. (disappointedly.):

"Oh, all right." T. closing door, "Bye bye. Work!")

T. (Wearily resuming - comes back and sits down at

desk.): Now what's this jazz "I can't let my life stop."
 You could too "I can't spend my life, for the rest of my
 life in a mental hospital." You certainly could! Nothing at
 all impossible about that!

C. (Dejectedly.): The prospect doesn't look very pleasant.
 T. Well! That's a dil - a different (C. sighs) statement,
 now, see?

C. (Sign-songy.): I want very much to lead a productive life,
 Mr. Farrelly.

T. ("Listing" wearily.): Well you want, you wish, you desire,
 it would be nice if .. see? You've felt all those things,
 haven't you?

C. Sure, b -

T. Well have you? Led a productive life?

C. (Hesitantly.): No.

T. (Of(handedly.): Well, you produced two children, but
 you know

C. (Dejectedly.): That doesn't mean anything.

T. (Quickly.): Yeah. I -

C. Unless I take care of them.

T. (Laughing.): Yeah! There you go! Glad you added that I
 would've had to .. You want very much and you
 certainly wish, and you're highly motivated - you know,
 the way they say it nowadays . see? You know .
 And "I desire deeply and I just crave to be, you know, a
 lully functioning person" - (Gesturing towards C.) But
 look at ya!

C. (Irritated.): All right, look at me.

T. Well Huh . I find it a little difficult to do it sometimes,
 you know, but .. (T. sighs, pause; T, reaches
 over and pulls C's hand down from in front of her face. C.
 pulls her hand back and doubles of her fist. T. "innocently")
 Well, what are you getting angry at me for? Well
 you look like -

C. (Laughs quietly.)

T. (Laughing.): Well, you're smiling!

C (Laughing.)

T. (Laughing.): Well what's this hand back for? You going
 to get violent or something?

C. (Grinning.): No! But I don't want you to put your hands
 on me

T. Oh! Even on your wrist, I shouldn't, just, I want to take
 your hand down from in front of your face. (C. grins.)

You're smiling! You don't feel angry at me, do you?

C. Well I, if I, but ... I dislike you about as much as anybody I know, Mr. Farrelly!

T. (Laughing.): Well you don't know many people though, you know Lone wolf like you (T. laughs.)

you know - you are a lone wolf, sort of, aren't you?

C. (Despondently.): Yeah.

C. (Laughing.): See? There's another one! I'm going to have to write this down, I can't remember them all. But, inadequate

-

C. (Annoyed.): You're recording it

T. Yeah, we could always, but you know, but inadequate, unlikeable, (C. sighs.) intelligent but stupid acting, immature, disorganized, irresponsible lone wolf (Pause) There you get that blank expression on your face - what

C. (Limp.): Well

T. (Mimicking her tone and facial expression.): Well, that's me. Huh (T. laughs.) Yeah . Thank God it's you and not me. (Pause) "Well" what? "Well" is a hole in the ground. "Well" what?

C. (Pause. Weakly.): Well what am I going to do about it That's what I keep wondering -

T. ("Stunned").: Boy, oh boy, that's a - boy, oh boy (T. whistles in wonderment.)

C. (Reflectively, in a low tone.): What am I to do about it.

T. If I were you, I'd stay away - it'd keep me awake nights.

C (Raising her voice.): Well, it does keep me awake nights.

T. (Bursting out laughing.): Well what do you think of that! Hell I'll be damned (C. Laughs.) And you laugh. What

C (Grinning.): Well, just because you're laughing.

T. (Laughing, speaking both for C. and T.): Oh! Uh-hah! You know, if I was - "If I were you, faced with the problem of myself, meaning you, I'd stay awake nights. 'Well It does keep me awake nights!' " (Laughing.) Well that's logical "What are you going to do?" Who knows?

C Well I can't stay this way

T. (Loudly, remonstrating.): Well you can, this is, that's the whole point, you certainly can. You have for - when was, how long ago was it, uh, how many years has it been since you were first hospitalized?

C. (Flatly.): When I was twenty-two.

T. (Firmly.): Twenty-two, and now you're thirty-seven, Now for fifteen years you've been basically the same, , , if not many years before that. Right?

C. (Not responding; staring ahead blankly,)

T. (Passes his hand back and forth in front of her face; abruptly.): Huh?

C. (Slaps T's hand; very irritated.): Well' Don 't do that!

T. Well, don't pass my hand in front of your eyes? You look so blank, I don't know where you are, you look like you're about a million miles away.

C. (Weakly.): Well, I'm -

T. (Triumphantly.): Withdrawn! There's another one. Oh, brother!

C. (Finally exploding loudly and angrily.): Oh, God! You call me every name you can think of under the .. book! I don't think you're in the right field if you .. if you dislike mental patients as much as you do!

T. (Exuding "reasonableness ".): It's not that I dislike mental patients, I like them, that's why I've chosen to work with them.

C. (Puzzled, still irritated.): Well " you sure don't Like me, Mr. Farrelly.

T. ("Amazed").): Well, can you blame me?

C. (Protesting loudly.): Well there must be something in me that's good!

T. Name three! Name one! ... "My children." They're not in you anymore .. "I have a healthy body." (Wearily.) Wellllll, O.K., so what? ... What else? You s - Can you think of anything else?

C. Well I want to change, I have the desire to change, I want to be ...

T. (Interrupting and wearily listing.): "I want," "I desire,"

C. be a-

T. (Sarcastically ignoring her.): "I wish."

C. (Continuing): live a good life, and,

T. (Snorts in disbelief.)

C. (Trying to forge ahead.): and ...

T. Incidentally, it doesn't necessarily follow that "there must be something in me that's good." ... No that doesn't necessarily follow.

C. ("Pollyanna"-Like.): There's something good in everybody, ... (Finishing weakly.) Mr. Farrelly.

T. (Disgustedly.): Ohhh, welll, huh! ... Good eyes

("Encouragingly") Do you, do you see clearly, I mean, you know.

C. ("Beaten"): Yes, I see clearly.

T. Yeah. How many fingers do I have up?

C. Two.

T. ("Supportively"): Two. There! Good eyes! What color is my coat over there?

C. (Looking in direction T. points.): Uhh, it's sort of grayish black.

T. ("Warmly"): Yeah! ... There, you - Good eyes! Your hearing is apparently in good shape ... Your hair isn't falling out ... You know So your ... you know, sense organs in your, that woolly covering on top of your skull is uh, they're good, you know, but it's that head in ya, that brain inside (Laughing) ... oh boy! (T. sighs wearily.)

C. (Puzzled, weakly.): Well you make me make - feel even worse.

T. Well how could that be? I mean how could you feel worse than you .. do?

C. Because here is a man who has had a lot of experience in the field and has met lots of .. sick people,

T. (Interjecting.): That's right, several thousand.

C. (Continuing.): ... and .. you feel that I'm .. hopeless

T. (Sighs; wearily.): Well don't you feel that?

C. (Brightly.): Yeah, but my perspective ...

T. Well there.

C. might be - my perspective might be warped.

T. Well on the other hand and a much more plausible hypothesis is, that your perspective of you, and you ought to know you, yourself better than anybody – your perspective of you is the only only, logical, rational, reasonable one that could be taken .. in light of, you know, your life, situation, your functioning - or non-functioning is more accurate .. See what I mean?

(Flabbergasted.): O.K., so granted I'm this mess.

Oh, well, uh, right, there's no argument about that. We're not going to have an argument about that, are we?

(Hesitantly.): No.

(With finally.): All right .. It always makes me feel warm and good inside

(Interrupting sarcastically.): Yeah, I'm sure it does.

(Finishing.): when people agree with me. ("Surprised" at

C's interruption.) Well, doesn't it you? ... Huh!
 When people agree with me?
 Yeah! When, you know, there's a certain unanimity of opinion
 (Cautiously.): Depends what the opinion is.
 Well, you and I agreed about you.
 Yeah, but you think it's a permanent thing, and I don't think it's a permanent thing.
 Well, it sort of has - it's semi-permanent, it has been for the last fifteen years or so, hasn't it?
 (Pause; whining.): But I haven't given up yet, Mr. Farrelly. It just shows you how some people persevere . 0 • They get a fixed idea in their heads and there's just no amount of evidence to the contrary . 0 0 you, it's not true that you haven't given up yet, you've given up every day, you know, for Lord knows how long 0 0 • You damn near did it, did the job that time you took all the pills and went out and started the ... car in the garage. Would you say you hadn't given up then?
 C. (Acquiescing.): Well I gave up then.
 T. (Triumphantly.): There you go!
 C. (Quickly.): But -
 T. (Pounding away at C.): Didn't you give up when uh your, you know, your uh,. 0 on the is divorce? Haven't you given up taking care of your children repeatedly long before your brother took them? (Phone rings.) You've given up repeatedly for, you know 0 • 0 Sure, you gave up. (Answers phone and talks, puts down phone, Jeans back in chair, sighs.) Well, I think we were talking about uh ... there must be something good in you.
 C. (Brightly.): Sure.
 T. (Pause.): Well what?
 C. (Firmly.): Well I haven't figured it out, that's why I've been so sick all my life, is because I've looked at myself as a . love regarded myself as a person who's no good.
 T. ("Reasonably".): Well, you've certainly had the weight of Provocative Therapy 90 evidence on your side, don't you think?
 C. (Weakly protesting.): Well I wasn't ... I wasn't born this way.
 T. ("Seriously".): How do you know? ... How do you know - (T. laughs.)

C. (Grinning.): Well I'm sure -

T. (Laughing.): Well, are you laughing?

C. (Laughing)

T. (Grinning.): Are you laughing?

C. (Laughing quietly.): Yes, I'm laughing.

T. ("Astonished".): Well, what do you know! You just make these flat apodie - apodictic statements, you know, you don't even examine the foundation. How do you know you weren't born the is way?

C. (Gropingly.): Because I know - .. when I look at babies and children I know they're good.

T. (Sarcastically and cynically.): You know they're good I When you look at a baby or child, you say, "One out of 10 chances that kid's going to spend some part of his life in a mental institution."

C. (Pause.): No, I don't think of the at when I look at a baby.

T. (Flatly.): You don't.

C. (Softly.): I look at a baby -

T. (Flatly.): You look al a baby girl and you say, "One out of t - uh. something like ... one out of seventeen chances she's going to be uh, uh pregnant before she gets married.

C. (Quietly.): Well I don't think of that.

T. (Protesting.): You - see there! You just don't think of it, see it in the right way. (Taking a different tack.) You weren't born this way? With your mother! .. and her history Maybe you're the one that came up with the twisted chromosomes You know, the weak genes.

C. No, no.

T. (Firmly.): The weak one of the litter.

C. No. it wasn't inherited.

T. It wasn't. (T. lights cigarette.) Well all right, they (i.e., her parents) blighted your life.

C. But I grew up thinking that I was. there was something wrong with me, and that I was no good.

T. Well. now. subsequent history has certainly confirmed your belief in yourself .. Hasn't it?

C. (Not responding.)

T. (Abruptly.). I didn't hear you.

C. Up "till now. I haven't! - I told you, there's not very much in my life that I can feel very good afoul.

T. There you go! Haven't made the grade as a mother, haven't made the grade as a . wife, haven't made the

grade as a person!

C. (In irritated disbelief.): Why do you keep telling me this!

T. Hell, you didn't even make the grade as a therapy client! Did ya?

C. (Doesn't answer.)

T. Did ya?

C. What does a client have to do?

T. Did ya? .

C. Well I progressed at times.

T. Ohhh, well, al times, and for a while, temporarily.

C. If there's no hope for me, now what about my children?

T. Oh well, you know, now that, uh, (sighs) if we can just attenuate your influence on them, maybe, you know ...

C. "Attenuate". I don't know what that -

T. Water it down, the in it out. ... Counter conditioning the horrible influence you had on them, maybe they stand a chance.

C. (Levelly.): Wow' You put it pretty strongly.

T. Well, didn't you think that? . They'd have a better chance without you, and uh ... you know, certainly needed somebody more stable and mature and mentally healthy than you. Didn't you think that?

C Yes, I did -

T. ("Reasonably".): Well, there you go! I'm just saying the same things, Sweetheart.

C. O.K., so what am I going to do about my children?

T. (Whistles in "stunned astonishment",)

C. This is what keeps me up at nights, more T. Huh.

C. than anything else.

T. Yeah. Sort of, well, we can't save the parent, but at least we might as well try to do something about the kids. Thai sort of thing?

C. Well, I don't know .

T. What(? Do you have tears in your eyes again?

C. (In a controlled voice.): Yes, I have tears in my eyes. (S.20)

Among several possible models (e.g. healer) for the psychotherapist, consider the court jester. This figure we are told, made playful comments about the king, his followers, and affairs of state; he punctured pretensions, took an upside-down look at human events. Now the patient, it might be said, suffers from gravity. To him Ute is a burden, his personality a riddle; yet viewed from the outside, he may seem altogether obvious and his problems nothing much. Indeed, just because he hurts and has a dreadful sense of failure, eventually he must find laughter in the midst of his accustomed tears and glimpse his own absurdity. Without irreverence, both he and the therapist stay mired in earnestness.

Fisher, 1970



Humor and Provocative Therapy

IT HAS OFTEN BEEN NECESSARY TO REMIND students that if the client is not laughing during at least part of the therapeutic encounter, the therapist is not doing provocative therapy and what he is doing may at times turn out to be destructive. Humor plays a central, crucial, key role in provocative therapy; it is encouraged and necessary, not just a tangential adjunct to the "real work."

Humor and its expression in laughter is such a ubiquitous phenomenon that we become almost unaware of it in our daily living. However, in the setting where psychotherapy occurs, most therapists are overcome with seriousness. Clients may in the initial stages of their treatment laugh, but this is most often viewed by the therapist as inappropriate, a facade, or a defence mechanism to be neutralized by appropriate confrontative comments so that the earnest business of therapy can be pursued. Perhaps Freud was typical and seminal in the regard; he wrote a very insightful treatise on humor (1928) but did not apply humorous techniques in his consulting room.

Humor is a valuable experience for understanding and dealing with the human condition. Consider that the contradictions of biology, culture, and technology impinge on the psychology of the individual. These influences and interactions rarely come into clear focus for long and of ten cause some degree of non-specific anxiety. In coping with these problems and their attendant anxieties the human must continually deal with his responsibility and finitude. Consider also that reality continuously changes, and thus our perception of it must change also if we are to respond adaptively. Our problem is to maintain balance and perspective, and this is precisely where humor can play a crucial role. The saying that "People laugh to keep from crying" illustrates this. Most people, hearing this, interpret

it to mean that humor can distract a person who is trying to cope with some underlying sadness. This interpretation is not opposed, but another meaning should be pointed out - namely, that if one adheres to an idea, belief, or perception too long or too rigidly, it is likely to lead to trouble and tears. Thus we need different perspectives which humor can provide. It becomes a safety mechanism enabling us to maintain equilibrium, perspective, and optimal psychological distance in our multivariate lives. A case in point is the continuing thinking vs. feeling conflict in our lives. Excessive thinking can effectively reduce the intensity of our feelings; excessive feeling can hamper our thinking effectively. Neither the over-intellectualizing rationalizer functioning like a cluttered computer nor the catastrophizing hysteric driven by the winds of her "real feelings" represent optimal human functioning. Two of the ways of monitoring the proportions of thought and feelings are through humor and play. **It** is quite impossible to be detached or excessively self-conscious while spontaneously laughing or playing. Humor can enable a person to obtain the appropriate psychological distance which lends a balanced perspective to his overwhelming feelings or irrational ideas. We are not speaking here of the withdrawn distancing of the schizophrenic, nor of the distancing of those who are excessively fearful of commitment and closeness in personal relationships, nor of the overintellectualizer who holds his experiencing at arm's length. We are speaking of the distance that lends perspective, enabling us to monitor and be critical of feelings, ideas, and behaviors, and thus more adaptively respond. Recently another intrapersonal aspect of humor has emerged more clearly through new therapy techniques which focus on the body (i.e. Gestalt Therapy, Bioenergetics, Rolfing, etc.). These at times have effected

powerful results. If one can accept the idea that repression is a muscular phenomenon or that psychological conflicts are expressed in the organism as a totality, then the benefit of laughter on a physiological level can be appreciated. For certain kinds of laughter are quite analogous to an orgasm with its release of physiological tension and the spontaneous, uncontrollable thrust to completion. Thus on many levels humor can be a helpful, freeing experience. Another important aspect of the intrapersonal functions of humor has to do with an individual's perception of and conceptualizations about reality. Reality exists independent of our perceptual apparatus, and no one individual could perceive or conceive all of reality. Indeed, we have enough trouble processing sufficient and correct sensory data to respond adequately and appropriately in all situations. Likewise our conceptions of reality are at times arbitrary and only logical abstractions not to be confused with the reality itself. After all, our sense organs only provide us with limited classes of data, and our creative powers of interpretation and combination are variable and limited. However, although somewhat arbitrary, our conceptions must always be judged in terms of utility and predictability. In order to continuously see these with maximum functional value, there is constant need for an optimum amount of perceptual and conceptual figureground fluidity. Humor provides a tool to insure this fluidity and evaluation.

More specifically, how humor can influence one's perceptions and conceptualizations of reality can best be understood by looking at the joke. At the risk of being overly simple, a joke can be seen as consisting of two parts: the setting up of a context and a punch line. Within an established context (ground) the punch line has as one of its main effects the reversing of the context very abruptly and bringing new elements into figure. This

momentary incongruity shatters and suspends normal perception. Real and not real are incongruously juxtaposed. Fantasy, and metaphor are intertwined with a new assemblage of data. It is our laughter which signals that this has occurred. With the punch line the rules of reality have become temporarily jumbled, and the joke comments upon another of the many multilevel processes concomitantly occurring either at the same or different level of abstraction .

At any one time there is an infinite number of levels of abstraction and reality which can be placed together, thus "blowing the mind", increasing awareness, and leading to at least momentary uncertainty in the person experiencing the incongruous juxtaposition or humor in a joke. Uncertainty can be very beneficial when it causes a person to examine his behavior, attitude, or construct of reality more carefully or from a different vantage point. In therapy this occurs functionally as a confrontation when the patient realizes that he is both the listener and butt of a joke that has personal relevance.

The punch line reveals the multileveled nature of reality by the reversal of implicit and explicit meanings, contexts, and levels of abstraction (i.e., similar to figure-ground reversals). Clinical sensitivity and judgment play a very large role in the therapeutic use of humor. When the implicit, suggested meanings in the therapist's use of humor have deep personal relevance for the patient, this usage of humor has therapeutic impact. Other uses of humor in therapy are to point to immediate feeling experiences as well as to free the client's creative imagination for "brain-storming" alternatives in problem solving. Turning from intrapersonal aspects of humor, we will now look at the interpersonal ones, for humor is a unique social phenomenon. Humor by its very nature is almost always shared with another person. Even an individual

experiencing a humorous perception in isolation is probably storing it in memory for future communication. Laughter can be real and in the present, bringing two people into the "now" of their relationship. People also tend to laugh more with friends and receive various forms of social "strokes" through humor. But people also compete and are concerned about their relative position with regard to each other; humor is often called into this fray as well. It is in the interpersonal sphere that such important issues and therapeutic themes as attack retreat, winning - losing, dominance - submission, superiority - inferiority and distance - nearness are contested with the camouflaged weapons of humor. Interpersonally humor is a form of play. One of the problems with adults is that their play too often becomes grim or too quickly degenerates into seriousness. As an illustration one can turn to football which probably started on a sandlot with inexperienced participants; it has evolved into a serious big business in the professional ranks. In contrast to sandlot football, roles have become specialized and the tackle cannot, without disastrous results, play quarterback even for a short while. In the same way creative fantasy and imagination wither linearly as seriousness increases, with the often unfortunate result that relationships and roles become rigid with less possibility of realignment. For optimum mental health adults must often decrease their level of seriousness and engage their imaginations to break out of an overly rigid perspective or myopic view of reality.

Play, much like psychotherapy, involves three elements:

- 1) "foundation" behavior (i.e., the serious struggle or competition that games evolved from - e.g. real fighting); 2) metaphoric behavior (i.e., analogous but either not as dangerous or in a different modality - e.g. fencing, verbal assaults, etc.); and 3) metacommunication (i.e., some

nonverbal behavior or the context which changes the usual meaning of the play or verbal message.) Humorous personal interaction is one form of play that can either start out in a playful context or can suddenly be reorganized into such a context at some point during the interaction. The playful context indicates that this particular communication process has meanings different from the one usually ascribed to its content. Just as the process of play creates a "real" fantasy or metaphor for reality, so also humor becomes paradoxically real and not real (Cf. Fry, 1963, p. 146) . 1

The metacommunicative aspects of the playful context are as necessary in provocative therapy as in play. These are communicated by non-verbal qualifiers such as a wink, a mock serious attitude, dialect, or the context itself.

However, the framework that "this is not for real" is often suddenly erased when the therapist's sensitive humor proves to be quite "real" and personally relevant, and the client suddenly realizes that "the joke is on him."

In dealing with the theoretical aspects of humor from an interpersonal point of view, one of her quality must be mentioned: humor is compelling and influential. It has impact. It changes people's minds. We suspect its compelling quality comes from the deeply paradoxical nature of our existence; people are more suggestible and compliant during the orgasm of laughter. We suspect that a humorous statement is just as likely to be remembered as a serious statement. Humor continues to influence us over time. It is a powerful interpersonal tool.

While we do not pretend that the foregoing is an exhaustive analysis of the subject, perhaps it is sufficient to provide a theoretical framework for understanding some of the uses of humor in provocative therapy. We need to stress here again that students have had to be frequently reminded that if their client is not laughing at least some

of the time, then they are not doing provocative therapy. Nonetheless provocative therapy is not just an entertainment hour. The therapist's use of humor is highly goal oriented and his purpose is to go beyond the laughter and have the client deal with personal issues, feelings, and behaviors in a direct and honest manner.

All therapy systems have dealt implicitly or explicitly with the nature of the therapeutic relationship, and most emphasize the importance of some personal involvement on the therapist's part. Involvement is also crucial in provocative therapy, but it is achieved in ways different from other therapies. In addition to being warm, kind, and friendly, the provocative therapist also achieves his involvement with anger and humor. Humor is consistently the main therapeutic vehicle for the expression of nonverbal warmth and positive regard in provocative therapy.

We tend to associate laughter with our friends, and experiencing something naughty and nice together builds affective involvement in a relationship. Clients tend to perceive easily the therapist's involved caring for them despite the therapist's verbal protestations to the contrary.

This is true whether the therapist expresses this in a warmly humorous or even angrily caring manner: Client (Shaking her head): "I don't care what you say - I know that you like me." One colleague after hearing a tape of provocative therapy stated, "You know, Frank, people are like dogs - they know whether you like them or not."

When our patients enter therapy, their lack of humor or the humor they express can indicate their disturbance.

Their thinking-feeling balance is out of proportion and their reality testing non-veridical. They have lost the freedom to tamper with inner repression and outer expression. Indeed, the ability to laugh, temporarily regress, lose control, and then reintegrate may be seen as a cardinal sign of wellbeing. Thus the patient's use of humor in therapy may

initially be diagnostic and later give objective evidence of successful intervention. The patient can learn to laugh congruently (again) and model the therapist in what is appropriate to laugh at, including himself. Specifically this means in provocative therapy that the therapist can laugh at himself, his foibles, beliefs, and life style to demonstrate that it doesn't destroy him, something that patients and many therapists seem to have forgotten.

It bears repeating that I used to tell clients truthfully, "I like you, I care for you," but I found out that they would explain these statements away: "You are trained to like us," or "I don't believe it," or "You like all kinds of people so your liking me really doesn't count," or "You are paid by the state to try to understand and like me." There was simply a credibility gap despite my protestations and genuine positive feeling towards clients; they found my attitudes unbelievable. Incredibly, however, when I started telling them in provocative therapy, "I can't stand you," I would get the response, "No, I know that you really like me," and I would reply: "It won't stand up in court!" or

T. (To female homosexual): Look George, if you spend half your life - fourteen years as you've done - in a nut bin, you're bound to get some distorted perceptions, some crazy ideas - and thars another one.

C. (Smiling assuredly): Every once in awhile you betray yourself, and I'm not so dense that I don't get it ... way down deep I know you like me.

T. (Protesting): Well, I used to be dedicated, and committed to, and liked clients, but now I've changed these attitudes pretty much and don't allow them to interfere with my work.

C.(Laughs) (S.21)

My obviously incongruent protestation would merely provoke them to laughter and a more firmly held belief. Operationally, there are many forms of humor used to provoke clients in provocative therapy. These are 1)

exaggeration, 2) mimicry, 3) ridicule, 4) distortion, 5) sarcasm, 6) irony, and 7) jokes.

By exaggerating we are speaking of the use of over- and understatement to test out the reality or feeling value of an issue; we mean the "Larger than life" caricature of the patient's ideation, affect, behavior, relationships, and goals. In this atmosphere the patient must decide for himself about reality options and the nature of his perceptions. For example, (5.22) in group therapy one patient of dull normal intelligence or less said that she wanted to be "another Carol Burnett" and go on radio, be a comedienne, and earn \$100,000 a year. I immediately became enthusiastic, jumped up in front of the group and said, "I can see it now!" I began an inept, highly tense, anxious, fidgety, and bumbling caricature of her first "radio show". Not only did the other group members burst out laughing but even the patient herself, who had spoken of this totally unrealistic goal, laughed and got the point. She blushed furiously, and said, "OK, OK, Frank, you can sit down. I get the point. I guess it was stupid of me. Do you think I could get a job in a hospital or nursing home, mopping the floors and helping with the cleaning and making 'beds?'" The rest of the group immediately nodded and said things like, "Now you're being more realistic, Mary," and "I think you'd make a good worker in a job like that. I've seen you work on the ward and you seem to like that kind of work and do it well."

Mimicking is accomplished by the negative modelling techniques described earlier where the therapist role-plays the patient's affect, ideation, behavior, or tone of voice. A five to ten second monologue in Jonathan Winters' style is usually very effective as a feedback device and quickly brings out the dysfunctional aspects of a communication or behavior.

Another example (S.23) involved a highly combative an

assaultive young patient who was talking in a threatening manner about her combative behavior during "psychomotor seizures" in the first interview. She was soon informed that I, too, had these types of "seizures." I then "uncontrollably" went into one of my "fits", holding my neck muscle so stiff that my head began shaking and trembling, staring fixedly at her with a frown, baring my teeth, making my hands tremble, shouting louder and louder as I rose menacingly out of the chair and took a step towards her. Through clenched teeth I gasped out an explanation that I had these types of "fits", too, and that if she ever upset me in one of our interviews, I too might go into one of these "seizures." I said I wanted to apologize in advance if I hurt her, because I certainly didn't mean to do so. She squinted, her eyes, looked at me quizzically, nodded her head, and then said, "OK, buddy, I get it. I get the point." (P.S. She never got combative, assaultive or had any "psychomotor seizures" in interviews with me.)

Ridicule is the form of humor which raises the most professional eyebrows and questions, and perhaps rightly so, for if not qualified, it can be hurtful. In defence of this technique, however, we would like to point out its potency. All across the country today people are using this powerful aversive stimulus to modify the behavior of others (families and playgrounds included). The late Saul Alinsky, the social organizer, has said, "Don't confuse laughter with the circus. Laughter and ridicule are the most devastating weapons that any organizer can ever use." Again it needs to be stressed that the provocative therapist ridicules not only the client's ideas and behaviors, but also his own role and "professional dignity." As an example, the therapist is leading a therapeutic community ward meeting. A middle aged, well educated woman leans forward to see around, other patients and looks intently at the therapist.

C. #1 (Seriously): Mr. Farrelly, have you ever noticed in therapy that your patients have difficulty distinguish you from God? Because when I was in psychoanalysis I couldn't distinguish my therapist from God.

T. (Leans forward as though half rising from his chair, stretching his arms out in a "suffering-Jesus-on-the-cross" position, assuming a "Messianic" facial expression; in a saccharine-sweet "forgiving" tone): Utter children ... (Therapist is continuing to extend his arms until his hand is in the face of a loud-mouthed, combative female patient sitting at his feet. She grabs his wrist, pushes his hand away while continuing to hold on to his wrist and, laughing loudly, interrupts the therapist):

C. #2: Aw shit, Frank - you ain't nothing' but a social 'worker! (Group laughs loudly.)

T. (Abruptly adopts a "surprised" expression, as though waking from a trance): Huh?

C. #1 (Looking at T., nodding slowly and seriously): I see, you don't let them get that dependent upon you. (S.24)

We think that the enterprise of psychotherapy must explore all available techniques to become a powerful, effective agent for change. We want the client to vigorously and insistently protest against his own self-destructive attitudes which have been externalized by the therapist. He provokes the client with content or mock pomposity to "put him down" and be assertive with him.

T. (Continuing to grimace): It's just, you're just such a .. stumble-bum and inept and ... ugh! (T. finishes by gesturing helplessly and sighing as though saying "wards fail me - I can't express how ugh you are!")

C. (Evenly): All right, I think ... I think the thing that has been missing the most in my life ... and the reason I'm such a stumble-bum and so ... ineffective .

T. (Flatly interjecting): Yeah.

C. : Is that I don't, I don't care for myself,

T. ("Supportively"): Well I don't blame you.

C. (Continuing uninterrupted): and I never have.

T. ("Supportively"): Well I don't blame ya! ... That's some - I'm happy to hear you've got some judgment.

C. (Pause; nonplussed): Wellll, I ... as I look back on my childhood ...

T. (Wearily): Oh must we? Oh, go ahead if you must ...

C. (Gingerly proceeding) ... there wasn't anything I did ... that ... that gave me any reason for ... for disliking myself intensely.

T. (Flatly): Well, you got it somewhere ... You've had ... plenty of reasons since then.

C. (Pause; persuading): But it's because I don't like myself that I do these things.

T. (Demonstrating): No, no, no! It's because you do these things, !hat's why you

C. (Interjecting): No

T. (Finishing): don't like yourself.

C. (Louder): No!

T. (Overriding her): Oh, you got it all back-asswards.

C. (Even mare loudly and firmly): You're wrong!

T. (Matching her tone): What do you mean, I'm wrong?

C. (Attempting to explain): It's 'cause -

T. (Pompously; not waiting for her reply): Hell, you're just a patient and I'm a therapist. Now how the hell do you know ... where do you get of! telling me I'm wrong?

C. (Evenly; with assurance): Well you're not infallible, Mr. Frank Farrelly.

T. (Laughs): Oh, I'm not? And I could be wrong, is that what you mean?

C. (With assured firmness): Yes, you're wrong. You're wrong about me. I'm not as ... as evil, and not as wicked, and not as ... damnable, and not as ... as hopeless (Phone rings; C. ignoring it, finishing) and not as (Phone rings again; T. puts hand an receiver but doesn't lift it, waits far C. to finish) ... inadequate as you ... contend! (C. laughs, nods head abruptly) There! (S.25)

The therapist uses these methods to get the client to defend himself realistically against the unrealistic and excessively negative evaluation when they come for himself or others. The therapist aids the client in practicing these learnings, and in practicing defending himself inside the "laboratory" of the therapeutic relationship so that

when met by these types of evaluations outside in other relationships, the client can cope with them more effectively. Many clients come to therapy not simply "thinned" but with virtually "no skin" at all; their psychological nerve ends are raw and exposed. The provocative therapist wants to help this type of client to develop "skin" and even some hide and callouses in the right places. The purpose is not to help the client become the psychological equivalent of a mollusk having an impenetrable suit of armor or to become an unfeeling, nonreactive robot. The purpose is rather to inure them somewhat to the "slings and arrows of outrageous fortune" and to aid them in relinquishing their hysterical, frequently over-reactive affective patterns.

Most of the time we can differentiate the patient's ideas, attitudes, and self-defeating behaviors from the patient himself. My two brothers who are priests and my sister the nun, state, "Love the sinner, hate the sin." Our colleagues say, "Accept the person, not his behavior." And we can assert, "Well, that's what we do also. We ridicule the person's screwball, idiotic ideas and behaviors, but not the person himself." However, we believe this to be a highly important but nevertheless subtle distinction, because operationally I am my behavior. "By their fruits you shall know them" was true 2,000 years ago and is still true. It is crucial to note that the patient does not usually make this subtle distinction between himself and his behavior initially. And we sometimes think they are right. We hate sinners, not just sin. Sin, self, fallible human beings, etc. are logical abstractions. We do hate certain kinds of deviancy and pathological, criminal, psychotic behaviors. With the growing trend towards the more behaviouristic types of therapy, the emphasis on behavior is becoming more 'accepted. The provocative therapist's message is "Never mind your insight, never mind how you feel within yourself,

you're still acting like a gouty loon, so how about shaping up in your relationships and behaviors?"

By and large patients are also at heart behaviourists. As a case in point, one of the problems that came up in a ward meeting was that one of the female patients was stealing objects out of the of her patients' nightstands.

T. (Defensively): Well, maybe she can't help it, did you ever think of that? I mean, you know, the mentally diseased need understanding and acceptance.

Several patients (Chiming in): Look, Frank, on that score we're mentally diseased too. It that mentally diseased person (pointing at offending patient) does it one more time, we're going to get mentally diseased more so, and she's gonna - we don't give a damn whether she can help it or not, she's gonna get it from us. (S.26)

And I thought, "How beautiful. Perhaps we have been misled by our own propaganda, but patients don't buy this 'I can't help it' routine from each other."

Another illustration of the same point concerns a young patient who had had thirty-six admissions between the ages of eleven and seventeen in six different county and state institutions (jails, mental hospitals, school for girls, etc.). When placed in seclusion with tuil restraints, she would somehow pull herself out of the restraints, stand the bed on its end, smash the ceiling lights, cut herself with the broken glass shards, and draw murals on the wall with her own blood - acts calculated to rattle the average administrative and clinical staff. Therapy was successful; during one of the last interviews:

T. (Puzzled): How come you've changed so much?

C. (Pauses; smiling): You know one of the reasons why I didn't change earlier?

T. (Frowning): No, I don't. Tell me.

C. (Closing eyes and shaking head): Because of the staff. Boy, are they suckers! (adopting a "bleeding heart" tone) "Oh the poor patient, she's upset, she can't help it."

(S.27)

Patients and clients do not believe in behavioral irresponsibility and neither should we. They will tell us, their families, and community authorities that they "can't help it" because it often stymies effective counter aggression. Clients are also behaviourists in that they operate on the assumption that they can't be accepted if they tell their "secret sins." We question why many clinicians spend hours trying to convince them that "I, unlike the rest of society, can accept and Like you no matter how YOL behave." How much simpler it is to start where the client is affectively and ideationally. Anybody who acts nutty, sociopathic, or neurotic is unlikable in that respect, and it would be better to change that so more people will respond in a positive manner. In the same manner, in the scientific evaluation of therapy it is not process but outcome, both in relationship and task performance areas, that counts: Has he obtained a job and can he hold it? Does he take supervision on the job, or does he walk off and get drunk? How is he getting along with people and what do significant others report: (As collegians have it, "If you can't make it with people, you can't make it.") Freud's response to his questioner who asked him what the criteria of mental health were is apropos here: How one works and how one loves.

A few parenthetical comments are in order regarding ridicule and current substitutional euphemisms. We don't say criminals anymore; we say "the adult offender". WE don't say "dum-dums"- we say "the exceptional child". In my work with some "exceptional children," they have told me, "Frank, I'm just not that smart. I don't get it." The } know they are not smart, but we baptize them with substitutional euphemisms which tend to distort reality adaptation. We were trained to "prize the worth and dignity of the individual," and not to say, "Look, you screwball

... " However, as a result of our experiences we have become pragmatic and want to use terminology that reaches these people. If patients can use the vernacular to get through to each other - and they do - then we, too, can use it with them.

Another distinction to clarify the use of ridicule in provocative therapy is that the therapist's ridicule is directed at the client's crazy ideas and self-defeating behaviors, while his non-verbal warmth and caring are directed at the person of the client. While persons should not be ridiculed, our stance is that ridiculous ideas and behaviors merit ridicule. As an example (5.28), a student therapist in a supervisory conference asked, "Now what do I do? I've got a patient that claims she's Christ's mistress," After a brief discussion we decided that the student would become the third woman in the eternal triangle, beating her patient's time with Jesus. With coaching the student (who was physically attractive and a plausible-looking candidate for the role of Christ's mistress in contrast to the patient who looked like a Mack truck with elephantiasis) was encouraged to ridicule the patient's ideation by claiming that she, the student, was Christ's real, favorite mistress! The student was urged to make statements such as "When I had my legs around Jesus the of her nig11t, He told me He was going to drop you in favor of me. He told me all about you and what a dull lump you are to screw." She was to tell the patient lengthy and specific details about her highly satisfying sexual and personal relationship, while making invidious comparisons between her and the patient's relationship with Jesus.

I also assured the student, who had religious sensibilities, that God would not strike her dead, that He would not regard the is as "blasphemy", and that since God was omniscient, it was a cinch that He understood the purpose and meaning of provocative therapy. And, who knows, He

might even give it His blessing with this poor delusional woman. Three interviews later the patient in a very embarrassed manner was asking the student to "quit talking in that crazy way. I didn't even half believe it when I was saying all that nutty stuff." And thus ended a four year delusional system.

Another case (5.29) illustration apropos here is that of a patient who told another student that "John Kennedy's penis rules the world." Again through supervision the student learned to ridicule this idiotic assertion by insisting in turn, in a highly inane, fanatically forceful manner, that "On the contrary, it is St. Joseph's pubic hair that is actually the cornerstone of truth," etc. etc. The student reported that the patient was looking at him askance, asking, "Who's crazy, you or me? I think it's you, buddy." When the student reported this in the next supervisory session, I responded, "When you get that kind of a response out of a nut, after you've role played in a ridiculous way his screwiness and crazy ideas or behaviors, then you're halfway home."

In short order the patient dropped his psychotic verbalizations and began to deal with his problems in a more effective, sane, and realistic manner. Ridiculing and laughing at craziness confirms that craziness is a game in disguise.

Ridicule can also be used effectively to counter condition excessive self-pity as in the following example.

C. (Pause; starts firmly): But I've also - wouldn't have spent all the is mo - money and time and effort in therapy if I didn't feel that there was ... the possibility of finding good in myself and, and leading a good life (finishing weakly; several words unintelligible)
T. (Interjecting loudly and firmly): Well after fifteen years you still haven't found it [therapist's thought: then it isn't in you] ... either that, or else you've had the wrong kind of therapists ... who haven't blasted through all the

glop and the mess and the inadequacy and incompetency and ... and, you know, discouragement and dependency and ... oh, you could just go on naming it, you know - who haven't, un ... you haven't found a therapist who could blast all the way through that crap to the (T. leans forward, puts his hand on C's arm "warmly") the real ... golden ... core that is you.
 C. (Disgustedly and laughing simultaneously): Ohh!
 T. ("Surprised"): Well what ... What?
 C. (Plaintively.): Now you're making fun of me. (S.30)

The provocative therapist utilizes humorous distortion which may take a variety of forms. The client's communication may be deliberately misunderstood to provoke him to clarify his thoughts and feelings; his obvious meaning may be clumsily and humorously misinterpreted to provoke him to reiterate and assert his meaning. Wildly distorted "psychological explanations" may be given to provoke the client into low level inferential explanations for his behavior. Example:

T. (Squinting at client, gesturing with both hands, and speaking with a "revival meeting" intensity): You may be in the grips of an UNCONSCIOUS that won't quit, that's got you by the balls where the hair's the shortest - (suddenly breaking his tone and speaking very straightforwardly in a normal tone of voice) - psychologically speaking, of course - (resuming his frowning intensity and "when in doubt pound the pulpit" tone) - a grip that has probably stifled your potentiality from being actualized -
 C. (Looking quicqually at therapist, then shaking his head and interrupting): No, I'm just a lazy lead ass, and ... (pauses briefly and meditatively) ... and you know, now that I think of it, I never have really disciplined myself and said no to myself. I always did pretty much just as I wanted (S.31)

Distortion can also be used to lampoon the client's expectations of the therapist's traditional role. He may plunge in with inane solutions to the client's yet instated problems to provoke clarification of the client's expectations.

Example:

C. (Entering the interviewing room, sitting down, pauses; holding his head in his hands; slowly, in a depressed tone): Do you think you could help me with -

T. (Interrupting enthusiastically and firmly): Yes! Now usually I tell people with that kind of problem, "No, don't do it" But lately I've come to feel, why not? I mean, if it feels good, do it; if it moves, fuck it.

C. (Impotently attempting to clarify): No ... see ... what I mean is -

T. (Interrupting, frowning angrily and loudly pounding the arm of his chair; dogmatically): That's just the point! And the solution to that problem is clearly - uh, what was your problem?

C. (Burying his face in his hands, chuckling, shaking his head): Jesus!

T. ("Waking up"): Huh? (8.32)

And finally the therapist can distort explanations:

C. (Slowly, in a puzzled tone): What's the matter with me? I must be ... promiscuous?

T. (Warmly, "supportively" patting the patient on her knee): You're not promiscuous, you just have a 367-day-a-year estrus cycle. (S.33)

The dictionary talks of sarcasm with words like cutting, hostile, contemptuous, caustic, and ironic. Although these adjectives could at times be applied to the provocative therapist's verbalizations, his "sarcasm" is almost invariably qualified by his facial expression, tone of voice, etc.

What follows is an example of the therapist using sarcasm with a promiscuous patient who had just obtained relatively well paying job.

Pt. (Coming into therapist's office; holding her hand out in a "Halt" gesture): Now, before you say anything, I want you to know that I got a job.

T. (Suspiciously): Where'd you get it?

Pt. (Triumphantly): In a laboratory.

T. (Sarcastically): As what, a specimen?
pt. (Annoyed but grinning in spite of herself): Oh you think you're so goddamn funny!
T. (Suspiciously and with a sarcastic tone): Oh yah, how did you persuade him to hire you, Sweetheart?
Pt. (Blushing): It wasn't like that! (5.34)

loony seems to have several connotations. Socratic irony is assuming a pretence of ignorance so that by adroit questions the patient's non-useful conceptions are made conspicuous. Another form involves the use of words to express something other than the literal meaning of those words. And dramatic irony involves making evident the incongruity between the actual situation versus the desired situation, between the outcome expected of the patient versus the probable sequence of events. This latter use is most effective in pointing out the negative payoff of a self-defeating

behavior sequence that the patient doesn't quite see or understand in total context. (5.35) A combative female patient, for example, has just been placed in seclusion room. She stands near the door grill, shouting obscenities at the staff for controlling her aggressive behavior toward another patient.

T. (Sidling up to grill, in full view of the patient; chartling loudly): AHa girl! You've got '-em on the run! They're scared shitless of you now, the son uv batching' bughouses and that crazy freak! Keep it up, don't let 'em break you (through clenched teeth) **No matter what! No matter how long they keep you in there!**

Pt. (Laughing in mid shout): Aw, go to hell, Frank! You ain't locked up in here. It's easy for you to say that. You try it, if you like it so goddamn much.

T. (Cringing, leaking furtively up and down hall, drops his voice to a conspiratorial whisper): Not me! They broke my spirit long ago, but I always have hopes that they'll finally meet somebody they can't break (suddenly glaring furiously, raising his voice in a fanatical shout) **No**

matter what tortures they -

Pt. (Laughing; interrupting in a conversational tone): Carefull, they'll put you in here next. Aw, piss on it, I'm shaping' up and shipping' outa here.

We have previously referred to jokes and the functional effects of the punch line's reversal and incongruity.

Provocative therapy gives the therapist permission to use any and all jokes in a therapeutic endeavour. The jokes can be made up of fragments of others, told with dialect, new creations on the spur of the moment, old punch lines in new settings, etc. An example in talking to a religious patient with sexual identity and performance problems follows:

C. (With an air of marked independence): I can do without men! (piously) I'll just become closer to God.

T. (Reminiscing; off-handedly): Reminds me of a friend, recently divorced. Of course, he had sexual feelings not like you. But anyway, he said that his divorce had really brought him closer to God. Of course I agreed with him - with one small I exception ... (pause).

C. (Lowering head, squinting at therapist; in a suspicious tone): What?

T. (Nonchalantly): Oh I just wondered how it was to crawl between the sheets with God.

C. (Blushes and laughs) (S.36)

This reversal of context brought us back to some real issues for this woman; she had used her conception of God and some bizarre avoidant behaviors to keep from dealing with her conflicted sexual feelings. With other patients an effective joke can help break their frame of reference and remove them from the crisis world they have created.

Having described the forms of humor employed by the therapist, we turn to some pragmatic reasons for using humor in provocative therapy. There are many genuinely funny incidents which clients report or which occur in

therapy; not to laugh at these would be ungentle. We have, as have many other therapists, almost chewed our lips off in interviews attempting not to laugh because it would be undignified, unprofessional, and would hurt the client's feelings, but if the therapist resists laughing at these incidents, he is lacking in congruity. Here is an example of what might be called "stuffed shirt professionalism." Early in my (F.F.) clinical experiences I began working with a patient who, although he had multiple problems, also had a very good sense of humor. I was tape recording my interviews. Entering my office he asked,

Pt. (Smiling): Are we on the air?

T. (In a grave, serious tone of voice, looking steadfastly at the patient): Would you like to sit down?

Pt. (Sitting down, smiling): Have we got the same sponsor we had last week?

T. (Frowning, in a very serious tone of voice): Let's talk about something closer to you. (S.37)

A contrast is this more recent sample from group therapy wherein a group of ten male patients had been discussing sexual concerns.

P-1. (Loudly, righteously): Let's get off the is filthy subject and talk about baseball!

P-2. (A mental detective, firmly): Let's talk about one subject at a time.

T. (To mental detective): George, which subject do you want to talk about?

P-2. (Grinning broadly): About sex!

(T and group guffaw loudly)

P-1. (Trying to control, interjects): But.

P-2. (Waving his hand at P-1 in a "pipe down" gesture): Aw, don't bring up your baseball problems now.

(T and rest of group laugh again) (8.38)

The following is another example of the therapist's congruity regarding humorous incidents. A highly promiscuous

patient entered my office and stated righteously,

Pt.: I haven't been with a man for the past ten days!

T. (innocently): Have you had the flu?

Pt. (Surprised): Why, yes, how did you know? I've had diarrhoea and been vomiting almost continuously.

T. (Laughing uproariously and throwing his head back spontaneously so that he almost falls out of his chair)
(S.39)

Another example is of a male homosexual who finally went on a date with a girl. Up in her room at her invitation "to listen to my stereo," he reported that she "slipped into something comfortable," sprayed perfume around and turned off the lights.

Pt. (innocently): What was that all about?

T. (Laughs heartily)

Another example:

T. (Sarcastically): Well, what are you going to say, Gorgeous, that you're in love?

C. (Lowers her head into her hand, shakes her head, in an embarrassed tone): No, I'm not in love, I'm in heat.

T. (Laughs)

These examples illustrate that there are some very funny incidents that happen in therapy.

If a client can laugh at himself and his behavior, this has several consequences. Self-pity will decrease; he will be practicing the ability to lose face and tolerate it more easily. Since in provocative therapy the therapist role models face-Losing, many clients even come to enjoy humorous face-Losing interactions. They learn to put themselves down in such a way that they are strengthening themselves.

T. (Waxing lyrical and gesticulating to a depressed, suicidal,

male patient): As you talk I'm getting the is beautiful picture of your suicide note; it could have been written by Albert Camus!

P. (Grinning): No ... more like George Babbitt.

(pt., T., and group of observers join in general laughter.)

Later in the same interview:

T. (Cynically, with slight sarcastic tone): Did all of your family fee I appropriately sorry when you made this suicide attempt?

P. (With sly humor): Well, I don't know ... but the thing about suicide is, see, I don't mind killing myself, but I don't want to hurt myself.

T. (Laughs uproariously.)

Still later in the same interview:

T. (Nonchalantly): Well, the reason I'm interested in your case is that I haven't had anyone commit suicide on me lately.

P. (Nonplused; then grinning): Lately?! (S.40)

Face losing and the incredible lengths we humans will go to save face are not solely Oriental social phenomena as the Irish song has it, "it's the same the whole world over" - and is centrally crucial for clients. Their fundamental sense of identity and self worth can hang in the balance between losing and saving face. Often they cannot seem to accept their own finiteness and the human animal's tendency to make mistakes. They will not engage in risk4aking behaviors because, if they fail, it would threaten their perfectionist self-image. They would "die of embarrassment."

Clients fail to realize that life is like piano lessons. In the acquisition of any skill, including social skills, one starts oft ignorant and makes obvious mistakes. In this process there is no possible way not to make mistakes, and since this is so, one either needs a teacher to point out mistakes

or learns to monitor his OWN behavior without being devastated emotionally. In the same way, unless clients can learn to accept failure with a balanced perspective as a necessary part of learning, they will never take the first step. On the other hand, if a client can view himself humorously, he will "catastrophize" less, be more realistic toward himself as well as others, and more realistic toward his own personal definitions of failure and his real failures. We suspect that a sense of humor toward one's self is an important part of a definition of maturity.

Therapy has to do with communicating ideas, attitudes, and coping behaviors. These forms of humor are often very effective ways to get a point across or to open anxiety ridden conflict areas more easily. Many a truth in provocative therapy is spoken in "idle jest." Humor can sugar-coat the bitter pills clients must swallow at times in therapy. It can soften and make more palatable some of the hard psychological lessons that need to be digested and assimilated.

Confrontation is a constant thread that weaves throughout provocative therapy. Using a confrontative joke or employing harsh words with a mock smile often gives the message: "Forget the why and deal with the bald fact!" To help the patient respond to and deal with a serious reality, humor is paired with confrontation to extinguish the associated anxiety. Humorous presentation can not only desensitize shame and anxiety, but humorous ridicule and sarcasm can sensitize clients to their own deviancy. Humor is thus a multi-edged technique.

Humor helps rivet the client's attention so that the therapist's messages can get through to him. Most of us remember the man who bought the donkey which responded solely to love and affection and needed no punishment; positive reinforcement was necessary and sufficient. He brought the donkey home, put it in the barn,

and later attempted to bring it out to harness it to a cart. Feeling like a fool, he engaged in the process of kissing and hugging and crooning sweet nothings into its ear with no discernable outcome. The donkey brayed continuously, stared balefully, and remained rooted in its place. Furiously he phoned the previous owner angrily protesting that he had been sold a bill of goods, that all the love and affection he was lavishing upon the miserable creature elicited no responses. The former owner placatingly agreed to a consultation. Upon entering the barn he stooped, picked up a 2 x 4, and slammed it forcibly across the donkey's nose. Its ears drooped, its eyes crossed, its knees buckled. It almost fell to the ground. The former owner, dropping the board, backed up and gently clapping his hands together, in a soothingly supportive voice whispered, "Come on, boy. Come on, boy." The donkey promptly walked out of the barn. The new owner exclaimed, "What the hell! You didn't tell me you had to half kill him first to get him to obey." To which the previous owner replied, "I forgot to tell you, you've got to get his attention first." This fable is analogous to people work; you've got to get their attention first.

In the therapeutic sphere the multi-levels and multi-uses of humor serve to catch the client oft-guard, to bypass swiftly his resistances, defences, and inhibitions while surprising him into a spontaneously felt experiencing as well as spontaneous verbalizations of his value assumptions and emotional sets. The provocative therapist wants to provoke this effective experiencing because experience is not only the best teacher, it is the only teacher of significant personal learnings. Thus the therapist attempts to provoke the client into being integrated, here and now and in this moment, with his experiencing or at least a facet of it. In the final analysis all we have is now. One of the problems of many clients is that they are either

"victims" of the past, fighting old vendettas (all of us have a strain of the Sicilian in us, "getting back at" comes as naturally as breathing), or are prisoners of the future (anticipatory anxiety - "What if ... " - perhaps more than conscience makes cowards of us all).

Humor can be used to place the client in an uncomfortably inferior position, thereby motivating coping responses in the relationship. If the client can assert himself with the therapist on a personal issue where the therapist has taken the negative side, the client is thereby establishing distance and superiority towards that problem. If the client has come to therapy expecting to be gently stroked and fondled, he is soon forced to deal with a barrage of unpredictable responses. This is especially important when dealing with the psychologically sophisticated client: humor here tears up the expected therapy scripts (no matter what their origin) and puts the client in the position of learning to cope.

A final reason not to be discounted is that the use of humor is fun for the therapist. It can keep him sensitive to the client, in touch with himself, and make therapy endurable and even enjoyable for him.

A caveat is here in order: If some is good, more is not necessarily better. From our experience we are strongly convinced of the benefits of using humor in therapy. However, too great an effort on the therapist's part to be continuously funny can render his humor forced and merely brittle, making him woodenly insensitive both to himself and to what the client is experiencing.

The Four Languages of the Provocative Therapist



Now brothers, if I come to you speaking in tongues, how shall I benefit you? If even lifeless instruments, such as the flute or the harp, did not give distinct notes, how would anyone know what is played? And if the bugle gives an indistinct sound, who would get ready for battle? So with yourselves, if you in a tongue utter speech that is not intelligible, how would anyone know what is said? For you will be speaking into the air. There are doubtless many languages in the world, and none is without meaning; but if I do not know the meaning of the language, I shall be a foreigner to the speaker, and the speaker a foreigner to me.

St. Paul, Corinthians: 14

IT IS A TRUISM, BUT ONE WITH EXTENSIVE ramification, that to communicate effectively with people, one must speak their language. St. Paul was probably not the first nor will we be the last to recognize this. In a word, if we as therapists are not really getting through to the client, our words, be they ever so profound, are not worth a damn to the client. They are glossalia. Taken out of context anything can be made to look ridiculous, but the reader is asked to ponder these metaphors which were actually said to clients: (1) Therapist (Looking existentially profound): "Life is Like a carrot." (2) "When I close my eyes and think of you, I see mushrooms."

often as a result of our professional training and socioeconomic subculture, we clinicians use words that simply have no meaning for the patient. As a result we are "broadcasting" on a different frequency and not "tuning in" to their wave length. I (F.F.) was working with a group of senior high school boys, and I brought up something about masturbation. I heard one boy in the group mutter to another, "Use English." Another guy made a small square in the air with his forefinger, and I thought, "Oh, oh, I'm almost dead - they're tuning me out." So I stated, "Well, when I was fighting in the Golden Gloves, in the locker rooms we used to call it jacking off, beating the meat, wanging your ding-dong, etc." They all blushed and burst out laughing. Some of them got noticeably embarrassed. I asked, "Do they still call it that?" They laughed, said "yes", and I thought, "Okay, we're back on the same wave length."

The constant task of an effective psychotherapist is to translate his concepts into terminology that is relevant and has significance for that client within his sociopsychological and semantic frame of reference. The of her side of the coin is then to use the client's terminology to give it new meaning and the us influence his thinking and perceiving.

The provocative therapist is constantly trying to do both: get inside a frame of reference and then change it. When we as beginning therapists entered the field, our language would have certainly been acceptable at any upper class tea and crumpet session. However, with time, experience, and provocative therapy we now talk in a much more gutsy, affectively charged, connotatively loaded language. We have found this to be effective because the kinds of things clients are struggling with are to them emotional dynamite; their conflicts do not fit into polite, socially correct terminology. These are the kinds of intense feelings that cause very serious pathology and social deviancy. Only certain kinds of words seem to carry the emotional freight that needs to be transported into the open.

Over the years provocative therapists have used many languages, words, dialects, etc. to enhance their communicational skills. However, the majority of these can be conceptualized as four different kinds of effective language: (1) a religious-moral language; (2) locker room, or language of the street; (3) a body or kinesthetic language; and (4) professional jargonise. The religious-moral language is parental, injunctive, authoritarian, based on black and white distinctions, and tends to deify the legalisms of certain subcultures or certain periods. Locker room language is adolescent, four letter, bawdy, expletive, and affectively loaded. Body language is communicated by position, carriage, gestures, facial expressions or the tactile senses. Professional jargon is stilted, polysyllabic, profound sounding, and usually scary. Examples are necessary to clarify these many adjectives. A combination of religious-moral and professional jargon in juxtaposition was given in 8.16, Chapter 111 where the client decided she was immoral, weak and lazy.

We have discussed in the role chapter the therapist

commenting upon the patient's body language in the communication process. However, the usage by the therapist of direct body language is very important when the therapist is having difficulty getting through to the client using only words. For example (5.41) a young, attractive, but acutely depressed client came into therapy because her husband was being sexually unfaithful to her. She presented herself as completely unassertive, utterly beaten down by this knowledge, and was thinking of suicide. The first interview was held on a rainy March day, and my shoes were caked with mud. After some discussion ...

T. (Sighing, wearily): You're a real door mat, aren't you?
C. (Almost inaudibly): Yes, I guess I am.

It pained me to do this, but dedicated and -committed to the client's welfare as I was, I proceeded to wipe my dirty shoes all over her expensive dress as she sat listlessly in the chair across from me.

T. (Blandly): Okay, doormat ... well, at least you're useful for something.
C. (Hurt and bewildered; in a whining tone, while slowly brushing the mud off her dress): Oh, please don't do that.

When she came in for the second interview, I placed my feet in her lap and kicked her in the leg (not too hard). In the third interview I dutifully started to do this again, but the is time she kicked back - hard - and there was a dramatic lifting of her depression. She became somewhat homicidal, but that was simply another clinical problem to work through.

Another example (5.42) of body language can be cited. A female catatonic patient who had been completely mute for six months was a problem to the ward staff. I was

convinced that she was putting on a big act, that she had even extinguished her started response, and that though she gave no sign that she was aware of anyone around her, she could be made to talk relatively easily. I made a bet of \$2.00 with some of the staff (even though you are not supposed to gamble on civil service time) that I could provoke a clearly articulated English sentence from her along with appropriate congruent affect - an integrated response- within one week's time.

My reasoning was two-fold: (1) She was treating us like pieces of furniture and not even acknowledging our existence as persons, and the us I (along with several other staff members, carefully chosen for their weight) would treat her as a piece of furniture and sit on her for ten three-minute "lap-sitting trials" per day for a week. (2) I reasoned that even though she was obviously "mentally diseased," nonetheless as I said to the staff, "The thigh bone is connected to the back bone, which is connected to the head bone, which is connected to the tongue bone, and she's gonna talk when her thighs feel squashed enough." My bet was, the conflicts in her thighs would outweigh those in her head.

The "lap-sitting trials" were begun and were immediately sequential!. On the fourth trial she pushed hard, but that non-verbal response, even though it demonstrated clearly that she was returning from her limbo, did not count. On the sixth trial she burst out laughing, pushed hard on the staff member's back, and clearly enunciated, "Get the hell off my lap." So much for mute catatonia: it six months of it can be counter conditioned after only eighteen minutes of innocuous lap-sitting, it obviously cannot be that serious a condition.

As an example (5.43) of locker room language I was interviewing a female adolescent in the dayroom of the hospital ward when another attractive but verbally aggressive

girl broke in and stated in aloud voice, "When I get discharged, I'm gonna become a whore."

T. (Laconically): Aw hell, Rocky, if you took up thai line of work, you'd starve to death within a week.

Pt. (Blushing, lasing some composure, but forging ahead aggressively): No I won't, because I'll charge two hundred dollars a night.

T. (Incredulously): Two hundred dollars! What the hell do you have to offer a guy in bed for two hundred bucks?

Pt. (Blushing, but assuming an air of nonchalance): Oh, never you mind, I can offer plenty.

T. (Trying to be helpful): Hey! I've got an idea. Did you ever try the banana girl routine?

Pt. (Puzzled; captiously): What do you mean?

T. (Ignoring the rapt attention of several patients and staff; enthusiastically): Well, see, I used to have the is patient in therapy who had been a whore, and she told me about the is one "trick," or "John," or customer who used to come to her every so often - not to screw her but with a big bunch of bananas. She had to peel the banana, stick it up her vagina, and squeeze it out in a controlled way while he ale it. Now, when you get discharged, you could specialize in that. What do you think?

Pt. (Blushes furiously, puts her hand to her mouth as though gagging; amid general laughter of patients and staff)

T. (Grinning broadly): Well, how afoul it?

Pt. (Still blushing, shaking her head): You are a bastard, Farrelly. No, I think I'll figure out some other discharge plans! (patient, staff, and other patients join in the general laughter.)

Many times clients are not really in touch with the emotional meaning of their behavior. Locker room language has a way of getting into the "nitty-gritty" and provokes the feelings appropriate to the behavior; it cuts through a lot of non-specific and euphemistic bullshit. For example:

Male Client (Offhandedly): I prefer 10 have relationships

with people of the same sex.

T. (With intensity): You mean you enjoy sucking cocks.
(S.44)

Another example which combines professional jargon and locker room language follows:

Male Client (Wearily): I just right now see that there are a lot of things that I've talked and talked and talked and talked ... about and ... I just never did anything about.

T. (Nonchalantly): Yeah ... yeah ... (sounding like a bored robot). Talk-talk-talk-talk-talk-talk, and you never !:let your ass in gear!

C. (Wearily agreeing): Yeah.

T. (Warmly): Or, another way of putting it might be (in a sing-songy tone, as though dictating a report), "The client verbalizes quite well but he does seem to lack some ... motivation. There is some indication within the dynamics of the interviewing situation which would tend ... to support the hypothesis ... "

C. (Laughs weakly.)

T. (Continuing): " ... that he utilizes verbalization as a defence ... and intellectualization .. "

C. (Pauses. Grinning sickly): Yeah.

T. (Bluntly): Yeah what?

C. (Agreeing): O.K., 50 I talk a lot and don't act.

T. (Emphatically): Well, there you go! Talk, talk, talk, like I said, but you don't get your ass in gear.

C. (Attempting humor): I understand ... (pause, seriously y) ... very well.

T. (Forcefully): Well, thars another thing you do. See? You understand, but you don't do a damn thing C.

(Interjecting): But I don't do.

T. (Triumphantly): There you go! See?

C. (Laughs)

T. (Solemnly): Or, as we say in the clinical field (Continuing to "dictate" in a sing-songy tone), "The client shows, ... uh, increasingly evinces a ... oh, rather well-balanced grasp ... " (To client, emphatically) This wouldn't necessarily apply to you, but I mean we could say this about somebody.

C. (Grins, laughs): Yeah.

T. (Continuing solemnly): - of the dynamics C.
(Guffaws.)
T. (Doing a "double take"): Uh-huh?
C. (Grinning broadly): Okay. Go on.
T. ("Dictating" again): ... of his conflicts ... semicolon.
At the present time, however, he does not seem to
be able to utilize the insights ... that he has obtained
through the course of the psychotherapeutic relationship.
C. (Grinning): Yeah.
T. (Warmly): You see?
C. (Grinning; in a ponderous tone, mimicking his own
intellectualizing): I understand.
T. (Loudly): There ... sure! There you go! Just! what I
said!
C. (Laughing quietly.)
T. (Not "noticing" the client's self-congratulatory grinning
and shifting into forceful tone): Yeah. You

An example (5.46) of the use of the religious-moral language will be included at this point. Provocative therapy enables one to talk the language of and work with patients from strict and varied religious backgrounds. Several months after the 91st interview, I learned that an Irish Catholic, middle-aged, professional woman was admitted to my ward as a drug addict. She was in an agitated depression, suicidal, and spent the whole day rooted to a chair in the day room. When I saw her for the first time, I went and sat beside her. I tried my approach on her and she tearfully agreed with everything I said, stating that she was "going to her!."

T. (Surprised): Oh yeah? (extending his hand, grinning)
Well, put 'er there! I've always wanted to meet someone
who was going to hell. Me, I'm going to heaven because
I'm so good, virtuous, and noble. I do the seven Corporal
and seven Spiritual Works of Mercy, have the twelve
Fruits of the Holy Ghost, made the nine First Fridays,
and five First Saturdays. Do you realize how much merit
in Heaven I'm gaining by talking to a lost soul like you?
And I have so many pearls in my heavenly crown (leaning

against the patient's shoulder and chortling as though sharing an insider's joke) that it'll weigh my head down and make my neck stiff and sore from wearing it.

With no discernible changed response from her, I spoke to her for about ten minutes and then left thinking, "This is the one. I knew I'd run into a patient sooner or later that would 'break' the system, that wouldn't protest." But I wondered, "What if I try it again tomorrow with her?" I did so, and was easily able to provoke supportive responses from other patients in the day room toward the hell-bound Irish gal, but no protest or self-assertive response from her whatsoever, despite trying my best and using repeated denunciations of "sinners who only got what they deserved. God, like the Northwest Mounted Police, always catches up with your type finally." Still no response. The next day, and the next and the next, I tried to reach her but with still no different response, only continuous tearful agreement with me that I was right, that she might as well be dead, and that she deserved to be punished and sent to Hell. And each day I would leave the day room puzzling, "What the hell ... ? But what if I push myself to try it one more time tomorrow?"

On the thirteenth day I sat next to her while she was crying, and speaking out of the corner of my mouth, growled, "Hello, you sinner, you know what people are calling you behind your back around here, don't you?"

Pt. (Nodding, crying): I know ... I know ... I deserve it.

T. (Continuing, while laughing): A hop-head, a -

Pt. (SLAP!)

With abrupt suddenness she swung and struck me across the face, charged out of "her" chair, screaming, cursing, kicking a waste basket across the day room, and throwing a chair after it. I grappled with her and, with the help of some staff, ushered her, fighting, to the seclusion

room. When I locked the door, I put my face to the grill and laconically stated, "Sweetheart, you blew it now. You can't go back to your fragile, China doll, and poor sinner routine again." The stream of invective that greeted me led me to believe that I was right.

She demonstrated no more evidence whatsoever of depression, and in subsequent sessions exhibited a more balanced approach to her religion. For example, she stated she now knew God loved her, and that:

Pt. (Seriously and sincerely): Mr. Farrelly, I was very angry at you, and I want to apologize to you and ask your forgiveness, because I now know you were not being heartless and cruel, but were being an instrument of God's grace and help to me.

T. (Extending his arm towards patient, with a gloating expression, offering his shirt cuff): Wanna kiss the hem of my garment? Aren't I wonderful? Do you want to call me St. Frank of Madison? (Folding his hands in a prayerful gesture, gazing heavenward with a beatific expression)
Oh God -

Pt. (Interrupting; smiling slightly, looking at therapist levelly): Okay, you can stop that - you're Catholic, and you know perfectly well what I mean.

T. (Feeling approximately one-half inch to 11; stalling for time): Huh?

This patient, who had had thirteen hospitalizations and eight different diagnoses over a ten year period, was generally regarded as being hopelessly chronic. She made marked progress, was discharged, and the cycle of recurrent hospitalizations was effectively broken.

Parenthetically, a significant learning for me was that many cases require more than a one trial learning experience, that if at first you don't succeed, try, try, try, try ...

I also learned that "incorrigible reprobates" could be effectively "converted."

Some years later at a presentation of provocative therapy the following dialogue ensued during the discussion

period.

Workshop member (In an irritated, annoyed tone): You're moralizing with these clients!

F.F. (Blandly): I try to.

Workshop member (Protesting): You're preaching at them!

F.F. (Again blandly): That's my aim.

I went on to explain that the therapist is the new priest in the is culture, that people who refuse to "confess their sins to a mere man" went to therapists where they recounted face-to-face and at length their "deviancies, conflicts. and inadequacies. "

The search for a value-free psychotherapy in the 1940's and 1950's was akin to the search for the Holy Grail.

Nobody ever found it. Furthermore, the quest was doomed because value-free therapy cannot exist, however subtly the therapist attempts to disclaim that he is "imposing his values, attitudes, and perceptions on the client."

In the history of attempting to help people with their problems of living, there have been a variety of models or paradigms of human behavior. The moral model, which spoke of good and bad, of vice and virtue, was "supplanted" by the medical model which spoke of health and sickness. In turn the medical model is being "supplanted" by various social-psychological paradigms which speak of self- and other-enhancing behavioral patterns as well as self-defeating and anti-social behavior patterns. But through all these models runs the theme of good and bad, desirable and undesirable. And since society, clients, and clients' relatives operate on the moral model, I use it not only because it remains a valid mode of conceptualizing human behavior, but also to tune in on their wave length, to speak their language.

Locker room language as well as the body-kinesthetic and religious-moral language usually raises some professional eyebrows and the question, "Is this professional?"

Our response is that the term "unprofessional" should only be utilized when it can be shown that such behavior is detrimental to the goals of a given profession - in our case to the welfare of clients - and not as a substitute for "naughty" or "I don't like it." It seems abundantly clear to us that it is merely an institutional definition to assert that words with Grecian and Latin etimologies are considered inherently more "professional" than Anglo-Saxon slang words for bodily functions, organs, or behaviors. A priest once observed, "The only real obscenity in our culture today is not four letter slang words for sexual relations or bodily functions, but rather words like 'nigger'." These words are more serious because they denigrate individual persons or whole classes.

Furthermore we use language like this with friends, families, and colleagues; and patients use language like the is among themselves and to staff. Why not then use this language and match theirs if it is effective? Because we desire to provoke an effective experience in the client (both to sensitize as well as desensitize), we try to avoid substitutional euphemisms and bland terminology when talking with them. In addition we find that very often clients use language to throw the therapist off balance, put him in a one-down position and gain control!. The following example (5.47) is instructive in this regard. The therapist, when thrown off balance, uses this to regain contra!.

C. (A young, verbally aggressive lesbian; with angry contempt):
God, are you a dumb bastard! You probably have
pimples on your prick!

T. (Taken aback; "impotently protesting"): I ... you ...
how do you . '.' what if ... I do not! (He hesitates,
looks uncertain) At least when I checked this morning, I
didn't have any on it.

C. (Turns her face away; blushes; bursts out laughing):
Boy, are you nuts!

T. (In a hurt tone; suddenly develops a facial tic): Boy,
Herman you sure know how 10 hurt a guy.

C. (Shakes her head; grinning; somewhat embarrassed): My name ain't Herman! (S.47)

If the therapist is not comfortable with or able to use this language himself, he very often cannot be effective with certain clients.

Thus in provocative therapy many languages are used to get into the client's frame of reference, try to change it, and provoke an affective experience. The type of language employed depends largely on the client's socio-cultural background and the specific topic being discussed. How it is used depends on the specific and immediate goals, the struggle of wills between therapist and client.

The Stages of Process in Provocative Therapy



IN THIS CHAPTER WE WANT TO PRESENT A highly impressionistic set of observations. When we speak of stages of process for the client in provocative therapy we do not wish to imply a rigidly defined or look-step progression. However, over the past decade some recurring themes have gradually emerged which we arbitrarily divide as "stages of process" in provocative therapy. We are well aware that the types of client responses are at least in part a function of the types of stimuli which the therapist proffers him. Although these differences in the rates and patterns of responses vary from client to client, there also seems to be a large degree of commonality. With these caveats firmly in mind we will attempt to delineate these stages.

Following the outlining of the four stages of process for the client we will address ourselves to client motivations for continuing in provocative therapy. Finally because of our commitment to training, we want to present some sequential experiences or processes that trainees appear to exhibit in learning provocative therapy.

From a previous chapter it should be remembered that the provocative therapist attempts to provoke the client to engage in five different types of behavior: 1) to affirm his own worth both verbally and behaviorally; 2) to assert himself appropriately; 3) to defend himself realistically; 4) to learn necessary discriminations to respond appropriately; 5) to engage in risk-taking in relationships. However, even if a client would agree with some or all of these generalized goals, his expectations of how to arrive there are often quite discrepant from those of the provocative therapist.

Stage 1.

In the initial interview, the client is precipitously provoked into a series of experiences that tend to leave him

astonished, incredulous, uncertain and even at times outraged. He experiences a marked clash of expectational systems; his expectations of the therapist's role are not only disconfirmed but are almost reversed. He will typically tend to react with such statements as, "What kind of therapist are you? I've never heard anybody talk like you." He will also characteristically tend to be astonished and surprised at the intensity of some of his own reactions when the provocative therapist quickly bypasses his defensive sets and succeeds in provoking him into immediate affective experiencing. His new found spontaneity has, as a corollary, uncertainty:

C. (Slowly.): I don't like the is ... I don't know what you're going to do or say next, but worse than that, I don't know what I'm going to say next.

Despite all the foregoing reactions, the client is almost invariably intrigued by the therapist's approach to his problem.

" Example (5.48): a female client was referred to me (F.F.), her thirteenth therapist. As she entered the office I asked, "What's your name again?" She said, "Rachel Levin" (a pseudonym). I said, "That's Jewish." Bristling, she replied, "Yeah." Detecting an accent, my next question was, "Where are you from?" "New Yawk", she replied. I fell dejectedly into my chair, "Oh, my God! A New York Jew bitch!" (She didn't even have her coat off, nor was she seated yet.) Halfway through the interview she stated, "\ can't believe my ears, do you actually help people this way? I am just continually angry at you." To which I replied, "Help? Who's talking about help? Talking you can get, but help is harder to come by. Now you haven't been helped by those twelve of her therapists whom you wore out, why demand the impossible of me? Besides (gesturing toward her), I need some material to work with." Then I

shifted and went on in a depressed tone of voice, telling her that "My lord, do you realize they even write books about your type, like How to be a Jewish Mother. You are an archetype in the clinical field." Needless to say, we were off to a roaring start. Although it may seem surprising to some (and was so initially to us), 95% of clients return after the first interview. There seem to be some recurring reasons why this is the case, and here we shall let the clients speak for themselves:

(1) "Something happened here, and fast." Clients tend to feel that some very real, gut level issues are immediately engaged by the provocative therapist, and although these are anxiety provoking clients also experience this as deeply supportive and relief-giving. As an example (5.49), I had used more traditional therapy techniques with a patient for over 170 interviews; when several years later he returned to see me, his traditional therapist had metamorphosed. He was non-plussed and as he stated later, "I left the state right after that, muttering to myself as I went." When he returned and spoke of my "turnabout", I replied:

T.("Supportively".): Well, I was only trying to help.

C. (Laughing derisively.): Help!? Help provoke!

Later in the interview he stated, "Now you're treating me more like an adult human being than a fragile, helpless patient like you did when I first saw you. You've taken off the kid gloves, and in some ways though it doesn't feel too good, in other ways it makes me feel like a man and more nearly equal to you."

(2) "I don't like what you're saying, but I'll say this for you, I don't have to sit around wondering what you're thinking of me like I did with my other therapist." Still other patients report that "pussyfooting" on the part of their former therapist simply frightened them; i.e., "I got scared because I got the distinct impression he thought I

was so fragile that I'd break in pieces if he came right out and told me what he thought was wrong with me." In a number of ways they may not like what the therapist says, but they do like feedback. It seems to give them something to hang on to: "I don't have to do all the talking myself; you carry your half of the conversation or more."

"Therapists I've seen (as another client phrased it who had seen six previously) were very reluctant to give me feedback. I'd ask them something, and they would stare at me or at the ceiling, and I could just see the wheels in their heads going around, the sorting and sifting going on as they were trying to figure out a good response to me. And then, after all the hesitation I'd get a question back in response such as, 'And why do you ask that?' But you, you just bloat it right out as you did in the first minute of the first interview with me."

(3) A third recurring theme of why clients tend to return to provocative therapy after the initial interview concerns that of the issue of control. Again, let a patient speak: "I found out I could twist of her therapists around my little finger, easily embarrass them and make them blush. I can't bully you - and that's good. And when I come in here and try to embarrass you with all that I've done sexually, you don't get embarrassed; you make me blush at your responses! And you know, that's good - you and Hank (her boyfriend) are the only persons I've found that I can't make jump through hoops."

(4) A fourth theme is the experience of being understood. Clients frequently misperceive the provocative therapist's burlesquing of their "doom and gloom" approach to living as deep understanding on the therapist's part. As one patient put it: "You're the only one who understands how stomach-churningly revolting and nauseating I really am way down deep inside of me. My family and friends don't know how bad I am, but you saw it inside of

several minutes." (!!!) However, the therapist .does attempt to understand deeply both the internal and external world of the client, to achieve not only empathies understanding but also an objective knowledge about the client as seen from the vantage point of his significant others. And clients sense the is: "You always say exactly how I'm thinking and feeling toward myself", and "You must have talked to my family - that's exactly the way they see me."

(5) A fifth reason - perhaps central to why many of them return - is because of the humor which is so close to the essence of provocative therapy. When asked if she would return for another interview, one client said, grinning, "Of course! This is the first time I've ever been the central object, of a really funny floor show!"

(6) A sixth reason is that the client tends to like the therapist, albeit at times ambivalently.

C. (Laughing.)

T. (Grinning.): What? (Client continues to laugh.) What are you laughing about?

C. (Grinning, wiping eyes.): Oh, I don't know, you're just cute sometimes, Frank.

And again, another client:

C. (Sincerely, warmly.): You're the kindest, most understanding man I ever met in my entire life - (Grinning)

wrapped up in the biggest son of a bitch I ever met. (7. and C. laugh together.).

(7) Clients don't say this but a final reason we strongly suspect is the Contest aspect of the encounter. Some clients seem to be aching for a fight, for the verbal and psychological equivalent of a waterfront brawl in which they neither have to observe the social amenities in their word choice nor fight fairly, a fight in Which they are given the freedom to be their nasty quarrelsome selves. Other

clients evince the desire to match wits, tactics, and strategies with the therapist. The provocative therapist is happy to oblige these clients and enthusiastically joins the fray.

Stage 2.

After the surprise and uncertainty of the first stage, the client typically decreases his protestations regarding the therapist's behaviors, begins to recognize that he and not the therapist must change, and starts reorganizing his expectational system toward the therapist. His characteristic mood is one of sulkiness: "Damn you, you're right about me." There may emerge the feeble beginnings of the five types of desired behaviors that the provocative therapist wants to provoke. And finally this stage is characterized by a marked diminishing if not total extinction of psychotic defences if these were initially present.

Example (S.50):

A deeply religious young man entered my private practice with his staunchly Catholic parents. He had a history of a psychotic break, several hospitalizations, and no jobs following a homosexual episode. Convinced that he was immortal, his behavior in traffic was bordering on suicidal.

In the first interview it quickly became apparent that his "immortality" was connected in his mind to his homosexual episode. He further averred to the consternation of his appalled parents that anyone who engaged in fellatio with him would also become immortal. The therapist, alternatively laughing uproariously and speaking with intense seriousness, expounded at length during the first three interviews on the social, theological, and economic consequences of his new "power": (1) the client would "go down" in history as the 20th century Ponce de Leon; (2) the National Institutes of Health would declare him a national resource; (3) world-wide religious organizations would be

completely revamped, basing their liturgies on the new dictum: "He that sucketh my cock and drinketh my sperm shall have everlasting life in him"; (4) world-renowned shrines and holy places would be deserted as pilgrims now flocked to him "on their knees"; (5) national and local health delivery systems (hospitals, health insurance programs, and the medical profession en masse) would become financially bankrupt; (6) he, in turn, would become wealthy beyond his wildest dreams as the terminally ill sold all their possessions for the newly discovered "Elixir - er, cream - of Life".

Therapist (Seriously.): "I also think it only fair and just that your mother and father here (gesturing toward parents), who are well into middle age and who gave you the gift of Life should, uh ... in turn ... uh . "

Mother (Holding hand up to her mouth as though gagging.): I think I'm going to be ill - do we have to talk about these things?

Father (Glaring at his son.): God, you have sick patterns of thinking!

Therapist (Trying, and failing, to keep a straight face but forging ahead): Uh ... it's only fitting that Mom and Dad should be the first uh, I don't quite know how to put this tactfully .

Client (Had been repeatedly laughing explosively throughout the three interviews, both at the therapist's zany theme developments as well as at his parent's obvious discomfiture; finally angry.): Dammit, will you quit talking on and on about this crazy shit? I never really believed this stuff for the past year anyhow, even when I was telling people it. It's just crazy, that's all.

Therapist ("Surprised".): What? What did you say?

Client (Forcefully.): I said I never really believed all that crazy crap anyway, so why don't you just shut up about it?

Therapist (With a Pollyanna-like smile; coaxingly): Would you repeat that?

Client (Laughing.): You heard me.

Therapist (Still smiling.): I know, but my favorite number is three and some things I like to hear three times.

Just once more.

Client (Noticing his parents are laughing with relief; laughing and smiling himself.): Go to hell.

Therapist (With eyes toward ceiling] hands folded as though in prayer.): Don't listen to him, God, you haven't for years. (To client, coaxingly.): Aw, come on, just once more for your friendly therapist.

Client (Smiling, nodding, in a serious tone.): O.K., O.K., 1 never really believed all that crazy stuff I said about being immortal even when I said it. There. Satisfied?

Stage 3.

This stage is characterized by clarification, choosing,

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and moving on the client's part. The hallmark of this stage is the client's congruent and increasingly firm protestations that the therapist's definition of him is a skewed, inaccurate one based on a distorted reading of inadequate samplings. (Cf. S.25)

C. (Pause; persuading.): But it's because I don't like myself that I do these things.

T. (Remonstrating.): No, no, no! It's because you do these things, that's why you

C. (Interjecting.): No -

T. (Finishing.): don't like yourself.

C. (Louder.): No -

T. (Overriding her.): Oh, you got it all back-asswards.

C. (Even more loudly and firmly.): You're wrong!

T. (Matching her tone.): What do you mean, I'm wrong?

C. (Attempting to explain.): It's 'cause -

T. (Pompously; not waiting for her reply.): Hell, you're just a patient and I'm a therapist, now how the hell do you know - where do you get off telling me I'm wrong?

C. (Evenly; with assurance.): Well you're not infallible Mr. Frank Farrelly.

T. (Laughs.): Oh I'm not? And I could be wrong, is that what you mean?

C. (With assured firmness.): Yes, you're wrong. You're

wrong about me, I'm not as ... as evil, and not as wicked, and not as ... damnable, and not as ... as hopeless (Phone rings, C. ignoring it and finishing.) and not as (Phone rings again; T. puts hand on receiver but doesn't lift it, waits for C. to finish.) ... inadequate as you ... contend (C. laughs, nods head abruptly.) There! (S.51)

The client mobilizes specific, concrete, easily observable and increasingly adaptive behaviors that have the ring of authenticity to prove the therapist is wrong about him. His identity and operational value system are coming into focus. He is increasingly clear about who and what he is and what he is not, and attendant upon this is a beginning confidence in his new crystallizing self.

Stage 4.

This final stage is one of consolidation and integration. The client is now protesting significantly less if at all about the therapist's definition of him as a person. If he does protest, he does it impatiently or humorously and is increasingly confident in his present self's adaptive and coping capacities. He will tend to dismiss the therapist's caricatures of him as "out-of-date" or his "old self".

C. (Laughing.): That's the way I was, Mr. Omniscient, but no longer!

He is establishing and consolidating his gains, and is in an integration phase, able to analyze and construe his experiences more appropriately and accurately.

c. (Thoughtfully, slowly, as though speaking with himself.): You know ... I have been getting so much warmth and real love from people lately ... I can see that now, now that I'm different ... But they really haven't changed that much, they were pretty much like that toward me all along ... And yet, I just couldn't see

it, or I would explain it away ... But it was there all along, and I was blind ...

T. (Pauses; quietly sarcastic.): Same old distorted perceptions, huh?

C. (Smiling; assuredly.): No, no distorted perceptions the is time, Frank - this time it's real, and it's been real for weeks. (Pause; thoughtfully.) You'd have to travel around with me for a couple of weeks to see the intensity of the warmth that people have toward me. I guess I never really, really noticed it before. But now that I'm more open to them, I can see it.

T. (Disgustedly.): Aw, shit, you're getting grandiose.

C. (Shakes head, chuckles and grins.) (S.52)

He is nearing the end of therapy, and has laid a basically secure foundation regarding his identity and self-worth, thereby freeing his psychological energy toward constructing the edifice of his life - his life style, relationships, goals and accomplishments.

Thus far in this chapter we have addressed ourselves to the four stages of process for the client, and to the client's motivation for continuing in provocative therapy. We will now turn to the sequential experiences that many trainees appear to exhibit in learning provocative therapy. But before proceeding, perhaps some comments from some respected colleagues are in order. Carl Rogers, in listening to a tape on provocative therapy, stated, "I know you, Frank, and I know your commitment to patients, but I wonder, if others used this approach, would they get the same results?" Carl Whitaker remarked, after watching a provocative therapy group session, "Yeah, it's authentic. And it's got to be alive - if it gets mechanistic, it would be dead and get no results." And Bill Jackson has observed, "I know you, I've done therapy with you, and I've seen your warmth and caring for patients. However, when some of your graduate students first hear of provocative therapy and try it, they come across like sarcastic pricks. And it's kind of like the novice versus the experienced

violinist. The novice looks at the experienced violinist and says, 'I get the idea. You tuck it up under your chin and then you saw back and forth with this thing you call a bow.' Well, different sounds are going to come out from those two violins. And therapy, in one way of looking at it, is mostly overtones. Or, as the man on the street puts it, 'It's not what he says, but how he says it.' " It seems to us that all three of these therapists were pointing to the fact that provocative therapy, to be effective, must be more than mere mechanistic techniques and requires a personal learning process.

In observing the process over the years we have been able in an impressionistic, observational way to decipher seven different stages in the process of becoming a provocative therapist.

Stage 1.

The initial reaction when hearing of provocative therapy might be termed a "cringe phenomena" characterized by the internal or external sentence, "My God! That's no way to talk to these poor people in pain." Or, as one clinician responded when asked for his "off the top of your head reaction": "O.K. I guess in a sense I feel, 'What the fuck is that son-of-a-bitch therapist doing to that poor unfortunate patient?' "

Stage 2.

The initial reaction tends to be followed by a secondary one of intrigued fascination which is usually implemented by requests to observe "live" interviews, group sessions, and video tapes of the therapist in action with clients, and to listen to audio tapes with individuals, groups, and families. The degree of the beginner's interest can be roughly measured by the degree to which he immerses himself in the secondary experience of observing and

absorbing.

Stage 3.

The beginner, after a period of listening and observing, soon wants to attempt engaging clients in provocative therapy and decides to do so with some anxiety that the client will be "scared off" (i.e., that he, the beginning provocative therapist, will! fail and be rejected). He soon learns that he can begin provocative discourse with clients, can provoke responses from them and even be confronting and humorous in his own individualistic manner. However, he often obtains significantly more information and affect from the client than he can comfortably handle; frequently in response to the intensity of the client's affect he is pushed (or flees) from the provocative role.

Supervision is vital throughout this process, but especially at this juncture. Trainees want to know, "Where do I go from here? I can provoke the client's affect but I don't know what to do with it once I get it. And my sense of humor is not good or quick enough to get the client laughing." The supervisor attempts to expand the trainee's awareness of the client's tactics and defensive ploys with their purpose, while helping the student "brainstorm" and develop some counter-strategies and conceptualizations of the issues and progression of therapy. He tries to loosen the student up and free his sense of the ridiculous about human behavior by giving sample responses to the student, by asking the student to "name three different humorous ways" he could have responded to the client regarding a specific point, and by patiently helping the student with this. He also helps the student by sensitizing him to the funny incongruities we all engage in, by aiding him to engage in quick, five to ten second, Jonathan Winters type role plays around a variety of therapist-client

interactions and, finally, by her ping the student lampoon his own therapeutic role with the client. For example, olie student brought to supervision a problem he regarded as insurmountable. The patient did not want a student therapist, but a trained staff member, to work with him. The student, who was quite threatened by the patient's rejection, was rapidly helped by several suggested responses with role-played affects:

1. (Anxiously.): "Listen, I told the staff what you said, but apparently they don't want to waste any of the real professionals' time on you."
2. (With mock anger at supervisor.): "Well, I don't want you either - here I am, a green kid just starting to learn and my supervisor dumps you in my lap!"
3. (Pleadingly.): "Aw, co me on, I have to practice on somebody."
4. (In obvious consternation.): "Good Lord! My supervisor said if I don't cure you, I'd flunk!"

Over the years when students have been coached to burlesque with humorous openness their own therapeutic role, the client's demand for a "real professional" rapidly ceases to be an issue. Clients get to work with what they have.

Stage 4.

In this stage the trainee typically tends to experience a sense of release from the relatively constricted role behaviors of the more traditional therapies, and senses this (as one trainee phrased it) as "an effective antidote to the emotionally sterile enterprise of dissecting psychotherapy from a research standpoint" . The quickness of therapist client exchange and the emphasis on the immediate interactional process is quite focal; the trainee typically wants to make sense out of his experiencing, to apply

cognitions to this exciting new process. Thinking and conversation are accelerated: "Wow, therapy can be fun! But how is this helpful?". One beginning provocative therapist, grappling with the issue of the client's pain, likened the process to "taking a bandage off the client. Provocative therapy is Like taking it off more quickly compared to pulling it off hair by excruciating hair. Maybe the client has to go through X amount of pain to grow, but the is way is quicker." The trainee also tends to deeply question his own position on the issues of client fragility and need as well as his view of the therapist's role; it is a time of much self-examination and internal dissonance. The student also becomes hungry to learn the "rules of relationships", begins to sense the lawful processes in interpersonal exchanges, and as a consequence experiences a developing sense of control both in his personal and therapeutic relationships.

Stage 5.

In this stage the beginning provocative therapist experiences the freedom to use more of his total range of responses and whole self as a therapeutic instrument. He becomes more aware of his own ongoing experiencing and receives floods of associations both in and out of therapy. He discovers and begins to use his "insides" as a hitherto untapped but now valued reservoir of responses to clients. Typically there is a rush of fantasies and remembered experiences, and a creative incorporation of these into his awareness, her ping him to catch the nuances, flavours, sounds and smells of his experiencing and that of the client. In his attempts to translate the foregoing into therapeutic interventions, he is sometimes wooden, sometimes playful, sometimes ineffective, and increasingly successful.

Stage 6.

The trainee is becoming more confident and is enjoying therapy more, but at times fails to avoid the two extremes of (1) excessively abrasive confrontation taking the form of unhelpful, indiscriminate sarcasm as well as (2) using his humor to meet his own needs at the expense of the client. Supervision reminding the student that the major purpose is to help the client is usually sufficient to contravene these occasional lapses.

He is becoming more adept at reading the client's nonverbal I communication, and sending his own contradictory provocative messages. He is learning an increasingly disciplined use of his newly-found therapeutic self, and is able to maintain a focus on the client's conflict areas while directing his interventions towards change.

Stage 7.

This is an open-ended stage, characterized by continual learning, growing, and developing on the part of the beginning therapist. By now he has internalized the supervisory process, is monitoring his own behaviors in therapy, and is no longer dependent on the supervisor, needing only occasional consultation. He is evincing an increasingly wide repertoire of therapeutic behaviors and is able to orchestrate and modulate confrontation, humor, external social reality, and the reasonable expectations of the client's significant others - all in response to the range of client behaviors and problems. He is experimenting with and adapting his skills to new settings and client populations.



*Provocative Group
and Family Therapy*

IN THIS CHAPTER WE WILL ATTEMPT TO generalize the previously delineated techniques and principles to group and family applications. The assumptions and techniques are not different, merely the therapeutic situation in which they are applied.

Provocative therapy lends itself to these modes of treatment because of its largely interpersonal and here and now focus. The goals of therapy are much the same and bear repetition at the is point. The provocative therapist in any setting will I attempt to provoke both positive and negative affective experiences in an effort to have the client engage in certain types of behavior: (1) To affirm self worth both verbally and behaviorally. (2) To assert himself appropriately both in task performance and relationships. (3) To defend himself realistically. (4) To engage in psycho-social reality testing and learn the necessary discriminations to respond adaptively. (5) To engage in risk taking behaviors in personal relationships - the expression of affection and vulnerability with immediacy as they are authentically experienced.

All of the above goals are applicable to the group and family therapeutic modalities. We shall begin this chapter by looking at group therapy and then turn to family therapy, leaning heavily on examples to illustrate the use of various principles. We do not pretend that what follows is an exhaustive analysis of group and family therapy, nor of provocative therapy's application to these client groups. Our purpose is simply to refer to some aspects and problems in group and family therapy by the use of samples illustrating provocative techniques.

Provocative Group Therapy

In striking contrast to the client population from which most other therapeutic systems emerged, provocative therapy grew out of experiences at a state hospital. Here patients are required to attend groups of various types as

part of the milieu treatment. The variables that characterize these groups would boggle the mind of researchers and most outpatient therapists. They are open ended with regard to membership. The number of sessions of any member is variable, as in the number of patients in any one session. Groups typically are quite heterogeneous with patients varying in symptoms, age, sex, diagnoses, I.Q. level, education, occupation, and marital status.

As a group progresses, the basis for the emerging cohesiveness is the universality of felt experiencing, which common denominator is both a key tool of the therapist in engineering some order from this apparent chaos as well as one of the central sources of gain for group members. In such a group the issue of control is crucial from the outset. The therapist must provide structure, communicate norms of behavior, and initially of necessity be the focus of the interaction. The issues that are engaged may be defined by the group (e.g., how the staff and patients are getting along), by the individual group member (e.g., "My problem is I'm here. When can I go home?"), or by the therapist (e.g., "What do you people want to name our groups - Loser's and Co., Weirdoes Ltd., Despair Inc.?")

When I first began using provocative therapy with a group (5.53) - approximately a month after the 91st interview with "Bil I" - I was surprised by the response of the groups members. No response. They sat quietly, looked at their watches, asked to quit early, and showed similar evidence of disinterest. After several of these puzzling sessions I discovered from one of the ward nurses the explanation. She asked, "What's going on in your group, Frank?!" When I responded, "Nothing, that's what, and I don't understand it," she rejoined, "Oh yes there is. They've been staying up late the last several times you've had your meetings and talking as a group among themselves, holding special sessions to discuss what went on

in your meetings with them." And I thought, "Good! I'm getting responses even though they're hiding them from me. Whoever said that the mentally disturbed can't form groups?"

At the opening of the next group meeting I stated, "I understand you gals have been holding your own little meetings among yourselves, and -"

C.#1 (Evenly.): It's easy for you to sit there and be sarcastic about and laugh at our pain. I'd like to be around when you suffer, Buddy, because it's coming in your life.

T. (Taken aback; somewhat embarrassed; ignores his reaction, chortles loudly.): Well, see ... we staff don't suffer like you all have, why, we just sail along from one success to another, our relationships are all warm and cozy, and we just never get anxious or depressed.

Now -

C.#2 (Nodding meditatively.): I get it - no, the difference between you staff and us patients is not that we suffer and you don't, but you handle your problems far better than we do.

Starting with this meeting the patients began and continued to bring their "special sessions" into the regular group meetings thereafter.

The provocative therapist attempts to provoke the whole group or individual members to respond affectively to the therapist or each other. Often he will! attempt to play group members off against each other or at least use some member's attitudes to reinforce his point. In keeping with the provocative nature of much of the commulication the therapist adopts the regressive, defensive, and anti-social values of the group members. Often the other members will! explain why the therapist acts as he does.

Example (5.54): An aggressive, mentally deficient patient often became furious at the way I was talking and kept threatening to come over and hit me. When I would ask her, "And when you hit me, what am I going to do to

you?" she would respond, sulkily, "Yeah, I know what you will do, you will throw me in seclusion." She became very tense and angry when I was talking about her behavior one session and threw a bunch of torn up paper at me. I had her get down and the floor and pick up every last shred. She was somewhat embarrassed but also relieved that "you're not going to throw me into seclusion." The other women in the group, in a motherly way, explained to this particular patient, "Can't you see what he's doing with you, Mary? He's actually trying to help you. He's trying to get you to practice controlling your temper so you don't get into so much trouble around here by hitting other people all the time."

The use of explanation and insight follows similar lines. For example (5.55), a female patient questioned why she had rushed into church at a funeral, thrown her arms around the casket and kissed it. I began offering plausible but untrue reasons why she had done so and remarked, "Well a good Catholic like you ... " She interrupted, stating that she did not consider herself a good Catholic and had not been to Mass for years (and at least in the early sixties that was the operational definition of a good Catholic). I continued, "Well, a good friend of the family and all ... " She interrupted again, stating that she had not known the family or the dead person at all. Her response elicited a series of long stares and puzzled frowns from the other patients in the group. One patient stated, "Well, you mean you went into - what do you call it, a funeral mass ... (C.#1: "Yeah") and you threw your arms around the coffin and kissed it ... and you didn't even know the dead person?" (C#1: "Yeah, that's right.")

T.: Well, maybe you had an excess of religious fervour and devotion.

C.#1: (Shaking her head and laughing.): Uh-uh, I was crazy in the head.

T. (incredulously.): What do you mean?

C.#1: It was just a nutty thing to do.

We had been' unable to get her to admit this, although the entire staff had previously been trying to tell her precisely the types of things she was provoked into saying. This woman soon got down to business and continued talking in a very uncrazy like way. She stated that no matter what the reason she was not going to kiss coffins or engage in any other weird, bizarre behaviors.

T. (Protesting.): Well you just can't do that unless you know the psychological and genetic roots of your conflicts. If you don't know how it all started, how can you stop it?

C. (Firmly.): I'm just not going to do that again, that's all.

T. Well, then you'll probably start doing some of her types of crazy behaviors - symptom substitution, as they call it.

C. Like hell, I know what's crazy and what's not. I'm just not going to do stuff like that.

(Group, patient, and therapist burst out laughing.)

As in individual provocative therapy the therapist frequently uses his humor to provoke group members (G.M.s) into disclosing and dealing with their problems. In addition to this, the following sample illustrates how the provocative group therapist can handle a group member's near rage by provoking him to laughter.

A powerfully built man in his early 30's was referred to

an all male group. Brought recently to the hospital by the police, he evinced a barely controlled rage reaction, and was considered potentially dangerous and unapproachable by staff. Entering the room after the session had started, he sat down opposite the therapist, breathing loudly through his nose, his teeth clenched, glowering fiercely.

T. (Finishing with another G. M. 's issue, turning to new

G.M.; casually): Hi there, what's your name?

G.M.#1 (Loudly, fiercely, through clenched teeth.): Never mind!

T. (Anxiously back pedalling.): O.K., you don't have to (Suddenly changing his mind; offhandedly puzzled) Oh, I know now (snaps his fingers), you're case number 93,322. Aren't -

G.M.#1 (Frowning at T., then looking around the group; loudly and angrily interrupting.): Who the fuck is this -

T. (As several G.M.s look back and forth at G.M.#1 and T. and begin laughing; T. clapping his hand to forehead, I then pointing at G.M.#1): Wait, don't tell me. See if I can I guess. Are you the guy whose wife sent him in here because he was out screwing the heifer, or -

(G.M.s 2, 3, 4, and 5 burst out laughing; four others are watching therapist and G.M.#1 carefully.)

G.M.#6 (Straightforwardly to G.M.#1.): This here is Frank Farrelly and he conducts this group therapy class (sic) twice a week. You have to get used -

G.M.#1 (Looking less fierce; interrupting G.M.#6, speaking to the group, some of whom continue to grin or chuckle; less loudly.): He sounds a little off himself -

T. (Interrupting, in a choked, hurt tone.): Well, maybe you're right, 93,322, but I used ... to be normal ... as blueberry pie ... before I started holding these meetings with this ding-bat crew here -

G.M.#1 (Looking at therapist, elbows on knees, hands clasped in front of him; then lowers his head, turns it to the left, bites his lower left lip obviously trying to hide his efforts to keep from laughing; next shakes his head from side to side, snorting to himself in a soft tone.): Shit!

G.M.#4 (Leaning forward to speak to G.M.#1; grinning.): We call this Weird Beard's Comedy Hour. It's the highlight of our -

(Several G.M.s laugh, along with G.M.#1, who has ceased looking so angry and is openly grinning at the group.)

T. (Looking at G.M.#1, smiling slightly; in a jocose tone.): Well, of' buddy, 93,322, you ready to tell us what you're so pissed off about?

G.M.#1 (Frowning; in much better control.): My name's

Fred Blank, and you'd be pissed off, too, if your wife had you thrown in here by a bunch of cops the other night.

G.M.#3 (Nodding agreement, looking at and addressing G.M.#1.): My wife did that to me a month ago, and I'm still angry at her in a way.

G.M.#1 (Looking quickly at G.M.#3; firmly.): I ain't staying in here for no month, that's for sure.

G.M.#4 (Sitting back, watching interaction; to G.M.#1.): What was her beef with you?

G.M.#1 began explaining his situation to the therapist and the group and admitted he had a "hair-trigger temper". This cooperation was quite a change, enabling him to make use of the resources of the hospital to effect an early discharge. (S.56)

The following narrative summary illustrates the manner in which the provocative therapist can provoke reality testing in a group setting.

A group member was in a severe depression because he was convinced that he had "killed" his father. While wrestling with him at a family gathering as was their custom, the father fell and struck his head. One month later the father was severely injured in a car accident, necessitating brain surgery. The group member felt that he had "killed" his father because his father was no longer the man he had been and was a "helpless chronic brain syndrome." Although depressed, the patient was determined to get out of the hospital and make a success of himself.

At this point the therapist interposed with, "You just want to go out and make a success of yourself and make your poor father more jealous and bitter!"

G.M.#1 (Bursting out laughing, very red in the face.): That's just the way he would feel!

T. ("Angrily. "): You vicious little prick. Just won't let up, huh? Want to make him feel even worse, huh?
(Much laughter in the group.)

G.M.#1 (Laughing.): You're putting me on but, you know, I really do feel that way.

He then compares himself to Lee Harvey Oswald, stating that they are both assassins.

G.M.#1 Six months after my lather gat hurt, Lee Harvey Oswald killed John Kennedy. He was a loner too, just like me.

G.M.#2 (A paranoid.) begins laughing at Group Member #1.

T. (Angrily and seriously.): Yeah, I see the connection. I see it now.

Of her group members laugh. G.M.#1, red-faced and embarrassed, also laughs. T. pushes the idea that G.M.#1 's connection with Oswald is quite apparent and that the is is "irrefutable logic." G.M.#2 scoffs at this, stating, "You can relate anything to anything if you want to." T. continues to call G.M.#1 a "vicious little murderer who should be locked up in prison." G.M.#1 agrees that he felt that way, but finally is provoked into shouting, "It was an accident! He always wrestled like that and we were kind of drunk, and it was just an accident." T. still doesn't believe it: "\ bet you got angry at your father when you were a kid and it just finally came out of your unconscious!"

G.M.#1 (Rationally confident.): Sure, I got angry at my father when I was a kid, like most kids do with their fathers, but that wasn't it.

He seems firm in his evaluation of his experience at this point. This is the first time that he has actually said that it was an accident; heretofore, family, staff, and friends had reiterated this to him, but he had continued to excessively blame himself.

At this point the hour is up and G.M.#1 comes over to T., who cringes in his chair and whines, "I take back all I ever said about you." G.M.#1 is laughing continuously and wants to shake hands with T., who finally does so,

asking tremulously, "Is this a ju-jitsu hold?", then tries to "tear away" his hand from the patient's "grip".

T. (Astonished.): God, you've got a grip like iron!

G.M.#1 continues to hold on to T.'s hand, laughing, saying that it was an excellent meeting: "I really got a lot out of this today," and says that he hopes to see T. again. All of this takes place near the door of the room in which the meeting was held; the other group members are standing around smiling and laughing. G.M.#1 follows T. all the way down the ward corridor. T. unlocks the ward door, quickly jumps through the narrow opening, and slams the door shut. Through the glass, G.M.#1 can be seen waving his hand, smiling and laughing at T. (5.57)

A further narrative summary follows, illustrating the therapist provoking reality testing and counter-conditioning of excessive self-pity in a group setting.

A short, frumpy-Looking, middle-aged, chronic patient (5.58) in an all female group had used numerous, blatantly diversionary tactics against the therapist to keep him from confronting her with her behavior. Her tactics mainly consisted of the themes of how "of her people did it to me" and of pointing at single traumatic episodes to find the cause of her "mental illness" - "if only that hadn't happened to me." She finally began speaking of the "worst of all": she had had a son out of wedlock over twenty years ago.

The therapist (knowing that 5 out of 8 group members had had illegitimate pregnancies), rises, pulls the crying patient to her feet, puts his left arm around her shoulder, takes her two hands in his right hand as though dramatizing the message, "I'll protect you, my child, from the rejecting onslaughts of a cold, cruel world," and in a choked, halting voice, with his throat constricted and swallowing loudly, he blinks rapidly to force tears to his

eyes while telling the group, "Nobody knows what a U.M. - er, unmarried mother feels. These are ... these are the ... wounds that cut so deep, and ... they never really ... heal. They can lie ... buried and festering in a poor l mother's heart (the patient looks up at the therapist, sniffles and lays her head on his left shoulder; therapist strokes her hair with his left hand while continuing his contrived, treacly soliloquy) ... these wounds can stay there suppurating and oozing psych ic pus over the years (some group members snicker), until ... until you see before you (therapist wipes tears from his eyes) ... a broken, despairing" guilt-stricken poor wreck of a -" At the is point the group members burst loudly into laughter with some exclaiming, "God, what an actor!" Others look annoyed, and say to G.M.#1, "Aw, get oft it, Frieda, four others of us in here were in the same damn boat you were." One group member, half annoyed but grinning, says, "Yeah, so 'cut the crap, Frieda." The patient rapidly ceased her "Poor Me" role in the group.

The following narrative summary portrays a recurring phenomenon in provocative group therapy: the therapist provokes other group members to engage in provocative interactions, in this case, to counter-condition massively preservative denial.

A paranoid schizophrenic patient (G.M.#1), recently admitted to the hospital and a new member of an all-female group, has asked repeatedly (literally twenty times in the session) about going home: "Can't I go home? Please let me go home. Why can't I go home?" She interrupts continuously with her refrain, and is listening to neither other group members nor the therapist in their efforts to help her examine the behavior that led to her hospitalization and was keeping her there.

G.M.#2 (A mentally retarded woman, interposes.): She's here for something, but she won't admit it.

G.M.s attempt to help G.M.#1 repeatedly, but she consistently broadcasts the message, "I don't need to be here," and adds to G.M.#3 (Blandly):

Don't think of me in your shoes. (Turning to T., repetitiously).
Can I go home?

At the is juncture (three-fourths through the session) T. compares G.M.#1's behavior to the "Chinese water drop torture," (explaining it to the group in detail) and then begins saying, "Slip" each time G.M.#1 asks her question, responding in effect, "If you're not going to address yourself seriously to your problems, I'm not going to address myself seriously to your questions."

Other G.M.s begin taking up the therapist's "Slip" refrain.
G.M.#1 (Hesitating; attempts to rephrase.): I believe I'm well now ... can I go home?
G.M.s (Laughing; some shaking their heads in disbelief; as a chorus): Slip!
G.M.#3 points out that G.M.#1 is not "consistent" enough yet to be discharged from the hospital.
G.M.#1 (Ta G.M.#3; persisting.): I'm consistent in wanting to go home.
G.M.#4 (Laughing.): Persistent is the word.
G.M.#2 (Interposing.): I disagree on that. She's not strong enough. She's sick. She's not ready to go home.
T. (In a sing-song voice, wearily, to G.M.#1.): Annie, do you think that if you just keep it up and keep it up and keep it up that the staff will get worn down and finally say, "O.K., damnit, we give up, go home?"
G.M.#1 (Smiling.): Well, I don't know, I might try it, if it'd work.

(G.M.s and T. laugh, provoking G.M.#1 to laugh along with them.) (S.59)

The next day in a large therapeutic community (T.C.) ward meeting, Annie opens the meeting with her deafeningly repetitious refrain. Several group therapy (G.T.)

members who had been in the small group the previous day, immediately respond as a chorus, "Slip!" and laugh. When other T.C. members look mystified, the G.T. members laughingly explain the comparison of Annie to the "Chinese water drop torture". Both T.C. and G.T. members begin humorously responding to Annie with "Blip" answers to her questions. Within the day she rapidly ceases asking these and begins listening and responding in a sane, appropriate manner both in group therapy and on the ward.

In addition to the above samples illustrating the use of provocative therapy in a group, the reader is referred to the chapter entitled "Humor and Provocative Therapy" for further group samples.

Provocative Family Therapy

The new emphasis on family therapy has historical, clinical, and utilitarian reasons. The provocative family therapist does not subscribe to what he regards as an overemphasis

on family therapy (some therapists refuse to see a client without his family), but there is no doubt that family therapy has a number of strong points to recommend it. Among these are the following:

1. Clients are far less able to control the information input; family members in provocative family therapy tend to "rat fink" on each other with alacrity and enthusiasm.
2. Family members, taking their cue from the provocative family therapist that they are not fragile, tend to confront each other quickly in therapy with specific behavioral data often contradictory to the individual family member's selection of 'data; they have broad, life-long samplings to choose from.
3. Family members know the emotional lexicon of each other and can frequently decode their communications quickly based on years of living together.
4. Blood is still thicker than water and the literally thousands

of times that family members have reinforced each of her serve as bonds which the provocative therapist utilizes as powerful change inducers.

In addressing ourselves to the subject of family therapy we do not purport to deliver a treatise on the varied interfamilial constellations that obtain in American society today, nor will we be discussing at length the pluralistic marital patterns that have emerged in our culture. We do, however, want to make some observations regarding family therapy, for clinicians using this mode of treatment in their practice must, of necessity, whether they are aware of them or not, make certain assumptions or adopt certain antecedent operational stances toward marriage and- the family with consequent results for their clients.

It has been noted that "the trouble with people is not that they're so ignorant, but that they know so many things that ain't so." LeMasters (1970) has listed a number of myths about parents and children that are given operational assent by many in our culture, including clinicians.

Some of these myths are:

- (1) Rearing children is fun.
- (2) Children will turn out well if they have "good" parents.
- (3) Children today really appreciate all the advantages their parents are able to give them.
- (4) There are no bad children - only bad parents.
- (5) Modern behavioral science has been helpful to parents.
- (6) Love is enough to sustain good parental performance.
- (7) American parents can be studied without interviewing fathers.

In provocative family therapy these myths (as well as other cultural, professional, and personal ones - Cf., S.50, Chapter VI) are frequently lampooned and burlesqued. In our experience there are some recurring themes in provocative family therapy that we shall discuss. The first of these can be phrased, "Who's in charge here?" Parents

frequently seem to have lost control in the family setting and the task of the provocative family therapist is to put the parents back in the driver's seat. The exercise of power in any group is to a certain degree arbitrary (in the power wielder's selection of criteria by which he makes judgments, how these criteria are applied to actual social situations, etc.). The provocative family therapist attempts to communicate this to parents by teaching them "therapeutic cruelty and joyful sadism" (Cf. Assumption No. 9, Chapter 11; Chapter VIII) and urges parents (especially those who feel they must rationally justify to their children's satisfaction every decision affecting their offspring) to "let your whimsey be your guide." He makes a travesty of the bugaboo of inconsistency, pointing out that the evidence is pellucidly clear that the behavioral sciences and child development experts themselves do not rigidly adhere to a monolithic concept of consistency. He further indicates that with laudatory flexibility these disciplines break their stone tablets and carve new ones every fifteen years. Parents in provocative family therapy are implicitly or explicitly urged to regain control over their children, and "make a rule, any rule." They almost invariably warm to the task, and arrive at a long-overdue, reasonable solution to a family problem (cf. the "If you don't work, you don't eat" example No. 7, Chapter 11). When this solution is put into practice with the therapist's help, the parent easily learns to generalize to other parent-child control problems. A second recurring theme brought up by children in provocative family therapy can be phrased, "My parents exist to meet all my needs." The provocative family therapist attempts to clarify what the child can reasonably expect from his parents (in return for specific behaviors on his part). Far from asking the child to "forgive" his parents, the provocative family therapist will make a travesty of the child's unrealistic expectations and implicitly or explicitly

suggest that (1) the need doesn't have to be met, or (2) he can wait until his parents meet it, or (3) he can satisfy them in other relationships.

For example (5.60), one young college man in provocative family therapy finally confessed in a choking voice and with a tearful eye that he wanted his father (who was a stalwart, reliable, laboring man) to "be a pal to me."

Questioned further, it became clear his expectation was that "he and his Dad would have long talks" together, preferably from one to four hours duration. The therapist, laughing, gestured toward the father, protesting, "Hell, we've already talked about Dad's way with words, his verbal facility. If he puts three whole sentences together, I'd think he had verbal diarrhoea - right, Dad?" The father nodded, chuckling, "You know I ain't good at talking, Boy." The son soon gave up his unrealistic expectation about his father, learned to accept his father's way of being together (cooperating together in repairing things around the house) and was able to meet his need for verbal companionship with other available paternal surrogates.

A third recurring theme in provocative family therapy (and closely related to the second) is the failure of children to view their parents as persons in their own right.

Children, because of their age and dearth of experiences, tend to have a quite narrow outlook, especially in regard to their parents. Since this fact alone leads to many familial conflicts, the provocative family therapist attempts to expand the child's view of his parents by a variety of methods. In an attempt to help the child perceive his parents as of hers see them, the therapist may ask the child to describe his parents from the viewpoint of some adult or some of his peers, while using in the therapy session his mother's maiden and his father's tuil name. "Miss Betty Jones" and "George Smith" sound and feel different to the child than "Mom and Dad".

In an attempt to flesh out the picture of the parents as individuals in their own right who existed separately long before the child was born, the father and mother may be asked to describe themselves when they were children to their children, with special emphasis on "how did you get in trouble with your parents and teachers?" Fathers and mothers are frequently asked to go home, write out their own "social history", and bring it for discussion the next session. One father, presenting the "social history" of his own adolescence to his sons, stated in red-faced embarrassment, "To begin with, during high school my home room was the principal's office." The family's laughter that followed not only helped to put into perspective the sons' view of their father, but the father's view of his sons' difficulties. Mothers, similarly, in presenting a detailed history of their dating anxieties, conflicts, and behaviors, rarely fail to hold their daughters' interest.

Although the above is by no means an exhaustive list of the recurrent themes in provocative family therapy we want to close the section by adding a fourth and final one that "parents have obligations and children have rights."

This idea is pervasive in our culture and perhaps rightly so to some degree. A children's protective services section is a necessary part of any well-functioning county welfare department for a variety of reasons. Furthermore, the legal rights of children are only beginning to be recognized operationally in our courts, and the emphasis on children's rights here is also well placed. However, if children have rights and parents have obligations, the converse is equally, and simultaneously, true, and the provocative family therapist attempts to give equal valence to both sides of the rights-obligation issue in dealing with parents and their children.

Questions and Responses



SINCE JULY OF 1963, PROVOCATIVE THERAPY presentations have been given in speeches, seminars, workshops, institutes, and symposiums to colleagues, students, trainees, and the lay public. Furthermore, hundreds of "people workers" have had access to numerous audio and video tapes which have been made during the past number of years, and they usually have questions and give feedback regarding this system of therapy. This chapter, then, is a culling of the discussion periods following these presentations. We are indebted to all those who provoked our thinking in these areas.

1. Question(Q.): You sound so confident and so damn positive you're right. What makes you think so?

1. Response (R.): Nobody, but nobody, has a cornerstone on "TRUTH". Frequently with my graduate students and psychiatric residents, I will talk about what I have conceived of as the "mosaic analogy". The clinical field can be conceived of as a mosaic, with each of the different therapeutic systems and theories about human behavior and motivation thought of as a piece of the mosaic. I think provocative therapy has a large hunk of that mosaic. It's a way of organizing our clinical experiences and has a logical framework and internal consistency which gives a provocative therapist confidence. And it works. You can see the if-then proposition in operation very quickly. In of her words: "It lam this way with this client, then he should, with a high degree of probability, respond in such and such a way." And that kind of predictability, that kind of sense of control over the varied clinical phenomena, does give a person confidence in what he's doing. And added experience gives the provocative therapist increased confidence because his behavioral repertoire is broadened.

There's another point which I think should be brought up here. I once attended a seminar on social action and

listened to the panel presentation of some young people advocating a particular line of action for changing a problem in a given community. Afterwards I told the prof, "My God, it sounds so simple, and they sound so confident that they are right." His response was one that I never forgot. He stated that when it comes time to act, you have to oversimplify, and pointed out that I as a therapist also did the is with clients. And I've come to believe that this is true in the one-to-one relationship as well as between groups, states, and nations. There are any number of "true" solutions in the personal, political, religious, social, cultural and economic arenas, but if action is called for, you have to choose, and then act in terms of your choice. You also have to do this in therapy. Frequently we do the client a great disservice if we pull our punches, hesitate, hem and haw, and offer frequent disclaimers that we don't know anything and that the "client knows best about himself" - which is an unalloyed clinical myth because frequently the significant others in our lives know us far better than we really know ourselves. Now I'm also well aware that to issue nothing but apodictic statements regarding the client's worth or prospects for change is just as ridiculous as being a therapist of the wishy-washy school. But to repeat, the provocative therapist derives his confidence from the if-then hypothesis in operation. And it works.

2. Q.: Always?

2. R.: No. And neither does motherhood, apple pie, chicken soup, or any other form of therapy work always. We aren't pushing provocative therapy as the twentieth century equivalent of snake-oil, a universal panacea for any and all intra- and inter-personal conflict situations and dandruff. But it is a fairly coherent, internally consistent system of therapy which provides an alternative to the more traditional methods and which, if given an

honest try, gets results in a high percentage of cases.

3. Q.: How about provocative therapy with alcoholics, then?

3. R.: You guys are giving me a hard time. Nobody is hitting home runs consistently in that ballpark. Doing therapy with alcoholics is like trying to chip through the permafrost with a teaspoon. But I have had some success in using it with these patients even though my own personal clinical experience wouldn't lead me to go as far as one clinician who, of ten trying a number of approaches with alcoholics and after getting his best and sometimes very dramatic successes using my approach, said, "Provocative therapy, in my experience, is the treatment of choice with alcoholics." There probably isn't any one treatment that's going to work with every one of them, but their behaviors can be changed, of that I'm sure.

In the future I think we're going to see some types of treatments for alcoholics which today we would consider very drastic, if not almost inhumane. Some examples of this would be the current experimental use of succinylcholine with alcoholics in England (the alcoholic is offered a drink in the hospital and as soon as he begins drinking, the succinylcholine is "turned on" from the intravenous feeding bottle next to him; he has an immediate physiological response of impending doom and the overwhelming feeling that he is dying). The idea is to pair a massive aversive stimulus with alcoholic intake and to condition an inhibitory response in him. In Russia an experimental program consists of bringing alcoholics into hospitals and suturing inside their stomach wall an electrochemical device which produces violent and painful cramping with the ingestion of minute quantities of alcohol. The person who told me about this particular program also added in a

bland voice, "Of course, they have not as yet published the suicide rates with this procedure." But these programs, I think, are some indication of the types of procedures we can expect in the treatment of alcoholism, treatments which will make provocative therapy look like the overture to a Sunday School picnic.

4A. Q.: Where do you get off talking to clients this way?

4A. R.: Easy. I disagree with your assumption that therapists shouldn't talk this way to clients. People talk the is way to other people. Clients are people, too.

4B. Q. (Angrily.): Do you mean to tell me that when you maliciously, viciously attack these poor patients you ...

4B. R. (Interrupting.): I don't mean to tell you anything of the sort. Now, if you'll listen, I'll tell you what I do mean. I don't attack the patient, but I do attack his ideas. I don't ridicule him, but his assumptions and self-defeating behaviors. And I also thought I made it clear when I was talking about the use of humor in provocative therapy that the therapist is just as quick to lampoon his own role as he is to burlesque the client's ideas.

Another point should be made in this regard. It is the experience probably of most of us that we have observed a relationship between two people and wondered why Person A continued the relationship with Person B. The answer is that we either have a very skewed sampling of B's behavior in the relationship and haven't monitored all the behaviors (positive as well as negative) that B exhibits towards A; or else we are giving different valences to B's negative messages to A than A is giving. If we examine our own person relationships, a saying that we have heard not infrequently goes, "Oh, he just sounds that way, but his bark is much worse than his bite." It's one thing,

in a word, to stand outside a relationship and rate it; it's another thing to live within that relationship. The former position can frequently lead to some very distorted conclusions. And, of course, the converse can be true also.

In the same way, in the provocative therapy relationship there are many positive, helpful elements that keep the client coming back, even though to an outside observer the negative aspects (the ridiculing, burlesquing, confronting, etc.) are almost immediately apparent.

5. Q.: How do you use provocative therapy with suicidal patients?

5. R.: Carefully. But if we conceptualize most suicidal ideation as stemming from depression, and if part of depressive states stem from introjected aggressive feelings, provocative therapy with its ability to provoke "fight" responses is especially suitable for these patients. Both the provoked angry responses as well as the laughter from the client are antagonistic to the depression, and most clients, despite their having "no reason to live", rapidly find themselves reacting spontaneously to the provocative therapist and thereby experiencing in their strong here and now reactions some *raison d'être*.

The provocative therapist will enact various scenarios: "viewing the remains", the funeral mass or service, the eulogy (which invariably turns out to be a stumbling fiasco of the clergyman desperately trying to find something good to say regarding the "deceased" and comically and miserably failing), the benefits of the "deep sleep", the deceased patient's arrival in hell (he never goes to heaven), counselling the family after his suicide, etc.

An example of the latter is as follows. A young man

in my private practice called in a panic for an unscheduled interview. He felt he was on the brink of suicide and wanted "one last interview". Upon his arrival he stated that the only reason - the "one thin thread" as he put it - holding him back was that his suicide would precipitate a psychotic break in his mother necessitating her hospitalization.

T. ("Warmly".): Don't you worry! I'll explain the whole thing to your parents after your funeral. I can see us now, ... your mother and father sitting there ... (T. points to two empty chairs) and your mother saying:

(T. role plays both the patient's parents whom he has never seen, stereotypically portraying with his voice, mannerisms, and facial expressions, the mother as a weepy Maude Frickert and the father as aloud, interrupting Billy Goat Grutt.)

"Mother" (Tearfully): Why ... why .. why did he do it, Mr. Farrelly?

T. (Placing his elbows on the arm of his chair, leaning back, finger tips together, looking at an empty chair, nodding supportively): I can understand how all this is a shock to you, Mrs. Jones, but we can explain this professionally to you. What is involved here is what we call psychodynamics, and -

"Father" (Interjecting loudly): WHAT THE HELL ARE THEY?

T. (Placatingly; holding up his hand in a "halt" gesture.): Now, Mr. Jones, I can explain that. It means the way your screwball son - er, poor George - felt and thought. You see (Leaning forward in chair, with an intent expression on his face), he had what we call an unresolved Oedipal complex.

"Father" (Loudly interrupting.): WHAT THE HELL IS -

T. (Hand in a halt gesture; placatingly.): Just - just a minute, Mr. Jones. I'm going to explain it. You see, he wanted to bali - er, excuse me, fu - uh, have relations with his mother here -

"Father" (Exploding.): GOD DAMMIT!

T. (With the halt gesture, nodding supportively.): I know, I know, Mr. Jones, but you have to understand this is the

way these diseased minds work. You see, the impulse or desire on his part was unacceptable to him -

"Mother" (Tearfully.): Oh, thank God! I never-

T. (Interrupting and continuing.): So he repressed this and projected it on to you, Mrs. Jones, and was convinced that you wanted to screw - uh, have sexual relations with him.

"Father" (Exploding.): WHA T THE SHIT, I'LL .

T. (Harassed.): Hold it, please, Mr. Jones -

"Mother" (Horried, defensively.): I never, never felt that way toward him, it's unnatural -

T. (Nodding supportively.): I know, Mrs. Jones. But then, he felt horrified at your unnatural feelings toward him and wanted to kill you -

"Father" (Exploding.): GOD DAMMIT!! I'LL KILL THE LITTLE PRICK -

T. (With the halt gesture; firmly.): You're too late, Mr. Jones. Now let me finish my professional explanation. (Turning to "Mother", leaning toward supportively, in a warm tone) But that thought too was unacceptable to him, so he repressed it also and killed himself. Because we know, Mrs. Jones, we know that every suicide is a homicide. Your son was a murderer at heart.

"Mother" (Tearfully.): Oh, Mr. Farrelly, I don't know what "

Father" (Interrupting.): WELL, GOD DAMMIT, I'M GLAD HE'S DEAD IF HE WAS THAT TYPE OF PREVERT

-

Patient (He has been observing throughout, increasingly frowning, with his mouth slack-jawed; interrupting therapist's role-playing with an angry tone.): Welllll, you sonuvabitch! That's another reason I ain't gonna commit suicide - have you tell my parents all them lies after I'm gone!

T. (Blandly.): What will you care? You'll be dead and long gone and it won't bother you one bit then. (S.61)

It should be noted that no matter what type of approach you use, if you work consistently with patients who have a history of suicidal ideation and attempts, statistical probability has it that sooner or later, somebody is going to commit suicide on you. And I deliberately phrase it that way - "on you" - because I think

most clinicians' experience it in this manner. One client even said to me,

C. (Glaring at therapist.): If I commit suicide, your name's gonna be professional mud in the is state.

T. (Nonchalantly.): Aw, forget it. I used to think that, but whenever it's happened over the years - why, my colleagues are so supportive, you wouldn't believe it. They usually say things like, "She was going to commit suicide anyway one of these weeks - nobody could have stopped her", or "I give you credit for having the courage to work with him, Frank - I was just too scared to." And they'll put the of' arm around me and say, "Come on, Frank, let me get you a cup of coffee. Cream and sugar?" And I'll say (T. assumes a hesitating, tear-choked tone, swallowing hard), "Yeah ... only ... one ... teaspoon of ... sugar ... O.K.?" (Wipes "tears" from his eyes). And (therapist abruptly switches his voice tone from tear choked to happy) well, right away, I'm feeling better, and by lunch it's all forgotten. And even the families invariably thank me, saying, "You did your best, and we're grateful." Or they'll say, "Well, he's sleeping with Jesus now" - which sounds a little queer (Client guffaws with laughter in spite of himself) - but ... no, I wouldn't let your fears about damaging my professional reputation stop you from committing suicide.

C. (Red in the face, biting his lip, snorting with laughter.): O.K., O.K., I get the point. (5.62)

A number of other examples could be listed; let me finish with a final illustration.

A female patient in her early twenties had been making steady progress over thirty interviews. We were nearing the end of therapy when she announced suddenly that this was her "last interview".

T. (Somewhat surprised, but agreeing.): O.K., Gorgeous, so what do you want to talk about?

C. (Blandly.): Just this - would you have any objection to my committing suicide?

T. (Taken aback, but disguising his response; enthusiastically

y.): No! Not at all! It shows you're choosing and abiding by the consequences, and self-determination is making a big come-back in the clinical field. Furthermore, it's the quality, not the quantity, of days that you live that counts. And there's some new thinking in the field - which I think I could find useful in your case that suicide does not necessarily represent a failure case, but may even be considered a success. Yeah, that's it, I think I'll chalk you up as a success if you kill yourself. Course, (he mutters in an aside to himself) if she lives and doesn't do it, I don't know how I'll categorize her case ...

C. (Looking at therapist throughout; in an angrily even tone): You're an unfeeling son of a bitch, aren't you?

T. (Incredulously.): Unfeeling! Not at all. (Laughing with relief at provoking her anger) I feel for your poor family which has had to put up with your suicide attempts before. I have deep sympathy for your co-workers and classmates. I have feeling -

C. (Interrupting with a part laughing, part angry snort.): Yeah! You're all heart, Frank.

Therapist goes on, visualizing her death, talking to her family of ten the funeral, etc. Client, obviously attempting not to laugh at times, is also glaring angrily at therapist. Therapist then picks up her purse, and her carton of cigarettes: "You shouldn't smoke these they're bad for your health, and besides, you won't be needing them anymore." When he takes her money from her purse, client objects:

c. (Grabbing for purse; T. jerks it back, laughing; client in a coldly angry tone.): It's not polite to go through a lady's purse.

T. (Laughing with relief at her "tight" responses.): Lady! Aw come on! Besides, why keep up these social niceties in your last hours?

Therapist continues to rummage around in her purse, makes derogatory comments about how sloppily organized

her purse is, but adds that she won't have to worry about that much longer, takes \$3, which provokes client to say:

G. (Obviously trying to keep a straight face.): Come on, Frank, I need those three bucks to get home in the cab.
T. (As though suddenly realizing his mistake.): Oh, I'm sorry. Here (handing her purse and money back), I forgot, you've got to get home to commit suicide. I sure as hell don't want you doing it here in my office ... (S.63)

A month later, she sent a check with a biting note saying, "You will notice that the bill is paid in full, less the cost of the carton of cigarettes you kept that night, Mr. Omniscient."

There is much more that I could say on the subject - e.g., the markedly aversive quality of the experience for the clinician, the responses of both clinicians and family to the suicide, the anxiety levels that the clinician needs to tolerate in working with potential suicides, the way death - any death - is treated as an obscenity in our society, the question of whether suicide is a legitimate and ethical option for the human person under certain circumstances, research on the subject, some of the issues around the founding of suicide prevention centres, and so on. Suicide invariably provokes in me a wide range of thoughts and feelings, and I hope it will continue to do so. But perhaps we should turn to some other questions.

6. O.: What do you see as the sources of change in provocative therapy?

6. R.: The provocative therapist is very behaviorally oriented in that he persistently and insistently calls attention to (either directly or by provoking a client to state them) the probable and plausible past, present, and future social consequences of the client's attitudes

and behaviors, and points out how these consequences are contingent upon the client's behaviors. Apparently another source of change can be found in the therapist's attempt to change the client's self-concept by agreeing with and leaning heavily and humorously on the negative characteristics that the client attributes to himself.

A still further source of change is that the therapist implicitly expects the client to change - drastically "so their own parents wouldn't know them" - and this expectancy can, in the nature of a self-fulfilling prophecy, induce change. Furthermore, the therapist, by encouraging self-defeating, deviant, pathological behaviors and provoking protest and resistance towards these behaviors on the part of the client, is building up inhibitions in the client to his own deviancy. In a word, the therapist hooks into and uses the client's own resistance and defences to get him changing and moving again in a more constructive direction. And finally, another source of change is the therapist's powerful use of role modelling (with his humor, and the ridiculous, zany alternatives he suggests to client). By the use of role modelling, the therapist is demonstrating that there is a different way for the client to conceptualize and feel towards his problems and engage in different types of behaviors.

7. Q.: What about the motivation of the client and the nonvoluntary client? Does the client have to admit or realize what his problems are?

7. R.: I used to think that this was important, and it is in the sense that it makes it easier for the therapist, but now I think, "Hell, just bring in the body, as long as it's still warm we'll have a go at it." Other therapies grew out of work with motivated, non-hospitalized clients by and large; provocative therapy grew out of work with

involuntarily committed patients. We suggest that if you don't have a motivated client, then have control.

As to the question "Does the client have to realize what his problems are?" - again, even though this is helpful, it is not entirely necessary in provocative therapy. If the client doesn't admit the problem, the therapist will tell him what the problem is, or ask him what his significant others state what his problems are, then agree with those significant others. The client, for example, may state that his only problem is "I'm locked up here", or "My only problem is I gotta come see you or my parents are going to kick me out of the house".

The provocative therapist's response is usually to guffaw in the patient's face and provoke him into saying specific, concrete statements that others have made about him, his attitudes, his behavior, and his general overall lousy reputation. In a word, it's not important for a client to admit or realize his problem as long as the therapist can provoke a client to recount the definitions _ of the client's problems from significant others.

8. Q.: What is the real reason why you formulated provocative therapy?

8. R.: In any given human situation there are, in all likelihood, at least a half dozen different factors which can explain a particular human behavior; the search for the one real reason is often illusory. As I tell trainees, "Beware of the Jabberwocky and the unifactoral hypothesis.

" Perhaps both because of my religious and professional training, and what I was taught regarding human motivation, I used to think that the deeper the motivation, the smellier it was. And the smellier it was, the realier it was. Thus the real reasons usually had the highest stench. I no longer believe this, nor do I any longer search for a unifactoral hypothesis to explain my or other people's behaviors. Rather, there are a variety

of low-level inferential explanations to explain adequately human behavior.

In regard to my development of provocative therapy, there was the nagging problem of how to effect change in those I was hired to help, the supportive environment of a number of therapists echoing the same problem, the accurate perception that monetary, professional, personal, and social rewards accrued to effective therapists, and even perhaps a bit of nobility involved: that it was an honorable endeavour to attempt to be of significant help to others in pain. And finally, I was competitive as hell; I wanted to be one of the best goddamned therapists who ever came down the pike, and clearly succeed with patients that others had given up on, or who were "untreatable".

But perhaps that still doesn't explain the genesis of provocative therapy. Perhaps still other factors can be found in what two of my sisters said to me recently. My oldest sister, Cissy, said the provocative therapy certainly fitted in with the way I was when I was a young boy. "You had this fantastic gift of mimicry long before you were old enough to start school." And my youngest sister, Jitty, remarked, "You just always liked to tease people. You used to tease me to death." But who knows for sure and certain the exact antecedent conditions of their consequent life style, vocational choices and their personal relationship? I don't, and neither do you, probably. The best we can do is give guesstimates.

9. Q.: You say that "inside of many traditional therapists there is a provocative therapist just screaming to be let out". What factors do you see impeding some therapists from adopting the provocative therapy approach?

9. R.: Over the years there have been a number of reasons which have come to my attention why some people have not adopted provocative therapy as their approach in

dealing with patients and clients. For some, they simply differ in their view of man, human behavior, and their assumptions regarding how to change people. For others, it is mainly their training. Some people seem never to go beyond their training and never unlearn aspects of what they were taught. Still others have given what have been termed socio-political reasons. For example, some psychiatrists apparently have difficulty in the role reversal, that is, learning a new mode of therapy from a member of a profession which they have been accustomed to teach. One psychiatric resident was overheard to say, "I'm really interested in provocative therapy and would love to try this approach, but I don't want to get known as his disciple." Some psychologists tend to question its theory and research, claiming that, although provocative therapy may be long on how to work with clients, theoretical explanations and research documentation for the changes seen in clients are weak. For some social workers, provocative therapy conflicts with the nurturing image of the social worker, a role that they have been trained in to work with markedly deprived clients. For nurses and the clergy, provocative therapy can really grate and run against the grain of the image of the professional helping person. In all the above we do not mean to imply that anybody who does not adopt provocative therapy shall be called anathema and has dandruff or VD, but in our heart of hearts, we know you're wrong. It's our modest belief that "Today Provocative Therapy, Tomorrow the World."

From a different point of view even though a given therapist has not adopted provocative therapy in the strict sense as his own mode of working with clients and patients, I have gotten massive feedback from literally hundreds of clinicians and people over the years

who have told me that the way I did therapy has changed their approach to clients and has helped them in a number of ways: "I no longer see patients and clients as so fragile and weak - and you know, they really respond to my 'get tough humorously' policy." And again, others have stated, "I can laugh and joke with patients now, something I couldn't have dared do before seeing you do therapy."

Others reported that after having heard of provocative therapy, they have "pulled a Frank Farrelly" on patients and have not believed the patient was so helpless and hopeless. They now see clients as much more capable of dealing with their work, relationships, and lives, and have witnessed at times startling changes in clients as a result of their change in expectations towards clients. Still others have told me that they can now engage relevant issues much more quickly with patients, can work with a wider variety of clients now, feel free to expand their own behavioral repertoire, are far more open and honest with their clients, and will now bring in reports about clients they have heard from others (staff members, family, fellow patients) as well as their own reactions. Some others have told me that instead of being fearful or anxious over their own "counter transference reactions" to their clients, they now see these reactions as plausible, "reasonable", and will I tell the clients how they think and feel towards them. Others have stated that provocative therapy has given them, and they in turn can give to their clients, real hope - that they now believe if clients had a hand in bringing about the mess they're in, then they can undo (by changed behavior) the mess and make their whole lives different.

10. Q.: How does provocative therapy compare with client centered therapy?

10. R.: Time doesn't allow us here an extensive comparative

analysis of the two systems, but, briefly, I would say that the provocative therapist agrees with the client centered therapist in his heavy emphasis on the importance of the self-concept, and on the crucial importance of empathy as a necessary ingredient in the therapeutic process. However, the provocative therapist holds that it is equally important for the client to understand the messages of others. The provocative therapist also agrees that despite his confrontation, mimicking, and ridiculing of the client's idiotic ideas, nonetheless some warmth is necessary from the therapist. As Bruno Bethlehem said, "Love is not enough", but warmth, positive regard, prizing the client's potentiality and worth - however you want to put it - does seem to be a necessary ingredient in the therapeutic relationship. Provocative therapy would also agree with the client centered therapist that getting the client to use his own feelings as a referent for actions in relationship is a sign that the client is maturing, that the "locus of evaluation" is residing more in the client, that he is becoming more self-assertive and more psychologically healthy.

11. O.: Do I detect some elements of rational emotive therapy in provocative therapy?

11. R.: Yes, in a sense I am indebted to Albert Ellis. Provocative therapy has been termed by some people to be "somewhat of a mirror image" of RET in that the therapist "catastrophizes" frequently, adopts in a ludicrous way Ellis' "twelve crazy ideas" to get the client to reject them, and rigidly upholds the validity of stereotyped ideas in an effort to get the client to discriminate them and differentiate them better. This fits in with 'some of George Kelly's work and also Rogers' and Rablin's psychotherapy process scale on the personal construct dimension or subscale: in the lower

reaches of the scale the client is rigidly adhering to certain types of personal constructs as though they were facts; in the upper reaches of the scale he has greatly differentiated these and no longer sees them as "objective facts" but as more tentatively held formulations and logical abstractions of his experience.

The provocative therapist, of course, want to personify these rigid personal constructs and states them as facts, as though they were the ultimate proof. He will use such statements as "What further need have we of proof?", and "Well, everybody knows that," or, "Only atheistic perverts wouldn't agree with what you just said", etc. And the provocative therapist does all this in a ludicrously rigid way as though he were Jehovah carving out stone tablets, in an effort to get the client to laugh at his over-rigidity and provoke him to engage in discrimination learning and differentiation of his own rigidly held personal constructs. He also does this to get the client to see them more as either "facts" that have been pounded into his head as pure propaganda, or as overgeneralizations based on some experiences that he has had, or as unwarranted assumptions based on lamentably few hard facts. But

RET is a little too straight for my blood, and I feel that it is much easier to get the patient or client to give up his rigid, crazy ideas by lampooning them rather than arguing "logically" against him.

12. Q.: Isn't provocative therapy just like the paradoxical intention of Viktor Frankl and Jay Haley?

12. R.: No. In conception and development I was not influenced by these ideas although we now notice some similarities. Provocative therapy descriptively has some facets that are very similar to their conceptions, but at the same time is much broader than just paradoxical intention. It was over two years after

the initial provocative therapy interview that colleagues brought to my attention some of the similarities between the systems.

On the other hand if it helps you understand provocative therapy better, let me make a few points about some of the lines of convergence between Haley, Frankl, communication-relationship theoretical approaches, and provocative therapy. Haley's conception of psychotherapy as an "ordeal" within a benevolent context tints provocative therapy in a partial, broadly descriptive sense. Frankl is one of the few therapists who uses humor and paradoxical intention, although differently from provocative therapy.

We agree with the communication theorist that you cannot not communicate in some fashion, since the emphasis in provocative therapy on non-verbal communication and incongruent qualifiers. Psychotherapy is seen in both systems as a mutual influence situation where both parties are trying to influence (provoke) the other. In this situation, control, metacontrol, and their techniques are often crucial issues.

Again in both systems, symptoms are seen as interpersonal and relationship based; they give their users an advantage in controlling his relationships. From time immemorial man has struggled to control his environment - initially to insure his survival, and then the quality of his life. In the same way each individual struggles for control of his social relationships from which he must obtain his psychological supplies. In this framework, "psychopathology" is seen as extreme manoeuvres to gain control of these unpredictable interpersonal relationships.

We too reject the conception of symptoms solely as defences against intrapsychic impulses or ideas. We do not agree with the modern day equivalent of the

search for the golden fleece: the schizococcus or biochemical aberration that will explain all symptomatology.

In the same way for the sake of utility do we not believe that situational factors alone account for many symptoms. This is not to say that these factors do not account for large portions of the variance in an individual's behavior; in certain contexts within defined limits they may be useful in predicting and controlling behavior (i.e., may be scientifically "true"). It is to say that pragmatically and in reality the changes that occur through psychotherapy have only the interpersonal system as the agent of change and the social and interpersonal consequences as the most important motivators of and payoffs for change.

The conceptions of one-up, and one-down, and symmetry are useful and parsimonious descriptions of relationships. Patients and clients typically are noted for their extreme usage of either one-up or one-down manoeuvres and evince an overwhelming need for control (i.e., in relationships they adhere to complimentary and indirect ways of interacting). It is the therapist's job to counter these manoeuvres and make them nonfunctional.

13. Q.: How did you ever find an agency that would sit still for your developing this type of therapy?

13. R.: Get a place like Mendota State Hospital to work in. By that I mean one that is open, experimentally oriented, and in which much research and training is going on. Your question clearly implies that most agencies and institutions are not that open to experimentation, and sadly I would have to agree it I can believe both my own experience and that of other colleagues across the country. But perhaps that's overstating the case. I've had many different people say to me after I gave a presentation on provocative therapy,

"You could work in our protective services for children agency", or, "You could work in a prison setting", or "with street gangs in New York", or "in our rural mental health clinic" etc., etc. So perhaps more and more agencies are becoming open to experimentation and innovation in work with clients and patients, provided that the basic welfare of our patient or client is kept foremost.

14. Q.: You obviously have a lot of warmth and real caring for clients and patients. How do you get this across to them in your interviews?

14. R.: In provocative therapy I now give nonverbally the positive messages that I used to say to clients verbally and which they didn't believe. Now I call them every name in the book, and what do they come back with?

"No, I know you like me ... " or, "I don't care what you say, I know you really like us patients." Now they know I like them in a powerful, intuitive way; and they're sure of my liking for them, despite my verbal I and at times laughing disclaimers. I can't keep a straight face very well.

It is a striking paradox in provocative therapy that on the one hand it is an artificial never-never land and that on the other it attempts to create a relatively realistic social microcosm rather than the closest approximation a client can get to a womb. In therapy, often the values of trust, warmth, and empathy get promulgated, but in the real world clients have to deal with when leaving our office, it is often rough and tough, shysters around, and "widows and orphans beware" out in the street. Often there is little or no correlation with life in the therapist's office. And this is one of the great strengths of provocative therapy. The therapist never gives the message that continual warmth, uninterrupted understanding, and honorable honesty will be

the order of the day. Instead he "lies" to the client, disgustedly "rejects" the client, and at times deliberately "misunderstands" the client in an effort to create this social microcosm and enhance the generalization of therapeutic effect.

15. Q.: What types of limits does this system have in terms of patients it can't help?

15. R.: In the first place systems of psychotherapy don't help people; people help people. Psychotherapeutic systems help therapists organize clinical phenomena and offer the therapist roles with facilitating attitudes and techniques to implement these, thus enabling him to help the client.

Provocative therapists do not seem limited by any specific diagnostic categories in the current psychiatric nosology (and here we are speaking of the functional disorders only), for they have been successful with all different diagnostic categories of patients.

However, there seems to be some limits placed by a responsivity continuum of client affective and verbal behaviors anchored by catatonic behavior on one end and acute manic behavior on the other. The problem is not that the markedly low or high responders are impossible to work with; both the mute catatonic and the acute manic have been successfully and dramatically provoked into sane, integrated responses in short order. Rather, the problem is that both low and high responders tend to extinguish the therapist's committed involvement; the low responders by their lack of responsivity require too much output from the therapist while the high responders by their excess of responsivity require too much data processing and control!. In a recent individual failure case a markedly withdrawn hospitalized young man told his visiting father, "He (the provocative therapist) wants me to be

more responsive, but I handle him by not talking." The patient's tactics would not in all likelihood have been as successful in family therapy for they could have been more easily countered with the help of other family members.

16. Q.: Why do you make fun of a patient's physical appearance which they can't change?

16. R.: I will mimic, ridicule, and burlesque a patient's physical appearance or demeanour, kinesthetic movements and general carriage, because oftentimes it reflects how they're feeling inside, or because I want to provoke some affect regarding their appearance, about which I am hypothesizing they might have a great deal of feeling. You can't change the body, it's true, but you can change one's perception of it. Let me list some examples.

To a stooped over patient who drifted down the hall to my office wearing a mask like expression and sat in my office chair Like an unfeeling mummy, I stated:

T. (Grinning and laughing.): "You're not human, Kiddo, you look more like a transistorized robot and you probably don't have pubic hair; you just have a bunch of clipped wires there." (T. points at her crotch.)

Pt. (Startled.): "That's no way to talk about anybody." (She rapidly lost her robot like appearance and began talking with more normal affect about her problems.) (5.64)

A person's body image has been termed the most intimately personal dimension of his self-concept and, if you can change this, you've changed a lot. For example, I worked with one patient who was acutely depressed because she felt that she was unattractive compared to her sister and couldn't believe that anybody wanted to go out with her for anything other than pure sex, because she was "ugly". She was a very

pleasant person in many ways and was definitely attractive, even though she didn't realize this.

T. (Disgustedly.): "Well, I see what you're talking about. My God! Nobody but a sex maniac could go out with a gal like you, with big feet, thick ankles, bulging calves, bowlegged ... "

pt. (Nervously laughing.): "No, I'm knock-kneed."

T. (In an annoyed, disgusted tone.): "Okay, okay, you're knock-kneed, you've got fat thighs, sagging buttocks, a protruding abdomen, thick waist, flat chest, broad shoulders, a lantern jaw, jug ears, bulbous nose, furry eyebrows, two little pig-eyes, and hair that looks like an abandoned rat's nest. But I'll say one thing for you, your teeth sure look good."

Pt. (Laughing explosively.): "They're false!" (T. and Pt. dissolve in laughter.)

With relative quickness she changed her thirty year old personal myth about her attractiveness. (5.65)

17. Q.: It seems to me that what you're doing is a gross exaggeration to the point where it's beyond insult and is simply there to be comprehended.

17. R.: Right. Thank you for your warm empathy. It always feels good.

18. Q.: How do you know that you were the one who caused the changes in the client?

18. R.: I don't. Not for sure - I'm never that certain.

Another point to consider here is that we're not dealing with metaphysical certitudes in therapy but probabilities, and the probabilities are that if he thinks he's changed, and I think he's changed, and if significant others (family, co-workers, etc.) think he's changed, and if he pays my bill, then the evidence suggests that the client has changed.

It seems to us that therapy provides the opportunity for the beginnings of attitudinal and behavioral changes which are then perceived by of her people. The

client is then rewarded (by others explicitly, by the therapist implicitly) for these changes and, instead of the client's being in a vicious circle, he finds himself in a beneficent chain reaction of change, in which his changing is rewarded, which begets more change, and so on.

19. Q.: How do you deal with your own feelings of anxiety after you have provoked the patient to anger or tears?

19. R.: First of all I'm not too anxious because that's what I set out to do - provoke an affective response - and I've also adapted in my years of therapeutic experience to the intensity of other people's emotions. Then, too, I've learned to run the risk of the client's disapproval and dislike of me (which usually quickly changes to curiosity about and attraction to the therapist). I can also use my anxiety in a number of ways as a deterrent for shaping my responses to the client. Some examples are as follows:

1. Patient (In a blaming tone.): "You could have made me a patient again [that is, could have precipitated a psychotic break in him] by the way you talked to me the last time."

Therapist (Laughing nonchalantly.): "Yeah, well, those are the chances I've got to take!"

Patient (incredulous; pauses, then laughing.): "You've got to take! Oh yeahhh! You've got to take ... " (5.66)

2. Patient (Sobbing, in a choked tone of voice.): "Can I have a Kleenex?"

Therapist (Looking quizzically at the ceiling; pauses; in a hesitant tone.): "Well ... I don't know. On the one hand I feel if I give you a Kleenex, it's just contributing to your dependency. And on the other hand I think, 'What the hell, give her a Kleenex, I don't want her snot and tears all over my office.' "

Pt. (Assertively grabbing for Kleenex.): "Well, while you're making up your mind, I'll take one whether you like it or not." (She blows her nose loudly.) (5.67)

3. Patient (A six foot two inch, 225 pound, lean, angry man.): "You must think you're pretty fuckin' smart, don't

you?" (He glares menacingly at T.)

T. (Looking levelly at the patient, talking very straightforwardly.):

"Well, Sir, I'm smart enough to know that the

State doesn't pay me enough to get my face smashed in by talking to somebody about a subject that he doesn't want to talk about. Now you just let me know the subjects you don't want to talk about - your relationship with your wife and family, your job, how you're getting along around here - and we won't talk about it. Because they don't pay me enough to get you angry at me, and I don't want to upset you in any way, even though the staff feels that you have to talk about these things or you're just going to sit here for quite a long time. Furthermore, (T. looks at the client and changes his tone of voice to a slightly whining tone.), I'm just a poor social worker, and I'm a yellow-bellied, lily-livered, chicken-hearted coward. So just tell me what you don't want to talk about, and we won't talk about it. Okay?"

Pt. (Staring at therapist throughout his statement; somewhat taken aback; snorts with laughter.): "No, you ain't afraid of me, I can tell that. Okay, God damn if, what do you want to talk about?" (5.68)

20. Q.: You know, verbally you come on like a hostile, snotty bastard, but how do you show your warmth to clients?

20. R.: That question makes me cringe. It reminds me of the time I cringed when a patient came up and said to me, "Last year I was here, and you saw me once and you said that I was getting by on my looks, labias, and Linguistics, but that I was really scum. And you were right." So the point is that it makes me wince at times when I hear from other people how I'm coming across. But either warmth or caring, I think, is crucial and is shown in provocative therapy in a number of ways, not the least of which is by the therapist's use of humor. However, to other people the therapist's warmth and caring comes across in a variety of ways, not simply by the use of humor. For example, one patient said

that it was the "intensity of attention" that I paid to her. Another stated that he knew that I cared about him because "you didn't kick me out of therapy". Still another patient stated that he felt the therapist's warmth because of the freedom given to him in therapy, "I can say anything that I want to you." Another felt that it was the therapist's acceptance, "No matter what I say to you, I can't shock you." A fellow therapist stated that, "Frank Farrelly gets down in the client's own personal sewer, wipes himself in the slime, and says in effect to the client, 'Come on in and don't be afraid. The water's fine.' "

21. O.: Do you ever do social work kinds of stuff, like discharge planning, pre-job placement interviews, etc.?

21. R.: Yeah. For example (5.69), there is the "Matilda the Crip" case in which the social worker who helped me on the case and I dropped the client off downtown with instructions to have a job interview about the possibility of becoming a "towel holder in a whorehouse". We had arrived at this job description and possibility through extensive discussions of her worthlessness. Another reason for doing this with her was that she was simply sitting around the ward doing absolutely nothing but talk, talk, talk. We decided, therefore, to set up a type of "provocative structure" and take her downtown to see if this "poor, helpless, confused" patient could do something, anything at all, if only to wend her way back to the safety of the hospital!. P.S. She arrived home safely in time for lunch.

22. O.: How does provocative therapy work with clients who are victims of systems?

22. R.: Provocative therapy, with its emphasis on self affirmation, self-assertion, and being realistically

defensive seems to work well with clients who had been victimized into "doing the shuffle" or who have become psychological door mats for others. In learning to deal with the therapist, clients learn that they just don't have to "take it Lying down", but can push back - hard, at times - against the people who are oppressing or taking advantage of them in their familial, social, economic, and scholastic environments. I could list specific examples to illustrate each of these, but perhaps this general response will suffice.

23. Q.: Of course you don't start right off like this, being provocative in the first interview. Of course you build rapport and are supportive, right?

23. R.: Wrong. I start right off the first minute of the first interview going for broke after the most available clue, whether it be the client's affect, ideational content in their first question or statement, the way they look, etc. For example, a middle-aged, female patient knocked inaudibly on my door; when I went to answer it, she stood there humped over and almost hunched in upon herself.

Patient (Querulously.): "May I see you, Mr. Farrelly?"

Therapist (Loudly.): "Of course, Gorgeous." (He strides back to his desk and sits down.)

Pt. (Coming into the room timorously.): "Where do you want me to sit?"

T. (Pointing at chair next to his desk; the patient begins to sit down in the chair.): "Sit right there."

T. (In a gruff tone; loudly.): "Hold it! No, (pointing to a chair at the opposite wall): Sit over there."

Pt. (Shuffles over to the chair at which the therapist is pointing.)

T. (In a commanding tone; looks around the office.): "No, wait a minute ... " (He pauses, looks uncertain.): "I've got it! Sit over there (Pointing to a chair near the door.)."

Pt. (Suddenly straightening up, frowning; loudly and forcibly.): "Aw, go to hell! I'll sit where I want!!" (She

plumps herself in a chair.)

T. (Throwing up his arms as though defending himself; plaintively.): "Okay, okay, you don't have to get violent!"

Pt. (Bursts out laughing.) (S.70)

We suspect that if therapists look back on their experience, they would realize as we have that the first interview, usually a time of crisis, provides opportunities to engage issues with the client which may not present themselves for awhile. Another consideration in this regard is that if you duck obvious issues initially with clients, you often are communicating to them, "You're too fragile to talk about the is now." Furthermore, being provocative in the first interview structures the relationship from the outset and strengthens the therapist's power position, especially with manipulative, acting out types of clients. Another consideration is that the client is very needy at this juncture (in the first interview) and is therefore most susceptible to the therapist's influence upon him.

24. Q.: Do you keep provoking the client or do you drop this in the fourth stage of process when the client is bringing in a lot of data that he's changed?

24. R.: Why quit being on a winning horse? No, I keep it up. Clients by this time will usually ask the therapist to be friends and "straight" with them, to which the provocative therapist characteristically responds, "Friends!? Do I look like the kind of guy who would take an emotional cripple home to dinner? For my hourly fee I'll talk with you, but be friends ... ? Come on, be reasonable now. And as far as being straight with you, can't you even tell that your friendly therapist has been telling you the truth, the whole truth, and nothing but the truth, so help me God?"

In the fourth stage the therapist knows that the client is able to decode him, and fully realize what the

therapist is referring to with his humor and provocation. He also continues to provoke the client up to and including the last interview to help the client assert himself and break felt dependency ties, as well as to communicate that the therapeutic relationship is both real and "unreal" in the sense that although the therapeutic relationship has many of the same qualities of a good friendship, it is unlike friendship in that the goal is work, the specific reason for being is to change one of the participants. The client's job is to build, in the social world outside of therapy, friendships that satisfy, are honest, and equal.

25. Q.: Do you ever work with couples?

25. R.: Yes, frequently. And there are some very funny examples of provocative therapy with couples, including the case of Brunhilda and Mr. Milquetoast, the case of the Computerized Husband and the Weepy Wife, and so forth. Next question.

26. Q.: Do you ever give any advice in provocative therapy?

26 .R.: By and large, no, not directly, although there are exceptions. A provocative therapist can give several inane solutions similar to the one which the client has been using unsuccessfully or state that he knows "some therapist who would suggest ... " To which one client responded, laughing: "You're always talking about some of these other therapists who would suggest this or that. Maybe I ought to go find some of those other therapists and listen to them. They give a hell of a lot better advice than you do with your sarcasm and snottiness." (Therapist and client burst out laughing.) Finally, the provocative therapist can give some straight advice and then down-play the client's ability to follow through. Thus, if the client does do anything, they own the success; they take responsibility for it. On the other hand, if they try the advice

and it doesn't work out, the provocative therapist would say, "I told you so!"

27. Q.: How do you get away with saying what you say to clients?

27. R.: Because basically it's the truth. I am not saying anything to them that they either haven't already said to themselves or that isn't first cousin to what they've already said to themselves, or it's what they think other people are thinking or feeling towards them, or, finally, what other people have already said to them. So that when I am saying these things to clients in therapy it sounds like old home week to them, and is not as startlingly new or overwhelmingly confronting as it might appear to an outside observer who is watching the therapy or reading a transcript.

28. Q.: Is anybody else doing provocative therapy besides you?

28. R.: Provocative therapy, I'm happy to relate, has been heard of and is being discussed or practiced in many states, not to mention England, Germany and Poland. The evidence suggests to date that the word is getting out and that provocative therapy is being discussed and practiced in an ever increasing number of places both in this country and abroad. Isn't that a heart-warming thought?

29. Q.: How do you know you really brought about change in a patient?

29. R.: In an effort to answer that let me cite the case of Mrs. Absolute Zero. I was called in for a thirty year old, female, depressed patient. The hospital staff couldn't find the reason she was depressed and in interviewing her in front of the staff the therapist asked a variety of questions designed to provoke responses about her functioning in different roles:

Therapist (Laconically.): You're probably a lousy mother, and you know it, and that's why you've had three hospitalizations.

The quickness and assurance with which she responded left little doubt that this was not her problem. She felt secure in her role as mother.

T, (Continuing on.): Well, then your house looks like the south end of the city dump? The fluff balls up to your husband's knees?

Pl. (Firmly.): It does not! It's as clean as any other you'll see in town. Sometimes it needs picking up, but that's to be expected with small children.

And so it went. Balanced, appropriate, assured responses to my "fishing expeditions" regarding every aspect of her role as mother, housekeeper, companion to her husband, daughter to her parents and daughter-in-law to her husband's parents and finally her health history which was unremarkable.

T. (Wearily.): O.K. Gorgeous, if you're so neat and competent and lovable in all these areas, what are you so depressed over?

Pl. (Looking down, pauses.): I don't want to talk about it. (What went through my mind was: Ah, ha, she's held up the red flag: Stop! So I decided to charge.)

T. (Triumphantly.): It's sex!

Pl. (Louder, looking up, angrily.): I told you, I'm not going to talk about it!

T. (Smugly.): I see, you're ashamed you're a pervert!

Quite briefly, it soon became clear what was causing her depression: she had had "dirty, perverted thoughts, feelings and desires" but was very ashamed of them and was scared to tell her husband because "he would be shocked to death". The therapist made fun of her feelings regarding this and role modelled

disgust and aversion to her desire to engage in oral and anal sex and experiment with any number of different positions at various times of day and night.

T. (incredulously.): You must be a sex maniac. How often do you have sex?

Pl. (Muttering.): Three times a week over the past 14 years.

T. (Pauses; does some calculating.): Well that's at most 2200 screws over the past 14 years. How many orgasms have you had?

Pl. (Grimly.): Five!

T. (Surprised.): Five? How do you know?

Pl. (Again with assurance.): Because I counted them ..

T. (Still questioning.): Sure?

Pl. (Firmly.): Absolutely!

T. (In a laughing aside to staff.): That's a pretty thin reinforcement schedule as the operant conditioners would say. (Group of staff observers in the room burst out laughing along with the patient and therapist).

This interview took place on a Tuesday and her husband was due to visit her on Thursday evening. I told the staff and patient that I wanted to see them both together. Her husband showed up the following Thursday. I interviewed them both, and immediately started off by summarizing the first part of the previous interview for him, and then stated that we had finally discovered the cause of his wife's depression which precipitated her three hospitalizations. Her husband inquired as to what this might be, and the therapist responded (grimly and with disgust), "The truth of the matter is, is that she has a lot of dirty, sexy feelings and thoughts and desires toward you which she feels unable to express." The husband immediately leaning forward in his chair, grinning, and looking from his wife to the therapist, said, "Oh yeah? O.K., Oh yeah?" The therapist burst out laughing, the husband was

laughing, the staff observers were laughing and even the patient, blushing furiously and hanging her head in shame, was laughing in spite of herself. The therapist then told the husband that he was calling her the case of "Mrs. Absolute Zero" because she was "beyond frigidity" with her rate of orgasm - five in fourteen years and 2200 acts of intercourse. By the is time the patient was laughing openly and gradually became less embarrassed. The therapist then asked her if, when they had sex, she "laid there like King Tut's mummy while he does it to you". Both agreed that this was pretty much the case. T. then told her that she would have to help her husband arouse her, and that she should masturbate herself and simultaneously fondle her breasts and nipples while he had intercourse with her: "Put your hands where they'll do the most good and that's not on his back, unless you have an erogenous zone between his clavicles."

The patient became embarrassed again (amid the laughter of her husband and staff) and confessed that she had thought of this but thought it "abnormal" .

T. (To husband.): Would you get disgusted with her and vomit all over her if she her ps you get her aroused to orgasm? The husband, who was almost drooling by this time, assured her convincingly that it was "fine, really fine with him". The husband asked if she could go on a home visit. The therapist agreed to this with the provision that she do some "homework". Husband and wife (Simultaneously.): What?

T. (Straightforwardly.): I want you to do three things: 1. Fuck! 2. Fuck! 3. Fuck! You have tour days to do it in, and I'll see you Monday evening.

The following Monday the patient and her husband were seen along with the staff observers. Quite briefly, she had equalled the frequency of the past 14 years in 4

days and experienced 5 orgasms in 7 acts of intercourse. This evidence suggests that the therapist was an "intervening variable" in this case and made a significant contribution in bringing about changes in this patient for this course of hospitalization. There are no controlled research studies as yet, but we think these will be undertaken in the future. (5.71)

30. Q.: For how many interviews on the average do you see patients?

30. R.: The range is from 2 to 100, with the majority being in the range of 20-25 interviews.

31. Q.: Wouldn't you call what you do sadistic?

31. R.: No, I Couldn't. I hesitate here, because I do not want to be misunderstood, but let me try to respond in this way. I want to address myself to a concept that I've come to term "therapeutic cruelty and joyful sadism" ..

It has been stated that there are basically only two ways of bringing about significant changes in the human animal's behavior: by either rewarding this behavior or by punishing it. It has become increasingly clear to me that the recidivism or preservative behaviors found in many of our clients is a result not so much of emotional deprivation or unmet psychological needs, but instead these deviant behaviors are oftentimes more the result of what I've termed misguided kindness. For example, the child who mutilates himself for the first time is almost invariably, and perhaps rightly so, responded to by adults with affection and deep concern. But if this is allowed to continue, even a rather dull child can rapidly gain control of the adults around him and get them running with some more of the good old T.L.C. by threatening to harm himself or by cutting himself. And, of course, the same control can be achieved by the client's escalating other types

of symptomatology.

It is ironic that from my experience what often seems on the face of it to be cruel can later on turn out to be kind, and what seems to be kindness at first toward patients and clients can, in the long run, lead to very damaging and anti-therapeutic consequences. Let me cite an example (5.72) to illustrate what I mean by this "short-term cruelty and long-term kindness" phenomena. I was seeing a young patient (about 19 years of age) on an outpatient basis. She had had a lurid history of self-destructive behavior and called me around midnight one snowy evening, stating that she had cut herself again. My response was that I would probably be able to help her on this and that I would call her back. I telephoned a psychiatrist friend of mine and told him the problem; he was acquainted with her case, but protested that he had not expected anything of this sort and had had several martinis and was almost prepared to go to bed. I remarked, "Good. Then your hand won't be so steady when you're sewing her up." He further protested that he had no novocain to make the patient more comfortable. Again I responded, "That's even better, and while you're at it, will you please charge her approximately 35 to 40 dollars for inconveniencing you at this hour." In short, she was sewn up by a pair of shaky hands, with no novocain, and charged. The sequel: she never cut herself again or engaged in any physical self-mutilating types of behavior. Question: Is this "cruelty and sadism" or long-term kindness? I submit that it is the latter. This particular patient used to brag to me that she never felt anything after she had cut herself, and even had gone so far as to sew herself up with dental floss on one occasion. The wound had begun to fester and she had taken out a pair of scissors, cut the dental

floss, rubbed the wound with Old Dutch Cleanser and a toothbrush, and sewn herself up again! I was very happy to note that she obviously did feel something while she was being sewn up on that night; I let her hold my hand to squeeze while she was being stitched, and she almost broke it. She also had tears in her eyes and I remember distinctly feeling, "I hope this hurts you so goddamn much that you will think ten times before you every try this again, sister!" Are these "sadistic" thoughts and feelings toward a client? When I told her about these feelings of mine during the next interview, she smiled and laughed and said, "When I used to cut myself in the hospital, the staff would immediately react, 'Oh, the poor patient!', but I never really hurt myself badly. I only cut the skin and through the fat, never down deep into the muscle." This patient, and there were others after her, was my first teacher in the phenomenon of "short-term cruelty and long-term kindness."

What I'm trying to say here is that, based on my clinical experience, I feel that a distinction has to be made between short-term "cruelty" and long-term kindness on the one hand, and short-term "kindness" which ends up in long-term detriment to the patient or client. There probably are such people in the clinical field as "sadists". But a distinction has to be made on the one hand between being a "sadist" and, on the other hand, in taking pleasure in venting long overdue, justifiably angry feelings towards a client or patient, seeing the immediate effect on the recipient, and then taking pleasure in the changed, "shaped" behavior in the "subject".

There are few pleasures that exceed the discovery of the appropriate and effective negative reinforcement and punishment in "people work" - a term I use to

refer to those who are engaged in shaping a child's behavior (parents), or a trainee's behavior (supervisors), or a patient's or client's behavior (therapist and ward staff). Guilt-free, joyful "sadism" that redounds to the long-term psycho-social benefit of the child, trainee, or patient is beautiful. I am not saying that love and positive reinforcement do not have a place in people work. They obviously do. Equally obvious to me is that punishment, negative reinforcement, and the withdrawal of positive reinforcement also have an important place in shaping behavior.

Let's look at this from another angle. Put yourself, if you can for a moment in the place of a small child and look at parents' child rearing practices from the child's perspective. And here I mean to talk about effective, warmly caring parents. Perhaps you, the child, gets angry, and with perfect justification, stamp your feet, 'throw a book, and loudly claim your constitutional rights to a peanut butter sandwich. You are suddenly met with massive counterforce by a nineteenth foot tall Brobdingnagian woman called MOTHER who swoops down on you and, loudly cooing what seems to you a completely phony love rhetoric to soothe you, lifts you to dizzying and frightening heights and, against your will, carries you bodily to a place where she will lock you behind bars in solitary confinement and social isolation in a jail called "crib".

Should you try to break jail, the all-seeing giant may burst in and inflict violence and physical punishment on you while baptizing this with the substitutional euphemism of "spanking". And it, after being released from jail, you should break another city ordinance, you might find all the foregoing repeated, along with the threat of malnutrition or starvation. My son, Timothy, when age four, was being ushered to bed without his

supper for having been particularly rambunctious. As he was reluctantly entering his room and being pushed from behind by his mother, he remarked in a piteous, tear-choked voice, "You know, you can starve little people to death by not feeding them."

To recapitulate: The socialization of children in any culture is usually done with love and tenderness, to be sure, and with massive counterforce, violence and physical punishments, withholding of food, torred solitary confinement and social isolation, and similar "dog-training-obedience" methods. We have the knowledge and skill now to help many patients hitherto considered "hopeless". What often keeps us from "reaching" them and breaking through their schizophrenic "glass wall" is the bind and bugaboo of "sadism" or "anti-humanitarianism".

32. Q.: Why the heavy emphasis on the present in provocative therapy?

32. R.: Because the reality is that the present is all we've got to deal with. Clients are not trying to resolve past conflictual situations such as Oedipal complexes.

They are hung up now in their feelings, for example, about authority and their feelings towards the opposite sex. And I would agree strongly with Ellis that it is the current self-talk that clients engage in that helps to maintain their problems.

The provocative therapist will use the client's past to point out how they developed their screwball attitudes and behaviors, or to simply demonstrate for how long a time a client has been self-defeating. And he will also frequently use the future to run different scenarios past the client, wild, implausible themes based on the client's present attitudes and behaviors, to provoke the "Ugh!" reaction in the client, to sensitize him to the

probable consequence of his presently held idiotic ideas and zany behaviors. For example (5.73): T.: "I can see you now, as the decades roll by, clamouring sloppily through your toothless gums, 'My Mother did it to me', and then, some moonless night, a light appears in a graveyard, and as we approach the scene, we see you, an old bat, squatting down and peeing with vengeance all over your Mother's grave!" Another example: T. (Looking at the far corner of the ceiling as thought clairvoyant.): "I just got a flash! I see a nursing home, a gloomy room, and a little old man strapped to the chair because he's a dirty old man and has been pinching the nurses. His head is bent and he is muttering to himself, 'I could have made it big, really big, if only ... if only ... ' " And to this remark the client, laughing, blushing, and holding his hands in front of face, responds, "Ugh! Quit it, will ya?"

33. Q.: You seem to be saying that if you just had enough techniques, you could damn near cure everybody.

33. R.: In some ways I really do believe this. That may very well be true. Techniques are crucial because they operationalize

and implement the therapist's attitudes; otherwise you can end up just being concerned but inept. Furthermore, we want to describe techniques at length, because a lot of books on therapy describe extensively the therapist's philosophical stance but say damn little about what he actually does. However, we do not wish to create the illusion that technique is everything. It's got to flow from what you are or from an aspect of you. But it's also true that "by their fruits you shall know them". Show me what you do with a client and I'll tell you what kind of therapist you are; I'll tell you what kind of values and attitudes you hold operationally.

34. Q.: What are the cues from the client that the challenge from the therapist is not over- or under-whelming?

34. R.: This is an excellent question and one for which I don't really have an answer other than "it depends".

Psychotherapy is both an art and a science and this question addresses itself to the art component. It is difficult if not impossible for me to condense a decade and a half of clinical experience into some distilled canned rules of thumb, some judgments applicable to all therapists about handling all clients on any occasion. It would be as easy for an artist to answer the question, "Well, Mr. da Vinci, just how did you paint the is here Last Supper?" Paul Hornung, of Green Bay Packer fame, was asked how he knew how to "run to daylight" - was it practice, intuition, or experience?

After a five minute fumbling response, it became clear that the question was basically unanswerable. Many people use the word intuition to describe the clinician's judgment, but this does not really clarify the issue. Intuition seems to be a lightning-quick processing of a wide variety of stimuli, both internal and external, and arriving at a judgment which is translated into a response toward the patient that provokes him in a helpful way.

When learning to drive a car, the beginner fails to observe all the data, with difficulty processes very slowly what he does observe, tends frequently to overcorrect

and arrives at wrong judgments and responses to the complex driving situation. With instruction, practice, and experience, he markedly speeds up his data processing ability, is able to initiate and maintain an ongoing process of minute corrections, and develops increased capacity to arrive at better judgments and smoothly execute them with a significant decrease

in his energy expenditure. A similar situation obtains in therapy. All of which is a response posing under the guise of an answer to your question.

I see there are a number of further questions which we could discuss, but as we say in the clinical field, "Our time is up for today."