

**THE EXPERIENCE OF PROVOCATION IN PSYCHOTHERAPY: A CO-CREATED
DESCRIPTION**

by

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To my grandfather, Derrick Roper, who provided our family with a legacy of humour.

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SUMMARY

As some criticism and hesitations have been expressed with regard to the implementation of provocation in psychotherapy, this study aimed to explore the experiences of clients and a therapist who participated in provocative psychotherapy. In order to do this, a concise theoretical description of the nature of provocative psychotherapy was provided along the lines of the work of Frank Farrelly and Maurizio Andolfi. Participants' experiences of provocation in psychotherapy were consequently presented by means of three case studies. A description of the experience of provocation in psychotherapy was co-created through the identifying of certain themes underlying of the three client groups' and the therapist's descriptions of their experiences. This was done by employing a qualitative research methodology to describe the experiences of clients and a therapist who participated in provocative individual-, couple- and family psychotherapy.

Keywords: Provocative psychotherapy, Provocative Therapy, client experiences, therapist experiences, humour in psychotherapy, couple therapy, family therapy, support, metaphor, qualitative research.

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CHAPTER 1

INTRODUCTION

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.

(Fisher, in Farrelly & Brandsma, 1974, p.93)

With this suggestion, Fisher (in Farrelly & Brandsma, 1974), just about captures the essence of provocative psychotherapy - an approach to therapy that apparently deviates from the usual friendly and accepting role expected of therapists and which attempts to directly and firmly challenge all clients (Corsini, 1984b). This approach has been termed "one of the more innovative of psychotherapies in current use" (Corsini, 1981, p.678). Several questions have, however, also been raised with regard to the use of provocation in psychotherapy, questions such as: "Can this technique be used without being subject to patient misinterpretation? Can the therapist's empathy still come through despite the provocative style?" (Fry & Salameh, 1987, p.81), and "Should a therapist employ such shock tactics even if they are personally distasteful to him or her?" (Corsini, 1981, p.678).

Criticism has also been expressed concerning techniques such as the use of humour employed by provocative psychotherapists. In this regard it is mainly Kubie (in Buckman, 1994b), who describes the use of humour in psychotherapy as destructive to the psychotherapeutic relationship. He believes that this is the case because humorous responses are "a confusing, confrontive option which blocks the client's free association and spontaneity" (Buckman, 1994b, p.20). It is furthermore believed that the use of humour can actually harm clients as it is regarded as being in contrast with the importance of clients' anxieties, illnesses and lives (Buckman, 1994b).

Therapists like Frank Farrelly, who practise provocative psychotherapy, however, strongly disagree with the above criticism. Farrelly, who initially specialised in the client centred approach to therapy, came to the conclusion that emphatic understanding, warm caring and genuine congruence are seldom sufficient as therapeutic strategies and often far too slow. In turn he discovered that when he "threw therapy out the window" (Farrelly &

Brandsma, 1974, p.19) and began telling patients how he found himself reacting to them, they began to improve. Farrelly called this new approach of his "Provocative Therapy" and found that this approach was as valid for private as for public sector clients and as appropriate for neurotics as for psychotics. He furthermore assumed that there are no patients for whom the provocative approach is clearly unsuitable (Farrelly & Brandsma, 1974).

Farrelly and Brandsma (1974) describe how beneficial this approach can be for clients, especially with regard to altering their negative behaviours. Clients are also reported to, after initial surprise, experience this approach as mostly positive. This assumption is supported by quoting that 95% of clients in provocative therapy return to therapy after the initial interview. Farrelly and Brandsma believe that the reason for this high returning rate is that "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" (p.132). Clients are furthermore quoted to have experienced provocative therapists to treat them more like adults than fragile, helpless patients. Farrelly and Brandsma also quote client experiences of being understood and of enjoying the humorous approach, coupled with an experience of being challenged.

Positive therapist experiences with regard to provocative psychotherapy are also quoted by Farrelly and Brandsma (1974). These positive experiences include a sense of freedom and enjoyment paired with an experience of being in control of the therapeutic situation. Farrelly and Brandsma argue that provocative therapists tend to experience a sense of release from the constricted role of the traditional therapist. This apparently brings about an experience of freedom to use more of the therapist's total range of responses and whole self as a therapeutic instrument.

Bloom (1992) also refers to therapists who have had positive experiences with regard to provocative psychotherapy. He indicates that some therapists reported that, after being exposed to the ideas of provocative psychotherapy, they felt differently about their clients. They reported that they no longer believed that their clients were as fragile, weak or incapable as they had previously thought. These therapists also apparently indicated that their exposure to provocative psychotherapy enabled them to use humour more successfully in their therapy sessions. Some therapists are furthermore reported to have found that they are more honest and open with clients when applying provocative techniques. They indicated that they can work more effectively with a wider variety of clients and that they are

far less uneasy about their own reactions to their clients because they are now able to use these reactions therapeutically (Bloom, 1992).

It is thus clear that there are strong arguments both for and against the use of provocative measures in psychotherapy. However, apart from the inquiries by Farrelly and Brandsma (1974) and Bloom (1992) no further inquiries seem to have been undertaken to support either of these positions or to find answers to the questions raised with regard to this approach. The aim of this study will subsequently be considered.

Problem Statement and Aim of the Study

Given the above-mentioned contradictory views and questions regarding the use of provocation in psychotherapy, the question that arose for the researcher and consequently guided this research process, is: How do both clients and therapists participating in provocative psychotherapy experience their involvement in this therapeutic approach? In other words, what effect does the implementation of provocation in psychotherapy have on both therapists and clients involved in it? Are there certain aspects of provocation that are experienced as negative and are there aspects that are experienced as positive? The aim of this study will thus be to explore the experiences of a small number of clients and a therapist who have been involved in some kind of provocative psychotherapy. Attempts will then be made to identify certain common themes embedded in the participants' descriptions of their experiences. This will be done in order to eventually arrive at a co-created description of the experience of provocative psychotherapy. The exploration will be undertaken with a constructivist epistemology as point of departure, which means that realities will be regarded as constructed, indefinite and multiple. The focus will thus not be on "entities," but rather on co-created linguistic realities or ecologies of ideas (Bateson, 1972).

It is, however, important to note that this study will not be concerned with the outcomes connected to the use of provocation in psychotherapy, but rather with the experiences of the parties involved. The effectiveness of this approach with regard to symptom relief will thus not come under scrutiny, but rather the specific experiences of the participants. This study must thus be regarded as a qualitative, exploratory research project concerned with the experiences of participants in provocative psychotherapy.

It is believed that inquiry into these experiences would allow the researcher, as well as the reader, to form a better opinion about both the usefulness and ethical appropriateness of the use of provocative psychotherapy. Elliot and James (1989) are also of the opinion that

an acquaintance with the types of experiences that people have in therapy, can lead to a better understanding of the process and action of psychotherapy. This, they believe, can in turn lead to better understanding of particular clients and to more effective interventions. Overall, they believe that studies of clients' experiences in psychotherapy are likely to enhance the understanding of psychotherapy on both practical and theoretical levels (Elliot & James, 1989).

A further aim of this study will be to fill an apparent gap in the existing body of knowledge. Elliot and James (1989) provide an extensive overview of studies pertaining to clients' experiences in psychotherapy. In their review of the literature on clients' experience of psychotherapy, these authors identify nine domains that had been focused on. None of these or other more recent studies, however, seem to specifically address clients' or therapists' experiences with regard to provocation in psychotherapy. Elliot and James also indicate that "clients' perceptions of what their therapists are doing (actions) or trying to do (intentions) have received little direct study," (p.453) and also that "more qualitative, exploratory research is needed on client experiences" (p.461). Seemingly, the only available substantial data with regard to participants' experiences of provocation in psychotherapy is provided by Farrelly and Brandsma (1974). This study will consequently aim to test the descriptions of clients' and therapists' experiences of provocation in psychotherapy as provided by Farrelly and Brandsma. Attempts will furthermore be made to provide a co-created description of at least certain clients' perceptions or experiences of a therapist's provocative actions. This will be done in order to answer some of the questions pertaining to the use of provocation in psychotherapy. Before this can be done, it is, however, believed that definitions of the key concepts referred to in this study, will have to be considered.

Definition of Key Concepts

In order to facilitate the reader's conceptualisation of this inquiry into the experience of provocation in psychotherapy, a description of the author's understanding of the concepts of "experience" and "provocation in psychotherapy" will subsequently be provided. These definitions must, however, by no means be regarded as absolute definitions for these concepts. Attempts will merely be made to describe the researcher's understanding of these concepts within the context of this specific study.

For the purpose of this study, "experience" can be defined in terms of Elliot and James's (1989, p.444) definition thereof, namely, both clients' and therapists' "sensations, perceptions, thoughts and feelings during, and with reference to, therapy sessions." Elliot

and James rightly state that this definition is a broad one which covers various aspects of experience. In the first place, they argue that many types of experiences are included in this definition, experiences such as arousal, states of mind, emotional feelings, internal physical sensations, perceptions of external stimuli, images, internal self-verbalisations, meanings, memories, wishes and intentions. Secondly, these experiences are perceived to have as their object the self, the therapist or the treatment itself. Thirdly, participants' extra-therapy reflections and reactions to therapy are also encompassed within this definition along with within-session experiences (Elliot & James 1989). For the purpose of this study all these experiences are viewed with regard to any provocative element of the entire course of treatment. According to Elliot and James such use of the entire treatment as a unit of research, has the one distinct advantage that clients' global perceptions and feelings can be tapped into.

A definition of provocation in psychotherapy must be regarded as less simplistic since a multitude of assumptions and techniques could be associated with this therapeutic concept. For the purpose of this study, provocation in psychotherapy can, nevertheless, be viewed as referring to an approach to psychotherapy where the main aim is to perturb clients to such an extent that they decide to transform their own dysfunctional, redundant behavioural patterns into more adaptive behaviours. This perturbation is normally done through the use of a variety of procedures including exaggerations, direct feedback, dramatisations and other unpredictable therapeutic manoeuvres which will be referred to in Chapter 2 of this study (Corsini, 1984b).

Andolfi, Angelo and de Nichilo (1989 p.39) refer to the fact that "provocation has commonly been understood as the verbal or nonverbal behavior, mostly intentional, of challenging the family system, which the therapist engages in order to modify the rules of the family's functioning." They, however, warn that this definition had led to both misunderstanding and prejudice related to the concept of provocation as confrontation. It is stressed by these authors that to provoke does not mean to attack, but that therapeutic provocation is always accompanied by support – an issue which will be discussed in the following chapter. Andolfi et al. consequently suggest that being provocative refers to a process by which the therapist touches on "elements that are especially emotionally meaningful for family relationships or images or ways of seeing that have become rigid over time" (p.45). The provocative therapist thus attempts to accentuate any obvious instabilities within the client system. Where there are no obvious instabilities, it will be the task of the provocative psychotherapist to bring the hidden instabilities to the surface. For Andolfi, Angelo, Menghi and Nicolò-Corigliano (1983) this is the essence of provocation. They

believe that this “bringing forth” of the hidden is implicated in the etymology of the word provocation namely “pro-vocare,” which means to call forth. A more detailed description of this and other concepts related to the practice of provocative psychotherapy will be provided in Chapter 2. It is believed that this theoretical discussion will assist the reader in drawing his/her own distinctions with regard to the concept of provocation in psychotherapy. A review of the chapters to follow will subsequently be provided.

Chapter Review

The researcher’s inquiry into the experience of provocation in psychotherapy will be described in the course of the following seven chapters. A review of these chapters is as follows:

Chapter 2 will provide the reader with a theoretical point of departure for this study. In this chapter a brief review will be provided of the work of two prominent practitioners of provocative psychotherapy, namely that of Frank Farrelly and Maurizio Andolfi. This will be done by considering both the conceptualisations and applications of provocative psychotherapy by these therapists.

In Chapter 3 the research design applied to the study will be discussed. Both the research paradigm and the research methodology that guided this research project will be presented.

Chapter 4 will contain a description of the experience of provocation in individual psychotherapy. A case description of an individual seen by the researcher in therapy will be provided. The background to the specific case will first be presented whereafter the therapeutic process will be reconstructed. This will be followed by a description of both the therapist’s and client’s experience of the specific process of provocative psychotherapy.

The experience of provocation in couple psychotherapy will be considered in Chapter 5. Once again background information to the case at hand will be provided whereafter the researcher will provide a description of the specific therapeutic process. The therapist’s experience of the use of provocation will then be presented whereafter the couple’s experience of provocative psychotherapy will be discussed.

Chapter 6 will provide the reader with a description of the experience of provocation in family therapy. After the background to the involved family’s case has been presented, a

discussion of the therapeutic process will follow. The therapist's experience of the use of provocation in family therapy will then be considered followed by the family members' description of their experience of provocation.

A review of the research findings will be provided in Chapter 7. The researcher will provide a co-created description of all the participants' experiences with regard to provocative psychotherapy. This will be done through the identification and discussion of common themes underlying the various participants' descriptions of their experiences of provocative psychotherapy.

Chapter 8 will be the concluding chapter. In this chapter, the study will be evaluated and the implications of the findings for the broader field of psychotherapy will be discussed. Recommendations for future research will also be made.

Conclusion

It is clear from the review provided in this chapter, that certain questions have been raised and that certain claims have been made with regard to the use of provocation in psychotherapy. Adopting a constructivist framework and a qualitative methodology, this study will attempt to either reinforce or question some of these claims and queries. This will be done through the exploration of the experiences of certain clients and a therapist who have been involved in provocative psychotherapy. The exploration will be preceded by a theoretical review of the concept of provocative psychotherapy in the following chapter.

CHAPTER 2

PROVOCATIVE PSYCHOTHERAPY: A THEORETICAL PERSPECTIVE

Upon considering provocative psychotherapy, there are especially two theorists' names that come to mind, namely, those of Frank Farrelly and Maurizio Andolfi. In this chapter an outline will be given of these two therapists' conceptualisation of provocation which has particularly influenced the researcher. Firstly the work of Farrelly (Farrelly & Brandsma, 1974) will be discussed and thereafter Andolfi's work (Andolfi et al., 1983; Andolfi et al., 1989) will be considered.

The Work of Frank Farrelly

Farrelly "discovered" provocative therapy while participating in a client centred project with chronic schizophrenics at Mendota State Hospital. This discovery grew out of his experience of working with hospitalised psychotic patients in the 1960's. It evolved from experimentation with different ways of relating to patients and unintentional discoveries along the way (Farrelly & Brandsma, 1974).

The theoretical base of provocative therapy as designed by Farrelly and Brandsma (1974), consists of ten assumptions and two hypotheses regarding the process of therapy. These assumptions and hypotheses will be discussed here, together with some prominent techniques applied by Farrelly (Farrelly & Brandsma, 1974).

Assumptions

Farrelly and Brandsma (1974) believe that the following ten assumptions guide the perception and organisation of clinical data as well as the responses of the provocative therapist and the responses he/she endeavours to provoke from the client:

People Change and Grow in Response to a Challenge

Many therapists emphasise the importance of creating a safe environment during therapy sessions. The provocative therapist does not, however, consider therapist acceptance alone as a sufficient condition for change. Farrelly and Brandsma (1974) believe that the providing of a safe environment to an organism could either lead to growth or to

stagnation in unproductive habits. Therapists often attempt to keep clients calm and comfortable while talking with a soothing voice. In provocative therapy almost the exact opposite is attempted as the therapist attempts to impinge on the comfort zones of clients in a way in which they are forced to cope and are unable to avoid the therapist. The rationale behind this is that, although a human organism needs safety, it also needs stimulation. Provocative therapists assume that change is more likely to occur when individuals are bombarded with non-overwhelming challenges which cannot be avoided and with which they are consequently forced to cope (Farrelly & Lynch, 1987).

One of the unique features of provocative therapy, highlighted by Farrelly and Brandsma (1974), is the degree of therapist intolerance towards client avoidance, even from the initial contact. Instead, the provocative therapist will attempt to provoke a certain type of constructive self-anger. The term "constructive self-anger" refers to a dissatisfaction with the self, accompanied by a desire to change (Farrelly & Brandsma, 1974). According to Farrelly and Brandsma, this desirable type of anger is often characterised by an intensity and attitude verbally expressed as "enough is enough" or "I'm getting fed up with myself, I've got to change" (p.36). It is believed that this annoyance with the self tends to lead to a decision to cope.

Farrelly and Brandsma (1974), however, note that although this experience of constructive anger is unlikely to be provoked in an overly safe environment, it is also not likely to be brought about in a threatening context where the client experiences the therapist as hostile or over-critical. The provocative therapist's role is thus regarded as twofold, namely, to support clients on the one hand while simultaneously challenging them on the other hand. By carefully combining indirect support with direct provocations, the therapist strives to assist clients in the abandoning of self-defeating behaviours (Farrelly & Lynch, 1987).

Clients can Change if They Choose

One of Farrelly's significant experiences at Mendota State Hospital occurred when he "threw therapy out the window" and expressed his anger at a psychotic patient for writing obscene letters to a young secretary. The patient angrily replied that he could not be held responsible, as he was "mentally ill." This experience, together with later ones, convinced Farrelly of the major role choice plays in the onset of mental disease (Farrelly & Brandsma, 1974).

Farrelly and Lynch (1987) acknowledge that many unfortunate experiences do happen to people even if they do not deserve it. Yet, if people are to change, the focus of therapy must, according to Farrelly, be on their responsibility for their lives and their maintaining of self-defeating beliefs and behaviours. It is thus expected from the provocative therapist to provoke clients out of their position of disability into an understanding that their dysfunctional patterns often result from their own choices (Farrelly & Lynch, 1987).

The assumption that clients can change if they want to is regarded as vital in order for therapeutic change to take place. It is believed that to hold people responsible for their actions, gives them hope and dignity. This, in effect, portrays the message that they may be responsible for their own misfortune, but that they can choose and change and that their whole life can be different. Clients are thus not seen as completely helpless or as determined victims of others or their unconscious (Farrelly & Brandsma, 1974).

The Psychological Fragility of Clients is Vastly Overrated by Both Themselves and Others

Many therapists tend to be impressed by people's weaknesses. They tend to see their clients as victims of their circumstances who will shatter rather easily if confronted. Although Farrelly and Brandsma (1974) acknowledge that human beings have breaking points and that victims do exist, they maintain that it is ultimately non-therapeutic to offer too much positive regard while withholding genuine feelings of occasional doubt, irritation or anger. In provocative therapy, the adaptability and resilience of clients are acknowledged. Instead of protecting clients, even unpleasant thoughts or characteristics are made overt and are even exaggerated. By doing this, the provocative therapist aims to draw clients' attention to the fact that they can handle their problems better than they or others expect (Farrelly & Brandsma, 1974).

While warning that one should be sensitive to the psychological and physical limits of this proposition in general, Farrelly believes that more can be demanded of clients. He believes that clients are prone to behave as they are expected to and that they are not as fragile as they are often assumed to be (Farrelly & Lynch, 1987).

Clients have Far More Potential for Achieving Adaptive, Productive and Socialised Modes of Living than They or Most Clinicians Assume

Pessimistic prognostic statements regarding clients' lack of ability are common in the clinical field. Some therapists may, even unintentionally convey the idea that a client is

incapable of change. This is regarded by Farrelly to often rather be a reflection of the individual therapist's subjective reaction to helplessness and hopelessness than any objective statement concerning the client. The provocative therapist, instead, seeks to provoke clients into expressing their inner resources so that they can get in touch with their own resilience and actively participate in the healing process (Farrelly & Lynch, 1987).

Clients' Maladaptive, Unproductive, Anti-social Attitudes and Behaviours can be Drastically Altered whatever the Degree of Severity or Chronicity

According to Farrelly and Brandsma (1974), clinical staff's expectations of hospitalised patients often tend to be enacted by patients. This implies that if staff members (or therapists) expect patients to get better, they tend to. If, on the contrary, it is expected from patients to get worse, they tend to become worse.

In the light of the above, the provocative therapist perceives all clients as capable of change, even those with severe chronic mental illnesses. Instead of being overwhelmed by clients' psychopathology, the provocative therapist attempts to enter clients' inner worlds and aims to utilise the resources in these in order to help them bring about constructive change. Farrelly believes that a significant aspect in this process has to do with clients finally choosing to improve their own behaviours (Farrelly & Lynch, 1987).

Adult or Current Experiences are at Least as Significant, if not More so, than Childhood or Previous Experiences in Shaping Client Values, Operational Attitudes and Behaviours

Inherent to this assumption is Farrelly and Brandsma's (1974) idea that the peer group, mass media, general societal values and reward systems and the individual's own choices, shape adult personality at least as much as the parents do.

Farrelly and Brandsma (1974) are of the opinion that parents send millions of messages to a child. These messages, they believe, are largely determined by the child's behaviour. Simultaneously the child is believed to choose to perceive selectively and respond only to certain messages and later, as an adult, to choose to continue responding to the ones that had been selected.

Adults are thus considered to have more information processing ability, more experience to generalise from, and the potential for a less self-centred approach to life. The provocative therapist is required to join with clients and to provoke them into better utilising

all their inner resources in order to enhance their potential for change. This is achieved by indirectly engaging clients in humorous and teasing behaviour in order to help them gain a broader perspective on their issues (Farrelly & Brandsma, 1974).

The main aim of this approach to therapy is thus to provoke experiences that are as real and significant to clients as their past life experiences have been. In this sense, provocative therapy cannot be regarded as a journey into the past, based on the belief that the significant causes of human behaviour are past experiences. Provocative therapy would rather attempt to focus on current life experiences (Farrelly & Lynch, 1987).

Clients' Behaviour with the Therapist is a Relatively Accurate Reflection of Their Habitual Patterns of Social and Interpersonal Relationships

This assumption suggests that therapy becomes a microcosm of the client's psychosocial life. In provocative therapy, the therapist is to observe client behaviours while getting actively involved with clients in order to provoke them into displaying an even wider array of their behavioural repertoires. When the therapist has personally observed clients' behavioural strategies, he/she can then proceed with helping them to alter or abandon their dysfunctional patterns. Farrelly and Lynch (1987) suggest that this can be done in three ways: By presenting clients with feedback of how significant others are likely to perceive or react to their attitudes and behaviours, by humorously imitating the negative social consequences likely to result from clients' attitudes and behaviours, and by reminding clients of the feedback available to them from their own social relationships (Farrelly & Lynch, 1987).

Farrelly and Brandsma (1974) believe that clients are likely to, sooner or later, display their defensive manoeuvres and behaviours, utilised in everyday life, as a reaction to the strong stimuli presented by the therapist. Clients' redundant behavioural patterns are thus believed to become apparent during interviews, which provides therapists with an opportunity to focus on particular self-defeating strategies of clients.

After sufficient counter-conditioning, clients are believed to learn to generalise their new coping behaviours to other situations. The therapist's aim is thus not to compensate for clients' emotional deprivations but rather to desensitise them to ordeals in order to guide them towards the development of more adaptive ways of coping in social relationships (Farrelly & Brandsma, 1974).

People Make Sense: The Human Animal is Exquisitely Logical and Understandable

Implicit to this assumption is the fact that human beings are regarded to be far more similar than what they are normally thought to be. Even those human beings suffering from severe psychological difficulties are not regarded as alien. This implies that what is most personal can also be regarded as most universal. Human similarities are thus believed to outweigh human differences by far. Basic experiences such as love, hate, joy, fear, and agony are seen as universally shared through the ages and regarded as central to human existence (Farrelly & Lynch, 1987).

No client is consequently perceived as uniquely mysterious or alien. Such a reaction to clients would just be ascribed to a lack of necessary data to understand their contexts. During provocative therapy, clients are thus at times sufficiently provoked in order to obtain the necessary data for understanding them and their situations or behaviours (Farrelly & Brandsma, 1974).

The Expression of the Therapist's Genuine Non-contradictory Negative Feelings Toward Clients can Markedly Benefit Them

It is believed that one of the reasons the so called mentally ill often feel rejected and unloved, is because they *are* frequently rejected and not loved. If clients feel hated, both by themselves and others, Farrelly believes that this might, at least partially, be due to the fact that many of their behaviours are indeed hatable. It became clear to Farrelly and Brandsma (1974) that genuine rejection expressed by the therapist with regard to such behaviours can be far more helpful to a client than superficial acceptance. They believe that a distinction must be drawn between short-term cruelty translating into long-term kindness on the one hand versus short-term kindness translating into long-term harm on the other hand.

Ludwig and Farrelly (1966) are of the opinion that punishments will always be used. The question which they believe needs to be asked, is whether the punishment will be effective and explicit or ineffective and apologetic. They argue that punishment, or long overdue justifiable anger towards clients, might have positive effects when this provokes clients to choose to change their dysfunctional behaviours to more adapted behaviours. It is, however, furthermore stressed that if acceptance is not enough, neither is punishment. Only when the two are utilised together, are they regarded as effective in changing behaviour.

The Most Important Messages Between People are Non-verbal

According to Farrelly and Lynch (1987), non-verbal communication has long been used by experienced therapists to decode messages and enhance understanding. In light hereof, Farrelly (in Farrelly & Brandsma, 1974) regards the most relevant messages between people to be implicit, covert, indirect and at times intuitive. This means that communication between people is believed to occur simultaneously on different levels. As a result of this, the most effective way for a therapist to experience a client is not only to observe by "listening with the third ear" but also by "seeing with the third eye" (Farrelly & Lynch, 1987, p.86).

Not only is the client's non-verbal language regarded as important, but the provocative therapist is also expected to depend on and utilise his/her own non-verbal messages in order to qualify his/her words in an often paradoxical and harsh verbal context. An essential aspect of provocative therapy is thus to learn to smile with the eyes and to practise sending humorously incongruent messages. Ultimately it is not what is said but how it is said that matters for the provocative therapist (Farrelly & Brandsma, 1974).

Hypotheses

In addition to the above-mentioned ten assumptions, Farrelly's provocative therapy is also based on two hypotheses (Farrelly & Brandsma, 1974).

The first hypothesis has to do with clients' attitudes towards themselves. It is hypothesised that, if provoked by a therapist, the client will tend to shift in the opposite direction of the therapist's definition of the client as a person. If a therapist, for example, agrees with clients' negative beliefs about themselves, they are seen as likely to defend themselves and consequently abandon their negative self-concepts (Farrelly & Brandsma, 1974).

The second hypothesis focuses on the client's overt behaviours. It has to do with adequate reality testing and with complying with reasonable expectations and needs of others in interpersonal relationships with, for example, employers, spouses and family members. This hypothesis states that if clients are provocatively encouraged to continue self-defeating, unacceptable behaviours, they will tend to engage in more positive behaviours, which are regarded as more acceptable by society in general (Farrelly & Brandsma, 1974).

Farrelly and Brandsma (1974) provide some variants on these hypotheses: In the first variant it is argued that if therapists excuse clients, clients will tend not to excuse themselves and will tend to take on more responsibility for their behaviours, values and attitudes. The second variant states that if the therapist can offer sufficiently ridiculous justifications for clients' maladaptive behaviours, clients are likely to offer more logical explanations and employ more rational principles of thought.

Techniques

Provocative therapy can be regarded as a procedure employing many techniques and allowing a lot of freedom in responding for the therapist (Farrelly & Brandsma, 1974). This allows the therapist to make use of a wide range of techniques in order to provoke an immediate, emotional experience in therapy. The therapist attempts to provoke both positive and negative responses and to integrate them with their social and interpersonal consequences. With regard to therapist conduct, Farrelly and Brandsma believe that provocative therapy can roughly be distinguished from other approaches by the following: its degree of directness and use of confrontation, its contradictory and ambiguous communication style, its systematic use of both verbal and non-verbal communications and the disregarding of professional dignity paired with deliberate use of humour and clowning (Farrelly & Brandsma, 1974).

Farrelly and Brandsma (1974) state that the aim of provocative therapy is to provoke an emotional and perceptual experience within clients in order for clients to engage in the following types of behaviour:

- Affirming their self-worth, both verbally and behaviourally.
- Asserting themselves appropriately both in task performances and relationships.
- Defending themselves realistically and genuinely against the overly negative assessments of others.
- Engaging in psychosocial reality testing and learning the necessary skills to respond appropriately.
- Engaging in risk-taking behaviours in personal relationships, especially by earnestly communicating affection and vulnerability to significant others.

For the client to reach these goals, Farrelly and Lynch (1987) argue that the techniques utilised by the therapist will have to provoke clients into experiencing themselves in a

spontaneous and genuine manner. They believe that such techniques must also allow the therapist a vast range of responses in order to beat clients at their attempts to control the therapeutic relationship. The therapist must thus always remain unpredictable which means that techniques such as obvious lying, denial, rationalisations, invention of instant research, crying and obscure ideas might be used (Farrelly & Brandsma, 1974). Some of the most important techniques applied to provocative therapy by Farrelly will subsequently be discussed.

The Use of Humour

According to Farrelly and Brandsma (1974), humour can be a valuable tool for the understanding of and dealing with the human condition. They stress 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" (Farrelly & Brandsma, 1974, p.95). Humour thus plays a central and crucial role in provocative therapy, where it is regarded as essential and not just as an accidental addition to the real work (Farrelly & Brandsma, 1974).

Humour is believed to provide a person with an opportunity to obtain the appropriate psychological distance which can provide a balanced perspective to overwhelming feelings or irrational ideas. The uncertainty created by the use of humour is also regarded as beneficial as it forces clients to examine their behaviours, attitudes or perceptions of reality from a different point of view. This occurs in therapy when clients realise that they are both the listeners and subjects of jokes that have personal relevance. Clients are also more inclined to remember humorous statements even long after therapy had been terminated. But one of the most important benefits of the use of humour is thought to be the fact that it allows the therapist to form a bond with the client. This is done by providing the therapist with an opportunity of expressing non-verbal warmth and positive regard (Farrelly & Brandsma, 1974).

Operationally, many forms of humour are used by Farrelly to provoke clients in therapy. These include exaggeration, mimicry, ridicule, distortion, sarcasm, irony and jokes (Farrelly & Brandsma, 1974), which will briefly be discussed here.

By *exaggeration* Farrelly and Brandsma (1974, p. 101) refer to "the use of over- and understatements to test out the reality or feeling value of an issue". A larger than life caricature of a client's ideas, emotions, behaviours, relationships and goals, is portrayed by

the therapist. In this context, clients are provoked to decide for themselves about the reality and validity of their beliefs. An example of this technique provided by Farrelly and Brandsma, is one where a female patient declared in a group therapy session that she wanted to become a comedian on radio like a second Carol Burnett. In response to this, the therapist jumped up with enthusiasm and started enacting an absurd, highly tense and stuttering caricature of her first radio show. This made both the group and the individual patient laugh and she consequently realised the absurdity of her idea.

Mimicking is accomplished by negative modelling techniques where the therapist role-plays the client's emotions, ideas, behaviours or tone of voice. Farrelly and Brandsma (1974) describe this technique as a very effective way of providing clients with immediate feedback which can instantly reveal dysfunctional aspects of clients' communication or behaviour.

In order to illustrate this technique, Farrelly and Brandsma (1974) describe an incident where a patient warned about her dangerous behaviour during seizures when she gets upset. The therapist consequently went into an uncontrollable fit while baring his teeth and trembling viciously. Through clenched teeth he proclaimed that he too had had such fits and that he might go into one of these seizures if the client should upset him.

Ridicule is the form of humour which, according to Farrelly and Brandsma (1974), is the most controversial. In defence of this technique they, however, point out its powerful impact when used correctly. It is stressed that the provocative therapist does not aim to ridicule the client as a person but rather the client's ideas and behaviours. The aim of this is to bring clients to a point where they protest against their own self-destructive attitudes, demonstrated by the therapist. Clients are thus provoked to protest against the therapist's ridiculous remarks and to display assertiveness. By doing this, the therapist attempts to get clients to defend themselves realistically against the unrealistic and excessively negative evaluations by themselves and others. The therapist assists clients in practising to defend themselves within the therapeutic context, so that, when met by these types of evaluations in other contexts, clients can cope more effectively (Farrelly & Brandsma, 1974). This is done by calling clients names such as "doormat" or "wimp." When clients protest about these names, a seemingly logical explanation is provided for calling them these names. The provocative therapist would also use ridicule by saying something like: "I don't blame you for not caring for yourself!"

Humorous *distortion* used by the provocative therapist may take on a variety of forms: Clients may deliberately be misunderstood in order to provoke them to clarify their thoughts

and feelings. Their obvious statements may also be misinterpreted to provoke them to rethink and assert their meanings. Ridiculous psychological explanations may also be provided to provoke clients into more logical explanations for their behaviours (Farrelly & Brandsma, 1974). An example of the latter is where the therapist says to a drug addict in family therapy that he believes that his *Thanatos* or “death wish” is just too strong to resist and therefore he has no choice but to destroy himself through the use of drugs.

Distortion can also be used to mock the client's expectations of the therapist's traditional role. The therapist may provide ridiculous solutions to clients' problems such as paradoxical interventions where the therapist explains to clients that they cannot help their dysfunctional behaviours and that they should therefore continue with them (Farrelly & Brandsma, 1974).

Farrelly and Brandsma (1974) believe that *sarcasm* can be used as a powerful tool to sensitise or desensitise clients to certain ideas and behaviours. An example of the use of sarcasm, provided by Farrelly and Brandsma, is one where a promiscuous client exclaimed that she had just found a job. In response to this the therapist asked: “How did you persuade him to hire you sweetheart?” (p.40).

Discretion is, however, regarded as an important factor when sarcasm is employed by a therapist. If sarcasm is to have the desired therapeutic effect on a client, Farrelly and Brandsma (1974) believe it has to be accompanied by non-verbal warmth and acceptance. The provocative therapist's sarcasm is therefore almost always qualified by facial expression, tone of voice and the like. Again, this technique is used in order for clients to reconsider their situations, attitudes and actions and to reinforce better-adjusted behaviours (Farrelly & Brandsma, 1974).

Irony seems to have several connotations within the field of provocative therapy: Socratic irony is employed when therapists take on a pretence of ignorance so that by skilful questioning, patients' unhelpful beliefs can be made overt. Another form involves the use of words to express something other than the literal meaning of those words. Dramatic irony, on the other hand, involves making overt the incongruity between the actual situation and the desired situation, between the client's expected outcome and the probable sequence of events. The latter use is, according to Farrelly and Brandsma (1974), most effective in pointing out the negative consequences of self-defeating behaviours which patients do not quite consider in context. In order to illustrate this, Farrelly and Brandsma provide an

example of a reply to an aggressive patient shouting obscenities to the staff after being placed in seclusion:

Atta girl! You've got them on the run! They're scared shitless of you now, the sonuvabitchin' bug-housers 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!" (p.40)

Jokes can be functionally used for the effects of the punch line's reversal and incongruity where the client is subtly implied. Provocative therapy gives the therapist permission to use any joke in a therapeutic context. The reversal of context brought about by the use of jokes is considered to have the potential to penetrate client's defences and consequently allow the therapist to concentrate on real issues. An effective joke can also help to penetrate clients' frames of reference and remove them from the crisis world they have created (Farrelly & Brandsma, 1974).

An example of a joke where the client is subtly implied is a joke told to an unassertive client who allows herself to be abused easily by others: Two girls were walking through a dangerous area at night. The one said to the other, "We'd better watch out that we don't get raped here." "Yes," said the other one, "and I am so easily raped!"

Farrelly and Brandsma (1974) believe that these uses of humour can be utilised to bowl clients over and to break through their resistances while surprising them into a spontaneous experience and expression of their value systems and emotions. This does not, however, mean that the therapist simply tries to irritate clients into mental health through sarcasm, teasing or ridicule. Farrelly and Lynch (1987) stress that for these humorous techniques to be successful, the client must experience the therapist as caring and supportive. The therapist is expected to enter the world of clients and perturb through the use of humour, clients' redundant thought patterns from the inside (Farrelly & Lynch, 1987).

Farrelly and Lynch (1987), however, note that although humour is an important tool of provocative therapy, it should not be regarded as the goal of treatment. They believe that humour can sometimes be placed aside when an experience of change is provoked. During these times therapist and client can together experience the client's feelings or the therapist can offer support through shared silence, touch or emphatic statements. Fisher (in Farrelly & Brandsma, 1974) agree with this view and stresses that the provocative therapist uses

humour only to respectfully provide clients with a different reflection through which they can also laugh in the midst of their tears and get a glimpse of their own absurdities.

Expressing Unverbalised or Implicit Client Thoughts

The provocative therapist always aims to explicitly verbalise clients' doubts, fears and socially unacceptable feelings so that these issues can be dealt with. This implies that the provocative therapist dares to speak about the unspoken, feel the unfeeling and think the unthinkable in order to bring the client's secrets out into the open. All clients' implicit doubts are thus verbalised and their worst thoughts and fears about themselves and the reactions of others towards them, echoed. Clients invariably find that they are not destroyed and that they do have the capacity to deal with these conflict areas in more appropriate ways. Farrelly and Brandsma (1974) point out that this technique often exposes some of the beliefs that guide client behaviours as quite ridiculous. They believe people may not grasp the absurdity of some thoughts simply by thinking them, but often become intensely aware of their irrationality when those thoughts are heard spoken aloud and others' reactions to them are experienced.

According to Farrelly and Lynch (1987), by entering the world of the client and then providing the client with honest feedback, the therapist inevitably joins with the client. They believe that this is likely to leave the client with a feeling of being understood as the technique is regarded as an extension of the reflection technique where both the said and the unsaid are reflected. Farrelly and Lynch furthermore state that this technique often results in clients responding in an astonished way, while admitting that it feels as if the therapist can read their minds. Although the abruptness of the provocative therapist's responses might be experienced as overwhelming by clients, it is believed that they are likely to feel that they are accurately understood. In this way trust can be established much sooner than in cases where the therapist waits for the client to reveal it all (Farrelly & Lynch, 1987).

Farrelly and Lynch (1987) believe that the benefit of making the client's thoughts and feelings overt is that clients' secrets are then less likely to become obstacles which separate therapist from client. In order to illustrate this they state that if an obese client seeks therapy for a problem other than weight, both therapist and client are likely to be more comfortable and able to work better together if the weight problem is acknowledged than when it is politely ignored.

According to Farrelly (in Farrelly & Lynch, 1987), many of the implicit thoughts verbalised by provocative therapists have to do with body image. This is regarded as significant, as much of human behaviour is related to how people perceive their bodies. Because body image tends to be an intimate aspect of people's self-concept, it is regarded as important to bring to the fore the attitudes, feelings and values that clients harbour, either consciously or unconsciously about their bodies. In order to provoke spontaneous reactions from clients about themselves in concrete, specific terms, the provocative therapist is expected to frequently talk in detail about clients' body images (Farrelly & Lynch, 1987).

Accentuating the Negative

Perhaps the most recognised of all provocative therapy techniques is that of overemphasising the negative. Whereas therapists of most other approaches would attempt to convince clients to relinquish distorted and overly negative ideas of themselves or of their environment, the provocative therapist would agree with clients' negative ideas. The negative half of the client's ambivalence is enacted by the therapist and even ridiculous evidence to support the client's irrational beliefs is provided (Farrelly & Brandsma, 1974).

One of the variations of overemphasising the negative to assist the client in reality testing used by Farrelly, is that of *reductio ad absurdum* (reduction to absurdity). Here the therapist takes over the client's irrational beliefs by ironically and persuasively elaborating on them. Attitudes are ridiculed and mocked, while continually agreeing with them and presenting them in a positive context. The therapist exaggerates clients' negative statements to their extremes until the client rejects them as absurd and illogical (Farrelly & Brandsma, 1974).

Another similar variation is that of accepting without reservation the client's claims of worthlessness or hopelessness. The therapist would, for example, say to a woman whose alcoholic husband had left her, that she is completely correct by stating that it is all her fault that he had left her, as it is obvious that she had not been a good wife to him. By doing this, the therapist attempts to provoke clients to affirm their own self-worth to assert themselves in their work and relationships. Attempts are being made to provoke clients into defending themselves against the unrealistic and overly negative evaluations by themselves and others and to relinquish the self-defeating ideas that are unproductive in their lives (Farrelly & Brandsma, 1974).

According to Farrelly and Brandsma (1974) two content areas that are especially frequent in this regard, are clients' lack of responsibility and their incapability to change. It is believed that clients tend to perceive and act only in terms of the negative and hurting elements in their lives. Clients tend to adhere to distorted beliefs which easily result in a negative worldview while neglecting the more positive, contradictory evidence. By concentrating heavily on the negative side of life, the provocative therapist attempts to provoke the client into considering concrete, specific evidence and experiences and give at least equal thought to positive experiences in their lives. Upon doing this, Farrelly and Brandsma believe that most clients can finally acknowledge that also they have had successes, coped with difficulties and received love and affection from others. In an ironic way, the therapist and the client thus relate to the client's strengths by having the therapist take over the weaknesses.

By utilising these techniques, Farrelly and Brandsma (1974) claim that the provocative therapist can simultaneously relate to clients on two levels. Firstly, by not arguing with the client's self-defeating claims and accepting the client's perceptions as literally true, the therapist is believed to enter the client's world and thus to join with him/her. Secondly, the therapist is seen as indirectly breaking down the client's negative beliefs by overemphasising and exaggerating them.

Change is furthermore encouraged by assisting clients in the process of internalising important functions which they have relinquished and projected onto others. It is believed that people within clients' immediate environment often take over clients' responsibilities when clients take on helpless, irresponsible or socially unacceptable roles. Farrelly and Lynch (1987) argue that as long as others, including well-intentioned therapists, continue to take on these responsibilities for clients, they are likely to remain stuck in their irresponsible and helpless modes of functioning. However, by overemphasising negative ideas and behaviours, the provocative therapist is believed to strengthen clients' resistance to their own dysfunctional behaviours and to lead them into more rewarding ways of being (Farrelly & Lynch, 1987).

Emphasising the Dreaded Aspects of Change and the Positive Aspects of the Status Quo

Related to the aforementioned technique is that of providing reasons and offering excuses for the client not to change. By doing this, the provocative therapist attempts to persuade the client with ridiculous and absurd arguments that change is too difficult or that the status quo is more desirable or normal (Farrelly & Brandsma, 1974).

Farrelly and Lynch (1987) propose mainly two techniques to encourage clients to let go of negative beliefs about themselves in order to focus on positive aspects. The first technique proposed by these authors is to focus on the dreaded aspects of specific changes, thus provoking clients to consider the positive aspects of change. The second technique pertains to the therapist talking longingly and nostalgically about what the client is missing out on when changing, thus further provoking clients to distance themselves from their past dysfunctional actions. Farrelly and Lynch provide some examples of such typical provocative responses such as: "That's OK, dear. You can always retrace your steps and go back to the you that you and I know" (p.96).

By frequently challenging positive statements made by clients about themselves, the therapist attempts to get clients emotionally involved in defending themselves appropriately. This is done by forcing clients to provide tangible evidence in support of their positive statements about themselves. It is believed that the use of this technique places the responsibility for the proof of positives squarely on the client (Farrelly & Brandsma, 1974).

The primary aim of this technique is to assist clients in the process of getting in touch with their inner resources. By questioning progress in therapy and refraining from "saving" the client, the provocative therapist attempts to lead clients into strengthening their self-esteem. Clients are provoked to actively seek feedback from their relationships and environments. Moreover, clients are provoked into mobilising their inner resources and becoming increasingly self-confident. This furthermore encourages clients to become active participants in caring for others rather than remaining in the passive and powerless state of waiting for acceptance from others (Farrelly & Lynch, 1987).

Supplying Immediate Feedback

Farrelly and Brandsma (1974) believe that in order for people to function optimally, they need frequent feedback from their environment. Supplying clients with immediate feedback is therefore regarded as a virtue. Perhaps because of their belief in client fragility, many therapists, however, tend to withhold feedback from clients. The provocative therapist, on the contrary, believes that clients have a right to the therapist's perceptions about them and to feedback from other sources to which the therapist has access. According to Farrelly and Lynch (1987), by providing this feedback, the provocative therapist helps clients become aware of the impact they have on others and to then ask themselves whether that is the impact they want to make.

Farrelly and Brandsma (1974) argue that therapists cannot expect clients to risk in relationships if therapists are not prepared to risk in the therapeutic relationship by providing the client with immediate, honest feedback. They point out that therapists often communicate their experiences of clients to their colleagues and supervisors, but rarely to their clients. In provocative therapy, the therapist will use props, role-plays, jokes, instant research and fictitious or previous clients or situations similar to that of the present client, in order to make the therapist's response known. The therapist will also constantly check for feedback from the client to ascertain whether therapy is on the right track (Farrelly & Brandsma, 1974).

Feedback does not, however, always have to occur within a sombre or tense context. Farrelly and Brandsma (1974, p. 62) point out that "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'". Implied by this, is that therapists must be willing to even do what clients' best friends will not easily do, namely providing them with immediate honest feedback, both positive and negative. Farrelly suggests that this can be done in a humorous and sometimes indirect way as with feedback through amplification and negative modelling (Farrelly & Brandsma, 1974).

According to Farrelly and Brandsma (1974) feedback through amplification implies that the therapist responds to the client's irrational ideas and behaviours in a larger than life style where voice intensity is louder than normal and thoughts are amplified to the extreme. An example of this, provided by Farrelly and Brandsma, is where a woman, who feels inadequate as a mother, is told that she is the psychological equivalent of the "plaque" towards her child. This is used to point out the absurdity of the client's self-concept. The technique can also be used to point out negative social consequences of clients' behaviours. While doing this, the therapist will not only elaborate on the client's responses but will also utilise his/her own subjective responses, thoughts and associations (Farrelly & Brandsma, 1974).

Another way of providing indirect feedback is what Farrelly and Brandsma (1974) call "negative modelling confrontation" (p.72). This briefly implies that the therapist enacts clients' behaviours, matching especially their interactional style and mocking those aspects of their functioning that are problematic. By doing this, the therapist is effectively telling clients how he/she perceives them. The responsibility then lies with the clients to evaluate this feedback and to decide whether they want to do anything about it.

Farrelly and Brandsma (1974) believe that genuine rejections of certain behaviours can definitely be more therapeutic than superficial acceptance or indifference. They continue to argue that the human mind needs truth to function properly in the same way as human lungs need air. A therapist's reaction to a client at a specific moment of a specific interview is consequently regarded as a social truth or reality, which can be of great benefit to a client in the long term.

The provocative therapist does not, however, only provide clients with feedback, but also attempts to increase clients' awareness of the sources and types of feedback that are potentially available to them. Farrelly and Brandsma (1974) believe that by doing this, the therapist provides the client with life-long resources for adapting to circumstances. This reminds clients that it is not only important for them to be understood by others, but also to learn to understand the opinions, needs and values of others. Clients are furthermore encouraged to reconsider their need oriented attitudes and over-determined actions and to start living in terms of their present realities. This is regarded as important because the rules of society are understood to determine that a person can only earn the right to be heard by taking up the responsibility of being productive and by continuously acting in a responsible way (Ludwig & Farrelly, 1966).

Listing

Another commonly used technique in provocative therapy is that of listing. By using this technique, the therapist not only forces the client to list reasons and examples to substantiate self-affirming and positive responses, but the therapist also engages in listing (Farrelly & Brandsma, 1974).

The therapist uses listing to support ridiculous arguments which echo clients' self-defeating ideas or to portray a negative image of clients. An example hereof is given by Farrelly and Lynch (1987,p.99) where the therapist says to a client: "So you are: dumb, ineffective, pushy broad, trying to shove everybody around, just intimidate the hell out of 'em, bulldoze them with a Niagra of verbalisations". The aim of this technique is, once again, for clients to take a good look at themselves and consequently develop a desire to move in the opposite direction.

Farrelly and Brandsma (1974) are of the opinion that therapists can also use lists of explanations regarding clients and their behaviours in order to provoke clients into more

assertive behaviours. They believe that this can be particularly useful where patients struggle to make sense out of their problems and consequently bombard the therapist with why questions. Upon answering these questions, ridiculous explanations of all types are offered. These explanations clearly indicate that behaviour and social reality are more important than understanding a specific problem. Farrelly and Brandsma (1974, p.74) provide an example of a provocative therapist's answer to a client who wanted to know why she is the way she is: "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".

It is clear that the main goal here is not to provide rational explanations regarding the origins of clients' conflicts, but rather to counteract their useless search for absolute answers. In this process of playing with the why question, Farrelly and Brandsma (1974) suggest that the therapist may give the client as many differing explanations as possible. The therapist may choose those explanations that indicate that everything is out of clients' control and that they are merely objects of fate. A wide range of possible theories can also be provided whereby the therapist appeals to the client to choose a theory from the array of confusing theories. Another option is the contrasting of logical, rather obvious explanations with more illogical and absurd ones and again leaving the client with a choice. It is often in this regard that certain theoretical approaches are favourite targets for satirisation since they have the dubious value of being able to explain anything at any time as demonstrated by the following example provided by Farrelly and Brandsma:

I can't figure out whether you are (1) immoral or whether you have learned self-defeating, acting-out, anti-social behavioural 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 dependant and overwhelmed by feelings of inadequacy in task performance areas. (p.74)

A second use of listing is that of challenging clients to prove or substantiate their self-affirming statements. Clients will, for instance, be asked to name three good things about themselves in order to substantiate their protestations against the therapist's negative remarks about them. By using listing in this way, the therapist can guide clients into focusing on their positive aspects and qualities (Farrelly & Lynch, 1987).

The Four Languages of Provocative Therapy

Farrelly and Brandsma (1974) believe that it is the continuous task of psychotherapists to translate their concepts into a language that is relevant and significant for clients within their frames of reference. They should furthermore be able to use clients' language to apply new meanings to and thus influence clients' thinking. The challenge to the provocative therapist is thus to continuously attempt to penetrate the client's frame of reference and consequently perturb it. Farrelly and Brandsma suggest that this can be done through the use of the four languages of provocative therapy namely: (1) religious-moral language; (2) locker room language; (3) professional jargon and; (4) body language. The provocative therapist uses these four languages to create a dramatised, exaggerated image of the client's world. By selecting and blending the four languages, the therapist creates images and provides feedback for the client's consideration.

The first of these languages is the *religious-moral language*, which is parental, imperative and autocratic in nature and based on absolute distinctions (Farrelly & Brandsma, 1974). The aim is to emphasise the absolutes of certain subcultures or periods where the theme of good and bad or desirable and undesirable is very prominent. This enables the provocative therapist to talk the language of clients from strict and varied religious backgrounds. Since many clients and their families are believed to be operating on the moral model, the religious-moral language is regarded as a useful tool to join with these families. An example of the application of religious-moral language is provided by Farrelly and Brandsma where the therapist says to a depressed Irish catholic woman:

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 the First Saturdays. Do you realise how much merit in heaven I'm gaining by talking to a lost soul like you? (p.124)

Farrelly and Brandsma (1974) believe that clients are often not completely in touch with the emotional meaning of their actions. They are of the opinion that *locker room language* can be used to dig into the detail of behaviours and to provoke feelings appropriate to such behaviours. It is believed to have the power to cut through pretences and unspecific, euphemistic talk. The nature of this language can be described as emotionally loaded and characterised by adolescent, four-letter, foul and explicit words and phrases such as "ass hole" or "get your ass in gear."

Professional jargon is described by Farrelly and Brandsma (1974) as the exact opposite of locker room language. This language is furthermore described as very professional and intelligent sounding with the aim of confusing clients in order to take on a stronger, more assertive stance. The language is characterised by artificially formal, polysyllabic, intelligent sounding and usually complicated words. A good example of this is provided by Farrelly and Brandsma where a therapist says to a client who complains that he only talks and does not do anything: "The client verbalises quite well but he does seem to lack some motivation. There are some indications within the dynamics of the interviewing situation which would tend...to support the hypothesis..." (p.123)

The fourth language used by the provocative therapist is a *bodily kinaesthetic language*. Farrelly and Lynch (1987) state that this language is, among others, communicated by position, posture, gestures, facial expressions, tone of voice, inflection and touch. The provocative therapist can employ this language to capture clients' attention, to facilitate being heard by clients, as well as to communicate warmth, acceptance and positive regard. Body language is also believed to be of specific value to a therapist in cases where it is difficult to get through to a client by using words only. In such cases, Farrelly and Lynch believe the therapist can sit close to the client in order to intensify the you-me, here-now quality of the relationship between therapist and client. Touch can also be used to portray intimacy or as an effective way by which unsaid messages of, for example, support can be communicated. Such physical touch may vary from a tap on the knee to a hand on the shoulder or forearm (Farrelly & Lynch, 1987).

Farrelly and Brandsma (1974) regard non-verbal body language as crucial with regard to the expressing of acceptance to a client. They believe that clients somehow have to experience that the therapist is on their side and not out to harm them. This has been termed by Rogers (in Corey, 1996, p.206) as "unconditional positive regard" and most therapeutic approaches somehow deal with this aspect of the therapeutic relationship. The provocative therapist, however, believes that the means of expressing this positive regard are much broader than other approaches have stressed (Farrelly & Brandsma, 1974).

Farrelly (in Farrelly & Brandsma, 1974) stresses that since the provocative therapist often comes across as unsympathetic and confronting, the non-verbal support becomes even more important. Touch, the twinkle in the therapist's eyes and the high levels of activity indicative of involvement then become important vehicles of positive regard. Provocative therapists thus regard their whole bodies as communicating vehicles. This makes it

necessary for them to skilfully use non-verbal communications in order to obtain the desired effects (Farrelly & Brandsma, 1974).

In provocative therapy, many languages are thus employed to enter the client's frame of reference, to try to perturb it and to provoke an emotional experience. Farrelly and Brandsma (1974) are of the opinion that the type of language employed would largely depend on the client's background as well as the specific topic that is being discussed. It is, however, believed that the therapist must always have access to whatever language a specific situation necessitates.

Applications of Provocative Therapy

While one benefit of provocative therapy is thought to be its ability to produce rapid client change, another benefit is its applicability to many different client types. Farrelly and Lynch (1987) are of the opinion that provocative therapy can be used successfully with almost any client. This statement is supported by noting that provocative therapy had, over the past decades, been used successfully with clients from every diagnostic category, from chronic schizophrenic patients to bipolars to personality disorders. It has been used with aggressive clients and those in acute psychotic episodes as well as with autistic children and the deaf. Age has also not been a factor in the use of provocative therapy as it has been used with clients from the age of two to those in their eighties. Clients' IQ has also ranged from the educable mentally retarded level to genius. Provocative therapy has further been used with both inpatients and outpatients within the context of individual, marital, family and group therapy (Farrelly & Lynch, 1987).

Summary

Provocative therapy is described by Farrelly and Brandsma (1974, p.55) as "a broadly based procedure applying many techniques and a wide range of freedom in responding for the therapist". This is echoed by Bandler and Grinder (1979, p.55) when they state: "Frank Farrelly, who wrote provocative therapy, is a really exquisite example of requisite variety".

This freedom apparently differs from many of the commonly accepted ideas on decency and the conventional therapist-client relationship. It should, however, be noted that provocative therapy does not consist of the therapist pushing the client into change with psychological force. Rather, the provocative therapist attempts to stand beside the client, humorously walking hand in hand through the client's world. Provocative therapy thus

embodies the expression that gaiety is wiser than wisdom, while simultaneously attempting to be aware of where the client is at a specific moment. By using humour in conjunction with other techniques, the therapeutic focus remains on clients' distorted beliefs and assumptions, painful feelings, and self-defeating behaviours. Clients are humorously and perceptively provoked or challenged in their dysfunctional ways in order to mobilise their own resources against themselves. This is done fearlessly by, among other things, speaking about the unspoken and accentuating the negative in the presence of the client.

In order to bring about change, an intensely emotional experience is thus deliberately provoked by the therapist. The therapist does this through the use of unpredictable responses which provides clients with an experience of being deeply understood on multiple levels, irritates and amuses them and rapidly connects them to their own resources (Farrelly & Matthews, 1981).

Maurizio Andolfi's Application of Provocation

Maurizio Andolfi is the scientific director of the Accademia di Psicoterapia della Famiglia in Rome where provocation forms an integral part of the training model (Bianciardi & Galliano, 1987). Andolfi and others have given special attention to the concept of provocation in specifically two publications namely: *Behind the family mask* (1983) and *The Myth of Atlas* (1989) where an entire chapter was devoted to this concept in each publication. The following discussion will then also mainly focus on the concept of provocation as explained in the above-mentioned two chapters.

The Therapeutic Challenge: Inducing a Family Crisis

According to Andolfi et al. (1983), families present with fake crises in therapy where it is expected from the therapist to help restore the rigid status quo. It is believed that in daily life, each member of these families chooses not to choose while they are driven by anxiety and tension to always act in such a way as to portray the myth of unity (Andolfi et al., 1983). This tension is believed to enhance the ongoing process within the family that ensures that nothing really changes. Andolfi et al., however, believe that the intensity of this tension may in time become so intense as to lead to change.

These families are, however, not thought to be ready to question their own rules upon seeking therapy. It is rather believed that, at this point, the tension within these family systems has reached such intensity that it can no longer be contained through the function of

the identified patient. The identified patient can thus no longer guarantee that the family's habitual interactional pattern can be maintained. This consequently results in increasing fears that the family's equilibrium will be disturbed with the accompanying possibility of having to renegotiate rules, each one's functions and defined space. The danger of uncontrolled change in each one's status is thus too much for the family to handle. Therefore the family approaches therapy with the paradoxical request of "Please help us, but please do not change us" (Andolfi et al., 1983).

The patient's symptom is regarded as representative of the family's dual request: On the one hand it is regarded as a plea for help but on the other hand as a fear of crisis. Instability, which Andolfi et al. (1983) regard as essential to reaching a new balance between unity and differentiation, is thus feared by the family. It is precisely this fear which is believed to have pushed the family members into their rigid, redundant patterns of interaction. The threat of crisis is believed to exacerbate these ineffective and worn out interactive patterns. Facing the need for therapy, it is thought that the family is now, more than ever, likely to feel threatened and thus unite in an attempt to avoid a crisis as much wished for as feared. If, in order to maintain their redundant patterns, the family finds that the use of the scapegoat (identified patient) is no longer sufficient, it becomes necessary to bring in new elements. An old strategy is then normally employed, namely, to focus on one person, in this case the therapist, with the goal of having him/her absorb all their conflicts (Andolfi et al., 1983).

The therapist is likely to be expected to manage the tension in such a way as to leave their established order untouched and, most importantly, without undermining their definition of the illness of the patient. They will expect the therapist to adhere to their logic by seeing the identified patient as the only source of distress. The hidden agenda or principal goal of seeking therapy is thus thought to be the avoidance of a crisis which appears too threatening to the family equilibrium (Andolfi et al., 1983).

Andolfi et al. (1983) believe that with such families, therapists should respond in a way that will increase the variables in play to a point where the family experiences a loss of control over their pre-existing equilibrium. If change wants to be introduced, it is believed that a state of crisis must necessarily be imposed. The role of the therapist, therefore, becomes the opposite of that which the family expects, as the therapist seeks to induce the very imbalance which the family seeks to avoid. Not only is the therapist's interpretation of the family's discomfort expected to be much broader than theirs, but the family's pain is also expected to be redefined by the intervention. The therapist will thus attempt to accentuate any existing instabilities. Where there are no obvious instabilities, it will be the task of the

therapist to bring them to the surface through provocation. For Andolfi et al. this is the essence of provocation, which is indicated by the etymology of the word, namely, "pro - vocare" which means to call forth. The real crisis in the family must be brought into the open by the therapist. Their masked interactive patterns which have become redundant, must be revealed. The therapist thus induces greater instability where the family asks for stability. A complete redefinition of the therapist's role is thus suggested. This will allow the therapist to disturb the equilibrium of the system and its members to such an extent that the system's inherent capacity to evolve new forms of encounter will be activated (Andolfi, 1979a).

Other therapists have also noted the uselessness of attempts to provoke rapid changes in families that are not in crisis and how sometimes it is much more effective to create a crisis which forces the family system to change (Haley, 1971; Hoffman, 1981). Also for therapists like Bowen (1978) as well as Selvini-Palazzoli, Cecchin, Prata and Boscolo (1978), the main goal of therapy is to increase the complexity of the situation rather than to restore order. In other words, to a family system that asks for help in solving its problems while merely wanting to maintain the status quo, it is regarded as appropriate to respond in an unsettling way by deliberately inducing a crisis which leads to a lack of control.

Andolfi et al. (1983) believe that the possibility of creating such a crisis in a family is strictly related to the intensity of an intervention. They argue that therapists often fail when they attempt to respect the family too much without being aware of the tension between the therapist's noble intentions and the family's rapid attempts to neutralise the therapist's manoeuvres. It is thus expected from the therapist not to get caught into that which the family presents at face value, but to be able to identify the patterns "behind the family mask."

Contrary to common belief, Andolfi et al. (1983) have come to realise that families normally feel supported by an intense therapeutic intervention. They found that it is by experiencing the ability of the therapist to quickly take control of the therapeutic relationship and to break with the interactive patterns of the family, that the family members feel secure and supported. It is believed that the family is likely to feel more secure if therapists do not allow themselves to be fooled by the family's scheme. They may consequently better accept the risks of change with the therapist's guidance.

Andolfi et al. (1983), however, believe that if the therapist's objective is to induce a therapeutic crisis, the therapist must be certain to have the strength to provoke such a crisis. The intensity of such a crisis is furthermore expected to be directly in proportion to the degree of rigidity present in the family system. The intervention should therefore be

formulated as a direct response to the messages sent by the family, even from the start of the therapeutic relationship. The procedures of setting up a meeting are believed to provide the therapist with an idea of the family's possible strategies and manipulations. Included in these procedures are, among others, the telephone conversations prior to the first session, the presence or absence of family members and the first minutes of the first encounter (Andolfi et al., 1983).

While observing the nature of the family's interactions with the therapist, the therapist is expected to attempt to always respond mimetically. This implies that certain messages will be imitated by which the therapist accentuates the family's intensity that was directed towards the therapist. Thus, the therapist does not attempt to argue with the family about who is right, but instead creates the impression that the family, with all its incongruent messages, is always right. By doing this, the therapist forces the family to experience the pain of its own contradictions. At this point the family members are believed to consider a change in their relationships as less threatening and possibly more freeing (Andolfi et al., 1983).

The Process of Provocation

Based on the aforementioned premises, Andolfi et al. (1989, p.45) believe that being provocative means, "touching elements that are especially emotionally meaningful for family relationships or images or ways of seeing that have become rigid over time". These are regarded as the elements that the system and its members seek to maintain unchanged, since these elements represent something that makes individuals feel vulnerable.

Andolfi et al. (1989), however, regard the concept of provocation as a relative concept as it is believed to involve the interaction of several components. This is demonstrated by an example described by Andolfi et al. where a mother is speaking to a therapist, while her adolescent son sits in silence with his head bowed, staring into space with a neutral expression on his face. Her husband also seems to be completely uninvolved as he looks around the room, apparently indifferent to what is being discussed. At a certain point the therapist asks the mother a question that touches on intimate aspects, which have never been discussed. The therapist asks the mother how long she had been feeling alone with her loneliness. In reaction to this question, the mother seems to be completely overwhelmed as she looks around the room while becoming more aware of her loneliness. After hesitating for a long time, the mother then embarrassingly refuses to respond. The husband, on the

other hand, is described as moving around in his chair while the son crouches lower into himself.

The above description clearly shows how the question posed by the therapist caused the tension to increase in the room, which indicates that the question was perceived as provocative by the whole family system. This demonstrates that provocation is brought about by the interaction of several elements such as the question posed by the therapist, the son's attitude and the husband's behaviour. Each of these elements can be regarded as important in shaping a response, as each of them is believed to contribute to the defining of the context in which the question is posed and thus to the defining of meaning.

The question is regarded as provocative not only because it touches on people's vulnerabilities, but also because it reveals the nature of their relationships and consequently disturbs the delicate balance that keeps them together. Questions posed in a certain unusual way can thus be very useful when provocation is intended. Andolfi et al. (1989) believe that such questions can be provocative when they create movement in a static situation and thus lead to a re-evaluation where family members question the meaning attributed to an experience. Past aspects of certain experiences that were either ignored or avoided can now be reconsidered, upon which new connotations and choices can be made.

When the therapist, in the given example, asked the question about the mother's loneliness, he also spoke about the unspoken in the family. By speaking of the mother's loneliness in such a direct way, he penetrated her defences and forced her to reflect on the relationships that are behind these defences. The mother's attitude is, however, also complementary to the others' attitudes and is thus reinforced by their apparent detachment. The therapist's provocation, apparently directed only at the mother, is therefore also a provocation of the interactions between the father and son, implicitly highlighting their detached attitudes. But at the same time, the system as a whole is provoked as the dysfunctional relational patterns among all three members are emphasised. Together with the provocation, one can, however, also observe a joining attitude when the therapist touches on the loneliness of the mother (Andolfi et al., 1989).

From another perspective, Andolfi et al. (1989) explain that what is provocative, is not only the therapist's question to the mother, but also the silence of the son and, in a more obvious way, the uninvolved of the father. What can be considered stimulus or response, depends on the punctuation that is given to a relational sequence. What is provocative or not can consequently only be defined within the specific relationship. An important aspect of

a provocative intervention is thus the presence of the rules of the specific relationship. This implies that the therapist will have to make overt and amplify both the explicit and implicit rules or norms present in the family system. This is normally done by the asking of provocative questions and the use of provocative metaphors or metaphoric objects. The aim of this is to break the rigidity of the family's interactional patterns by increasing the internal pressure (Andolfi et al., 1989).

This brings forward another important aspect of provocation according to Andolfi et al. (1989), namely provocation within a system. These authors stress that, although the individual may appear to be the only target at which provocation is directed, the individual always forms part of a system. If one member of a family is provoked, it should always be done while the others are present. Within the family context, the contents and intention of the provocative intervention are also communicated to the other family members. This is even more obvious in cases where the therapist turns intentionally towards one person in order to speak to someone else, pretending to communicate only with the first person. Provocation must, according to Andolfi et al., thus involve at least three components, namely, the therapist, the person to whom the provocation is directed and a third party. In this way, there is a succession of triangular interactions, connected in different ways, which the therapist continuously enters and leaves during the course of therapy. The therapist enters upon interacting with one of the family members, placing another member in the observer's position. Withdrawal takes place at the point where the place of the observer is taken while the second participant is prompted to interact with the first one. In the perception of the client, the therapist thus becomes a person who knows how to enter into a relationship and how to move out. All this contributes to the unpredictability of the therapist who, at different times, can be caring, detached, supportive or provocative (Andolfi & Angelo, 1988).

The therapist's behaviour is, however, not regarded as provocative unless it probes the varying responses and relationships in the system regarding the specific aspect that is touched on by provocation. If this goal is reached, a chain reaction is thought to be activated which consequently upsets the family equilibrium. The result of this is described as resistance from family members who feel disorientated by the provocation. This is believed to occur when aspects of relationships, or of people, that are very sensitive or in contrast with a person's self-image, are touched on and revealed to others. In these cases, those affected are likely to react by distancing themselves or by opposing the proposed image or definition as it was seen in the above given example (Andolfi et al., 1989).

In the above-mentioned example, Andolfi et al. (1989) regard the mother's embarrassment as an indicator of her resistance to the probing of an emotional experience which is seen as the result of a series of emotional instabilities in her unsatisfactory relationships. The amplification of this experience, which is regarded as a characteristic of every successful provocation, is believed to transform static states such as loneliness into more fluid processes where interactions with others are also implied. It is clear from the above-given example that the process of resistance also involved the father and the son. This is demonstrated by their responses to the therapist's question: the father moved nervously in his chair, thereby enhancing his detachment, and the son crouched down further into himself.

Andolfi et al. (1989), however, state that there are cases where family members do not resist provocation but, after some initial confusion, support what is said in order to partake in the creation of a new context. If this happens, provocation is thought not to be incompatible with the family's perceptions of the introduced stimulus. Whether provocation is complied with or resisted, Andolfi still believes it provides the therapist with valuable information regarding the rules and interactional patterns of a family (Andolfi et al., 1989).

Another consideration for Andolfi et al. (1989) is that the validity and quality of the family rules are relative to a specific context. This means that what is met with indifference in one context, may create tension in another. The created context emphasises the importance of some elements more than others. In some contexts a certain therapist's behaviour may thus be more provocative than in other contexts.

Andolfi et al. (1989) also distinguish between the intention to be provocative and really being provocative. They argue that actions that are seemingly provocative may in fact not be experienced that way at all by clients. To summarise, the following are regarded as factors that determine genuine provocation: the perturbing or modification of the rules or patterns in relationships, the encountering of a particular inflexibility or the introduction of such different views as to create severe tension and the enhancing of these aspects by the specific context. All these factors are believed to lead to a time and place in which they are defined. At the same time, it is recognised that there is a space in time during which each element plays a role to enhance the effects of provocation. This can be illustrated by the example where the therapist's question to the mother is provocative precisely because it is preceded by the indifference of the father and the son towards her emotional experiences (Andolfi et al., 1989).

The Identified Patient as Entrance into the System

Andolfi et al. (1983) believe that therapists often make the mistake of underestimating the power connected to the function of the scapegoat. The power of the identified patient is seen to be seated in the involuntary quality of the symptom which allows the patient to define and control his/her relationships in the family. Consequently, the agreement which usually covers all the differences within these families, is that the identified patient is the only sick one and thus the only one who needs help. Andolfi et al. believe that this process assigns the identified patient the function of "the homeostatic regulator of every family transaction" (p.47). This implies that the identified patient becomes the one who controls every relationship in the family through his/her illness so that his/her presence may become essential to all family members (Andolfi et al., 1983).

Andolfi et al. (1983) also note that the identified patient is usually brought into therapy by other family members. This stresses the fact that families normally do not grant the identified patient any right of decision. Even in cases where the identified patient requests the intervention and thus acts as the central element in bringing the family together, he/she is thought to be allowed this only in the role of being different.

In summary, Andolfi et al. (1983) believe that the identified patient's behaviour in therapy appears to reinforce at least five basic aspects which the entire family displays in therapy:

- The centrality of his/her function as the sick one, which preoccupies the family's thoughts so much that all other issues are ignored.
- The illogic of his/her interactions, even the most insignificant and seemingly normal.
- The involuntary nature of all the patient's behaviours so that all his/her behaviours are accepted with sad resignation. All family members seem to hold this belief and, in taking this cue, the identified patient is permitted to display any type of behaviour.
- The negative consequences which the identified patient's illness has for the entire family.
- The uselessness of all efforts to change the patient's behaviour. This implies that the family portrays the message that no one has been able to help them thus far and that no one will thus ever be able to help.

It is believed that with this mask in place, the family members expect the therapist to help them change the patient without interfering with their relationships. An example of such a situation would be where a father and mother take their psychotic son for therapy while

refusing to get involved in the therapy process. They expect from the therapist to “cure” their son without probing the familial relationships. The tension and frustration which such a situation normally brings about for the therapist, moved Andolfi et al. (1983) to conclude that these family communications contain highly provocative elements. When the therapist is asked to help, while being paralysed at the same time, the therapist is likely to be extremely provoked. The question that now arises is, “How should a therapist handle such a situation”?

According to Andolfi et al. (1983) the importance of the function of the scapegoat explains why all attempts to shift his/her centrality and spreading the symptom to include all the family relationships, are so difficult and usually likely to fail. It is believed that the acceptance of such a redefinition of the organisation in the family will result in the family losing its most effective means of maintaining its habitual patterns. It is furthermore believed to challenge the poverty of the family’s interactions, the closed nature of any real exchanges and the limited personal space left to each member. Such attempts by a therapist have been found to occasionally result in the family’s leaving therapy or entering into useless arguing with the therapist (Andolfi et al., 1983).

Andolfi et al. (1983) suggest that, instead of attempting to oppose or reprimand the family, therapists can utilise the very elements which might have drawn them into an unproductive position. This would imply that the therapist would focus on the provocative aspects of the family’s communications and imagine the strategic interventions that the family would possibly respond with. The therapist would then respond in such a way as to emphasise the provocative elements of a family’s messages instead of ignoring or opposing them. This is believed to have the potential to lead to a new and intense relationship between therapist and family wherein a new interactional pattern may develop. In this new relationship the therapist is believed to have the freedom to be in control of the relationship, while, at the same time being an integral part of the system.

It is suggested by Andolfi et al. (1983) that the therapist’s counter provocative responses utilise the identified patient as the point of attack in the system. They hypothesise that if the family provokes the therapist and controls the therapeutic system through the identified patient, the therapist could also try to provoke the family and control the therapeutic system through the same channel. Instead of opposing the centrality of the identified patient, the therapist would thus seek to use it. The identified patient would then become the therapist’s point of entry into the family system through the maintaining and accentuating of the position of the scapegoat. The rationale behind this is that if the system itself had chosen the identified patient to embody the family problems and to mediate every interaction, then

the therapist would do the same. The identified patient, who is by definition the central figure due to an inability to behave satisfactorily and independently, would have to be openly challenged by the therapist. It is suggested that this can be done by acknowledging the centrality of the identified patient, while, at the same time, framing his/her behaviour as completely voluntary or intentional. By doing this, the understanding of symptoms and of the therapist-family relationship is believed to have been radically redefined by an intense and perturbing provocation to the entire family system. Andolfi regards such a reframing as an integral part and as the final outcome of provocation (Andolfi et al., 1983).

By entering a family system through the identified patient, Andolfi et al. (1983) believe that many things are simplified and that the therapist is freed from being bound to the rules of the family. This, they believe, should form the point of departure in therapy as, by doing this, the therapist is believed to act upon the same mechanism which led the identified patient to become the scapegoat.

A good example of how a therapist could enter the family system in such a way through the identified patient, is described by Andolfi et al. (1983). A case is described where a mother phoned the therapist, requesting therapy for her son who believed he was an Indian. During this telephone conversation the therapist noticed that the mother spoke enthusiastically about her son's symptoms, while speaking monotonously about their family life. At the start of the first therapy session, the therapist called the boy "Sitting Bull" and greeted him with an Indian yell. The boy was not impressed by this and asked the therapist to stop making fun of him. In his reply to this, the therapist stated that the boy's voice was not the voice of an Indian but that of a cowboy and that he thought that the boy was not good at being an Indian. The therapist then asked the boy for his name upon which he replied: "It's the name of the sainted evangelist: Saint Mark" (Andolfi et al., 1983, p.53). This reply was used by the therapist to ask the boy about the characteristics of the saint. The boy could, however, not answer this question. Eventually the therapist commented on the boredom in the family by saying to the boy:

You know, a lot of interesting people come to us, but you're not even slightly interesting. In fact, I'd say you're rather boring. I was led to believe that you were creative on the subject of Apaches; your mother clued me in. But as soon as we talk about classical themes, about the saints for instance – there's just deadly boredom. (Andolfi et al., 1983 p.53)

The forbidden theme of boredom, never admitted by the family, was introduced by the therapist through the identified patient. The provocative quality of the boy's symptomatology had been made an essential element of the therapist's counter provocation. By doing this, the therapist deprived the boy of the control he exerted over the family relations through his behaviour. The voluntary aspect of his behaviour was emphasised so much that it became uncomfortable for him and the other family members (Andolfi et al. 1983).

From the Function of the Identified Patient to the Network of Functions of the Family

Andolfi et al. (1983) believe that provocative interventions should connect the therapist to all the family members in the same way that they are connected to one another, namely, through the identified patient. In order for this to take place, it is regarded as necessary for the therapist to assign to the patient a function other than the official controller of the family, without whose commitment the others will not be able to manage. The family is believed to have assigned this function to the identified patient through the acceptance of the patient's control over them, through his/her illness. In effect, the family is seen as admitting to the therapist that the identified patient controls their behaviour, although they believe that this is not done deliberately. Andolfi et al. only accept the first part of this message while rejecting the involuntary part thereof. The involuntary is made voluntary by defining the function of control as necessary and the identified patient as irreplaceable. The therapist is basically saying to the family that they need the identified patient as he/she acts in ways that are useful to the functioning of the family (Andolfi et al., 1983).

By exaggerating and reinforcing the identified patient's function, the therapist acquires valuable information about the family's functioning. The therapist, furthermore, becomes aware of the nature of the family interactions by observing the way in which family members communicate uncertainties and problems, both spontaneously and during provocation. This helps the therapist to form a hypothesis about the family's functioning and the relational script, which guides their interactions. At this point the therapist can connect the function of the identified patient to the functions of the others and place him/her in his/her role as the supporter of certain interactive patterns. In this way the identified patient will not be provoked as an isolated individual but rather as an integrated part of a larger system (Andolfi et al., 1983).

Such provocation of the family system and its interactions can be reached through the use of metaphors or metaphoric objects, paired with dramatisation, where the function of each family member is amplified (Andolfi et al., 1989). An example of this would be a

metaphor of cowboys and crooks for a family where there is harsh conflict between the rigid father and son who is a drug addict. The father is portrayed as the cowboy who is supposedly always right in what he does and who always checks on the son. The son is portrayed as the crook that always has to hide things from his parents and lie to them. The mother also plays a role in this metaphor as the nurse who is seemingly impartial and who tries to please both parties in the "war". By using such a metaphor, the therapist is amplifying each one's role in the family. If the family's interactional patterns are uncovered and made overt in this way, it makes it harder for the family to fool itself into believing that all its difficulties are the result of the problem of one individual. Andolfi (1979b) believes that this will make it easier to introduce change to the family.

The above-mentioned example is an example of direct confrontation where the identified patient is included in the confrontative conversation. The same manoeuvre may, however, be used effectively by obviously excluding the identified patient from the confrontation. An example of this is given by Andolfi et al. (1983) where the therapist seats an anorexic girl behind his back, excluding her completely from the circle he has formed with the rest of the family. The therapist then talks to the rest of the family about the identified patient. Here an attack on the role of the identified patient is made through her exclusion.

Andolfi et al. (1983), however, stresses the importance of emphasising the centrality of the identified patient when using any of the above-mentioned strategies. It is believed that the therapist should never dispute the centrality of the identified patient, nor should the therapist actively aim at eradicating the symptom. Instead the therapist's task would be to exaggerate, play with and "enjoy" both the centrality and symptoms of the identified patient. The choice of strategy is, as usual, dictated by the family whose style should always be respected and emphasised. Where the identified patient tends to control the family openly and actively, the therapist would tend to apply the first mentioned technique of direct confrontation. If control and centrality are exercised through self-withdrawal and refusal of, for instance, sexuality, food or speech, the therapist would apply the last mentioned technique of exclusion (Andolfi et al., 1983).

These are examples of how therapists can induce a therapeutic crisis and thereby push the family system beyond its state of stability. This is done by assigning a function to the symptomatic behaviour which has been keeping the members of the system together and by activating the tension which has been invested in the identified patient. The aim is to spread the tension, which had all been focused on the identified patient, among all the family members. This goal is reached by also amplifying each of the other members' functions in

the system. The resistance used by a family to protect its redundant patterns is thus utilised by the therapist in a manner directly opposed to theirs. The identified patient, who has always served as the means to close the family in, becomes the most important means for opening up the entire system. This is done in order to construct a new system through a different, but equally credible, and intense emotional framework, where both the therapist and family play an active role (Andolfi et al., 1983).

Challenging the Function while Supporting the Individual

Andolfi et al. (1983) explain that it is important to involve the whole family in the therapeutic process as from the first session. The main obstacle in achieving this goal is regarded as making contact with the individual members and helping them to choose between that which they normally do and that which they would like to do. Agreeing with Farrelly and Brandsma (1974), Andolfi et al. (1983) believe that the idea of each one taking responsibility for his/her own choices can be very useful in this regard. They proceed to warn against the tendency among psychotherapists to consider clients as victims of external forces and consequently encourage therapists not to be impressed by clients' fragility. With Farrelly and Brandsma (1974), Andolfi et al. (1983) also use the technique of exaggeration where clients' symptoms or functions within the family system are exaggerated beyond everyday life. For Andolfi et al. the therapist is also permitted to sometimes use vulgar language in order to verbalise the doubts and taboos which family members may not even allow themselves to think of. By verbalising the unspoken in this way, the therapist attempts to reduce the burden which prevents family members from being clear and explicit. An example of this technique is supplied by Andolfi et al. when a therapist asked a famous surgeon who covered his sense of inferiority with the façade of his professional prestige: "How come that without a scalpel in your hand you always must feel that you're shit?" (p.64).

Andolfi et al. (1983) also maintain that feeling anger amidst one's weaknesses, can lead to the abandoning of the victim role and to the beginning of making choices. Provoking an immediate emotional reaction, even an unpleasant one, is seen as providing clients with an opportunity to respond in a way that is more congruent with their true feelings. By provoking clients in such a way, a significant obstacle in the way of change namely the discrepancy between clients' emotions and actions, is thought to be removed.

Andolfi et al. (1989) do not believe in paying too much attention to the origin or effect of symptoms provided by a family. They state that they have noticed that the less they preoccupy themselves with symptoms, the more symptomatic improvements take place.

Therefore, they would rather concentrate on the function or role of each member in the family system. These functions or roles are believed to always be related to the other family members and to the system as a whole. After each member's function has been identified, the therapist's role would be to challenge these functions through provocation. By challenging the function of the identified patient as well as the functions of the other members of the family, the therapist attempts to lead the family to a clear definition of their needs and their individual potential. Therapists may also use such provocation to enhance their own understanding of the family's situation. It is believed that this goal can be reached, as provocation is likely to bring forth the real issues in the family (Andolfi et al., 1983).

However, Andolfi et al. (1983) also maintain that the above-mentioned therapeutic goals are difficult to achieve when dealing with exceptionally rigid families. Such families have been experienced as exercising strict control over individual emotions by repressing them for the sake of abiding to the long respected family rules. Boszormenyi-Nagi and Spark (in Andolfi et al., 1983) are of the opinion that it is almost impossible to bring about change in such instances unless the therapist is able to create such tension that some family member feels obliged to breach the family loyalty. Someone must, in other words, be made to feel that it is easier to react in a personal and differentiated way to the therapist's provocation than to remain faithful to the family's well-rehearsed script. Andolfi believes that this can only be achieved once the therapist, through provocation, has made the latter much more difficult to abide with (Andolfi et al., 1983).

Andolfi et al. (1983) describe the task of the therapist as taking the negative half of the ambivalence which family members have towards their functions upon him/herself. This is done by carrying these functions to their extreme consequences. By doing this each family member is forced to intensely experience the limitations and suffering which accompany these functions. Only in this way, the family is thought to be likely to make a choice towards change. This decision is, like its counterpart of non-change, regarded as emotional in nature or as a kind of instinctive reaction which becomes inevitable at a certain point in time. Provocation is regarded by Andolfi et al. as an extraordinary powerful instrument for creating these emotional conditions for change as it causes the tension within the family to increase. From the therapist is then expected to channel such tension towards growth.

Before, each family member felt obliged to fulfil only that function which fitted with the functions of the other family members. Now the therapist creates a strong emotional intensity, designed to connect the family members' suffering to the fulfilling of their assigned

roles. The family members are thus provoked on the level of their most stereotypical functions. This is done through provocative questions, ridicule, exaggeration, the use of metaphors and the like. An example of such provocation through the use of metaphors was provided above when reference was made to the family who played cowboys and crooks.

Upon introducing such provocations, family members are believed to find it impossible to sustain the delusion that they are progressing within their old, assigned functions. Each one, thus, becomes obliged to redefine him- or herself in terms of his/her own ambiguity and to start making choices. Above all, Andolfi et al. (1983) believe that such provocation forces the identified patient to choose between two roles: that of the patient, in which differentiation can only take place in terms of the illness, or that in which differentiation may come about through behaviours independent of the assigned functions.

Andolfi et al. (1983) are of the opinion that families become enmeshed by the force of provocation which challenges each member personally. This is done through the same means of manipulation used by families such as gestures, language, silence, humour, dramatics and the like. These challenges are such that their attraction is unavoidable and that families thus regularly return to therapy. This attraction can, according to Andolfi et al. be ascribed to the fact that the family members become unable to bear the confusion resulting from the provocation. They are also believed to start feeling uncomfortable in their rigid functions which they can no longer maintain. At this point the family members themselves are described as revealing a dignity and autonomy which had previously been hidden (Andolfi et al., 1983).

It is, however, important for Andolfi et al. (1989) to note that to provoke, does not only mean to attack. They strongly believe that provocation must always be accompanied by support. The people in the system who feel that their defences or roles are being attacked are expected to simultaneously feel that the therapist has understood their underlying problem and the difficulties that it creates. In order for provocation to be therapeutic it must thus be accompanied by a joining attitude so that the family members will experience that the therapist is supporting them as individuals while attacking their functions.

Appearances notwithstanding, Andolfi et al. (1989) believe that an effective way of supporting a person is to allow him/her to get in touch with his/her own level of suffering and fears of inadequacy. This can be done by speaking about unspoken issues such as the body image of an overweight client. An important element of such an intervention is regarded as the therapist's unconditional trust in the positive resources of the individual. It is believed

that if clients are able to confront their own fears and feelings of destructiveness, they are in fact drawing from their own resources of strengths and self-esteem. This echoes Farrelly's argument that provocation is likely to connect clients to their own inner strengths (Farrelly & Brandsma, 1974).

With regard to support, Andolfi et al. (1989) differ from therapists such as Minuchin (1974) who believe that support is expressed by explicitly showing appreciation for the strengths already present in individual family members and their relationships. Andolfi et al. (1989) found that the accentuating of clients' positives have often hampered their efforts to adequately support the family in their working through more problematic areas. They state that after having explicitly stressed a family's positive aspects, they felt as if they were no longer allowed to enter the family system.

Andolfi et al. (1989) prefer to think that their support for each individual family member is expressed in two ways, namely, directly and indirectly. Support is directly, above all, thought to be expressed on the non-verbal level. This is done by acknowledging each individual as a whole and competent person despite what is apparent and despite of the role that has been assigned to each person in the family. This support is likely to be portrayed through the way therapists interact with the individual family members. It is important that each individual will experience that the therapist regards him/her as an important human being. Rogers (1951) termed this process as "unconditional positive regard."

Indirectly, support is expressed through an attempt to transform therapy into a learning context. Within this context, it is believed that each family member must be provided with an opportunity to learn to recognise links and to ascribe complex meanings to actions and emotions and therefore to grow. Family members are furthermore expected to learn to offer themselves as therapeutic resources whenever a new problem arises in a later phase of the family's life (Andolfi et al., 1989).

According to Andolfi et al. (1989, p.57), one of the therapist's essential tasks is "to assure a family of the 'solid walls' that mark off within them a 'flexible space'". It is suggested that this can be done by linking and dramatising each family member's present and past anxieties related to the problems of the identified patient. These anxieties are regarded as derived from other, past relationships and as burdening present relationships and shaping future relationships. This does not mean that personal suffering or distress is not regarded as important. The aim, in fact, is to provide a contextual frame in which different values and meanings can be attached to individual suffering (Andolfi et al., 1989).

Andolfi et al. (1989) believe that it can be to any family's benefit to accept the challenge of facing new interpersonal crises and to actively participate in therapy aimed at amplifying and redefining the initial problem. They believe that this can either result in a remission of the symptoms for which therapy was requested, or in newly found skills of problem-solving. Therapists are consequently urged not to hesitate to accept the risk of inducing a crisis in a family. It is believed that if therapists are not able to be provocative while containing a family's anxieties and interpersonal conflicts, therapy can never get started or progress satisfactorily (Andolfi et al., 1989).

Summary

Andolfi mainly practises family therapy and therefore regards it as important to not only provoke the individual but especially the system as a whole. He argues that the family presents in therapy with a fake crisis and it becomes the task of the therapist to create a real crisis. The function of this provocation is to bring forth the real issues within the family structure and interactions. This is done by defining family members in terms of their functions within the family system. By utilising the identified patient as the entrance into the family system, the family members are provoked on the level of their functions within the system. These functions are provoked by explicitly emphasising, amplifying and caricaturing the functionality thereof through the use of, among others, provocative questioning, metaphors or metaphoric objects and humour (Bianciardi & Galliano, 1987).

This makes for active, sometimes flamboyant therapy that often demands emotional strength and creativity from the therapist. Andolfi's provocative use of metaphor, humour and metaphoric objects makes him a master at entering the family. He enters the family in such a way as to allow himself to cut through the superficiality of symptoms in order to unmask the true face of the family. This is done by aligning with the mask so that the functions are provoked while the individuals are supported. Andolfi prefers to get rid of the family mask, not by denying or rejecting it, but rather by amplifying it. This provokes family members to free themselves from the relational functions with which they have rigidly identified themselves in the past (DiNicola, 1985).

Synthesis

From the above discussion it is clear that both Farrelly, and Andolfi are not impressed by clients' fragility. They both believe that, upon provocation, clients may resolve to more

adaptable behaviours or relationships. It can also be said that the techniques used by both these therapists are rather unconventional and mostly humorous in nature. They make for high levels of energy and activity displayed by the therapists, and they often leave clients amazed or amused. It is specifically the unpredictability of both these therapists' behaviours that renders clients perturbed and astounded.

Slight differences, however, exist among the two therapists that were discussed, with regard to the aim of therapy. These differences can most probably be ascribed to their diverse epistemologies. From the literature, it seems as if Farrelly mainly concentrates on individuals in therapy with the aim of provoking them to more assertive and well-adjusted attitudes and behaviours. Andolfi, on the other hand, focuses on families from a family systems point of view with the aim of provoking family members into reconsidering and changing their roles in the family system. It is important for Andolfi to utilise provocation in the process of bringing forth the real crisis or relational patterns in families. The system is provoked rather than the individual and individuals are therefore always provoked in the presence of their family members.

In both cases the importance of supporting clients within the process of provocation, is stressed. This implies that the aim of therapy is never to ridicule or attack clients' personhood, but rather to ridicule or attack clients' behaviours, attitudes and relational patterns. For the therapist to do this efficiently, he/she will, however, first have to join with clients and continuously provide them with an experience of support.

As it was said in the beginning, the court jester as metaphor for the therapist, as suggested by Fisher (in Farrelly & Brandsma, 1974), will probably best resemble the essence of being a provocative therapist as described by Farrelly and Andolfi. Like the court jester the provocative therapist provoke people into thought and laughter by playfully commenting on people and events through the puncturing of pretences and by taking an upside-down look at the world around us. In the following chapter a plan of research for this study will be provided whereafter both the client's and therapist's experience of this approach to therapy will be considered more closely.

CHAPTER 3

RESEARCH DESIGN

According to Kerlinger (1973, p.300) the research design is “the plan, structure, and strategy of investigation...”. In this chapter the research design or plan which guided this specific research project will be outlined. This will be done by briefly discussing the research paradigm from which the research was conducted, whereafter the methodology which guided the research will be described.

Research Paradigm

The paradigm or perspective from which this research project was approached was the qualitative or naturalistic paradigm. This approach was selected as it is believed to be particularly useful when inquiry into people’s experiences of the therapy process is made (Maione, 1997). Maione (1997) is of the opinion that by applying qualitative research methods, therapists are able to learn about their work in ways that can positively influence their future therapeutic endeavours. This can, in turn, be of great benefit to such therapists’ future clients.

The qualitative research paradigm is essentially different to the traditional quantitative research paradigm, especially with regard to the conceptualisation of constructs such as reality, truth, knowledge and objectivity. According to the qualitative research paradigm, there is no single reality existing autonomously ‘out there’ (Moon, Dillon & Sprenkle, 1991). Instead, reality is regarded as co-created, multiple and existing within people’s minds (Guba, 1990b). Reality is furthermore regarded as something that continuously changes from moment to moment and thus not as a static entity (Bopp & Weeks, 1984). When operating from this paradigm, claims of getting to the truth via the correct methods are thus regarded as futile. It is rather believed that multiple kinds of knowledge can be obtained through a variety of methods (Gergen, 1985). This is the case as it is acknowledged that “the rules for ‘what counts as what’ are inherently ambiguous, continuously evolving and free to vary with the predilections of those who use them” (Gergen, 1985, p.268). It is thus believed that phenomena can be meaningfully explained by a number of different theories. This renders the conceptualisation of phenomena theory-determined with no absolute meaning attached to it (Lincoln & Guba, 1985).

Absolute objectivity is regarded as impossible when a qualitative approach to research is employed. The reason for this is the recognition of the observer's tendency to influence the observed phenomena while finding it impossible to completely separate from the observed (Moon et al., 1991). It is assumed that any social phenomena can be described from various perspectives and that any perspective has various advantages. This implies that observers see what they want to see and report what they want to report. Researchers' frames of reference would thus determine which data are highlighted, which are ignored, and in what way data will be presented. This implies that researchers' descriptions of their observations are regarded as mere reflections of their own epistemological lenses. Distinctions drawn from obtained data are consequently believed to reveal as much, if not more, about the researcher as about the research participants. The search for absolute objectivity and value free inquiry is thus seen as futile and it is believed that attempts should not be made to eliminate researchers' biases but rather to openly admit them (Lincoln & Guba, 1985).

This also implies that time- and context-free generalisations are regarded as impossible. Findings may thus not arbitrarily be generalised to other contexts. Only time and context bound working hypotheses are regarded as legitimate. The aim of inquiry is consequently viewed as the creating of an idiosyncratic body of knowledge that can only be utilised to describe a specific case within a specific context. Within this description a circular stance is maintained, which implies that all entities are believed to be in a state of mutual, simultaneous shaping so that it becomes impossible to distinguish cause from effect. Also, the researcher is regarded as part of the researched system and must therefore be included in any description of it. The researcher's interaction with the participants and obtained data within a particular context are believed to complete the system. This further implies that researcher and participants are continuously interacting to influence one another (Lincoln & Guba, 1985).

These assumptions underlie flexible research designs which evolve in response to the researcher's interactions with the obtained data (Moon, Dillon & Sprenkle, 1990). The specific aim of a qualitative or naturalistic research project will thus vary according to the particular ongoing research process. Qualitative researchers, however, attempt to describe and interpret some human phenomena, often in the words of selected individuals. While doing this, these researchers attempt to be clear about their own biases, presuppositions and interpretations so that others can draw their own conclusions from what has been presented (Heath, 1997). In the following section the specific research strategies employed during this study will be outlined.

Research Methodology

When conducting qualitative research, researchers are faced with a number of choices regarding the research methodology. Researchers must, for instance, decide who will participate in the study and how data will be generated. Maione (1997) consider these choices to be of vital importance to any researcher as they are believed to continuously guide and shape the research process. In this section the selected research procedures applicable to this study will be discussed. It is, however, important to note that, adhering to the qualitative research paradigm, it would be impossible to provide a complete and final research design at this stage of the inquiry. The reason for this is that the qualitative or naturalistic researcher always allows for the research design to emerge with time, rather than to construct it in advance. This occurs as a result of the continuous, unpredictable interaction between researcher and phenomena (Lincoln & Guba, 1985).

Nevertheless, data collection and analysis have been guided by the research question which concerns the experiences of both clients and therapists involved in provocative psychotherapy. In the search for answers to this question, the qualitative method of case study illustrations was employed, discussing three different cases dealt with by the researcher. This method, together with the sampling, data capturing as well as data analysing methods employed during this study, will be described in this section. Finally, a description of methods employed to ensure research credibility will follow.

The Case Study Method

The case study method was preferred, as it is believed to be more accommodating to a description of the multiple realities of the researcher and respondents. This method provides an opportunity to present data in terms of the constructions used by respondents. In other words, attempts are being made to provide readers with a glimpse of the respondents' worlds through the eyes of the respondents. This is done by providing information through the use of respondents' own language (Lincoln & Guba, 1985). With Lincoln and Guba, it was felt that the uniqueness of the ecology of a specific individual could only be considered satisfactorily through the use of this method.

The case study method was furthermore preferred, as it was believed to have the potential to provide a thick description of contextual information. This would render it an effective tool for portraying the specific nature of the interaction between researcher and

respondents. By providing readers with a vivid, lifelike description of specific cases, they are presented with an opportunity to draw distinctions on the basis of their own interpretations, which permits an assessment of transferability. As Lincoln and Guba (1985, p.359) state: "The reader has an opportunity to judge the extent of bias of the inquirer, whether for or against the respondents and their society or culture." In conclusion it can be said that the case study method can be particularly useful in demonstrating the variety of mutually shaping factors imbedded in the research process (Lincoln & Guba, 1985).

Sampling

Research participants for this study were selected on the basis of purposive sampling (Lincoln & Guba, 1985). This implies that selection of respondents took place with a specific purpose in mind, namely, to inquire about their experiences of provocative psychotherapy. Respondents consequently had to have participated in some form of psychotherapy where the provocative approach was employed. In order to ensure this, as well as to eliminate the variable of individual therapist style, all participants were selected from the population of the researcher's clients. This selection was also made on the basis of convenience sampling, which implies that time, money and effort were saved by selecting the specific participants (Lincoln & Guba, 1985). These participants were, of course, easily accessible to the researcher, as relationships had already been established and because of the fact that their identifying particulars were already known to the researcher. The researcher, furthermore, had first hand knowledge of the nature and course of the conducted therapies, which made the choice of appropriate respondents easier. Selecting respondents from the population of clients seen by the researcher also made the study of personal relevance to the researcher.

It should, however, also be noted that the sampling was done in collaboration with the researcher's supervisor who acted as a knowledgeable expert in the field of provocative psychotherapy. In collaboration with the supervisor, it was decided to attempt employing maximum variation sampling which is described by Lincoln and Guba (1985, p.201) as "the sampling mode of choice". This means that attempts were made to include as much varying sources of information as possible (Lincoln & Guba, 1985), by including participants who respectively participated in provocative individual- couple- and family psychotherapy. It was thus decided to inquire about the experiences of three different groups of clients who participated in provocative psychotherapy within three different therapeutic settings.

As this study was conducted from a constructivist, qualitative point of view it was also decided to include the therapist as a respondent. The therapist thus also provided

descriptions of his experiences of the implementation of provocative psychotherapy with the involved clients. This was done in the form of self-reflective reports where the therapist particularly reported what effects the conducting of the therapies had on him.

The researcher telephonically contacted the participants to request their participation in the study. The nature and aim of the study was briefly explained whereafter their co-operation and participation in the study was obtained and arrangements made to meet with the researcher.

Participants' written consent for participating in the study was obtained by requesting all participants to sign a letter of consent (see Appendix A). In this letter the aim of the study as well as details about the nature of the participants' contributions were described. It was stated that the researcher wanted to inquire about the participants' experiences of provocation in psychotherapy. Their participation in the study was described as the participation in video recorded interviews during which they would be granted an opportunity to relate their experiences of provocative psychotherapy. The participants were furthermore assured that they were under no financial commitment or obligation with regard to the research project and that all information would be treated with strict confidentiality. To ensure anonymity, all names and identifying particulars have been changed in the case reports provided in Chapters 4 to 6. The respondents were also informed that the researcher could not guarantee that they would derive any benefits from participating in the research project.

Data Capturing

According to Lincoln and Guba (1985. p.236) "the instrument of choice in naturalistic inquiry is the human." The personal relating of human experiences of provocative psychotherapy had therefore also been the major source of data for this study. Data was mainly collected by means of semi-structured interviews involving the researcher and the selected collaborators. The researcher had, however, also consulted process notes of conducted sessions in order to refresh his memory with regard to the relevant therapeutic processes. This aided the therapist in providing a background to each reported case as well as a self-reflective description of his experiences of the conducted therapies.

Initially one interview of approximately two hours was conducted with each of the participant groups. These interviews were video taped by the researcher and afterwards transcribed and analysed. An interview was first conducted with the individual participant at

the University of South Africa (UNISA) whereafter the couple was interviewed, also at UNISA. The family, consisting of three members, was interviewed in their home north of Johannesburg. These interviews can be labelled as semi-structured as the researcher formulated certain questions and categories of questions in collaboration with his supervisor prior to conducting the interviews. These pre-set questions were categorised as follows:

Reason for Therapy

From what you can remember now, what was the reason for your initially seeking therapy?

Expectations of Therapy

Before participating in therapy, what did you expect therapy would be like?

How was it different from what you expected it to be?

Were your expectations met?

Reconstruction of the Therapeutic Process

Which themes, topics or processes of therapy can you remember?

Experience of the Therapeutic Process

In general, how did you experience therapy?

If you had to explain to someone else what therapy was like, how would you do that?

What did you like about therapy?

What did you not like about therapy?

What was difficult during therapy?

What was easy during therapy?

Were there any funny or ridiculous moments during the course of therapy?

Did you feel provoked or challenged during the course of therapy? Explain.

Did the therapy have any effect on you? Explain.

What metaphor would you ascribe to the therapeutic process?

Experience of the Therapist

Did you feel supported by the therapist? How?

What metaphor would you ascribe to the therapist?

These questions and categories were, however, used as a mere guideline for conducting the interviews. Attempts were not made to strictly adhere to these, as it was believed that the interaction between the researcher and participants would play a significant role in the evolving of these interviews. This phenomenon can clearly be seen in the conversations between researcher and participants presented in Chapters 4 to 6. It is clear from these interactions that the above-mentioned categories became somewhat superficial as they often overlap notably. The categories and questions were, however, used by the researcher to provide some structure to the inquiry and as an attempt to enhance transferability.

The interviews were conducted in such a manner that they took on the form of a conversation instead of a formal questioning session. This was done in order to facilitate collaboration between researcher and respondents. Interviews were thus flexible and informal and were allowed to progress spontaneously in order for rich descriptions and emergent themes to be generated (Sells, Smith & Sprenkle, 1995). Conversations were subsequently listened to and transcribed. The researcher studied these transcriptions for emerging themes upon which follow up meetings with each participant group took place. The purpose of these follow up meetings was to clarify certain aspects of the related experiences and to further enhance collaboration between researcher and respondents. The researcher and participants thus co-created a "shared domain of meaning" (Anderson & Goolishian, 1990, p.162) through the various epistemological distinctions drawn by them (Keeney, 1982).

Data Analysis

In analysing the obtained data, the researcher was guided by the domain analysis procedures described by Spradley (1979). According to this procedure, data is analysed by reducing the body of information into common themes and categories. Complex information is thus broken down into shorter semantic units or segments. Constructing a list of domains in this way, then becomes the first step in capturing the underlying meaning of respondents' reports of their experiences. These domains are consequently compared to one another by searching for similarities and differences across the domains. Upon doing this, a category system emerges based on themes and patterns across domains (Sells et al., 1995).

Following a domain analysis of each interview, specific questions arose that were then asked in the follow up interviews. Towards the end of the research process, the researcher then went back to the respondents to verify the themes and patterns that emerged from the domain analysis. This process is called informant verification (LeCompte & Preissle, 1993). By applying these procedures, internal validity is also enhanced as emerging themes are verified with all participants. If discrepancies occur, categories are redefined or modified accordingly. The emerging themes are thus, either supported, rejected or modified by all the participants involved in the research project (Sells et al., 1995).

For the purpose of this study the interviews conducted with the various groups of respondents were first analysed for emerging themes by the researcher whereafter these themes were verified with the involved participants. After this process had been completed, the researcher compared the data obtained from the different participant groups in order to identify shared themes on the basis of his own idiosyncratic distinctions.

Establishing Credibility

In this study credibility was enhanced by the employment of several measures. The first step that was taken to enhance credibility was the examining and acknowledging of personal biases and preconceptions regarding research in general, as well as the cases at hand. This was done by outlining the researcher's frame of reference with regard to research at the beginning of this chapter as well as the providing of background information on each case in the chapters to follow. This is regarded as relevant as the qualitative researcher views bias as unavoidable and therefore as something that needs to be admitted instead of avoided (Maione, 1997).

Credibility was further enhanced by what Lincoln and Guba (1985, p.313) call “referential adequacy”. This entails that obtained data is accessible to the reader in the form of video recordings and field notes. For the purposes of this study video tapes of the initial interviews conducted with the participants as well as field notes are kept safely for reference purposes.

Member checks, which are regarded by Lincoln and Guba (1985, p.314) as “the most crucial technique for establishing credibility”, were also employed in the course of this study. As previously described, this was done by verifying the obtained data, analytical themes, interpretations and conclusions with all the involved participants. This process of member checking occurred continuously through the course of this study.

Credibility was lastly enhanced by providing transcripts from the interviews conducted with the participants as well as background information to each presented case. By having access to these portions of data, readers are provided with an opportunity to make their own judgements with regard to the claims made and distinctions drawn by the researcher. Readers are thus free to use this information to draw their own conclusions while evaluating the researcher’s conclusions and interpretations (Maione, 1997). By doing this the community of research consumers will ultimately be the ones to have the final say on the credibility of this and other research projects. This idea is echoed by Atkinson and Heath (1991, p.161) when they write: “...the legitimization of knowledge requires the judgement of an entire community of stakeholders”.

Conclusion

By employing a qualitative research design, this study aimed to create a context in which both the respondents and the researcher could express their experiences with regard to their involvement in provocative psychotherapy. These experiences were expressed by respondents in the context of semi-structured interviews and by the therapist by means of self-reflective reports. Co-created descriptions of these experiences consequently evolved as a result of this interactive process. These descriptions and the themes that emerged from them will be presented in the following chapters.

CHAPTER 4

THE EXPERIENCE OF PROVOCATION IN INDIVIDUAL PSYCHOTHERAPY

In this chapter, the case of Linda will be considered as an example of provocative psychotherapy with individuals. The researcher will first provide his conceptualisation and experience of the specific process of psychotherapy whereafter the focus will shift to the client's experience of the process as described by her in a personal interview with the researcher.

Background to the Case of Linda

Linda was referred for therapy to the researcher by her lawyer after she had consulted him about divorcing her present husband. The therapy took place within the setting of an outpatient community clinic. Six individual sessions were conducted during which the provocative approach was utilised by the therapist.

Linda (25) presented for therapy after her husband of two years, Frank (27), had left her and their two-year-old daughter. They initially decided to get married after Linda had fallen pregnant with their daughter. Before their marriage they had been involved in a long-term relationship of eight years. During this period there had also been a time during which her husband had left her without explanation. He returned after a year and she was very willing to take him back. Their relationship had, according to Linda, always been characterised by conflict and her husband, Frank, had been drinking heavily since the start of their marriage. Frank had also not been able to hold a stable job as he regularly changed jobs. Linda had always been willing to move where-ever Frank expected her to move to. This resulted in Linda not being able to establish a stable career as secretary for herself and in her sacrificing many of her own desires. Frank, on the contrary, seemed to be doing just as he pleased. He, for instance, regularly went out with friends and often returned very late and in a drunken state. That upset Linda a lot and often led to her refusing to sleep with him in the same room. Linda said she had, however, always been willing to "forgive and forget" as she regarded her marital relationship as very important.

Frank had apparently previously left Linda on several occasions but she believed that that time it was more permanent as he removed all his belongings from their flat and instructed her to give up the flat and find a smaller one to rent. That served as a tremendous

source of distress to Linda as she believed that she truly loved her husband and that she would be unable to live without him. She reported that she continuously cried and that she felt completely out of control of her life. The reason for this, she believed, was that her husband had always been her connection to the outside world and without him, she felt completely lost and isolated. She also experienced severe financial difficulties in the absence of her husband. However, she admitted that, even when her husband was at home, they had always had financial difficulties. Because of these circumstances, Linda appeared very tearful during the first few therapy sessions.

With regard to her family of origin, Linda was the youngest of three sisters of whom each one had a child born out of wedlock. Her eldest sister (30), who was described as highly intelligent and very religious, fell pregnant in her first year at university but gave the child up for adoption. As described before, Linda and her husband decided to get married after she had fallen pregnant with her daughter. Her middle sister (28), on the other hand, decided not to get married when she fell pregnant with her daughter. Instead, she decided to break up the relationship with her boyfriend at the time and to raise her daughter by herself. This theme of unplanned pregnancies is quite significant as Linda originated from a very conservative, rural, Afrikaans family with her father being a pastor.

She explained that she had tremendous respect for her father but never experienced him to be easily accessible as she had always feared him and attempted vigorously to gain his approval. He was furthermore described as a strict person who was easily angered. His father was also described as a terrible person with a quick temper who emotionally abused his wife. A theme of abusive men is thus clearly discernible within Linda's extended family. This theme is furthermore highlighted by Linda's statement that her maternal grandfather had also been abusive at times.

Contrasting to the theme of abusive men, is that of submissive women. Linda described her paternal grandmother as a woman who always obeyed her husband and who gave up her life for him. Her maternal grandmother was also described as someone who sacrificed a great deal in order to look after her husband in the same way as a mother would look after her child. She stated that this was the case because her grandfather had been crippled.

Linda's mother is believed to have taken over the role of submissive wife from her mother by also diligently submitting to her autocratic husband. This role was seemingly once again taken over by Linda in her marital relationship. Linda's relationship with her mother

had, however, always been very good as she described her mother as her best friend. Her parents' marital relationship was also described as a relatively stable one with her mother being the traditional submissive housewife and her father the autocratic head of the family. This implies that her mother had been Linda's predecessor as doormat.

Linda said that she had always been the good girl at school and at home, trying to please everyone always doing the right thing. This, however, never brought her happiness. Her husband, on the contrary, had always been the irresponsible one who never abided by the rules. Everybody warned her against her husband, saying that he was a bad influence. She, however, believed that this daring attitude of his was a great source of attraction to her.

During therapy Linda presented as a very timid young woman with a low self-esteem who could be somewhat naïve and easily influenced by others. She has, however, always been very well-groomed and came across as reasonably intelligent.

For clarity sake, a genogram of the client under discussion is provided in Figure 4.1.

The Therapeutic Process

During therapy Linda presented as very tearful and depressed. She made a very strong appeal to the therapist to give her advice and to help her to feel better. The therapist, however, aimed at provoking her into taking responsibility for her own life in order to help herself. He would, for instance play one down saying things like " I don't know, I could never be such a good doormat as you are". This and other techniques described by Farrelly and Brandsma (1974) were particularly utilised during this process which will be briefly described here.

During the first interview the nature of the relationship between Linda and her husband was explored through, among other techniques, the use of circular questioning. This process assisted the therapist to come up with the metaphor of mother and child for the client and her husband. She was dramatically portrayed as the good mother who always exerted herself for her naughty son (husband). She was portrayed as the one who provided him with stability while he was providing her with excitement.

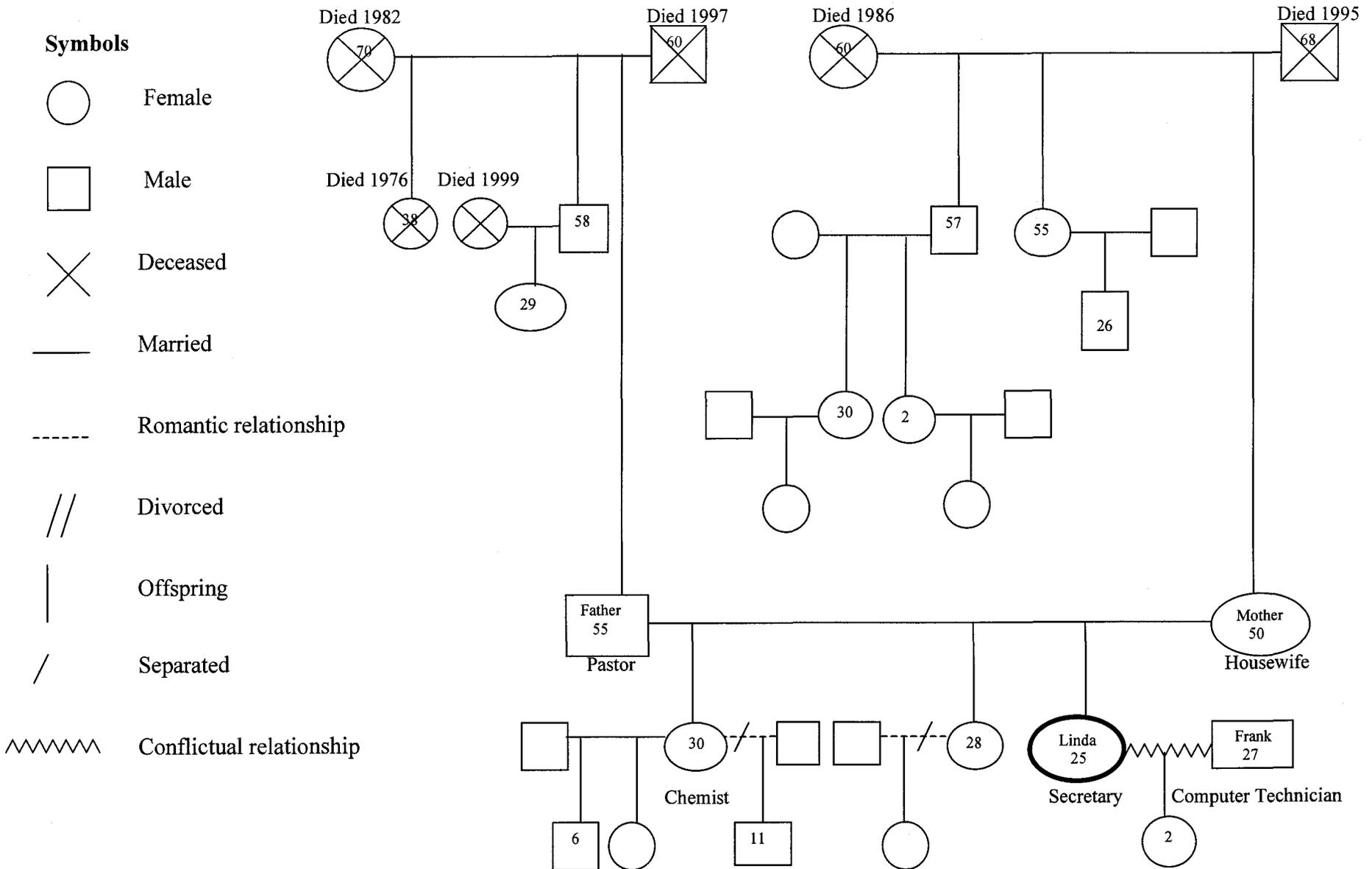


Figure 4.1 Genogram of Linda's Extended Family

From the second session onwards, the metaphor of doormat was introduced. The therapist also brought a doormat into therapy and every time the client displayed a self-defeating attitude the therapist, without saying anything, lifted the doormat. This was particularly useful when the client said that she was wondering whether it was not all her fault that her husband left her. She said this in response to a book that her father gave her on how to be a good wife. Upon reading this, she was convinced of the fact that she was not being a good wife as she did not always obey her husband's commands. The therapist accentuated this negative perception by fully agreeing with her in this regard, stating that she is completely right and that she should make sure to confess all these sins of hers (religious-moral language).

The therapist complimented her on being a very good doormat who even took the initiative to check on herself in order to improve her skills as a doormat. It was suggested that, with her experience, she could write a book on "how to be a good doormat." The client laughed at this suggestion and said that she did not want to be a doormat. In replying to this, the therapist decided to emphasise the dreaded aspects of change while pointing out the positive aspects of the status quo. This was done by saying to the client that he did not know whether it would be possible for her to change as she had been so used to being a doormat for 20 years – first her father's and now her husband's. He also said that he was not sure that she did not want to be a doormat as he did not know how well she knew her own needs since she had been so used to focusing on the needs and desires of others such as those of her husband and father. This provoked her into saying to the therapist that he could not say such things about her, as he did not know her. He immediately replied by asking her to list three good examples of behaviours that illustrated that she did not want to be a doormat. The client was unable to do this. This led the therapist to "advise" her that before she decided not to be a doormat, she first had to go and think about it carefully while concentrating on being a doormat. The reason for this was said to be that she had to find out for herself whether it was not after all what she wanted to be. This seemingly annoyed the client upon which she replied that she knew that she was not going to be a doormat anymore.

Positive aspects of the status quo was further emphasised by explaining that the client's distress was completely understandable as she was going through a period of mourning. It was further explained that psychological theory stated that the mourning process normally extended over a period of two years. Her sadness was thus endorsed by the therapist instead of attempting to eradicate it. The aim of this intervention was to provide

the client with support in the form of understanding as well as to place the responsibility for change on the client's shoulders.

Jokes were used to ridicule the client's doormat behaviour. One such joke was one where two girls are walking in a dangerous area at night while the one says to the other one: "We must be careful that we don't get raped here." "Yes," said the other one, "and I am so easily raped!" The client was intended to be both the listener and subject of this joke. Indirectly it was implied that the client was also easily raped.

The therapist also provided the client with direct feedback by referring to a woman with characteristics similar to the client's who "irritated the hell out of him". Negative modelling was employed by the therapist when he spoke in the same high-pitched girlish voice as the client. Research was invented by stating that there was a psychologist who did research on people's capacity to change upon which he found that everybody had the capacity to change if they wanted to. The therapist, however, said to the client that she might have been a freak who was so different to most people that she would not be able to change. This caused her to disagree with the therapist by saying that she could not be different to other people.

During the course of therapy, the client gradually started changing her stance from a self-defeating one to a more assertive one. Her husband returned to her but she started behaving differently towards him. In the last session she admitted that for the first time in her life, she had started to feel irritated with her husband as well as with her work. She said that she did not think that she would again be so hopeless if her husband had to leave her again. She also stated that she thought that she was also like a doormat at work where she just had to do everything her employer told her to do. She said that she had been thinking of studying something more creative so that she could be her own boss and do something more creative like photography. The therapist again warned her not to try and change too much too quickly as that might have just have been a phase that she was going through. She also rejected this idea fiercely.

The above-mentioned provocations were coupled with support by various means, both directly and indirectly. Support was offered directly mainly on the non-verbal level where the therapist used humour, a caring attitude, touch and body posture to assure the client of his unconditional positive regard. It is believed that by providing the client with an opportunity to laugh in spite of her misery, she already experienced the therapist's supportive

attitude towards her. This was further enhanced by the proverbial twinkle in the eye and the use of touch such as a pat on the shoulder.

Indirectly, support was offered by allowing the client to tell her story while remarking humorously on and further ridiculing, ridiculous aspects of her conceptualisation of herself and her circumstances. This form of feedback, coupled with other forms of feedback such as negative modelling, provided the client with a different, honest perspective of herself and her circumstances. She consequently came to learn more about herself and her coping mechanisms while being encouraged, through provocation, to tap into her own internal resources. The therapist's experience of the therapeutic process will subsequently be outlined.

The Therapist's Experience of the Use of Provocation in Individual Psychotherapy

I experienced this therapeutic process as great fun as it allowed me a great deal of freedom. By not having to take the client's problems too seriously, I felt a sense of lightness and freedom. I did not have to work too hard or take too much responsibility for the client as I regarded myself as only a perturber and not as a saviour. I have previously struggled with wanting to be a saviour to clients as I pressurised myself to supply answers to all clients' problems and to consequently "cure" them. I also used to believe that therapy is a very serious matter and that I, as the therapist, will always have to put up a serious face and attitude even if I do not feel like it. This caused therapy to sometimes be a great burden for me, which I dreaded at times. This idea, furthermore, frequently rendered therapy as a rather hypocritical exercise, which often made me feel uncomfortable.

With my "discovery" of provocative psychotherapy, it was as if therapy became more enjoyable and much less of a burden on me as a therapist. I also started feeling that I too could be a therapist as I experienced that I could not fit as a therapist when playing according to the rules of many other approaches to therapy. Being an active person who likes to say what I think, I often felt boxed in and uncomfortable in therapy. The playful, emotionally honest and often humorous approach as dictated by provocative therapists such as Farrelly and Andolfi, gave me new hope and a zest for therapy. This freed me to also be myself in therapy without fearing that, I might do something wrong to harm clients.

With reference to the specific case at hand, the jokes, the metaphors such as doormat and the dramatisations gave me a great deal of pleasure. I could laugh with the client, sometimes amidst her tears. This, I believe, helped me to join with the specific client

and also provide me with a sense of hope to see her laughing in the midst of her misery. The active and playful stance helped me to be more spontaneous and this, I believe, also freed the client to be more honest and spontaneous.

I, furthermore, believe that this stance helped me to confidently confront the client with emotionally laden and difficult issues without being too serious about it. As a therapist I thus felt very mobile and free to say or demonstrate whatever I thought. This made this therapy experience a very real and honest one.

I did, however, sometimes feel a strong pull from the client to take responsibility for her in the form of giving advice when she persistently asked for it. I consistently had to remind myself not to do this, but rather to use these appeals in a creative manner to the client's benefit. The client often gave me ample opportunity to act as a saviour and to allow her to become dependent on me as therapist. This trap was avoided by playing one down and stating that she was the one who should write the book about how to be a good doormat and that I had no experience with the writing of "how to" books.

Another area of difficulty for me was to be able to maintain a balance between provocation and support. I realised that the specific client had a strong need for support in her circumstances. This sometimes caused me to be afraid that I would be too harsh on the client and that this would cause her to quit therapy. On the other hand I also wanted to make sure that I perturb her adequately in order for her to break with the redundant patterns in her life. For me, this sometimes resulted in feelings of confusion about whether to continue being provocative and about the intensity of the provocations. This uncertainty was specifically present both at the beginning and towards the end of therapy. At the beginning, I did not know how much provocation she would be able to take in her vulnerable state. Towards the end the client started showing real insight and spoke about how she was changing and wanted to change even more. This created an uncertainty within me of how much I should continue to emphasise the negative and how much I should give the client credit for what she had achieved.

The client's self-actualisation which I noticed later in the course of therapy, as described above, gave me a feeling of satisfaction. This further motivated me to believe in therapy as a means to assist people in walking along unexplored pathways.

In conclusion it can be said that, although there had been some difficulties and questions with regard to provocation, this series of provocative therapy sessions provided me

with a great deal of pleasure and freedom. I felt that the provocative stance assisted me in joining with the client while at the same time confronting her with real issues which she could work on.

The Client's Experience of Provocation in Psychotherapy

The client's experience of provocation will be discussed according to her answers to the questions posed to her in an exploratory interview upon completion of therapy. This interview was conducted on Tuesday, 15 February 2000, at UNISA. The interview was video taped and consequently transcribed by the researcher. Questions and answers had to be translated into English as the initial interview was conducted in Afrikaans. It is important to note that both these questions and answers formed part of the therapist's and the client's subjective experiences and can thus not be regarded as an absolute reality. One could rather here talk about a co-created description within a specific context, which may differ completely from similar descriptions in other contexts or by other role players.

The answers to the given questions will be presented here under the headings that were suggested in Chapter 3. The categories that have been introduced to systematically portray the client's experience are as follows: Reason for therapy, expectations of therapy, reconstruction of the therapeutic process, experience of the therapeutic process and experience of the therapist. It must once again be noted that these categories are somewhat superficial as several of them overlap notably. The categories were, however, introduced for the sake of enhanced clarity.

The relevant information regarding the client's experience of the provocative style of therapy will be presented here. A discussion of the themes that emerged from these experiences will follow thereafter.

Reason for Therapy

Therapist: From what you can remember now, what was the reason for your initially coming into therapy?

Client: I felt so lost, I had to do something. I felt so entrapped, I couldn't sleep, I couldn't eat, and I just wanted to get help from someone. I couldn't cope. I just felt that somewhere I had to get help. This all started when my husband left me. So, I think it was mainly because he had left me that I started feeling

that I couldn't cope anymore. This made me feel like a little girl and that I couldn't do anything on my own. It made me feel that I needed help from an outsider. I felt that I needed someone else's advice or opinion. I don't think it's normal for a 25-year-old woman to feel like a little girl just because her husband had left her. I couldn't stop crying. I was crying permanently, all day. I cried myself to sleep at night. I was hoping that someone would have been able to tell me how to get on with my life.

Therapist: Did I provide you with such advice?

Client: No, in fact you told me that I should cry. You didn't make me feel bad about crying. I felt that you understood because you gave me permission to cry after I've lost something. It was actually a nice thought that someone allowed me to cry because one somehow has to deal with the loss and you gave me permission to deal with my loss.

Therapist: You have just mentioned something about feeling understood.

Client: Yes, it feels like that. Maybe it is because you made an effort to understand me or maybe it is because it is your job (laughing).

Therapist: How did you know that I understood you?

Client: Because you said things that proved to me that you understood. I mean you didn't negate my problem, you looked into my problem. In more than one instance you've helped me to see what my real problem was and you didn't just tell me to stop crying. I don't think it is good advice to say to someone that he should stop crying and just carry on; it doesn't solve the problem.

Expectations of Therapy

Therapist: Before participating in therapy, what did you expect therapy would be like?

Client: I wasn't very fond of the idea of seeing a psychologist because it felt to me that when you go to see a psychologist, you are admitting that you have a problem and that you are a psychological case and I don't like to see myself in that way. I must honestly say that you surprised me with regard to what it is

like being in therapy. It didn't really feel as if I was coming for therapy, it only felt like I was talking to someone, someone who really listened to me. I can even say someone who really cared, who took an interest in me. So, it was completely different from what I expected it to be.

Therapist: How was it different to what you expected it to be?

Client: I thought that seeing a psychologist would mean that I had to lie on a bed while he listened and then said: "Okay, time is up." Or I thought of sleep therapy or drug therapy or something like that, like you would see on television. I didn't expect that a psychologist would make you see what your real problem is. I thought he would just listen, and then give me his professional opinion. But from what you and I spoke about, I can clearly remember the doormat and the mother and child metaphor, so I concentrated on that. It was just good to speak to someone who listened and who made me laugh and made me forget about my worries. Even during the time when Frank was away, you made me laugh when I never thought that I would be able to laugh. This made me feel better. I enjoyed coming to see you; it was as if I looked forward to coming for therapy.

Therapist: Were your expectations met?

Client: Yes, I think in more than one way. The major thing that I was looking for was someone that would listen to me. Someone that would acknowledge me as a person, who would talk to me about my issues, not just issues in general, because we don't all have the same problems. You made me as a person, see what my problems were. You acknowledged me as a person, it is important for all of us to be acknowledged.

Reconstruction of the Therapeutic Process

Therapist: Which themes, topics or processes of the therapy can you remember?

Client: That you were shitting on me all the time! (Laughing). You were telling me how bad I was. You also made me laugh. I can specifically remember the one session when I felt really down when I came to see you and I really felt

much better when I left. I remember how you gave a demonstration of being a doormat. You made me feel better and you made me laugh.

I clearly remember what you said about me and Frank being like mother and child. I often remind myself of that as it made an awful lot of sense to me. I realised that I was able to be a mother to him but when I wanted to be a little girl, he couldn't be a parent to me. I must say, I often think about that.

Therapist: Isn't it weird that, although I scolded you, you still felt better?

Client: You didn't scold me in the same way as one would scold a child. You made me see the absurdity of my behaviour. I couldn't help to see the humour in that. You made my behaviour look ridiculous by continuously saying to me that I will never be able to not be a doormat. That's actually ridiculous, of course I would be able to start not being a doormat.

Therapist: So, do you think that these statements of mine could have had the opposite effect?

Client: Yes, often when you tell someone that he is bad, he will deliberately go and do the opposite just to prove you wrong. I particularly wanted to show you that I wouldn't remain a doormat. Even if it were only to prove you wrong, I would go out and concentrate on not being a doormat.

Experience of the Therapeutic Process

Therapist: In general, how did you experience therapy?

Client: I enjoyed it. I looked forward to coming to see you. It was nice to talk to someone who listened to me, who didn't always interrupt me and who did not always want to tell me what to do. Because that is the general mistake that I believe people make, that they just want to tell you what to do and how you must do it. That's not practical, it's not always possible. It was just nice to know that someone was listening to me or that someone understood me and really made an effort to listen to my part of the story.

It was funny and made me feel better. It also made me think further whether I was not maybe really like the way you portrayed me to be. Subconsciously it then helped me to not want to be like that. It also helped me to see myself from the perspective of an outsider. It gave me another way of looking at my problems. It also provided me with a challenge as it definitely forced me to demonstrate that I wanted to change.

It is a whole new way to make me realise what the situation is really like. Subconsciously, I answered my own questions and the responsibility for my own behaviour was placed solely on myself. This forced me to become strong enough.

Therapist: Do you think I sometimes exaggerated things?

Client: Yes, definitely. I don't think I can be as bad as you said I was.

Therapist: What was the effect of these exaggerations on you?

Client: It revealed to me that things had to change, because things could not go on like they were. Just now things would have become as bad as you made them out to be and then my situation would really have been bad. I was thinking: "Maybe I should stop it before it really gets that bad." You made me realise that I had to do something as things were not what they should have been and if I had to go on in that fashion, I would only have harmed myself. There are different ways in which one can talk to other people. You could have, for example, spoken to me in a serious way by saying: "Linda, you can't do this or that." I think that if you had done that, I would have switched off. None of us really wants to admit our mistakes, it is only human. If you only said to me in a serious fashion: "Linda, do this or that," I would have rejected it.

Therapist: Had there ever been moments in therapy that were funny or ridiculous?

Client: Oh, all the time. Especially when you demonstrated the doormat. Every time I said something ridiculous, you took the doormat and put it in front of me, which reminded me, that what I had just said, must have sounded like a

doormat. I had to realise that what I had just said made you think of a doormat. Yes, definitely it was funny most of the time.

Therapist: What was the effect of this on you?

Client: Maybe to concentrate on how I talk and conduct myself. I understand things much better when they are explained visually. Whenever you threw the doormat on the floor, I realised that what I had just said, showed you, as an outsider, that I was behaving like a doormat. In other words, I had to say it in another way or act in a different way so that I wouldn't be a doormat.

Therapist: Could you identify with the metaphor of a doormat?

Client: Absolutely. I must admit it is the way I was. I did allow myself to be abused by others.

Therapist: What about when you were outside of therapy, did you ever think about this metaphor of being a doormat?

Client: Oh yes, definitely. The only problem is that it was not as easy outside as in therapy. It was as if the people outside did not understand me as well as you did. There were stages that I felt an urge to tell my husband, Frank, that my main problem was being a doormat.

Therapist: Have you spoken to anyone about what had happened in therapy?

Client: Yes, I've spoken a lot to my mother about it, also a little to my father but I am a little bit afraid to speak too much to him about it. I've also mentioned something about therapy here and there to Frank.

Therapist: If you had to explain to someone else what therapy was like, how would you do that?

Client: I spoke to my mother about therapy and I said to her that Leon agreed with the negative things I said about myself and that he pointed out the mistakes that I had made and that he emphasised my mistakes. That made my mother laugh and she asked whether it didn't make me feel bad, but I said: "No, it

didn't make me feel bad." On the contrary, it forced me to go and think, even if it was only to prove you wrong. I wanted to show you. You did that without me realising that. If you had to say to me, okay here's R10-00, go and do that, it would not have been a challenge to me. Because you kept on saying to me that I wouldn't be able to do it and that I was a lost case, I felt more determined to show you that I was able to do it. I said to my mother that I felt at ease talking to you, that although it was difficult in the beginning, I was able to talk to you.

I also told her that I had been laughing even while I was crying. This was weird because I was so sad because my husband left me and I felt lost, but yet I was laughing at things you were saying. It really was something which I couldn't really explain because I was not supposed to be laughing. I mean, I was actually mourning because I lost something but now I was laughing. It's almost surprising that you could succeed in making me laugh and you didn't even force me to laugh. It was just the way you were talking to me that made me laugh.

Therapist: Was this good or bad for you?

Client: Definitely good.

Therapist: Why do you think this was good for you?

Client: When you laugh, you see things in a lighter way. You don't feel so heavy, you just feel lighter and free and as if it is not really that bad after all. Laughter in itself, I think is therapeutic. If you can just laugh through the day, you will anyway feel so much better.

Therapist: Did you experience any of the things that we did in therapy as unusual?

Client: Definitely. As I said, I didn't expect you to react to me in the way you did. You knew me from nowhere. You did sympathise with me but not in such a way that I felt sorry for myself, you sympathised in a way that I really felt that you cared.

Therapist: Does that mean that you felt supported by the therapist?

Client: Yes, definitely, because you continuously made me realise that I was not as bad as you made me to be. Although you kept on saying that I would not be able to change, I realised that you actually meant the opposite. I realised this through the way that you spoke to me. I realised that I was not that bad and that it was not all my fault that Frank started drinking. You didn't say it in a direct way but I realised that that was what you meant. If you had to say it in such a direct way, I probably would not have listened to you. I would have regarded you as just another guy who wanted to preach to me and who didn't care. I would say that that really helped me a lot.

Therapist: Did you not start feeling worse about yourself because of the therapist's comments?

Client: No, on the contrary. I don't know how to explain it, I don't know whether it was just a psychological game, but it made me think that I couldn't be that bad. I couldn't have really driven my husband to alcohol. I could also not have been such a bad doormat after all. I couldn't have been as bad as the books portrayed me to be.

Therapist: Did the therapy have any effect on you?

Client: I feel better, I definitely feel better. I also feel that if Frank decides to leave again, I will be able to handle it in a better way.

Therapist: Why do you say that?

Client: I now see many things differently. I didn't really previously realise that I was being a doormat and now that you pointed it out to me, I've got no choice but to acknowledge it. I feel that if Frank decides to leave again, I won't again feel so lost, it's almost as if the little girl is all right now, as if I no longer have that terribly lonely feeling. I won't say I would be able to cope a 100%, it would still be sad and everything but I do believe that it won't be that terrible for me. It's just as if I feel more positive about my self.

Therapist: What was difficult during therapy?

Client: I think the most difficult was in the beginning to tell you as a stranger about my problem. I don't think I'm the kind of person who easily talks about my problems. I would rather keep it to myself and go sit somewhere and cry by myself. I would rather withdraw and keep it to myself. I would rather want to hide it, as if I don't want to admit to others that I've got a problem.

Therapist: Anything else that was difficult?

Client: No, not really.

Therapist: What was easy about therapy?

Client: I again want to say talking to you, because you made it easy for me, because I find it difficult to talk about myself but just the way in which you handled me, the way in which you spoke to me, made it easier for me. It felt as if I could open up.

Therapist: And what about it made it easier for you?

Client: Your style was casual. You didn't corner me. You never forced me to say anything that I didn't want to say. You asked me a question but if I didn't want to answer it, you left it at that. In other words, you rather gave me something to think about, but yet you forced me to realise what was happening. You forced me to realise that there was something wrong which I had to work on. You did this without preaching to me. I would rather say it was the way in which you spoke to me that made the difference rather than what you said.

Therapist: Can you describe the way in which I spoke to you?

Client: It was casual and humorous.

Therapist: When I was so humorous, didn't you feel that I was not taking you seriously?

Client: No, not even once. I didn't once think about that. You did it in such a way that I never felt that you were not taking me seriously.

Therapist: Did you feel that I was taking your problems seriously?

Client: Yes, definitely. I also felt that you sympathised with me.

Therapist: What didn't you like about therapy?

Client: I don't know, I don't think there was something. Maybe the fact that you always said to me that I won't be able to do it. I know you said it in a humorous way but I also felt that I wanted you to also believe in me. On the one hand, this made me to want to prove you wrong, but on the other hand, I also felt that I wanted you to believe in me as a human being.

Therapist: What did you like about therapy?

Client: Everything. The way you spoke to me. The fact that you made me laugh, this was really important to me. You know I was very sad and you made me laugh even while crying. I also felt that you listened to me. I felt that there was someone there for me, someone who cared for me.

Therapist: Did you feel challenged in therapy?

Client: Yes, definitely. By saying to me all the time that I won't be able to do it, I felt that I was going to show you. I wanted to prove you wrong. It definitely was a challenge for me but I would say an indirect challenge because I don't know if it would have worked well if you had challenged me directly.

Therapist: If you have to think about a metaphor for the therapy, what would it be?

Client: It is difficult because there are more than one image that come to mind. On the one hand I would say that it was like an ointment or like a plaster which you put on, which really took the hurt away. I feel ten times better today than the first time I came to see you. So I would definitely say it helped me to feel better. It's like an ointment. But I would also say that it was sort of exciting, like something you would drink, an exciting drink, a drink with a pleasant taste. Because you made me realise that everything is not as bad as it seemed to be, not as dark as it seemed, that there is something exciting in it after all. Even if we did speak about difficult issues, you made it easier to talk about. I saw a lot of positive things through the way that you spoke to me. I think it all

had to do with the way you spoke to me because you could have said the same things in a different way without having any impact.

Experience of the Therapist

Therapist: Did you feel supported by the therapist?

Client: Yes, definitely.

Therapist: Can you maybe give me an example of how you felt supported?

Client: You gave me permission to feel the way I felt. You often agreed with me, which made me feel that you understood me. You implied that it was not all my fault that our marriage didn't work out. In your saying that it was my fault, I actually felt supported. I knew you meant the opposite. I also knew that it could never have been as bad as you portrayed it to be. It was logical that it was actually the other way round and that you wanted me to realise that the opposite is actually true. By doing this, you made my negative ideas about myself sound ridiculous.

Therapist: What metaphor would you ascribe to me as a therapist?

Client: A clown. You were dancing around the room like a clown and made me feel better with the remarks you made.

Therapist: Is there anything else that you would like to say or ask?

Client: No, not really.

Conclusion

In the researcher's view there are particularly eight main themes which can be identified within the specific client's experience of provocative psychotherapy. The eight themes are: unexpectedness, being understood, support, freedom of expression, enjoyment, challenge, news of difference and healing. These eight themes clearly emerged from the client's descriptions and particularly from the metaphors which she suggested for therapy, namely, that of plaster or ointment and that of an exciting drink. A ninth theme of a need for

affirmation could also be added to the list of identified themes. These themes will subsequently be discussed in more detail.

The theme of unexpectedness was introduced with Linda's remark that the therapist surprised her with regard to what it is like to be in therapy. She clearly expected a more stereotypical therapist-client relationship with the therapist taking on the role of expert or "doctor." She, furthermore, did not expect to be laughing during the sessions especially not while enduring so much hardship. The therapist's humorous replies and reluctance to provide the client with advice seemingly also came as a surprise to her especially as he 'knew her from nowhere'. She did, however, indicate that she felt understood by the therapist, which introduces the next theme.

The client's experience of being understood seems to be related to specifically two of the techniques employed by the therapist, namely, that of emphasising a positive aspect of the status quo and the use of metaphors. By giving permission to the client to cry by explaining to her that she was in a state of mourning, seemingly provided Linda with an experience of being understood. This left her feeling that the therapist understood her situation at the time. Linda's experience of being understood was further enhanced by the use of the metaphors of mother/child and doormat. She indicated that she felt that these metaphors portrayed her real situation as well as her 'real problem'. She said that the mother/child metaphor accurately portrayed the nature of her relationship with her husband. Also did she have to admit that she had been a doormat who allowed herself to be abused by others. This theme of being understood is obviously closely related to the next theme of support.

With regard to the theme of support, it is clear that the client felt supported by the therapist throughout the course of therapy. This experience was enhanced by an experience of being listened to and understood. The client often remarked that she felt that the therapist understood both her situation and her communications and that he was listening to her story. She also felt that he was considering her issues as real and worth talking about. Connected to this was her experience of being acknowledged as a person by the therapist. She said that she felt acknowledged as she did not feel that the therapist was directly trying to change or correct her behaviour. This particularly seems to be referring to the therapist's "theory" that it was natural for her to cry as she was in a state of mourning. The client thus seemingly felt supported by the therapist's reluctance to attempt to eradicate obvious symptoms or discomfort experienced by the client.

Linda furthermore indicated that the casual, humorous style that was employed by the therapist really fitted with her and consequently enhanced her experience of being supported by the therapist. She said that she realised that the therapist was supporting her indirectly through the way he spoke to her. This experience was seemingly further enhanced by Linda's experience of unconditional positive regard. She indicated that the therapist continuously made her realise that she was not as bad as he seemingly made her out to be. This implies that the accentuating of the negative had a positive effect on the client in that this actually improved the client's self-esteem.

Also related to the theme of support is a theme of freedom of expression. This theme refers to the client's frequent indications that she felt that the therapeutic style made it easier for her to express her thoughts and feelings. This was a specifically meaningful experience for Linda as she described herself as the kind of person who does not easily speak about her problems. She explained that the way in which the therapist treated her and spoke to her during therapy made it easier for her to 'open up'. It was specifically the humorous and casual style of the therapist that was described as helpful in this regard.

The theme of enjoyment is derived from the client's description that she thoroughly enjoyed therapy although difficult issues had been dealt with. She stated that she often found the therapeutic process humorous and that she was able to laugh even while crying. It was particularly the use of the doormat as metaphoric object, which she described as 'funny.' She said that these humorous moments caused her to look forward to attending therapy sessions. The metaphor of a clown that was suggested for the therapist and the metaphor of an exciting drink that was suggested for the therapeutic process further describe the client's experience of enjoyment. The ridiculous dramatisations, however, also often challenged the client, which touches on the next theme of her experience namely that of challenge.

The client reported that she often felt challenged by the experience of psychotherapy. This was specifically true with regard to the metaphors of doormat and mother/son, which were introduced by the therapist. She claimed that these images, paired with the therapist's accentuating of the negative and the positive aspects of the status quo, challenged her to actively change herself. The techniques used by the therapist challenged her to prove him wrong and to show him that she was able to change herself, contrary to his statements. Furthermore, she felt a desire to change her behaviours as the therapist made them seem increasingly absurd through his dramatisations and exaggerations. Enhanced responsibility thus seems to have been the result of these challenges experienced by the client.

Related to the aforementioned theme, is that of news of difference. This can be described as an experience where the client obtained a different view of herself and her behaviours due to the therapist's provocative interventions. It seems as if such experiences were specifically connected to the therapist's use of the metaphors of doormat and mother/son. The client stated that, as a result of the provocative interventions, she started considering her own behaviours more instead of looking to external factors to improve her desperate situation. The metaphors and dramatisations provided the client with an alternative perspective of her situation and behaviours. As a result of this, she came to see many of her behaviours as absurd or ridiculous. She, for example, came to realise and despise her doormat- and "motherly" behaviours. Seeing things differently, thus seems to have been like an "a-ha" experience for the client, which motivated her to change her behaviours and attitudes.

The next theme that was identified by the researcher is that of healing. This theme seems to be closely connected to all the aforementioned themes as all the previous themes seemingly played a role in the healing that took place within the client. Healing as a theme, is derived from the client's frequent statements that the therapy helped her to feel better. This healing was described to have taken place through, among other things, the humorous context that was often created within the therapeutic sphere. The client stated that she believed that laughter in itself could be therapeutic, especially when one is in distress, as she had been. Also the support that she felt, coupled with provocation, seem to have facilitated her healing process. The metaphor of plaster or ointment provided by the client is of course also related to this theme of healing. Healing is furthermore implied by the client's claims of increased responsibility, which she was prepared to accept as a result of the therapeutic process.

A last theme, which certainly also deserves attention is that of a need for affirmation. This theme was introduced by the client's comment about what she did not like about therapy, namely, that the therapist kept on accentuating the negative. She felt a need to also be commended for the progress that she had made in therapy. A desire for the therapist to express faith in her and her abilities was directly expressed by the client. This theme is clearly in contrast to the previously mentioned ones but must certainly be regarded as just as significant with regard to the client's experience of provocative therapy.

At the end of this chapter it would be fitting to note that the themes that emerged from Linda's experience of provocation in psychotherapy flowed from the researcher's idiosyncratic way of drawing distinctions at a specific moment in the research process.

Another researcher may undoubtedly have identified different themes or asked different questions. The specific client's experience of provocation may have been different in a different therapeutic context or with a different therapist involved. The experiences described here were thus, as are the experiences still to be described, specific experiences within a specific context at a specific time and they can not necessarily be generalised to other contexts.

CHAPTER 5

THE EXPERIENCE OF PROVOCATION IN COUPLE PSYCHOTHERAPY

A case study report of a couple therapy, conducted by the researcher, will be considered in this chapter. Once again the background to the therapy case will be provided whereafter the process of therapy according to the researcher's perception will be described. This is to be followed by the therapist's experience of the application of provocative psychotherapy, upon which the couple's experience of provocation will be outlined.

Background to the Case of the Fourie Couple

The researcher first started seeing the Fourie couple for couple therapy after the husband, Allen (50), had been admitted to Sterkfontein psychiatric hospital as an inpatient. During that time, the researcher was completing his internship in the above-mentioned hospital's therapeutic ward. Allen was admitted to this hospital after he had attempted to commit suicide by gassing himself in his room at home. This incident occurred after Retha (40), his wife, had decided to be separated from him after discovering that he had an extra marital affair with a colleague at work. When Retha discovered this affair, she immediately ordered Allen to leave their house. Allen then moved in with the other woman, where he had stayed for about a week, after which that woman decided to return to her ex-husband. This left Allen with no alternative but to move back to the family home where Retha and her 14-year-old son were still staying. Retha refused to stay in the same room with Allen or to talk to him at all. She consequently moved to the guest-room and ignored him totally. Even the letters that he wrote to her were completely ignored. This frustrated Allen immensely and he decided to commit suicide. In a drunken state, Allen one night sealed off the door to his room, opened a gas bottle and lay down on the bed. Retha was alarmed by the smell of gas, which urged her to phone the local police. The police rescued Allen from his room but this caused him to act in an extremely aggressive way towards them. This suicide attempt and consequent aggression led to Allen's admission to Sterkfontein Hospital.

In hospital the researcher initially started seeing Allen for individual therapy. During these sessions he came across as quite aggressive and reluctant to co-operate fully. He displayed a strong external locus of control whereby he especially blamed his wife, Retha, for what had happened to him. He said that Retha continuously accused him of having an extra-marital affair, even though it had never been the case. This, he said, moved him to actually

get involved with another woman. Due to the complexity of this scenario, it was decided to also involve Retha in therapy.

During the researcher's initial therapeutic encounters with Allen, he learned that he came from a family of eight children consisting of two sons and six daughters. Allen was the second eldest after his older sister, Loraine, who, together with her husband, was also his employer. Both his parents, who had been divorced, had already passed away. Allen stated that his relationship with his parents was characterised by severe conflict and after going to the navy, he had never really had any contact with them. The reason for this breach, he said, was his parents' lack of respect for his opinions and desires. His mother apparently wanted him to become a technician and his father urged him to take up a career as a policeman. Allen, however, wanted to qualify himself as a minister of religion. He felt very strongly about the fact that his parents did not respect him and this consequently became a theme throughout the therapeutic encounter.

Allen also stated that he did not have any contact with any of his brothers and sisters except for his eldest sister whom he worked for. He had also broken off all contact with his four children who had been born from his first marriage. His second eldest daughter, however, still occasionally phoned him to enquire about his well-being. A definite theme of breaking off or separating is thus clearly identifiable in Allen's life. This is reiterated by his divorce, which he said occurred because of his ex-wife's adultery. (She apparently became involved with his ex business partner after 16 years of marriage.) The theme of divorce was further amplified by the fact that his eldest sister was also divorced and married to her second husband. This theme was of course, already prominent in the parents' divorce.

It later on became clear that the theme of separation or divorce had also been notably present in the family of origin of Allen's wife, Retha. Her parents had also filed for divorce after 6 years of marriage from which three children, namely, two daughters and one son were born. Retha was the eldest of these three siblings of whom her brother was the youngest. After the divorce, Retha's mother remarried and gave birth to another two daughters. This marriage, however, did not last either and once again she got divorced and later married another man who died after only one year of marriage. All, but one, of Retha's siblings had also divorced their spouses. Her brother and sister just younger than her had both been involved in two unsuccessful marriages. Also her second youngest sister's first marriage ended in divorce. Retha herself divorced her first husband with whom she had three daughters. All three of these daughters had later been removed from Retha's care and placed in foster care. After her divorce, Retha got involved in a relationship with another

man. Her youngest son was born from this relationship. This relationship did not last very long before it was also ended. Soon after the birth of her son, Retha met Allen whom she consequently got married to. The theme of divorce can clearly be seen in the couple's genogram provided at the end of this section.

Allen and Retha had been married for 13 years and they described their marriage as relatively stable with occasional conflicts. The latest conflict with regard to Allen's extra marital affair had, however, given their relationship a serious blow. Retha's youngest son of 14 years had also been living with them since they got married. Conflicts did occasionally arise with regard to this son, but they had never been a major concern for either of the marriage partners.

At the time of the therapeutic intervention, the family resided on a smallholding near Magaliesburg in the North West province. On this smallholding they were operating a small dairy which basically took up all their time, as they were unable to afford any employees. That meant that the whole family was involved in the operating of this farming endeavour. Retha experienced a great deal of pressure as a result of this as she had to manage the farming activities while Allen was at work. Allen worked for a cleaning company, owned by his sister and her husband, situated a fair distance from their hometown. He often complained about the long distances that he had to travel every day and about the poor circumstances at work, coupled with a relatively small salary.

Retha used to work as a sales lady but had to quit this job due to the fact that Allen did not like her to work. He maintained that taking up a job would only provide her with ample opportunity to be unfaithful to him. She then started running a tuck shop on their smallholding in order to supplement their income. This had become necessary as the couple were experiencing severe financial difficulties.

The therapist experienced Retha as a fairly attractive, well-groomed woman who could become very emotional at times. Outbursts of anger as well as tearful spells occurred regularly during the course of therapy. During these outbursts she would often extensively blame those around her for things that went wrong in her life. Despite of this, Retha created the impression of a very strong and resilient person with a definite ability to overcome hardships.

Allen, on the other hand, had been very quiet in therapy although he had also at times demonstrated temper tantrums. The outbursts were experienced as quite manipulative as

they were often accompanied by suicide threats. He also often created the impression that he did not really want to take part in therapy, although he diligently attended all sessions. He exhibited a general sense of dissatisfaction with all and everything, which undoubtedly perturbed the therapist.

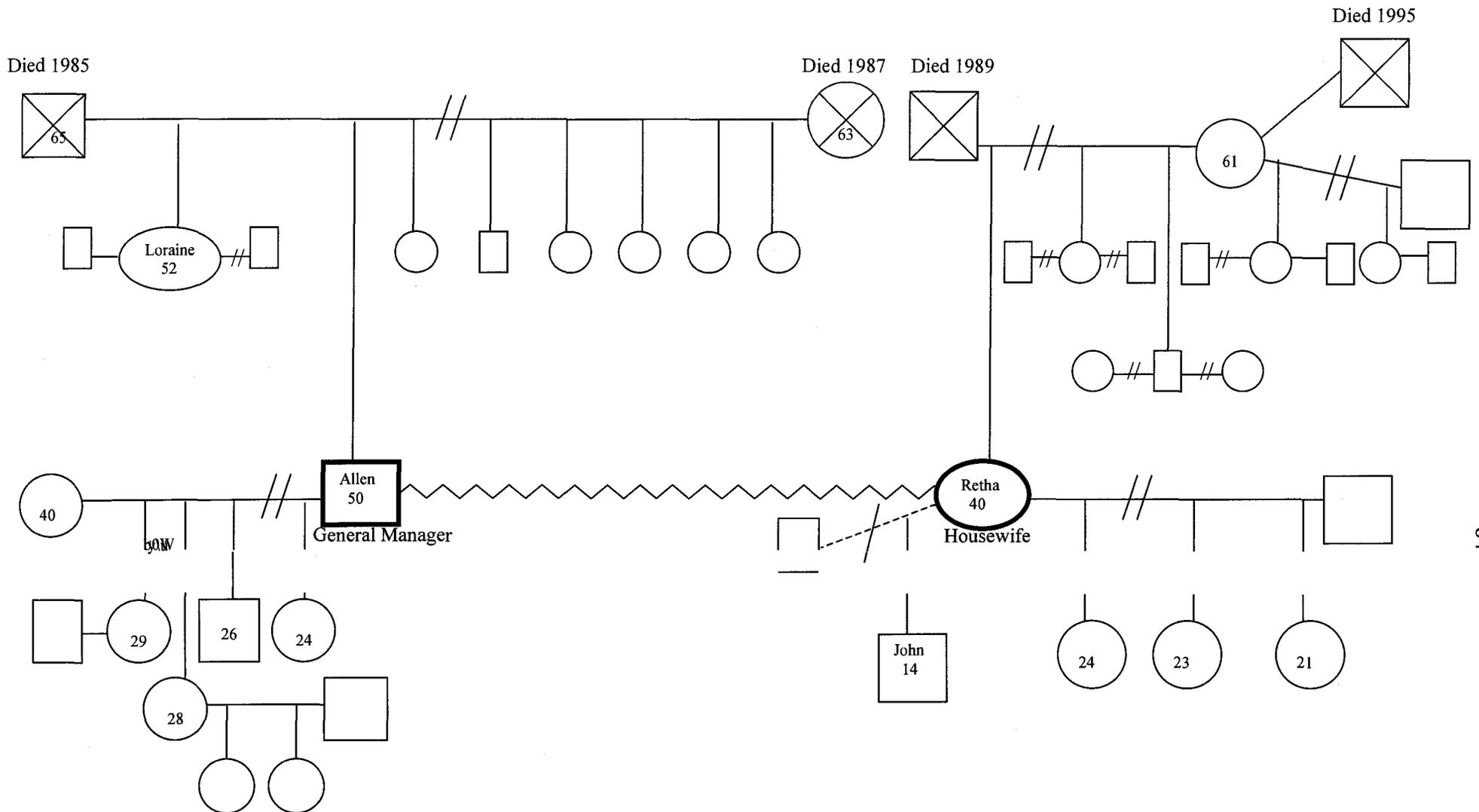
For the sake of clarity, a genogram of the couple's families of origin is provided in Figure 5.1.

The Therapeutic Process

Allen and Retha had been seen for therapy once a week during Allen's stay in Sterkfontein Hospital. Upon his discharge from the hospital, the couple requested a continuation of the couple therapy. This wish was granted and the couple continued therapy with the researcher for another eight months. In total, 24 couple therapy sessions were conducted with this specific couple. Later on, Retha's son, who was still living with the couple, was also included in the therapy. For the purpose of this study, the focus will, however, remain on the couple therapy.

Provocation, as described by Farrelly (Farrelly & Brandsma, 1974) and Andolfi (Andolfi et al., 1983; 1989), was applied by the therapist during this therapeutic process. An attempt was made to define each marriage partner in terms of his or her function in the relationship in order to accentuate their interactional patterns. This was done through the use of metaphor, which played a major role in the conducting of the therapeutic process. The aim of these metaphors was to provide the couple with direct feedback concerning the therapist's perception of them and thus perturb them on the level of their most stereotypical caricatures.

The first metaphor that was introduced by the therapist was once again that of a mother and child. It was said that by being overprotective towards Allen and not trusting him to go anywhere by himself, Retha was acting like an over concerned mother. Allen, on the other hand, acted like the naughty boy by drinking, getting involved in fights and by childishly throwing tantrums such as his attempted suicide. It is also important to note that the way the therapist experienced Allen and Retha's interactions at the time strongly resembled a relationship between a strict mother and a naughty, manipulative son. This experience was communicated to the couple through the use of the above-mentioned metaphor as well as through direct feedback in the form of negative modelling.



Symbols

- Female
- Male
- ⊗ Deceased
- Married
- Romantic relationship
- // Divorced
- ⋈ Offspring
- ⚡ Conflictual relationship
- / Separated

Figure 5.1 Genogram of the Fourie Couple's Extended Families

The therapist sarcastically emphasised this metaphor several times during therapy, especially in the initial stages. The couple, especially Retha, sometimes also referred to this metaphor. It was particularly Retha who said that she was fed up with mothering Allen like a little boy. Yet, the therapist perceived her to somehow be enjoying this role of hers. This was also communicated to Retha and doubt was expressed about whether they would be able to relinquish these roles as both of them seemed to somehow enjoy playing these well-rehearsed roles (accentuating the positive aspects of the status quo).

A second metaphor that was introduced to the couple was that of a nymph and an old man. This metaphor was introduced after the therapist had got the impression that Retha was working very hard at getting Allen's attention and love while he was being very aloof and withdrawn. Related to this metaphor, was the one of their marriage being like a little boat on the sea. The old man steered the boat to wherever he wanted to go, while the nymph just had to travel with him. He sometimes steered the boat into very stormy waters, which frightened the nymph terribly and caused her to feel insecure and distrustful. She, however, wanted to trust him and wanted to row the boat with him. These metaphors particularly emphasised Retha's feelings of loneliness, powerlessness, confusion and mistrust as well as Allen's loneliness and feelings of being alienated from Retha and others.

A last metaphor that is worth mentioning is one that was introduced only later in therapy, which included Retha's son, John. This metaphor portrayed Allen as the boss or owner of a bankrupt farm, Retha as the maid who was in charge of the operations on the farm and John as the "piccanin" who had to run around doing a whole range of tasks. The reason for introducing this metaphor was the fact that the therapist came to realise that each family member was so entrenched in his/her own suffering that no one actually realised that the others were also suffering. What made this situation even worse, was the fact the family was experiencing severe financial difficulties at the time.

Allen was portrayed as the owner of the farm who had to bear the financial burden of providing for his family and who carried the dual responsibility of his job at his sister's company as well as that of farming. He had to leave the management of the farm in his wife's hands during the day while he went to work. When he returned from work he, however, again had to take up the responsibility of managing the farm. This "boss" therefore never had any time off and this clearly exhausted him. More pressure was consequently placed on the "maid" who had to run the farm. She had to exert all her strength to see to it that everything went well on the farm. The "maid" thus felt pressure from two sides: firstly from the "boss" and secondly from being alone on the farm and having to run the farming

operations entirely by herself. She also could not afford to take a rest, as there was no one else to do her job and as she felt obliged to be of assistance to the boss. What she resolved to in this unbearable situation, was to blame both the “boss” and the “piccanin” when things became too difficult. This again placed pressure on the “piccanin” to work even harder. The “piccanin” was also affected by the outbursts of anger, which both the “boss” and the “maid” occasionally had as a result of their stressful circumstances.

It is believed that these metaphors provided ample opportunity for the spouses to speak about the unspoken in their relationship. This was seemingly specifically true with regard to the suffering experienced by each spouse. Retha often used the metaphors as departure points to speak about her experiences of alienation and fear. Also Allen seemed to be able to identify with some of the metaphors, especially the one of the bankrupt farm. This seemingly served as a stimulus for him to speak about the pressurised situation he had found himself in. Where it had otherwise been difficult for him to speak about his feelings, this metaphor seemingly helped him to express himself better. Although the metaphors served as provocation, they seemingly also provided the clients with a sense of being understood.

Metaphoric objects were also introduced into the therapeutic process in order to capture the nature of the couple's interactions. Examples of these were the use of a box filled with blocks, which the therapist threw vigorously on the floor in order to demonstrate the chaotic state of the relationship at the time. The damage done to the relationship was further illustrated by wrapping toilet paper around the couple. The toilet paper kept on breaking upon which the therapist continuously tried to mend it in vain. It was suggested that the chaos at least provided some excitement in their otherwise boring lives (accentuating the positive aspects of the status quo).

Apart from metaphors, humour had also been utilised regularly. This was done by the telling of jokes which implied the clients and by mimicking the clients' ridiculous behaviours. Both Allen and Retha's behaviours were mimicked by the therapist: Allen's childlike tantrums and stubbornness and Retha's emotional outbursts. This served as a form of direct feedback to the clients and it was complemented by questions such as, “Since when have bitching and whining become your favourite pastime?” Direct feedback was also supplied by comparing the clients to another couple seen by the therapist. The other couple's situation was grossly exaggerated and portrayed as similar to the situation of the Fourie couple. Feedback was furthermore provided by the use of ridicule in the form of calling the clients names such as “bitch” and “Martie martelgat.” The aim of these forms of

direct feedback had always been to provoke the clients into asserting themselves and modifying their destructive behaviours.

Emphasising the negative while accentuating the positive aspects of the status quo had also been regularly used during the course of this therapeutic process. The therapist, for example, said to the couple that they were perhaps continuously quarrelling because that was simply the way they fitted together as a couple. It was implied that they might have been different from most people in that they had to quarrel in order to stay together. Quarrelling was portrayed as the bond that kept them together and they were therefore also at times encouraged to quarrel. Destructive behaviours such as distrust, continuous quarrelling and blaming were often enjoyed, applauded and exaggerated through dramatisations rather than discouraged directly. Locker room language was also utilised in the implementation of these provocative techniques. These therapeutic endeavours were often met with surprise and laughter by the clients.

Provocation was coupled with support during this therapeutic process by again employing both direct and indirect strategies. Because of the severe pain and confusion displayed by the clients during the course of this therapeutic process, several direct attempts were made by the therapist to assure the clients of his belief in their inherent strengths. The therapist did this by, for example, expressing his amazement at the couple's continuous efforts to save their marriage when other people whom he knows, would have given up long ago. Statements like these assured the couple that the therapist was for them and not against them. It is believed that also the humour employed by the therapist provided the couple with a direct sense of support. This was further enhanced by the occasional use of touch and an attitude of sincere interest and perseverance.

Support was provided in an indirect manner specifically by portraying each spouse's situation in a very overt and emotionally intense way through the use of, among others, metaphors and dramatisations. It is believed that this gave the clients a feeling of being understood while perturbing them simultaneously. The therapist's experience of this process will subsequently be described.

The Therapist's Experience of the Use of Provocation in Couple Psychotherapy

Conducting therapy with Allen and Retha was extremely provocative for me as therapist. I often felt discouraged and bowled over in my own game. So much anger and hurt were displayed during the course of therapy, that at times, it provoked in me a desire to

flee. It was consequently difficult for me to stay in therapy and to keep on provoking a system that had already been severely provoked by the extra-marital affair, attempted suicide and consequent hospitalisation of Allen. What further complicated this situation, was the fact that both spouses occasionally demonstrated severe emotional outbursts during therapy.

The challenge for me as therapist was not to get drawn into the couple's conflict by getting emotionally involved in their arguments. I had to concentrate on remaining neutral and unpredictable, particularly because of the unpredictability of the couple's behaviours. I specifically remember how Allen smashed his hand against the wall, causing blood to splash onto the wall during one of our initial couple-therapy sessions. At the same time Retha became so emotional that she stormed out of the room. Incidents like these really perturbed me, especially in the beginning of therapy. At that stage I felt uncertain whether I should further provoke the couple or whether I should not have just reflected their feelings and comforted them. However, I attempted to continue provoking the couple while also holding or supporting them. The aim was to support the individuals while provoking the system. Although I continuously attempted to persevere in striving to reach this goal, it was very difficult at times. I think the reason for this was because I, especially in the beginning of therapy, was taken aback by the couple's manoeuvres. I was very sensitive to the turmoil that the couple was going through and was concerned that I would harm them further through my provocations.

The use of metaphors and metaphoric objects certainly helped me a great deal in refraining from getting drawn into the couple's conflicts too much. By using these techniques it enabled me to confront the couple more effectively with their own behaviours without preaching to them or directly pointing to mistakes. I believe that the use of the metaphors and metaphoric objects also made it easier for the couple to reflect on and talk about their own behaviours and feelings. The reason for this, I believe, is the fact that this redirected the tension away from a specific individual to the couple system as a whole. Blaming was thus partly illuminated by the use of these techniques.

Although this process had often been very difficult, it also had its fun moments which made me laugh spontaneously and which I enjoyed thoroughly. It was specifically the dramatisations of the couple's destructive behaviours that were thoroughly enjoyed. These dramatisations normally brought up new themes or feelings for discussion.

Something else that really touched me was when, during one emotional session, both the spouses cried in immense pain whereafter they laughed through their tears at themselves. It touched me to see that people with such immense pain could still laugh together. This made me feel more hopeful on their behalf. The use of locker room language by both the therapist and clients also made therapy very funny at times and brought light into an often sombre situation.

Upon reflecting on the course of this therapy, the metaphor of a seesaw comes to mind: At times it was really difficult, which made me feel stuck and on a "low". At other times, it was great fun and I felt that we were making progress, which again helped me to experience a therapeutic "high." In retrospect, I must say, that I think the "lows" were especially bad when I tried too hard to take responsibility for the clients in order to "cure" their relationship. This placed a heavy burden, which I found very difficult to carry, on me. The "highs", on the other hand, often occurred during times when I was able to relinquish responsibility for curing the couple of their symptoms and just attempted to enjoy their symptoms. During these times I would play with the symptoms, exposing them and examining them from a different angle with an attitude of irreverence. This certainly freed me from the responsibility I placed on myself and it was during these times that I noted how the couple would take more responsibility for their own behaviours and growth.

In conclusion it can be said that this was a very difficult therapy to conduct and it often provoked me more than the clients. In the beginning, I was very reluctant to continue with this therapy, but it somehow grew on me. It taught me to relax, to trust the clients more with their own abilities to heal themselves and to be, like Farrelly and Andolfi, less impressed with clients' fragility, so that I can support the individuals while continuously provoking the system.

The Couple's Experience of Provocation in Psychotherapy

The couple's experience of provocation will be presented by means of verbatim extracts from an interview conducted with the couple on 14 February 2000 at UNISA. As the original interview was conducted in Afrikaans, the researcher translated the original dialogue into English. The translated version of the interview was consequently transcribed by the researcher, categorised in terms of the selected headings and once again analysed for emerging themes. After this, the researcher went back to the couple to ask about newly arisen questions as well as to discuss the identified themes. The reader's attention is once again drawn to the fact that the verbalised experiences can only be considered in terms of

the specific context in which they occurred. The aim is thus not to draw any generalisations from these specific experiences as they are viewed as context bound.

Reason for Therapy

Therapist: From what you can remember now, what was the reason for your initially seeking therapy?

Husband: Because I was in Sterkfontein.

Therapist: Why were you admitted to Sterkfontein?

Husband: Because I attempted to commit suicide.

Therapist: What was the reason for the suicide attempt?

Husband: My wife got a court order against me. The court order stated that I was not allowed to harm her or the child, also that I was not allowed to remove any shared assets from the property. I don't remember what else. My wife chased me out of the house, so I took my stuff and moved in with the other woman. Soon after this, the woman landed up in hospital because of a work-related injury. I then moved in with my sister but heard from a magistrate that I was permitted to still live in my house so I decided to move back into the house. After moving back to the house, Retha ignored me completely.

I was in the room where I was staying by myself, having a few drinks. I don't know what happened to me, but I just felt that I didn't want to live anymore. I felt alone because the other woman went back to her ex-husband and Retha was not talking to me. There was a gas bottle in the room. I sealed off the door and put a wet towel underneath the door. I then opened the gas bottle and went to lie on the bed. I continued drinking at this stage. Later on, the police arrived and I was very aggressive towards them because they didn't want to allow me to do what I wanted to do. I was then admitted to Sterkfontein Hospital. I was very upset when I was admitted to Sterkfontein Hospital. I felt that Retha did not want me anymore but she also didn't want

me to do what I wanted to do. You started to do therapy with me in Sterkfontein Hospital and later called Retha to join us for couple therapy.

Wife: We just couldn't cope anymore. When Allen was in hospital, everything fell apart.

Expectations of Therapy

Therapist: Before participating in therapy, what did you expect therapy would be like?

Wife: I thought the psychologist tells you this and this is your mistake and you can do this and this to correct it and this or that is another alternative. Basically that he shows you the road you should take.

Husband: I thought that a psychologist is a person who supplies you with solutions.

Therapist: How was therapy different from what you expected it to be?

Wife: You didn't show us which road to take. Basically, you only showed us what the situation was and we had to find our own way through it.

Husband: Basically in the same way than for Retha. You didn't provide us with solutions, you made us look for solutions. You identified the problem and said: "This is the problem, find a solution for it." Often, it also was as if you were saying to me: "If you want to do something, do it. Do as you please." You didn't try to convince me to not do something that was bad for me. This was quite unexpected.

I also didn't think it would be so funny. The thing with the bankrupt farm was particularly funny.

Therapist: Were your expectations met?

Wife: Yes, you made me realise why I felt the way I did and why I reacted the way I did. You helped me to understand things that confused me.

Husband: Yes, I felt that my problem was identified and that you provided me with the means to deal with my problems.

Reconstruction of the Therapeutic Process

Therapist: Which themes, topics or processes of therapy can you remember?

Husband: I remember how you used a box filled with blocks saying that this is how Retha had given her heart to me and I threw it out on the floor by having an affair. This made me realise that I was wrong. It felt as if you were showing us the issues and it was our responsibility to correct them. I can specifically remember that I came to realise that each one of us saw things only from our own perspective. Each one of us only heard what we wanted to hear. I really took this to heart and I am trying to listen to Retha in a more efficient way and not to only jump to my own conclusions.

I can also remember the story about the boss, the piccanin, and the maid on the bankrupt farm. The maid worked herself to death and blamed the piccanin when things went wrong. The boss was upset with the maid when she didn't do what she was supposed to do and no one on the farm took a rest because everybody worried too much and worked too hard.

Wife I specifically remember the incident with the toilet paper. You took the toilet paper and you said that we built a house while wrapping the toilet paper around me and Allen. While doing this, you tore the toilet paper and then you said to us that we wanted to mend our house and you tried to make a knot with the toilet paper upon which it broke again. You then said that it was the same way with us when we tried to mend our relationship, it kept on breaking. This exactly said how I felt. It felt as if there was this marriage which broke up and which Allen was trying to just mend instantly and I felt that it didn't work like that. I can also remember that you used a metaphor for our relationship. It was a metaphor of a boat that we rode in and this boat rocked at times. For me it was so bad at times that I felt that I was going to drown. I also remember the metaphor of the nymph: that I was dancing around Allen and that he was like an old man who just didn't want to know anything. It was exactly how it felt for me. I tried everything I could to get Allen's attention and

to win his love but it felt if he just was not interested at all. At that stage he was still very fond of this other woman; he couldn't really break away from her.

I can also remember that you used a metaphor of a mother and a little boy, you said that I was like a mother to him and he was like my naughty son. I also remember that once when I cried a lot about what had happened. I said that I hated Allen and upon saying this, you started clapping hands at me. For the first time I could express my emotions and you allowed me to do that. I then came to realise that I did not hate Allen for being what he was but for what he did. This encouraged me to speak about my feelings.

I can also remember that you said to us that you thought that maybe we had to fight. You said that that was the way our relationship worked, it would always be like that, but this made me realise that this fighting of ours is not real fighting, it is actually just blaming each other, throwing mud at each other. You made me realise that I had to look at the real issues. I realised that often when we fought, we brought up old issues, which were not helping us at all.

I also remember that at one stage you told us that we had to go and fight but then we couldn't fight. This made me very tense because I realised that you were actually saying that we shouldn't fight and that caused me to hold back. This was not a good experience for me.

I also remember the story about the boss and the maid and John was the piccanin who was running around the farm. The boss drove out of the gate, thinking to himself: "Thank God, I leave them here." When he returned at night, he complained about everything that was not right. I was the maid who was described as a go-getter and who worked very hard. No one listened to the others.

Experience of the Therapeutic Process

Therapist: Would you have preferred me not to open up your feelings and experiences?

Husband: No, because then I would just have closed in and then I would never have been able to get over it.

- Therapist: In general, how did you experience therapy?
- Wife: I got to understand my own feelings and to understand why I reacted in the way I reacted. Because you were an outsider, you saw the situation from another perspective. You showed us that this was really the situation. You pointed out to us what we couldn't see. Allen and I only saw this hole and we didn't know any further. Through your acting you created a picture of what it looked like and that made me realise how someone else, as an outsider, must perceive us. When you said certain things and demonstrated them, I realised that that was the way I felt and that was why I reacted in the way I did. I also remember that you spoke about a process of mourning.
- Therapist: What was that all about?
- Wife: When I said that I couldn't trust Allen, you said that you could understand that and maybe I should not trust him. You said that it was a mourning process and there's a theory that says the mourning process takes about two years. You didn't try to take away my pain. You just showed us things but you never gave us answers on how to solve our problems. You never gave us answers. Whenever I asked how I should do this, you always said "I don't know." You opened up the problem instead of trying to take it away. You rather exaggerated it.
- Therapist: When I did this, didn't you sometimes feel frustrated that you were not supplied with answers?
- Wife: Yes, it frustrated me a lot at that stage. I was frustrated because you didn't supply me with answers. You didn't even give me direction, not even an indication of where we should be going. I just wanted someone to tell me to try this or that.
- Therapist: Allen, what was your experience of the therapy?
- Husband: In the beginning when I got to Sterkfontein, I felt that the team there thought that there was something wrong within my head. I had to go for CAT scans and such things. The problem was with me and not within my head. You didn't want me to overcome the problem but wanted to ascribe it to something

else within my head. But later in therapy I felt that we had identified the problem and you, as the therapist, wanted me to resolve this problem.

Therapist: When did you come to this realisation?

Husband: It was about after a month in Sterkfontein that I came to realise this. I then felt that the problem was being identified and that you were going to help me to solve it. Maybe not as much help me, but providing me with the means to deal with my problems.

Therapist: What do you think was the real problem?

Husband: The problem was the shit that I caused.

Therapist: How did you come to realise that?

Husband: I realised that after about a month in Sterkfontein. In the beginning it felt as if everybody just wanted to get me into Sterkfontein because I wanted to commit suicide because I drank a lot. I just realised that it was not other people who made the trouble, but it was me. I would not have been in Sterkfontein if I hadn't caused the trouble. If I hadn't had an affair and neglected my marriage, I would not have been in Sterkfontein.

Therapist: Had there ever been moments in therapy that were funny or ridiculous?

Husband: Yes, as I said the story of the bankrupt farm was quite funny.

Wife: Your dramatisations were funny. You also continuously made funny remarks.

Therapist: If you had to explain to someone else what therapy was like, how would you do that?

Husband: It is difficult, but I will recommend it to others because it helps you to see things differently. Some metaphors helped me to gain this insight. I came to realise what the maid must have felt like because I felt like the maid at work.

Wife: It was difficult, every time. Things that were inside me came out and I hated it. Things came out which I would rather have wanted to keep inside. But it was also an eye-opener because when you are in a situation you don't really see what is actually happening.

Therapist: Did the therapy have any effect on you?

Wife: Yes, it changed a lot in our relationship. I stressed a lot about this thing that Allen told me to do this and that and when he came home he used to ask: "Why didn't you do this or that? What did you do all day?" That stressed me out. I just decided to take a rest. I realised that I was a go-getter and that I was also placing pressure on myself to work hard. I just decided, "Fuck that, fuck everything!" I just decided to relax and to forget about everything.

Husband: It was interesting. I came to realise that we were ignorant of each other's problems. I just took it for granted that Retha was at home and that she looked after the cattle. I came to realise that she was experiencing the same problems at home as I was experiencing at work. When she spoke about her problems, I thought to myself: "That is exactly how I feel at work every day." You don't always realise that the next person is experiencing the same problems as you are.

The metaphor you used was funny. It created a picture in my mind of the situation at work. At work I am like the maid, the owner is like the boss and the workers are like the piccanin. The workers don't want to do their work and the boss doesn't want to do his work, so I have to do everything. I came to realise what it must be like for Retha. It made me think: "Are we not in exactly the same situation?"

Therapist: Did you feel challenged in therapy?

Husband: Yes, I didn't quite feel comfortable with the metaphor of mother and son. At first it felt as if it was not quite what it was like in our relationship and made me feel uncomfortable because I felt that I was being humiliated for not taking responsibility. Inside me I felt: "What do you anyway know about me? I can take responsibility." I felt determined to prove you wrong. What I said all along while being in Sterkfontein, was that no one in Sterkfontein could do

anything for me, I was the only one who could help myself. They could help me to do something for myself but no one could do anything for me. I felt determined to do something about it because I don't want people to think that I am a little boy.

Wife: I also felt challenged by the image of the mother and son. I felt I didn't want to be a mother to Allen, I was sick and tired of mothering him. I also felt challenged when you called me a "bitch" and "the maid." I realised that I did not want to be like that, I don't always want to bitch and moan.

Therapist: What did you not like about the therapy?

Husband: I didn't like the therapy at all. Everything about therapy was not nice. I did not enjoy it at all. I just wanted to forget about it. I wanted to forget about everything that happened and carry on with my life and I felt you just wanted to open it up again. I just wanted to forget about it and get on with my life. It felt as if I was continually hurting. You continuously focussed on the bad things that happened and I had to speak about them.

Therapist: Why did you then keep on coming to therapy?

Husband: Because it helped me.

Therapist: How did it help you?

Husband: Not only because it hurt, but also because it helped me to gain more insight into what I had done and about how Retha felt about what I did. I went to therapy because I realised that I needed it and because you helped me. Because, in reality, you helped me, but I hated it. I hated it because it hurt. I felt confronted with myself because I started seeing myself from another angle. I started seeing myself as the real person that I was.

Therapist: And you Retha, what did you not like about therapy?

Wife: I did not like it when you said to us that we had to go and fight. I knew you meant the opposite and that put pressure on me. I also sometimes felt awkward when I left therapy, like the time I cried so much. I didn't like to cry.

Therapist: What did you like about therapy?

Wife: The fact that I could express my anger and hurt. Also the metaphors you used because they exactly portrayed the situation and my feelings.

Husband: The fact that you provided us with a different view of our situation and the humour.

Therapist: What was difficult in therapy?

Wife: I never knew what was going to happen in therapy. Every time things that were inside of me came out, things which I would have preferred to keep inside. All the emotions that came out were difficult to handle. It was also difficult to trust you because you were a stranger and a man.

Husband: It was very difficult to talk about the affair and about everything that happened. I just wanted to forget about everything.

Therapist: What was easy in therapy?

Wife: It was easy to identify with the metaphors you used. It felt as if you described the situation exactly how it was. The story of the bankrupt farm, for example, was exactly how it was in our family.

Husband: The metaphors made it easier for me to also see Retha's side of the story. It also made it easier to talk about difficult issues.

Therapist: What metaphor would you ascribe to therapy?

Husband: For me therapy was like a hiding, a hiding which a father gives to his son. It was not nice, but it was necessary. I went to therapy because it was necessary and it is the only way through which one can solve something.

Wife: For me it was like the story of the Chinese. The one Chinese stood on the bridge and the other Chinese passed by and gave the one on the bridge a fish. Thereafter another Chinese passed and gave the one on the bridge a

fishing rod. So the one said to the other, "Why are you giving him a fishing rod?" He replied, "You can give him a fish and he will have food for today, I gave him a fishing rod so that he will have enough food for tomorrow." In other words, what you did, was to point out the problem to us, to open it up and to examine the whole thing and we had to take the fishing rod to go fishing to see what we could do about the problem.

Experience of the Therapist

Therapist: Did you feel supported by the therapist?

Wife: Yes, I did feel supported. I felt that you wanted to help me but you were giving me all the hell. It felt to me as if you were just showing me what I had been doing wrong and that's it. Although you were saying that I was a bitch and all those things, I never got the impression that you didn't support us.

Husband: At first I thought that you were just helping me because it was your work, but later I came to realise that you really cared. And you really wanted to help Retha and me so that the two of us could sort our things out. I got the impression that you really cared and that it was not just a job for you. You were not only doing it because they said: "That's your patient and you must look after him." On the one hand I felt that you challenged me but on the other hand I also felt that you cared.

Therapist: How did you realise that I really cared?

Husband: I realised that you really cared for Retha and myself to get together again. I had an experience that you didn't think that I was just another patient. It was as if you wanted to help us.

Therapist: Did you feel that you could trust the therapist?

Husband: Yes, all the time. In the beginning maybe not completely because I was uncertain about you but thereafter definitely.

Wife: No, you were just another man. It was difficult, the fact that you were a man and I normally don't speak easily about my feelings. It was difficult to trust

you. The one time I went for therapy I was thinking to myself: "I wonder what is going to happen now and how I am going to be torn apart again." Sometimes I didn't want to go, but I am glad that I did go because it was good for me. But I learnt to trust you in a way. This was not an easy experience. It was rather difficult. You often reacted in an unexpected way, like when Allen threw his tantrums, you just ignored him. Every time he had a shit attitude, you didn't fall for it. You were quite unpredictable.

Therapist: And you Allen, how did you see it?

Husband: You were not very predictable, you were not easily manipulated, I would say.

Therapist: What metaphor would you ascribe to the therapist?

Husband: That of a bank manager, because we were bankrupt and you helped us out of it. You did not give us money but a new way to see our situation.

Wife: A stranger or outsider who gave us a fishing rod to catch fish with so that we could help ourselves to survive. You did not give us advice but helped us to see our situation differently so that we could help ourselves.

Conclusion

From the above interview the researcher identified the following themes: Discomfort, challenge, helpfulness, news of difference, being understood, humour, unexpectedness, support and freedom of expression. Each of these nine themes will be discussed below.

A very prominent theme that evolved during the interview is that of discomfort. The clients often admitted that they both felt uncomfortable throughout the course of therapy. Both of them specifically said during the interview that they did not like being in therapy or that they even hated it. The main cause of this discomfort seems to have been the exploring of their relationship which had been extremely conflictual, especially due to the extra-marital affair. It seems as if it was very difficult for Allen to talk about this topic as it reminded him of a stage in his life that he would rather want to forget. Retha similarly wants to forget about this period in their relationship, as she felt humiliated by what had happened. The adultery brought up so much hurt and anger that she felt she could not deal with it so that she rather

wanted to avoid or suppress it. The therapist's attempt to bring forth the issues of distrust and loneliness were thus met with reluctance and extreme discomfort.

Allen described his experience of discomfort with special reference to the metaphor of mother and son. This metaphor, he said, caused him to feel humiliated, probably especially because it was introduced in the presence of his wife. He clearly did not want to be seen as his wife's naughty son, as this made him feel uncomfortable. His discomfort was also described as a result of the fact that he came to see himself and his behaviours in a new light, which he did not always like. Retha's discomfort, on the other hand, was especially related to the experiencing of intense emotions of particularly anger and sadness as a result of her husband's extra marital affair. She did, however, also experience discomfort because of her assigned roles of 'mother' and 'maid' who bitched a lot. This discomfort was further exacerbated by the fact that she at first felt that she could not trust the therapist, as he is also a man. Because of her personal history she finds it particularly difficult to trust men.

Retha also indicated that she experienced discomfort with regard to the therapist's paradoxical intervention of instructing the couple to quarrel. She said that this put a lot of pressure on her, as she knew that the therapist meant the opposite and she thus vigorously attempted not to quarrel with her husband. Retha consequently said that she did not like this pressure. The pressure was further increased by the unpredictability of the therapist as she indicated that she often wondered what was going to happen next in the therapy. She said that she sometimes went to therapy thinking: 'I wonder how I am going to be torn apart again today?'

The couple's discomfort was apparently further exacerbated by the reluctance of the therapist to provide them with advice. Both spouses indicated, on more than one occasion, that the therapist was reluctant to provide them with direct advice, direction or solutions. Instead he focused on their problems and even exaggerated them. This was contrary to their expectations and often led to frustration. They did, however, indicate that this lack of advice challenged them to take more responsibility for themselves and search for their own solutions to their difficulties. This already touches on the next theme, which will consequently be discussed.

Being challenged to take responsibility for their own behaviours, is another prominent theme that evolved from the conversation with the couple. It is specifically Allen who indicated that he was challenged during therapy to take more responsibility for his own behaviours. This was clearly indicated by statements such as: 'The problem was the shit

that I caused.' In the light of his earlier lack of responsibility, this change in attitude can be regarded as particularly relevant.

Allen also admitted several times that the therapy helped him to see the mistakes he had made in the past and that he felt motivated to correct these. Some of the mistakes which he felt he had to correct were the fact that he only saw things from his own perspective and that he failed to consider his wife's situation. He claimed that he was now trying to listen more to his wife and to consider her situation more. It seems that what particularly provoked him into taking more responsibility was the fact that he related the metaphor of the bankrupt farm to his situation at work. This apparently provided him with better insight into his wife's situation and consequently challenged him to take more responsibility for his own behaviour.

The metaphor of the little boy seemingly challenged Allen into taking more responsibility for himself. He admitted that this metaphor made him feel uncomfortable and that he consequently wanted prove that he could take responsibility for himself.

Retha also indicated that she felt challenged or provoked during therapy to take more responsibility for herself. She admitted that she felt challenged to take responsibility for her own behaviour instead of blaming her other family members for things that went wrong. She also described how her attitude changed in order to concentrate less on others' needs and more on her own. This apparently caused her to be more relaxed. Retha, furthermore, indicated that she felt challenged by the role of mother that was ascribed to her. She admitted to being sick and tired of mothering Allan and that this made her determined to change this role of hers. She furthermore admitted to being challenged by the direct feedback received from the therapist in the form of the metaphor of the maid and the portrayal of her as a bitch. She said that this made her realise that she did not always want to bitch and moan.

Apart from feeling challenged, both spouses also indicated that they found the therapeutic process to be helpful. This introduces the theme of helpfulness. Both Allen and Retha indicated that they found therapy helpful in that they were provided with means to deal more effectively with their experienced difficulties. For Allen, the helpfulness of therapy was related to the new insights he gained as a result of the therapy. Although he did not experience therapy to be pleasant, he did, however find it helpful as he started seeing himself as 'the real person that he was.' He therefore ascribed the metaphor of a hiding to the process as he experienced it as something that was unpleasant, yet necessary. The metaphor of bank manager that he ascribed to the therapist also touches on the theme of

helpfulness. In his explanation of this metaphor, he stated that the therapist helped them out of their bankruptcy by helping them to view their situation in a new light. Retha echoed this idea through the metaphor she ascribed to both the therapeutic process and the therapist. Through the introduction of the metaphor of the Chinese who gave them a fishing rod to fish for themselves, Retha explained how the therapist helped them to help themselves. According to her, he did this by providing them with a different view of their situation which also introduces the next theme to be discussed.

The theme of news of difference clearly emerged from the researcher's conversations with the couple about their experience of provocative psychotherapy. Both spouses indicated on several occasions that they came to see themselves and their behaviours in a different light as a result of the therapeutic process. They furthermore indicated that they felt that the therapist revealed issues to them to work with which they did not consider previously. In other words they came to perceive the essence of their difficulties in a new light. Of specific interest here is Allen's declaration that he came to realise how similar Retha's situation was to his own. He declared that he realised that Retha's situation at home was very similar to his situation at work where his role was that of the 'maid.' Furthermore, he indicated that the therapy helped him to perceive both his own and Retha's behaviours in a new way. In this regard, it is also significant to note that Allen came to see his own behaviours as contributing to the difficulties in their relationship. This is quite different from his initial stance where he forthrightly blamed Retha for his mistakes. He also obtained more insight into Retha's situation, which led to more empathy with her situation and consequently increased consideration for her difficulties.

The perspective of an outsider was also of use to Retha. She stated that this helped her to understand her own feelings and behaviours better. Apparently it helped her to accept her feelings more, to demonstrate them and to work through them. It was especially the emphasising of the fact that she pressured herself to work so hard that apparently provided her with new insight into her own behaviours and frustrations. This different view of herself brought her to a point where she could relinquish some of the responsibilities she solely took on herself. The result of this was that Allen started taking on more of these responsibilities and started understanding her situation better.

Related to the theme of news of a difference, is that of being understood. It was Retha, in particular, who indicated that the techniques used by the therapist provided her with an experience of being understood. She said that she could easily relate to the metaphors used by the therapist as she felt that those accurately portrayed the real situation.

Metaphors mentioned here, were those of the nymph and old man, the mother and son as well as the boss, maid and piccanin. Also the metaphoric objects used, such as the blocks and toilet paper apparently provided her with assurance that the therapist understood her situation. Retha often said during the interview that the therapist's portrayal of the situation was exactly how it was for her or that it portrayed exactly what she was thinking. This reminds of Farrelly and Brandsma's (1974) remark that clients often indicate that the provocative therapist portrays their situation so accurately that it seems as if the therapist can read their minds or that he/she had spoken to their family members.

Allen also indicated that he felt that the therapist understood their situation as he often said that he felt the therapist accurately identified their real problems. He furthermore stated that he too could relate to the metaphors and metaphoric objects used by the therapist. It was in particular the metaphor of the bankrupt farm that he could easily relate to as this reminded him of his situation at work.

Both spouses indicated that they experienced the therapeutic process as humorous at times. Although this experience was not as strongly felt as in the individual therapy discussed in the previous chapter, it still remained a theme brought up by the couple. It was Allen who brought this theme up more than Retha did. He indicated that he experienced the metaphor of the bankrupt farm as particularly humorous. For him, the humour in this metaphor lay in the similarities it had with his situation at work. The humour in therapy clearly came as a surprise for Allen as he admitted that he did not expect therapy to be humorous. His wife, Retha, also indicated that she found the therapist's dramatisations as well as some of the remarks he made humorous.

The theme of unexpectedness has been a major theme during the couple's narration of their experience of provocation in therapy. Occasionally, the couple pointed out that therapy was quite different from what they expected it to be. Apparently it was particularly different from their expectations with regard to the role of the therapist. They both indicated that they believed that the therapist would provide them with direct advice or solutions.

Allen indicated that he found it unusual for the therapist not to be taken aback by his suicide threats. He indicated that the fact that the therapist said to him that he could commit suicide if that is what he wanted to do, endorsed his decision to not take such drastic procedures. As a result of this, he described the therapist as 'not easily manipulated.'

Retha echoed this by stating that she found it unusual for the therapist not to pay attention to Allen's tantrums like when he smashed his hand against the wall with blood splashing on the wall. She stated that the therapist reacted in an unexpected way when he ignored Allen's tantrums and negative attitudes.

Despite the fact that both spouses indicated that they felt provoked during the course of therapy, both of them also admitted to feeling supported by the therapist. Retha said that she felt understood and because she could tell from the therapist's attitude that he was on their side. Allan agreed with this, saying that he sensed that the therapist was committed to helping them to resolve their conflicts. He specifically indicated that his experience was that the therapist did not only regard him as just another patient but that he really cared about them.

Related to the theme of support is that of freedom of expression. It was mainly Retha who indicated that she felt that the therapy provided her with an opportunity to express her emotions. She explained that therapy provided her with an opportunity to especially express the anger and hurt which she had felt. Also Allan indicated that he felt that the therapeutic context enabled him to 'talk about difficult issues.' In his case, it was specifically the introduced metaphors which enhanced his freedom of expression.

Upon considering the above themes, it is interesting to note how each spouse tended to emphasise different themes in their descriptions of their experience of provocative psychotherapy. Although both of them indicated that they experienced extreme discomfort at times, they particularly displayed nuances in their experiences of feeling understood and of news of difference. It seems like Retha emphasised the theme of feeling understood more so than Allan. The metaphors used by the therapist seemingly provided her with an experience that the therapist understood her difficult situation. The same metaphors, however, enhanced Allan's experience of getting new insight into Retha's situation and consequently provided him with an experience of being challenged.

These nuances in the spouses' experiences clearly illustrate the impossibility of talking about an absolutely objective human experience. It highlights the fact that each person's experience is unique as it is coloured by the perceiver's existing attributions of meaning and idiosyncratic ways of experiencing (Von Glasersfeld, 1984). This will further be illustrated in the next chapter where the experience of provocative psychotherapy within a family therapy context will be considered.

CHAPTER 6

THE EXPERIENCE OF PROVOCATION IN FAMILY PSYCHOTHERAPY

As in the previous two chapters, the experience of provocative psychotherapy will once again be considered in terms of a specific case study. This time the focus will, however, be on the experience of provocation in family therapy. Background information will be supplied to the case of the specific family that was seen by the researcher, whereafter a description of the therapeutic process will follow. The therapist will consequently relate his experience of the therapeutic encounter, which will be followed by a discussion of the family's experience of provocation in therapy.

Background to the Case of the Du Toit Family

The Du Toit family was seen for therapy by the researcher after the son Peter, was admitted to Sterkfontein Hospital. Peter was admitted to this hospital after several psychotic episodes over a period of two years. Initially he was seen for individual therapy upon which the therapist decided to involve the family in therapy too. The decision to include the family was based on the reason for the patient's admittance to Sterkfontein hospital. The reason for admission was the fact that he physically attacked his father while being in a state of psychosis. He assaulted his father because he believed his father had an affair with a girl whom he (Peter) was in love with.

Upon starting family therapy, the therapist learned that Peter (21) was the youngest of three children of whom the eldest was a girl and the middle one a boy. Peter's brother (27) worked as a journalist and lived on his own. He had a girlfriend in America. His sister (29) had been married for four years and had a 5 month old baby girl. Peter was six years younger than his brother and eight years younger than his sister. The mother explained this age gap in terms of the death of her younger brother. Her brother, who was her only sibling, died at the age of 31 in an aircraft accident. This, she said, caused her and her husband to decide to have another child as they realised how easy it could be for a family's offspring to get killed. Peter was consequently born about a year after the death of his maternal uncle.

His mother reported that Peter had normal developmental milestones and a happy childhood. He was, however, prescribed Ritalin for hyperactivity as a primary school boy. At the beginning of his grade 9 year, Peter commenced his schooling in Cape Town at a private

school which his father also attended during his high school years. This meant that he only saw his parents, who still lived in Johannesburg, during holidays. Peter described this period as very lonely and that he consequently often missed his family in Johannesburg. He says that his father promised that they would move to Cape Town, which they never did. During his grade 11 year he started smoking marijuana. This, he claimed, had been as a result of peer pressure.

Peter's academic progress at school had been satisfactory although his marks were not good enough to meet the entry requirements for a B. Com. (Accountancy) degree course, which he was planning to enrol for. He consequently enrolled for a regular B. Com. degree at the University of Cape Town where he stayed in a university hostel.

During this time Peter started taking drugs such as marijuana, ecstasy and cocaine on a regular basis. His first psychotic episode also occurred during this time as he became excessively obsessed with a girl whom he met at a nightclub. He broke into her house at night where he found her with another guy. This upset him so much that he wanted to physically attack the couple. She consequently called the police who removed him from the premises. Shortly after this incident he was kidnapped and assaulted by a group of men while he was, once again, on his way to the girl's house. Peter believed that it was this girl who hired the men to assault him. He was floridly psychotic at the time and consequently taken to hospital. His father flew down from Johannesburg and took Peter home with him.

He returned to Cape Town the next year to finish his studies. This time he rented a room in a house of a man who was also using drugs such as marijuana and cocaine. Peter stated that he often used drugs with his landlord at the time. He once again became psychotic as he started believing that his landlord had a relationship with the girl with whom he was in love. This resulted in him physically assaulting his landlord whereafter he drove off in his landlord's car to go to the house of the girl whom he was in love with. The landlord called his parents who in turn called Peter's cousin who was able to trace him and take him to hospital. In hospital he was prescribed an anti-psychotic drug and was then transferred to Tara Hospital in Johannesburg, where he spent three months.

Upon his discharge from Tara Hospital, Peter enrolled for a computer course. While doing this course, he met a young lady with whom he again fell in love. Although he only went out with her once, he also became obsessed with her and contacted her several times a day. When this girl got involved with another guy, he believed that his father slept with her.

This caused him to physically assault his father. His father then had him certified and admitted to Sterkfontein Hospital where the researcher started seeing him for therapy.

In the conversations with Peter's father (Mark), the researcher learnt that he (the father), came from a family characterised by conflict ridden relationships. He is the eldest of his mother's three children of which the others are a son and a daughter respectively. His father had been a captain in the British navy and died at the age of 35 during the Second World War. After this, his mother remarried, once again to a captain in the army. Both his brother and sister were born from his mother's second marriage. He stated that he had not got on well with his stepfather and consequently became a boarder at a very young age. After the death of his stepfather his mother married a man with five children from a previous marriage. This man died at the age of 85 and she was once again widowed. Mark claimed that he had never really had any contact with his stepbrothers and -sisters. He also said that he never learned how to be a father to his children, as he himself never had a father who could serve as a role model.

Something else that is quite significant with regard to Peter's father's family, is the theme of divorce as both Mark's half brother and sister had divorced their spouses. His half brother remarried, but is also now separated from his second wife.

Peter's mother's family, on the other hand, had not been marked by much conflict. She was the eldest of two children until her brother died at the age of 31, which left her as the only child. Her father died at the age of 79 after which her mother never remarried. She describes her relationship with both her parents as satisfactory.

In general, the family presented as quite disengaged with very little real communication taking place among family members. It was particularly the father and son who found it extremely difficult to communicate their feelings to one another. It seemed as if there were many unsaid things in the family.

The father came across as quite rigid and distant. He displayed a number of set ideas, especially with regard to Peter's "illness" and was initially reluctant to be involved in therapy. Furthermore, he gave the impression of a highly intelligent and perfectionistic person for whom facts were very important. These characteristics fit in well with his occupation as an accountant.

His mother, on the other hand, came across as a quiet, good-natured person who only speaks when asked to do so. She seemed to be fulfilling the traditional role of mother and housewife who is willing to give up everything for her husband and children. It also seemed as if the mother had been suffering immensely, especially as a result of Peter's illness.

The therapist's impression of Peter was that of a lonely young man who struggled to express his deeply felt emotions. It was clear that he was an intelligent young man desperately searching for meaning. He furthermore displayed a strong external locus of control whereby he blamed other people, such as his parents, for the ordeals he experienced in life.

With the above background information in mind, a genogram of the family under discussion is presented in Figure 6.1.

The Therapeutic Process

In this section, the therapeutic process from the perspective of the therapist will be briefly described. In describing this process the therapist has drawn from process notes on therapy sessions as well as his own memory. The description must therefore be regarded as completely idiosyncratic and not as an absolute portrayal of the therapeutic process.

After several individual interviews with Peter, it was decided to involve the family in family therapy. At first the father was reluctant to participate in family therapy, as he was still very shocked after being assaulted by Peter. The mother thus came alone for the first two sessions. From her the therapist just got some background information about the family and the history of Peter's condition. From the third session the father also started attending therapy and the family was consequently seen for 8 sessions on a weekly basis. These sessions that included Peter and both his parents were conducted at Sterkfontein Hospital. During this time, Peter's brother and sister also attended one of the sessions.

The aim of therapy was to explore each member's role in the family and to identify the relational patterns within the family. Upon identifying these roles and patterns, it was furthermore attempted to amplify these in order to provoke the family into considering their roles and patterns and consequently modify their own behaviours and attitudes. Attempts were made to do this in accordance to the therapeutic techniques described by Andolfi

Symbols

- Female
- Male
- ⊗ Deceased
- Married
- /// Divorced
- / Separated
- | Offspring

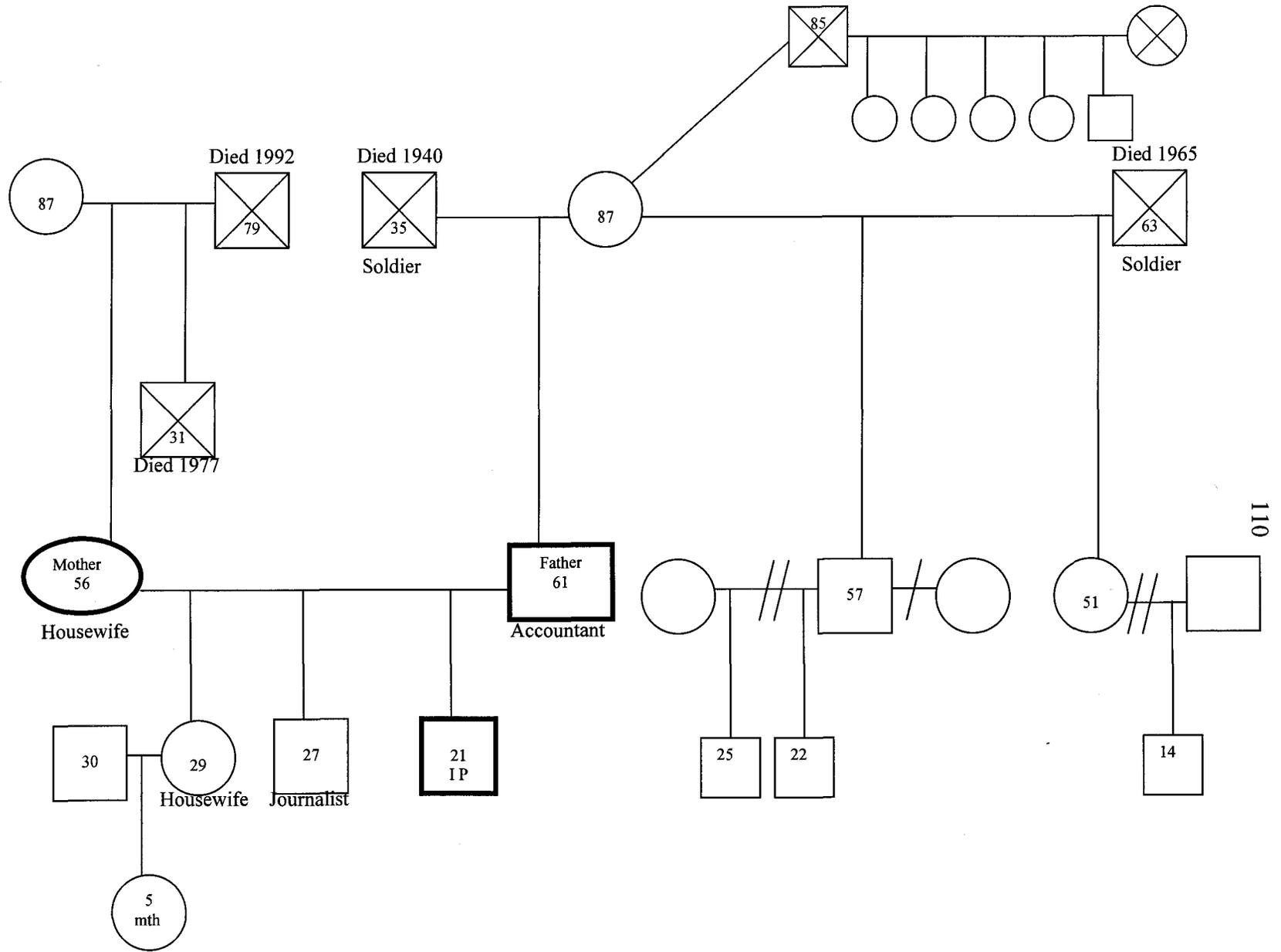


Figure 6.1 Genogram of the Extended Du Toit Family

(Andolfi et al., 1983, Andolfi et al., 1989) in particular. Several of the techniques suggested by Farrelly and Brandsma (1974) were also utilised.

From the very first interview it was clear that the relationship between Peter and his father had been extremely tense. This tension was clearly exacerbated by the assault. The mother seemed to have acted as a mediator between the two conflicting parties. Attempts were made to get father and son to communicate their feelings to each other in the therapy room without the mediation of the mother. The aim of this was to induce a crisis in the family system by further escalating the tension between father and son. It was thought that the son's psychotic features represented the "fake" crisis in the family. These features were thought to be merely symptomatic of the dysfunctional, redundant communicational patterns existing within the family. The therapist regarded it as his role to provoke the family in order to create a real crisis. This was done, among other things, by the introduction of several metaphors that accentuated the family's interactional style.

The first metaphor introduced by the therapist was that of diligent professor and lazy student, portraying the interaction between father and son. The father's communicational style strongly resembled the speech and attitude of a very intellectual, self-righteous and distant professor. He was continuously questioning Peter about his behaviours. Peter, in turn, had to answer like a student under scrutiny. Peter did this, often also in an intellectual manner, but mostly very avoidant. This metaphor was introduced and amplified through the use of exaggerations and mimicking while the father and son were trying to communicate with each other about what had happened between them. The aim of this was to supply the individuals with feedback with regard to the therapist's perceptions of them.

The mother was put in the role of co-observer with the therapist, who had to discuss the father and son's ways of communicating with the therapist. An attempt was thus made to provide further feedback to the father and son while seemingly only communicating to the mother. This process clearly left all family members very uncomfortable and it seemed to be very difficult for the family to communicate to each other in such an open and honest way. Not only was it extremely difficult for the father and son to talk about their feelings, but the mother also seemed to be very uncomfortable in the role of commenting on her husband and son's interactional styles in their presence.

During the session where Peter's brother and sister were also present the metaphor of a king's court was introduced to portray the family interactions. The father was assigned the role of the king who sat on his throne and ordered everybody around to do as he

pleased. He was in charge, the centre of attention and the one who made the rules of the country. To illustrate this role, the therapist asked the father to sit on a large chair in the centre of the room. The mother, on the other hand, was not portrayed as the queen but as the servant. The therapist asked the family to decide whether the mother played the role of the queen or the servant. The siblings were unanimous in saying that she was not the queen but the servant, as she just had to run around for her husband and children. They believed she had given up everything for her husband and children without receiving any acknowledgement for that. So she was asked to sit on the floor as the servant. By doing this, the therapist provided the marital couple with direct feedback with regard to the nature of their relationship as perceived by others.

Peter was portrayed as the prince as he was thought to be the family's hope for succeeding the father. This role was ascribed to him on account of his parents stating that they thought that he would become the star of the family, as he seemed to have the most intellectual potential. He was also going to study B. Com. (Accountancy) to follow in his father's footsteps. His psychotic episodes and consequent hospitalisations had, however, crushed these hopes the parents had for Peter. Peter was therefore portrayed as a rebellious prince who did not want to stay in his father's court but who wanted to start his own kingdom with his own rules. He, in effect, wanted to oppose his father's authority and to do things his own way. He thus still had the capacity to become a king, but he did not want to become his father's successor, as he could not identify with his father's style of government. This emphasised that he was similar to his father in some ways for instance with regard to his strong will and inner strength but also different from his father with regard to aspirations and ways of doing things. This situation was compared to the myth of Lucifer who used to be an important angel in the kingdom of heaven but who also decided to break away from God's kingdom in order to establish his own kingdom. To portray this situation Peter was placed on his own "throne" somewhat distanced from the rest of the family.

Peter's sister was placed in the role of the court jester, as she seemed to be the one who brought up real issues and who punctured the family's pretences. She could criticise the family members and their behaviours from outside the family as she had already started her own family. Yet, she still felt part of her family of origin and still wanted to make a positive contribution to this family.

Peter's brother was assigned the role of messenger boy who became the family's link to the outside world. He brought in messages from outside and also delivered messages to the outside world. This very much gave him the role as an outsider to the family who kind of

withdrew from the family and their conflicts while still staying attached to them by sometimes being sent around. Although being useful to the family system, this role placed him in a very lonely position which was emphasised by the therapist and which clearly touched him and the rest of the family.

Peter had thus been quite distant from his siblings and was mainly interacting with his parents. He was fighting his father, the king, and seeking support from his mother, the servant, who also had to support the king. Applying the technique of inventing a psychological theory paired with the use of professional jargon, as described by Farrelly and Brandsma (1974) the therapist described Peter's struggle with his father as an important process which every boy has to go through in order to become a man. The therapist stated that as Peter never had the opportunity to oppose his father as a teenager in Cape Town, he was now using the opportunity to oppose his father's authority in his development towards manhood.

The introduced metaphor, with accompanying exaggerations, mimicking and ridicule, served as a means to bring forth the real issues in the family, hidden by their redundant interactional patterns. On the other hand, it is believed that the stereotypical portrayal of roles within the family system also provided the individual members with support. It is believed that support was offered through the identification and highlighting of the individuals' real situations. The loneliness experienced by the members of this system was, for example, acknowledged and highlighted by the introduction of this metaphor.

Towards the end of the therapeutic process, after Peter's psychosis had cleared significantly, the issue of his marijuana abuse had become a major point of discussion during therapy sessions. Peter's parents desperately wanted him to give up smoking marijuana while he admitted to finding it extremely hard to do that. He said that although he knew it was bad for him, he still wanted to carry on smoking marijuana as he enjoyed doing so. In response to this, the therapist decided to emphasise the dreaded aspects of change as well as the positive aspects of the status quo. This was done by amplifying Peter's affinity for marijuana by covering the therapist's office walls with large posters stating: "I love dagga." This made Peter feel very uncomfortable and he consequently asked, "What is this all about?" The therapist's reply to this was, "I just wanted to join with you". The parents found this quite amusing.

The dagga issue was further addressed by the use of humorous distortion as described by Farrelly and Brandsma (1974). This technique was employed by saying to

Peter that the therapist fully understood his continuous dagga use. He said that he was convinced that it was the result of Peter's overpowering Thanatos. When Peter asked about the meaning of the term, the therapist explained to him that it was a term created by Freud and that it referred to people's death wish. The therapist seriously stated that he was convinced that Peter's death wish was so strong that he had to use drugs in order to bring about his death as soon as possible. This caused the family to laugh in disbelief. The therapist also employed the technique of accentuating the negative. This was done by stating to the parents, in the presence of Peter, that he doubted whether Peter would ever want to stop smoking Marijuana. It was explained that this gave him an excuse to become psychotic which in turn provided him with an opportunity to express his true emotions such as the hate he harboured against his father.

With the theme of marijuana still very prominent the therapist later on introduced a new metaphor to portray the family's interactions, namely that of 'cowboys and crooks'. The involuntary was made voluntary by stating that Peter and his father had at last managed to be able to have fun together. The father was portrayed as the cowboy or good guy who always did everything right and Peter was the bad guy who just wanted to smoke dagga and lie to his parents. This got them involved in a game where Peter kept on having to hide his activities such as dagga smoking from his father. His father, on the other hand, continuously spied on him in order to reveal his bad behaviours and hiding places.

The mother's role was seen as that of the nurse in the war between the cowboy and the crook. She tried to remain neutral and to help both parties whenever they needed her help. The ambiguity involved in this role was emphasised. It was emphasised how difficult it had to be for the mother to please both Peter and his father, to listen to both of them and to support both of them. This caused Peter to call the nurse an impostor, as one never really knew which side she was on. It was clear that this remark by Peter caused both parents to become very uncomfortable. The mother consequently used the opportunity to speak about her difficult position in the family of having to please everybody. It was thought that this was a good example of creating a real crisis within the family system and providing an opportunity to speak about the unspoken.

A last metaphor introduced to the family played on the ambiguity embedded in their surname. The therapist suggested that their family name might be a metaphor for the rule in the family that things are not what they seem. It was said that the family's surname created the impression that the family is Afrikaans speaking whereas they cannot really speak Afrikaans at all. There were also other things in the family that are not really what they seem

to be. One of these things was the fact that Peter gave up smoking marijuana. He convinced his family that he stopped smoking but yet it seemed like he was still smoking. He felt obliged to hide many things from his parents and lied to them about things he did and thought. This was done to portray a better image of himself to his parents. The family members furthermore never let the others know what they were really thinking or experiencing. Each one was suffering, yet they pretended to be a happy, healthy family. The father admitted that he did not really like the pressure attached to the head of the home and provider for the family, yet he portrayed an image that everything was fine. The mother felt lonely and alienated in her role as servant, yet she never said anything about it and just carried on fulfilling her role. The family's interactions were consequently not real but rather superficial so that things were not really what they seemed to be like on the surface.

This metaphor provided a valuable opportunity to both the therapist and family members to speak about the unspoken issues within the family. It was clear that all the family members really wanted this openness while simultaneously fearing it. Although these provocations must have been perturbing to the family system, it is also believed that they have simultaneously provided the individuals with support. Support was offered by providing the family members with an experience of understanding of their real situations and an opportunity to express their real feelings.

The metaphors described above were all introduced to the family in an often humorous and dramatised manner. By doing this, the therapist attempted to help the family see themselves in a new light while simultaneously joining with them. Attempts were made to reach this goal by amplifying symptoms and dysfunctional patterns rather than to try to eradicate them. An example of this was the 'I love dagga' proclamation.

Ridicule was also used to provide direct feedback to the system. This was done by calling Peter names such as "bastard," "shit head" and "baby" in the presence of his parents. Although these names must have perturbed the family members, they were also employed by the therapist to establish rapport with specifically Peter. Peter, as well as his parents, often laughed at these remarks, probably because of the therapist's attitude and facial expressions when using this type of locker room language. It is believed that these lighter moments provided the family members with support and "breathing space" in an often harsh context.

The family, however, did not always readily accept the therapist's interventions. The need for family therapy was often questioned by especially the father and Peter. This made it difficult for the therapist at times, and it will be discussed further in the next section.

The Therapist's Experience of the Use of Provocation in Family Psychotherapy

Conducting therapy with the Du Toit family had been a very difficult endeavour. I found it particularly hard to break through the family's defences in order to get to the core of the family interactions. It felt as if the family was working very hard to maintain the smoke-screen that everything was in order. A very strong message of "help us but please do not change us" was perceived. It felt as if every now and then the family would reveal some of its real face to the therapist whereafter it would again withdraw behind its mask. It took a lot of courage to speak about the unspoken and to deliberately create a crisis within a family that had clearly been suffering severely.

Joining was also very difficult, especially with the father, as I felt threatened by him. This must have been because of my own insecurity at the time coupled with the father's intelligence and aloofness. The father's continuous questioning and demands to cure his son were unsettling at the time. I could clearly feel how I had become the focus of the family while being pressurised to absorb the familial conflicts. It was clear that I was expected to manage the tension in the family in such a way as to leave the established order in the family untouched. This was especially true with regard to the definition of the illness of the identified patient. Especially the father made it clear that the problem was merely organic of nature and that the family therapy was unnecessary. It was furthermore communicated in no uncertain terms that the identified patient was the only "sick" one and source of distress. This made me very cautious to provoke or challenge the system. From the first session, I realised how important it would be to provoke the whole system with all members present. I was, however, frightened to do this, as I was afraid that the family would reject me as a therapist. It was specifically difficult to introduce the first metaphor of professor and lazy student to the system. I was hesitant to do this, as I was afraid of what the father's response to this would be. Great was my surprise, however, when the introduction of this metaphor created an opportunity for the family members to speak more openly about their experience of one another. I got the impression that this metaphor brought the family members closer to each other and to the therapist. I can clearly remember the relief and sense of achievement I felt after the session. This was specifically due to the fact that the introduction of the metaphor made it easier for all of us to talk about the situation in the family. Communication almost immediately became more honest and open. It seemed as if the metaphor also

helped the mother to talk more freely about the interactional styles of her husband and son. I came to realise, with a sense of amazement, how powerfully direct feedback can be used in therapy.

Throughout the course of therapy, I felt reluctant to provoke the family, mainly because of their pain and because I often felt intimidated by them. However, whenever I persevered and provided the family with feedback, either through the use of metaphors or directly, it always produced some therapeutic rewards. It was as if this often cracked the family's defences. The further we went along the therapeutic road, the easier it became to provoke the system; and the more risks I could take, the more results could be seen. I, however, always remained nervous before conducting a session with the Du Toit family as I felt under scrutiny most of the time. I was able to share this with the family and relate it to Peter's experience, which opened up new discussions and realisations.

The image of a bullfight comes to mind when thinking about the therapy conducted with the Du Toit family. I felt small with this bull storming towards me, and I only had a red flag to manoeuvre the storming bull. It felt like a continuous game where I had to go back to the drawing board after every session to reflect again on the therapeutic process and on my own feelings and behaviours. This forced me to be as creative as possible and I realised that only by being unpredictable and continuously surprising the family with new provocative manoeuvres, was I able to stay alive in this battle.

In this battle the use of metaphors, humour and dramatisations certainly helped me to stay manoeuvrable and to persevere with provocation. The metaphors, in particular, made it easier for me to provoke the system with regard to issues that were difficult for me too. It made it easier to create a crisis within the system as it rendered the challenge more indirect, so that I did not feel that it was me challenging the individuals but rather that I was perturbing the system with regard to the functions of the individuals in the system. This made the interventions to a system that had endured a great deal of misfortune less threatening for both the family members and me.

Furthermore, I found it amazing that therapy could be such fun at times in such difficult circumstances. I experienced that when I did not focus on eradicating the symptoms but rather on provoking the system on the level of the individual's roles in the system, the context became freer, less frightening and often fun to be part of. It was especially the dramatisations and ridicule that provided for the lighter moments which I enjoyed thoroughly.

In conclusion it can be said that, although extremely difficult, it was rewarding to conduct therapy with the Du Toit family on the basis of provocative interventions. The rewards were especially seated in the fact that I felt that the family trusted me more as the therapy progressed and that the crises created by the provocative interventions caused the family to reconsider their functioning. The family seemingly came to see themselves in a new light and started abandoning their old roles. The family's experience of the therapeutic process will subsequently be discussed.

The Family's Experience of Provocation in Psychotherapy

The family's experience of provocative psychotherapy will be presented here by once again providing extracts from the interview the researcher conducted with them. This specific interview was conducted on Friday, 18 February 2000 at the family's home in the northern suburbs of Johannesburg. The interview was videotaped by the researcher and afterwards transcribed and analysed. It must, however, be noted that problems were experienced with the video camera so that the whole interview could not be taped successfully. However, during the interview the researcher did take down comprehensive notes which were also consulted in the reconstruction of the conversation. After the interview had been transcribed, the researcher went back to the family to clarify certain bits of information and to ask about newly arisen questions. Hereafter, the analysis of the conversation for themes took place. The results of this analysis were once again discussed and verified with the family involved.

In the presentation of the extracts from the conducted interview, the aforementioned categories were once again introduced for the sake of clarity. It must, however, be noted that the last two categories, namely that of the experience of the therapeutic process and of the therapist, were combined as a separation of these two categories were thought to be too artificial in this instance.

Reason for Therapy

- Therapist: From what you can remember now, what was the reason for your initially seeking therapy?
- Mother: Because he had a problem. This is Peter. He obviously needed psychotherapy in addition to his medication to sort of get to the bottom of what his problem was.

Father: The reason for the therapy was that Peter was in hospital and he had been quite ill. It was quite clear. And you were combining with the psychiatrists and the nursing staff to try to discover what was the problem; and hopefully to treat it. And even better, to cure it.

Therapist: And for you Peter?

IP: I think it had more to do with our family, I think our whole family needed therapy because we didn't communicate as a family at all and et cetera, et cetera. It wasn't just to do with me but also so that they could thoroughly understand what I was going through.

Therapist: According to you, what were you going through?

IP: An illness of some kind.

Expectations of Therapy

Therapist: Before you came into therapy, what did you expect therapy to be like?

Mother: Well, I imagined they would ask a whole lot of questions about his background. I thought it would deal mainly with Peter's problem but then I realized that they seem to home in a lot on family problems as well; because we spent a lot of time to talk about what the family was like and how we communicated within the family and what was going on in the family.

Therapist: So was that different from what you expected it would be?

Mother: Yes, it was. Because I had never experienced therapy before.

Therapist: For you Mark, what did you expect therapy to be like?

Father: I hadn't expected anything because I didn't expect psychological treatment at Sterkfontein. I thought it was going to be entirely psychiatric and that they would treat him on medication. When I think about therapy, I think about our

experience we had at Tara with group therapy when we spoke about things. In the whole, I thought that they were helpful, although sometimes a little superficial and short in time. But what you were doing later was building on that, although you may have been a contrast to that. Except you were concentrating more on, what do they call it? An antagonistic relationship or something like that (laughing).

Therapist: Peter, before you went into therapy, what did you expect therapy to be like?

IP: I think what I was expecting was pretty much similar to what we got. Sort of dealing with feelings and going under the surface and dealing with them.

Mother: I didn't really know what to expect. But to be quite honest, I really thought that we would deal more with Peter. But I think dealing with the family was actually very helpful.

Therapist: And for you Mark, was it what you expected it to be or not?

Father: I can't answer that question.

Therapist: Why not?

Father: Because it is yes and no. In some ways it was what I expected and in other ways it was not what I expected.

Therapist: In which ways was it not what you expected it to be?

Father: I think, perhaps in that it concentrated to a certain extent on the inter-family relations. I suppose it rather leaves me wondering where you stop. Because if you're going to enter the family, you should be doing the wider family and perhaps the residents of this area and then the whole of the province (laughing). Because they all have a bearing on you, they are all part of transience in one's life.

Therapist: So, for you Mark, it was also a bit like it was for Jane who didn't expect us to talk about family relationships.

- Father: Yes.
- Therapist: And for you Peter, did you expect that we would talk about family relationships?
- IP: Not before I went into therapy.
- Therapist: So was the therapy a bit different for you from what you originally expected from therapy?
- IP: Yes.
- Therapist: How was it different?
- IP: Just the way we did things.
- Therapist: Like?
- IP: Like the games we played playing roles, et cetera (Mother agrees by nodding her head).
- Therapist: Jane, do you agree with that?
- Mother: Yes, I do, definitely.
- Therapist: And for you Mark, the role-play, was that also a bit different?
- Father: Yes, it was. And perhaps I could add something, something that was a little bit different. That was your concentration on feelings and emotions rather than on facts. My vision in my mind of psychological assessment was one of putting people on a sofa and putting them in a trance and taking them back to their early childhood. Because that's not emotions, that is facts and what the facts did to them. But you were concentrating on what emotions and feelings did to people.

Reconstruction of the Therapeutic Process

Therapist: Which themes or topics or processes or anything else about therapy can you remember?

IP: Well, as I said, I remember the role-plays.

Therapist: What role-plays can you remember?

IP: Just each having different roles and that those were representing our roles within the family.

Therapist: Can you remember what those roles were?

IP: Not entirely. But it was like a king and queen and the rest of it was just dealing with issues such as communication. That's about it.

Therapist: Mark, what can you remember?

Father: I'm sure what Jane would tell you is that she remembers her role as a queen and the queen wasn't the queen. The queen was the skivvy or something. That of course is the role of many housewives. That is their function, one of them. I clearly remember the session where all five of us were present, where we had the role-playing and where I was the king, Jane was the servant, Peter the prince and Derek the messenger and Carol the lady in waiting. And that's about it.

Therapist: Jane, what can you remember?

Mother: Also, it was about the different roles we played in the family. I'm sure Carol was the joker or something and Mark was the king, Peter was the prince or something. I just remember discussing feelings a lot and his role in the family. At one time you asked him how he had felt about what had happened in that incident last year in March and he didn't seem to show much emotion over it. I remember other sessions we used to sit in different chairs because you moved us around. I also remember the roles you assigned to us later on where Mark was the cowboy and Peter the crook and I was the nurse.

IP: I remember you calling me a bastard and saying that I was bullshitting my parents.

Mother: I remember you came down quite heavily on him. I also remember in the very first session we had together as a family, you asked Peter and his father to speak to each other about their feelings with regard to the incident that happened between them and that they found it very hard to express their feelings.

Experience of the Therapeutic Process and the Therapist

Therapist: If you had to describe to an outsider what therapy had been like, how would you do that?

Father: Necessary, helpful, remedial.

Mother: I also remember you calling Mark a Professor (laughing).

Father: It was progressive. Every time we seemed to build a little bit on what was there before. We looked forward to it in a sense that we needed it. We looked forward to it with some apprehension when Peter was actually in the hospital because we never knew quite what we would find or what he would have been up to or hadn't been up to. That was an extremely difficult time for us. It was an extremely distressing time but the therapy was very helpful. It was a little bit strange for me because in a hospital set-up like that, I always felt that the main emphasis would be on the medical treatment, the psychiatric element of it and even more so there than at Tara. There seemed to be an ongoing tension between the two disciplines of psychiatry and psychology which is a little bit strange if one comes from outside because we don't know anything about these sort of matters. I felt a tension between the medical side on the one hand and psychological side on the other hand.

Therapist: And you Jane, if you had to describe what therapy was like to an outsider, how would you do that?

Mother: Well, also like Mark, I felt the sessions were very helpful. At that stage we needed help. We needed reassurance. We needed to know what was going on and you certainly did try to get into Peter's mind, you know, more so than any of the other people that he had seen. And you seemed to be a very caring, sort of a compassionate person. We always had long sessions with you. It wasn't a case of: "Oh, time is up, you must go". And I thought they were very good actually. I also liked the idea of getting the whole family involved, I thought that was a good idea.

Therapist: And you Peter, how would you describe the therapy to an outsider?

IP: I would also say that it was very helpful and worthwhile.

Therapist: Why?

IP: Because it helped us to sort out a few issues within the family.

Therapist: Do you think that sorting out the issues made things easier for you?

IP: Yes.

Therapist: In what way Peter?

IP: In that I could express my feelings and hopefully the rest of the family would react to that.

Therapist: What was your experience of therapy in general?

IP: It was helpful and worthwhile doing and going through and it helped us a lot.

Therapist: What was difficult about therapy?

IP: Expressing our feelings, especially within the family.

Therapist: What was easy in therapy?

- IP: The fact that you used metaphors helped me a lot to express my feelings because you could relate to something else while thinking of the situation. You didn't have to speak directly about yourself. Like when I said that the nurse was an imposter. I don't think I would ever have said to my mother that she is an imposter but because I could speak about the nurse, it distanced it from myself.
- Therapist: Was there anything else that was difficult?
- IP: Sometimes the issues that we discussed in therapy were quite difficult and it brought up a lot of anger. Sometimes I felt like my parents were undermining me and underestimating me and treating me like a little child, like they didn't want me to go on with my life. So that was quite hard.
- Therapist: How did you perceive the metaphors which I used for you?
- IP: I thought they were interesting. It was interesting to hear how you perceived me. It brought me new insights about myself.
- Therapist: How did it bring new insights for you?
- IP: It touched me because I could relate to it. I sometimes didn't like what you said.
- Therapist: Can you remember what you didn't like?
- IP: Well, when you called me a bastard. It made me a bit angry, pissed off (laughing).
- Therapist: Did you sometimes experience therapy to be fun?
- IP: Yes, it was sometimes funny and it was also fun because I got an opportunity to express my feelings but I can't remember a specific incident.
- Therapist: Jane, did you sometimes find things funny?

Mother: I thought that session where we all had to sit in different positions and you called us this, that or the other, I thought it was quite amusing. Actually it made us laugh again and it lightened the whole thing up. By lightening things up, I think you made it easier for us to speak about serious matters. It made it easier.

Therapist: And for you Mark, what was your experience of therapy?

Father: The first session in which we played kings and queens was a little bit difficult to relate to initially, but I did see the point of it later. The subsequent sessions were easier to relate to, I think. I found that the further we moved into therapy, it was easier to relate to the therapy and the therapist.

Mother: You didn't want to come for therapy for quite a while. I had to persuade you.

Therapist: Were there some things that you didn't like maybe?

Father: There wasn't really anything that we didn't like, although certain aspects of it were a little unsatisfying. We didn't make much progress in certain areas. But that had nothing to do with the psychological aspect of it, it had more to do with Peter's illness. But he has made a lot of progress ever since. He is taking more responsibility now. His healing process has been rapid since coming out of hospital in July. I would say that his relationships are normal now. I think it has got to do with his friends. I am wondering whether one should not consider including friends in your therapy sessions.

Therapist: What was the effect of the used metaphors on you?

Father: They did not annoy me, but they definitely made me think at times.

Therapist: Could you relate to the metaphors which I ascribed to you?

Father: Yes, definitely. I could see aspects of myself in them.

Therapist: Did you sometimes experience the therapy as fun?

Father: It had its fun moments. The humour had a purpose. You can't be serious all the time. I often thought that the humour was connected to us as a family.

Therapist: Was there anything that was difficult in therapy?

Father: To accept Peter's attitude at the time when he was in hospital. It was also difficult when you touched on my relationship with Jane in the family therapy sessions. Like with the metaphor of the king and the skivvy. It made me feel uncomfortable.

Therapist: Did you feel challenged at times?

Father: Yes, continuously. There was no time that I did not feel challenged.

Therapist: And you, Peter, have you felt challenged in therapy?

IP: Yes, I sometimes felt pressurized and on the spot and uncomfortable. It was difficult at times especially when we spoke about the dagga. I sometimes felt forced to talk about things that were difficult to talk about. During therapy things were brought out into the open, things that were hidden before. I remember when you covered the therapy room with 'I love dagga' posters. This really made me feel uncomfortable. I didn't know how to react to that.

Therapist: And you Jane, have you felt challenged at times?

Mother: Yes, I definitely did, especially when you pointed out my role as the nurse who wanted to please everybody. Also because you brought out things that were difficult to talk about at times. I sometimes felt uncomfortable to speak about things in the presence of the other family members. I sometimes wished that I could have spoken to you alone. It was difficult to speak in front of them.

Therapist: Did you feel supported by the therapist?

Mother: Yes, definitely.

Therapist: How did you feel supported by the therapist?

Mother: I could tell from your attitude that you supported us.

- Therapist: And you, Peter, did you feel supported by the therapist?
- IP: Sometimes I did feel supported but sometimes I did not feel supported. I sometimes felt lonely but I also knew that you were supporting me even though you were calling me names.
- Therapist: How did you know that I was supporting you?
- IP: I could tell from the tone of your voice. You were being playful. I sometimes thought to myself that you were speaking rubbish, especially when you said that I had a strong death wish. I thought that this was rubbish.
- Therapist: Did you feel that you would prove that it was rubbish?
- IP: Yes, I did feel determined to prove that to you.
- Therapist: If you had to think of a metaphor for therapy, what would it be?
- IP: A teacher, because it teaches you how to deal with difficult issues.
- Therapist: And what metaphor would you ascribe to the therapist?
- IP: That of a joker because you made it fun and enjoyable while at the same time pointing out issues which we could work on.
- Therapist: And you Mark, what metaphor would you ascribe to therapy?
- Father: I would say it was like a scan because it got into the family situation. Things that were hidden were revealed. We were made aware of things which we were not aware of before.
- Therapist: What metaphor would you ascribe to the therapist?
- Father: That of the operator of the scan who pushes the button as he helps us to see things in a new light.

- Therapist: And you Jane, what metaphor would you give for therapy?
- Mother: That of a soap opera. It was like a drama in which each one had a role to play.
- Therapist: And what metaphor would you ascribe to the therapist?
- Mother: That of director. You were like the director of the drama who zoomed in on the role of each one.
- Therapist: Have your expectations been met in therapy?
- Mother: Yes, the sessions were very helpful and we enjoyed them. They helped us to cope with situations and gave us more understanding about what had been going on in the family. I think it would have been nice if we could have had more sessions with the other two children as well.
- Therapist: And your expectations Mark, have they been met?
- Father: Yes, definitely.
- Therapist: What effect do you think did the therapy have on you as a family?
- Father: It brought us together more than before. It also helped us to understand where Peter was and why. How we all fitted into the picture.
- Therapist: Have your expectations been met, Peter?
- IP: Yes, partly. If we could have done more therapy, I think it would have brought out more and I would have been able to gain insights. I did get a lot of insight into myself but was sometimes reluctant to talk about them, as it was too difficult to talk about.

Conclusion

Upon considering these conversations, the following themes were identified with regard to the family's experience of provocative psychotherapy: unexpectedness,

helpfulness, discomfort, challenge, news of difference, support, freedom of expression and enjoyment.

The first theme that is very prominent in the family's narration of their experience of the therapeutic process is that of unexpectedness. All the family members involved indicated that the therapeutic process was surprisingly different from what they expected it to be. The unexpectedness seems to be specifically related to the probing of the interfamily relationships. They seem to have expected that therapy would be solely directed towards the symptoms of Peter, the identified patient.

This theme was introduced by the mother when she said, 'they seemed to home in a lot on family problems'. She stated that a lot of time was spent on discussing what was going on within the family. The father echoed this when he said that he did not expect the therapist to concentrate so much on the interfamily relations. It seems as if the family did not expect to be so closely involved in the treatment of their son's psychosis. The exploration of each one's role in the family seemingly surprised them. In fact, the father stated that the mere use of psychotherapeutic interventions at a place like Sterkfontein Hospital took him by surprise.

A further aspect of the therapeutic process that took them by surprise was the so called 'games we played, playing roles et cetera'. This refers to the assigning of roles within the family system and the dramatisations of these roles. These dramatisations and 'role-plays' were referred to by all the family members with a sense of amusement. They particularly found the metaphor of the king's court and each one's role in it quite unusual. The mother also referred with surprise to the therapist calling the father 'a professor'.

The father furthermore found the emphasis on emotions or feelings unexpected. It seems as if he rather expected to be hypnotised instead of being assigned different metaphoric roles where emotions played an imported role. He expected that the therapist would be more interested in facts than emotions. Peter, on the other hand, found it quite unexpected when the therapist called him names like 'bastard' and telling him that he was 'bullshitting' his parents. Also his mother seemingly found it unexpected that the therapist 'came down so heavily on him'.

A second prominent theme that is identifiable from the family's descriptions, is that of helpfulness. All the family members stated that they found the therapeutic process helpful. The father touched on this theme when he described the therapy as 'necessary, helpful and

remedial'. He furthermore stated that they needed the therapy and that it was progressive. For him, the helpfulness of therapy was seemingly seated in the fact that it brought the family members closer to one another. This might refer to the fact that his relationship with Peter had been quite conflict ridden before they had started therapy. He stated that the therapeutic process helped them to understand where Peter was and why. He furthermore said that it helped him to realise how they all fitted into the picture. This is summarised in the metaphor he ascribed to therapy, namely that of a scan which helps one to see things that were previously hidden.

The mother echoed this experience of helpfulness in stating that she found it helpful to deal with the whole family instead of only with the identified patient. She furthermore stated that it was helpful as it provided them with reassurance and consequent support (a theme which will be discussed later on). Mrs Du Toit also said that therapy was helpful because the therapist tried to 'get into Peter's mind, more so than any other person that he had seen'. She also believed that therapy helped them to cope with their situation and provided them with understanding about what had been going on in their family.

Peter also echoed the theme of helpfulness in stating that the therapy was 'helpful and worthwhile' because it helped them to sort out a few issues within the family. He furthermore stated that it was helpful in that it provided him with an opportunity to express his feelings in the presence of the other family members, who, in turn, could react to that. This, he said, was made easier for him by the introduction of the metaphors to the family system. He said that this helped him to express his feelings, as he did not have to speak about himself or the others directly. He quoted the example of his calling the nurse an impostor and said that he would never call his mother an impostor. The use of the metaphor thus helped him to express some of the feelings he had harboured with regard to his mother. The direct feedback also seems to have been helpful to Peter as it gave him an indication of other people's experience of him. He also seems to have found speaking about the unspoken as helpful. Peter, however, summarises the helpfulness of the therapeutic process by ascribing the metaphor of teacher to it. This metaphor was used as he thought that therapy taught him how to deal with difficult issues in his life.

Seemingly contrary to the theme of helpfulness is that of discomfort, which was also expressed by all family members. All family members indicated that they sometimes felt uncomfortable during the course of therapy. It seems as if the mere fact that the therapist involved all the family members in therapy already caused severe discomfort to the individuals. This was something they did not expect and which consequently often put them

'on the spot'. All the family members indicated that it rendered them uncomfortable to speak about sensitive issues in the presence of the other family members. Peter said that he found it unusual and difficult to express his feelings in the presence of his other family members. This expression of emotions often resulted in a crisis in the family where they had to deal with their emotions and differences. Peter said that this evoked anger within him as he felt that his parents were underestimating him and treating him like a child.

Discomfort was also experienced by Peter when the therapist called him names like 'bastard' and 'bullshitter' in the presence of his parents. He said that this made him 'a bit angry'. He also indicated that he felt pressurised at times to speak about difficult issues such as his use of dagga in front of his parents. This, he said, made him feel 'on the spot' and uncomfortable. He particularly referred to the incident where the therapist pasted 'I love dagga' posters on his office walls. Apparently he was bowled over by this as he admitted that he did not know how to react to this. It seems as if it was especially the speaking about unspoken issues that left Peter extremely uncomfortable.

Peter's father, Mark, also indicated that he felt uncomfortable at times during the course of therapy. His discomfort was particularly related to the roles assigned to the family members when metaphors were introduced to the system. He seems to have felt particularly uncomfortable with the idea that he was portrayed as the king while his wife was portrayed as the 'skivvy'. He indicated that he experienced any reference to their marital relationship in the presence of their children as difficult and uncomfortable. Also he indicated to have experienced discomfort as a result of the confrontations that took place between him and Peter during some therapy sessions. He said that he did not know what to expect from Peter and that he did not like Peter's attitude at the time. His discomfort was further emphasised by his wife's declaration that he was reluctant to come to therapy at first and that she had to persuade him to participate in therapy. This indicates that the mere thought of psychotherapy must have rendered Mr Du Toit uncomfortable.

Also Mrs Du Toit indicated that she experienced discomfort at times during the course of the therapy. Her discomfort was also mainly related to expressing her true feelings in the presence of the other family members. She indicated that she sometimes wished that she could have spoken to the therapist in private. It was stated that this was the case as some of the issues that were brought up were difficult to talk about. One of these issues seemed to be her role as the 'servant' of the family who wanted to please everybody. It was seemingly difficult for her to oppose or criticise her husband in any way.

Related to the theme of discomfort, is that of challenge. All the family members once again indicated that there were moments that they felt challenged by what had happened in therapy. It seems from their conversations that the mere participation in family therapy had been challenging to them. The father touched on this aspect of his experience of therapy when he said in no uncertain terms that he felt continuously challenged during the course of therapy. He emphasised this experience of his by adding that there was no time that he did not feel challenged. This challenge seems to have been related to the roles assigned to the family members and specifically to his role as king, which was in sharp contrast to his wife's role of servant.

The challenge for Peter seems to have also been seated in the mere participation in family therapy in the presence of his parents. This, coupled with the therapist's direct feedback in the form of metaphors, negative modelling and ridicule, seems to have confronted Peter with himself in a way which often challenged him vigorously. He admitted that things which had been hidden before, were brought into the open. This apparently also caused him to feel challenged. The humorous distortion where the therapist put it to Peter that he had a strong need to kill himself because of his inherent death wish, was also experienced as a strong challenge by him. Peter admitted that this intervention challenged him to prove the therapist wrong. In summary it can be said that Peter felt challenged by the reflections he saw of himself, provided by the therapist. What made this challenge even more intense was the presence of his parents.

Peter's mother indicated that she also felt challenged at times and specifically with regard to her role as servant or nurse. She felt challenged when reminded of the fact that she worked so hard to please others while sacrificing herself. This must have been exacerbated by her son's comments of her being an impostor. It seems as if the bringing forth or revealing of the real issues in the family posed a strong challenge to all the family members. The theme of news of difference will subsequently be discussed.

The theme of news of difference refers to the family's experience of obtaining new insights into themselves and their interactions. This normally happened when very real but hidden issues were brought to the fore through the use of provocation. In this family's case, it seems as if it was particularly the introduced metaphors which brought hidden aspects to the fore and which provided them with new insights.

Peter acknowledged that he gained new insights about himself through the introduced metaphors and direct feedback provided by the therapist. He stated that he found

it interesting to hear how the therapist perceived him, as this also sometimes challenged him. Peter also indicated that the therapeutic process revealed previously hidden aspects of the family interactions. The metaphor suggested by Peter for the therapeutic process, namely that of teacher, also suggests that he gained new insights into how to deal with difficult situations. It can thus be said that Peter experienced the therapy as a learning context, which also, according to Andolfi et al. (1989) serves as a form of indirect support.

Mark (the father) also indicated that the introduced metaphors helped him to gain better insights into his own and his family's functioning. He admits to having identified aspects of himself in the introduced metaphors, which also consequently challenged him. This is echoed in the metaphor which he suggested for therapy, namely that of a scan which 'got into the family situation'. He furthermore claimed that the therapeutic process revealed things that were hidden and made them aware of things which they had not been aware of before. The role of the therapist was also described as the operator of the scan who helped them to see things in a new light. This theme was further reiterated when the father stated that the therapy helped them to understand where Peter was and why and how they all fitted into this picture. It must be regarded as quite significant for the father to have made such statements, as he had previously been very rigid. He, for instance, previously created the impression that he regarded Peter as the only "sick" one who needed to be cured. Now, he was able to recognise the role each family member, including himself, played in their distressing circumstances - truly news of difference!

Also Jane, Peter's mother, claimed to have gained new insights as a result of the therapeutic process. For her this news of difference seems to have been particularly related to her role as servant and nurse in the family. She seemingly came to realise these behaviours of hers could have perpetuated already redundant patterns in the family. The fact that she also referred to each one's role in the family drama and how the therapist, as director, zoomed in on these roles, further reiterated this theme. She also admitted that the therapeutic process helped them to gain more understanding about what had been going on in their family. Mrs Du Toit furthermore expressed the wish that her other children could have been included more in therapy as well. This already hints on the next theme under discussion namely that of support.

According to Andolfi et al (1989), providing the family with news of difference already serves as an indirect measure of support. The family members, however, also indicated that they felt directly supported by the therapist. This support was, among others, experienced in the form of reassurance during a time when the family was suffering severely. It was

especially the mother who referred to this experience of being supported by the therapist. She said that the therapist came across as a very 'caring, sort of compassionate person'. She furthermore felt supported by the fact that the therapist did not limit the sessions to a definite time span. The competence of the therapist experienced by her also seemed to have supported her as she indicated that she thought that the therapy sessions were actually 'very good'. Mrs Du Toit concluded by saying that she could tell from the therapist's attitude that he supported her. It is, however, also believed that the depicting of roles within the family also provided Mrs Du Toit with support as she seemingly never had a voice in the family before. The speaking about the unspoken seemingly empowered the mother more.

Although not directly admitted, it seems from his conversations that the father had also felt supported during the course of the therapy. This is indicated by the fact that he said he looked forward to the therapy sessions as he felt that they needed them. He also felt that they were building on what had been there before. This statement is indicative of an experience of support as the father did not previously want to attend therapy. The mother stated that she had to persuade him to attend therapy in the beginning. Mr Du Toit, however, stated that the subsequent sessions became easier to relate to. He said that the further they moved into therapy, the easier it became to relate to both the therapeutic process and the therapist.

Peter seemed to have had a similar experience than his father namely that of support coupled with uncertainty at times. He seemingly felt supported by the fact that therapy provided him with an opportunity to express his feelings, especially with the aid of the metaphors. It seems as if this opportunity to speak about the unspoken helped him to make contact both with his own feelings as well as with his parents. He supposedly saw this as an opportunity to respond to his parents as he apparently felt paralysed to do this before. The experience of being understood which Peter had as a result of the used metaphors and direct feedback through, among others, ridicule, must have also left him with an experience of being supported. The playfulness, which Peter sensed in the therapist's ridicule, also provided him with a sense of support. He indicated that he could tell from the therapist's tone of voice when he was calling him names, that the therapist was actually being playful and thus supporting him. Despite of this experience, Peter, however, still indicated that he sometimes did not feel supported during the course of therapy as he felt lonely at times. This experience of loneliness can be regarded as a unique theme touched on by Peter and in contrast to the theme of support.

Related to the theme of support, is that of freedom of expression which was touched on by Peter. Peter indicated that the therapeutic context provided him with an opportunity to express his feelings to which his parents had to respond to in return. He stated that it was specifically the metaphors that aided him in expressing his feelings more freely. The metaphors were described as helpful in this regard as they provided him with an opportunity to speak his mind in an indirect way. An example of this was the incident where he indirectly commented on his mother's behaviour by calling the nurse an impostor. Peter admitted that he would not have been able to call his mother an impostor but that the metaphor provided him with the necessary emotional distance to do so.

The last theme of enjoyment or fun was also touched on by all three the family members involved. The first indication that the family sometimes enjoyed participating in provocative psychotherapy came from the father when he admitted that they looked forward to attending the therapy sessions. He also referred to the humour employed by the therapist, stating that he felt that the humour was used purposefully and with reference to the family.

Peter also indicated that therapy had its funny moments, although he could not remember any specific incidents. He did, however, ascribe the metaphor of joker to the therapist as he thought that the therapist made therapy 'fun and enjoyable'. This is further stressed by the fact that he perceived the therapist to be playful at times.

Peter's mother echoed this theme of enjoyment when she called the session where all the family members were assigned different roles 'quite amusing'. She said that this made them laugh which in turn lightened the atmosphere. This, she said, made it easier for them to speak about serious matters. Also the metaphor of soap opera in which each family member had a role to play tapped into the theme of enjoyment.

In conclusion it can be noted that the humour employed by the therapist served a purpose for both Mr and Mrs Du Toit. For Mr Du Toit the purpose of the humour was to make fun of the family members' roles. Mrs Du Toit, on the other hand, saw the purpose of the humour as that of lightening the atmosphere in order to make it easier for them to speak about difficult issues. It is thus clear that each individual assigned different, yet equally valid, meanings and emphases to each identified theme. In the following chapter attempts will be made to integrate the themes accentuated by the different research participants in order to arrive at a co-created description of the experience of provocative psychotherapy.

CHAPTER 7

DISCUSSION OF FINDINGS

In this chapter themes that emerged from both the therapist's and the clients' descriptions of their experiences of provocative psychotherapy will be discussed in order to arrive at a co-created description of the participants' experiences of provocation in psychotherapy. During this process themes that emerged from the therapist's descriptions of his experiences will be examined whereafter shared themes will be identified from the participating clients' experiences. This will once again be done on the basis of the idiosyncratic distinctions drawn by the researcher. The themes and descriptions that evolved during this research process can thus by no means be regarded as absolute. It is important to note that any other researcher might have drawn completely different conclusions from the same set of data. The following discussion ultimately reflects the researcher's point of view with regard to the obtained data.

The Therapist's Experience of Provocation in Psychotherapy

It is clear from the therapist's self-reports provided in Chapters 4 to 6 that he had both pleasant and unpleasant experiences with regard to provocation in psychotherapy. Certain themes which emerged from these descriptions were identified and will subsequently be discussed. It is important to regard these themes as relative to the specific context within which they emerged and as subjected to the researcher's idiosyncratic drawing of distinctions.

Emerging Themes

The themes that were identified with regard to the therapist's experience of provocation psychotherapy are as follows: freedom, honesty, empowerment, rewards, enjoyment, challenge, uncertainty, unexpectedness and discomfort. Each of these emerging themes will subsequently be discussed in more detail.

Freedom

The theme of freedom is very prominent in the therapist's descriptions of his experiences. This sense of freedom seems to have stemmed from the fact that the

provocative style of therapy permitted the therapist a release from the direct responsibility of having to actively change clients. The fact that he could exaggerate, dramatise and “play” with symptoms instead of attempting to eradicate them certainly enhanced this sense of freedom. This experience of freedom was further enhanced by the fact that the provocative stance gave the therapist permission to provide clients with direct feedback as they were regarded as resourceful individuals rather than brittle victims. The therapist thus did not have to harbour certain thoughts and feelings with regard to clients while feeling obliged to keep these to himself. Instead, this approach provided him with a newly found spontaneity within the therapeutic context which fitted very well with the specific therapist. This also enhanced the therapist’s manoeuvrability as the freedom provided him with a multitude of options with regard to his responses to clients’ manoeuvres. His effectiveness at being unpredictable was consequently enhanced by this experience of being free to respond in whichever way he found befitting for the specific circumstances.

The therapist also experienced a sense of release from the constricted role of the traditional therapist, as described by Farrelly and Brandsma (1974), while applying provocative techniques such as direct feedback, dramatisations and humour. The therapist most definitely experienced a freedom “to use more of his total range of responses and whole self as a therapeutic instrument” (Farrelly & Brandsma, 1974, p.141). He did not have to pretend to be serious about issues which he did not feel serious about. The high levels of activity and playfulness characteristic of the provocative therapist also fitted well with the therapist, as this provided him with an opportunity to be an active, creative therapist. This, in turn, fitted well with the therapist’s personality and interpersonal style. The provocative approach thus allowed the therapist to be what he really was and to say what he really felt. This experience of freedom can be summarised in Farrelly’s (in Farrelly & Brandsma, 1974, p.27) remark: “I had discovered *me* in the therapeutic relationship and all parts of me seemed freely available to me for use in helping patients.”

Honesty

The theme of honesty is closely related to the aforementioned theme of freedom. The therapist felt that the provocative approach provided him with an opportunity to honestly express his perceptions and feelings with regard to clients and their behaviours. This was normally done in the form of direct feedback through the use of metaphors, dramatisations and negative modelling. The therapist could do this more easily as the provocative stance guided him in trusting in the clients’ inner strengths instead of overemphasising clients’

fragility. It is believed that the emotional honesty underlying such an approach may also provide clients with a context within which they can express themselves more honestly.

It is further believed that the metaphors introduced into the client systems as suggested by Farrelly and Brandsma (1974) and Andolfi et al. (1989) have certainly helped to enhance the therapist's experience of honesty. These metaphors helped to transform therapy into a safer context where difficult issues could be discussed with more openness. The emotional distance and playfulness introduced by the use of metaphors made it easier to talk about otherwise unspoken issues. An example of this would be the metaphor of professor and student suggested for the relationship between the father and son of the family discussed in Chapter 6. It certainly would have been almost impossible to forthrightly tell the father that he was acting in a distant, overly formal way in relation to his son. The metaphor of the professor, however, indirectly provided the father with this honest feedback, which in turn perturbed the father with regard to his interactional style. It is thus clear that the introduction of such metaphors also empowered the therapist to provoke clients more effectively – a theme to be discussed subsequently.

Empowerment

Farrelly and Brandsma (1974, p.141) writes that the provocative psychotherapist normally “experiences a developing sense of control both in his personal and therapeutic relationships”. For the therapist involved in this study, a sense of control or empowerment was undoubtedly experienced within the described therapeutic contexts. The assumptions and techniques advocated by therapists such as Andolfi and Farrelly certainly provided the therapist with a sense of empowerment as a therapist. This was the case, as the therapist felt able to better define himself as a therapist in terms of the assumptions and techniques underlying of provocative psychotherapy. He reported this in Chapter 4 when stating, ‘I also started feeling that I too could be a therapist as I experienced that I could not fit in as a therapist when playing according to the rules of many other approaches to therapy’.

The therapist's experience of empowerment is further related to the fact that the applied provocative techniques empowered him to join with clients while provoking them. It was specifically the use of humour which empowered the therapist to better join with his clients. The playfulness and lightness introduced to the therapeutic context through the use of humour certainly provided the therapist with a valuable tool to successfully join with his clients. Farrelly and Brandsma (1974, p.100) echo this idea when they write, “Humor is

consistently the main therapeutic vehicle for the expression of non-verbal warmth and positive regard in provocative therapy”.

Humour also empowered the therapist to provoke clients with regard to often sensitive issues. The use of humour certainly lightened up the therapeutic issues and made it easier to bring forth and talk about previously untouched issues. This experience links to Farrelly and Brandsma's (1974) idea that the purpose of humour in psychotherapy is to go beyond laughter to provoke the client into dealing with personal issues, feelings and behaviours in a direct and honest way.

The use of metaphors as suggested by Andolfi et al. (1983) certainly also played a role in empowering the therapist to break through clients' defences or “masks”. The therapist indicated that the use of metaphors and metaphoric objects empowered him to confront clients more effectively with their own behaviours without preaching to them or directly pointing to their mistakes. These metaphors facilitated the creating of crises within the clients systems as it rendered the provided challenges more indirect. The therapist thus did not feel that he was directly challenging individuals, but rather that he was perturbing the system. Clients have indicated that this had helped them to speak about the unspoken and obtain news of difference with regard to themselves and their behaviours.

The use of metaphors, humour and dramatisations further empowered the therapist to remain mobile and creative in therapy. This in turn empowered the therapist to continuously remain unpredictable in his therapeutic interactions. The unpredictability of course further helped with the creating of crises which often rendered the conducting of provocative psychotherapy most rewarding – a theme to be discussed next.

Rewards

As the therapist felt empowered and free to enjoy the therapeutic process, he also found the experience of provocative psychotherapy to be most rewarding. The rewards were specifically related to the effects of the introduced provocations. Effects such as clients' increased openness, news of difference and a reconsidering of their behavioural patterns filled the therapist with a sense of satisfaction and hope. The hope was not only with regard to the role of the therapist but also with regard to the clients' future prospects. This rewarding experience of hope is also described by Farrelly (in Farrelly & Brandsma, 1974) when he reports that some therapists had told him that the provocative stance to therapy had provided them with real hope. This hope was apparently related to the hypothesis proposed

by Farrelly and Brandsma that clients can change if they choose. Therapists who believed that clients played a role in bringing about the difficulties they were in, consequently also believed that these clients had the capability to change their own situations (Farrelly & Brandsma, 1974).

In all the described cases the therapist experienced that the clients had reconsidered their roles and had taken on more responsibility for changing their own behaviours. These rewards were particularly experienced in cases where the therapist was at first reluctant to provoke the clients who in the end responded well to the introduced provocations. The therapist, for example, described how the Du Toit family's defences were overcome as a result of the provocations used by the therapist. He felt that they had started trusting him more and that the family had started seeing themselves in a new light. This consequently made it easier for the therapist to apply more provocative techniques and build a constructive therapeutic relationship. Farrelly (in Farrelly and Brandsma, 1974) had a similar rewarding experience when he first started practising provocative psychotherapy. He describes this experience as follows: "By confronting and being 'emotionally honest'..., I found I could build a relationship of trust in one hour better than I had with some patients in months of interviews" (Farrelly & Brandsma, 1974, p.15).

The enjoyment which the therapist derived from the implementation of provocative techniques, furthermore increased the rewarding quality of the conducted therapy. This already touches on the next theme.

Enjoyment

The therapist indicated in all three the provided reports that he, at times, thoroughly enjoyed conducting therapy according to the provocative model. He sometimes found it amazing that psychotherapy could be so funny and enjoyable, especially while sensitive issues were being dealt with. This enjoyment or sense of fun stemmed from the implementation of the techniques suggested by Farrelly and Brandsma (1974), Andolfi et al. (1983) and Andolfi et al. (1989). The dramatisations, metaphors, jokes, exaggerations, use of locker room language and other humorous elements often rendered provocative psychotherapy a delightful and memorable experience. This naturally enhanced the spontaneity in the therapeutic context which again aided the therapist in successfully joining with clients. Farrelly and Brandsma (1974, p.116) refer to this process when they write, "the use of humor is fun for the therapist. It can keep him sensitive to the client, in touch with himself, and make therapy enduring and even enjoyable for him".

The therapist had, however, not always experienced provocative therapy as enjoyable as he often felt challenged during the course of the conducted therapies. This experience already introduces the next theme.

Challenge

The therapist often found himself facing difficult challenges when conducting provocative psychotherapy. The challenges mainly pertained to when to provoke and when not to provoke. The therapist described how he often felt afraid to either start or continue provoking clients who were in great distress. This fear seemed to have been related to mainly two aspects of the therapeutic relationship, namely that of harm and rejection. On the one hand, the therapist sometimes feared that he would harm his clients through the use of provocation. This was the case as he often dealt with severely distressed clients and he was consequently wary of hurting them further. On the other hand, the therapist was sometimes cautious to use provocative techniques due to a fear of rejection by the clients. This was specifically relevant in the case of the family where the therapist found it extremely difficult to provoke especially the father. This was ascribed to the therapist's own insecurities at the time as well as to the father's apparent intelligence and aloofness. It has thus sometimes truly been a challenge for the therapist to adhere to Andolfi et al.'s (1983) suggestion of deliberately creating a crisis within the family system. This did not always come naturally for the therapist and he had to continuously remind himself of his therapeutic role of crisis inducer. What further complicated the use of provocation was the clients' resistance to it. Here it was especially the family who strongly portrayed the message of 'Help us but please do not change us'. The guardedness accompanied by distrust and confusion displayed by the family truly made it a challenge to both join with them and to provoke them at the level of their redundant interactional patterns. In order to illustrate this challenge, the therapist proposed the metaphor of a bullfight as he felt he had had little means to take on the bull of a family.

A further challenge was posed by the behaviours which often resulted from the therapist's introduced provocations. This was especially true with regard to the couple therapy described in Chapter 5. The crises created within the system as a result of the introduced provocations often led to strong emotional reactions by the clients. These reactions had to be dealt with therapeutically. This posed a further difficult challenge to the therapist. It is thus clear that the therapeutic process of provocation demanded a great deal of courage and skill from the therapist.

The therapist also felt a definite challenge with regard to refraining from giving in to clients' claims of helplessness. This was especially relevant in the cases of the individual and couple therapies described in Chapters 4 and 5. The challenge was to continuously adhere to Farrelly and Brandsma's (1974) hypothesis that the psychological fragility of clients has been vastly overrated by themselves and others. Thus, the therapist had to be careful not to fall into the trap of feeling too sorry for clients so that he took on the role of saviour while placing them in the role of helpless victims. If he had to be impressed by clients' fragility in this way, it would have been impossible for him to continue provoking the clients into more adaptive, responsible behaviours. The therapist had to be particularly careful about this as he had often found himself playing the role of saviour in the past.

In conclusion it can be said that the therapist did not always find it easy to follow Andolfi et al.'s (1989) guidelines of challenging clients' functions while supporting the individuals. The therapist was not always sure whether the clients actually felt the support that he was trying to convey while provoking them. Sometimes he felt uncertain whether he was supporting the clients sufficiently and sometimes he felt uncertain whether he was actually applying sufficient provocation. The notion of provocation coupled with support as proposed by both Farrelly and Andolfi thus clearly posed a challenge to the therapist. He had, however, found that when he had the courage to continue the use of provocation he was more often than not amazed by the therapeutic effects it produced. This reminds of Farrelly and Brandsma's (1974) idea that therapists cannot expect their clients to take risks if they themselves are not prepared to take risks in therapy. The theme of uncertainty will subsequently be discussed.

Uncertainty

As it has already been indicated in the discussion of the previous themes, uncertainty had been a common theme of the therapist's experience of provocative psychotherapy. This uncertainty was related to how much to provoke clients without harming them. The apparent "cruelty" inherent to many of the provocative techniques had been the reason for the therapist's hesitance. As described in the above section, he was often uncertain about the clients' possible reactions to his planned interventions. He was certainly concerned that the clients might feel hurt and consequently reject him as therapist as a result of the unconventional, unexpected techniques employed. Farrelly (in Farrelly & Brandsma, 1974) also states that when he started implementing his new provocative approach he was afraid

that his clients would reject him or even file lawsuits against him. He, however, states that none of this came true.

On the other hand, the therapist's uncertainty was related to the impact of the applied provocations. Just as he did not want to be too harsh on the clients, he also did not want to be too impressed with their fragility and thus not provoke them sufficiently. It was thus difficult to always know how to maintain the correct balance between provocation and support. The therapist wanted to make sure to provoke his clients sufficiently while also holding them sufficiently. As in Farrelly's (in Farrelly & Brandsma, 1974) case the therapist, however, often found that when he was able to break through these uncertainties and fears of his, it often produced quite unexpected results. The theme of unexpectedness will subsequently be considered.

Unexpectedness

Despite the uncertainty about the frequency and intensity of provocations, the therapist still found that when he persevered with provocation, it often rendered unexpected outcomes. The therapist indicated that he had been surprised by clients' positive reactions to his provocations when he actually feared their rejection. This is particularly relevant to the case of the family described in Chapter 6. In this case the therapist was hesitant to provoke the family through the introduction of a metaphor. When he, however, did introduce the metaphor of professor and student, it created an opportunity for the family members to be more open with one another. The therapist stated that he got the impression that this metaphor brought the family members closer to one another and to the therapist. He was amazed at the powerful impact that this intervention had.

Another component of provocative psychotherapy which the therapist experienced as rather unexpected, was the fact that people could laugh amidst their tears. It was rather surprising to see people laughing although they were experiencing immense pain at the same time. The therapist found it surprising that both he and the clients could have fun together even though they were discussing rather difficult issues. These unexpected elements certainly came as a pleasant surprise to the therapist. He, nevertheless, still often felt uncomfortable, which introduces the next theme of discomfort.

Discomfort

Upon considering the discussion of the previous themes, it becomes clear that the therapist did not always experience the therapeutic context as a comfortable one. In fact, he stated that he sometimes felt a desire 'to flee' from the therapeutic context. This discomfort was brought about by the challenges posed to him as a provocative psychotherapist but also as a result of clients' reactions to his interventions.

Discomfort was particularly experienced in the contexts of the above described couple and family therapies. With regard to the couple therapy, the discomfort was a result of the couple's extreme emotional reactions to the provocations. The husband, for example, hit the wall with his fist and the wife at one stage left the therapy room. The 'bringing forth' of the real issues thus perturbed the couple so much that they resorted to desperate measures, which in turn perturbed the therapist.

The therapist also experienced discomfort while conducting provocative therapy with the Du Toit family. In this case the discomfort was experienced as a result of the resistance provided by the family. The therapist stated that he felt threatened by the family's, and specifically the father's, attempts to counteract his provocations. As described by Andolfi et al. (1983) the family attempted to make the therapist the focus of the family while pressurising him to absorb the familial conflicts. It was clear that they expected the therapist to manage the tension in the family in such a way as to leave the established order in the family untouched. The pressure that was placed on the therapist, coupled with his own insecurities, often made it difficult for the therapist to persevere with provocation without feeling uncomfortable. The experienced discomfort, however, forced the therapist to reflect on his own behaviours and epistemology, which created new opportunities for growth and learning.

Conclusion

It is clear from these nine emerging themes that the therapist had had both pleasant and unpleasant experiences during his conducting of provocative psychotherapy. The pleasant experiences are eminent in the themes of freedom, honesty, enjoyment, empowerment, unexpectedness and rewards. These experiences are mostly in line with Farrelly and Brandsma's (1974) and Bloom's (1992) reports on provocative therapists' experiences as described in Chapter 1 of this study.

The unpleasant experiences described by the therapist are reflected in the themes of challenge, uncertainty and discomfort. These unpleasant experiences were specifically related to the frequency and intensity of provocations in often unsettling therapeutic contexts. The therapist indicated that he often felt provoked by clients' unexpected behaviours and demands which made it difficult for him to introduce or continue with provocative interventions. These unpleasant experiences must, however, not necessarily be regarded as negative experiences as these unpleasant experiences sometimes led to positive outcomes such as therapist growth and learning.

One must, however, be cautious not to regard these themes of experiences as unconditionally transferable to other contexts. As it was said in Chapter 3 of this study, the implementation of a qualitative paradigm does not allow for time and context free generalisations. This would naturally also be true of the clients' experiences, to be discussed in the following section.

The Clients' Experience of Provocation in Psychotherapy

In Chapters 4 to 6, certain themes pertaining to the clients' descriptions of their experiences of provocation in psychotherapy were identified. These themes will subsequently be compared and examined in this section in order to co-construct a description of clients' experiences of provocation in psychotherapy.

Emerging Themes

The themes identified from the clients' descriptions of their experiences of provocation in psychotherapy are as follows: unexpectedness, discomfort, challenge, news of difference, support, being understood, freedom of expression, enjoyment and helpfulness. A description of each of these emerging themes will subsequently be provided.

Unexpectedness

Unexpectedness had been a very prominent theme in all the clients' descriptions of their experiences of provocative psychotherapy. This unexpectedness seems to have been specifically related to the role of the therapist. All participants either directly or indirectly indicated that they expected the therapist to take on a more traditional role of expert or doctor. Such a traditional therapist's role would entail that the therapist acts as an expert on clients' lives who provides clients with direct advice or solutions. This type of expectation

was specifically held by Linda and the Fourie couple. These participants clearly stated that they expected that the therapist would point out their mistakes and provide them with advice, solutions or his 'professional opinion.' Instead, they found that the therapist was merely provoking them in order to bring forth their real issues (Andolfi et al., 1983). They realised that the therapist was not going to take responsibility for directly changing their behaviours. Linda and the couple stated that they were surprised by the fact that the therapist made them see what their real problems were while placing the responsibility for finding solutions solely in their hands. In this regard, the couple was particularly overwhelmed by the therapist's irreverence with regard to their attempted manipulations of him. They, for example, indicated that they were surprised that the therapist was not taken aback by Allen's suicide threats and 'tantrums'.

Linda and the Du Toit family also indicated that they expected the therapist to react in accordance to the principles of the traditional medical model. According to this model it is expected of the therapist to take on the role of doctor in order to "cure" the patient. Linda's remarks that she expected having to lie on a bed during therapy and undergo drug or sleep therapy are indicative of her expectations in this regard. Peter's parents' expectations that the therapist would focus on the curing of Peter's symptoms instead of concentrating on intrafamilial relationships also echoed the principles of the medical model. This experience of unexpectedness is further reiterated by Mr Du Toit's comments that he was surprised to find the therapist concentrating on emotions rather than facts. He indicated that he expected the therapist to get behind the real facts through the use of hypnotherapy.

The playful humorous and unorthodox ways by means of which the therapist provoked clients in order to expose the real issues in the client systems also came as a surprise to the clients. Linda stated that the therapist was 'shitting' on her all the time and that he made her laugh during a time in which she least expected to laugh. Allen also indicated that he did not expect therapy to be so funny. He found the metaphor of the bankrupt farm described in Chapter 5 particularly funny. The family members who participated in the family therapy again thought that the introduced metaphors with the accompanying dramatisations or 'role plays' were particularly amusing and unexpected. Such experiences of unexpectedness are masterfully summarised by Farrelly and Brandsma (1974, p.132) when they write that the client in provocative psychotherapy "experiences a marked clash of expectational systems; his expectations of the therapist's role are not only disconfirmed but are almost reversed".

The theme of unexpectedness, however, not only pertains to the role of the therapist, but also to the clients' reactions. The participants in both the individual and couple therapies indicated that they did not expect to laugh so much in therapy, especially when dealing with distressing issues. The family members involved in the family therapy again expressed amazement at the fact that they took part in so called 'role plays'. These experiences of unexpectedness are referred to by Farrelly and Brandsma (1974, p.132) when they quote a client as saying to a provocative psychotherapist, "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".

Discomfort

An experience of discomfort had been reported by all the involved participants. This is certainly in line with one of the major aims of provocative psychotherapy, namely to provoke a crisis within the client system. The discomfort experienced by the various participants had, however, not always been similar. The discomfort experienced by the individual participant seemingly pertained to her need for affirmation. She indicated that she had a need to feel that the therapist believed in her. The continuous over-emphasising of the negative by the therapist discouraged her at times and strengthened her need for affirmation from the therapist. She thus expressed a desire to be given credit for her achievements in therapy.

The discomfort experienced by the participants involved in the couple and family therapy had been quite different to that of Linda's. Their discomfort mainly pertained to the speaking about the unspoken in the presence of their family members. The bringing forth of hidden or unspoken issues through the use of, among others, metaphors, exaggerations, dramatisations and direct feedback in the presence of others, left all of these clients uncomfortable. Participants also experienced the exploring of the nature of their relationships as unsettling. In this regard both the couple and family indicated that the metaphors introduced by the therapist, and the exploring of their roles along the lines of these metaphors, rendered them rather uncomfortable. These participants admitted that the presence of their family members exacerbated these experiences of discomfort. This reminds of the emphasis that Andolfi et al. (1989) place on the concept of provocation within a system as described in Chapter 2 of this study. According to this concept, individuals should always be provoked in the presence of other family members in order to enhance the therapeutic impact thereof. Such provocations are normally experienced as extremely challenging – a theme to be discussed subsequently.

Challenge

The theme of challenge is closely related to the previous theme of discomfort as the clients often experienced their discomfort also as challenging. These challenges were mostly connected to clients' being confronted with undesired aspects of themselves and their relationships. Clients consequently felt challenged to take on the responsibility to modify these undesired behaviours of theirs. Such challenges were described to be experienced in response to the therapist's mirroring of their dysfunctional behaviours and relationships. This mirroring normally took place through the use of, among others, metaphors, humorous distortions, exaggerations, dramatisations, accentuating of the negative and direct feedback. These techniques often emphasised the absurdity of clients' behaviours and consequently left them determined to change these absurd behaviours. Clients also felt challenged to change their behaviours in response to the therapist's accentuating of the negative and positive aspects of the status quo. As the therapist in these cases enacted the negative half of the clients' ambivalence (Farrelly & Brandsma, 1974), it made the clients determined to prove the therapist wrong.

Linda, who partook in the described individual provocative psychotherapy, for example, indicated that she felt challenged to prove the therapist wrong with regard to his gloomy predictions about her prospects for change. In this she was joined by Peter who also felt challenged to discredit the therapist's statements about his 'death wish.' The couple also felt that they had to prove the therapist's statement that they had to argue in order to stay together, as untrue. In all the described cases the introduced metaphors seem to have challenged the clients to modify their behaviours. This had been the case as the roles assigned to the individuals through these metaphors, rendered the clients rather uneasy with the way in which they had been perceived by the therapist. They consequently felt a strong challenge to start exploring possible new roles.

The challenges experienced by the participants in this research project are clearly in accordance with the aims of provocative psychotherapy as described by Farrelly and Brandsma (1974) and Andolfi et al. (1983). For Andolfi et al. (1983) the main aim of provocative psychotherapy would be to create a crisis within the client system in order for clients to feel challenged to take responsibility for modifying their own behaviours. Farrelly and Brandsma (1974) similarly believe that the task of the provocative psychotherapist is to challenge clients to engage in reality testing and risk-taking behaviours in order to assert themselves appropriately in relationships. This normally only occurs once clients have experienced news of difference – the next theme to be discussed.

News of Difference

News of difference refers to the participants' claims of gaining new insights as a result of their participation in provocative psychotherapy. All the participants indicated that they came to see themselves and their behaviours in a new light as they progressed through the therapeutic process. These newly obtained insights were brought about by clients' confrontation with themselves, to such an extent that they could no longer avoid or deny their own behaviours and roles. Once again, the use of metaphors as a form of direct feedback paired with ridicule, exaggerations and other provocative techniques played a role in bringing about these new insights.

As a result of the news of difference, clients also admitted to beginning to view the cause of their problems differently. This had been the case in Linda's instance as she came to realise that she was allowing herself to be abused by others. The couple, on the other hand, gave up their simplistic view of cause and effect and started realising that various factors have played a role in the creating of their difficulties. Each spouse also came to realise his/her role in the development of their conflicts. This brought them to a point where they started realising the importance of taking responsibility for their own actions.

For the family members who participated in provocative family therapy, news of difference was mainly brought about by the exploring of the interactions in the family and each one's role in these interactions. As a result of this they too began to see the development and maintaining of symptoms in a different light. They started realising that each family member was fulfilling a particular role within the dynamics of their familial interactions. The exploring of these roles provoked the individuals into reconsidering previously hidden aspects of each of their individual roles. Andolfi et al. (1989) are of the opinion that such experiences of news of difference within a therapeutic learning context can also be regarded as an experience of support which introduces the next theme.

Support

As it was stated in Chapter 2, Andolfi et al. (1989) believe that support can be experienced on two levels, namely directly and indirectly. According to Andolfi et al. support is directly experienced through the therapist's attitude and his/her interactions with clients. This happens when the therapist conveys a message of acceptance and acknowledgement to clients, mainly through his displayed attitude towards them. Indirectly support is believed

to be experienced when therapy is perceived as a learning context within which clients learn to recognise links and ascribe complex meanings to actions and emotions. Clients are also thought to experience support when they are allowed to get in touch with their own level of suffering and fears of inadequacy. Farrelly and Brandsma (1974) agree with this assumption and add that humour is a further important vehicle for support.

All clients participating in this study indicated that they experienced support from the therapist. These experiences of support seem to have occurred both directly and indirectly. On the indirect level all clients gave some indication that the therapeutic context was experienced as a learning context. They said that as a result of the provocative interventions, they came to view their relationships and behaviours in a new light. On the direct level, all three client groups stated that they could tell from the therapist's attitude that he was on their side and serious about helping them. Linda indicated that she realised that the therapist was supporting her through the way he spoke to her. She claimed that the therapist continuously made her realise that she was not as bad as he seemingly made her out to be. The accentuating and exaggeration of the negative thus provided her with an experience of support. Linda also experienced that the therapist was always listening to her and that he was acknowledging her as a person by conveying the message that her issues were real and worth talking about. She furthermore confirmed Farrelly and Brandsma's (1974) assumption that clients experience support through the therapist's use of humour. Linda stated that the casual and humorous style of the therapist caused her to feel more at ease. The couple echoed the experience of support by stating that they could tell from the therapist's attitude that he was on their side, committed to helping them and really caring about their well-being.

The mother and son who participated in family therapy also indicated that they had a direct experience of support. This was, once again, experienced through the therapist's attitude which was described by the mother as 'caring' and 'compassionate'. The son, Peter, indicated that he could tell from the playfulness in the therapist's tone of voice that he was supporting him even while ridiculing him. Humour thus once again functioned as a vehicle for communicating support in this instance. The family members further felt supported through their experience that they were given a voice through the introduction of, for example, the metaphors. This was particularly true of Peter and his mother who had previously felt that they could not speak about their feelings within the family context.

It is, however, interesting to note that both Linda who, participated in individual therapy, and Peter, who participated in family therapy, reported that they were actually

yearning for more support from the therapist. Linda, through her expressed need for affirmation, indicated that she was yearning for a more traditional way of being supported as described by, among others, Minuchin (1974). This type of support is expressed through the therapist's explicit showing of appreciation for clients' perceived strengths and achievements. Peter, on the other hand, said that he had felt lonely at times during therapy. One wonders whether such direct expression of appreciation was not what he was yearning for too.

The experience of being supported by the therapist had often been enhanced by an experience of being understood which will subsequently be discussed.

Being Understood

Farrelly and Brandsma (1974) state that clients who participate in provocative therapy frequently report an experience of being understood. These authors are of the opinion that clients often perceive the provocative therapist's ridicule of their negative worldview as understanding on the therapist's part. Clients are quoted as saying to a provocative psychotherapist: "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" (Farrelly & Brandsma, 1974, p.134).

Clients participating in this study described a similar experience. In this regard it was specifically Linda and Retha who described such experiences. Linda, who participated in individual psychotherapy, stated that she felt understood as the therapist did not attempt to stop her from crying but rather permitted her to do so. Here she was commenting on the therapist's emphasising of the positive aspects of the status quo by stating that she was undergoing a mourning process which normally lasts at least two years. Linda also admitted to feeling understood as a result of the introduced metaphors. She claimed that the metaphors of doormat and mother/son exactly portrayed her real situation and 'real problem'.

Retha, who participated in the described couple therapy, echoed this experience of being understood by also referring to the metaphors that were used. She stated that the metaphors and metaphoric objects introduced by the therapist accurately portrayed the real state of affairs in the couple's lives. Her husband agreed with this by stating that the therapist accurately identified their real problems and realistically portrayed their actual situation.

It is thus clear that techniques applied to ridicule clients' behaviours often result in them experiencing therapists as understanding of their situations. In this regard the use of metaphors seem to play a major role to enhance this experience of being understood. Such an experience of being understood often provided clients with an opportunity to express themselves more freely, which introduces the following theme to be discussed.

Freedom of Expression

In all of the described cases, clients indicated that the provocative style of psychotherapy provided them with an opportunity to express themselves more freely. This theme was firstly touched on by Linda who stated that the humorous, casual style employed by the therapist put her at ease and consequently facilitated her talking about difficult issues. The fact that the therapist did not directly prompt her to change her behaviours also made it easier for her to 'open up' as she did not feel boxed in or preached to.

The couple also believed that the provocative style of therapy provided them with an opportunity to express their true feelings. They stated that it was particularly the use of metaphors which accurately portrayed their situation that facilitated their expression of their feelings. As they could identify with the introduced metaphors, it provided them with cues to relate their experiences more clearly. Retha indicated that she particularly felt more freedom to express the anger and hurt she had felt. She believed that this experience of freedom of expression was enhanced by the therapist's applauding of her expression of anger. This encouraged her to further express her real emotions.

Metaphors also served as an encouragement for the expression of thoughts and feelings in the case of the described family therapy. In this instance it was specifically the son, Peter who indicated that the therapeutic context provided him with an opportunity to express his emotions more freely. He indicated that within the therapeutic context he could confront his parents with issues which had otherwise been difficult to speak about. An example of such an issue was when he called the nurse, which served as a metaphor for his mother, an impostor.

It is believed that such freedom of expression is, in provocative psychotherapy, facilitated by the active stance taken by the therapist. The fact that the therapist displays a freedom of expression by speaking freely about unspoken issues using metaphors, exaggerations, ridicule and the like is believed to facilitate a context wherein clients can also express themselves more freely. This is possibly further enhanced by the emotional honesty

facilitated by the techniques of provocative psychotherapy such as direct feedback. The discomfort and crises created within the context of provocative psychotherapy are believed to further provoke clients into expressing themselves more freely and honestly. This freedom of expression was, however, also often facilitated by an experience of enjoyment which is the next theme to be discussed.

Enjoyment

Farrelly and Brandsma (1974) found that an important reason why clients return to provocative psychotherapy is the enjoyment of the humorous approach. One client who was asked if she would return after one session of provocative psychotherapy is quoted as saying, "Of course! This is the first time I've ever been the central object of a really funny floor show!" (Farrelly & Brandsma, 1974, p.134). Clients who participated in this study related similar experiences of enjoyment. Linda, for example, stated that she thoroughly enjoyed therapy as the therapist made her laugh even during times when she never expected to laugh. It was particularly the metaphor of doormat and accompanying dramatisations that were described as funny. These humorous moments caused Linda to look forward to attending the therapy sessions. Humour thus served as a joining mechanism in this case. Her enjoyment is further expressed in the metaphors she ascribed to both the therapist and therapeutic process, namely that of a clown and an exciting drink. The couple also indicated that they found various elements of the therapy to be humorous. Elements such as the metaphor of the bankrupt farm, the dramatisations and funny remarks were experienced as humorous in this case.

In the family's case all the family members indicated that they found the therapeutic process humorous at times which caused them to experience some enjoyment. The father indicated that he enjoyed therapy as he was looking forward to attending the sessions. He also felt that the humour served a specific purpose as this often referred to issues within the family. For Peter, the therapist made therapy 'fun and enjoyable' while simultaneously pointing out important issues which they could work on. This experience was communicated through Peter's introduction of the metaphor of a joker for the therapist. Peter's mother, Jane also stated that she found some therapeutic incidents quite amusing especially the assigning of metaphoric roles to the family members. She believed that the humour made it easier for the family members to speak about difficult issues.

The various clients' experiences of enjoyment seem to vary in intensity and nature. The individual client emphasised her experience of enjoyment as one of her major

experiences during provocative psychotherapy. For the couple, therapy was quite difficult and therefore they did not always enjoy it, although they did find some elements to be quite funny. The family members involved in family therapy indicated that the humour used in therapy served a specific purpose. For the father and son the humour was used to point out certain issues about themselves and their relationships. The mother, on the other hand, believed that the use of humour lightened the atmosphere and consequently made it easier to talk about difficult issues. This refers to the last theme to be discussed, namely that of helpfulness.

Helpfulness

A last theme that was quite prominent in all the participating clients' reports of their experiences of provocative psychotherapy was that of helpfulness. All the clients believed that participating in provocative psychotherapy was beneficial to them. Linda indicated that she experienced some healing as a result of her participation in provocative therapy. She found the process particularly helpful as it apparently provoked her into taking more responsibility for herself and feeling more positive and hopeful about herself. She further indicated that the therapy taught her how to cope better in stressful circumstances. This, she believed, would also be of future benefit to her especially when she would once again be faced with trying circumstances. Linda also often reported that the therapeutic process helped her to feel better and stronger. The laughter was furthermore described as therapeutic as this made her feel lighter and freer within difficult circumstances. Linda summarised this experience of helpfulness through the suggesting of the metaphors of plaster and ointment for the therapeutic process. She said that she had chosen these metaphors as she felt that therapy had relieved her emotional pain in the same way as a plaster and ointment would relief physical pain.

For the couple the helpfulness of provocative psychotherapy was seated in the bringing up of problematic issues and gaining of new insights into their situation. This apparently challenged them to search for solutions and answers for the difficulties they were experiencing. Especially Allen said that the provocative interventions made him realise the mistakes that he had made and challenged him to correct them. It is thus clear that Allen came to accept more responsibility for himself as a result of the provocative interventions. His wife said that she had found the process helpful as it brought about definite changes in their relationship. She, for instance, thought that Allen was being more considerate as a result of therapy and that she had started to accept herself and her emotions more. Their experiences of helpfulness are summarised in the metaphors provided for the therapist and

the therapeutic process. Allen compared the therapist's role to that of a bank manager and the therapeutic process to a hiding which is hurtful, yet necessary. Retha suggested the metaphor of a Chinese who gave the couple a fishing rod to fish for themselves, for the therapist. By this she implied that the therapist had helped them to help themselves through providing them with a different view of their circumstances. Allen echoed this idea when he indicated that for him the helpfulness of therapy was also seated in the different view they acquired of their situation.

For the family members involved in family therapy, it was once again the bringing forth of the family's interactional patterns and familial roles that were regarded as helpful. They indicated that this had provided them with better understanding into each family member's specific behaviour. It was realised that each one was fulfilling a specific role within the family dynamics. As a result of this they started considering previously unconsidered processes. Peter also felt that the therapy was helpful in that it provided them with an opportunity to speak about previously unspoken issues such as the conflict between him and his father. The introduced metaphors apparently assisted them to speak about these unspoken issues. Therapy was thus also considered as a learning context within which new social skills such as talking about emotionally laden issues were acquired.

It is clear from the above description that the experience of helpfulness was very prominent for each participant yet also slightly different for each participant. All of the participants, however, indicated that the 'bringing forth' of relational patterns and emotional experiences were particularly helpful as these provided clients with new insights with regard to themselves and their relationships. This different point of view consequently provided clients with a challenge to modify their behaviours. For some, the newly found task of taking responsibility for themselves was also accompanied by increased assertiveness and an improved self-esteem. These experiences are clearly in accordance with the aims of provocation as described by Farrelly and Brandsma (1974) and Andolfi et al. (1983), namely to provoke clients into realising the absurdity of their behaviours and into taking more responsibility for their own behaviours and modify them accordingly.

Conclusion

The themes that emerged from the clients' reported experiences of provocation in psychotherapy clearly show that they too had both pleasant and unpleasant experiences during their participation in provocative psychotherapy. Their unpleasant experiences are particularly reflected in the theme of discomfort. The pleasant experiences are again

reflected in the themes of support, being understood, freedom of expression, enjoyment and helpfulness. The themes of unexpectedness, challenge and news of difference can be seen as representative of both pleasant and unpleasant experiences.

Most of the unpleasant experiences, which can be viewed as a direct result of the introduced provocations, were, however, not regarded as negative experiences. These experiences of discomfort had been viewed in the same light as they were intended to be, namely as beneficial to the clients. Clients indicated that the experienced discomfort, challenges and news of difference often provoked them into considering more appropriate alternatives to their dysfunctional behavioural patterns.

It is furthermore significant to note that no harmful experiences were reported by any of the participants. Neither of the applied techniques, including the use of humour, was considered potentially harmful by any of the clients. This finding is in contrast to Kubie's (in Buckman, 1994b) opinion that the use of humour in psychotherapy can be harmful to clients. None of the clients participating in this study indicated that they felt that the use of humour had taken away from the importance of their issues. On the contrary, humour was regarded as a technique which facilitated clients' communication about emotio

therapists' efforts to effectively enter the family system. The question thus remains whether provocative psychotherapists should actively affirm clients or not.

In the final analysis, provocative psychotherapy had been described as a mostly positive experience by all the participating clients. They indicated that, although often unusual, participating in provocative psychotherapy had frequently been freeing and enjoyable while simultaneously perturbing them and providing them with new insights. This consequently challenged clients to take on more responsibility for modifying their interactional patterns. These experiences are clearly in accord with most of the client experiences of provocation in psychotherapy as quoted by Farrelly and Brandsma (1974).

Synthesis

Both the therapist and clients who participated in this study indicated to have experienced provocation in psychotherapy as mostly positive, yet perturbing. Fresh insights were acquired by both therapist and clients and all participants indicated that some form of personal growth had taken place as a result of their involvement in provocative psychotherapy. These shared experiences are evident from the overlapping themes that emerged from the clients' and therapist's descriptions of their experiences. The overlapping themes are those of freedom, enjoyment, challenge, discomfort, unexpectedness and helpfulness. Of these, the themes of freedom, enjoyment and helpfulness consistently represented pleasant experiences whereas the themes of discomfort and challenge referred to unpleasant, yet growth-producing, experiences. The theme of unexpectedness, in the therapist's case referred to mostly pleasant experiences whereas in the clients' cases to either pleasant or unpleasant experiences depending on the specific context. It is, however, interesting to note how the use of provocative techniques was experienced as provocative by both therapist and clients alike. The implementation of therapeutic provocation clearly posed a challenge to both the therapist and the clients involved in this study. Provocative psychotherapy had thus at times been experienced as unpleasant and at times as pleasant by both the therapist and clients.

It is, however, important to note that the described unpleasant experiences had not always been negative experiences. In fact, only two negative experiences had been cited by two individual clients, namely those of loneliness and a need for affirmation. Although these negative experiences must be given serious consideration, it is encouraging to note that all the other unpleasant experiences can actually be viewed as positive experiences within the context of provocative psychotherapy. These experiences are regarded as essential for both

therapist and clients alike as they present them with a challenge to take the risk of exploring new, creative ways of being. The implications of these experiences for the broader field of psychotherapy will be considered in the final and concluding chapter.

CHAPTER 8

CONCLUSIONS AND RECOMMENDATIONS

In this concluding chapter a general review of the conducted research will be provided whereafter an evaluation of the study will follow. The implications of the findings of this study for the field of psychotherapy will also be considered, followed by certain suggestions for future research.

General Review

The aim of this study was to explore the experiences of a selected sample of clients and a therapist who had participated in provocative psychotherapy. The researcher aimed to establish a co-created description of the experience of provocation in psychotherapy via the identifying of certain themes underlying clients' and a therapist's descriptions of their experiences of provocation in psychotherapy. It is believed that this aim was adequately reached during the course of this study.

In the process of achieving this goal, the researcher provided the reader with a concise theoretical description of the nature of provocative psychotherapy. This was done by considering the work of two influential provocative psychotherapists, namely Frank Farrelly and Maurizio Andolfi. From this description it was clear that therapeutic provocation refers to a communicative modality which includes an element of challenge and which aims to arouse or "bring forth" areas of vulnerability within clients and their relationships. The provocative therapist thus attempts to stimulate a reaction which will permit clients to overcome relational problems through the reconsidering and modifying of redundant behavioural patterns. This is done through an array of suggested techniques while simultaneously providing the involved individuals with therapeutic support (Andolfi et al., 1989).

A description of the plan that guided this research project was provided in Chapter 3. It was explained that this study had been undertaken according to the principles of the qualitative or naturalistic research paradigm. This implied that constructs such as reality, truth, knowledge and objectivity were regarded as arbitrary and fluid. No single perspective was thus regarded as the correct point of departure. Instead, multiple ideas and distinctions were allowed to evolve throughout the process in order to arrive at a co-created reality that fitted with the idiosyncratic system at hand (Anderson & Goolishian, 1988). This study did

thus not aim to obtain the truth about people's experiences of provocation in psychotherapy. Together with Auerswald (1987), truth was rather defined as heuristic. The aim was consequently not to prove or validate any universal truth about participants' experience of provocation but rather to describe the involved participants' experiences and to make sense of the obtained data along the lines of the researcher's own frame of reference (Fourie, 1998).

Guided by the principles and methodology underlying a qualitative research paradigm, descriptions of the participants' experiences of provocation in psychotherapy were presented by means of three case studies. In these case studies the experiences of provocation of participants in individual, couple, and family psychotherapy were presented. The experiences of both the therapist and clients involved in the described cases were considered. This was done by means of the provision of self-reports by the therapist and the presentation of transcripts of interviews conducted with the various clients. In each case certain themes that emerged from the clients' described experiences were identified. These themes were eventually compared in order to identify certain shared themes from all the clients' expressed experiences. The interconnected themes that emerged from this process are as follows: unexpectedness, discomfort, challenge, news of difference, support, being understood, freedom of expression, enjoyment and helpfulness. Themes from the therapist's experiences were identified likewise and included the following: freedom, honesty, enjoyment, empowerment, rewards, challenge, unexpectedness, discomfort and uncertainty.

It is clear that both pleasant and unpleasant experiences were described by the therapist and clients involved in this study. Both therapist and clients indicated that they felt extremely perturbed at times, yet at other times they indicated that they thoroughly enjoyed participating in provocative psychotherapy. The experiences were, however, mostly described as positive or beneficial by all the involved participants. These experiences correlate well with both the client and therapist experiences described by Farrelly and Brandsma (1974) and Bloom (1992). Attention will subsequently be given to an evaluation of the study at hand.

Evaluation of the Study

An evaluation of this study can be considered in terms of the strengths and limitations of the study.

Strengths of the Study

It is believed that the strengths of this study are mainly related to the qualitative methodology employed during the course of the study. This supposition is supported by Baillie and Corrie (1996, p.308) when they argue, "Given its retrospective nature, we suggest that a qualitative methodology is the most appropriate way of addressing the global aspects of client experience". With regard to the study at hand the qualitative approach was believed to be particularly helpful in that it provided the research participants (clients and therapist) with an opportunity to speak for themselves. Unlike quantitative methodologies, the qualitative approach does not reduce human experiences to quantifiable statistics. Especially the case study method, employed in this research project, allowed for the obtaining of information through the use of respondent's own language. As was said in Chapter 3 of this study, by employing the case study method, attempts were made to provide readers with a glimpse of the respondents' worlds through the eyes of the respondents. This, furthermore, provided for a 'thick description' of the participants' experience of provocation in psychotherapy (Lincoln & Guba, 1985). Lincoln and Guba are of the opinion that multiple realities are difficult to communicate through quantitative methods, as are the interactions between researcher and respondents, the background to cases and the many mutually shaping processes that occur during a research process.

Another advantage of the case study method, cited by Lincoln and Guba (1985), is that it provides the reader with a vicarious experience of the inquiry setting. This implies that the reader is likely to experience the case report as grounded, holistic and lifelike. The reader is furthermore provided with an opportunity to draw his/her own distinctions from the provided data to subsequently either agree or disagree with the distinctions drawn by the researcher. This was particularly the case in this study as transcripts of the conducted interviews as well as background information to each described case had been provided.

The inclusion of the therapist's experience of provocation can also be regarded as a strength of the study at hand. Such an inclusion of the therapist's experiences does not only broaden the scope of this study but also brings the study in line with the principles underlying second-order cybernetics. According to these principles any description of a system has to account for the observer as much as for the members of the system. This implies that the observer is part of the observed system and that the observer and observed mutually influence each other (Hoffman, 1985). The therapist was thus not regarded as an objective

outsider to the therapeutic system, but rather as part of this system with his own human experiences.

The equality between researcher and respondents was further enhanced by the fact that the clients were continuously consulted with regard to the research findings. The themes that were identified from the clients' descriptions of their experiences of provocation were continuously verified with the clients in the form of member checks. Member checks, which were carried out regularly, allowed for descriptions to be co-created through interaction as it provided participants with an opportunity to query any misunderstandings immediately (Reason & Rowan, 1981). Respondents thus played an active role throughout the research process to consequently provide for a truly co-created description of the experience of provocation in psychotherapy.

A last advantage of this study that deserves to be mentioned is the inclusion of participants who participated in three different therapeutic contexts, namely, individual, couple and family therapy. This provided the reader with a thicker description of clients' experiences of provocation in psychotherapy. Unique variations that emerged from different conditions and contexts had thus been provided (Lincoln & Guba, 1985). The study had, however, also been subjected to certain shortcomings which will subsequently be considered.

Limitations of the Study

One of the major limitations of this study could be regarded as the narrow scope of the study. A description of only three groups of clients' experiences of provocation as understood and implemented by a single therapist, had been provided. A very limited sample of provocative psychotherapists and their clients had thus been included in this study. The therapeutic provocation referred to in this study is furthermore limited to the specific therapist's unique understanding and implementation thereof. This implies that the study was limited by certain personal and unique contextual factors such as the involved therapist's understanding and implementation of provocation, the unique therapeutic interactions that took place and the participants' idiosyncratic way of drawing distinctions. No claims can thus be made with regard to a description of a universal experience of provocation in psychotherapy. Arbitrary generalisations of the findings to other contexts should thus be regarded as illegitimate. As the researcher employed a descriptive, qualitative method, the findings cannot either be proved or verified by future replication. If considered from a traditional quantitative perspective, this would be viewed as a serious

limitation in terms of reliability (Rawsthorne, 1998). From a qualitative perspective the aim of the inquiry would, however, be to merely create an idiosyncratic body of knowledge that can be utilised to describe a specific case within a specific context (Lincoln & Guba, 1985). From this perspective, the lack of transferability and generalisability would thus not be viewed as a disadvantage.

A further limitation of a qualitative research methodology is that a researcher would tend to select data that fits with his/her own working hypotheses and initial impressions (Moon et al., 1990). The researcher's frame of reference would thus largely determine his/her idiosyncratic way of drawing distinctions. The themes identified during this study as representative of the therapist's and clients' experiences of provocation in psychotherapy should thus be regarded as arbitrary and context bound. Another researcher might very well have drawn completely different distinctions which might have been equally legitimate. The same would be true of the readers of this study who may possibly also attribute different meanings to the provided data.

The fact that the therapist who conducted the therapies with the involved clients, also conducted the interviews to enquire about their experiences of provocation can also be viewed as a limitation. This can be viewed as a limitation as the possibility exists that clients could have been cautious about offending the therapist and thus refrained from being completely honest with the therapist about their experiences, especially their negative experiences. In this regard Elliot and James (1989) rightly remark that, under certain circumstances, clients might be imperfect sources of information. These authors state that clients might sometimes deliberately or unconsciously limit or distort provided information. This might specifically happen where clients have an established relationship with the therapist/researcher and consequently do not want to cause harm to the relationship. Clients might furthermore not be conscious of or remember particular aspects of therapy and/or their experiences thereof. Their reports might also be biased by response sets, unknown pre-existing beliefs and ideas, self-presentation style, situational cues, and the like. The reliability of client reports might further be reduced by unknown external influences, a lack of vocabulary, a lack of interest in participating in the research project or an idiosyncratic understanding of questions or concepts such as provocation (Elliot & James, 1989). Failure to talk about a certain topic can, for example, not be interpreted as indicating that the specific topic did not form part of a participant's experience. It might simply reflect the particular angle adopted in answering the researcher's questions (Baillie & Corrie, 1996).

Implications for the Field of Psychotherapy

Farrelly (in Farrelly and Brandsma, 1974) states that there had been a number of reasons why some therapists have not adopted a provocative approach to psychotherapy. Some of these reasons are reported to be related to a fear of harming clients or to stagnation by therapists in their tried and tested ways. The descriptions that evolved during the course of this study have certainly challenged such hesitations with regard to the use of provocation in psychotherapy. These descriptions have clearly indicated that provocation can be used with confidence and with positive effects, as both the therapist and clients participating in this study had described their experiences of provocation in psychotherapy as mostly positive. It is thus believed that this study can play a role in further legitimising the use of provocation in psychotherapy. The fact that no harmful experiences with regard to the implementation of provocation had been reported suggests that therapeutic provocation can be legitimately implemented in an ethical manner.

This study can furthermore provide therapists with a better understanding of certain affective processes underlying the use of provocation in psychotherapy. It is believed that this can in turn lead to a better considered and more effective implementation of therapeutic provocation. A consideration of the findings of this study is thus likely to enhance the understanding of the effects of therapeutic provocation on both clients and therapists on a practical and theoretical level (Elliot & James, 1989). Upon considering the descriptions that evolved from this study, therapists can draw their own distinctions and make their own choices with regard to the use of provocation in psychotherapy.

This study would further urge therapists to consider the possible perturbing effects that the implementation of therapeutic provocation could have on both clients and therapists. It is clear from the descriptions provided in this study that the likelihood exists that the implementation of a provocative approach could often render both therapist and clients uncomfortable and consequently demand a great deal of courage from all participants. The taking of therapeutic risks are, however, encouraged by the findings of this study as it has been described how the taking of risks and enduring of discomfort had often resulted in therapeutic and personal rewards.

It can also be argued that the findings of this study could serve as an invitation to therapists to experiment with the use of provocation in psychotherapy. This is likely to be the case as many pleasant experiences, such as enjoyment, freedom, honesty and helpfulness, had been described by participants participating in this study. Both therapist and clients

participating in this study found that these pleasant experiences of provocation had often lured them into the exploring of new and exciting ways of being. The researcher would thus confidently recommend the use of provocation in psychotherapy and urge prospective provocative therapists and clients not to hesitate to take the necessary risks underlying the implementation of provocation in psychotherapy. These risks are believed to often produce exciting and growth producing results.

The researcher would, however, also want to recommend that therapists never neglect the providing of support as recommended by provocative therapists such as Farrelly (in Farrelly & Brandsma, 1974) and Andolfi et al. (1989). It is believed that such a provision of support is vital in order for therapeutic provocation to have its desired effects.

It is finally recommended that provocative psychotherapists continuously consider their experiences of provocation in psychotherapy from a self-reflective stance. Therapists are furthermore urged to also continuously be sensitive to, and inquire about, clients' experiences of provocation in psychotherapy. The researcher is of the opinion that such a continuous exploration of the experience of provocation in psychotherapy could enhance the therapist's ongoing growth and learning process. This can, in turn, lead to more effective and meaningful therapies for both clients and therapists (Metcalf & Thomas, 1994).

Recommendations for Future Research

Although it is believed that this study has made some positive contribution towards the existing body of knowledge with regard to clients' and therapists' experiences of provocation in psychotherapy, some recommendations can be made for future research.

The first matter that is believed to merit further research is that of clients' experience of therapist support during the implementation of provocation. This is recommended as two of the participants in this study expressed a need for a more direct form of support or affirmation as described by therapists such as Minuchin (1974). Inquiries can be made into the experience of certain different forms of therapist support and the effects thereof on the therapeutic process and outcomes. The experience and effects of therapist support expressed in a more indirect way as recommended by Andolfi et al. (1989), can, for instance, be compared to the experience and effects of support expressed in a more direct way as suggested by certain other therapists (Bloch & LaPerriere, 1973; Framo, 1982; Minuchin, 1974; Minuchin & Fishman, 1981).

It can also be recommended that research be conducted on the experiences of provocation of a broader spectrum of clients and therapists. In this regard, the experiences of more than one therapist could be compared as well as the experiences of clients of a number of therapists. It is recommended that such studies should once again be conducted from an exploratory, qualitative research paradigm as such a paradigm is believed to best facilitate the nuances of human experiences.

Much attention has been given to clients' experiences in psychotherapy (Elliot & James, 1989), but very little research has been conducted on therapists' experiences in psychotherapy. It is therefore recommended that future studies also include the descriptions of therapists' experiences of psychotherapy and particularly of the use of provocation. It would be interesting to explore the effects of the use of provocation on a variety of therapists and specifically the perturbing effects thereof, as it was described in this study. Such explorations of therapist experiences would certainly be in line with the principles of second – order cybernetics, which stress the inclusion of the therapist in the therapeutic system. The continuous consideration of therapist experiences can most certainly also be helpful in creating new learning opportunities for all psychotherapists.

Conclusion

Elliot and James (1989) and Baillie and Corrie (1996) pointed to the need for more qualitative, exploratory research with regard to participants' experiences of especially whole courses of treatment. They explained that this level of inquiry has the advantage that it can be utilised to tap into global perceptions and feelings, particularly in relation to the therapeutic relationship and the elements of therapy experienced as most helpful. It is hoped that by describing the experiences of both clients and a therapist who participated in provocative psychotherapy, this study has made some contribution towards fulfilling such need for exploratory research as cited by the above-mentioned authors. It is, however, recommended that inquiries into therapists' and clients' experiences of provocation be regularly undertaken from a variety of perspectives in order to continuously "thicken" the description of such experiences.

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APPENDIX A

Letter of Consent

Your participation in my Master's research project is greatly appreciated. The aim of the study will be to inquire about your experience of the therapist's use of provocation in therapy.

Your participation will simply involve participation in video recorded interviews during which you will be granted an opportunity to relate your experiences of provocation in psychotherapy. It is hoped that our conversations will be mutually beneficial and rewarding in shedding new light on the experience of provocation in psychotherapy.

Please note that:

- You are under no financial commitment or obligation.
- All information will be treated with strict confidentiality.
- I cannot guarantee that you will derive any benefits from participating in this project.

Thank you again for agreeing to participate.

NAME: _____ DATE: _____

ADDRESS: _____

SIGNATURE: _____