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CONFRONTATION IN PSYCHOTHERAPY

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The use of the term *confrontation* is relatively recent in the field of psychiatry; and, like many of the terms in frequent usage, a clear definition has been difficult to reach. Since, however, it is a most meaningful concept, it is important that we make some attempt to explain it.

The process of confrontation is essentially communicative. A therapist might point out to a patient something he does not know about himself, something he knows only vaguely, or something he knows but thinks others don't know. He might also point out aspects of reality that are being denied, or he might extrapolate from present reality in order to help the patient use his foresight more effectively. But when we refer to these communications as confrontations, we not only imply that the patient is being made aware of certain aspects of his neurosis that require exploration and analysis; we also imply that pressure is being exerted on the patient to give up certain neurotic patterns of behavior.

Since neurotic patterns of behavior can take many forms, the opportunities for using confrontation are innumerable and the basis for such use will vary from case to case. In this chapter only a few general issues

concerning the role of confrontation will be discussed.

Many neurotic patterns of behavior are derived from attitudes of excessive entitlement. When a therapist confronts his patients with these patterns of behavior, he must also point out the underlying attitudes of entitlement in order to foster further analysis. For example, one patient who was a businessman commented *en passant* to the effect that he expected a high degree of loyalty from his employees, as anybody would. Since this comment was made in a manner that communicated an attitude of excessive entitlement, I tried to explore what the patient meant by "loyalty." He went on to express indignation toward some former employees whom he had taught the business and who had deserted him to take positions elsewhere. As the material unfolded, it became apparent that for this patient loyalty meant that no one to whom he had become attached had a right to leave him. When this implication was pointed out, he became angry; but he immediately realized that it was correct. In subsequent hours he revived memories of severe reactions to brief separations from his parents during childhood and of his extreme reluctance to accept the fact that such separations were necessary. After working through this material, there was considerable mitigation of his pathological attitudes of entitlement.

This confrontation helped the patient not only to gain insight into his excessive entitlement but also to give up his neurotic overpossessiveness in

regard to his employees. It was as though he received and accepted the following mandate for change: “You really do not have a right to enslave your employees and to restrict their opportunities for growth and advancement. This type of behavior is selfish, childish, and unfair. It is therefore necessary for you to analyze the childhood basis for this behavior so that you can give it up and eventually have more mature relationships with your associates.”

It is not uncommon for a patient to express his excessive entitlement through provocative behavior during therapy. In fact, a patient may be dedicated to making the therapist angry and may also be quite talented in doing so. Under such circumstances, it may be necessary not only to point out the attitudes of excessive entitlement but also to inform the patient that he has succeeded in evoking the therapist’s anger. Following such a confrontation, the patient may complain that the therapist has no right to be angry at him; but he then has to be made aware of the fact that this attitude, too, is a form of excessive entitlement. In other words, the patient’s self-defined “rights” must be repeatedly questioned since they not only negate the rights of others but also complicate his relationships.

When a patient reacts to these confrontations by controlling his provocative behavior, it may appear that he is merely responding to the threat that therapy will be terminated if he does not change. One might, therefore, be tempted to conclude that the only effect of the confrontations is

to motivate the patient to check the acting out and that this motivation hinges primarily upon his libidinal attachment to the doctor and his fear of abandonment. I believe, however, that these confrontations often lead to additional therapeutic effects; namely, to major insights as well as to further exploration and analysis. And the further exploration is usually directed toward determining how this patient reached adult life with the attitude that he was entitled to have so many of his demands met by others.

Although confrontations concerning excessive entitlement can often be made with the therapist presenting a relatively neutral affect, they are often more effective if his anger is not totally suppressed, since an important aspect of the insight being sought is the patient's awareness that the expression of his infantile entitlement *does* evoke hostility in others and *has* evoked hostility in the therapist. Furthermore, whether or not the therapist makes his confrontations with anger, one would expect the patient to respond with anger, since the exposure of his excessive entitlement typically produces a narcissistic injury. The resulting hostility of the patient can then be gradually resolved as he works through the narcissistic injury and advances to a higher level of maturity. It is therefore apparent that a competent therapist has to be prepared to face his patient's hostility in order to make effective confrontations. The therapist who has poor tolerance for hostility may adopt the defensive posture of waiting for the patient to bring forth additional material, in the hope that new insights will arise spontaneously; and he may

rationalize this defensive posture by claiming that he is using it "voluntarily" in order to foster the analytic process.

Although many patients have attitudes of excessive entitlement, there are others who have attitudes of restricted entitlement, which may lead to severe inhibitions. In a recent paper (Levin, 1970), I noted that the patient who has attitudes of restricted entitlement may repeatedly defer to others and may even allow others to steal many of the rewards that rightfully belong to him. This type of patient has to be confronted with the fact that he is not standing up for his rights. Such a confrontation also elicits hostility, since the patient tends to feel that he is being called a "weakling." But after assimilating the confrontation and resolving the narcissistic injury resulting from it, the patient usually moves ahead in treatment and explores the excessive childhood fears that have prevented him from asserting himself. Furthermore, he usually begins to face these fears and to master them.

These kinds of confrontations represent the exerting of pressure in a particular direction. When an attitude of excessive entitlement is present, the therapist pushes back the patient's hostility, indignation, and over-assertion and forces him to rework his expectations so that he can arrive at a more mature level of "normal entitlement." When an attitude of restricted entitlement is present, pressure is exerted in the opposite direction. The patient is helped to recognize that, since many of his expectations are

restricted, he has to rework them so that he can arrive at a more mature level of "normal entitlement." He is also helped to realize that in order to translate this reworking process into action he has to dare to be more assertive and to master some of his fears (Levin, 1962).

When combined treatment of a husband and wife is undertaken, confrontations represent an important component of the therapeutic armamentarium (Levin, 1969a, 1969b); and it is often necessary for the therapist to use confrontations in the early phases of treatment. For example, in treating one couple I noted that every time the wife began to talk about the husband, he turned the spotlight away from himself and started to cross-examine her. If she mentioned that he showed some hostility toward her friends, he would make a defensive remark, such as, "When was that?" If she then told him a specific occasion, he might answer, "Are you sure that's what I said?" and so forth. I pointed out to him that he was behaving like a cross-examining attorney and that he really did not discuss what his wife had said. He was startled by this comment but replied with surprise, "Yes, you're right." It was then possible to help him understand the basis for this type of response; namely that he became self-conscious and embarrassed whenever the spotlight was turned onto his own behavior. Following this phase of treatment he was freer to look at himself. In a later interview I confronted him with the fact that whenever his wife discussed her unhappiness, he reacted sensitively, as though he felt attacked by her. I pointed this out after

his wife had made a neutral comment. I stated that his wife's remark did not sound the least bit critical, yet he was reacting as though it were. He seemed surprised, but it was then possible for him to say that he was beginning to realize how sensitive he was. Subsequently the quality of the interviews showed a pronounced change as his defensive, attacking posture was replaced by a subjective, self-examining posture.

In another married couple whom I saw in treatment, the husband's domination was pronounced. As soon as the wife would make a brief comment, she would be quickly and subtly squelched by the husband, who would then monopolize the interview. I confronted him with his tendency to "jam" her communications and his inclination to intimidate her with his self-righteous attitudes. He was initially surprised, since he could not believe that his wife was afraid of him. But he soon realized the accuracy of my remarks and began to exert control over his dominating behavior. It was not long before the character of the interviews changed and the wife began to communicate more freely.

The use of confrontations should serve the purpose of facilitating the therapeutic process and should not serve as a vehicle merely to effect a change in behavior accompanied by closure concerning the dynamic issues involved. For example, if a patient brings gifts to his therapist and is told only that he is behaving inappropriately, this confrontation can act as a simple

prohibition. However, if the confrontation is worded in such a way as to help the patient explore his need to bring gifts, not only will his behavior change, but the process of self-examination and the gaining of insight will be facilitated.

It is worth noting that confrontations which are incomplete may at times be anti-therapeutic. In a previous article (Levin, 1971), I reported a case in which the analyst pointed out the patient's strong dependency needs but neglected to point out his excessive shame concerning these needs, a shame that resulted in his making strong efforts to hide his dependency from others. Due to the analyst's omission, the patient's shame was reinforced, and he reacted by trying even harder to hide his dependency. It was only later, when the patient's shame was clarified, that it lessened. As a consequence, the patient became more tolerant of his dependency needs and was then able to subject them to careful analytic scrutiny.

Since confrontations tend to produce narcissistic injuries, the therapist usually tries to present them in doses that are tolerable, gradually increasing the dose as he judges it to be appropriate. One might, therefore, think of the therapeutic process as a form of desensitization. Even one's terminology may change as one prepares a patient for a confrontation or builds up to a more complete one. Early in therapy one might indicate to a patient that he has a fear of missing something, later that he feels deprived, and finally that he is

greedy or selfish. Or initially one might tell a patient that he appears annoyed, later that he shows resentment, and finally that when he becomes angry, he tends to withdraw into a stubborn form of sulkiness.

Correct timing is obviously of considerable significance, because the therapist has to be reasonably sure that the patient is ready to give up some of his defenses, especially that of justification. If the patient is not ready, he usually responds with a hostile rejection of the confrontation rather than with the more common reaction, hostile acceptance of it.

Although it is usually necessary for the therapist to be tactful, he can easily fall into the trap of being too tactful and thereby deprive a confrontation of its therapeutic impact. In fact, a therapist may use tact defensively in order to avoid struggling with the patient.

Sometimes a therapist has to rely on speculative confrontations. For example, if a patient wants to cancel an hour and gives somewhat vague reasons for making the request, the quality of the patient's responses (suggesting that something is being acted out) may evoke an uncomfortable reaction in the therapist. A therapist's statement that he feels material is being suppressed, even though he does not know what it is, may be the type of confrontation that can lead the patient to bring forth additional data. This content may then substantiate the therapist's speculations concerning "acting

out" and lead the patient to consider options other than cancellation. It is, therefore, necessary for a therapist to take his countertransference responses seriously at all times and not be afraid to express his reservations about the patient's stated reasons for his behavior. A therapist must be an explorer, and he is often in the position of Columbus, who dared to sail out across the ocean not knowing where he was going but knowing that he was going to find something new.

But there are also times when confrontations must be carefully avoided. For example, when reality is being grossly distorted, a premature attempt to confront the patient with this fact might lead to a flight from treatment. In a recent paper on the depressive core in schizophrenia (Levin, In Press b), I discussed the therapy of a schizophrenic patient who had a delusion of having a penis growing inside her vagina. This delusion was essential to the patient's psychic equilibrium and had to be respected. I therefore totally bypassed the delusion and focused on the underlying depressive currents. It was only after the psychosis had cleared that I analyzed the basis for her delusion.

Many therapeutic confrontations include a clarification of intense shame reactions, their connection with childhood experience, and the numerous projections to which these reactions give rise. These projections take the form of expecting and often experiencing criticism, ridicule, scorn, rejection, etc., from others, including the analyst. Before the patient's

excessive shame can be analyzed genetically, he has to be confronted repeatedly with these projections. It is apparent that one of the basic questions that eventually has to be answered through analysis is "How did the patient become so ashamed of himself?"

It has been my experience that careful explorations of shame are necessary in order for many patients to move ahead in their development. Since shame acts as a barrier to the libido (Levin, 1967), one often has to help the patient make new efforts to overcome this barrier. These efforts tend to arise after the patient realizes that, due to shame, he often does not dare to feel his love for others and often does not dare to express this love. Once this daring process is initiated and mastery of the underlying shame occurs, the ability to love is liberated and many derivative forms of loving are then possible. I believe that this is what Freud meant by reaching the genital level of development. Clinical experience indicates that the inhibitions our patients manifest often arise from excessive shame over sexual thoughts, feelings, and impulses and that, in order for these inhibitions to be successfully removed, the excessive shame must be pointed out and eventually mastered.

The degree of understanding and technical ability that an analyst must have in order to use confrontations effectively can be illustrated by the type of decisions he must make in analyzing shame. In a previous publication (Levin, 1967), I used the term "secondary shame" to refer to instances in

which a person feels ashamed of reacting with excessive shame. In a later article (Levin, 1971), I noted that, when a patient's intense primary shame results in severe blocking, he usually experiences intense secondary shame over the blocking itself and may therefore make strong efforts to override his blocks. But if this effort leads him to bring forth content that mobilizes intense primary shame, he may suffer excessively. In such instances the analyst can usually relieve the patient's suffering by mitigating the secondary shame. This effect is achieved by confronting the patient with his excessive shame concerning silence and by clarifying the projections resulting from this shame; namely the unrealistic expectations of being severely criticized for his silence by the analyst. This confrontation usually leads the patient to relax his efforts to overcome his blocks. On some occasions, however, the patient may relax his efforts too much. It may then be necessary for the analyst to confront the patient with the fact that *now* he is not trying hard enough to express his thoughts. This type of confrontation reactivates the patient's secondary shame and usually leads him to try a little harder to communicate. The analyst may also reinforce the secondary shame by waiting longer before interrupting the patient's silences. However, if too much pressure is exerted in this way, excessive secondary shame may be produced, leading to anger and often depression. In fact, the patient may even become highly resistant and terminate the analysis.

In order to avoid excessive shame, therefore, the analyst often has to

make confrontations with the following aims in mind: (1) to exert some pressure upon the patient to reveal his thoughts so that he does not remain silent and therefore experience intense secondary shame; and (2) not to exert too much pressure upon the patient to verbalize, because he may then experience intense primary shame. Furthermore, since the patient will react to each confrontation as a criticism, it is necessary for the analyst to evaluate the patient's sensitivity carefully, since such evaluation enables him to decide how much pressure to exert at any particular time without evoking a severe narcissistic injury. If confrontations are properly dosed, the patient will not experience either excessive primary shame or excessive secondary shame; and he will be appreciative of the fact that, although he is being pressured to communicate, he is also being protected against overexposure.

In order for a person to become a competent therapist, considerable mastery of his own fear as well as considerable resolution of his own shame reactions is necessary. He will then be able to confront his patients appropriately, with confidence that the hostility he evokes in them can be worked through successfully.

It is worth noting that the impetus for making a confrontation often arises from the fact that the therapist has responded with hostility to the patient. The hostility may be mobilized not only by the frustration that the therapist experiences in trying to overcome the patient's resistances. A

competent therapist will monitor his own hostility and use it primarily as a barometer so that he can analyze his patient's provocative tendencies, but sometimes he has to express his hostility along with his confrontations. When he does express his hostility, he will try to do so creatively rather than in the interest of exploiting the therapeutic situation for purposes of his own abreaction. Furthermore, the confrontations that he employs will usually carry with them an expression of some positive feeling and a desire to be helpful. The therapist's ability to understand what is going on enables him to continue to feel some affection for his patients even when they are being provocative. However, affection should not be forced. The therapist who believes that he *must* feel positively at all times may actually manifest a complicating type of countertransference in which the predominant feature is a reaction-formation of excessive tolerance with a pathological denial of his own hostility.

In some respects, a therapist's role is akin to a parent's, for each must exert appropriate quantities of pressure at appropriate times in order to facilitate developmental steps. This requirement puts the therapist in the position of having to make difficult decisions. Freud (1926) pointed out the problems that parents face in deciding how to deal with the child's sexual behavior and the ways that they can show either too much or too little permissiveness. Parents are often in the position of searching for a "golden mean" in applying psychological stress to the child. The same can be said

concerning a therapist in regard to the use of confrontations. He, too, is constantly searching for a "golden mean" in applying psychological stress to the patient.

Each therapist undoubtedly has his own ideas about how he should behave toward his patients. These ideas are acquired primarily during training, mainly through supervisory experiences, and include ideas about the degree of activity advisable. But there is another factor that influences the degree of activity; namely his own personality structure. If a therapist has strong fears of spontaneity, he may be *too passive*; if he is impatient or impulsive, he may be *too active*. If he is too active, he may not permit the patient to struggle through his blocks and to bring forth certain memories and fantasies. If he is too passive, the patient may knock himself out trying to get a response and may become more and more depressed when there is none. If the patient perceives his therapist's silence as disapproval and this feeling is not explored, the patient can thrash around trying to please and can make little progress. Even though the patient's associations might include significant memories, such as times when his mother showed her disapproval through silence, this type of material may not be effectively used until the therapist clarifies the concomitant transference responses.

It is generally accepted that a therapist must not only be free to be spontaneous; he must also be able to exert self-control. There are those who

are too active because they are emotionally and verbally incontinent. There are also those who are too active because they have an excessive need to be liked by the patient, and they may therefore deal with the patient's productions in such a way as to reinforce his suppression of hostility. Furthermore, in order to minimize the patient's hostility toward them, they may be too ready to introduce parameters that reduce frustration unnecessarily or avoid essential narcissistic injuries.

It is well recognized that in psychoanalytically oriented psychotherapy, one usually waits for the patient to build up a solid libidinal tie to the therapist before major confrontations are offered. It is this tie that gives the therapist his leverage so that he can make comments to which the patient can respond with anger without fleeing treatment. Although we realize the importance of this libidinal tie, we also realize that people are not cured by their love for us or by our love for them. It is essentially through the acquisition of insight and the consequent building up of new ego structure that the patient eventually moves ahead to higher levels of maturity. And it is essentially with these goals in mind that the therapist introduces his confrontations as major steps in the therapeutic process.

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