Psychotherapy Guidebook

Confrontation in Psychotherapy

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DEFINITION

The Oxford English Dictionary defines the verb “confront” as “to bring a person face to face with.” Exactly how psychotherapists bring their patients “face to face with” their problems in a way that will lead to change is what differentiates the various psychotherapies that have developed since the classical psychoanalytic approach of Freud. The dictionary’s alternative definition of “confront,” “to face in hostility or defiance ... to oppose,” has lead many people to view “confront” as an aggressive means to express opposition. This is not the sense in which the term is used in psychotherapy.

HISTORY

The psychoanalytic use of confrontation was, of course, originated by Sigmund Freud. Freud believed that the pathological factor in neurosis was not the patient’s ignorance of his mental mechanisms but his “inner resistance,” which brought the ignorance into being in the first place. Therefore, Freud generally remained passive and limited confrontation to interpretation of transference and resistance, and to occasional reality

testing. Freudian psychoanalysts have in general continued to follow this practice.

Many analysts who followed Freud used confrontation in a less limited way. Karen Horney, who broke with Freud over the importance of the influence of cultural factors, rejected the role of the analyst as merely an “interpreting voice” rather than a reactive human being. If she believed the patient was “running into a blind alley” she would not hesitate to actively intervene and suggest alternatives.

Alfred Adler was the first of these analysts who actively confronted his patients with their self-deception. He encouraged them to relinquish negative “life-styles” and to adopt “positive roles.” Sandor Rado, who also began as a classical analyst, originated the “adaptational” school of analysis. He confronted patients with the need for change and emphasized that insight occurs only through practice in daily living as the patient “automatizes” new, more healthy behavior. Bernard Robbins was originally identified with Horney, but later went on to develop confrontation to its ultimate therapeutic advantage. He believed that it is necessary for therapists to actively intervene in getting patients to change their actual practice: “Inner growth does not come from within, but through man’s practice on the outside world (Robbins, 1952).

Many family therapists use even more active confrontation techniques. For example, Salvator Minuchin uses confrontation in a process he calls “restructuring operations” which are “the therapeutic interventions that confront and challenge a family in the attempt to force a therapeutic change.”

TECHNIQUE AND APPLICATIONS

The techniques of confrontation described here are used by many present-day practitioners, especially those who employ short-term therapy, family therapy, group therapy, and crisis intervention. From the foregoing history it is clear that what the patient is confronted with and how the therapist makes the confrontation have changed through the years. Today, practitioners of the various schools of therapy generally continue the original techniques.

The theory and technique of confrontation that follows is based on the proposition that neurosis is a disturbance or distortion of our view of ourselves and of others, and Can be changed ultimately only through new, correct, and undistorting experience. Of course, as in all scientific processes, the therapist must wait until a significant block of information is gathered to point to the modes of thinking and functioning that most likely are producing the patient’s problems. The therapist’s views must be communicated at the appropriate time, and in a manner that can be clearly understood and

accepted by the patient. This is the essence of what is called “timing” and “interpretation.” New ideas in the form of the resulting “insight” do not in themselves produce change. The confrontation of interpretation is only the beginning of the process of an active interchange between the patient and therapist. Since we are interested in useful change for the patient, and not merely insight, further confrontation is required to insure a change in the actual interpersonal and social activities of the patient. The requirement of confrontation is absolute in therapy when a change in behavior is crucial to avert a crisis. This confrontation must take place in a friendly and supportive manner, and in the spirit of collaboration, so that the patient understands that it is the therapist’s wish to help him or her live in a new way that is more effective, productive, and gratifying. This is the type of confrontation that has made short-term therapy possible and can increase the efficiency of other therapies.

How can the therapist, through such confrontation, help the patient to overcome resistance to change, which in routine psychoanalysis takes years to “work through”? It is the acute suffering of most of the patients who seek our help that is the main source of motivation to change. Resistance to change is often overcome by suffering. Moreover, once relief from immediate pressure occurs, the patient is willing to examine other areas of disturbed functioning with diminished resistance. In assessing sources of difficulty, it is essential to confront the patient not only with the effects of his own behavior

and thinking but also with the effects of confusing, limiting, and exploiting behavior of others. This includes the basic limitations embedded in the patient's specific social and economic reality. In this way we can help patients deal with destructive life situations that are not exclusively of their own making. When we help patients to realize what they are not responsible for, they are more able and willing to accept their actual contributions to existing problems.

Since all dysfunction takes place within a disturbed system of human interaction, it is additionally essential that wherever possible we bring family, peers, and even appropriate community members into the therapeutic situation. In this way, not only can confrontation be appropriately directed, but needed change in whole social units can be effected. Individuals in these units can learn to be therapeutically confronting with one another.

Pointing out sources of the patient's difficulty should be only a prelude for the confrontation of needed change. When the therapist sees that change is required to avoid a crisis he, using appropriate timing and supportive manner, will confront the patient with the needed changed activity. Changed activity will produce a new, healthier consciousness and existence. This is the only source of inner growth and useful insight. We know a person's consciousness only by its practice. Confrontation leading to changed human practice will produce the therapeutic "cure" — a changed person with a

changed consciousness.