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CONFRONTATION IN PSYCHOTHERAPY

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In the interest of finding a focus for discussing a topic that has so many ramifications as the concept of confrontation, I decided, at least to start with, to choose an empirical approach, hoping that the nature of the phenomenon rather than *a priori* ideas might help me select a meaningful aspect of this subject. In preparation for this paper, therefore, I asked a number of colleagues to describe clinical vignettes in which they felt they had "confronted" a patient during some phase of psychotherapy. Several of the examples that were reported referred to the therapist's interventions at the onset of treatment where a patient was reluctant to remain in therapy or to become involved with the therapist. In these instances the therapist actively indicated to the patient the hazards of not staying and not becoming involved. For example, in one of the more extreme examples, the therapist stated that he would hate to see the patient in ten years if he did not commit himself fully to the therapy. In other instances, the therapist "confronted" the patient with his unwillingness to recognize one or another distressing aspect of a person close to the patient. One therapist insisted that his patient face the fact that his mother had in fact rejected him.

The majority of the examples reported appeared to fall into two

categories of psychotherapeutic interventions. In these, the therapist either actively pointed out to the patient how his behavior affected other people, including the therapist or the therapist persisted in demonstrating to the patient a feeling or urge that he was reluctant to acknowledge.

What all of the examples appeared to have in common was the element of forcefulness in the therapist's attitude and behavior. The therapist apparently at these times felt the therapeutic situation called for forceful, persistent, insistent interventions and carried them out in this fashion. *Forcefulness*, *persistence,* and *insistence* are relative terms that inherently suggest contrasting attitudes and modes of behavior; *e.g.*, gentleness, tentativeness, persuasiveness. In a general sense the notion of a *confronting* intervention suggests a contrast with an approach that aims at *enhancing* the patient's capacity to observe one or another aspect of himself that he has been reluctant to recognize.

The use of a comparative term such as *criteria* to decide whether or not the therapist's approach is confronting obviously presents difficulties. What one therapist considers to be gentle persuasion may be viewed by another as forceful persistence. One therapist may "confront" his patient's regressive behavior in an abrasive, direct manner, while another may "confront" the same behavior with patience and persistence. Moreover, what on the surface appears to be a gentle enhancing approach may be responded to by the

patient as if it were a demand placed upon him. Therapists or observers of the therapeutic process have no absolute indices to decide whether one approach is more or less forceful or persistent than another, particularly in view of the fact that in any given context the patient's perception or meaning he ascribes to the therapist's intervention is so often an unpredictable but decisive factor.

Nonetheless, the use of comparative terms in discussing the concept of confrontation is relevant, for it corresponds, I believe, to the *state of the therapist's mind at the time* when he decides to confront his patient and likewise in many instances when he decides to employ a more enhancing approach. One of my colleagues, in reporting how he confronted his patient, emphasized that he had "seized the initiative to show his patient something he was avoiding" in contrast to "leading him gently to some insight or letting him develop at his own pace," the latter seeming to meet the criteria of an enhancing approach. Quite apart from how observers might rate it on scales that contrasted forcefulness and gentleness or confrontation and enhancement, he himself felt that he was confronted with a choice—should he "seize the initiative" or should he lead "him gently to some insight" or let "him develop at his own pace." Let us concede, especially because a clinical vignette can only be a stop-action view of events that are isolated from the overall context of the unfolding therapeutic process, that this particular therapist's decision to seize the initiative was based largely on well-thought-

out therapeutic principles and that it was a highly appropriate way of intervening. Yet, based on introspection into my own therapeutic experiences and on observations of therapists I have supervised, I believe that if we do examine the context in which we decide to confront or not to confront, we will frequently find that our decision is influenced in part by nonrational factors, in effect by our countertransferences. This is not to say that our decision at such instances, whether we decide to confront or not to confront, may not be appropriate or useful for our patient, though it may not be. What I am pointing out is that we will better understand the process of confrontation and of many apparently nonconfronting approaches if we examine the context in which we as the therapists decide to confront or not to confront.

This mode of examination, in fact, corresponds to what we do in the therapeutic situation when we are functioning most therapeutically. We not only ask ourselves what kind of changes we want to effect in our patient and/or what kind of relationship we want to establish with our patient so we can effect these changes, but we also ask ourselves why we are choosing at this particular time to effect these changes and/or establish this kind of relationship. This is particularly the case when the therapeutic situation gets heated up—when we sense that we and our patients are interacting in an intense manner. It is at such times, I am suggesting, that we decide, consciously or preconsciously, whether or not to confront.

It is generally true that attempts to conceptualize the psychotherapeutic process start from the vantage point of the therapist's intention to effect changes in the patient or patient-therapist relationship and are discussed in terms of the reasons why he is choosing to intervene. For example, in recent years there has been much discussion and writing about the therapeutic alliance, the therapist as a real person, the therapist presenting himself as a mother of separation, the therapist as someone holding out for the patient the possibility of change, etc. The focus of these presentations is on how the therapist can best present himself to the patient so that their relationship is most useful in the therapeutic process and ultimately in effecting changes in the patient. The emphasis is on the rationale for the therapist's mode of presenting himself or his manner of intervening and not on the context in which he decides to present himself or to intervene in one or another ways.

This is equally true of Edward Bibring's (1954) systematic and thoughtful way of delineating the psychotherapeutic process. Bibring's formulations start from the vantage point of an emotionally uninvolved therapist who, on the basis of his knowledge of how psychotherapy works and of his clear notion about what he wants to accomplish, decides which is the appropriate intervention to produce the desired changes in his patient. The intervention is the stimulus and the change in the patient is the response. This frame of reference allows us to examine and give partial answers to such fundamental questions as what methods we have of modifying the patient's

behavior, how our various efforts work, and what happens to the patient as the result of our efforts. However, this frame of reference puts us in the somewhat unreal position of the detached, basically uninvolved therapist rather than in that of the position of actual therapist trying to work with his resistant patient. Thus his approach is not applicable if we are considering how far and in what ways our emotional reactions to our patients and their emotional reactions to our reactions actually influence, interfere with, and sometimes promote the therapeutic process.

Bibring asked how the various principles work. For example, Bibring indicated that manipulation, one of his principles, accomplishes this effect when the therapist can mobilize or activate what he designated as an "ego system" in the patient. For example, the therapist, presumably in a calm and detached manner, manipulates an uncooperative patient to become more cooperative by telling him that he doubts if he will be a good patient. In short, he challenges him. According to Bibring's formulation, the patient's potentiality for being challenged is the ego system, which has been mobilized or activated by the intervention of the knowledgeable and detached therapist. Yet an uncooperative patient, for whatever reason he may be uncooperative, generally produces a heated-up therapeutic situation. How really calm and detached is the therapist who challenges his uncooperative patient? What is the patient really reacting to if a somewhat annoyed or, even for that matter, a "cool" therapist tells him he doubts if he will ever be a good patient? Is it his

potentiality for being challenged that is activated? Or do we come closer to the nature of the therapeutic process if we consider how he reacts to the therapist himself, who tells him he doubts if he will ever be a good patient—is his reaction one of fear, anger, or admiration? And don't we have to consider, if we are trying to understand the patient's reaction, how the therapist himself was feeling when he manipulated his patient?

Bibring also delineated the criteria that distinguish clarification from interpretation, two of his other therapeutic principles. He found these criteria primarily in the response of the patient. He indicated that an interpretation leads a patient to resist what has been pointed out to him because it touches the patient's unconscious conflicts. He contrasts this with a clarification, which the patient accepts with some degree of pleasure because the new knowledge evokes in him a sense of mastery rather than a sense of danger. A clarification does not threaten the patient; and if it is relevant, it is accepted. An interpretation does threaten and, if it is relevant, will increase the patient's resistance. A detached therapist decides to interpret, to point out something he thinks will evoke connections with his patient's unconscious conflicts; he will then have some indication that his intervention is effective if his patient stops talking, gets angry, comes late the next time, etc., but later on appears to know something new about himself. This way of conceptualizing tells us a great deal, but it depicts events in terms of a stimulus-response sequence. The therapist decides to interpret: the stimulus; and the patient

partially accepts, partially rejects the interpretation: the response. But what really happens is much more complex. Not only is the therapist's decision to interpret based on a number of factors, some unconscious; but even more significantly, the patient reacts not merely to the interpretation but also to the therapist who is interpreting rather than doing something else, such as approving of him or being supportive in one way or another. The patient's coming late next time may be due as much to his annoyance that the therapist chose to interpret and the way he interpreted as to his perturbation at the latent content of the interpretation.

Bibring's principles, as I have indicated, are delineated from the vantage point of the therapist's intention to effect one or another type of change in his patient. As such they are of value in helping the therapist himself or the observer of the therapeutic scene plan for or follow the sequence of events, even if one does not consider the effects the therapist's less conscious motive may have upon his decision about how and when to intervene with his patient. The concept of confrontation I am delineating appears even more directly related to the therapist's state of mind than do Bibring's principles. The decision to confront or not to confront occurs in the context of a tense therapeutic situation. It is, therefore, essential for understanding this process to consider the possibility that the decision can be influenced by the therapist's countertransference.

As I have suggested, the decision of whether or not to confront is best examined in the context of the overall therapeutic process. For example, a therapist decides to interpret some aspect of the transference with the intention that this will inhibit his patient's regressive or uncooperative behavior and further the treatment. The therapist intends that his patient will realize he is struggling with angry feelings towards the therapist and will consequently try to be more cooperative. However, the therapist may find after he has made his interpretation that he encounters further resistance. It is in this context that the therapist becomes involved with the issue of how forceful he should be, and this concern often stems as much from his irritated reaction to his patient's resistance as from an objective evaluation of the factors relevant to the question of forcefulness.

When the therapy reaches this point the therapist cannot escape, to some extent at least, the sense of being in a struggle with his patient. His decisions of how forceful or how enhancing he should be in making his remarks are inevitably influenced by his countertransference and his counteridentification with the patient. His decision about his forcefulness will, to some extent, be influenced by his need to overpower his patient's resistance. He will either justify the force he uses or be influenced by his fear of hurting his patient and, therefore, advocate a nonconfronting, enhancing technique. He will put himself in the place of his patient; and depending on how much he welcomes or resists being confronted himself, he will tend to

act in a forceful or a less forceful way. The more the therapist knows about his own impulses and his fears of his impulses when he makes his decision about how confronting he should be, the less likely his decision to confront will be influenced by his countertransference. Nevertheless, however meticulously we try to think out what we are doing, once we are in the real, emotionally charged situation where we are trying to modify another human being's behavior and are confronted ourselves with our patient's reluctance to change, we cannot avoid being somewhat influenced by the way we have resolved our own problems about forcing, being forced, hurting, and being hurt. Moreover, our patient will be influenced in one way or another, not just by our conscious intentions, but by the way we react to the way he reacts to us, by our irritated concern at his resistance or by our apparent patience in the face of this resistance filtered through his correct and not so correct perceptions of our motives for behaving the way we do.

I have chosen a fairly well known clinical vignette to illustrate the relevant factors that one might consider in trying to understand the nature of the process of confrontation. In this instance the therapist felt it was essential to modify aspects of his patient's uncooperative behavior that interfered with his capacity to make use of the treatment—that, in effect, served as an impediment to a therapeutic alliance. The therapist attempted, through his confrontation, to alter a behavior pattern in his patient rather than to interpret aspects of his unconscious conflicts.

The vignette I will discuss is one described many years ago by Franz Alexander (1950), which he used to highlight his concept of a corrective emotional experience. His patient was a young man who had been overindulged by his father and who started an analysis because of difficulties in his interpersonal relationships. From the start of his therapy, this man was complaining and demanding. He dressed in a disheveled manner, was frequently dirty, whined a great deal, and reacted to Alexander's clarifying remarks with complaints that he was being criticized and was not being helped. His behavior on the couch paralleled the way he related to many people outside of the analytic situation.

In the analytic situation his behavior and attitudes precluded the establishment of a working relationship. After a period of nonproductive work, Alexander confronted him with the maladaptive character of his behavior and its effects on other people, including himself. The actual confrontation occurred after the patient had reacted to a clarifying remark by protesting that no one liked him and no one tried to help him. Alexander stated that it was no wonder no one liked him if he behaved in such an unpleasant manner when people tried to help him. This confrontation had a striking effect on the patient. He stopped complaining and became much more cooperative. He subsequently was able to listen to what Alexander was trying to point out to him. They established a therapeutic alliance, and the patient profited from the subsequent period of analysis.

Alexander's approach fits the criteria of a confrontation as I described it earlier. He was involved in an intense way with a patient who was reluctant to change his behavior, and Alexander had the option of choosing between more and less forceful methods of effecting a change in his patient. He chose a quite forceful method to modify the patient's behavior in the treatment situation. Alexander himself delineated his intervention as a corrective emotional experience. He apparently felt that he intervened with the intent of presenting himself to his patient in a manner that corrected certain misconceptions the patient had about the way his own behavior affected other people. He believed that the patient had not known that his regressive behavior antagonized other individuals. It was not until he recognized this disturbing fact through his analyst's response to his behavior that he could enter into a meaningful cooperative relationship with the analyst and presumably with other individuals outside of the analytic situation.

Alexander's intervention might also be considered as a manipulation. From Bibring's frame of reference, this type of intervention might be made with the intent of activating a potential ego system in the patient—the therapist might have intended through his remarks to challenge the patient, having correctly judged that the patient could respond to a challenge. However, this way of viewing the effects of the intervention appears even less complete than Alexander's manner of conceptualizing the sequence of events. I find it hard to escape the conclusions that the average therapist in

Alexander's position, who might tell a patient that it is no wonder no one likes him, is at least somewhat irritated at his patient's regressive behavior and that the patient is at least somewhat affected by the therapist's irritation. Thus I am presuming that Alexander's decision to be confronting was made in the context of his increasing annoyance at his patient's reluctance to be cooperative and his resistance to change and that the effectiveness of his confrontation bears a relationship to the way his irritation was perceived by the patient.

We have no way of knowing, of course, whether Alexander consciously considered other options for coping with his patient's lack of cooperation. Therapists in Alexander's position will, to varying degrees, be aware of their own irritation and will, to varying degrees, take it into consideration as they decide how forcibly "to confront" their patients' regressive and defensive behavior, which is the source of their irritation. Thus there will be therapists who become quite irritated in similar therapeutic situations, who are relatively unaware of it, and who "decide" to be confronting. Other therapists, equally irritated and equally unaware of their irritation, will "decide" upon other options. Under these circumstances the other options may turn out to be as much a way of not dealing with the patient's resistance as of serving to effect the changes the therapist has in mind. Therapists who are more aware of their irritation and use it as a signal to help them understand what is happening in the therapeutic situation are generally in a better position to

choose between various therapeutic options and to intervene in a well-considered way, whether or not this way involves forcibly and persistently facing the patient with his resistant behavior.

What are some of the options open to the therapist who is in touch with his own irritation and takes it into consideration in his decision how to intervene? He might, of course, decide to be confronting and express himself quite similarly to the way Alexander intervened in this episode. On the other hand he might decide upon interventions that, in his mind, would be relatively less forceful and confronting. For example, he might consider the patient's regressive behavior to be essentially a transference defense; that is, a way of avoiding experiencing the dangers of closeness to the analyst, the dangers of yearning for love without hope of the love's being returned and of experiencing intense rage at not being gratified. Bearing this formulation in mind, the analyst might have tried to give the patient another type of corrective emotional experience but in a more gradual and less drastic manner. That is, he might, through patient and gentle attempts to clarify aspects of his behavior, try to show him that the analysis was not a place where he would flounder from want of help or be left to rage because of frustration but was a place where in fact he could discover something about himself. Or another analyst might have tried to demonstrate to him that his demandingness and complaints were a reaction to certain disappointments he was experiencing in the analytic situation; the analyst would try to tune in

with the events that evoked his sense of disappointment and carefully and tactfully indicate the connection of these with his demandingness. Both of these alternative approaches appear to be more enhancing than confronting.

It is easier to explain why an approach fails than to ascertain the reason why it works. If, for example, we confront a demanding patient in a similar manner to Alexander's and the patient hears only the "no wonder I don't like you" and stops treatment, we can conclude that we inflicted a narcissistic blow: the patient was too narcissistically vulnerable for the kind of confrontation we made to him. If another demanding patient responds by hearing only the "I don't like you because you are so unpleasant" and becomes a good patient in the sense that he stops his demands but does not subsequently listen to what we are saying, we can conclude that we frightened him into adopting a compliant attitude: the patient was too afraid of abandonment to be other than compliant when confronted in this manner. If still another patient's enjoyment in having us treat him roughly leads to a transient cessation of complaints but is followed by frequent efforts to provoke us into being forceful once again, we would feel that the patient's masochism interfered with our therapeutic attempt.

Similarly, one might compile a list of reasons why a patient fails to respond favorably to one of the more enhancing approaches I have just delineated. There are, for example, many patients who can respond only to a

much more active demonstration of the therapist's involvement with them than is possible if he decides to offer clarifications to indicate he is trying to be helpful or if he decides to point out the connection between regressive behavior and disappointment in the therapist.

As I have stated, it is more difficult to account for the success of any one approach than to understand why it fails. Alexander apparently was successful in achieving his goal with a confronting approach. One cannot tell, of course, whether a less confronting technique might also have achieved essentially the same goal. But let us assume that Alexander had, through his clinical intuition and his knowledge of psychodynamics, found the keystone for promoting a favorable change in his patient. Under this assumption, only a confronting technique of the nature Alexander employed could be successful in the sense of involving the patient in a cooperative way in his treatment. Sometimes, after trying a variety of approaches, a therapist evolves a method of reaching a patient. If this was the case, what was the specific factor or factors in Alexander's approach that were responsible for its effectiveness? Also what were the corresponding specific aspects of his patient's personality that allowed him to respond favorably to this approach?

Alexander's intervention indicated, at the very least, that he was directly interested in the patient, that he wanted him to grow up; and more immediately, he conveyed his concern about the patient's demanding

behavior, stating that this type of behavior alienated people. This might have been what his patient needed to hear at this particular time. Alexander felt the patient was behaving like a young child who is demanding and complaining but who is ashamed of his behavior and wants someone to show interest, to tell him that his childishness is inappropriate, to imply that he is capable of acting in a more grown-up way, and to indicate how he can be more grown-up. Alexander intervened in a way that convinced his potentially responsive patient that he was deeply interested in him. This patient, like many others, may have both needed and been capable of responding favorably to the analyst's very direct, concrete type of involvement, which indicated to him that, while regressive behavior was not acceptable, the analyst had confidence that he could behave in a more cooperative fashion. There is a directness and genuineness to this kind of interchange that is not satisfactorily delineated by the concepts of manipulation or corrective emotional experience. Other individuals, of course, may not be reached by this type of intervention and may perhaps respond unfavorably to its intensive aspects.

Many therapists treating this patient would be more than "involved with" and "concerned about" him. They would be irritated with him. In addition, the more the therapist is aware of his irritation, the more likely he will be able, if he decides to be confronting, to intervene without communicating his irritation in a manner that is distressing to the patient. But

is communication of the therapist's irritation sometimes the essential factor that leads the patient to shift from a regressive to a cooperative relationship even when the therapist himself is not truly in touch with his own irritation? Is the therapist's irritation itself, in the context of his overall concern and involvement even when he is unaware of his annoyance, the crucial quality that reaches some patients and affects them favorably? Is it the therapist's irritation that convinces these patients that he is real, truly involved, and interested in his welfare? It may be that therapists without much awareness of their irritation who also have an overall concern and care are more effective in reaching some patients in this kind of therapeutic impasse than therapists who pay too close attention to their countertransference. Too close attention to inner reactions may sometimes limit the directness of their confrontations and give their patients the sense that they are not being genuine.

Obviously the way the patient perceives or the meaning he ascribes to what the therapist is attempting to convey to him is the decisive factor in whether the therapist's response is appropriate. The question raised by this case vignette is how best to delineate the nature of the character structure of individuals who respond appropriately to intervention of the type made by Alexander; *i.e.*, who shift from a regressive demanding mode of interacting to a cooperative relationship without becoming unduly compliant or masochistic. This is a difficult question to answer in the light of our present

knowledge about character structure. What is the best way of describing the elements of the personality structure that allow someone, when confronted by a therapist's irritated concern, to stop his demands and complaints without developing dependent and unresolved transference that interferes with his becoming open about his feelings and listening to what the therapist has to say? Bibring's principle of manipulation, whereby a potential ego system is mobilized, and Alexander's concept of a corrective emotional experience, whereby a distorted notion of a relationship can be corrected by the way the therapist presents himself, try to get at this process, although these concepts are not addressed to the question of which individuals the process is effective with. Moreover, the way these concepts are delineated does not consider what I believe to be crucial; *i.e.*, how the affective tone of the therapist affects the patient.

There are many other issues already alluded to that are raised by this case vignette. Which patients will respond inappropriately to this approach? How do they perceive and what meaning do they ascribe to the affective tone associated with the therapist's intervention? What is the nature of their character structure? To what kinds of interventions do they best respond, and what is there about the therapist's attitude and affective tone when he intervenes that is most appropriate for these patients? These are difficult questions. But they have to be asked, and we should try to answer them. Till we do, I submit that the therapist's best instrument is his awareness of the

nature of his countertransference when he is faced with a resistant patient and chooses a confronting or nonconfronting approach.

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