CONFRONTATION IN PSYCHOTHERAPY

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e-Book 2015 International Psychotherapy Institute

From *Confrontation in Psychotherapy* edited by Gerald Adler and Paul G. Myerson

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On speaking with colleagues about confrontation in psychotherapy, I have a distinct impression that there is an underlying agreement among many therapists on this issue. I think that deep inside, many feel that confrontation is a highly effective instrument when properly used but that it must be used wisely and not at all in a haphazard manner. The conditions for its proper use are very specific and will be defined later.

First, I would like to deal with the underlying elements of the treatment situation that make the use of confrontation desirable and at times mandatory. The basic element in all manifestations of psychopathology is a simple, clearly definable fact. Man is a creature of two worlds—one the pregenital world outlined in Freud's conception of the early months and years of life, with its special system of logic, interpretive function, and emotional relations. These are the years when reactions are dominated by the patterns of reflex limbic lobe response (to use the neurological model), dominated by characteristics beautifully set forth by Freud in his description and definition of the responses and attitudes of the pregenital era. The second and later-appearing world is the world of cortical control, the world of reality, dominated by cause and effect. The patterns of this world of ego control begin

to dominate at the time when the formal educational process is introduced into the life of the developing child. It is with this in mind, I believe, that Boris (Chapter Nine) describes the ego as "Janus shaped," with one face looking toward the external, real, or social world and the other toward inner feelings and fantasies. I agree with Boris that confrontation can be effectively utilized in dealing with situations that arise from either of the two sources, from the external world or the inner one.

In my view the primary purpose of the confrontation under these circumstances is to unite the two different functioning worlds in a common meeting ground, as Freud defined when he described the purpose of psychoanalysis by saying that where id was, there shall ego be. To paraphrase this statement in terms of a neurological model, where the limbic lobe (primitive paleocortex) reflex response obtains, there shall the cortex take over and dominate. It is the failure of these two worlds to get together in effective functioning that is the basic cause of the phenomena of psychopathology. The conflict between the two is the determining factor. And I believe confrontation is an important element in the technique of resolving the conflicts between the two worlds.

Confrontation implies use of force (Myerson, Chapter One), but is force appropriate? Freud specifies that in repression a force is always and continuously at work—a force that must be overcome if repression is to be

dissolved. The same is true in avoidance, an early phase of repression. In the course of our analytic work, over and over we encounter avoidance and repression that require force to alter the pattern. As a matter of fact, each interpretation has an element of force.

Freud's work clearly demonstrates that a libidinal position once assumed is given up with the greatest reluctance. To overcome this great reluctance, at times force—direct force—is appropriate; but it must be expressed with love, with understanding, with sympathy and not from a vis-à-vis position such as exists when the patient conceives of the analyst as a being similar to a hostile introject.

To enlarge this conception of the importance of the patient's attitudes, let me turn to the most valuable work of Wilhelm Reich (1933) on character analysis and the role of psychoanalysis in the problems of so-called character neurosis. The cardinal question is: Is this an appropriate sphere of psychoanalytic involvement and endeavor, or should we limit our endeavors entirely to libidinal conflicts and to the trauma associated with childhood sexuality? Should we not broaden our endeavors to include the comprehensive analysis of the characterological defects that arise from the defensive, regressive return to pregenitally oriented patterns of reaction set up to protect the child from the pain of these experiences? These patterns of reaction are permanently established and returned to in the forms of their

neuroses and reproduced in the transference. The impetus for this regression takes place in reaction to the frustration of the Oedipal situation. The patient as a child experiences frustrations; he receives these in a traumatic way; he develops anxiety, fear, and phobias; he experiences loneliness. And as a reaction to these traumas, he regresses back to the earlier emotional patterns of his pregenital experiences that now become a working part of his way of life. If you reject the need for the analysis of these characterological defenses, I believe you will rule out nine out of ten cases that consult you for your help. In my practice, at least nine out of ten patients have defensive attitudes based on regression to pregenital elements in their character structure that must undergo alteration before the potentials of maturity are able to be utilized. This involves the expressions of their love life as well as of their character. And so I believe the attitudes involved in this sick way of life must be analyzed and altered. Franz Alexander (1953) expressed agreement with this point of view:

…obviously the great variety of patients makes necessary variations in approach…. The fact that most psychoanalysts used precisely the same, so-called classical procedure for all their patients has been due to various circumstances. For many years the general practice among psychoanalytic therapists was to accept those cases for therapy which appeared suitable for the classical procedure and to advise the others not to undergo psychoanalytic treatment. In other words, the patients were selected to fit the

tool.

Moreover, psychoanalytic treatment is the primary source of psychoanalytic knowledge and the original procedure is best suited for research. Since in the early phases of psychoanalysis the primary concern was quite naturally that of increasing basic knowledge, the classical procedure was rather universally used. Some of us have come to the conviction, however, that the time is now ripe to utilize the accumulated theoretical knowledge in different ways, so that not only those patients who appear suitable for the original technique, but the whole psychoneurotic population as well, could benefit from our present knowledge. This extension of psychoanalytic help to a great variety of patients is another important new trend in our field, (pp. 282-283)

In extending psychoanalytic help to patients of this kind and in order to accomplish this effectively, more or less force needs to be applied (with love!) to change the pattern. A regressed patient wallowing in his symptomatic behavior is acting out part of his character neurosis and illustrates a most important element in the "greatest reluctance" to give up the pattern. We have to apply a greater or lesser degree of force if the patient is to accept reality and to experience the limitations imposed by his illness and to be willing to live within the limits of the social mores, as opposed to the world of his childish fantasies of omnipotence and narcissistic entitlement. These two worlds are opposed to each other and frequently a confrontation has to occur if change is to be possible.

Myerson (Chapter One) describes a confrontation by Alexander of a patient who regressed in the analytic situation to a whining, complaining position. In spite of Alexander's clarifying and interpreting statements, he complained that he was being criticized and was not being helped. After a long period of this behavior, Alexander finally confronted him that it was no wonder that no one liked him if he behaved in such an unpleasant manner when people tried to help him.

First I wish to make certain basic assumptions about the clinical aspects of the case and the resultant problem that Alexander faced. I assume he was well aware that his patient was suffering from a definite character disorder of a considerable degree of depth. This is the number one facet of the clinical problem, and he knew from Wilhelm Reich that one had only a vague chance of altering symptoms due to instinctual conflicts until some effective analysis of the character defenses and structure was accomplished.

My second assumption, which I make from years of experience in contacts with problems of this kind, is the belief that in this patient's developmental history he resolved his Oedipal conflicts by regression to earlier pregenital attitudes and made these regressive pregenital attitudes a very important part of his basic character structure and his attitude toward the world around him. And thirdly I assume that his character structure was based on what I have so often described—Murray's triad (Murray, 1964):

first, regression to narcissistically determined great expectations to have life on his own terms; second, massive rage reactions following the inevitable failure of the narcissistic expectations; and third, projections and other pregenitally determined character patterns to justify, validate, and continue the rage reactions and underlying hostility.

If my assumptions fit the clinical facts of this patient, one day he has to face them as facts—reality demands it—and give up looking at all people as hostile introjects. I believe Alexander was correct in what he did—to delay would have been to have the patient identify his analyst with his regressive defensive patterns and to continue the regressive, nonproductive pattern.

A case illustrating these issues concerns a twenty-three-year-old undergraduate who throughout his life had presented behavior of a deeply narcissistic and aggressive character, rather devoid of the attributes of friendliness and desire for mature social relationships. All his social relations were based on regressive rivalry reactions and deep feelings of hostility to all his associates, including his family, his peers, and his teachers.

Following graduation from college, he went to another university in an advanced study program. In this new situation, he immediately began to get into trouble. The only reaction he had to his colleagues was one of very hostile rivalry. He began to develop anxiety reactions and became phobic to

various situations that arose in his educational program. He began to react with feelings of depression as these regressive reactions continued to intensify. They increased to the point where the anxiety and depression were so great that he had to withdraw from the university.

During his earlier years, he had been continuously in analytically oriented treatment programs with three different, highly competent analysts. These endeavors were ineffectual and resulted in no improvement or change or development of insight into the nature of his maladaptation. He had an impervious system of projections and rationalizations to justify his hostility, and this remained unaltered in the treatment situations.

He consulted another well known analyst who was dubious about the outcome of further treatment and suggested there was a high probability of a psychotic reaction that would require hospitalization. This angered and frightened the patient but did increase his realistic relation to his life's problem. When he approached me about taking him into treatment, the rigidity of his defensive patterns had lessened; and he had some healthy trepidation about his future.

Very early in his first interview with me I pointed out to him the intensity of the rage that I felt was behind all his relations with people and things. This was surely an abrupt confrontation. But he responded in a

positive way and agreed as to the correctness of my interpretations. This was a marked turnabout from his attitude and his relations with his previous therapists. It was also the beginning of his acceptance of the intensity of his rage and aggression and his willingness to question the propriety of these feelings and to evaluate them realistically. On his third interview he stated that he had many problems in his sexual life that he had deliberately withheld from his three previous therapeutic experiences. He said he was now willing to talk about his sexual reactions. At the next hour he spoke frankly about sex. He spoke about his compulsive masturbation, of his exciting fantasies about older, aggressive women as sexual objects, and of his intense rivalry fantasies with other boys and his hatred of them for successes he did not enjoy.

He left this hour with the determination to continue speaking of his sex life at the next interview. On the next occasion, however, he avoided dealing with sexual topics and reported a dream that took place in a New England country town with a central green and two white churches on the green. In the dream he dealt with an older man, an untrustworthy, scurrilous, red-faced alcoholic, of whom he was very suspicious. He was aware of the connection of this character with his analyst and saw the dream as a warning that the analyst was probably not worthy of the trust given him in speaking frankly for the first time about his sexual life. On the following day he came to his hour in a towering rage and began an attack on his university, saying it was dominated by a narrow group of socially oriented prep school graduates and

Jewish boys like him were excluded and discriminated against. He then lapsed into an attack on the whole American scene as being a narrow-minded WASP culture that he hated.

At this point I determined he was at the important crossroads of a return to his previous paranoid attitude or of holding onto the alternative positive relationship he had established with me. I decided that an abrupt confrontation with this fact was in order if the treatment situation was not to deteriorate into a psychotic-like acting out experience akin to his three previous treatment situations.

I confronted him with the fact that his basic rage was against me, a response to the fears engendered by his approaching facing his sexual attitudes and anxieties. I stated that his raging at the American scene was just a cover for his rage at me who was identified as an exponent of the culture, being a wasp myself. I went on to say that I had many friends and colleagues who were Jewish, most of them highly intellectual; but I did not know of one who did not basically feel that the American way of life as formulated by the wasp founding fathers was the culture in which they wished to live, in spite of some minor disagreements with the way it was carried out. No other country would be as agreeable to them.

The reaction to this confrontation was most dramatic. The paranoid

reaction was practically completely dissolved. A most effective therapeutic alliance was immediately established wherein he identified with me and went to work vigorously on the analytic task at hand—to understand the vicissitudes of childhood upon which his sickness was based. There was no return again to the paranoid defense device or even to set up differences between us which precluded a meeting ground. I would call the response almost miraculous, so far as overcoming the paranoid defensive attitude was concerned. Of course we had a long hard journey down the analytic road of understanding his neurosis, but the confrontation resulted in a resolution of the critical defense reaction, which at that time was an immediate threat to the treatment situation and which, if not overcome, would have resulted in a long acting-out period of his paranoid defenses. I recognize the fact that his previous therapeutic failures had placed him in a receptive frame of mind to respond positively to my procedures and that I was working with a distinct advantage over my predecessors. But the confrontation itself turned out to be a very appropriate procedure and truly effective in its response. The patient later stated he had real affection for his university and looked back with fondness to his years there. He also saw that his criticisms were largely projections and that his attitude was primarily responsible for the shortcomings of his undergraduate days.

And now let us examine the nature of this wallowing in neurotic patterns of a pregenitally determined nature. Freud (1916) has given us a

magnificent picture of this phenomenon in his paper "The Exception." In brief his thesis is as follows: to live in culture one accepts restraints as one pays taxes. Primitive aggression and its direct manifestations are taboo and are accepted as such by non-neurotic people. But as Freud says, some regard themselves as exceptions to this and lead their lives expressing defiance to this taboo to a greater or lesser degree. Freud's example of Shakespeare's Richard III and his quote of Richard's soliloquy, plus his interpretation of its meaning are given in preference to clinically determined supporting case history material. As you know, Richard was born a cripple and Shakespeare accords him this soliloquy:

> But I, that am not shaped for sportive tricks,
> Nor made to court an amorous looking-glass;
> I that am rudely stamp'd, and want love's majesty
> To strut before a wanton ambling nymph;
> I, that am curtail'd of this fair proportion,
> Cheated of feature by dissembling Nature,
> Deform'd, unfinished, sent before my time
> Into this breathing world, scarce half made up,
> And that so lamely and unfashionable,
> That dogs bark at me as I halt by them;
> And therefore, since I cannot prove a lover,
> To entertain these fair well-spoken days,
> I am determined to prove a villain,
> And hate the idle pleasures of these days.
>
> (I, i, 14-31)

The soliloquy then signifies: nature has done me a grievous wrong in

denying me that beauty of form that wins human love. Life owes me reparation for this, and I will see that I get it. I have a right to be an exception, to overstep those bounds by which others let themselves be circumscribed. I may do wrong myself, since wrong has been done to me.

And now we feel that we ourselves could be like Richard, nay, that we are already a little like him. Richard is an enormously magnified representation of something we can all discover in ourselves. We all think we have reason to reproach nature and our destiny for congenital and infantile disadvantages; we all demand reparation for early wounds to our narcissism, our self-love. And so Richard emerged a lust murderer as part of his way of life and justified this attitude by the fact that he was a cripple.

So many neurotics like Richard III emerge from their Oedipal experiences with a rejection of their loving qualities and adopt a regressive return to their pregenital hostile and aggressive attitudes and allow this orientation to become the essential element of their character structure, based upon the triad I described earlier. Hence the intense tendency to wallow in the transference situation and repetitively act out these patterns. I believe that force is required to overcome and change the pattern—and again force *with love*. To delay confrontation too long is, I believe, to risk allowing the analysis to become becalmed, ineffective, unproductive, and to encourage wallowing in transference acting out.

All of these remarks are predicated on my earlier comments that nine out of ten neurotic illnesses we encounter today have elements of a defective character structure based upon a regression to pregenital dispositions. As stated, some analysts feel these cases are not suitable for classical analytic endeavors. My feeling is that we have to face the clinical problems as we encounter them and do our best as therapists to overcome all aspects of the illness.

To develop my convictions further I wish to make brief reference to the Dora case. Freud (1905) used the Dora case as an illustration of the unconscious fantasies at work behind somatic symptoms and the meaning the symptoms have in terms of unconscious fantasies. Dreams were revealing of her tabooed sexual and incestuous fantasies and were expressive of the wishes that were closely related to her symptoms. Her resistances to change and negative transference were great, and she abandoned treatment before any definitive therapeutic response occurred. In detailing her life history and fantasy life, Freud makes it amply clear that Dora had undergone a definite regression to pregenital attitudes and had a deep seated hostile attachment to three women: to her mother, to Frau K, wife of her fantasied Oedipal substitute lover, and to her governess. This paranoid homosexual attachment of a deeply hostile nature is all too apparent in Freud's case history of Dora. The intensity of her primitive rage is likewise clearly shown.

Felix Deutsch (1957) published a paper following Dora's death stating he had seen Dora as a patient after Freud and outlined her subsequent life history. She turned out to be a very sick, almost psychotic, paranoid personality, whose main object in life was to be as mean as she possibly could both to her husband and her only son. This life history was quite predictable from the material Freud wrote in her case history. And so we see two layers or levels of illness in Dora: first, superficial hysterical or somatically determined illness expressing her unconscious erotic fantasies and the conflicts which ensued from them; and second, a deeper more malignant core of a paranoid nature, stemming from her regressive pregenital hostility toward the women in her life. This was a deep-seated regressive character illness. Attention is directed to the interconnection of the two basic elements of Dora's neurotic composition—her libidinal conflicts and her character neurosis.

The all important question now comes up: can psychoanalysis relieve Dora's libidinal conflicts and straighten out her love life without an alteration in her neurotic character structure? Reich indicates the answer is no, and I would agree. I do not believe one can analyze and transform such regressive character structure without confrontation, without experiencing her acting out and wallowing in the transference situation. Her pregenital orientation must undergo analytic transformation and this demands a greater or lesser degree of confrontation repeatedly. Dora's insight into the symbolic meaning

of her symptoms would not have provided a permanent and effective way of expressing her love needs without some alteration in her character structure. And as Freud says, this libidinal position would be given up with the greatest reluctance. This is why some force is required.

And now what are the essential goals we aim at in the psychotherapy of an illness like this? The first goal is the alteration of the pregenital character traits. In attempting to clarify what is necessary to accomplish this I would like to call attention to what takes place when the growing child normally transforms his primitive impulses into feelings of value to him in a family and social setting. Again I refer to Freud's (1916) paper on "The Exception":

…the doctor in his educative work makes use of one of the components of love. In this work of after-education, he is probably doing no more than repeat the process which made education of any kind possible in the first instance. Side by side with the exigencies of life, love is the great educator; and it is by the love of those nearest him that the incomplete human being is induced to respect the decrees of necessity and to spare himself the punishment that follows any infringement of them. (p. 312)

In viewing the function of love as an educator one frequently encounters the role of confrontation. It is an important ingredient of love in action. One's love for an "incomplete human being," be it a child or an overgrown and emotionally underdeveloped child, prompts one to confront

him with his areas of immaturity. Love exhorts the child to abandon the delusional hope of getting life on his own terms and replacing this with the dictates of the reality principle.

One of the great joys of reading Freud is to so frequently encounter a gem, a jewel of a comment sort of hidden in the substance of his main theme. This jewel is so apt, so pertinent, so revealing. The above quotation from "The Exception" is surely one of these gems. In it, I believe, is contained the whole basic essence of what we are striving to accomplish in our analytic work with the character neuroses. The basic developmental failure and defect in these patients' growth was in the fact that they never really left behind the special world of omnipotence and narcissistic entitlement to embrace the world of true object relations and to develop the joys of loving objects in the outside world of non-self. If analytic work and activity can belatedly achieve this objective, then analysis can be a greater or lesser success. If it fails to accomplish this, analysis will have a very limited meaning, both in the area of character and adaptation and in relation to neurotic libidinal conflicts.

A neurosis is like a diamond—it is comprised of many facets, all of which must be dealt with in the analytic situation. What I have described refers to but one facet of the neurosis, but it is a most important one. And in my approach I have stressed that if we can foster and develop the ability to love, to achieve genitality, then the ego can assume its proper role in adaptive

functioning and replace the primitive reflex patterns that comprise the neurotic reactions. Anna Freud (1936) states that this task goes beyond the field of strict analysis and is part of the task of the business of education. She states:

When the ego has taken its defensive measures against an affect for the purpose of avoiding "pain" something more besides analysis is required to annul them, if the result is to be permanent. The child must learn to tolerate larger and larger quantities of "pain" without immediately having recourse to his defence-mechanisms. It must, however, be admitted that theoretically it is the business of education rather than of analysis to teach him this lesson, (p.69)

The results of our analytic endeavors in illnesses of this kind hinge on one factor—how malleable is the process in the character structure. Will the patient accept the return of the pain that prompted the original regression and turn to new patterns? Will the patient respond to our efforts for change, or is he so rigid and inflexible that alteration is not possible? Our therapeutic efforts are directed to reestablishing the education process, to developing the potential for growth into maturity, against which the pathological character structure is rigidly opposed. I believe a majority of patients will respond to a greater or lesser degree in a positive way, though certainly there are those who will not give up their narcissistically determined entitlement and prerogatives. But I believe our attempts to give the patient a new choice in his

way of life are worthwhile and often effective. Therefore, the described analytic approach to the problem of character neuroses is a justifiable expedient.

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