ASPECTS OF CONFRONTATION

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CONFRONTATION IN PSYCHOTHERAPY

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This chapter aims for a brief and simple statement of ideas and observations on two aspects of confrontation. The verb, *to confront*, is defined in *Webster's New Twentieth Century Dictionary* (1962) as "to face, to face defiantly, to set face to face (as an accused person and a witness)," and "to set together for comparison." In common psychiatric usage, the term has acquired a valence of aggression. In this essay, the last meaning about a friendly comparison of views is implied in my definition of confrontation. I see confrontation as a regular but unobtrusive technical manuever that, without drawing attention to itself, assists in the elaboration of content. Its form in the actual therapeutic dialogue or interchange is expressed thus: "It seems to me that…and I wonder how it seems to you." Such a confrontation will be contrasted with confrontation as a style that dominates and shapes the therapeutic relationship and the patient's vision of the therapist; that is, the structure gains dominance over the content. I shall first discuss my own concept of confrontation.

Confrontation is the first in an orderly sequence of steps (confrontation, clarification, interpretation, and working through) by which the therapeutic work is carried out (Greenson, 1967). Its purpose is to show the patient what

he or she is resistant to talk and feel about. It is not an attempt to uncover unconscious fantasies and motivations. Although the therapist is prepared to admit that he is wrong or only partially correct in his assumption, nevertheless his statement reflects his dynamic formulation and therapeutic strategy of the moment. It goes without saying that progress in therapy, be it five times weekly psychoanalysis or once a week casework—*i.e.*, regardless of the level of discussion and the nature of the dialogue—a pertinent and productive issue must be sorted out and its built-in resistances appreciated. However, by virtue of this preparation, any confrontation, whether directed towards a minor omission or a painful revelation and in spite of the fact that it was based solely on a genuine concern for the patient, also expresses the therapist's authority over him. By confronting any one link in the material, the therapist leaves out something else; through this selection he controls the situation. The greater his skill and the more careful his assessment of the state of the ego and the therapeutic alliance, the less anger and resistance he stirs up and the more successfully can he lead the development.

I shall now describe a clinical episode that illustrates the relationship between confrontation and content. The patient is a thirty-year-old graduate student from a poor background who has been in analysis for about two years. He is married to a woman who comes from an illustrious family and who is wealthy and accomplished in her own right. During a particular stretch of the analysis two observations were noted. He was not talking about his

studies, which earlier had been a regular fixture of his hours. He was increasingly expressing anger at his wife, accusing her of making him into an appendage of herself; for example, letters concerning their properties and finances were addressed to her and not to him. She had also reminded him that his spendings had increased. He wanted to quit his field and go into politics. I sensed from him at this juncture an enormous pressure to comfort him, to take sides, and to become engaged in a battle or a crisis. I was aware of being annoyed. I realized that he had regressed into a familiar pattern of crisis and that behind his aggressive shouting about becoming a political figure was his passivity, which had always escaped clear focusing. However, I restrained myself and simply confronted him with my observation that he was no longer talking about his studies and that maybe this indicated that he was no longer working at them. If that was so, maybe we should talk about it. He had indeed stopped working and was several papers and exams behind schedule. In the associative material that followed over the next few hours, his resistance against telling me about the studies became clearer. He wanted to avoid a clarification of the obvious fact that by failing to pursue his academic studies, which promised him some independence and self-esteem from his own efforts in his own field, he put himself in the position of becoming an appendage.

Now, a more direct confrontation of the "face it as it is" kind, but probably heavily infected with my anger, would have been: "Stop the shouting

and don't let us waste more time. It is clear that you want to be dependent on your wife's money and be passive and taken care of. If not, you would have done your homework." I believe I would have been shooting straight from the hip and certainly would not have been fussy. My confrontation, "You want to be dependent," would have been correct and would no doubt have stirred him up. There would have been some obvious advantages to this position. I might have emerged as a strong person—the "awakening father" would be a good phrase for it—who is not afraid to stick his neck out and to tell the truth and if necessary to battle over it. In addition to gaining a clearer definition of the image of the therapist, some analytic time might have been saved.

Naturally, there would have been drawbacks. The creation of guilt would have burdened the ego, and a sense of attack would have interfered with the working alliance. However, the greatest drawback to this approach might have been that the patient's own initiative was bypassed and that this confrontation contained an admonition to behave differently and not simply to talk about something in order to explore and elaborate a system of fantasies. But in telling somebody to be different—and telling someone that he is passive is to tell him that he should not be that way—there is a subtle and implicit assumption of responsibility by the therapist to get the patient to do his homework. The ideal aim of therapy might not be to get the patient to work and be active. After all, the patient alone can do that and assume that responsibility himself. Instead this ideal aim might be to interpret an

unconscious fantasy, in this case, to be a woman's phallus and hence to satisfy his passive wish of being part of her.

Any one confrontation in the sense used here is wedded faithfully to the content of the patient's associations. Once the therapist departs from the text of the hour and instead dips into his general pool of impressions of the patient, the authority inherent in the dynamic theme itself is broken and is replaced with the authority of the therapist's own motivations. It is reasonable to ask how the idea of associating freely to the patient's material and of maintaining a free-floating attention fits into this approach. The answer is that these activities issue strictly and honestly from the material and that a successful practice of them is dependent upon the therapist's having a clear and full comprehension of his own narcissism and that his self-centeredness does not rate high on a scale.

A bind or resistance is particularly apt to develop when the confrontation is formulated and delivered *as if* in tune with the patient; *i.e.*, the therapist was in form only trying to figure out where the patient was at, while in fact he was ambiguously and covertly telling the patient where he should be at. This is an example: A resident is reporting an hour with a patient. The patient had started the hour with a long silence that had made the resident impatient; at the same time he was preoccupied with the content of the previous hour, which had interested him partly for personal reasons

and partly for reasons that he was to see his supervisor. He had become eager to get started but did not direct his attention to the silence as a source of information and study. He then had said, "It seems to me that you are reluctant to talk about…," and he mentioned the issue that was on his mind. The patient answered, "I don't know, maybe so," and then she went on to talk with much feeling about something else, which disappointed the therapist but which nevertheless contained her unconscious comments upon the therapist's maneuver. She told about her mother, who always controlled her and never really considered the patient's own needs. For example, her mother always insisted upon the kind of clothes she should wear, which were never coordinated and never matched. She put one kind of plaid on top of another kind, and it looked confused. Nothing fit her. But she could never tell mother because she would get impatient and angry.

This is not confrontation. Rather it is an awkward and clumsy way to get a patient to talk about something and the form itself creates resistance. And rightly so! Now the resident would have been much better off even if he ignored the silence by frankly stating that he did *not* know where she was at, but that such an issue was on his mind. Did she think it might be useful to talk about, or was she really concerned about something else?

I shall next discuss the second category of confrontation, which is not an unobtrusive part of a total approach but is a major technical tool whose aim is

to have the patient face how he feels and where he is at as quickly and as thoroughly as possible. The ramifications of such an approach are many for the transference, the countertransference, and the vicissitudes of the self in the therapeutic encounter. In this small essay only a few aspects will be studied.

We probably can agree with the view that in therapy we want to enlarge the patient's awareness of the self to the point that the patient as he knows himself is recognizable as the person interacting with others. This self-awareness to be achieved needs, first of all and as a start, a full acceptance by the therapist and a respect for the patient as he presents himself and feels about himself. Confrontation of the kind, which is only a part of a larger therapeutic encounter, attempts to remove the resistances to such a self-revelation. Ultimately and ideally, the patient takes responsibility for revealing it, and he has a choice. In contrast, confrontation as practiced as a style might tend to tell the patient how he feels and what he is like. He has less of a choice and less authority. Importantly, the transaction of self-revelation is personified in the therapist himself; his voice and his words come to stand for the truth, however accurate the truth might be. The other kind of confrontation ultimately forces the patient, if he is able, to reveal himself; and at least for a moment, he has to face himself alone. To be poetic, but with some justification, he has to face himself from the inside.

The following brief description of a therapy case will serve as a basis for discussion. A twenty-seven-year-old man was referred to me as a patient by his wife, who knew of me through a friend. His chief complaint was that he did not always tell his wife the truth; *e.g.*, he was on a diet and had bags of cookies secretly hidden in the house. He also failed to pay small bills, which he stated upset his wife. He presented himself as having a psychopathic personality although there were no real clues to such a diagnosis. Clinically he seemed to be a compulsive-obsessive person with great personal charm and considerable warmth. The issue of control seemed a fundamental problem. I saw him for about eight interviews with the goal of evaluating the need for therapy as well as his wish for it. He idealized his wife and referred to her authority in all matters psychological. During these interviews I did not come on strong, but mostly listened. When I did make a comment about his behavior, he usually told me in a seemingly approving fashion that his wife had suggested the same. In general the case puzzled me, and I felt that something was missing in my comprehension of it.

One night I got a phone call from his wife telling me that my patient had left without telling her his whereabouts and that the "game was up." The "game" was that he was a financial speculator and that for the third time in their marriage, his plans had failed, his money was lost, etc. When I asked her why she had not told me the true state of affairs earlier, she answered that she had wanted me to find out for myself and not to interfere. After many

crises, he returned but still told me very little about what was going on. He then left for a stay in another city and while there visited with an old friend of his. During that trip, he was introduced to a well-known therapist whom the friend himself had consulted and who was a proponent of active therapy. Spontaneously, the patient referred to him as a "confronter." The friend had told the therapist about the patient's difficulties, both in business and in his personal life. Over a short period of time, the patient was exposed to what seemed a marathon-like confrontation. The therapist obviously knew the content of a compulsive-obsessive neurosis very well and was able to confront the inventory of the patient's behavior, thinking, and feeling with an amazing clarity, which impressed him. Truly, the accused came face to face with the evidence and the witnesses to his neurosis: his smiling revealed his insecurity and hostility, as did the picking of his fingers; as for his low voice, "You really want to scream." From the way he sat in the chair, it was predicted (accurately) that the patient urinated against the sides of the toilet bowl and not into the center. Although much of the therapist's activity seemed a caricature, some of his statements were based on the patient's actual accounts and were coldly to the point. The patient, who had a pilot's license, told him that he felt comfortable flying commercial airlines because he always knew by the "feel" of the plane what the pilot was doing. The therapist carefully explained to him that he was living an illusion and that his sense of control was a denial of the fact that if something happened to the plane, he

could do nothing about it. He tied this to other aspects of his living.

His confrontations had a large element of provocation and an insistence that the patient interact with him. His relationship with me was carefully scrutinized, and he was told that I too knew all these things about him but that I had not told him, the moral being, I believe, that I should have. The patient felt very elated leaving the friend and the therapist. However, when he boarded the airplane, he suffered an acute anxiety attack and had to leave the plane. After the third attempt, he was able to stay and fly.

He eventually returned to tell me the story. The patient thought the experience meaningful and helpful and admired the therapist for his honesty and fearlessness and for having "shot straight from the hip." He wanted to do likewise. I thought he would now be looking for a "confronter," and I was wondering to whom I could refer him. To my surprise, he told me he wanted to thank me for having stayed with him in spite of all the bad things I had known about him without telling him and that I really must have liked him. He had been looking forward to talking to me again. He seemed very relieved, almost happy.

I selected this case both because it affords a close description, perhaps a caricature, of confrontation and its meaning to the patient and because it is representative of a special group of patients who tend to attract persistent

and forceful confrontations. He has a basic compulsive-obsessive personality structure with considerable isolation of affect and a pleasant remoteness. Subtle but distinct passive and masochistic trends are paired with real and often impressive accomplishments. There is a diminished sense of self in the face of an apparent sense of ease and fluency in dealing with people. In other words, there are rough incongruities that invite responses.

In any beginning therapeutic relationship, I consider these phenomena to be regularly observable in the patient:

(1) A deep dread of self-revelation and change that evokes hostility and sadistic fantasies because of the psychic work demanded.

(2) Concomitant wishes for closeness, a sense of communion, and the bridging of the gap between him and the therapist.

(3) A reaction to his hostility and these wishes with anxiety and fear of rejection.

The therapeutic task is to reduce the affective distance between the therapist and the patient while at the same time to foster independence. When the patient tries to orient himself to the above psychic phenomena, his responses can be traced on an imaginary continuum that is progressively marked with these defining psychic states:

(1) The patient has the belief that there is a lack of separation between himself and the therapist; hence, neither can hurt the other. The sadistic impulses are then controlled. This state can also be described as a fusion between self and object representation. There is a maximum sense of sameness and a minimum of separation anxiety.

(2) The patient tries out real and imagined qualities and aspects of the therapist partly through imitation but always in the service of pleasing and maintaining the object; there is also high narcissistic return for the patient.

(3) The patient actively and *selectively* (that is, he has a choice) takes on qualities of the therapist in his efforts to cope with conflicting ideas and affects. There is a minimum of fusion and confusion between the self and the other. The working alliance is maximal and the gratification comes from the competence in exercising psychological skills.

It is my contention that the behavior of the therapist, his style and tone of approach, tends to influence selectively these three modes. I would propose that the less authority you give the patient the more primitive the mode of identification tends to be. A passing comment on cognition and feeling in therapy might be useful here. I do not imply that therapy is mainly cognitive, but confrontation as a practiced style can be provocative and seductive in its magical expectations. What is often confronted is what the

therapist *thinks* of the patient and the patient's mode of handling feelings with the implicit demand to be different: be and act differently with the covert message (and promise), "Be like me." Sensitivity and encounter group techniques have alerted us to the "here and now" feelings of the patient, but it must have its start and basis in the patient's own feelings.

I shall turn to a study of the actual case. When this patient returned from his therapeutic experience, much had seemingly been accomplished. He certainly was a different person in specific ways when he returned to consult me. His speech was more direct and animated, and he expressed a convincing wish to involve himself in our work. But what was the nature of the change? On the surface it was a change in style and approach. Central to his account of his other therapeutic experience was that image of the therapist's constantly intruding into his thoughts and feelings, constantly pursuing and prodding him. It over-shadowed the content. His remarks are illustrative: "He made me sit up straight. I no longer felt like a shit-ass who knew nothing. I felt great. Before, I felt like nothing. Man, he was strong! " This from a patient with considerable learning and sophistication. He expressed openly and almost enthusiastically that his pleasant personality was apparently unreal and that it really expressed badness. I shall not concern myself with the superego aspect of the material and the existence of an identification with the aggressor. Instead, I shall take the material as evidence of the patient's dawning awareness that these were psychological forces and factors of which

a person might not know. But this awareness seemed predicated upon the barely existing alliance that had been established between us before he interrupted his therapy with me. I state this because he had eagerly looked forward to returning to tell about the things that were being pointed out to him.

The maintenance of his belief in his newly gained strength seemed to have depended upon the continued presence of the "confronter." Away from him, the belief tended to shrink. For example, when he collapsed at the airport and was afraid to fly, I doubt that his anxiety resulted simply from the therapist's having exposed his defenses against the feared loss of control in and of an airplane, but just as much from the failure to maintain the belief issuing from the fusion between the self and the therapist, expressed overtly as being and feeling like the therapist. Needless to say, this psychological state is precarious and unstable and depends for its maintenance on the appropriate object.

I shall next investigate another meaning of the therapeutic encounter with the "confronter" and suggest that the "confronter" had also been tricked and further that this type of patient might characteristically do so. On the surface, then, it seemed for a long time as if that therapist had overpowered the patient's defensive positions and gained entrance to his inner feelings. However, further therapeutic work suggested an alternative picture

characterized by the question, “Who had seduced whom?” Had the “confronter” gotten beyond his defenses or had his style simply made room for the patient’s deeper neurotic needs. In actuality, it turned out that the patient’s wife was also a “confronter.” He clearly had added to the inner representation of his wife part of his own self; namely, his phallus. Unconsciously, he believed her to be his phallus and source of strength. He harbored the same belief in regard to the therapist except that the instinctual mode for the transaction was different in the two cases; for the wife, it was predominantly oral; and for the confronting therapist, it was anal as well. She had very much encouraged in him the belief that she had rescued him from the ghetto in which he had grown up and that without her he would still be there aimlessly living an indifferent existence; without her, he was fuzzy and without a straight goal. In many ways, she was correct. His relationship with her had enabled him to be aggressive and socially and financially successful. But it was unstable and fluid, highly sensitive to the vicissitudes of the same relationship. He very much felt that without her he would fail and she, on her part, literally insisted that if she left she would take his success with her. She had what he needed to do it. No doubt to be helpful, she had regularly confronted him with the fears behind his pleasant and bland exterior.

When he had first come to me, my approach had worried him, and he had been afraid of my technique or absence of it. I had constantly stressed his own talents and initiative. The discontinuity between his wife and myself had

been noticeable and had enhanced his fear of separation, essentially a separation from his own phallus bestowed on his wife. The style of the other therapist readily filled that void and need. Hence, the encounter, while it lasted, had been in some way reassuring and comforting, because he had lent him his phallus.

We can assume that the gratification of an unconscious wish to be penetrated by the confrontation, even though it might momentarily give a sense of strength, ultimately interferes and limits the effectiveness of the therapist in his task to expand the awareness of the self. The patient's smiling insistence that he was *bad* reflected the gratification of a forbidden wish. Naturally, this is not self-revelation but rather a contraction of self-awareness. That is, the chances for confronting the wish, giving it up, and mourning it had been bypassed.

I shall last and briefly indicate a problem that perhaps is not readily discernible.

We talk a great deal about the therapist's influence upon both the patient and the pattern of progress in therapy based on what he says to the patient. However, it may also be legitimate and educational to inquire about its effect upon the therapist himself.

To that end, simply to stress the complexity of the apparatus, I shall

roughly schematize the ways and methods through which a therapist gathers information about the patient.

(1) He inquires directly about the patient's feelings, ideations, and historical data. He listens to what the patient actually tells him and draws inferences from what is not said.

(2) He empathizes with the patient, which means that he imaginatively and affectively contemplates the patient's internal and external psychological situation.

(3) He examines carefully and continuously the feelings, ideas, and tendencies that the patient's words, affect, and behavior now generate in himself.

For the average therapist the task of maintaining these channels of information free and unpolluted by self-centered reveries, bad tempers, and fatigue requires attention and a special psychological state that I shall briefly sketch for the sake of my subsequent argument. The ingredients are a maximum level of passive receptiveness, patience, and a capacity to tolerate uncertainty and not to jump to conclusions.

Now, any kind of confrontation that the therapist truly believes in and is not merely thrown at the patient requires a certain amount of aggression in

its execution. When we observe ourselves carefully and honestly we sometimes might discover a flush of sadistically tinged affect even in the most timely and correct confrontation. It often requires self-discipline to prevent belief from becoming conviction and instead for the therapist to return to an ego state when *listening* is again possible. There is a need in most therapists to be active, to intrude, and to control; and there always lurks a tendency to grandiose and impatient narcissistic manipulation. In the holy name of interacting with patients and of being involved, we, at times, try to exercise off our restlessness and frustrations.

I am not saying anything novel. I am merely stressing the problem of aggression, the constant threat it poses to the ego state of passive receptiveness, and the need to control it in its manifold manifestations.

I believe it is legitimate to ask how active a therapist can be, how intent upon being "in there," and still remain reflective, fully listening, and judicious in his assessment of the therapeutic possibilities. I believe there are limits in most therapists and that excessive involvement contaminates both the therapeutic field and the therapist's own cognitive processes.

Finally, it probably is healthy to remain doubtful about the correctness of one's conclusions and to leave the door open for new possibilities and problems; that is, one must safeguard one's curiosity. Is it possible to

maintain that curiosity while at the same time constantly to point out to the patient with aggressive conviction what he or she feels or thinks?

Confrontation as a technical maneuver subordinated to an overall therapeutic strategy has been compared and contrasted to confrontation as a major style characterizing the therapy and aiming less for content and more for *getting to the patient*.

These ideas are framed by a view of psychotherapy that has as a primary goal the expansion of self-awareness and independence. Crucial for the success of these tasks is to provide the patient with choices and to *help him confront them*. In this chapter, the question is raised whether confrontation as a style interferes ultimately with this goal in these ways:

(1) Fostering magical attitudes like being the therapist or being or feeling like the therapist.

(2) Gratification of unconscious wishes; *e.g.*, related to penetration.

Both interfere with self-awareness and the mastery of separation even though behaviorally there is the superficial suggestion of greater emotional freedom.

Finally, in addition to dealing with the effect of confrontation as a style

upon the patient, the effect upon the therapist has been discussed. I feel this is a neglected area of inquiry. Naturally, participation with the patient is a significant part of the observation of him, but there has to be a harmonious balance between these two modes for the sake of an ego state conducive to optimal thinking and reflecting about the patient.

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