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CONFRONTATION AS A MODE OF TEACHING

CONFRONTATION IN PSYCHOTHERAPY

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It is wholly impossible to engage in psychotherapy or in psychoanalysis without necessarily confronting the patient once, twice, or many times. Confrontation cannot be avoided; nor should it be avoided. The issue, rather, is to accept confrontation as an integral aspect of psychotherapy and to raise critical questions as to the effect that confrontation is intended to produce following on our understanding of the nature of confrontation as a process. Some answers to these questions may then lead to a clearer appreciation of how best to confront a patient.

As is true in all psychological issues, the subject of confrontation is multifaceted. There are many vantage points from which one may study confrontation. It may be worthwhile, however, to seek out among the many avenues to confrontation some central focus or issue that may be pertinent regardless of the particular theoretical or clinical approach one may take. With such a central issue in hand one may then extend, think through, and test out the various rich ideas and approaches to the meaning and clinical use of confrontation.

I would like to consider the central issue as consisting of the statement

that, whatever else it may be, confrontation is predominantly a device for teaching. Whatever the mode of confrontation and whether it be in individual psychotherapy, psychoanalysis, group psychotherapy, or encounter-sensitivity groups, the aim of the confrontation is to teach something to the recipient of the confrontation. At stake in this discussion is not whether the substance of a confrontation is correct but rather whether our mode of teaching is more or less effective.

A discussion of confrontation from this point of view illuminates the three basic underpinnings of any kind of teaching: one, teaching by explanation in order to enhance understanding; two, teaching by employing a system of rewards and punishments, which presumably will reinforce desired behaviors; and three, teaching by offering oneself as a model with the expectation that the student (or patient) will take the best qualities of the model and will internalize those qualities and the lessons that go with them so that they are experienced as a syntonic part of oneself.

All these modes of teaching are present in the various meanings of confrontation. In some a single mode is easily distinguishable and in others one may observe a mix of two or even of all three. We must ask, therefore, whether the purposes of confrontation are best served by explanation, by rewards and punishments, by offering oneself as a model, or by what kind of mix of two or of three of these. It may be equally important to determine

whether all confrontations include all three of these basic tenets of teaching and whether the decisive factor is the extent to which one or another dominates.

Generally, we tend to think of confrontation in psychotherapy as being a means of bringing up for the patient's consideration certain attitudes, character traits, and life styles that, by virtue of the preceding work of psychotherapy have now become conscious or preconscious. There is also a type of confrontation that addresses itself to that which is unconscious, distorted, and expressed primarily in the seemingly mysterious symbolic communications of the patient. The second instance refers, of course, to the psychotic patient in psychotherapy. I believe that this is a vastly different situation and carries significantly different meaning as compared to the more usual use and meaning of confrontation.

Confrontation may foster a therapeutic alliance in any case at some given moment, but that is not the same thing as saying that confrontation and therapeutic alliance are necessarily related one to the other. In the more neurotic type of patient, his inner life remains unknown to him for the most part. A variety of ego defenses and adaptive moves as well as symptoms serves to keep out of his conscious mind the conflicting wishes and fantasies that would make life even more unbearable were they to be undefended. A very different state of mind exists in the psychotic patient. His inner life,

unfortunately, is not secret, and the defenses against knowing it are few and vulnerable. His adaptive moves and his symptoms barely serve to maintain survival. To the psychotic patient, his inner life is a ghastly cesspool of horrible secrets of which he is all too much aware. Confrontation that reads through the distorted, symbolic communications of the severely disturbed patient is not, strictly speaking, a mode of teaching. It is not explaining anything; it is only, in an exquisitely subtle manner, rewarding or punishing; and it is not offering oneself as a model. Rather it is a means of letting the patient know that the therapist knows; a means of telling the patient that one knows what the patient is suffering. It is a means of letting the patient know that the therapist knows too that the patient did not know how to communicate to others and could barely tolerate knowing himself. In this sharing and in the relief for the patient in finding someone at last who also knows and yet continues to attend, a therapeutic alliance is established that rests on the most profound meaning of empathy. This kind of alliance becomes the prelude to the more difficult work that will follow in reconstructing what has happened to the patient. In a lighter vein, the situation is not unlike that of two evil-appearing men meeting in the dark forest and discovering that they are both psychiatrists or psychologists.

Gentle, caring concern of the therapist for the patient may well be the most important element in a proper, effective confrontation. Such an attitude in the therapist is important not only because all people need to know that

someone cares and is tender in his caring but also because such behavior in the therapist carries with it a genuine message that the therapist is equally devoted to the maintenance of the patient's autonomy—his unique individuality. It communicates to the patient his privilege to choose the direction that he would like to move in rather than communicating a directive to which the patient feels impelled to yield. Implicit in a confrontation that is affectively shaped with gentle, caring concern is a mode of teaching that enhances understanding and offers a model for identification rather than teaching by suggesting reward or punishment according to whether the patient does or does not do as we might wish him to do.

It is apropos that we be sensitive to the fact that certain styles in the treatment of psychiatric patients are directly influenced by the historical tides that are current. At this time in history, confrontation is the order of the day in widespread areas of our lives. Instant demands are often made for instant action. Encounter groups, marathon groups, and so-called sensitivity groups are in good measure responses to demands for instant change. It is no accident that the primary so-called therapeutic method in these groups is confrontation, in which the reward is acceptance and the punishment rejection by the group. In our individual work, too, we should remain aware of the extent to which we may be responding to the demands of patients for instant change in a profession in which instant change is impossible.

From this point of view, the particular emphasis on gentle, caring concern and respect for the individuality of the patient as central should not be underestimated as a most positively weighted teaching method at a time when all of us are tempted to exercise control wherever we can. After all, we are very much limited in how much control we may exercise in the conduct of our own lives.

Another aspect of confrontation arises in the comparison between the therapeutic methods of the psychoanalyst as compared to the psychotherapist. In this connection, certain myths continue to thrive. These are at least two-fold: first, that the analyst is, for the most part, extremely passive, spends too much time saying nothing, does not intervene actively, and does not use himself in the treatment process; second, that the analyst pays little attention to the *reality* of the patient's past and current life experience. Both these myths perpetuate an image of the psychoanalyst at work in an ivory tower. The further implication is that confrontation is clearly outside the province of the psychoanalyst insofar as he has separated himself both from the real life of the patient as well as from any kind of activist position in respect to his therapeutic relationship with the patient.

Again, in this active historical period, active consideration of the patient's reality and active intervention by the use of the self in the treatment process too often come to mean that it is the job of the therapist to determine

what the reality is *for the patient*. It follows then that he is to tell the patient how he should conduct his life. Is it not a better teaching method with more effective reverberations in the patient if the therapist limits himself toward helping the patient discover which new choices or alternatives previously obscured or unknown to him because of his neurotic distortions are now open to him? Is it not for the patient to make the choice as to the direction he will take? He may choose to continue as he always has or he may choose a new direction. Whichever he does choose must be of his own doing and responsibility. The patient's privilege of maintaining his own individuality must be secure even if it means making no change at all and even if we do not ourselves like the kind of change he chooses to make. The freedom to change and the wish to change will flow from the relationship with a therapist who explains so that the patient better understands and who, in his confrontations, offers a model of gentle, caring concern. We need not concern ourselves with the concept of 100 percent neutrality in the therapist since such a state simply cannot exist in any kind of sustained relationship, therapeutic or otherwise.

It is not an unusual experience to find that our well considered, affectively appropriate explanations are met by a "so what" from the patient. This type of response is too often accepted as an invitation to the therapist for action, to do something about it and not just talk. There is enormous temptation as well as culturally sanctioned inclinations for the therapist to

respond with action. The danger lies in the fact that it becomes too easy to read into this an appeal to force as the missing ingredient in psychotherapy, let alone psychoanalysis, today. Too much emphasis may be unwittingly placed upon teaching by a system of rewards and punishments. This may readily lead to the misuse of such a system so that the eventual result becomes control of the patient and identification of the patient with the aggressor model. Unknowingly, we may find ourselves adherents to a variant of the Skinnerian model. Such a state hardly leads to the kind of inner freedom to choose that speaks for mental health; rather it directs the patient toward social adjustment, and the nature of the social adjustment is dictated by the therapist according to his lights. The cry of certain groups today that psychiatry and psychoanalysis are means of brainwashing young people may, as is usually true in delusions, have its small core of truth. Characteristic of the contradictions that exist in these very same groups is the fact that it is these same groups that seem to seek most the instant change suggested by the various kinds of encounter groups in operation. Basic to this is the wish for magical solutions to problems, and it behooves us to be careful ourselves that we fall prey neither to their demands nor to our own wishes to exercise some magic.

There is much to say for the voice of reason tempered and softened with compassion and even with passion. How can we combine objectivity and passion at the same time? Since no one therapist of any persuasion has the

one correct answer, each of us seeks to find his own way. Nevertheless, in any discussion of confrontation in psychotherapy or in psychoanalysis, the weight lies heavily in favor of a concept in which gentle, caring concern becomes our guide. Such concern does not mean passivity, nor does it mean avoiding confrontation; but it does mean that we leave the way open for our patients to *learn* to make their own choices, as much as is possible in the light of their own wishes rather than ours. All varieties of psychotherapy and of psychoanalysis are processes of *reeducation*, of *reteaching*. The issue then is whether we choose to teach by explanation, to enhance understanding coupled with offering ourselves as a model, or whether we choose to teach mostly by a system of rewards and punishments centering on a core of coercion. The more we experience increasing pressure and coercion in our everyday environment, the more must we guard against taking it out on the patient under the guise of treatment.

Of course, every patient brings to the treatment situation attitudes about and reactions to rewards and punishments. Only the use of some kind of mechanical speaking device could avoid the communication by the therapist of some degree of approval or of disapproval. Each of us does have the moral and ethical and human judgments by which we live and in which we express our sense as individuals. After all, gentle, caring concern is itself a reward.

The problem becomes one of deciding on which of the three aspects of teaching shall the therapist *attempt* to place greatest emphasis. Each of the three is complex; each plays upon the past history of the patient, and each is so related to the other as to be impossible of total separation. Explanation and gentle, caring concern as a method of confrontation, in good times and in bad, will lead to identification with a model that, more than anything else, will allow the patient freedom of choice. Such a result speaks for the highest order of both teaching and learning. This result is the proper goal of confrontation.