

**PETER E. SIFNEOS, M.D.**

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SHORT-TERM,  
ANXIETY-PROVOKING  
PSYCHOTHERAPY**

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# **Confrontation in Short-Term, Anxiety- Provoking Psychotherapy**

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Confrontation is a therapeutic technique that is widely used in various kinds of psychiatric treatment. During desensitization therapy, for example, the therapist confronts the phobic patient repeatedly with the object which he fears. In snake phobia, first a snake is shown to the patient on film or video tape. This fear-provoking confrontation is repeated until the patient is ready for the next step, which involves the introduction of a toy snake. A child playing with a live snake (nonpoisonous, of course) is then presented to the patient. When he is able to deal with a fear-producing situation adequately, a more anxiety-provoking task is presented to him until he, finally, is able to handle the snake all by himself. This progressively painful confrontation helps desensitize the patient. Great success has been claimed by this technique for these kinds of monosymptomatic phobias (Bandura, 1968).

In hypnosis, the therapist confronts the patient who seeks to stop smoking with the harmful effects of tobacco on his health, while he is under a trance, and suggests to him ways by which he can overcome this self-destructive habit.

In this chapter I shall discuss confrontation as it is used in a kind of dynamic psychotherapy of short duration that is called “anxiety-provoking.” During this treatment the therapist uses anxiety-provoking confrontation early in order to stimulate the patient to deal with the emotional conflicts in an effort to help him solve his emotional problem. If the therapist makes a decision to act forcibly and present to the patient certain aspects of his behavior that he is ignoring and that make him anxious, he must be convinced that such a technique will achieve better results than a less forceful and more gentle approach. Although there may be countertransference reasons that play a role in the therapist’s choice to use confrontation, for all intents and purposes, the achievement of the therapeutic goals will be considered to be his main motivating force for the use of confrontation here. (Sifneos, 1969)

It must be fairly obvious that the therapist’s goals must be more or less in tune with what the patient wants to achieve, but this may not always be the case. The patient who is ordered by a judge to seek psychiatric treatment or face a jail sentence because of her periodic sexual offenses has no clear cut goals. The patient who has unrealistic expectations of the results of psychotherapy and who is unwilling to accept more modest and realistic goals creates a situation that sooner or later will end in an impasse. Finally, there is the patient who wants “to place himself” in the hands of his therapist and whose passive attitude projects the therapist into a role of the omnipotent healer who is expected to perform a miraculous cure. Such an

attitude is reinforced by the familiar pattern of the doctor-patient relationship that is usually encountered in medical practice and that, at the same time, relieves the patient from taking any action and responsibility for his own treatment. Mutual agreement, then, about the therapeutic goals has a great deal to do with getting the treatment job done well.

The selection of appropriate patients who are able to arrive at a decision with their therapists about the goals to be achieved by psychotherapy is, in my opinion, of crucial importance for future success. In addition, after the completion of the psychiatric evaluation, based on his observations of the patient's capabilities, the therapist must be in a position to know what kinds of technical tools to utilize in order to achieve these specified goals.

In short-term, anxiety-provoking psychotherapy, we use five criteria as guidelines for the selection of appropriate candidates to receive this kind of treatment. These criteria attempt to evaluate the patient's psychological strengths. Every effort is made to define clearly the emotional problem that brings the patient to the therapist and that he had been unable to solve by himself. One of the reasons for this failure has to do with the patient's reluctance to experience the painful emotions that are associated with his emotional conflicts. Furthermore, some kinds of agreement must be reached on the area of emotional conflicts that the therapy should concentrate on in

order to solve the patient's emotional difficulties.

Short-term, anxiety-provoking psychotherapy is based on psychoanalytic theoretical concepts. Technically there are some differences. Anxiety is generated rather than suppressed during the interviews and is used as a signal to alert the patient of dangers and to motivate him to continue his efforts to solve his emotional problem. Throughout this type of psychotherapy the therapist communicates to the patient that he has confidence in him to be able to face and to experience unpleasant emotions in order to understand his conflicts, but this is not based on blind faith.

In contrast to gentle persuasion, confrontation creates pain. The therapist who plans to use it must be fairly certain that it will help set in motion a process of self-understanding that eventually will be beneficial to the patient. He must also be convinced that the patient is able to withstand considerable strain. It is because of this latter consideration that a great deal of time must be spent during the psychiatric evaluation on the assessment of the patient's strengths of character and on his ability to face the vicissitudes of this kind of psychotherapy.

As has already been mentioned, confrontation then is the key technical tool. By virtue of the fact that anxiety-provoking psychotherapy is going to be of brief duration, it compels the therapist to perform his work as quickly as

possible before complications set in that will make this therapeutic task impossible. In my opinion, this occurs invariably whenever the transference neurosis is allowed to develop, and it always happens when psychotherapy continues over a long period of time. Because the therapist does not have access to all the patient's fantasies as the analyst has when he uses free association and because he is limited by the face-to-face interaction as well as by the lack of frequency of the interview, the psychotherapist is unable to analyze the transference neurosis as the analyst must do in order to bring the psychoanalysis to a successful end. It is for this reason that dynamic psychotherapy of long duration ends so often in an impasse.

One must consider the possibility that confrontation is sometimes used as a result of the therapist's annoyance at some behavior pattern of the patient that he considers to be anti-therapeutic. In short-term, anxiety-provoking psychotherapy the therapist, instead of being taken by surprise by some destructive action on the part of the patient, is, on the contrary, well prepared for whatever may happen. When he confronts the patient with the reality of an unpleasant or ambivalent aspect of his relationship with some member of his family, he anticipates that sooner or later the same unpleasant features will be repeated in his transference relation with him.

As an example of confrontation used during the early part of short-term, anxiety-provoking psychotherapy, let us consider a thirty-five-year-old man



who complained of angry outbursts at work and of a rapidly deteriorating relationship with his wife, despite his love for her, and had mentioned that these difficulties in some vague way stemmed from his relationship with his parents. From the information that he gave during psychiatric evaluation, it seemed indeed likely that his present difficulties with his wife were connected with his unresolved and ambivalent feelings for his mother.

During the third hour the therapist had observed a fleeting but ecstatic smile on the patient's face when he described picking wild flowers while he was walking in the woods with his mother at an early age. This seemed to be unusual to the therapist because he had observed that during the two previous interviews, the patient's facial expressions had been distorted with rage when he had talked about his mother's preference for his younger brother, who was three years his junior. With this discrepancy in mind the therapist decided to confront the patient as follows, "You have repeatedly emphasized how angry you were at your mother and enumerated episodes when you have felt discriminated against by her. Your facial expressions spoke eloquently of your anger during these occasions." The patient nodded in agreement and the therapist went on, "On one occasion you clenched your fist when you spoke about the time when your mother had taken your brother shopping with her; and although you had cried and had begged her to take you along, she had refused and had sent you to practice the violin. It seems that you are making an effort to tell yourself and convince me that you

hated your mother.” The patient again nodded approvingly. The therapist continued, “This seems paradoxical, however, because a few minutes ago when you described to me the episode when you were picking wild flowers in the woods while in your mother’s company, an angelic smile came on your face.” The patient looked completely surprised, was silent for a while, and soon tears came to his eyes. He spent the rest of that interview reminiscing of the good times with his mother *before* his brother had been born.

The therapist’s confrontation produced an emotional response that helped clarify an area in the patient’s early life and that, by virtue of its being partly suppressed, had been unavailable to him up to that time. His awareness that it was his love for his mother that was responsible for his jealousy and rage at her and his ability to see that the same feelings were repeated toward his wife whom he loved, helped him to keep her out of this emotional conflict of his early childhood and lead to a rapid improvement in their relationship.

The therapist was neither angry nor annoyed at his patient; but rather he saw himself clearly in the advantageous position of an outside observer who, by virtue of his not being involved with the patient’s emotional difficulties, was best suited to confront him with paradoxical situations and to stimulate him to face the unpleasant emotions involved. It is, of course, possible in longer term psychotherapy after the transference neurosis has set

in—which is actively avoided in this kind of treatment as it has already been mentioned—that the patient’s persistent resistances and endlessly repetitive behavior patterns are more trying for the therapist and may lead him at times to make an angrier confrontation than he would ordinarily have liked to do.

There is no doubt, however, that confrontation indeed does involve a certain degree of harshness on the therapist’s part. In this sense, it could be compared to a surgical intervention. The surgeon, however, before deciding to operate, must first of all assess whether his patient’s organism has the strength physiologically to withstand this painful procedure. In a similar way the therapist creates a kind of emotional crisis knowingly because he is confident of the patient’s capacity to withstand his unpleasant feelings and his motivation to understand himself.

I am convinced then that for short-term psychotherapy, confrontation is a key technical procedure. One may think, however, that I am not being permissive enough or that I am trying to defend the use of this technique too vehemently. This is not the case. In my opinion there is a certain degree of passivity in the therapist who uses gentle persuasion exclusively. If one has to be unusually gentle, persuasive, and permissive, he must view the patient as being too weak to endure the therapist’s powerful force. Since this superior power should not be inflicted on another human being, the conclusion is reached that the patient must be dealt with very gently and he must be

pampered and protected. Such an attitude on the part of the therapist may emanate from his own ideas of omnipotence and exaggerated superiority over the patient. In this way, an excessively gentle persuasion does not seem to give the patient the benefit of the doubt. I have purposefully exaggerated this point in order to make the simple observation that gentle persuasion exclusively is neither gentle nor persuasive. As Myerson states (Chapter One), we cannot be absolutely certain whether confrontation will be effective or not, but I do think that we should make an attempt to answer this question.

At the Ciba Foundation Symposium on the “role of learning in psychotherapy” held in London (Porter, 1968), experimental psychologists, psychoanalysts, psychiatrists, ethologists, and educators attempted to delineate certain aspects of learning theory and its impact on the effectiveness of various kinds of psychotherapy. The stimulus-response concept, which has been used to explain how psychotherapy works, can be incorporated partially within the context of learning theory; but in this case the word *learning* must not be used in its strict cognitive (neocortical) sense, but rather in a combination of both cognitive and emotional (limbic autonomic nervous system) factors.

We have been interested in this type of learning because the patients who were seen in follow-up interviews after they had received short-term, anxiety-provoking psychotherapy emphasized that as a result of this

treatment, they had “learned a new way to solve their emotional difficulties.”

These follow-up findings encouraged us to set up a controlled study to evaluate the outcome of short-term, anxiety-provoking psychotherapy. The results of this study have been published elsewhere (Sifneos, 1968). Suffice it to say that, having learned to solve his emotional problem, the patient feels better about himself; this change in his self-esteem helps improve his interpersonal relations. Although the symptoms sometimes persist, their painful impact is greatly diminished so that they do not seem to interfere with the patient’s overall performance. One aspect of this improvement, in my opinion, has to do with the patient’s identification with his therapist both during and after the end of the treatment. This identification implies an ability on the part of the patient to learn and to utilize the techniques that the therapist has used during psychotherapy. Since confrontation is a *sine qua non* of this kind of therapy and has been used extensively by the therapist, it is this same kind of technique that the patient uses on himself. He does this to look for cues, to explore possibilities, and to raise questions, as he has learned to do during his psychotherapy, that will lead eventually to the solution of his emotional problem.

The best way to demonstrate this kind of confrontation is to quote from one of our patients who was seen in follow-up two years after the end of his therapy. “There I was, trying to find an answer to my new dilemma. I didn’t

know what to do until I started remembering what my doctor used to do, and all of a sudden I found myself trying to jolt myself in the same way that he was jolting me. It was like trying to jar something loose in my brain in order to get myself going. I said to myself, 'You are pampering yourself, Mr. W,' in the same way as Dr. R used to say during my treatment."

A case example at this point may be in order. A twenty-three-year-old female graduate student was seen in anxiety-provoking psychotherapy over a period of four months. Anxiety was the symptom that brought her to the clinic. It usually became intense whenever any one of her numerous boyfriends would try to change their platonic friendship into a sexual affair. During such time she would always break up the relationship. The oldest of three sisters, she was an attractive young woman, who thought of herself as being unattractive and felt jealous of her sister who was four years younger. She had been very close to both her mother, whom she described as being somewhat passive, and to her youngest sister, who was eleven years her junior. She claimed that she had always been proud of having helped her mother to bring up her sister. During the evaluation interview, it became apparent that her anxiety alerted her to avoid getting intimate with her boyfriends and soon motivated her to reject them. It was also thought that her ambivalent feelings for her father were being reexperienced with her boyfriends and shaped the pattern of her behavior with them. It was decided that this should be the area to concentrate on during the short-term

psychotherapy.

In the early phase of the treatment, the patient made several attempts to understand the reason for her anger at her father and claimed that she had experienced similar feelings for her last boyfriend, whom she had stopped seeing recently. On one occasion she made a slip of the tongue and had referred to her father as her “mate.” The therapist wanted to collect all the facts, and on that occasion he decided not to make a comment about it. Another time she referred to her younger sister as “my baby.” Again the therapist did not say anything. On the fifth interview she related a dream. The scene of her rejection of Rod, her last boyfriend, was being reenacted in the dream. She was married to Rod, yet she was unsure of his identity and added that it could be someone else. She was also pregnant. While she was recounting the events, she remembered clearly how she had ordered Rod to get out of their apartment and how very sad she had felt for having done so. In the dream she cried bitter tears, and constantly she kept referring to herself as “poor Mrs. M.” The one thing that had impressed her most in the dream was the sorrow that she had felt about her rejection of Rod. This seemed peculiar to her because, in reality, she had not given their separation much thought.

When the therapist asked her what the name “M” reminded her of, she was vague at first; but then she mentioned casually that she remembered that

her paternal grandfather had a hyphenated Spanish name. When he had emigrated to the United States, he had dropped one of the two names and that name was “M...” At this point the therapist had all the evidence that he needed to make this confrontation. He proceeded as follows:

Dr. What is your dream trying to tell us?

Pt. Oh well. The usual thing! I always seem to dream about separations. The whole mess with Rod was repeated all over again.

Dr. Was it really the separation from Rod that you dreamed about?

Pt. What do you mean?

Dr. You seemed to dream about a separation, but the question is a separation from whom? Putting it in another way, I wonder if Rod represented someone else. Don't forget that you were unsure of his identity and that you emphasized how painful it felt in the dream.

Pt. Yes, it is true, but who else could it be?

Dr. What comes to mind?

Pt. Well... Yes, there was something about it in the dream that seemed to come from the past; I don't know exactly.... the apartment?...There was something old-fashioned about the apartment...Yes! It was somewhat like the one we lived in while we were in Memphis. We moved to New York when I was eight years old.

Dr. So?

Pt. Well, maybe it had something to do with my father.

Dr. Not only with your father but also with your husband, Mrs. “M.”



The patient was silent. She seemed to be thinking.

Dr. Well, do I have to spell it out?

Pt. I vaguely know what you are talking about, but...(becoming teary)

Dr. Let me put it this way. You may remember that you had made a slip of the tongue some time ago and called your "father" your "husband." Today you had the dream when you were Mrs. "M." You used the hyphenated Spanish name of your father's family. It was disguised somewhat but not completely. There was a great deal of pain in your dream, a great deal of sorrow. You were not sure if it was Rod who was your husband. It was someone like him. You were also pregnant. Was this child your baby sister, Mrs. M?

At this point, the patient started to cry; but despite her strong feelings, she was able to reminisce about how close she had been to her father when she was young. He seemed to have changed, however. He had started to drink and had become cold and uninterested in her when she grew up.

I assume that one may consider this confrontation as being possibly somewhat too harsh. In my opinion, this was not the case. The therapist could rely on the facts. This solid evidence was provided to him by the patient during her treatment. The emotional outburst and the ability of the patient to associate to the earlier experiences with her father seemed to confirm that the confrontation was timely. The question is was it therapeutic?

The answer to this question must come only from long-term follow-up of patients who have received this kind of anxiety-provoking psychotherapy

of short duration.

From what we learned in our controlled study already mentioned, we are able to answer this question in the affirmative. Our patients not only mentioned that they had learned how to solve their emotional problem during the treatment but also that, as a result of it, they were able to utilize effectively this newly acquired problem-solving ability to solve new problems after the treatment had terminated.

In the opinion of two independent evaluators who interviewed these patients, this new attitude was confirmed only when the patients were able to give examples of new problems that they had solved. This they were able to do in the majority of the cases. There was also evidence that a dynamic change had taken place.

In sum then, confrontation, in order to be effective, must be based on the therapist's observations about a series of paradoxical behavioral patterns, contradictory statements, accumulated details; and by arousing the patient's feelings, it must motivate him to look at himself from a different point of view.

If the patient is willing to learn from this experience and tries to apply it in various situations, he may eventually be able to use it to solve new emotional problems that he may encounter in the future.

In short-term, anxiety-provoking psychotherapy, confrontation has both a therapeutic and an educational role. In this latter sense, it may have a great deal to do with learning, which plays a crucial role in making psychotherapy therapeutic.

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