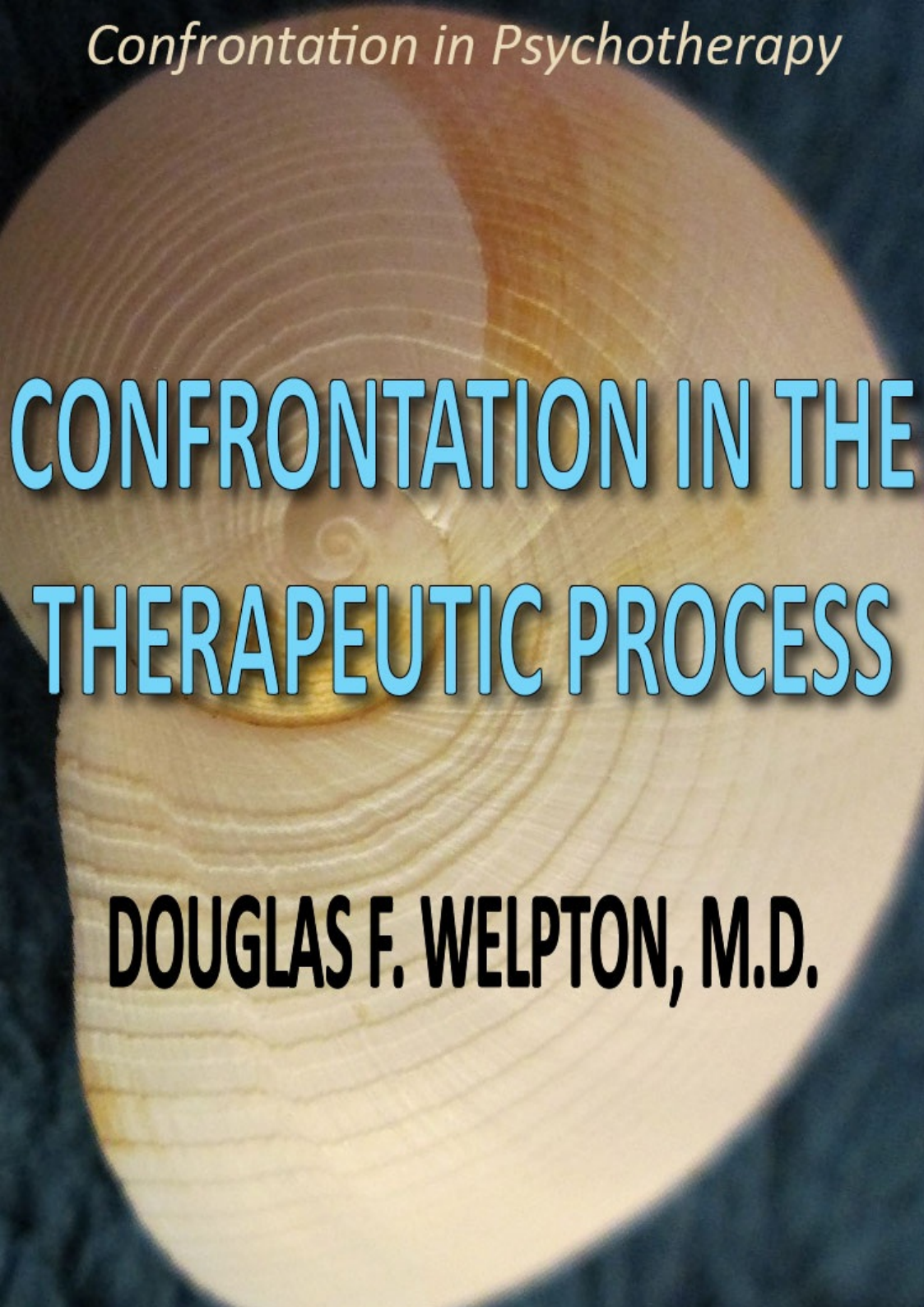

CONFRONTATION IN THE THERAPEUTIC PROCESS

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For some time I, like others, have felt the need in our field to develop a two-person psychology of the therapeutic process, a theory that includes the psychology of the therapist as well as that of the patient. While we have learned a great amount from focusing on the psychology of the patient, I have been concerned that efforts to conceptualize the therapeutic process in terms of a one-person psychology distort what really happens in such a way that we will not be able to advance our understanding of what helps patients grow and change unless we broaden the scope of our study to include the therapist. This is, I have found, easier to say than to do.

The complexities of trying to describe and comprehend the intricacies of the therapeutic interaction are considerable, especially when it is often the nonverbal behavior, or the tone of voice rather than the content of the words that counts. To be able to capture and render to someone else how the therapist knows what he does, how his empathy and his free-floating attention actually operate so as to enable him to be open to his own feelings, fantasies, and unconscious processes is a considerable task. To study the two-person psychology of therapy also requires that we relate these psychological events in the therapist to those in the patient to study the interplay between

them. Finally, and this is what I have found most difficult, such a study requires that the therapist open up aspects of himself and his work that he would prefer to keep private. Here, for example, I have found it difficult to describe an intervention that I regard as a mistake and far from ideal. Revealing more openly what we really say or do is most difficult, and yet I do not know how we can truly study or advance the process of therapy unless we describe actual experiences from treatment for study. In the course of doing so, our own personalities inevitably emerge, since we do convey ourselves and our values to our patients and we are not blank screens. Many years ago Alice Balint (1937) wrote: "The character of the analyst is an integral factor in the analytic situation and with the best will in the world it cannot be eliminated" (p. 13-14). The consequence of our knowing this fact is that most of us turn to our trusted colleagues or to other friends to get help in our struggles to be therapeutic, and this is understandable. It has, however, left us without a complete theory of the therapeutic process because we have focused on the patient and tended to exclude the therapist.

There is another problem with all efforts to understand and theorize about human behavior, which is that theories by their very nature are simplistic and reductionistic; they tend to simplify experience in their efforts to describe and understand it. This simplification of experience is true whether the theories are based on a one-person or a two-person psychology. It is probably an inevitable limit of psychological knowledge that it is easier to

fit people into theories than to develop theories that do justice to the complexities of people and human behavior. In spite of these difficulties, this paper is an effort toward a two-person psychology of therapy. The issue of use of confrontation in therapy is a timely one in developing this interactional psychology, since confrontations are interpersonal processes and are an aspect of the patient-therapist encounter that is the very heart of the therapeutic process.

Two Kinds Of Confrontation

In my clinical work, by my paying special attention to my confrontations during the last several months, I have observed that confrontation is more than one thing and cannot be talked about as though it refers to one single type of intervention. All confrontations do involve a moment of intense encounter between the therapist and the patient, one in which forcefulness is a crucial aspect of the experience as Myerson (Chapter One) has observed. My thesis, however, is that we should distinguish two different kinds of confrontations; namely, what I would call the angry confrontation to be compared with the empathic confrontation. In making this distinction between two different kinds of confrontations, I am aware that I am being reductionistic and contrasting the extremes of the confrontation process for heuristic reasons, and that the real experiences of therapeutic confrontations may lie anywhere along a continuum between the angry prototype, on the

one hand, and the empathic prototype, on the other.

The Angry Confrontation

An angry confrontation is one in which the therapist is annoyed, angered, or even enraged at something he does not like that the patient is doing. Frequently the therapist feels unfairly and unjustly treated by his patient, and his feeling dislike for this behavior of the patient invariably underlies his anger and his confrontation. It is the anger of the therapist that produces the forcefulness of the confrontation; whatever the therapist says in his confrontation, the patient experiences as the basic message: "I don't like your behavior when you are this way, and I have my limits in tolerating it." When I have been made angry in this way by a patient, I have usually found myself sitting on my initial angry feelings for a little while in an effort to be calmer and more restrained when I bring the matter up; and I have observed that at other times, when I have avoided being confronting, I have treated the patient to an angry silence. When an angry confrontation of this sort was successful, the patient got the message and stopped behaving as he had been toward me. I felt relieved that our relationship had improved, at least in this regard. The difficulty with which I was left, even after such a "success," was my concern that the patient had changed out of submissive compliance. Because of his wishes to remain in treatment with me and to have me like him —and these are very powerful motivations for most patients—he had given

in and submitted to my wishes by giving up a part of his behavior, at least in his relationship with me. He had changed for me, not for himself—this is what has troubled me most. His adaptation to me had fostered his feeling like the underdog and identifying with the victim. I was in the position of feeling I had forced someone to change, perhaps against his will, and of having to cope with my guilt for having done so. I was further troubled by my thoughts that I had fostered the patient's dependency on me through his changing for me and my approval, with the result that I found myself reinforcing a dependency pattern that patients generally need help to free themselves from.

In my observations, there are two basic processes in the psychology of the therapist that lead him to make an angry confrontation. One is that he dislikes the way the patient is behaving; he disapproves of it. The second, and this is the more important element, is that he feels a need to change the patient's behavior. The more he dislikes the patient's behavior, the more driven he may feel to have the patient change it; and his anger conveys with force this expectation to the patient. His disapproval of the patient for his behavior may border on rejection of the patient, conveying to the patient explicitly or implicitly that he does not want to work with someone who behaves as the patient is behaving. The patient may well change in the face of such forceful anger and disapproval; but if he does so, it is inevitably out of his need to please the therapist and to hold on to him, which forces on the patient a need to submit and comply with the therapist's expectations. It

comes as no surprise to me, when I review my experience, to find that the patients who have elicited angry confrontations from me are those who have the greatest problems with passive submission, who unconsciously provoke angry attacks from others, who complain characteristically of feeling like victims, and who are torn between identifications with the aggressor and with the submitter (victim). Brenman's (1952) observations on the teaser and the teasee describe the sadomasochistic interactions in these processes, while Loewenstein (1957) has captured the psychology of provoking angry confrontations most cogently when he speaks of "the seduction of the aggressor," which is the masochistic patient's role in these interactions.

I remember with some embarrassment an episode in the analysis of a phobic and compulsive engineer who was constantly feeling guilty and struggling with his masochism with his parents, whom he experienced as demanding perfectionists. He felt he could never fully please them and meet their standards for success, especially since he came from a highly successful family. In the analysis we had worked on his highly demanding and aggressive superego, with some alleviation of his guilt and self-inflicted suffering during the first year of our work. The bind that we got into developed around the issue of the appointments, since he had to change the hours of our meetings three different times during our first year. Part of his need to change arose from his inability to tell an employer that he was in analysis, for fear this would prejudice them against hiring him on a

permanent basis. In my efforts to provide him with a less rigid and compulsive model about these matters, I had indicated to him that I had some flexibility in my schedule and I thought we should be able to shift hours if necessary. By the time we had come to discussing our third schedule change, however, I had begun to feel very put upon, not so much because I thought the changes impossible to make, but because I felt the whole burden for working out these changes had fallen on me. In my effort to free myself from my burdened feelings, I indicated to the patient that my schedule was not infinitely flexible and that when it came to this latest change I would be able to offer him one new hour each afternoon (we were switching from morning to afternoon appointments because of his work schedule) when I could see him. He took this to mean I could offer him only one possible time each day, probably partially communicated by my somewhat terse tone, for I was feeling much less flexible at that moment than I had before. He reacted with an explosive outburst, telling me that such an arrangement was unacceptable and a breach of faith. In a most provocative tone he asked what would happen if he could not meet at those times, and I responded with restrained but obvious anger that then we could not continue with his analysis. This was an angry confrontation produced by my dislike for his rigid and demanding behavior about the appointments and my need to have him change it immediately. I not only was disapproving of his behavior but was indicating to him the possibility that I could reject him (no longer see him as a patient) if

he did not change. He responded with more anger by threatening to sue me for malpractice; and since I had by then gotten over my anger, I said to him that I thought we both hoped we could work out mutually acceptable appointments but that I felt he was expecting from me more flexibility about the schedule than I had. After he left the hour he evidently cooled off and began to feel quite guilty for his exploding, a pattern of which he was well aware. He called me and offered to meet at the morning hours we already had even though he had told me earlier that these would be very difficult for him. I heard in this his readiness to submit to me in a compliant identification with the victim, and I told him that I remembered he had said these hours would be very difficult and I thought we should give the whole issue more consideration in our next appointment.

In the subsequent hours we were able to work out mutually acceptable appointments. I found that all my inclinations were toward forgetting this angry confrontation, since I felt that it was a mistake on my part, that I had clearly acted on countertransference, that I had played my role in the seduction of the aggressor; and I felt guilty for it. I did not, however, follow my inclination to forget it and instead pursued the episode with the patient, who confirmed my observations of how victimized he felt; he spoke of feeling "bullied" and needing to "bully me back" with his threats of malpractice, for which he felt embarrassed. He said that he kept wanting to bring up this episode because he felt I had made a mistake and he wanted to make me pay

for it. I acknowledged his honesty about his wishes for revenge and told him that I agreed with him that I had made a mistake, that I was not above making mistakes, but that I had said what I had because I felt he needed to know that there were limits to how far I could go to meet his demands on time changes. He was quite surprised that I could admit to making a mistake and went on to make clear that he never felt free to do so, especially with his family. I felt that we had made a therapeutic gain of my mistake through this work. After my admission of how I saw what I had done and why, he was free from his need to get revenge and could pursue the issue of how he came to put me under such pressure as he felt under himself, which led us back to a very alive analysis of his unfriendly and aggressive superego.

Indeed it often seems that when an angry confrontation can be pursued fully by both therapist and patient, it opens up for discussion a previously obscure aspect of the patient's behavior, and the force of the confrontation enables the patient to see something he would otherwise ignore. This shared investigation is possible, however, only when the therapist has gotten over his anger and ceased to experience the patient as someone who is tormenting him. The therapist's return of empathy requires that he realize the patient is not behaving the way he is just to torment his therapist, but behaves this way with others as well and restricts his personal relationships by doing so. When I was able to return to a more empathic position with this patient, I realized that I had gained a deeper understanding of this man's demanding superego

for having felt under the pressure of it myself; I really knew how he felt when trying to meet what he experienced as his parents' demands. In his own way the patient had unconsciously fostered this understanding in me by treating me as he does himself with his demands.

The Empathic Confrontation

I would now like to contrast this angry confrontation with the empathic confrontation, a process that is no less forceful but that comes from a very different psychology on the part of the therapist. I find that I am able to confront patients in this caring way when I feel free from the need to change them. Instead of feeling under pressure to make them different, I find myself accepting them for what they are and then in a free position to take up whatever behavior interferes with their capacities to form close, caring relationships with me or the others in their lives. When working this way, I follow my own feelings of liking or disliking the behavior of the patient very closely, for this is my best guide as to where we are and what is important to the patient at that time. Not only is it important to the patient, but it is also what counts most in the treatment at that moment since the patient and I have to work out those things we dislike about one another if I am going to be of help to him. I have found that there is no better indicator of my potential helpfulness to a patient than my feelings of like for him: that if I can truly accept him for who he is and what he is and like him whatever his drawbacks,

then I can be my most helpful self. If I cannot work out a relationship with a patient in which I like him, I cannot be of much help and should send him to another therapist. I offer the following example to help clarify what I mean by an empathic confrontation in which I attempt to make use of my feelings of dislike within the framework of an accepting attitude.

A married nurse had been seeing me in twice-weekly therapy for two months during which she had talked a lot and conveyed a good deal of emotion. In spite of this I was feeling that I was not really getting to know her better or feeling closer to her. I liked her and had been working to help her with her depression, which was linked to her demanding, perfectionistic standards for herself, which she had taken over from her hard-driving, upwardly mobile mother. We had discussed her anxiety about therapy and particularly her intense concerns about what I would think of her if she revealed to me the things she did not like about herself. My comments had been directed toward questioning why she thought so poorly of herself, what she expected of herself, and of likening her own harsh demands of herself with those of her mother in the past. I attempted to help her toward a position of being open to understand herself rather than one of constantly judging herself as good or bad, right or wrong. In this discussion she said that she had an even greater fear of meeting me outside my office for fear I would not talk to her and would want nothing to do with her.

I had noted from the start of our work her tendency to bolt into and out of my office so as to avoid real greetings and partings. Based on my feelings, and the information from her, and my observations, I made the following confrontation. I said that, while I knew how afraid she was of me for fear I would not like her and had observed how she bolted into and out of my office, I felt that she was really keeping distance between us in a way that made it harder for me to like her. I said this in a calm, gentle tone because I felt general acceptance and liking for her and because I only wanted to understand with her why she behaved in a way that elicited from me the opposite feelings from what she wanted, and I said this to her in our discussion that followed the confrontation. I did not feel under any pressure to change her; I just wanted to understand her. She responded with a sigh of relief that she knew she had been keeping me at a distance and felt some relief to be able to discuss it. She repeated how afraid she felt of me and said that her bolting into and out of the office represented her efforts to avoid dealing with me in a real situation, akin to our meeting outside the office. In the following interview she told me how upset she had been since last time about her need to keep me at a distance and especially with my comment, which she mistook as my telling her I did not like her. I reminded her that this was not what I had said, although I could understand her tendency to take it this way. I said that I had told her she made it difficult for me to like her more when she kept such distance. She fell silent, then began to weep and almost

inaudibly said, “Why did I have to have such a crazy father! ” I asked what she meant, and she then began to convey with intense sadness what a difficult time she had had with him.

She had been born while he was away in the armed service and when he returned she was three years old. From the start he rejected her almost as though she were not his child. He showed obvious preference for her older sister and not only treated her coldly but told her she was “ugly.” The most difficult part came during her early teens (at this point her embarrassment and hurt were conveyed through her remorse) when he had crawled into her bed to wake her in the morning until one time when she thought he was naked and jumped out of bed. He stopped this behavior, and she felt even more hurt when her mother would not believe her about her father’s behavior. It was these events that caused her the greatest pain, and she related them directly to her inability to trust me and her fears of developing more closeness with me. She also said during this hour that she had come to realize that she had chosen her husband because he did not threaten her sexually. All of this history came forth with deep feelings, and at the end of it, when she said that she did not know how to get beyond her problems with men to form a closer, friendlier relationship as, for example, with me, I replied that I thought she had already started to do so in what had just been happening. Indeed I knew that I felt closer and more friendly toward her for knowing what she had been through in her past and for sharing with her

these experiences with genuine feeling.

What I am calling the empathic confrontation, as shown in this example, is based on facing myself and my patient with a vivid, here and now, mutually shared experience that has been happening between us in the therapy. While it may be something that the patient is doing that frustrates me in my efforts to be a special kind of friend, which is how I think of myself as a therapist, I am not angry with the patient nor do I feel that he or she has to change. I feel instead that I am accepting of their behavior but ready to question it with them so as to understand them better. If the confrontation is successful, I have found that it deepens my empathy for them and how they have come to be the way they are. The empathic confrontation places a premium on here and now experiencing, for I am impressed that it is the first-hand experiencing of new or different ways of being with the therapist that truly facilitates change. My observations confirm those of Hobbs (1961) that patients change first through their experiences and that the insight gained from such a change follows it rather than precedes it. With this patient, for example, the change in her behavior toward more closeness with me appears to have come from the experience of the confrontation, in which I was saying and showing her that I was interested in developing a closer and friendlier relationship with her. She had already mentioned, as part of telling me her history earlier in our work, her father's advances toward her; but now it came with intense and believable feelings and led to what I felt was a real insight

for her that her experiences with her father sexually were interfering with her relationship with me. The transference was no longer an intellectual understanding but had become a real and alive experience.

I must say that when I approach patients through these empathic confrontations I feel somewhat anxious and not just because of how I am confronting the patient, for I have usually assessed through my inner senses that the patient is prepared for it, but because I am also confronting myself. I am putting myself on the line about our mutual relationship and where it stands as I see it, and I believe that I must be open to examining what I have thought and felt about it as I hold the patient to doing. This empathic confrontation is really an open clarification to the patient of my countertransference responses, and I have to be open to discover how much they have been elicited predominantly by the patient (patient-induced countertransference) and to what extent they arise within me without much stimulus from the patient (self-induced countertransference). For example, if this patient had asked me if something were interfering on my part from my liking her more, I would have taken the question seriously and done my best to answer her. This would have required my efforts to be as open as possible with myself about my feelings toward her, including my self-induced countertransference, if present. I had already gone through this process and knew that I liked her and that I felt blocked from liking her more; this concerned me because I felt that I could be of more help to her if she could

safely get closer to me and if I could like her more.

To return to the issue of confrontation, I am saying that my experience has led me to distinguish two types, one made out of anger and the other out of empathy. Between these two types lies a continuum on which a given confrontation may fall in proportion to how much it has elements of the angry type, on the one hand, and how much of the empathic type, on the other. The angry confrontation involves some behavior of the patient's that the therapist dislikes and feels a compelling need to change. His anger and force communicate to the patient that he must change what he is doing if he wishes to continue with the therapist as well as that the therapist does not like him for the way he is behaving. The danger inherent in these angry confrontations is that the patient changes out of a submissive compliance in which his needs to have the therapist stay with him and like him win out. Change on these terms means that the patient is changing to please the therapist rather than changing for himself. The potential therapeutic gain from such a confrontation appears to lie in the openness on the parts of both the patient and the therapist to look at this episode together for mutual self-understandings.

Like the angry confrontation, the empathic one also centers on the here and now experience between therapist and patient, but the therapist feels in a different position. Instead of feeling angry, he feels anxious about bringing

directly to the patient and himself a piece of their shared experience that reflects on his own feelings about the patient. He is basically accepting of the patient's behavior, which he is not when making an angry confrontation. His anxiety, as I understand it, comes from the direct experiencing not only of the patient's feelings toward him, but even more so from experiencing and having to examine his own feelings toward the patient. In my example with the nurse I had taken up her transference although in doing so I had brought my own countertransference feelings about the state of our relationship into it. In my training along more classical lines, I had been taught not to do so, but I have come to wonder about this. I am sure that it takes discrimination on the part of the therapist concerning when and how to do so. For me the value of using something having to do with me increases the impact on the patient and also permits me to be a real person with my patients. Keeping myself and my own feelings hidden most of the time turns me, I have found, into someone who is carrying out a role rather than being a person. To put it another way, it has made me feel as if I am a therapist first and a person coincidentally rather than a person first and a therapist coincidentally. It has also caused me distress as a therapist with the problem of how this role-playing helps patients, since many of the people who come to me for help do so because they are so much caught up in their roles and appearances in life that they have never developed their potential selves to find out who they really are. To be a therapist who invites them to be themselves and attempts to develop a

trusting and caring situation in which they can do so cannot be done when I am not being myself with them, but instead have allowed my role as a therapist to imprison me.

For many years Rogers (1958) has emphasized the importance of the therapist's need to be himself as one of the major curative factors in psychotherapy. He has called this factor "congruence" and described it as follows:

> It has been found that personal change is facilitated when the psychotherapist is what he is, when in the relationship with his client he is genuine and without "front" or facade, openly being the feelings and attitudes which at that moment are flowing in him. We have coined the term "congruence" to try to describe this condition. By this we mean that the feelings the therapist is experiencing are available to him, available to his awareness, and he is able to live these feelings, be them, and able to communicate them if appropriate. No one fully achieves this condition, yet the more the therapist is able to listen acceptantly to what is going on within himself, and the more he is able to be the complexity of his feelings, without fear, the higher the degree of his congruence, (p. 61)

The research findings of not only Rogers and his group (1960) but also of Truax and his co-workers (1966) confirm the importance of realness on the part of the therapist in providing a helpful therapeutic experience.

The Process Of Change

It seems to me that underlying these contrasting types of confrontations

and the question of how useful the confrontation process is to therapy lies the more fundamental problem of what in therapy helps patients change. When a therapist makes an angry confrontation, he is forcefully pressuring a patient to change. We know that the usefulness of anger is that it often gets people to stop frustrating us and behave in ways that are more acceptable to us. In his unique and fascinating approach to treating children through mutual story-telling, Gardner (1971) has helped to emphasize this aspect of anger. In therapy, however, we are interested not just in the patient's adaptation to his therapist but also in his capacity to change himself for relationships beyond the one he has with his doctor. It is in regard to the process of change that I question the value of the angry confrontation or of any therapeutic intervention that puts pressure on the patient to change. If change occurred in response to such pressure, then it would seem to me that the "nagging superego" would be a much more effective force than it is in producing change. Instead the patient feels in conflict with himself and under pressure to behave in accord with his superego dictates, while knowing at the same time that he is sacrificing another part of himself when he submits to his superego pressures. The angry therapist forces a similar change on the patient through submission and in doing so becomes another voice of the "nagging superego." In the process he loses his alliance with a more reasonable part of the patient, his ego, to arrive at a more sensible way of behaving.

To return for a moment to my work with the engineer, I see myself as having felt under the burden of his kind of demanding superego (because such a superego exists as an aspect of me and because he helped to foster my falling under its sway through behaving toward me as he does toward himself) over meeting his needs in the appointments. My angry confrontation shifted this burden back to him, and he responded by submitting to his own superego pressures to comply. I had fostered his falling under the sway of his harsh superego through my anger. In the work that followed I reestablished my temporarily lost alliance with the more reasonable part of him (ego) to work out the appointments as one reasonable adult with another.

A very different process seems to me to be at work in the empathic confrontation. In this process the therapist works toward understanding, empathizing with and accepting the patient as fully as he can. He becomes alerted to whatever interferes with this process and works on these interferences with the patient both in their relationship and the patient's other relationships. This work consists of trying to understand with the patient how these blocks came about and why they exist. Free from the need to change the patient, as for example, to get rid of or overcome these blocks, the therapist is opened to accepting the patient for what he is, including his blocks or limitations.

This approach is grounded on the observation that when anyone,

patient or otherwise, can accept himself for what he is, then he is in a freer position to change and has much better chances to change, which he may then do without even realizing it. On the contrary, if the same individual puts pressure on himself to change, to get rid of those aspects of himself that he does not accept and does not like, perhaps even hates, then he is not free to change. Instead he goes to war with himself over what he is and cannot accept; one part of him demands, "You must change!" and another part replies, "I can't; that's why I am this way." Inevitably he becomes depressed over himself and what he does not like about himself.

It is not that the empathic therapist does not want to help his patient change, but that the change he is working toward is to help his patient accept himself for what he is. Through working toward his own acceptance of the patient, the therapist frees himself from the patient's prejudices about himself and is then able to question why the patient finds it so difficult to accept himself, what it is that he so dislikes or hates about himself that he has to disown, as a consequence of which he becomes divided against himself. The lifting of repression, which Freud (1916) described as "to make the unconscious conscious" and (1932) "to build ego where id used to be," is this very process of coming to accept all aspects of oneself so that no part need be disowned and rejected or kept out of one's awareness.

A therapist who helps the patient work toward greater acceptance of

himself for what he is helps to free his patient from this demand to change into a different person and facilitates the patient's becoming more tolerant and understanding of himself. This is what happens in the process of empathy and of an empathic confrontation. On the contrary, a therapist who pressures his patient to change allies himself with the patient's self-critical superego, which is already telling the patient he is no good, inadequate, defective, or worthless for being what he is. In response, the patient becomes more depressed with himself and/or angry with the therapist. This is what happens in the process of the angry confrontation. The therapist may feel successful to see the patient change in response to the anger, yet what he sees is not real change through freedom but submission. He may rejoice that the patient has finally gotten angry with him and expressed it so that now the negative transference can be worked on, but the anger the therapist has helped produce in the patient is not real transference but a response elicited by the demands of a therapist who has allied himself with the patient's critical and condemning superego.

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