THE TECHNIQUE OF CONFRONTATION AND SOCIAL CLASS DIFFERENCES

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Confrontation in Psychotherapy

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In this essay I will discuss a wide range of models of intervention usually grouped together in a particular category as psychotherapeutic techniques. By illustrating the ground rules for each and the different factors operating between therapist/leader and patient/member, I will show that the choice of technique, particularly when it involves confrontation, may be influenced by social class factors. The drug addict, because his plight is much in the public eye at the moment, makes a good example of the need to see these techniques as a means to an end. My discussion will use the addict to show how the perception of a technique by both practitioner and subject can be thought of as a value statement and an end in itself.

Since much of the discussion concerns placing the technique of confrontation within a range of more familiar interventions, I will specify what I mean by the word *confrontation*. Almost anything said by a therapist to a patient or by one group member to another can be thought of as a confrontation if the literal dictionary definition is used. *Webster's Third New International Dictionary* (1965) provides (1) to stand facing, to face; (2) to face boldly, defiantly or antagonistically, to oppose; (3) to set face to face, to

bring into the presence of; (4) to set together for a comparison. Generally speaking, modern psychoanalytically oriented techniques are thought of as closest to the third definition. Comments of the therapist/leader are intended to be evocative, to clarify, to distinguish relationships among apparently unrelated thoughts and feelings. Only perhaps with interpretation as defined by Edward Bibring (1954) does the boldness of the second definition become predominant. A reading of Freud's early cases suggests that he was not then so circumspect as he later became, and he often used the bold confrontation. At that time he was more interested in making (forcing) the unconscious into consciousness than in studying the repressing forces themselves. Thus, as his goal (ends) changed, so did his technique (means), leading him in his practice to the third definition.

For the purposes of this essay, the definition of confrontation as a technique will be limited to the second sense; and it is to be understood as a technique used between one person and another, as opposed to its use by one person to evoke an intrapsychic confrontation within the second person. Although this definition could and does cover what might happen in a one-to-one situation, I am using it in this essay exclusively in a group context. Encounter groups gather together for the purpose of boldly, defiantly telling each other "how it is." They report directly not only on what each participant feels but also on their direct emotional responses to what another says or is. While *boldness* and *opposition* are both words present in the definition, they

are not synonyms. Boldness can be humorous, even gentle, and not antagonistic or forceful, but it is direct and related to affect.

The old saying is, “For example is no proof,” but what I want the reader to think of when I use the word *confrontation* is a group situation where one member responds to another’s statement of feeling by saying, “Make me believe it! You say it but I don’t feel it. Make me feel what you feel.”

One-to-one psychotherapy is the usual therapeutic model (Chance, 1971). Doctor and patient roles are clearly defined. Until the recent growth of community psychiatry and case-finding, the patient sought out the doctor, made an appointment, and explicitly agreed that he had an emotional conflict to discuss. Generally this procedure required some similarity of life experience between the patient and the therapist that permitted them to work out a shared level of ego perceptions and verbal representations. Thus, the therapist’s expectations—that is, what he wants for the patient and from the patient—can be made fairly explicit.

Even when the therapist ventures into the community as part of a community health or case-finding team, he goes to seek out troubles; and he maintains a clear view of his position of doctor. Who is to be considered “patient” may be less clear, though this must be defined before a therapeutic situation can be officially established. When the therapist takes the initiative

for the therapeutic encounter, there may be confusion over what he wants from the patient or for him.

Small therapy groups follow the individual psychotherapy model. The groups are artificial, arising from the shared, stated desire of each member to study himself. While the members test reality against each other as part of an aggregate, the purpose for which the group was created—work with the individual member—is never entirely lost sight of; nor is there any doubt as to who is the patient and who the doctor, though the various wishes and expectations involved in these roles become a lively part of the therapeutic process.

Large groups that are therapeutic in intent represent a different model. The first reporting of this approach by Dr. Pratt at Tufts Medical School in 1902 emphasized the search for an active solution to a problem. Today there are many such groups organized around a variety of diseases, of which the best known is Alcoholics Anonymous. The individual is essentially anonymous. Anyone who has found a way to transcend the problem qualifies as a therapist, though he becomes recognizable as a patient again if his mastery over the problem falters. Hence patient-therapist is a variable division, but there is no ambiguity about what would be “better” for the patient—whether it be to stop drinking, adjust to an ileostomy bag, or think cheerful thoughts rather than succumb to the hopelessness of depression.

So-called dynamic groups also have a more or less therapeutic purpose. Here the "patient" is not the individual himself or the symptom but rather a task; for example, knowing more about oneself in order to be more effective as a teacher, psychiatric resident, group leader, or whatever. Individuals discuss their conflicts and how they see the world but with the focus, explicit or implicit, not on themselves as patient but on their function outside the dynamic group.

The social distance between leader and member in a dynamic group is clearly less than that between doctor and patient in a therapy group. The group leader is a professional colleague who could easily be socially confused with other members of the group but whose differentiated role creates distinct psychological distance between him and the other group members. The group goals are considerably less structured than in the large problem-mastering groups like Alcoholics Anonymous, but more so than in individual or group therapy. While it could certainly be argued that it is no easier to say what makes a better teacher than what makes a better person, there are more specific task designations around even jobs as ambiguous as group leadership or teaching.

When dynamic groups are assembled by drawing from all over persons who do not know each other, they are artificial, created for the purpose of working with individuals, and are then similar to therapy groups. However,

when the group is made up of teachers from the same school or residents from the same hospital, the dynamic group comes closer to a natural group. These people are part of a preexisting social network and have relationships with each other that are external to the group. In this situation, the stated goal of working toward greater understanding for the individual becomes less sharp. The group behavior of a participant can have direct consequences for him and for his institution outside of the group meeting. Once the need for attention to and preservation of these extra-group networks is recognized by the group, the priority of working toward individual goals receives greater consideration.

The potential importance of this dual concern for individual and system can be seen when one looks at other therapeutic efforts such as couple therapy, family therapy, and milieu therapy. The therapist frankly no longer works with the individual but with the system. A married couple, a family, or the ward of a mental hospital forms a natural situation, a small social system, that occupies much of the life space of the individuals involved. In therapy, as in the rest of his life, the individual appears as part of his usual social setting. The therapeutic endeavor is to preserve the system and to consider the individual's responses only insofar as his communications, positive or negative, reflect on the system that is threatened.

In the actual clinical situation of "marital counseling," for example, the

question of what the therapist has been hired to do may not be perfectly clear. Just as a dynamic group of residents from the same hospital learns that their goal of knowing more about their individual responses as beginning psychiatrists may need to be modified to protect the system of a closely integrated residency training program, so may a couple who want their marriage treated find that the study of each of them as individuals intrudes on that goal. Thus, in contrast to individual or group therapy, where the value of studying the individual case is accepted as worthwhile, in systems therapy the study of the individual case may be recognized as destructive of the system and, hence, of the therapy. There is no doubt as to who is the therapist in systems therapy, but conflict sometimes arises from the need to give priority to the system over the individual.

The therapist, by his willingness to work to preserve the system, shows that he accepts the system as valuable, and by implication perhaps other conventional social institutions as well. This indeed limits the therapeutic relationship. The more traditional the social structures accepted by the therapist, the smaller the area where he and the patient can meet to consider objectively, without defensiveness, the patient's responses to his social setting.

Encounter or marathon groups, which under the rubric of a therapeutic encounter use confrontation as a technique, place their emphasis on highly

charged emotional interactions among participants. These interchanges get tensions out into the open and expressed. The resultant behavioral manifestations of this emotional interchange are accepted and valued. Conversely, a reflective study of the individual as a separate entity and of the factors inhibiting his expression of feelings is devalued. In fact, to focus on conflicts within an individual may be conceived of as a derogatory procedure in the encounter situation. All are in the group together and all are there to "give" to others. There is no group "leader," just as there are no patients.

It would not be too farfetched to describe these groups as a systems therapy in which the system to be treated is the larger social setting itself. Instead of exploring the inhibitions and fears that might interfere with an individual's ability to adjust in society, these groups assume that unreasonable social conditions have resulted in his present distress. The (debatable) premise of psychotherapy—that a transfer of learning takes place from therapy to other life situations—is used here to explain how the experiencing of strong emotion in the confrontation situation can make the participant aware of, and free him from, the constricting influence of more usual social settings. One may wonder why a middle-class person, who is socially accepted, possessed of verbal and intellectual skills, whose emotional problems of living stem from a difficulty in using what he has, needs to fear such social influences so greatly. But we shall later consider how this concept may make more sense when applied to a drug user, labeled deviant by society

for his drug use *per se*, or to an inarticulate, low-skilled, working-class black.

The position of the therapist in usual individual or group therapy situations has remained essentially as it was defined by Freud (1913). The therapist, in effect, leases time to the patient. Freud analogized with a music teacher who brought his skills to the time during which he was hired. This view of the therapeutic situation stresses the total voluntariness of treatment and the resulting equality between teacher and pupil. The patient-pupil decides whether he wants therapy lessons; he can stop at any time, but he is responsible for the time that has been contracted. Thomas Szasz (1968), particularly, has stressed equality through contract. Two equal individuals with similar rights and privileges but not identical tasks or responsibilities work together on a common problem. The therapist will do this work for an agreed fee in agreed upon hours, and he will not save hours that are not paid for but neither will he lease the contracted hours to anyone else.

This clarity about arrangements insures the equality of the participants. For if the therapist were to set aside extra time when a patient is called away or suffers a long illness, out of his humanistic subjective concern for the patient, he would be behaving as though he were a philanthropist—a benevolent spirit who graciously provides for the needy patient. Freud believed that a therapist with such total conviction that what he had to offer was “good” for the patient that he could not in all conscience withhold it

raised questions about what he wanted from the patient in return. While the payment of a fee does not *per se* guarantee that some therapists will not want and indeed feel entitled to returns of gratitude, the patient's moral betterment, or simply "improvement," it at least sets the stage for an objective, collegial relationship.

This objective relationship calls for the therapist's presentation of himself as relatively invulnerable. No matter how personal or how intense the statements and the feelings of the patient, whether affectionate or angry, the therapist treats them as manifestations of transference. His benevolent acceptance of these expressions and his attempts to make sense of them are part of the skill for which he is paid. The therapeutic contract protects the therapist's objectivity and offers the patient the freedom to express his emotions without fear. Many people find it harder than one would imagine to differentiate between act and thought, endowing the latter with magical properties. If a patient misses hours because of emotional turmoil or a vacation and desires to continue the therapy, he must pay for those hours. Should he remain silent out of a wish to punish the therapist, he soon realizes that it is his therapy that suffers. The situation is designed to make clear that it is the pupil's desire to learn music that provides the impetus for the lessons, not the teacher's wish that he do so.

While this invulnerability supports the crucial therapeutic neutrality, it

also becomes one of the most delicate therapeutic problems. Anyone who can accept without flinching feelings as powerful as the patient regards his own deeper responses must be either callous and uncaring or enormously powerful, with the capacity to succor, to retaliate, or to judge. The therapeutic neutrality can be experienced by the patient as degrading or dehumanizing: "You are too weak and unimportant to have an effect on me," the therapist seems to say. The therapist of course knows all too well that he is not so totally strong, objective, or invulnerable but rather that these properties derive from the situation and his skill at his job. But his ability to show the patient that reactions to the therapist's objectivity are part of the work—perhaps the most difficult though potentially the most fruitful part—depends upon the invulnerable position of the therapist.

In the one-to-one situation, then, the therapist is objective, committed to the study of the individual case, and invulnerable. He values the shared work of the situation and, without disregarding the importance of nonverbal messages, relies heavily on verbal communication and, eventually rationality. His generally neat appearance and carefully selected surroundings announce at least some interest in material comfort and the avoidance of any deviant or disruptive social atmosphere. As the overwhelming majority of his patients share the values implicit in these nonverbal announcements, they contain no mysteries or hidden potential. The questioning of the therapist's value neutrality occurs over issues on which the patient anticipates conflict or

disagreement. This anticipation arises when the patient experiences as coming from the therapist some less conscious aspect of his own conflict. Moreover, such projection is usually sanctioned by old parental attitudes, ideological or religious convictions, or official cultural positions. They range from "Stand up straight" and "Thou shalt not even wish to kill" to embarrassed confessions of cheating at cards or an illicit sexual act accompanied by the conviction of the therapist's moral outrage.

Of course therapists are attacked by their patients for their speech, appearance, and surroundings; but they are usually attacked, not questioned, because in almost every case their patients are people who have shared similar life styles and are expressing their own demonstrable personal conflicts. The therapist's own analysis prepares him with an awareness in depth of his own position on such issues. The nearness of the patient's preoccupation to the therapist's own life does not interfere with the therapeutic position of appropriate psychological distance. Thus, by restricting his offering to a discussion of the patient's conflict rather than the manifest reason for the attack, the therapist does not strive for agreement, closeness, or the avoidance of criticism. By not taking the patient's criticism personally the therapist makes it clear that he does not want anything beyond the contract for or from the patient. This sharp break with the niceties of conventional social interaction is meaningful because both parties acknowledge it as a break. Thus, the working model of two relative equals—

one of whose input supplies the subjectivity, the other the objectivity—operates smoothly because both know and accept the same social values.

In the traditional therapeutic groups the positions of therapist and patient follow the same principles save one. As in the one-to-one relationship, the "patient" supplies the individual cases to be studied. The "patient" group hires a group leader of similar social class to bring his objectivity and skills to bear on the problems, with an awareness of the broad outlines of how he might proceed and an acceptance of their interest in his actions as part of the process. All of these factors, including the leader's psychological distance and relative invulnerability, follow the original working model of equality and difference. But in the one-to-one relationship if either party is physically absent no actual therapeutic session can occur. The patient, albeit at a cost, can halt the proceeding, just as the therapist can. In a group, an individual patient loses that equality with the therapist. Group sessions can proceed without any one individual, as long as the leader is there.

One would then expect such groups to be extremely concerned with the issues of authority and dominance as they relate to the leader and to the issue of closeness among members. When the life of the group depends essentially on the existence in that time space of that one person, while others are expendable, he automatically becomes endowed with great power. (Leaderless group meetings occur, but unless the group is greatly

experienced, such meetings are idiosyncratic and desultory.) So much power, in fact, does the leader have, that at some conscious or unconscious level almost any group discussion needs to take him into account. One should never underestimate the force of the transference reaction in the one-to-one relationship, but there are times when the interaction with the therapist is submerged. Individual patients do become involved in their interpersonal conflicts with others outside the therapeutic situation, and they do review everyday decisions they must make with little regard in their associations for the immediate transference implications. Members of a group, on the other hand, find it extremely difficult to minimize in their discussions the constant ongoing emotional relationships to other group members, particularly to the leader; and when they seem to, it is usually a transparent defense against a previous or forthcoming group issue.

Dynamic groups, in contrast to therapy groups, are for something other than the study of the individual case. Whether they are assembled to learn about groups or because of the members' desire to function more coherently as teachers, social workers, or psychiatrists, as a result of the knowledge gained from the group experience, they have a stated goal related to an accepted social institution and not just to the individual member. This specific inclusion of the social institution in the relationship between group leader and group member shifts the patient-therapist position as outlined in the one-to-one situation. This acceptance in dynamic groups of a social goal other

than the study of the individual case suggests value positions in the leader that raise the question of what he might want personally for the group members and from them. By joining them in an effort to be better social workers or more learned about groups, he indicates that he knows what a good social worker or group leader is, something about the proper way to become one, and suggests that to be one is a "good" thing.

The members, for their part, by their very presence in the group, show confidence in their ability to attain a group goal. The leader may have something special to teach them, which exalts him; but they can legitimately regard themselves as students with a potential social use for what they learn. The role of student differs sharply from that of patient in our society. "Patient" is a deviant role implying sickness or weakness, while "student" promises achievement and the possibility of surpassing the teacher. In fact, to maintain "student" as a viable social role requires hope and activity, as contrasted to "patient" with its accompanying feelings of passivity and helplessness.

In therapy groups it is a long time before a patient can accept the possibility that what another patient has to say may mean nearly as much to him as any comment from the leader (Zinberg, 1964). He longs for curative interpretation from an omnipotent leader. In dynamic groups, anyone who enters as a neophyte social worker, psychiatrist, or group leader—no matter

how ill-at-ease or uninformed he feels—wants to be seen as a potential contributor. To gain such regard he must give it. Often the regard is given and accepted grudgingly. But no matter how undeserving he may feel, the group member understands that he must solicit the regard of his fellows. Members, by this giving and accepting, confer status on each other and thus restore a differential equality to their position vis-à-vis the leader.

It is difficult enough in a one-to-one therapeutic situation for a leader to say undeviatingly to a patient: "Yes, I will help you study yourself, and doing so is often an illuminating procedure that will lead you to a greater awareness of choices and inhibitions. But what choices you make, what being 'better' means to you, is your business and not mine." In a dynamic group, once the leader announces (by his presence alone) that he wants the group to achieve a specific state of "betterness" and is willing to work with them to that end, he will find it much harder to deal with the question: "What should we be doing?" His position as dominant in a magical sense has been eased by the group's specific goal and the status that this gives to members, but the idea that there is a "place" for the group to "get" makes the leader more of a grading teacher and less a neutral therapist.

That the dynamic group leader can legitimately be considered to have a value position about where the group should go does not increase the *social* distance between him and the group members; rather the opposite. His age,

social circumstance, general demeanor are all similar to theirs; and there is agreement that the group has a purpose or goal more specifically related to a social value system than the study of an individual case or the process of therapy. Hence, the *psychological* distance evidenced by the different functioning of the group leader becomes both more necessary and more irksome to the group members—more necessary if the group members are to learn what they want to learn by observing their difficulties in dealing with each other, particularly with that differentiated other, the leader (of this they are largely unaware throughout much of the life of the group); more irksome, because once having agreed upon a goal relating to a third party (pupils, clients), it seems only the peculiar stubbornness of the group leader that prevents them from achieving it. If he would stop his habit of commenting on what is happening in the group—or worse remaining silent—and give them straight answers, they might get somewhere. As the group progresses and members become more aware of the hopes implicit in their annoyance with the leader, they tend to shift their attention toward analyzing these hopes and away from the expectation that they be fulfilled. This shift represents an acceptance of the therapist's psychological distance. In the dynamic group the leader's position demands this distance not only because of the social closeness to members but because he trades a degree of objectivity—wanting something for them—for their strengthened identity as goal-oriented professionals.

One would thus imagine that in a dynamic group much of the group work would center on persuading the group leader to join them, to be more like them in function. One would expect it to be harder to get group members to recognize that the study of the group process and their part in it is an end in itself, which each must apply in his own way to his function as teacher or social worker. The group leader's behavior might be seen as less omnipotent than in a therapy group, but equally incomprehensible. Hence he remains clearly differentiated.

The systems therapies (family, marital, milieu) not only find the study of the individual case troublesome, but even more than dynamic groups they struggle with the value positions implicit in the therapeutic goals. Conducting marital therapy commits the therapist to the value of marriage as an institution, though the therapist may maintain his neutrality about the value of the particular marriage he is treating. Once he is committed to that much of current social convention, is it not fair to wonder what other cultural values he holds as "good"? If he has clearly defined positions on what these good behavior patterns are, will he not judge deviations?

The situation is clearest in mental hospital milieu therapy (Zinberg and Glotfelty, 1968). There the therapist is not paid by the patient, but by the hospital. The "patient," is effect, is the hospital ward itself, which exists to establish a milieu that is "better" for all. The hospital also operates on the

belief that learning is transferable and that for a person to achieve improved functioning in a hospital ward should enable him to function better in society. The therapist's job has far less to do with individual idiosyncratic responses than with the general demands of establishing a coherent milieu. And that milieu must be coherent within a framework of rules, regulations, mores, values, and principles acceptable to his employer, the hospital. The patient too is limited in his expressions because in ward meetings, no matter how free in intent, he does not leave his usual social setting. Despite verbal agreements about objectivity, the participant's responses can have real-life consequences for him. He can please or offend other participants, including the authorities running the meetings, with whom he must contend after the meeting. Hence in the ward group, as in family, couple, or other institutional groups, it is possible to study the workings of a system, how it uses or rejects parts of persons, what are the open or closed avenues of communication and the sources of power within it, but at the cost of basic restrictions on the freedom of members to study themselves. There are similar restrictions on the leader's flexibility as he becomes the proponent of "reasonable" behavior. The therapist as an individual dealing with a system is clearly differentiated socially and psychologically from individuals who are members of the system, and no effort is made to close that gap. Doubts as to who the therapist is "for" in systems therapy and the extent to which he indeed wants, because of the demands of his job, social conformity from the participants indicate a doctor-

patient model quite different from the traditional one-to-one with an objective therapist and a defined patient.

The traditional model contrasts even more sharply with the "patient"-"therapist" relationship in the encounter or confrontation situation. In such groups the concept of leader is resisted. Once the person who calls the group together has performed that function, he makes little effort to differentiate himself from other participants. He talks freely about his own feelings and reactions, and bases his relationship with other group members on these highly charged, emotional interactions, just as they do with each other. The impact develops as a result of these direct expressions of feeling.

Once the "leader" participates directly and indicates that he has feelings that can be aroused or hurt, that he will defend or attack just like anyone else, he relinquishes his invulnerability. This does not prevent group members from having all those transference concerns about authority and dominance discussed earlier. Further, if there is a putative "leader," it is he who is the most natural repository for such feelings despite his renouncing the role. The other group members, paradoxically, find themselves in a position where the free expression that is so valued may have to be curtailed. If a member wishes to please or to attack the putative group leader, he runs the risk of rejection, retaliation, or feeling guilty. He finds this situation very close to an ordinary interactional social situation in spite of the group's emphasis on expression of

feeling. For although the decisions about what to express may be different in a confrontation situation—hence loud, angry feelings may please rather than offend—the essential decision is the degree of control or lack of it that one exercises, as opposed to the study of what may or may not originally have inhibited feeling. Little attention is given to understanding past conflicts and inhibitions. Hence, members' reactions to a leader, who takes the privileges of a participant, relinquishes control over his own responses, and thus declares his vulnerability, are experienced as active, rational, and in the present.

This therapeutic method tries to reduce the psychological distance between leader and participants to zero and frankly wants this for participants. It is considered *per se* "better" for people to face each other freely and without shame. The groups are supposed to be democratic and to have the idealistic goal of helping group members to cleanse themselves of hidden poisonous feelings so that they can care for and about each other. Here a means-end conflict develops. Is this reduction of psychological distance a means to an end or the end itself? What are the participants in these groups searching for?

Some encounter group participants, particularly those from the middle class, hope that the experience will teach them, force them to "feel." They express little curiosity as to what may have *stopped* them from feeling, which, after all, is as much part of the human birthright as breathing. If, in their

struggle to experience, this comes up at all, it is given a social rather than a psychological explanation. Confrontation groups assume anthropomorphically that our increasingly mechanized society victimizes individuals by recreating them in its own depersonalized image.

In their case the means, reducing psychological distance, seems to become an end. It is not that participants literally do not feel but rather that they do not like what they feel any better than they like internal restrictions against some feelings. They want both the process of feeling and the feelings themselves to be "better." They long to be cleansed not only of hate and anxiety but also of greed, lust, cruelty, sorrow, and especially envy, leaving only love and caring for one's fellow man. An ideal human interaction that eliminates dominance or submission requires more than freedom from conflict: there must also be freedom from difference. The differential equality, described earlier, is not enough, because where there is difference there can always be jealousy, desire, and disagreement. Should such feelings exist, there is no hope for noetic fulfillment, oceanic gratification, or a mystic oneness with each other.

Certainly dynamic groups of all sorts desire to close the division between group and leader and, by reducing that distance, to achieve a unity that would permit them to relate to an outside, third entity (Boris *et al.*, 1972). They cannot be better teachers or group leaders, they believe, until

they can decide together what "better" is. Thus they are intolerant of the leader's insistence that they study their differences and divisions. Unrealistically, the group believes that by confronting each other with their "real" feelings, they can eliminate social and psychological differences. Members hope to eliminate narcissistic barriers. In answer to the question "Is each man an island?" they want to be able to shout a "no" so resounding that for an instant each could believe that he might truly and totally share another's feelings.

To the extent, then, that confrontation techniques become an ideologically endowed end for those trying to escape internal and external conflicts and inhibitions, the method appears a gimmick or a fad. In groups so motivated, it is no paradox that the "leader" can become a tape-recorded instruction. What is wanted from the leader is impossible, and hence it matters little what or who he is. Michael Oakeshott (1968) once said, "To try to do something which is inherently impossible is always a corrupting enterprise." Once the aim of these confrontation groups is to exalt humanity to a totally loving state, the result is the denial of the dignity of the human struggle.

However, this is a *misuse* of the confrontation techniques and a misunderstanding not only of people but also of the therapeutic process as a process not an end or an ideology. The relationship between leader and

group, therapist and patient, teacher and student each has elements that allow an interaction to proceed. This essay details how some of them—transference, vulnerability, value positions, and the like—operate differently when relationships among participants differ or when social or institutional variables intervene. The technique is but a means whose elements may be analyzed in terms of who are the participants and what are their potential social and psychological relationships to an ongoing therapeutic operation.

Some groups—drug addicts, for example—also expect little from leaders. Their monumental apathy in the face of efforts to show them their self-destructiveness is striking but perhaps not surprising. One realizes, however, that many "therapeutic" efforts have had little to do with the addicts' plight and much more to do with a desire that they be improved for the benefit of a society from whose paths they have deviated. Often this greater interest in the society than in the patient may be conveyed by demanding that he use the "accepted" means of a traditional technique. When that occurs the traditional therapist unwittingly may be misusing a technique as an end rather than a means in a fashion similar to the faddish middle-class confrontation groups.

It is my contention that the position of a deviant, particularly for those members of an underclass who have chosen deviancy, imposes a barrier to communication that must be overcome before any meaningful work on

interpersonal conflict can occur (Zinberg, 1972). To be a deviant means *per se* to be socially distant from one who is not. Most drug addicts are virtually lifelong deviants. Middle-class addicts (the word *addict*, representing as it does a stereotype, is purposely chosen in order to distinguish the group from the new large group of social drug users) are almost invariably people with a long history of psychological disturbance. Fearful childhoods lead them to a search for an escape from sorrow or anxiety that may begin with sniffing airplane glue and end with any one of a number of substances. Generally, in this country it is heroin; but the drug itself makes little difference, for the addiction lies in the total commitment to its use; and it can be anything called psychoactive whose effect is psychopacifying.

Addicts from low-skilled, working-class backgrounds show an astonishingly consistent characteristic profile. Their personal histories have been to follow a distinct pattern: cigarettes at age six or seven, liquor or sex by thirteen, marijuana soon after. Promiscuity and petty thievery merge almost automatically, in late adolescence, into prostitution and organized crime. Drug abusers of this type show a definitely ascending use of drugs, typically moving toward the one with the big kick, H (Chein, 1964). But other things we know about this type are puzzling—in particular, the ways in which their pattern differs from that of the nonaddicted delinquent. To begin with, Billy E. Jones (1960) finds that Lexington, Kentucky, drug users are surprisingly intelligent—their average verbal IQ is 105. Contrast this with

Sheldon and Eleanor Glueck's (1940) study of penitentiary prisoners. There, sixty-seven percent have a verbal IQ of less than 90. Nor are the family histories of criminals and addicts closely similar. Fifty-two percent of addicts come from homes broken by death before age sixteen. (Indeed, twenty-eight percent of these occurred before age six.) These figures do not refer simply to the loss of fathers, so common to the lower socio-economic class strata; more than twenty percent lost their mothers very early. But nonaddicted delinquents are even more deprived of a stable family situation, with seventy-one percent of homes broken by various means, and twenty-eight percent having lost their mothers by age six. So while broken families seem to have something to do with addiction, it is not clear how much they have to do with it.

It also is true that drug takers are only children or youngest children to a statistically significant degree. Yet birth order has never been proven to be a significant factor among delinquents, alcoholics, or the mentally ill.

The most striking single correlation to have been established between parental history and drug dependency is parent-child cultural disparity (Vaillant, 1966). Among Negroes, for example, Northern-born drug takers had Southern-born parents twice as often as would be expected from the census figures. This statistical incidence is shown to the same degree by children of immigrant parents. By contrast, the incidence of drug dependency in a

Northern urban sample who were themselves immigrants or Southern-born Negroes was only twelve percent, which is less than half of the percentage an average projection from census figures would lead one to expect.

Most surprising of all, however, is the fact that seventy-two percent of the patients studied by George Vaillant (1966) still lived with their mothers at age twenty-two; indeed, after age thirty, forty-seven percent continued to live with a female relative. Approximately seventy percent were either married or maintained a relatively stable, common-law relationship. These marriages tended to continue in spite of hospitalization. This holding on to relationships is striking, and markedly greater than similar studies show for alcoholics or other delinquent groups. The Gluecks' study of criminal delinquents, for instance, shows only twenty-two percent continuing to live with their family of origin after thirty, while about the same proportion maintained some form of married life.

An incidental finding of the Gluecks' study supports the contention that the drug taker strives for closeness with a maternal figure. When hospitalized or imprisoned, drug takers, like other institutionalized persons, frequently engage in homosexual activity. But in only three percent of the cases studied by Vaillant (1966) do the patients report that homosexual activity is a source of significant gratification to them in their outside adult life. This is a surprisingly low figure, particularly in view of the popular notion that drug

addiction and homosexuality go together.

Addicts choose drugs to show their contempt for society and to gain status and companionship. If they happen to destroy themselves to this grim quest, little matter to them or, they believe, to others. Their broken homes, poverty, and closeness to immigrant status are *de facto* deviance from the larger social norm before they turn to drugs. Hence, for those whose personality dictated the addict's path, little change in perceived social state is involved.

Society, including middle-class "helping" professionals and members of their own class who become socially mobile by making a living or giving up drugs, seems only to desire for them that they become like everyone else. As Harold Boris has said (1971)

> It is not seen that this group has other ways of doing things, another culture and social organization, another form of personality patterning; rather it is seen that this group, lacking our own folk-ways and mores, is considered deprived or, more sociocentrically still, disadvantaged; and so we want things for them. Sometimes it is clear—almost—that we want things from them: to get off the streets and stop making trouble, or off the relief rolls and stop costing us our hard-earned money or to stop their profligate impulse-serving behavior so that we can stop contending with our unconscious envy. (pp. 161-162)

These desires of society regarding the underclass that Boris so cogently describes increase geometrically when drug abuse is the issue. We want to

confine addicts so as to get them off our consciences and avoid contagion. The social distance between someone in this outcast status and anyone not defined as deviant is virtually unbridgeable. How can anyone not a deviant in a communication situation (a term chosen advisedly over therapeutic situation) show that he can step back from the general social attitude toward the addict and want to know how he chose this path and how it served him, instead of trying to get him off it? Traditional therapeutic techniques, which depend on psychological distance between leader and group, communicator and constituency, therapist and patient, leave few bridges.

In situations where the social distance is great, the reduction of psychological distance is necessary. This is true for professionals working with addicts and with troubled, low-skilled, working-class patients; also in educational projects (Boris *et al.*, 1972) where teachers are supposed to abandon their traditional roles and to act more or less as group leaders with adolescents who want to talk about sex, prejudice, and drugs. The social distance between teacher and pupil is so great that if the self-study group leader maintained the usual psychological distance, there could be few bridges of communication. The leader can readily relax the psychological distance by personal remarks without fear of loss of position, so completely sustaining are the differences in social roles. Surely something of the same sort is involved in child therapy techniques where therapist and patient play games together.

The confrontation technique allows the therapist-leader to express his personal feelings directly and unequivocally. With addict groups, where so much language is not held in common, feelings serve as a *lingua franca*. Here there need be little concern about the fantasies of interchangeability of one member for another, or a desire to reduce ego boundaries and thus threaten the dignity of separate identities, described earlier. The social distance assures separateness and a sense of human individuality between leader-member, communicator- constituent. In their ability to feel similar things and to "make me know it," they establish their common humanity and their potential ability to understand each other.

Here confrontation is a technique—a means, not a gimmick, fad, or end. Answering a question with a question, the establishment of a single pattern in a series of apparently unconnected associations, are techniques just as is a statement from a leader such as, "The way you dribble at the mouth and the way you smell make me feel queasy in this tiny room." They are all ways of establishing communication. There is nothing inherently "better" in puzzling out the meaning of a question or discerning the submerged current of thought in a river of content than in relying on the authenticity of one's own emotions. All such human interactions depend upon the capacity of therapist and patient, leader and group, to achieve an empathic understanding of each other's efforts and of the processes that interfere with these efforts. Techniques may differ; one may spell out the procedures in more conceptual

terms than another, but each is a way to begin communication and should not be a goal in itself.

Choosing the right technique to use with different groups is a complex matter; one cannot simply adopt as a rule of thumb that when there is great social distance one should choose a technique that minimizes psychological distance, and vice versa. With groups who have somehow fallen into social crevices, we find some of the same problems as those encountered in systems therapy. Society defines an addict as deviant; not surprisingly, he organizes a relatively coherent identity around what such social institutions as the law, the school, the church, and conventional public opinion think of him. Erik Erikson (1959) describes this as a negative identity. The acceptance of himself as an embodiment of bad characteristics protects the addict from internal conflict but as part of the same dynamic process insures him continued conflict with society. He is seen and sees himself as part of a delinquent social subsystem.

When the leader/therapist does something similar and organizes *his* identity around acts that are really only part of a technique but that he begins to see not as means but ends, then individual interactive elements get lost; and it is system versus system. Traditional therapeutic techniques require the psychiatrist to individualize his patients, to listen carefully and gently and objectively to indicate how he has understood what he has heard. Such

techniques are benign and reasonable, hard to fault. However, this behavior leaves the therapist an inviolable, invulnerable, distant being. Furthermore, at this point in history, these techniques must be viewed not just as they are meant by the technician but as they are perceived by the recipient. For such techniques are now well known and can represent stereotypes as readily as do the acts of the drug addict. The stereotypical view associates this sort of approach with the social desire that the addict get "better." Even when "better" means such neutral states as greater ego activity or autonomy for the addict, more choices, and the like, the addict perceives only a representative of the reforming social system—the very social system whose repudiation provides him with a *raison d'être*.

Is the addict justified in his suspicions of a therapist who automatically uses a traditional technical approach? I think so. Insofar as the leader/therapist holds to his traditional techniques, he insists that the addict's conflict is an intrapersonal one and not one between the addict and society. The origin of the conflict that led him to choose deviancy may indeed have been intrapersonal; but once deviancy is defined and accepted, the locus of the conflict shifts. In clinging to a specific technical approach, the therapist does indeed seem to say not only that he wants the addict to get better but that he knows what better is; and we are back to Boris's observation about what practitioners want for and from their constituents. The practitioner's effort to maintain his objectivity, even his gentleness and concern for

individual difference within the intrapersonal conflict, which is intended to be extremely relativistic, becomes an absolute value-laden view. His technique has become an end rather than a means, and he and the addict engage in a conflict between different social subsystems rather than in human interpersonal interaction.

The middle-class therapist/leader has often been called upon to empathize with someone with whom he could not share specific subjective experiences: males with pregnant women, females with premature ejaculators, tall persons with short ones, and so on. Hence, his assumption that his invulnerable, relative objectivity permits communication that surpasses difference is rooted in his experience. But what he fails to see is that his experience, as pointed out earlier, is usually with people who have sought him out, who see the problem as an intrapsychic one, and who share a large number of perceptions, assumptions, and values, chief among them their varying degree of relatedness to the social system. Thus the specific subjective experiences that are not shared are surrounded by myriads of shared understandings that slowly overcome mistrust. When a junkie or a migrant worker expresses mistrust of people who haven't experienced what they have experienced, it is hard for the middle-class therapist to separate it from similar statements about differences among people who may be members of his own social class. He fails to see that he and the junkie represent two different social subsystems with little shared social experience

that might open avenues of communication and begin a working relationship.

The ex-addicts who try to tell their addict clients that they have indeed shared their experience and can show them the way out often fare scarcely better. In one-to-one situations where the ex-addict, like the member of Alcoholics Anonymous, can frankly fight his own addicted *doppelganger* in the person of his client—where the client knows what the ex-addict wants from him—an understanding can be reached. But when the ex-addict has to join the social system and cleanse it of drugs in order to save himself, when his struggle is not personal but moral (members of Alcoholics Anonymous do not say that alcohol is bad, just that they can't handle it), when he is sure he knows what "better" is, the ex-addict represents the same social subsystem, the same absolute value view, and the same substitution of ends for means as the middle-class professional.

Confrontation techniques become one means for a therapist/leader to indicate that he is not a representative of a system. He confronts his constituent and so becomes a vulnerable practitioner who, despite his social distance, manifestly feels, responds.

Though the therapist may present himself as an individual who feels, this does not negate his awareness that he does not share the powerful impulses that have seemed undeniable to the addict and led him to drugs. The

use of the confrontation technique with addicts merely recognizes that fat people may have self-destructive impulses, but they are not specifically victimized by our social institutions. One tries with the addict to base the working alliance on a mutual recognition of each participant as an individual and not as a member of a system that needs change or reform by representatives of another, reforming system. Once an alliance is established much more will be needed, perhaps including the more traditional analysis of why the practitioner's humanity was doubted in the first place. But without an alliance, little or nothing can be done.

Today, people from all social classes think they know a great deal about psychiatrists, social workers, and all potential therapist/leaders. As in so many areas of sudden high visibility, much of what is presumed to be known is myth and distortion. However, these myths, once formed, have the power to enable people to construct stereotypes whose existence affects and changes the subject of the original distortion. Sometimes, if great care is not taken, the subject can become surprisingly like the stereotype. Dr. Grete L. Bibring (1965) once described Freud by saying, "He was many things, but never banal." She meant that he approached each issue freshly, with enthusiasm, even force, and so could not easily be trapped into a litany that spelled agreement with a stereotyped image. Social class differences have been long neglected by most students of therapeutic techniques. This neglect has nurtured an image of rigidity and middle-class specificity for the whole

art. This need not be true, and it need not be believed to be true. However, for it to be neither true nor believed to be true, therapists must take questions concerning social distance and system representation into account when they select a technique. For a technique is merely a means that can be as useful at one time with one group as it can be foolish at another time in another group. And it is not to be confused with ends.

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