

## CONFRONTATION TECHNIQUES<sup>1</sup>

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One of the people who has done much work with confrontation techniques, possibly the most, is Dr. Garner, who is right here in the audience. It was he who started me thinking in terms of confrontation techniques, to try to figure out what he was doing (4). And I asked myself, "Just what is it that Adlerians do that can be considered confrontation techniques, and when and why do we use them?"

Dr. Dreikurs has given us examples of some confrontation techniques, and Dr. Kurt Adler and Dr. Helene Papanek earlier this morning mentioned certain kinds of confrontation. I should like to take up very briefly the whole issue of confrontation.

The first person to have written about confrontation seems to be a psychoanalyst named Devereux (1) who defined confrontation as a device which directs the patient's attention to the bare factual content of his actions and of his statements, or shows him a coincidence which he professes not to have perceived or is not aware of. The purpose of confrontation is to force the patient to pay attention to something he has just said or done. In other words it has a here-and-now quality.

The difference between confrontation and interpretation is that the confrontation forces the patient to pay attention to, and to respond to something right here and now. Dr. Garner especially uses confrontation to focus on what goes on during the interview. It is a direct approach to a problem or an issue, a way of getting to the heart of something right away. To the extent that an interpretation accomplishes this by itself or by an additional response-demanding statement or question, it becomes a confrontation. Otherwise the interpretation may leave the patient just listening, in the mood of "thinking it over," or silently rejecting the proposition—without being forced to take a frank stand now.

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<sup>1</sup>The paper as read, while largely based on an earlier one (6), does contain some new aspects and different examples. The present version omits the earlier material as much as possible and attempts to bring out the latter, so that it may be considered a supplement to the earlier publication.

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An example of an interpretation might be, "Alright, so you thought your mother wouldn't love you if you hated your little brother." This is an explanatory, clarifying statement that can be made to a patient in a certain therapeutic situation. An Adlerian might turn this into a confrontation by adding the question, "How much longer do you intend to feel that way? How much longer are you going to believe that your mother will stop loving you if you hate your little brother?"

Especially therapists who are action-oriented and group-oriented will tend to use confrontation techniques. Among these especially role playing is designed to create a here-and-now situation to which the patient must respond on the spot.

A number of confrontation techniques have been used particularly in Adlerian psychotherapy. While the Adlerian therapist is not necessarily directive, his aim is to help the client recognize the mistaken goals which Dr. Dreikurs was talking about, and the associated beliefs, moods, and actions. We do not use the concept of "working through" a conflict, nor the concept of an "inner conflict" as being responsible for the problem. Instead, we are trying to help the patient see what his mistaken way of dealing with the world, of living with the world, is at any given moment. And since we like to use mirror techniques—showing the patient what he is doing, right on the spot—these often become confrontations.

What exactly does the therapist confront the patient with? Without claiming to be exhaustive, I shall briefly describe eleven categories: moods and feelings, hidden reasons, biased apperception and private logic, private goals, mottos, responsibility for the responses of others, self-defeating behavior, existing alternatives, responsibility for change, and time factor. These categories are not necessarily mutually exclusive.

### *Mood States, Feelings*

We confront the patient with his subjective mood states, with his feelings, as these appear to us. For example, I might say, "From the way you wear your hair, not one hair out of place, I can see that you are afraid of falling apart." Or, "From the look on your face, I can see that you don't believe a word I am saying." Or, "From the way you talk about your husband, you must be very angry at him." These are statements that deal with something that the patient is demonstrating at the moment.

*Hidden Reasons*

Another matter with which we confront the patient is what Dr. Dreikurs calls the "hidden reason" (2, p. 108) for the patient's behavior, his private justification, his private rationalization, or the reason he gives to himself—in distinction from the reason or rationalization he gives publicly to others and often to himself. Usually he is somewhat aware of his hidden reason, but he has not brought it to the front of his awareness, has not looked at it, or examined it. We bring it to his awareness by asking, "What did you say to yourself when you did this?"

For example, a man insists on staying at home while his wife would have wanted him to go out with her that evening. He may tell her, "Well, I'm too tired," his public reason, while he may have said to himself, "She doesn't really deserve that I should take her out," the hidden reason.

*Biased Apperception and Private Logic*

The third matter with which we confront the patient is his biased apperception, from which follow his ways of thinking about the world (private logic) and of dealing with it. For example, you may ask the patient, "If you put on dark glasses, how do you expect the world to look?" Or, "If you have already decided that you have no chance in life, how do you expect to make it any better?" Or, "If you already felt that you can't be helped, then why are you here anyway? Just to prove that you are right and that you can't be helped?"

*Private Goals*

Another kind of confrontation is regarding the patient's private goal. This was the case in Dr. Dreikurs' interview with Mike and his parents. Dr. D.: "Why do you do this?" Mike: "I don't know." Dr. D.: "Shall I tell you? Could it be?" So, the Adlerian asks questions like, "Do you know why you did that?" Or, "If you don't know, do you want me to tell you why I think you did it?" And then it is a "Could it be?" or a "Didn't you?" kind of statement. "Didn't you feel a little bit powerful when you were able to get your mother all upset like that? Didn't you enjoy it a little bit when all these people were making a fuss over you?"

One of the early recollections that Dr. Papanek described was about the patient who was sick and whose father showed a tremendous concern over her. The confronting question would be, "Didn't you

feel glad that you were able to get your father this concerned with you?"

### *Mottos*

Sometimes, instead of confronting the patient with a goal or reason, we say, he acts as if according to a certain motto, and then confront him with this motto. For example, "I must never let anyone catch me making a mistake. I must always be right." Or, "Above all, if anybody gets ahead of me, I must get even." Sometimes we'll stress this by giving the patient a sort of certificate. You can write it out for him and say, "Here, you can take this and frame it and hang it on your wall, next to your bathroom mirror, and you can look at it every morning to remind yourself, because this is the motto by which you are trying to live."

### *Immediate Behavior*

Sometimes we confront the patient with his immediate behavior in the therapy session. This is the "What did you just do?" question. "When I asked you about your parents, you stopped talking. How come?" Or, "You just made a slip of the tongue, did you catch it? I wonder what it means?" Or, "How do you feel right now when I'm talking to you?" Or, "A look just passed over your face, what just went through your mind?" Or, "I notice you keep swinging your leg when you talk. What does it mean?" Or, "Your face just turned red, what's up?" That is, you are asking the patient to deal with his immediate behavior in the situation. You are asking him first of all to look at it. This is part of the mirror technique, holding his behavior up for him to see what he is doing.

### *Responsibility for Responses of Others*

Another point with which we confront the patient at times is his own responsibility for the responses of others to him. When a patient asks, "Why do people walk over me? I'm only trying to be a good guy," the therapist answers, "Because you want them to walk over you. After all, it is a lot easier to be a good guy if you let other people walk over you than if you don't let them walk over you. You are the one who is causing it."

### *Self-Defeating Behavior*

Especially useful are confronting statements which call attention to repeated patterns of self-defeating behavior. "Look how you are

bringing on the symptom." We show the depressed patient how he depresses himself every day. You can sometimes teach the patient this. The following sequence with a depressed patient who was telling how badly she felt and how all of her thoughts were unpleasant, will illustrate this.

DR. S.: What do you like to do most of all? If you felt completely well, what would you like to be doing?

PATIENT: I would like to be in Florida bone fishing.

DR. S.: Well, tell me about bone fishing.

PATIENT: (*Telling me for about two minutes about bone fishing.*)

DR. S.: Now how do you feel?

PATIENT: I feel better.

DR. S.: Why do you think you feel better?

PATIENT: Well, I was talking about something I liked.

DR. S.: All right, now tell me about your depression.

PATIENT: (*Spends about two minutes talking about her depression.*)

DR. S.: How do you feel now?

PATIENT: Now I feel bad.

DR. S.: Why do you think that a few minutes ago you felt good and now you feel bad?

PATIENT: Well, it was what I was talking about.

DR. S.: Do you think that you can make yourself feel better or make yourself feel worse by what you talk about?

PATIENT: Well, maybe I can.

DR. S.: Well, all right, then all you have to do is spend the day talking to yourself about bone fishing and you will feel better.

Now one does not expect the patient to give up her depression immediately so easily. After all people work pretty hard to get depressed. The purpose is to show the patient that he has some immediate control over the way he feels by what he chooses to think about. This particular technique is very close to what is described by Ellis and Harper (3, pp. 14-18) under "Feeling well by thinking straight."

One may also say to the depressed patient, "Well, you have just berated yourself again. Keep it up and in five minutes you will really be depressed. Is that what you want? Or, do you think that you could stop berating yourself?" Or, "You just spent two-thirds of your session complaining about your mother. What do you want, to spend the rest of the session tattling on your mother, or do you want psychotherapy? Do you want to help yourself, or do you just want to complain about what a victim you are? Unless you start talking to me about yourself, I can't help you." Do you see what a strong confrontation that is, asking the patient to do something immediately?

*Existing Alternatives*

Confrontation is also a dramatic way of presenting alternatives. This is certainly seen clearly in role playing where you give the patient an alternative role to play. But you can confront him with an alternative merely by saying, "You're going to take an examination. You are worried about the examination. Now you have a choice. You can study and try to pass the exam or you can goof off and pretend that you don't care. Which will it be? You make the choice." Or, "You don't have to spend your life complaining about how little money your husband makes, you can get a job and help out. What do you want to do about it?" One of the things you are in this way telling the patient is, "Look at the choice you are making."

*Responsibility for Change*

We also try to confront the patient with the fact that he has the responsibility for changing. And we will say, "Do you want to change or do you want to just sit and talk about it for a while?" The patient often says, "What should I do?" One of the statements that Adler used to make with irony in it was "Above all, don't do anything yet. After all you've been this way for many years, another few months won't hurt" (7, p. 101). The object is again, to help the patient see as clearly as possible that the responsibility for change is his.

*Time Factor*

Now since, when we get to the question of choices, you've heard that Adlerians are future oriented and use interpretations that deal with the here and now, the Adlerian therapist often asks questions like, "Okay, do you see what is going on? You now have the insight, what are you going to do about it?" And the patient will say something like, "Well I have to do such and such." The next confronting question is, "How long do you plan to wait before you do it? Ten years?" This is a nonsense statement calculated to provoke the patient into recognizing that nothing will change until he takes the first step to change.

*Three Main Issues*

The confrontation techniques that Adlerians use are then intended to create an atmosphere of an immediate challenge. They are examples of direct focusing. It is a way of stirring things up, but doing

so in connection with an important therapeutic issue. There are three such main issues according to which the confrontation techniques can be divided.

First is the issue of insight—confronting the patient in order to help him become aware of something. The first six categories would belong here.

Second is the issue of helping the patient to recognize where he is running away from his responsibilities. Adlerians talk about the life tasks, but we could also use Heidegger's concept of being or *Dasein* (5, p. 136). For Heidegger the task of living is to give a meaning to life. The Adlerian therapist recognizes that the patient gives his own private meaning to his life, which is a mistaken meaning, and that he is going after the wrong things. Why wrong? Because they violate "common sense" and have accordingly gotten him into trouble. Adler, as a clinician, from the start was concerned with a meaning that one can give to life which is not neurotic, not psychotic, nor a predatory or criminal meaning, but a meaning which is ethical, moral, and respectful of humanness. Thus Adlerians to this day end up with *social interest* as being the mentally healthiest meaning that one can give to life. It is the meaning that permits the most satisfying fulfillment of life. The seventh to tenth confrontation categories would belong here.

The third issue for the Adlerian therapist is that the patient recognize where the power to change lies and that the moment of change is decided by the patient. And thus the confrontation he uses, the eleventh category, is the one that was used by the ancient Rabbi Hillel who said, "If you are not going to do it now, then when?"

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