

## THE CONFRONTATION PROBLEM-SOLVING TECHNIQUE: APPLICABILITY TO ADLERIAN PSYCHOTHERAPY<sup>1</sup>

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In bringing up the question of confrontation, related as it is to brief psychotherapy, Dr. Shulman called to my attention the fact that those of you who have been to the entire series of these conferences have had an opportunity to see continuity in what was presented. The beginning conference which dealt with an introduction and general approach to brief psychotherapy, was followed by one on confrontation problem-solving psychotherapy and one, last year, on behavior therapy. The present conference with which you are familiar was concerned with Adlerian approaches. The material which Dr. Shulman brought together is pertinent to several of these conferences. I shall try to present something which could be considered a summation of this year's conference: to discuss some of the thoughts that were expressed, their significance as I see it, and their relation to our previous conferences.

*The technique of therapy in confrontation problem-solving psychotherapy includes the presentation of a statement and a question.* It has been described in several articles and a book by the author (4-11). The basic psychotherapeutic framework in which the technique has evolved might be described as psychodynamically-oriented psychotherapy. When insight is not involved, because of the technique used or because the treatment goals are limited, transference interpretations or dealings with the relationship of past and present may be totally avoided. The goal is then to bring about a change in symptoms or improved social functioning rather than an alteration of personality structure.

*Choice of the statement with which the patient is confronted will vary in light of the clinical picture of the patient, and the nature of the relationship at the initial use of the confrontation.* The area of conflict selected will vary from case to case. The patient may be confronted with (a) a prohibitive statement: "You must never, under any circumstances,

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masturbate," (b) an expressive or permissive statement: "It would be better if your husband dies," or (c) an adaptive statement involving a mature value orientation: "I want you to continue to work at your job." By and large, all confrontation statements may be classified in one of these three categories. The confrontation, once stated, is used continuously. The process of developing self-assurance through mastery and achievement is not inhibited by fear of punishment, shame, failure, or fear of loss of love, because of the noncondemning nature of the relationship and the encouragement to seek a solution suggested by the repetitive question.

The steps involved in establishing the action to be taken by a therapist in confrontation problem-solving psychotherapy are in essence the steps taken in any rational psychotherapeutic action, which will offer the opportunity for developing a teachable psychotherapy, and which have been described by Berne (2) with regard to transactional group therapy. They are:

1. "What am I trying to 'cure' the patient of today? What is the nature of the disabling syndrome and what are my immediate goals and long-range goals for this patient?"

2. "Has he said or done anything which could form the basis for a therapeutic hypothesis?" You have heard several expressions of this with relationship to Adlerian concepts. Dr. Dreikurs, Dr. Adler, Dr. Papanek have all expressed certain hypotheses around which the therapeutic work proceeded.

3. "What therapeutic intervention is needed immediately and will it have therapeutic potential for later work with the patient? Will efforts be directed at increased compliance and magical expectations or will problem-solving be more profitable?"

4. "What is the hypothesis about his personality?" You heard the description of a life style here. "What is the major deforming factor of a repetitious nature around which character developed and the failure at adaptation occurred?" What is this repetitious factor? Dr. Mosak was certainly dealing very actively with something he called the life style.

5. "How many of my interventions must be directed at furthering my understanding of the patient and how much immediate help can occur simultaneously? For instance, should I intervene with an exploratory request, 'Tell me more about you and your sister,' or is the need for supportive help from a confrontation such as 'Stop be-

lieving you are capable of harming your child,' more important at this time?" Certainly in our demonstrations here some interventions were directed at immediate information getting, some at reassuring the patient, and some at long-range goals which Dr. Dreikurs had in mind with regard to the help that might come.

6. "Which form of intervention or interventions are indicated for psychotherapy?" Should the confrontation statement be worded to deal with the acute needs, the rigidity of personality structure, concern with the lack of effective controls, a vicious cycle pattern, etc.? All have been implied in the material presented, with regard to the Adlerian approach.

7. "How will he respond transactionally to what I say? I expect compliance, non-compliance, or problem-solving reactions to the confrontation statement being considered. Which will it be?" This is the most important question about psychotherapy that one can ask oneself. Basically this is what we saw taking place in the interviews here. Either the individual was being compliant, and he put his microphone to his mouth, or he was being non-compliant and when told to put the microphone to his mouth did not do so, or in fact some things took place that were in the way of an attempt to solve a problem.

8. "What type of mental set will be mobilized?" A compliant fear of punishment, a non-compliant temper outburst, or a desire to explore a problem?

*Statements in the confrontation problem-solving technique are made to the patient with the intent (a) to work on a limited therapeutic focus or (b) on the resolution of a core conflict suggested by the earlier life history of the individual.* The choice between these alternatives requires another paper.

#### EMPHASIS ON THE INTERPERSONAL

*The emphasis on the interpersonal rather than the intrapsychic* has been one of the significant points of difference between Individual Psychology and Freudian therapists. The physical and social balance of the individual is understood in relationship to how he faces (a) his fellow man, (b) work and occupation (for the adult)—school (for the child), and (c) sex (love and marriage). It is around these elements that much discussion of the Adlerian exploration of the person's life took place. Within these three groups an infinite number of social

interaction experiences can be classified. To the Adlerian it is in the experiencing of the mutual give and take between the individual and his fellow man and his community that one shows how he can meet the problems of living with honesty, sincerity and courage, and thereby establish a non-neurotic life style. A life style in which exclusively individual problems are made out of general social ones, through being afraid and withdrawing, or acting against the community or against one's social feelings, is the neurotic life style. The theme for healthy human living includes the participation in life with courage, common sense, objectivity, and social feeling. The sickness syndrome is represented by discouragement, egocentricity, and an asocial or antisocial feeling.

#### PURPOSIVENESS OF THE NEUROSES

That the sick use "mental illness" to achieve some fictitious superiority is a premise of Individual Psychology which is accepted by all major theoretical frameworks which are currently used by mental illness healers. I don't see very much difference in any of our conferences in what has been said about this problem as a sort of repetitious pattern throughout the life of some neurotics. The use of the cloak of disease as a means of attaining one's goal is seen as a dangerous deception not only by Adlerian therapists, but all those who understand the significance of this form of withdrawal from society.

Any rational therapist must question the possible alternatives and whether they offer the individual and or society a better answer than the sickness role. He must inquire how the person can find the alternatives and whether he has the assets to use them once they are evident to him; what therapeutic involvement is necessary to bring about self-actualization, and finally does the therapist have that commitment to help which will be in the best interests of his sick fellow man.

The emphasis on the interpersonal rather than the genetic past, on ego psychology rather than on the instincts and their immediate gratification, and on the need for immediate behavior change, was certainly the Adlerian therapist's emphasis before the current popularity of such viewpoints supplanted the initial concern with genetic reconstruction of the past in psychoanalysis.

The therapist's awareness of the significance of the repetition compulsion tendency—another way of talking about the life style—

for the person in deep trouble, and the compliant tendency of the patient must be appreciated as significant elements in patient improvement or "cure." If we do not keep this in mind, we are totally overlooking the significance of what is taking place. How can one be sure that a neurotic life style has not been replaced by a façade of better work, sex, and social feelings which represent attitudes in keeping with the need to please the therapist? I call your attention to what the father said in the family therapy meeting here this afternoon when Dr. Dreikurs asked him whether he thought that what he said was appropriate and correct. He said, "You are the expert." We can expect that individuals who say, "You are the expert," are going to be very interested in pleasing the therapist.<sup>3</sup>

My feeling is that the technique of establishing a therapeutic focus and then repeatedly asking the patient "What do you think and feel about what I told you?" will help to answer that question more effectively than any technique with which I am familiar. It has never been answered completely, but I think the repetitive question, "What do you think and feel about what I told you?" may help give you some idea as to how compliant the patient really is. If the patient's response is always, "Oh, you are right, Dr. Garner," you know that the patient is not exploring a problem at all; he is being compliant.

#### INFERIORITY-SUPERIORITY DYNAMICS

*In Individual Psychology there is an emphasis on a basic or generalized repetition compulsion, that is, the attempt to get rid of the feeling of inferiority, inadequacy and weakness. It has been expressed as the striving to rise from below to above. The task of the Adlerian therapist in treating the neurotic is that of disclosing the neurotic system or life style, encouraging the facing of reality, and redirecting the patient toward useful goals in life. In this task the therapist sees himself faced by an adversary who is striving for a superior position in the relationship. You should have noticed this very definitely here in the relationship between even the youngsters and the therapist. The therapist saw himself involved with some adversary who was trying to be one up on him. Therapy is seen as a process of education, enlightenment, discovery, and encouragement. The sense of*

<sup>3</sup>It is noteworthy that the week following this family-therapy session the father stated he did not learn anything at the session, whereas the mother felt that she had learned a great deal, and the boy thought at least that he had been understood (see p. 221n above).—Ed. note.

inferiority is seen as being overcome by understanding through discussion, training, and suggestion. That is what is said happens!

Indeed, inferiority feelings can be overcome by a number of experiences. The mastery of a task through knowing; removal of the task either by allies, unknown forces, or magical means; the presence of an ally, especially if he seems unusually strong; using the ally for solving the problems of the task through demonstrating how it is done, or through being encouraged to achieve a solution by trial-failure, and then trial-achievement; or denial of the presence of the task. I suppose there are other satisfactory or unsatisfactory solutions to the feeling of inferiority.

Whether or not an all-encompassing concept for all repetition compulsion activity, such as a striving for superiority, is accepted, is neither crucial to nor necessary for the work of brief psychotherapy. Identifying a specific theme, not necessarily interpreting it as a struggle for seeking supremacy over other humans, is helpful in setting up the work to be done together. For instance, the compulsive hand-washing phenomenon may be seen by the Individual Psychologist as a striving to be superior through being the cleanest human being on earth. Others may see it as a striving to rid one's self of evil and dirtiness. In either case the problem-solving venture must resolve the compulsive urge to wash in order that one achieve comfort and effective social living. The achievement of comfort may come about through lessening of the feeling of guilt rather than washing it away. Improvement could also follow upon a recognition of its value as a means of controlling others and the realization of the unsatisfactory nature of the superiority gained thereby.

#### COMPLIANCE AND PROBLEM SOLVING

There are several possible reactions of the patient to the therapist.

1. Essentially the patient may become compliant to the obvious expectation of the therapist and all others in the community for whom the behavior has created concern and annoyance. Such change in behavior can come about only when the patient's expectation is that there will be a reasonable freedom from distress if the behavior is controlled. The change will be dependent on the fear of loss of love or fear of punishment coupled with the endowing of the therapist with the capacity to protect the patient against all those unreal dangers which are expected if the behavior were unaltered.

2. Problem solving through critical appraisal is obviously a more satisfactory approach, and is most satisfactory when accompanied by acts which are consonant with solving the problem. In all psychotherapies, but especially in those where the therapist takes an active role, it becomes crucial to understand why the patient changes. Too often the therapist sees improvement as related to insight, understanding, self-actualization, achieving the aspired to, or, as the analyst would put it, replacing id by ego, etc. I have learned that even with the most persistent prodding to encourage understanding and insight only a limited number of patients seek understanding with significant consistency. Some, although basically responsive in a compliant manner, will from time to time venture off on a problem-solving trip. The majority, however, prefer to find their answers through faith. One may of course change the ratio of compliant patients as against those who would prefer problem-solving answers by being highly selective in one's choice.

3. Non-compliance may follow the patient's recognition of the inadequacy of the therapist or his inappropriate interventions. In most cases, non-compliance is found because help is seen as unwarranted, potentially harmful, or as unwanted and coercive pressure. Regardless of the origin of the non-compliant behavior, in order that he be treated the patient must show at least that degree of compliance needed to accept help. The initial task of the therapist becomes that of converting the refusal of the non-compliant patient into accepting that change is necessary and that it comes about through psychotherapy

#### CONFRONTATION

The Adlerian therapist must ask himself if his confrontations create the climate for a patient to respond by being compliant to expectations overtly and covertly implied by the therapist. He must ask himself if he sees as improved or "cured" those who fulfill his (the therapist's) requirements for appropriate attitudes in social feelings about other humans, work and sex. Does the patient or the therapist, or do both recognize when the patient is using value systems based on his own knowledge, judgment, and social values, or when he is merely blindly accepting those offered by the therapist? The repetition of and the response to the question, "What do you think or feel about what I told you?" help with the answer to these questions. To some extent Dr. Dreikurs is involved in a strategy which has similar but not the same implications.

*Adlerian therapists have rather actively pursued the patient's avoidance behavior by bringing it into focus. "What would you do if you were well?"* (1, p. 332; 3, pp. 97, 132). This question might clearly bring into the open that which the patient wishes to avoid. In a sense Adlerians have been confrontation therapists and adherents of brief psychotherapy in using such direct approaches. What needs clarification with regard to such confrontation is the therapist's interpretation of the change in behavior which follows upon the identification of the problem. The change may represent, as it so often does, the compliant response in anticipation of a magical cure. If in such a case the therapist recognized the change as, "the patient has identified the problem, he has gained insight and acted to solve the problem, and has gained a new capacity to solve his own problems," there has been a failure on the part of the therapist which may diminish his value to the patient.

The importance of prodding a problem-solving attitude into being is an important aspect of the technique described in confrontation problem-solving therapy. The patient under the circumstance in which he seeks help generally finds that solution which comes easiest. Confrontation problem-solving creates the most likely technique, within any psychotherapeutic procedure, which encourages the search for answers through knowing or through learning by the trial-achievement pathway.

*The question, "What do you think and feel about what I told you?" and its continued repetition is a crucial strategy in my technique and is one closely attuned to the therapeutic task as seen by the Adlerian.* This was described in our second conference. The therapist and patient seek to work through the patient's attitudes and difficulties together. However, I see the continued repetition of, "What do you think or feel about what I told you?" as the element in psychotherapy which discourages compliance and seeks a problem-solving attitude from the patient. The patient uses illness as a cloak to disguise the discouragement, egocentricity, and asocial patterns of relatedness. The confrontation statement followed by the question, "What do you think or feel about what I told you?" and its stereotyped repetition are related to the patient's failure to see and feel that the realistic solution of a conflict is better than living with the neurotic illness. Individuals tend to repeat solutions previously found effective long after their usefulness is lost. Exploring the unknown is generally not easily



accepted by most individuals because assumptions about the end result are frightening. Compliant rather than decision-making attitudes are mobilized when an individual is distressed and seeking help. However, it is important to understand that the therapist in asking the patient the question, "What do you think or feel about what I told you?" is involved in a prodding to encourage a mental set in which decision-making attitudes predominate.

If techniques evolve which can improve upon the prodding by the above question as a means of encouraging a problem-solving attitude in a patient who might with reasonable comfort use it, then I feel this approach should be replaced. Although the "What would you do if you were well?" and other specific questions used in Adlerian technique have many similar implications, their use and therapeutic value are in my opinion different.

#### THERAPEUTIC FOCUS

*Therapeutic focus is an important item of psychotherapeutic work, and I think there is a great deal of emphasis on it by Adlerian therapists.* The focus can be on any or all of the three main groupings of social problems stressed in Individual Psychology: attitudes toward fellow man, work, and sex (love and marriage). Adlerians emphasize the therapeutic focus and the immediate integrative task more than the Freudians with their emphasis on genetic reconstruction of the past. The latter's concepts that one dismantles the total structure and then allows its parts to fall in place has limited acceptance today. I think the involvement of the Adlerians in a therapeutic focus is a very important contribution they have made before any of the more recent involvement by others in focusing on a specific problem.

The Adlerians particularly focus on the intent of the patient, as distinguished from the psychoanalytic genetic reconstruction of the past. The Adlerian says, "What does he intend to do?" The psychoanalyst in the past, and I say past because there is considerable change, said, "What was he?" This was a different kind of orientation.

The social orientation and a person's intentions, as distinguished from concern with the unconscious, are fundamental concepts which differentiate psychoanalysis and Individual Psychology. However, whether seen as stemming from unconscious needs or as obviously inappropriate in the intent, social interaction patterns can be the basis for a therapeutic focus. For instance, the overt expression of hostility of a father by physical injury to a child might be the basis

of a therapeutic focus, "Stop being such a mean bastard. What do you think and feel about what I told you?" How the problem is solved (ceasing to be an overtly mean person) can include concepts of psychoanalytic theory involving the unconscious reason for the behavior, or such concepts as seeking superiority through antisocial means. Or the conditioning effect of such an intervention may be the explanation for improvement offered by the behavior therapists. In keeping with the three conferences we have had so far, one could expect to find each therapist involved in this kind of intervention, using the same material in a somewhat similar way for dealing with this psychotherapeutic focus. Responding to the intense feelings of inferiority which drive the patient to seek absolute domination over his surroundings, an Adlerian therapist might have used a confrontation such as, "Your feelings of inferiority cause this inappropriate antisocial behavior of yours!" And then there is an implied, "What do you intend to do about it?" or "Do you intend to go on with the same kind of goal?"

The different purposes served by the psychic disorder are often identified as part of the life schema by the Individual Psychologist. Such purposes are (*a*) the alibi value, the excuse not to assume responsibility, (*b*) postponement of decisions, and (*c*) achieving self-satisfaction and recognition by illuminating achievement. From such patterns of human interaction a therapeutic focus and a confrontation statement can evolve. There is in Adlerian therapy a therapeutic focus and confrontation when the patient is told, "Tell yourself, 'Here comes the lowliest wretch on earth.'"<sup>4</sup> This kind of statement was not made at this conference, but was implied as one of the common focal involvements of the Adlerian who sees the patient as downgrading himself, and the therapist might confront him with just such a statement. Establishing a therapeutic focus was obviously an aspect of Individual Psychology approach from its inception so that it has been involved in contributing very much to those aspects of psychotherapy which we call brief psychotherapy.

The goal-oriented striving as a basis for therapeutic intervention is seen in such confrontations as the following, "Stop being such a mean bastard. What do you think or feel about what I told you?" Such a statement may move the therapist away from a therapeutic involvement in which causal relationship and guilt feelings are empha-

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<sup>4</sup>H. L. Ansbacher, personal communication, July 10, 1970.

sized to one in which the repetition of antisocial pathologic behavior must be stopped immediately and the behavior recognized as repeating a dangerous, useless, egocentric, and antisocial pattern because of an intent to acquire fictitious and unattainable goals.

*The treatment transaction should be viewed from the perspective of the patient's present, his past, and future expectations.* What will be seen from that perspective and the relationship between its elements will depend upon the point of reference. The number of sightings is infinite, each with different definition of the parts and different relations among them. Which of the impressions are right? It seems we have no answer as yet that is any better than the mystical absolute explanations. The absolute may be described as God, the *Ur*-defenses of man described by Masserman (12), as the delusions which man needs to provide emotional assurances, the faith in the achievements of science, or faith in psychotherapists. So far, these are the only concepts we are reasonably sure to be significant in relation to the transactions which we must take as absolutes.

#### CONCLUSION

What is particularly characteristic of the past perspectives reflected in the present view of those who seek help is their fixity and circular nature. The Adlerian is constantly involved in calling the patient's attention to this. When this fixed circular pattern is changed, the therapist must ask himself if the patient has accepted a new point of reference out of a compliant need to fulfill the expectations of the therapist. It is much like a blindfolded person turning himself over to another person who then leads him to a path from which the view is entirely different. In my opinion a new perspective which comes from the knowledge of how to change the landscape by sensing it from different points of reference and then actually changing position so that the senses would experience it differently, is a difficult achievement. To become aware of a possibility that is better than the reliance on attitudes and behavior which create troubles, to challenge the person seeking help to sense and think about the pathogen (the troublesome perspective), and to alter the pattern that constantly recreates it, is part of what happens in treatment.

The working alliance between therapist and patient was described by Adler as "an exercise in cooperation and a test of cooperation" (1, p. 340). The working out of attitudes and difficulties together assumes the presence of a problem-solving venture in which the

therapist clarifies the problem, offers a solution to a problem for consideration, or points out the maneuvers being used to obscure or deny the nature of the problem to be solved. What Adlerian therapists as well as all others must be constantly alert to is the compliant as distinguished from problem-solving attitudes, and if in fact the greater benefit at a problem-solving level is being made available. Although Adler recognized the importance of and emphasized the problem-solving aspects of psychotherapy, I am doubtful that what happened in therapy was likely to encourage problem-solving, except among those who identified him as a person from whom one learned rather than from whom one sought healing. I think it is a very important point. Most people don't want to solve any problems. They come to us because they are seeking healing, and not seeking an answer to a problem. This fact is unfortunately true of much of the psychotherapeutic work, regardless of the strategy used. However, there can be no doubt that the strategies used by Adlerians help point to the directions which the brief psychotherapist must explore.

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