EMPATHIC CONFRONTATION IN THE TREATMENT OF CHILDHOOD ABUSE SURVIVORS, INCLUDING A TRIBUTE TO THE LEGACY OF DR. DAVID CAUL

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ABSTRACT

Patients who are survivors of severe childhood abuse may present with complex post-traumatic and dissociative symptoms, as well as significant disturbance of characterologic development. These difficulties may lead patients to use a variety of dysfunctional and self-destructive patterns of behavior, many of which may be ingrained coping mechanisms which were developed in response to early abusive experiences. Dysfunctional behaviors which interfere with psychological growth and healing must be confronted to allow the therapeutic process to continue. However, patients are often quite resistant to letting go of their painful but familiar coping mechanisms. In addition, the often tenuous therapeutic alliance between abuse survivor patients and their therapists makes the necessary confrontations even more difficult. This discussion examines the nature of therapeutic confrontation and presents a model of empathic confrontation. Finally, this paper presents summary materials drawn from the late Dr. David Caul's use of empathic confrontation, and his unpublished writings on relating to patients with multiple personality disorder.

INTRODUCTION

Recent research and clinical experience has shown that many adults who have experienced childhood abuse may present with difficulties in at least three major areas of psychological disturbance: dissociative symptoms (Kluft, 1985; Chu & Dill, 1990; Braun, 1990), post-traumatic symptoms (van der Kolk, 1987; Ulman & Brothers, 1988), and disruption of personality development and maturation as is seen in borderline personality disorder (Herman & van der Kolk, 1987; Zanarini, Gunderson, & Marino, 1987; Herman, Perry, & van der Kolk, 1989; Ludolph, et al., 1990; Ogata, et al., 1990). Persons who have been most severely abused may present with complex clinical syndromes which may include all three of these areas with extreme forms of symptomatology such as multiple personality disorder. Such persons commonly present with a bewildering range of psychiatric symptomatology which represents challenges in terms of diagnosis and treatment. Such persons also routinely present complex therapeutic dilemmas which often result in conflict and impasses in psychotherapy (Chu, 1988; Kluft, 1989; Chu, 1992a).

Patients with trauma-based disorders frequently have worthwhile ideas concerning the course of their therapy, as if guided by a kind of internal road map. However, it is also common for patients to advocate unwise treatment strategies, or to cling to very dysfunctional but ingrained behaviors. For example, patients may vigorously advocate for premature abreactive work without having established the psychotherapeutic foundations for safe exploration (Chu, 1992a; Herman, 1992). Similarly, patients may insist that they have no control over their post-traumatic and dissociative symptoms, may persist in self-destructive and re-victimizing, risk-taking behavior, or may demand inordinate therapist availability and reassurances which result in boundary violations (Chu, 1988, 1992a, 1992b; Kluft, 1989, 1990). When such issues emerge in psychotherapy, patients often manifest extraordinary resistance to change. After all, many of the dysfunctional patterns have long served as coping mechanisms, and no matter how unpleasant, are more familiar than the well-intentioned but threatening treatment course advocated by therapists.

Confrontation of patients' dysfunctional behavior is often an extremely difficult task. Patients with severe childhood abuse and a lifetime's experience of abandonment and betrayal may have a tenuous sense of alliance with their therapists. Hence, therapists often fear to confront patients even with important therapeutic issues because they fear the patients may react with withdrawal, anger, and regressive and self-destructive behavior. However, confrontation of unsafe and dysfunctional patterns *must* be a part of the therapy, not only to guide the therapy in a positive direction, but also to prevent the therapist from becoming an unwitting enabler of continued destructive behavior.

This discussion examines and reviews the role of confrontation in psychotherapy, and specifically examines the model of empathic confrontation for use with traumatized patients. Finally, this discussion recognizes the work of Dr. David Caul and his highly skilled use of empathic confrontation and brings one of his important unpublished manuscripts into the scientific literature.

THE ROLE OF CONFRONTATION IN PSYCHOTHERAPY

Discussions of the role of confrontation in psychotherapy appear predominately in the psychoanalytic literature.

Greenson (1967) described confrontation as one of four essential procedures in psychoanalysis (the others being clarification, interpretation, and working through), particularly in helping patients acknowledge resistance. Myerson (1973) viewed confrontation as an intervention to effect changes in patients where resistance to change is encountered, and Mann (1973) saw confrontation as a mode of teaching. Many of the discussions in the psychoanalytic literature focussed on the use of confrontation in the treatment of narcissistic disorders, pointing out to patients the effects of their self-absorbed behaviors.

Additionally, Buie and Adler (1972) and Adler and Buie (1972) described confrontation in the treatment of patients with borderline personality disorder. These two papers, describing the uses and misuses of confrontation, are highly applicable to work with traumatized patients. For example, confrontation was seen as necessary at times to help patients recognize "(1) the real danger in certain relationships; (2) the real danger in action used as a defense mechanism; and (3) the real danger in action used for discharge of impulses and feelings" (Buie & Adler, 1972, p. 101). The authors felt that confrontation of patients' denial allows the therapist "(1) to help the patient become aware of his impulses, so that he need not be subject to action without warning; (2) to help him gain temporary relief through abreaction; and (3) to help him gain a rational position from which he can exert self-control or seek help in maintaining control" (Buie & Adler, 1972, p. 103). In discussing the misuses of confrontation, the authors stressed the patients' vulnerability to harm from confrontation due to their propensity to feel abandoned, intense impulses, inadequate defenses, and tenuous capacity to form a working alliance (Adler & Buie, 1972). They noted that the therapist often misuses confrontation due to countertransferrence "rage and envy when he feels he must rescue his helpless, demanding patient and then finds his efforts met by increasing demands and regression" (p. 109).

Many of the observations noted above are surprisingly apt in the context of the treatment of survivors of childhood abuse, which often is far from psychoanalytic. The necessary confrontation used in the treatment of abuse survivors frequently is not subtle, and often falls into the category of "heroic confrontation" as described by Corwin (1973):

> A heroic confrontation may be defined as an emotionally charged, parametric, manipulative, technical tool demanded by the development of an actual or potential situation of impasse and designed ultimately to remobilize a workable therapeutic alliance. (p. 73)
>
> The heroic confrontation, however, says essentially either the patient must do something — i.e., *change* in some way within the analysis — or he and the analyst will have to stop the analytic work, which has become non-productive. When such a statement is made, it is an *emergency situation*, acute or chronic. The analyst knows it, the patient is either vaguely or distinctly aware of it. But both know the moment it is uttered that it may have a prophetic significance for the patient. In short, it implies that a psychic reaction must lead towards the re-establishment of a working alliance. ...There is very little doubt that the immediate mechanisms of such a confrontation is that the patient is forced to accept and make the change for the time being. Not to accept the confrontation will leave him the choice... that the analysis or the therapy will not go on or cannot be successful... He may do it simply out of his fear... [but] at another level he may get the message that the analyst has cared enough to interact in a vital way with him, in a manner that the love of the therapist was available. ...If no element of love is discernible by the patient, then the confrontation can be taken as proof by the patient that in the end the analyst will be just as cruel, rejecting, demanding, punitive, or unnecessarily harsh as the negative side of the parent in transference. (pp. 83-85)

It is these kinds of "heroic" confrontations that are so often necessary — and so difficult to implement — in the psychotherapy of patients with severe childhood abuse. The need for confrontation may be obvious such as danger to the patient, therapist, or therapeutic relationship, or behaviors that are out of control or sabotage the therapy. However, therapists may be extremely reluctant to confront the patient, either due to countertransference difficulties (Chu, 1988, 1992a; Comstock, 1991), or simple concern that confrontation will be misunderstood and make the patient feel abandoned and betrayed. In fact, therapeutic confrontations are often initially misunderstood, but patience in reiterating concern for both the patient and for the therapy often allows the confrontation to eventually be heard and understood as intended. The model of empathic confrontation offers a way of intervening that is effective in helping patients ally with therapists in a direction that is positive and therapeutically sound.

EMPATHIC CONFRONTATION

Welpton (1973) describes the difference between angry and empathic confrontations:

> The danger in...angry confrontations is that the patient changes out of a submissive compliance in which his needs to have the therapist stay with him win out. (p. 263)
>
> A very different process seems to me to be at work in the empathic confrontation. In this process the therapist works towards understanding, empathizing with and accepting the patient as fully as he can. He becomes alerted to whatever interferes with this process and works on these interferences. ...This work consists of trying to understand with the patient how these blocks came about and why they exist. (p. 266)

When making a confrontation, the demonstration of empathy for the patient's position is absolutely essential. With survivors of extensive childhood trauma, particularly early in the therapeutic process, it should never be assumed that there is a firm therapeutic alliance. In fact, it is an essential part of the therapy for patients to be compelled to re-enact the abusive style of relating that they experienced in childhood, and for the therapist to help them move into a more mutual and collaborative mode (Chu, 1992a). Thus, if no empathic resonance is established prior to making a confrontation, the patient is compelled to hear the intervention as simply an attempt of the therapist to control (and perhaps abuse, exploit, or deprive) the patient. As Mann (1973) notes, the "gentle, caring concern of the therapist for the patient may well be the most important element in a proper, effective confrontation. ...It communicates to the patient his privilege to choose the direction that he would like to move in rather than communicating a directive to which the patient feels impelled to yield." (p. 44)

In practical terms, empathic confrontation often takes the form of a statement in two parts. The first part strongly communicates that the therapist understands the patient's position, feelings, and experience. The second part (often connected to the first part by a "but" or "however") contains the confrontation concerning the patient's behavior. Some examples follow:

Example #1: A 24-year-old woman who had been brutally sexually abused throughout much of her childhood chronically cut herself on her arms and legs with a razor. She tended to cut herself whenever she was overwhelmed with feelings, particularly when angry or ashamed. Despite the urgings of her therapist, she continued to self-mutilate, claiming that she found the cutting helpful, and that it was only her therapist who found it objectionable. Moreover, she argued convincingly that the cutting was not intended to be lethal, and that she had no other ways to cope with her feelings. Her therapist gently confronted her on this behavior saying, "I understand that you don't want to give up cutting yourself, and that the cutting has helped you survive. However, unless you begin to work together with me on this, you will not find other ways to deal with your feelings, and your therapy will not be successful." The patient responded by angrily accusing her therapist of trying to control her, to which the therapist responded, "I know you have often been controlled by other people in your life, but I'm asking you to do something that will be helpful in your therapy, not to do something my way." After some discussion, the patient was able to acknowledge the need to find a way to control her cutting and noted, "When people used to try to get me to stop, I always felt that they thought I was bad and didn't want anything to do with me."

Example #2: A 35-year-old woman with multiple personality disorder was hospitalized because of frequent flashbacks of horrendous childhood abuse. In the hospital, she continued to be out of control, frequently having flashbacks late in the evening in which she was so agitated that she needed to be physically restrained. When asked to control her behavior, she angrily claimed to have no control over the flashbacks, and, in fact, didn't remember them since *she* wasn't "out." Her therapist said, "I know that it feels as though the flashbacks just take over and that you have no control. I also understand that you feel very separate from the other parts of you that were out of control. However, unless you can work very hard with me to *begin* to establish some control, and to communicate with your other parts, the therapy will not work, and neither I nor the hospital will be able to help you." After a period of angry denial, the patient was observed to be exercising extraordinary efforts to maintain control, pace the therapy, and promote internal communication.

Example #3: A 27-year-old man who had been severely physically and sexually abused in childhood was admitted to the hospital following a serious suicide attempt. He angrily rejected all support, refused to contract for safety, and demanded to be discharged. There was a long period of stalemate in which he claimed that "maybe" he would be okay, but that it was his life and his business as to whether he killed himself. Finally, his therapist said to him, "I know that sometimes you don't feel like living. I respect that, especially since I know that your ability to kill yourself helps you to have some feeling of control. I would never ultimately try to take away your choice whether to live or die. However, unless you are willing to make a commitment to being alive over the short run, and to wrestle with your conflicts about living, you will not have a workable therapy. You cannot expect a therapist to make a commitment to you if you can't make a short-term commitment to the therapy by staying alive for the foreseeable future." After thinking about this issue for a day, the patient was able to negotiate out a workable safety contract and was discharged.

THE LEGACY OF DR. DAVID CAUL

No discussion of the use of empathic confrontation in treating childhood abuse survivors, especially patients with multiple personality disorder (MPD), would be complete without mentioning David Caul, M.D. Dr. Caul was a skilled therapist with MPD patients, combining consummate skill with warmth and compassion. As noted by Mrs. Lois Caul (personal communication), "David became involved with MPD in the early 1970s while working at the Athens Mental Health Center, and his interest continued until the time of his death.

He first taught at the annual American Psychiatric Association meetings in Atlanta in 1978. He helped with the formation of the International Society for the Study of Multiple Personality and Dissociation and the Ohio Component Society. At the time of his death [in 1988], he was serving as president of the ISSMP&D. David was truly an exceptional person. He filled his life with his care and concern for his patients, and cared for his family with a bonding warmth that most people have never known."

Dr. David Caul had an extraordinary gift in his work with patients. With his down-to-earth wisdom, he was a formative influence for many clinicians who are currently working with patients with MPD and others who have survived childhood abuse. Dr. Caul was a masterful therapist when it came to relating to patients, and, although he never labeled it as such, an expert in the use of empathic confrontation. It is only fitting that this discussion conclude with an edited, but nearly complete, version of one of his unpublished papers which demonstrates his skill and wisdom.

ON RELATING TO MULTIPLE PERSONALITIES
by David Caul, M.D.

A review of the literature on this subject finds very little formalized and specific information. This particular brief paper is for the purpose of covering some of the more specific issues as a primary focus. Therapists should always remember that good basic psychotherapy is the first order of treatment regardless of any specific diagnosis. Also, one should recognize the wide variety of backgrounds, attitudes, approaches, and techniques that are brought to bear in any therapy situation, all of which must be taken into account so that extreme flexibility may be used in treating such diverse patients, even though they all have the same diagnosis of "multiple personality." What follows is the result of nearly eight years of experience in treating MPD patients both individually and in groups on virtually a day-to-day basis. Some of it will certainly have a "cook book" flavor and must be accepted as generalization, always remembering that such matters may not apply to any given individual and unusual situation.

One of the first things that must be dealt with before serious therapy begins is the issue of "informing" the patient. Who do you inform? Very often the person owning the birth certificate and the Social Security number is not readily available for such a discussion. However, there is a basic principle that should be followed. Depending on the age and apparent level of understanding of the patient confronting you, words must be found to express the notion that there is a serious condition present, that the patient is caught up in being part of that condition, that it is a very serious psychiatric condition, and will most likely require particular and usually extensive treatment. The therapist must explain this many times over, if necessary, and must be quite patient. Also, the therapist must be prepared for and tolerant of a full range of emotion which may include extreme anger and possibly violence. At this point, there must be some declaration to the patient that the therapist will always be truthful. However, do not demand the same from the patient, who ordinarily would not be able to carry out such an agreement. The therapist should be prepared to discover that these extraordinary patients have all of the human failings encountered in therapy, including lying and manipulation. It should be remembered that the umbrella of dissociation has served to displace the old stand-bys of repression and denial.

> *Example:* "I know this is very difficult for you, but I must explain these things to you as I understand them. Something has happened to you in your life a long time ago which caused changes to take place within your own mind. I understand how strongly you feel about who you are, but I must tell you that you have a legal identity and that you are known to the world, for the most part, as _____." Be prepared to do this over and over again, especially in the beginning. Bringing about co-consciousness is very difficult, and one cannot assume that the explanation will reach all "ears."

Another issue is that of trust. It is very difficult for MPD patients to trust anyone, including the skilled therapist in the room. It is important to deal with that subject frontally very early in therapy.

> *Example:* "I know that it's hard for you to trust people. I am sorry you feel that way, and I can understand how you got that way. But now we have an opportunity to change things. I can't tell you to trust me, but if we are going to work together, I think it is important that you learn how to give others the chance to earn trust, especially while we are in therapy and especially as it relates to me."

The therapist should be willing to exhibit appropriate respect for the patient and all alter personalities—respect, not indulgence. Respect does not preclude firmness and insistence on working together for progress. Respect does not preclude normal differences in feelings of the therapist with recognition that a wide variety of feelings toward the therapist will be forthcoming, especially early in therapy. Do not remonstrate with one personality and challenge a personal attitude because of recent drastic change in such an attitude.

> *Example:* "I am sorry you hate my guts today. Are you aware that just yesterday someone who is a part of you told me that she thought I was a good doctor and was trying to help her? How do you suppose that comes about, and what do you think caused the change of feeling that is different today?"

In a situation like this, try not to be resentful. If you continue with the therapy, you will probably be called something worse than that.

There has to be an element of cooperation that is woven as a thread throughout the course of therapy. The fact that

a patient keeps coming back for sessions may be the main indication (even if unspoken) of cooperation by the patient. The therapist should always be willing to listen and accept suggestions and workable ideas. Sometimes it is difficult for a therapist to acknowledge the exquisitely sensitive nature of this "two-way street." Continue to emphasize the fact that productive therapy will require some sort of partnership between the parties.

> *Example:* "In order to get anywhere we must work at this together. I will need your help, not only yours, but whatever or whoever there is within you that might be of help to us."

As with all therapy, in all cases there is the element of *quid pro quo* that usually reaches significant proportions at some time during the therapy. It appears that most MPD patients know more than they tell, especially early in the therapy. This is probably related to their natural mistrust of others. However, most MPD patients at some point are quite able to enter into agreement and, for the most part, to keep them, especially if they feel there is some personal and sometimes private benefit. The therapist should recognize that and use it.

> *Example:* "I understand that you've been getting impatient and that you want to do a lot more than you have been able to do in the past. You are probably right, but I need more information and some more things from you to help with the therapy. I happen to know that you have the ability to achieve co-consciousness. I will feel much better and you would be much safer if you could work on your exercises to do that before I give you my blessing for you to go to Florida on your own for two weeks.

The therapist should be able to distinguish between candor and sometimes cruel hostility. Remember that these people are very sensitive and very vulnerable. I suppose candor might be described as being truthful in addition to being caring, considerate, and concerned. The therapist should not be afraid to appropriately admit that there are difficulties in the treatment and should attempt to openly discuss them. All attempts should be made to do this in a positive way and to relate it to the therapy, and not direct it toward the patient.

> *Example:* "We seem to be having a hard time, especially over the last several sessions. One of the problems is that one of your hostile alter personalities is always reported to me by you rather than by my meeting that personality directly. I know it may be scary for you, but please try to understand that it will probably be necessary to do this at some point. Maybe you don't want this to happen, and maybe I am pushing too hard. At any rate, let's keep working on this because you remember that I still need your help."

Countertransference is certainly a peculiar phenomenon in dealing with MPD patients. Who is the person you feel for? Who is the person that triggered off the feelings in the first place? The therapist should remember and try to accept that it will be difficult to deal with only a single countertransference issue virtually up until the time that there is some sort of satisfactory resolution. It is all right to have parental feelings for one, collegial feelings for another, anger and hostility for another, and feelings that transcend *agape* and *philia*, reaching toward *eros*. It is how these feelings are handled that is important. What does one do with a three-year-old alter personality who insists that you are her biological father? Especially when you "know" that you are a good father and have father feelings toward this "child" who is actually an attractive nineteen-year-old woman.

> *Example:* "I am sorry that you didn't have a nice daddy. I know that you think that I am a nice daddy and that you wish I were your daddy. I like you a lot and care about you a lot, but I have to tell you that I am not your daddy, but I am a doctor who does care a lot about you and wants to help you to grow up and be well."

These are obviously but a few fragments of something less than oracular wisdom that may serve to stimulate a process and may serve to give any therapists who are encountering multiple personalities for the first time some guidelines. By no means are the above examples the only proper way to deal with the described issues. It will remain for the therapist to use whatever energies there are toward good judgment and careful consideration in providing therapy for this phenomenon that is of such magnitude that it will require all the help that we can get.
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