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The Effective Use of Confrontation in Family Therapy: A Process Study

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THE EFFECTIVE USE OF CONFRONTATION IN FAMILY THERAPY: A PROCESS STUDY

by

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ABSTRACT

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Although contemporary practitioners have rejected the confrontational style and perceived aggressiveness of earlier family therapists in favor of a more "collaborative" stance, confrontation, as a technique, is still widely used in almost all forms of psychotherapy, including family therapy. The present process study explored what makes confrontation more or less effective in motivating clients to recognize and reevaluate counterproductive ways of interacting. Using videotaped family therapy sessions, confrontation *clarity*, *emotional reactivity*, and the *use of suggestion* were examined in relation to client levels of acceptance of confrontation immediately following the confrontation, as well as in relation to overall client change within the session. Findings indicate a significant positive relationship between *clarity* and understanding of confrontation suggesting that direct and focused confrontations are more likely to be understood and accepted than indirect and unfocused confrontations. Findings also indicate that *client confrontation response* is positively and significantly correlated with *within-session change*.

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CHAPTER 1

Introduction

Edward Bibring's (1954) classic paper "Psychoanalysis and the Dynamic Psychotherapies" described the basic techniques of psychodynamic psychotherapy. He included suggestion, catharsis, manipulation, clarification, and interpretation. Despite not being explicitly mentioned by Bibring as a technique, Karpf (1986) states that, when combined, Bibring's conceptualizations of manipulation and clarification represent a fairly clear description of the contemporary therapeutic technique of confrontation. That is, manipulation was used to "mobilize the existing forces in the patient that would further the goals of treatment" and clarification to "make the preconscious conscious" (p. 189). Although these definitions stem from psychoanalytic theory, the technique of confrontation in any therapy modality involves preparing clients to take action by pointing out something that they had previously overlooked (something that was preconscious or unconscious). Confrontation is, in fact, a widely used technique common to almost all schools of psychotherapy (Miller, Duncan, & Hubble, 1997), including psychoanalytic psychotherapy (Greenson, 1968; Kernberg, 1999; Nichols, 1986), supportive psychotherapy (Kernberg, 1999), and family therapy (Nichols & Schwartz, 2006). In recognition of the importance of confrontation in therapy, Nichols and Paolino (1986) expanded Bibring's list to include confrontation as an essential technique of psychodynamic psychotherapy.

In a general therapeutic sense, confrontation involves pointing out something that a client is doing that is problematic (Nichols, 1986; Shectman & Yanov, 2001). Most often, the client has previously overlooked the subject of the confrontation and has not

recognized it as problematic, or has otherwise avoided dealing directly with the subject of the confrontation. A confrontation invites clients to examine these previously overlooked choices and experiences (Nichols, 1986). Confrontation essentially involves a therapist directing the patient's attention to behavior or thought evident to both the therapist and the patient and then in effect stating, "Take a look at what you are doing," or "Consider what you just said," so that the patient is better able to observe and consider his or her own thoughts and actions (Langs, 1973, p. 419). Confrontation may be used as a prelude to an interpretation, or may be used without subsequent interpretation. For example, a therapist could confront a mother by saying, "Are you aware that you allow your children to freely interrupt your conversations with your husband?" This might be followed by an interpretation such as: "When you allow the children to interrupt whenever they wish, you're sending the message that the two of you as adults don't have any right to your own space…And you may be telling your husband that the children have priority over him." Confrontation takes various forms and may be delivered as a short and direct statement, numerous statements drawn out over a conversation, a question, or a humorous or surprising remark (Nichols, 1986). For example, a therapeutic confrontation in family therapy might involve a therapist pointing out to a father that his harsh criticism of his son only makes the son more rebellious. In this example, it would be likely that the father had previously overlooked that his own actions were related to increases in his son's anger.

Confrontation in Psychoanalytic and Supportive Psychotherapy

In psychoanalysis and supportive psychotherapy, confrontation is utilized to analyze a patient's resistance, to aid in the identification of defenses, and to help the

patient to understand "that he is resisting, why he is resisting, what he is resisting, and how he is resisting" (Greenson, 1968, p. 104). Confrontation is used to demonstrate resistance when a patient is unaware that he or she is resisting and should be used only when it is likely that the confrontation will be meaningful to the patient (Langs, 1973). A correctly executed confrontation can modify defenses and allow for a patient's better understanding of thoughts and actions (Langs, 1973). When confrontation is used prematurely, it is not likely to make sense or be accepted by the patient, and its use can potentially lead to frustration or anger on the part of the therapist. That is, the therapist confronts, the patient rejects, and then the therapist needs to decide whether to continue attempting to overpower the patient's resistances and defenses (Karpf, 1986). Continuing to confront a patient in a way that engenders resistance creates an antagonistic relationship in which patient and therapist become adversaries rather than partners. Thus, confrontation as a technique – pointing something out – is not only different from a confrontational style – aggressive and attacking – but to be effective, confrontations must not be confrontational – that is, antagonistic.

Confrontation in Family Therapy

In family therapy, confrontation has fallen out of favor in recent years due to an emphasis on the collaborative model of family therapy, which was a reaction against the perceived aggressiveness of structural and strategic approaches. This perceived aggressiveness was likely due to structural family therapists' utilization of forceful confrontations to provoke changes in families. In the 1980s and 1990s, family therapists, including leading figures Harlene Anderson and Harry Goolishian, advocated approaching families less as experts able to repair broken structures and cure family ills,

and more as democratic partners (Anderson, 1993; Anderson, 1997; Anderson & Goolishian, 1988). Also in the 1990s, Michael White's narrative therapy and Steve de Shazer's solution-focused therapy became the two most popular forms of family therapy, both of which saw little need for confrontation. In narrative therapy, neither the patient nor the family is considered the problem. Rather, the focus is on the problem's burden on the patient or family. The goal of narrative therapy is not to help solve the patient's problems by focusing on behavioral interactions, as in systems theory, but instead examining family members' stories and separating family members from their problem-saturated stories so that they can view themselves in more constructive ways (White & Epston, 1990). Thus, confrontation is eschewed in narrative therapy. Family members are not challenged to look at what they are doing to perpetuate the problems that plague them; rather, they are challenged to rethink their problems as something that is not part of them, but that is afflicting them and that they therefore should mobilize to combat.

Likewise, in solution-focused therapy, clients are not confronted with what they are doing to perpetuate their problems, but instead are encouraged to remember what they have done in the past that was more effective (de Shazer, 1985). Thus, again, there is no use of confrontation. But just as in narrative therapy, clients are in fact redirected from counterproductive ways – not of acting, but of thinking – toward more helpful ways of approaching their dilemmas.

In both narrative and solution-focused therapies, patients are trusted to reach their own goals, there is little emphasis on pointing out problem behaviors, and there is a great emphasis on collaboration. In these approaches, there appeared to be little room for traditional therapeutic techniques such as confrontation that focused mostly on behavioral

interactions. Subsequently, as the popularity of these models increased, and as clinicians in general began moving away from rigid adherence to any particular schools of thought, confrontation continued to fall out of favor as a useful technique. However, while postmodern approaches like solution-focused and narrative therapy pride themselves on being collaborative and avoid any kind of direct confrontation, they do energetically manipulate how clients think about their problems. Thus, although these approaches do not point out what clients are doing that may be problematic, they do push clients to see things differently – in narrative therapy to see themselves as heroically struggling against problems rather than being their victims, and in solution-focused therapy to focus away from their problems and toward previous successes.

In structural family therapy, which is often viewed as less collaborative than narrative and solution-focused therapies, the therapist focuses on altering the structure of the family, modifying boundaries, and creating parental hierarchies (Minuchin, 1974; Minuchin, Lee, & Simon, 1996). The goal of structural family therapy is not to solve problems but to modify family structure and functioning to allow families to solve their own problems (Minuchin & Fishman, 1981). A key component of structural family therapy is the use of enactments – in-session dialogues that enable therapists to see how family members interact with each other. Confrontations are used when enactments break down, at which point, the therapist can point out to the family what they are doing that is influencing the continuation of their difficulties. In structural family therapy, therapists' challenges to family patterns of interaction are considered essential, because family members are often unable to see their own roles in their problems (Nichols &

Schwartz, 2006). Thus, confrontation is utilized to help achieve a major goal in therapy – to empower clients to gain perspective on problematic ways of interacting.

Despite the integral role of confrontation in structural family therapy, even those practitioners avoid the term "confrontation" and instead refer to the technique as "challenge," believing that the latter implies less combativeness. For example, Salvador Minuchin (Minuchin, Lee, & Simon, 1996) wrote:

> I think it is important to repeat here that there are different ways to create change. Confrontation is one of them. But challenge and confrontation are different animals. You can challenge a pattern by being soft and supportive. In a violent family, being soft and polite is a challenge. So is being concrete in a family fond of intellectual abstractions, or being courteous in a rude family. My particular skill of amplifying differences and encouraging conflicts has been called confrontation. I think it is more complex than that. (p. 135)

Despite less perceived combativeness with "challenges," there can still be variation in challenges, with some being delivered in a calm and clear manner as compared with those that are antagonistic or unclear. The goal of challenging in family therapy is to point out patterns that are keeping people stuck, and to not simply switch blame from one person in the family to another, but to broaden the problem to an interactional one, as in the paradigmatic example, "The more you do X, the more he does Y – and the more you do Y, the more she does X' (For X and Y, try substituting nag and withdraw, or control and rebel.)" (Nichols & Schwartz, 2006, p. 67). Therefore, what Minuchin prefers to call "challenge" appears to be the same thing as confrontation, which is distinct from a confrontational style that is aggressive and antagonistic. And although the ordinary

language connotation of "confrontation" conveys a sense of combativeness and opposition, therapeutic confrontation should be neither combative nor antagonistic. Aggressive and antagonist confrontationalism is more appropriately viewed as a sign of countertransference and should not be confused with therapeutic confrontation (Langs, 1973; Nichols, 1986; Karpf, 1986). As such, it is not necessarily contraindicated to have a collaborative and empathic stance and to use the technique of confrontation within that stance to point out behavior that causes problems. Mitchell, Bozarth, and Kraft (1975) even suggest that empathy is often essential for successful confrontation. Therefore, contemporary family therapists' opposition to the use of confrontation may be unwarranted.

Goal of This Study

The goal of this process study was to explore the ingredients of effective confrontations in family therapy. Specifically, this study examined the relationship between confrontation *clarity*, *emotional reactivity*, *use of suggestion*, and immediate client responses to confrontation as well as *within-session change* in client families.

Hypotheses

1) Clear, direct, and focused confrontations will be positively correlated with greater client acceptance as well as greater *within-session change*.

Clarity refers to the directness and focus of a confrontation. A confrontation with high levels of *clarity* is direct, focused, and lacks obscurity or vagueness. Therapists who deliver a clear, focused message should have more influence than those who deliver a less direct, vague, or rambling confrontation (Nichols & Schwartz, 2006). Langs (1973) believes that therapists should, "endeavor to be accurate and precise, and as concise and

specific as possible" (p. 608). Langs (1973) further says that a lack of clarity in confrontation may suggest a lack of understanding of the patient's difficulties and concerns, and may be related to impatience or poor use of technique by the therapist. And although the present study will not examine the appropriateness of timing in the use of confrontation, confrontations made in too hasty a manner will likely be unclear, misguided, inaccurate, and will tend to be less well accepted by the client.

2) Lower levels of therapist *emotional reactivity* in confrontations will be correlated with greater client acceptance as well as greater *within-session change*.

Emotional reactivity refers to the extent to which the therapist appears agitated, annoyed, or critical as opposed to calmly pointing something out without emotion. People tend not to listen well when someone is scolding them in a voice full of emotion. High *emotional reactivity* tends to raise the listener's anxiety which then gets in the way of hearing what is being said. Based on Rogers' (1957) work regarding the "necessary and sufficient" conditions of therapy, including congruence, empathy, and unconditional positive regard, confrontations delivered from a position of concern, respect and from a calm, congruent, and empathic therapist are more likely to be accepted by clients than confrontations made in an aggressive, angry, or antagonistic manner by an angry, reactive, or frustrated therapist. Langs (1973) further states that therapists should confront "not in an angry or threatening manner, but with a strong tone of concern for the welfare of the patient" (p. 447). Henry, Shacht, and Strupp (1990) report that a high level of therapist hostility, which is linked to a high level of negative emotionality, is detrimental to the therapist-client alliance and therefore detrimental to therapeutic

outcome. Hammond (2006) also found that empathy in structural family therapy is positively correlated with within-session change and that clients are more accepting of therapist interventions as long as the therapist makes empathic interventions and makes the clients feel understood. Therefore, it is likely that a confrontation without empathy (as conveyed through emotionality) will not get past a client's defensiveness. That is, clients will listen to confrontations only so long as they feel that the therapist hears them and understands their concerns. Therapists who are emotionally reactive will not convey understanding to clients because they are acting in a knee-jerk emotional fashion, rather than calmly and objectively (Nichols, 2010). Therefore, greater client acceptance of confrontations and within-session change are expected to correlate with lower levels of therapist emotionality.

3) *Use of suggestion* by the therapist will correlate negatively with *within-session change*. That is, telling clients what they are doing wrong, without telling them what to do to fix the problem will be positively correlated with greater levels of client acceptance and *within-session change*.

Confrontation calls clients' attention to what they are doing and puts them in a position to decide to change their own behavior. Adding a direct suggestion to a confrontation, however, shifts the clients' attention away from their own behavior and onto what the therapist is suggesting that they do. Even though some clients may want a therapist to suggest how to solve their problems, the premise of transformative therapies, like structural family therapy, is that helping clients see themselves – and the consequences of their actions –empowers them to figure out more effective ways to behave and interact, at the time of therapy and forward into the future.

Once a therapist shifts from pointing out something to giving advice, the client's attention shifts from his or her own behavior to the therapist and the therapist's advice, thereby decreasing the tension that would encourage family members to determine how to best solve their problems (Nichols & Schwartz, 2006). In structural family therapy, it is not the therapist who should be making suggestions. Rather the therapist should help determine who in the family could be taking the role of offering suggestions, and then encourage that person to do so. In this way, it is thought that clients are less likely to become dependent on the therapist (Greenson, 1967). Further, suggestion may actually also obscure understanding by clients (Ducey, 1986), and be negatively correlated with patient-therapist collaboration (Allen, Coyne, Colson, Horwitz, Gabbard, Frieswyk, & Newson, 1996). That is, suggestions and advice-giving can result in unintended negative consequences and opposition by clients, which may cause resentment of the therapist (Kolb, 1986) and subsequently lead to lesser acceptance of the therapist's interventions and greater resistance to change.

CHAPTER II

Method

Design and Procedure

This study was designed to investigate the relationship between therapist confrontation and within-session change. First, a sample of videotaped family therapy sessions was selected. Second, measures were selected for data analysis. Following the selection of measures, clinician judges and undergraduate raters were recruited and trained to rate the study variables. Data was collected from the clinician judges and undergraduate raters, data was analyzed, and results were summarized.

Data

Data included 18 videotaped structural family therapy sessions obtained from the archives of the Minuchin Center for the Family. The Minuchin Center for the Family is a nonprofit organization that provides structural family therapy training and consultation to agencies in New York City. Videotaped sessions were chosen by a clinical psychology doctoral student (Timothy DiGiacomo, M.A.) and a professor of psychology at The College of William and Mary trained in structural family therapy (Michael P. Nichols, Ph.D.). Families in the videotaped sessions provided authorization to the Minuchin Center for videotaped sessions to be used for the purpose of research by the Center or colleagues of the Center, including Dr. Michael Nichols. Video recordings were utilized with the understanding that recorded material is confidential and accessible only to investigators responsible for this project. As such, material was used in accordance with the "Ethical Principles of Psychologists and Code of Conduct" (American Psychological Association, 2002).

Selection of Confrontations for Analysis. Confrontations were selected for analysis from each videotaped session by three clinician judges. Only confrontations with a clearly observable beginning and end were utilized. Further, all confrontations were directly related to the session's core-problem dynamic. Clinician judges reviewed sessions together and discussed and recorded start and stop times for confrontations. In some instances, confrontations were brief statements, whereas in other cases confrontations were extended throughout a conversation. The end of the confrontation was indicated by the therapist moving on to another topic or switching conversations so that the confrontation was no longer the focus of the session. For example, the following vignette involves a confrontation directed toward a teenager who complains that he has no privacy from his parents:

> **Therapist:** Maybe you don't want privacy. Because you do certain things that keep your parents very involved... I mean...you have them involved in your homework, bathing, waking up in the morning...I don't know...I don't know why that is exactly...Do you like them to be uh, is it...?
> **Son:** No, I don't like them to be on my back all the time.
> **Therapist:** Well, no, of course not, but do you suppose you get something out of it? I mean something maybe, I don't know, something subtly out of it? Like, do you get a certain good feeling that they love you and they care about you? I mean, nobody likes to be criticized all the time, but maybe it gives you a good feeling to keep them involved with you in some ways...At least you know you're not on your own, huh?

The therapist uses confrontation to point out that the son may be gaining something subtly by behaving in a way that invites his parents to be overly involved. Upon completing the confrontation to the son, the therapist and son continue to briefly explore these ideas about privacy and then the conversation changes and is directed towards the parents.

Measures

Analysis involved quantitative scales to measure *clarity, emotional reactivity, use of suggestion, client confrontation response* and *within-session change*. Clinician judges rated confrontation-related *clarity, emotional reactivity*, and *use of suggestion.* Undergraduate raters measured *client confrontation response* and *within-session change.*

Confrontation Clarity Scale. The *Confrontation Clarity Scale* (Appendix A) was developed for this study and used observer ratings to measure the clarity and focus of a confrontation. Ratings were made on a 7-point Likert scale ranging from 1 (very unclear, obscure and confusing) to 7 (very clear, very direct, and very focused). Qualitative descriptions for scores were also provided. *Confrontation Clarity Scale* ratings were recorded on each session's *Rater Report Form.*

Confrontation Emotional Reactivity Scale. The *Confrontation Emotional Reactivity Scale* (Appendix B) was developed for this study and used observer ratings to measure the extent to which the therapist appears to be agitated, scolding, and critical as opposed to calm during confrontation. Ratings were made on a 7-point Likert scale ranging from 1 (very calm, no agitation, and no scolding) to 7 (very agitated and scolding). Qualitative descriptions for scores were also provided. *Confrontation Emotional Reactivity Scale* ratings were recorded on each session's *Rater Report Form.*

Confrontation Suggestion Scale. The *Confrontation Suggestion Scale* (Appendix C) was developed for this study and used observer ratings to measure the extent to which the therapist provided suggestions to clients in relation to their core problem. Ratings were made on a 5-point Likert scale ranging from 1 (no suggestion) to 5 (explicit,

directive, and forceful suggestion). *Confrontation Suggestion Scale* ratings were recorded on each session's *Rater Report Form.*

Client Confrontation Response Scale. The *Client Confrontation Response Scale* (Appendix D) used observer ratings to measure the clients' level of acceptance or rejection of confrontations. Ratings were made on a 7-point Likert scale ranging from 1 (no understanding and no acceptance) to 7 (clear understanding and clear acceptance). Qualitative descriptions for each score were also provided. *Confrontation Response Scale* ratings were recorded on each session's *Rater Report Form.*

Change in Core Problem Dynamic Scale. The *Change in Core Problem Dynamic Scale* (Miles, 2004; Appendix E) is a 7-point Likert scale which measures *within-session change* in reference to a defined core problem. Qualitative descriptions for scores were provided. For example, a rating of 1 (significant negative change) includes the description, "A destructive session which may threaten either the continuation of treatment or family relationship or both." A rating of 7 (significant and manifest change) includes the description, "Client understands and accepts the therapist's interpretations and begins to make clear behavioral changes in the session; client accepts his or her own role in problems and begins to interact more effectively in the session." *Change in Core Problem Dynamic Scale* ratings were recorded on each session's *Rater Report Form.*

Rating Procedures

Undergraduate Raters. Volunteer undergraduate raters from the psychology department at The College of William and Mary were recruited to rate *client confrontation response* and *within-session change*. Potential raters attended recruitment meetings during which they were given a brief introduction to family therapy and

watched videotaped family therapy sessions. The potential raters then provided a description of the therapist and client interactions to two clinician judges. During viewing, the two clinician judges identified undergraduates who showed good observation skills. Nine undergraduates were selected from the recruitment meetings to participate as raters.

The undergraduate raters attended seven two-hour training sessions. This provided enough time for the raters to view seven entire family therapy sessions and receive training on the use of the rating scales. Students were encouraged to discuss the problem dynamic associated with *within-session change* as well as factors related to *client confrontation response*.

Practice session ratings were examined for interrater agreement by the clinician judges. Ratings were compared to a benchmark established by the clinician judges, and three undergraduate raters who were closest in agreement with the benchmark were selected as primary raters. Alternate raters were also asked to make ratings in order, if necessary, to replace primary raters who were no longer able to participate in the study (e.g., due to emergency, drop-out, etc.). Raters were not informed of primary or alternate status. Raters were instructed to rate recordings independently and only after watching each session twice.

The undergraduate raters were provided with a description of the core problem for each session and the types of interactions that would characterize positive change. Ratings for *within-session change* were made for each individual client participating in the session and for the family as a unit. Ratings for *client confrontation response* were made for each individual client to whom the confrontation was directed.

Clinician Judges. Clinician judges consisted of two clinical psychology graduate students and a clinical psychologist who is an expert in structural family therapy. Clinician judges practiced making ratings on the three therapist variables related to confrontations until at least 80% interrater agreement was achieved. Once agreement was established the clinician judges rated confrontations separately. Interrater agreement sessions were interspersed throughout the study in order to maintain agreement.

Statistical Analyses

All statistical analyses were performed in accordance to the standards set forth by Tabachnick and Fidell (2007).

Interrater Reliability/Agreement. Percentage agreement and Cronbach's alpha were utilized to assess reliability for clinician judges' and undergraduate rater ratings.

Analyses for Clarity, Emotional Reactivity, Use of Suggestion and, Client Confrontation Response, and Within-Session Change. Multiple regression analyses were used to examine the relationships between *clarity, emotional reactivity, use of suggestion,* and *client confrontation response* and *within-session change.* Additional Pearson product-moment correlations were utilized to further examine these relationships.

CHAPTER III

Results

The following section presents this study's findings. It describes the Training Phase and Project Phase of this study as subsections of this Results section. The Training Phase subsection presents: a) a summary of the undergraduate raters' data, b) information regarding missing data, and c) the percentage of agreement for *client confrontation response* and *within-session change* ratings among undergraduate raters. The Project Phase subsection presents: a) a summary of the undergraduate raters' data, b) information regarding missing data, c) descriptive statistics for *client confrontation response*, *within-session change*, *clarity, emotional reactivity*, and *use of suggestion*, and d) percentage agreement and interrater reliability for *clarity, emotional reactivity*, and *use of suggestion* for the clinician judges. Finally, this section presents significant relationships between *clarity* and *client confrontation response* as well as between *client confrontation response* and *within-session change*.

Training phase: Summary of data

As noted earlier, nine undergraduate raters participated in 14 hours of training in which they were familiarized with structural family therapy theory, viewed seven videotaped sessions of structural family therapy in their entirety, and rated the degree of clients' *client confrontation response* and *within-session change* using the *Client Confrontation Response Scale* and the *Change in Core Problem Dynamic Scale.* Table 1 provides a summary of the undergraduate rater's *client confrontation response* and *within-session change/core-problem dynamic* ratings during the Training Phase of this study. A total of 19 *client confrontation response* ratings and nine *within-session change*

ratings were expected from each rater during Training. Table 1 shows that Raters A, C, D, E, F, G, and H provided the expected number of *client confrontation response* and *within-session change* ratings and therefore had no missing data. Rater B provided only 13 of the 19 *client confrontation response ratings*, and only four of the nine *within-session change* ratings, leaving a total of 11 missing data points. Rater I provided only 14 *client confrontation response* ratings, and missed one *within-session change* rating, leaving a total of six missing data points during Training. Rater B and Rater I each failed to provide entire sets of ratings to one session each.

Table 1

Summary of Data Points Per Undergraduate Rater: Client Confrontation Response and Within-Session Change During Training

Raters	Missing Tapes	Missing Data Points		Total Training Points	
		CCR	WSC	CCR	WSC
A	0	0	0	19	9
B	1	6	5	13	4
C	0	0	0	19	9
D	0	0	0	19	9
E	0	0	0	19	9
F	0	0	0	19	9
G	0	0	0	19	9
H	0	0	0	19	9
I	1	5	1	14	8

CCR = Client Confrontation Response
WSC = Within-Session Change

Training phase: Missing data

Raters B and I each failed to attend one of the seven Training sessions. Rater B failed to provide ratings to one entire session from the Training Phase resulting in six missed *client confrontation response* ratings, and five missed *within-session change* ratings. Rater I also failed to provide ratings for one videotaped session resulting in five missed *client confrontation response* ratings, and 1 missed *within-session change* ratings. Although mean imputation was utilized to replace missing data in the Project Phase of

this study, no missing data points were replaced during the Training Phase because doing so would potentially provide an inaccurate representation of a Rater's ability to make ratings.

Training phase: Client Confrontation Response and Within-Session Change Ratings.

Upon completion of the Training Phase, the researcher examined the data in order to determine if training had been successful and who among the raters obtained the highest percentage agreement with a predetermined benchmark on *client confrontation response* and *within-session change*. The benchmark had been reliably determined by the three clinician judges who conducted the training. Table 2 provides a summary of instances when the undergraduates' ratings were in complete agreement with or fell within one to four points of the benchmark for *client confrontation response*.

Table 2

Percentage Agreement Among Undergraduate Raters During Training: Client Confrontation Response

	Point Discrepancies and Percentage of Occurrence									
Raters	0	%	1	%	0-1 %	2	%	3	%	4	%
A	11	57.89	5	26.32	84.21	1	5.26	1	5.26	1	5.26
B	6	46.15	4	30.77	76.92	2	15.38	1	7.69	0	0.00
C	8	42.11	8	42.11	84.21	2	10.53	1	5.26	0	0.00
D	13	68.42	5	26.32	94.74	0	0.00	1	5.26	0	0.00
E	10	52.63	6	31.58	84.21	1	5.26	2	10.53	0	0.00
F	8	42.11	8	42.11	84.21	1	5.26	2	10.53	0	0.00
G	12	63.16	3	15.79	78.95	2	10.53	1	5.26	1	5.26
H	8	42.11	6	31.58	73.68	3	15.79	2	10.53	0	0.00
I	4	28.57	7	50.00	78.57	3	21.43	0	0.00	0	0.00

As shown in Table 2, Rater D was in complete agreement with the *client confrontation response* benchmark 68.42% of the time and fell one point away from the benchmark 26.32% of the time. Therefore, Rater D demonstrated the highest percentage agreement during training, falling within zero to one point from the benchmark a combined total of 94.74% of the time. Raters A, C, E, and F fell within zero to one point from the benchmark a combined total of 84.21% of the time. Raters G and I were in either complete agreement or fell within one point from the benchmark 78.95% and

78.57% of the time respectively. Rater B was in complete agreement or fell within one point from the benchmark 76.92% of the time.

Table 3 provides a summary of instances when the undergraduates' ratings were in complete agreement with or fell within one to four points of the rater for *within-session change*.

Table 3

Percentage Agreement Among Undergraduate Raters During Training: Within-Session Change

	Point Discrepancies and Percentage of Occurrence						
Raters	0	%	1	%	0-1 %	2	%
A	2	22.22	7	77.78	100.00	0	0.00
B	1	25.00	2	50.00	75.00	1	25.00
C	4	44.44	3	33.33	77.78	2	22.22
D	5	55.56	4	44.44	100.00	0	0.00
E	2	22.22	7	77.78	100.00	0	0.00
F	4	44.44	5	55.56	100.00	0	0.00
G	3	33.33	6	66.67	100.00	0	0.00
H	5	55.56	4	44.44	100.00	0	0.00
I	1	12.50	6	75.00	87.50	1	12.50

As shown in Table 3, Raters D and H were in complete agreement with the *within-session change* benchmark 55.56% of the time and fell one point away from the benchmark 44.44% of the time. Raters D and H demonstrated the highest percentage agreement during Training, falling within zero to one point from the benchmark a combined total of 100% of the time. Raters A, E, F and G also fell within zero to one point from the benchmark a combined total of 100% of the time. Rater I was in complete agreement or fell within one point from the benchmark 87.5% of the time. Raters B and C were in complete agreement or fell within one point from the benchmark 75% and 78.8% of the time respectively.

At the end of the Training Phase, it was determined that each rater demonstrated sufficient understanding of the rating systems and could fairly accurately and reliably rate *client confrontation response* and *within-session change*. Raters A, D, and E were assigned as primary raters due to their proficiency with both rating instruments. Raters B, C, F, G, H, and I were assigned as alternate raters. The raters did not know which group they were assigned to, and all raters were asked to rate the 18 videotaped sessions for the Project Phase of this study. In the event that Raters A, D, or E were unable to complete this study then data from the alternate raters would be used.

Prior to viewing the sessions, raters were provided with session-specific *Rater Report Forms* describing the session as well as the core-problem dynamic and the locations of confrontations throughout the session. Similar to the sessions used during the Training Phase of this study, the *core problem dynamic* was defined by the clinician judges. Raters were asked to watch each session twice before making their ratings. After watching a session in its entirety, raters used the *Client Confrontation Response Scale*

and the *Change in Problem Dynamic Scale* to independently rate each client who was an active participant in the session. Active participants included those who were defined as part of the core problem dynamic or those who had been confronted during the session. The mean of those ratings were then used to obtain a final *client confrontation response* and *within-session change* rating for each active participant and for each videotaped session.

Project Phase: Summary of data

Table 4 provides a summary of the undergraduate rater's *client confrontation response* and *within-session change* ratings during the Project Phase of this study. A total of 48 *client confrontation response* ratings and 63 *within-session change* ratings were expected from each rater during the Project Phase. Table 4 shows that Raters A, C, D, E, F, and G provided the expected number of *client confrontation response* ratings. Raters B, H, and I failed to provide the expected number of *client confrontation response* ratings with 31, 40 and 45 ratings respectively. Raters A, D, E, and G provided the expected number of *within-session change* ratings. Raters B, C, F, H, and I failed to provide the expected number of *within-session change* ratings with 40, 62, 62, 53, and 59 ratings respectively. Rater B failed to provide entire sets of ratings to seven sessions. Similarly, Rater H failed to provide entire sets of ratings to three sessions, and Rater I to one session. Rater B was removed from this study due to inconsistency in providing ratings in a timely manner. Rater H asked to leave this project early after taking a job and was subsequently unable to provide the entire set of ratings. Rater I failed to submit one session's ratings by the due date for all ratings to be returned to the experimenters.

Table 4

Summary of Data Points Per Undergraduate Rater: Client Confrontation Response and Within-Session Change During the Project Phase

Raters	Missing Tapes	Missing Data Points		Total Imputed Means		Total Project Points	
		CCR	WSC	CCR	WSC	CCR	WSC
A	0	0	0	0	0	48	63
B	7	17	23	0	0	31	40
C	0	0	1	0	1	48	62
D	0	0	0	0	0	48	63
E	0	0	0	0	0	48	63
F	0	0	1	0	1	48	62
G	0	0	0	0	0	48	63
H	3	8	10	0	0	40	53
I	1	3	4	0	0	45	59

CCR = Client Confrontation Response
WSC = Within-Session Change

Project phase: Missing data

As a rule, any undergraduate rater who failed to provide entire sets of ratings to three or more videotaped therapy sessions was removed from this study. Rater B missed a total of eight videotaped sessions from the Training and Project Phases resulting in 23 missed *client confrontation response* ratings, and 28 missed *within-session change* ratings. Rater H also failed to provide ratings for a total of three videotaped sessions

resulting in eight missed *client confrontation response* ratings, and 10 missed *within-session change* ratings. Ratings from Raters B and H were subsequently not utilized for this study. Of the remaining seven undergraduate raters, there were a total of nine missing data points from the Project Phase. Of the nine missing data points from the Project Phase, two missing *within-session change* data points from Raters C and F were replaced with imputed means. The remaining seven missing data points from the Project Phase were not replaced with imputed means because these were instances in which the rater had made no ratings at all for these sessions. That is, in the instance of Rater I, a total of two entire tapes were not rated resulting in seven missing Project Phase data points (three *client confrontation response* ratings and four *within-session change* ratings). These missing data points were not imputed because Rater I had not viewed or rated these tapes at all. In contrast, even though Raters C and F failed to provide a complete set of ratings for a session, they did view the session and provide most of the ratings needed.

Project phase: Descriptive statistics for Client Confrontation Response and Within-Session Change

The mean, standard deviation, skewness, kurtosis, minimum and maximum of *client confrontation response* and *within-session change* ratings are presented in Tables 5 and 6 and are further categorized by rater. Note that Raters B and H were not included as they were removed from this study due to missing data. Table 7 presents the aforementioned descriptive statistics of all seven Undergraduate Raters after conversion to means.

Table 5

Descriptive Statistics for Client Confrontation Response by Undergraduate Rater During the Project Phase

Rater	Mean	Standard Deviation	Skewness	Kurtosis	Minimum	Maximum
Rater A	4.47	1.30	-0.26	-0.13	1.60	6.50
Rater C	4.88	1.24	-0.61	-0.58	2.40	6.60
Rater D	4.14	1.73	-0.32	-1.48	1.50	6.33
Rater E	4.61	0.82	-0.91	1.38	2.50	6.00
Rater F	3.91	1.85	-0.17	-1.43	1.00	6.50
Rater G	4.83	1.55	-0.36	-1.02	2.00	7.00
Rater I	4.21	1.33	-0.27	-0.64	1.80	6.40

Note. N = 18 for Raters A, C, D, E, F, and G
N = 17 for Rater I

Table 6

Descriptive Statistics for Within-Session Change by Undergraduate Rater During the Project Phase

Rater	Mean	Standard Deviation	Skewness	Kurtosis	Minimum	Maximum
Rater A	5.04	1.03	-0.62	-0.71	3.00	6.50
Rater C	4.98	0.85	0.46	0.72	3.50	7.00
Rater D	4.79	1.03	-0.67	-0.34	2.50	6.00
Rater E	4.08	0.92	0.47	-0.65	3.00	6.00
Rater F	4.62	0.88	-0.78	0.02	3.00	6.00
Rater G	4.63	0.81	0.36	1.18	3.00	6.50
Rater I	4.76	0.92	-0.63	-0.26	3.00	6.00

Note. N = 18 for Raters A, C, D, E, F, and G
N = 17 for Rater I

Table 7

Descriptive Statistics for Means of Client Confrontation Response and Within-Session Change for the Seven Undergraduate Raters During the Project Phase

Variable	Mean	Standard Deviation	Skewness	Kurtosis	Minimum	Maximum
Client Confrontation Response	4.46	1.13	-0.62	-0.20	2.31	6.00
Within-Session Change	4.69	0.59	-0.16	-0.87	3.14	5.71

Note. N = 18

Table 7 shows that the mean *client confrontation response* rating for all sessions and for all seven undergraduate raters was 4.46 suggesting that clients showed at least some understanding in the majority of confrontations, but did not clearly accept these confrontations. The minimum *client confrontation response* rating was 2.31 and the maximum was 6.00. A minimum of 2.31 indicates that there were few confrontations in which the client clearly did not understand or accept the confrontation. A maximum of 6.00 suggests that there were fewer confrontations in which the clients clearly understood and clearly accepted the confrontation.

For the main analyses of this study, only data from the three primary raters were utilized. Table 8 provides a summary of descriptive statistics for the primary raters' (Raters A, D, and E) *client confrontation response* and *within-session change* ratings. Although Table 7 shows descriptive statistics for all seven raters and Table 8 for only three raters, the data presented are largely similar.

Table 8

Descriptive Statistics for Means of Confrontation Response and Within-Session Change for the Three Primary Undergraduate Raters During the Project Phase

Variable	Mean	Standard Deviation	Skewness	Kurtosis	Minimum	Maximum
Client Confrontation Response	4.40	1.06	-0.37	-0.24	2.33	6.17
Within-Session Change	4.63	0.77	-0.49	-0.19	3.00	5.83

Note. N = 18

Project phase: Descriptive statistics for Clarity, Emotional Reactivity, and Use of Suggestion

After viewing each videotaped session in its entirety, clinician judges independently rated *clarity, emotional reactivity,* and *use of suggestion.* Ratings were made for each family member who was defined as part of the confrontation. From these individual ratings, means were obtained so that each videotaped session had one rating per variable. For example, there were three confrontations in Session 1, each directed to an individual family member. A total of nine *clarity* ratings were made for these three confrontations. That is, three clinician judges each made three individual *clarity* ratings for each of three confrontations, yielding a total of nine ratings. The mean of these nine ratings was then determined and the subsequent score was considered the final *clarity* rating for Session 1. A total of 18 final ratings were expected for each variable, yielding one variable rating per videotaped session.

Tables 9, 10 and 11 present the mean, standard deviation, skewness, kurtosis, minimum and maximum of *clarity*, *emotional reactivity*, and *use of suggestion* ratings for each clinician judge. Table 12 presents the aforementioned descriptive statistics after being converted to means.

Table 9

Descriptive Statistics for Clarity by Clinician Judge During the Project Phase

Rater	Mean	Standard Deviation	Skewness	Kurtosis	Minimum	Maximum
Judge A	5.86	0.80	0.04	-1.16	4.50	7.00
Judge B	5.87	0.77	-0.07	-0.97	4.50	7.00
Judge C	5.92	0.72	0.15	-1.25	5.00	7.00

Note. N = 18

Table 10

Descriptive Statistics for Emotional Reactivity by Clinician Judge During the Project Phase

Rater	Mean	Standard Deviation	Skewness	Kurtosis	Minimum	Maximum
Judge A	1.97	0.86	0.96	0.13	1.00	3.80
Judge B	1.97	0.80	1.07	1.01	1.00	3.80
Judge C	1.87	0.87	1.03	0.49	1.00	3.80

Note. N = 18

Table 11

Descriptive Statistics for Use of Suggestion by Clinician Judge During the Project Phase

Rater	Mean	Standard Deviation	Skewness	Kurtosis	Minimum	Maximum
Judge A	2.34	0.87	0.04	-1.12	1.00	3.67
Judge B	2.39	0.91	0.11	-0.88	1.00	4.00
Judge C	2.29	0.85	0.25	-0.93	1.00	3.67

Note. N = 18

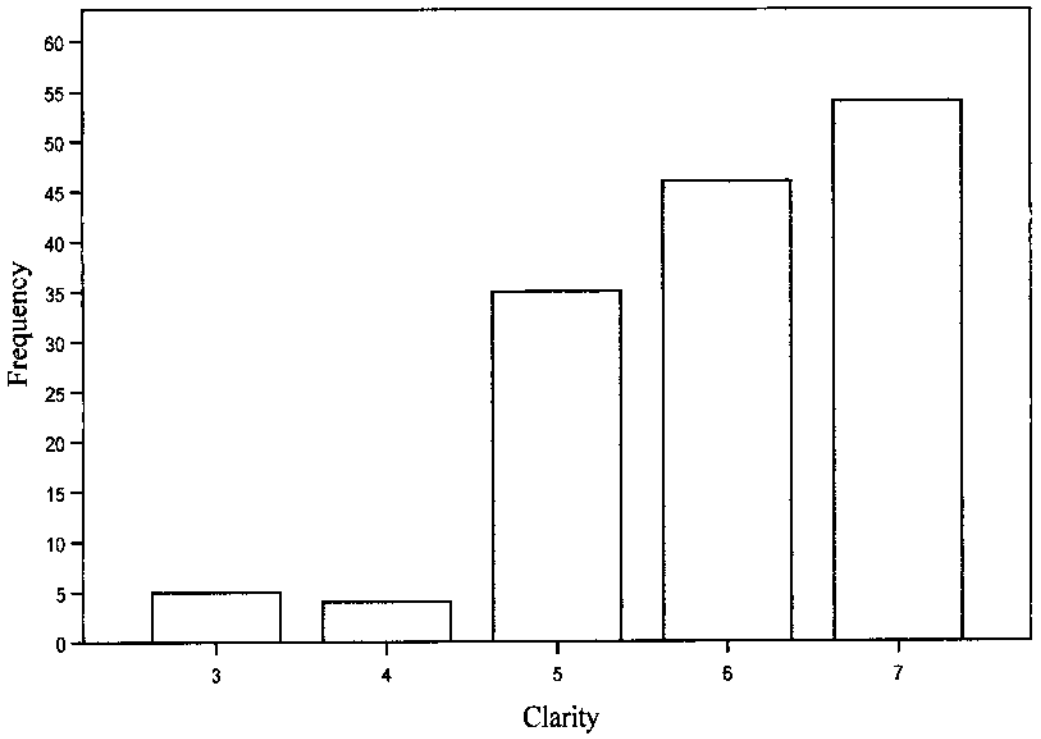
Table 12

Descriptive Statistics for Clinician Judge Variables During the Project Phase After Conversion to Means

Variable	Mean	Standard Deviation	Skewness	Kurtosis	Minimum	Maximum
Clarity	5.94	0.71	-0.03	-0.99	4.83	7.00
Emotional Reactivity	1.94	0.83	1.09	0.72	1.00	3.80
Use of Suggestion	2.28	0.87	0.32	-0.95	1.00	3.67

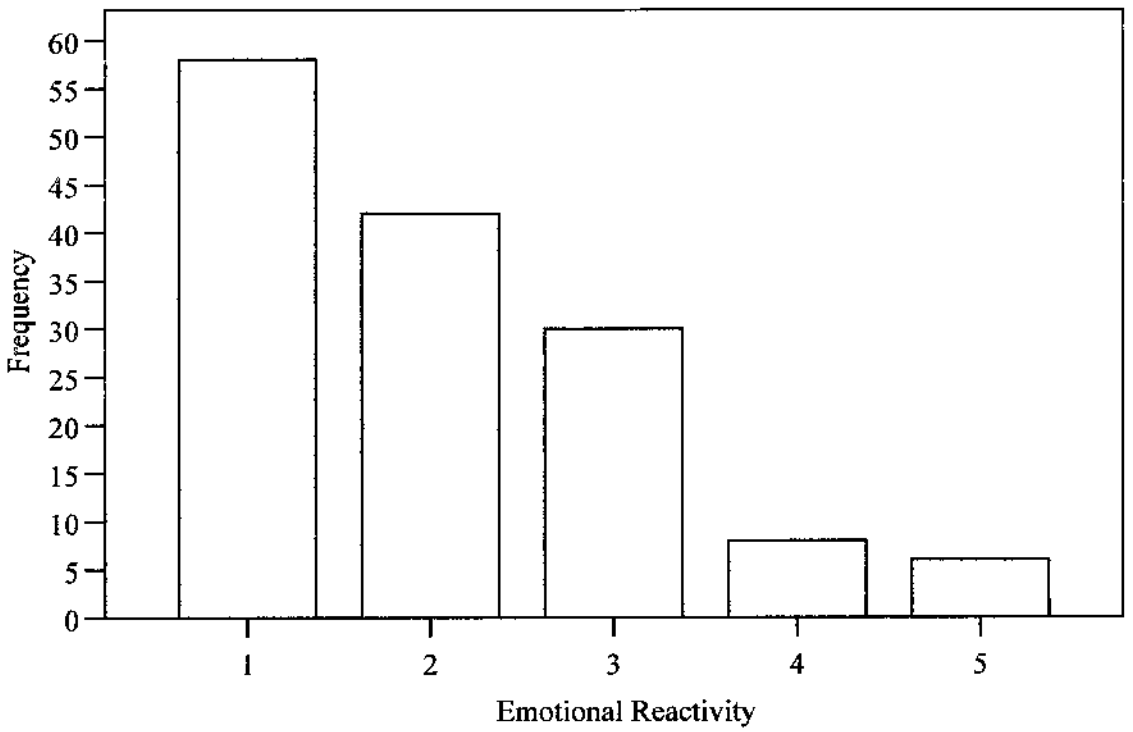
Note. N = 18

Table 12 shows that the mean *clarity* rating for all sessions and for all three clinician judges was 5.94 suggesting that confrontations were often moderately clear, direct and focused. The minimum *clarity* rating was 3 and the maximum was 7 (see Graph 1). A minimum rating of 3 indicates that there were no confrontations which were deemed "unclear" or "very unclear."



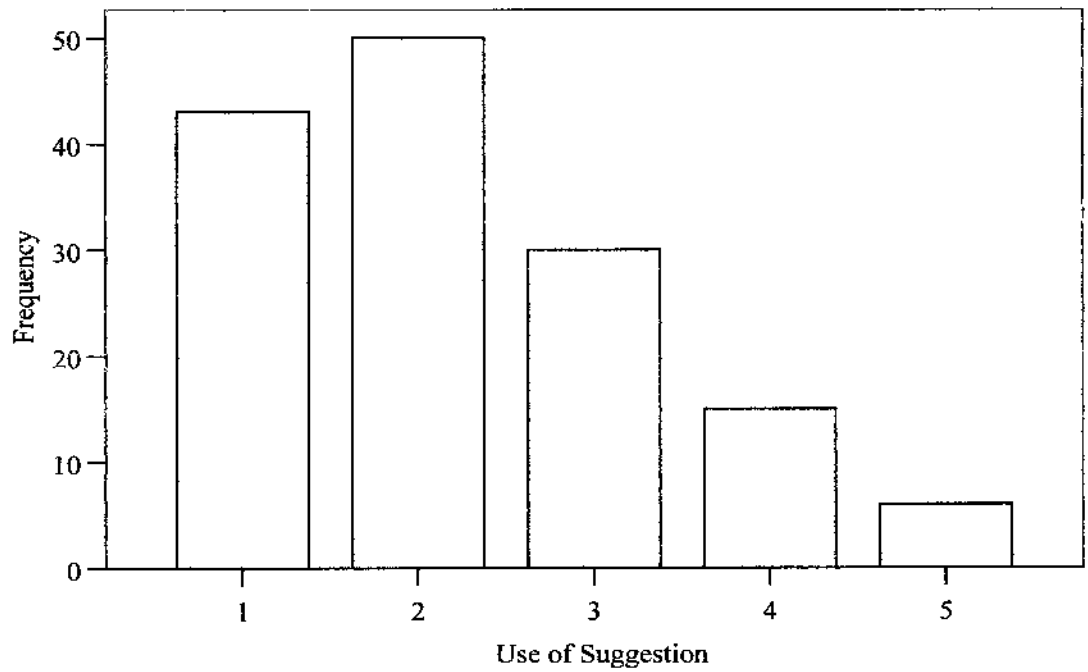
Graph 1. Distribution of Clarity Ratings.

The mean *emotional reactivity* rating was 1.94. The minimum *emotional reactivity* rating was 1 and the maximum was 5 (see Graph 2). The majority of ratings suggested generally low levels of *emotional reactivity* for the confrontations examined in this study.



Graph 2. Distribution of Emotional Reactivity Ratings.

The mean *use of suggestion* rating was 2.28. The minimum *use of suggestion* rating was 1 and the maximum was 5 (see Graph 3) indicating that confrontations more often included "implied suggestion," "some suggestion," or "no suggestion."



Graph 3. Distribution of Use of Suggestion Ratings.

Project phase: Interrater reliability for clarity, emotional reactivity and use of suggestion

Clinician judges practiced making ratings on *clarity, emotional reactivity,* and *use of suggestion* together until they were within zero to one point from each other at least 80% of the time. Table 13 presents the percentage agreement for clinician judges. When making independent ratings of *clarity*, clinician judges were in complete agreement with each other 80% of the time, differed by one point 16% of the time, and differed by two

points 4% of the time. When making independent ratings of *emotional reactivity,* clinician judges were in complete agreement with each other 76% of the time, and differed by one point 12% of the time. When making independent ratings of *use of suggestion,* clinician judges were in complete agreement with each other 80% of the time, and differed by one point 20% of the time.

Table 13

Percentage Agreement of Clarity, Emotional Reactivity, and Use of Suggestion Among Clinician Judges

	Point Discrepancies and Percentage of Occurrence						
Variable	0	%	1	%	0-1 %	2	%
Clarity	41	80	8	16	96	2	4
Emotional Reactivity	39	76	12	24	100	0	0
Use of Suggestion	41	80	10	20	100	0	0

Cronbach's alpha levels were also determined and showed an impressive degree of homogeneity for *clarity* (0.96), *emotional reactivity* (0.98), and *use of suggestion* (0.98).

Relationships between Clarity, Emotional Reactivity, Use of Suggestion and Within-Session Change and Client Confrontation Response.

To test the potential relationships between *clarity, emotional reactivity, use of suggestion* and *within-session change,* a multiple regression analysis was employed. As shown in Table 14, *clarity, emotional reactivity,* and *use of suggestion* were not significant predictors of *within-session change,*

F (3,14) = .54, *ns.*, R = .32 and Adj. R^2 = -.09.

Table 14

The Effect of Clarity, Emotional Reactivity, and Use of Suggestion on Within-Session Change

Variable	B	β	sr_i^2
Clarity	0.28	0.26	0.06
Emotional Reactivity	-0.11	-0.12	0.01
Use of Suggestion	-0.01	-0.02	0.00

Note. R = .64 and Adj. R^2 = -.28 (N = 18, *ns.*).

A multiple regression analysis was also utilized to test the potential relationships between *clarity, emotional reactivity, use of suggestion* and *client confrontation response*. No significant relationships were identified when the combined effects of *clarity, emotional reactivity,* and *use of suggestion* were examined, F (3, 14) = 3.27, *ns.*, R = .64 and Adj. R^2 = -.28. However, as shown in Table 15, there was a significant

relationship between *clarity* ($\beta = .59$, $sr_i^2 = .31$) and *client confrontation response* such that for every one-unit increase in *clarity* scores, the *client confrontation response* scores increases by .87 points. Similarly, a Pearson product-moment correlation between *clarity* and *client confrontation response* also indicates a positive and significant relationship, $r\,(16) = .63, p < .01, r^2 = .40$.

Table 15

The Effect of Clarity, Emotional Reactivity, and Use of Suggestion on Client Confrontation Response

Variable	B	β	sr_i^2
Clarity	.87	0.59*	0.31
Emotional Reactivity	-0.06	-0.05	0.00
Use of Suggestion	-0.13	-0.11	0.00

Note. R = .64 and Adj. R^2 = -.28 (N = 18, *ns*).
*$p < .05$.

Client Confrontation Response and Within-Session Change

A Pearson product-moment correlation between *client confrontation response* and *within-session change* revealed a positive and significant relationship, $r(16) = .66, p < .01, r^2 = .44$.

Summary

The mean *within-session change* and *client confrontation response* scores for the entire sample rated by the Primary undergraduate raters were 4.63 and 4.40 respectively.

The means for *clarity, emotional reactivity,* and *use of suggestions* were 5.94, 1.94, and 2.28 respectively. Percentage of agreement and Cronbach's alpha revealed a strong degree of homogeneity among both the clinician judges' ratings and the undergraduate raters' ratings. A series of multiple regression analyses suggest that there was no relationship between *clarity, emotional reactivity, use of suggestion* and *within-session change.* Similarly, no relationship was found among the combined effects of *clarity, emotional reactivity, use of suggestion* and *client confrontation response.* However, a significant and positive relationship was found to exist between *clarity* and *client confrontation response.* A significant relationship also exists between *client confrontation response* and *within-session change.*

CHAPTER IV

Discussion

The goal of this process study was to explore the ingredients of effective confrontations in structural family therapy. Specifically, the relationships between confrontation *clarity*, *emotional reactivity*, *use of suggestion*, and immediate client responses to confrontation as well as *within-session change* in client families were examined.

Clarity, Client Confrontation Response, and Within-Session Change

It was predicted that clear, direct, and focused confrontations would be positively correlated with greater client acceptance as well as greater within-session systemic change. Clear, direct, and focused confrontations were significantly and positively correlated with greater acceptance immediately following a confrontation, suggesting that clients are more likely to understand and accept confrontations when they are presented in a clear, direct, and concise manner.

Despite a significant and positive correlation between *clarity* and *client confrontation response*, no significant relationship was revealed between *clarity* and *within-session change*. That is, although the data did show a positive correlation between *clarity* and *within-session change*, as had been predicted, this correlation was not significant.

Emotional Reactivity, Client Confrontation Response, and Within-Session Change

It was predicted that lower levels of *emotional reactivity* in a confrontation would be correlated with greater client acceptance of confrontations as well as greater within-session change. Analyses did reveal negative correlations between *emotional reactivity*

and *client confrontation response*, as well as *emotional reactivity* and *within-session change*; however, these correlations were not significant. The data did trend in the direction expected for both correlations, but there were only small to modest effects. This may partially be due to a restriction of power related to the decreased range of scores. That is, the *emotional reactivity* scale itself had seven rating points but the actual range of ratings spanned only from one to five, indicating that there were no instances in which raters believed that the confrontations were marked by even "moderate" levels of agitation by the therapist.

Use of Suggestion, Client Confrontation Response, and Within-Session Change

It was predicted that *use of suggestion* by therapists would correlate negatively with *within-session change*. That is, it was predicted that telling clients what they are doing wrong, without telling them explicitly what to do to fix the problem would be positively correlated with greater levels of client acceptance and *within-session change*. *Use of suggestion* did trend in the predicted direction, but there were only small effects and the correlations did not reach levels of significance.

Client Confrontation Response and Within-Session Change

This study was conducted on the premise that confrontation is a useful and effective technique for enacting change in various types of psychotherapy, including structural family therapy. Although not an explicit hypothesis, it was expected that *client confrontation response* would be positively correlated with *within-session change* ratings. This study did reveal a significant and positive relationship between *client confrontation response* and *within-session change* with a moderate to large effect size. This suggests

that confrontations that are understood and accepted by clients can be effective in enacting client change within the therapy session.

Limitations and Future Research

One of the more serious limitations to this study was the small sample size. Although approximately 42 videotaped structural family therapy sessions were reviewed for instances of confrontation, only 25 sessions actually contained confrontations. Of that 25, seven sessions were utilized for training purposes. The remaining 18 sessions were utilized to obtain Project Phase ratings. Within those 18 sessions, there were 48 instances during which a rating of *client confrontation response* could be made and 63 instances in which ratings of *within-session change* could be made. In order to enhance the precision and stability of the data, averages were created from these ratings so that a total of 18 ratings were made each for *client confrontation response* and *within-session change*; that is, one rating per variable per videotaped session. Therefore, although the data is more precise and stable, this study was then left with a smaller sample size. The small sample size limited the statistical analyses that could be appropriately performed and resulted in reduced power for this study. That is, the ideal way to analyze this data would be to utilize a more complex hierarchical modeling procedure to enhance the sensitivity of the analyses. However, this would require a much larger sample size. Using a more complex modeling procedure with the current sample size would not drastically affect the results of this study.

Sample size, however, is not the only limiting factor in process studies such as this. This particular study relied on not only a small sample size, but a sample with a limited number of therapists. A total of four therapists conducted the therapy sessions,

and unaccounted for therapist-related variables may have contributed to this study's results. Future research might be inclined to re-examine this study's hypotheses using a larger and more diversified sample size.

During this research, it was noticed that it was difficult to find therapists who were able to actually perform the technique of confrontation. There were many instances in which inexperienced therapists attempted to use the technique of confrontation, but instead provided something that looked only modestly like a confrontation. Although the therapists may have actually been using confrontations, these were less clear examples of confrontation and there was not 100% agreement among the clinician judges that these were in fact confrontations. Had these instances been considered examples of confrontation, they would have been poor examples of confrontation and would have increased the range of confrontation ratings. Perhaps re-examining these instances of potential or poor confrontations and improving the sensitivity of rating measures might yield important information about confrontation.

An additional factor to be considered is that this study only examined change demonstrated within the therapy session; and often only one session per family. Examining change within the session as well as outside the session may have yielded different results. That is, a future study might incorporate post-session measures to assess levels of change after the clients leave the therapy session and might also attempt to assess families longitudinally by measuring levels of change in successive therapy sessions, thereby determining the level of change over the course of therapy.

Future research might also consider examining other confrontation-related variables which may account for the effectiveness of confrontation. This study examined

only *clarity, emotional reactivity,* and *use of suggestion*, but these are not the only factors thought to be influential to confrontation. For example, as noted earlier, the timing of confrontation may be an important factor in acceptance and understanding of confrontation, which might then affect clients' within-*session change*. Perhaps it could be useful to also examine whether *within-session change* is affected by who in the family is confronted. For example, if a therapist confronts the head of the family, what effect will this have on *within-session change*? If the head of the family accepts and understands the confrontation, then perhaps the rest of the family will follow his or her lead and more change would be evident in the session. If, however, the confrontation is dismissed then perhaps this would reduce the power of the confrontation and yield less *within-session change*. Finally, perhaps the frequency of confrontations within a session, or over the course of several sessions would affect *client confrontation-response* and *within-session change*.

Conclusion

Although confrontation has fallen out of favor in recent years due to an emphasis on more collaborative models of family therapy and the perceived aggressiveness of confrontation, this study suggests that confrontation is an effective technique for bringing about client change when the confrontation itself is presented in a clear, direct, and focused manner. Interestingly, although *emotional reactivity* was not significantly correlated with the effectiveness of confrontation, the data did trend in the expected direction and the majority of confrontations were made with little to no agitation or scolding. This finding runs counter to the perception that confrontation is an aggressive, combative, and unempathic technique. Therefore, while the recent emphasis on a

collaborative, rather than combative, relationship to client families may be appropriate, eschewing the use of confrontation may be a case of throwing the baby out with the bathwater. And although it probably is a good thing that therapists have gotten away from a combative stance, this study shows that this does not necessarily mean getting away from confrontation.

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APPENDIX A

Confrontation Clarity Scale

1	2	3	4	5	6	7
Very unclear, obscure and confusing.	Unclear and confusing.	Somewhat unclear, indirect, and not well-focused.		Somewhat clear, reasonably direct and focused.	Moderately clear, direct, and focused.	Very clear, very direct, and very focused.

1: Confrontation is very unclear. Language is very confusing.

2: Confrontation is unclear. Language is confusing.

3: Confrontation is somewhat unclear. Language is indirect, and not well-focused.

4: Confrontation is neither particularly clear nor particularly unclear.

5: Confrontation is somewhat clear. Language is reasonably direct and focused.

6: Confrontation is moderately clear. Language is moderately direct and focused.

7: Confrontation is very clear. Language is very direct and focused.

APPENDIX B

Confrontation Emotional Reactivity Scale

1	2	3	4	5	6	7
Very calm & No agitation & No scolding	Calm & Little agitation & Little scolding	Not much agitation or scolding		Somewhat agitated & Scolding	Moderately agitated & Scolding	Very agitated & Scolding

1: Therapist very calmly points something out, without any agitation or scolding.

2: Therapist calmly points something out, with little agitation or scolding.

3: Therapist points something out, without much agitation or scolding.

4: Therapist neither very calmly points out something nor does the therapist point out something in a particularly agitated manner.

5: Therapist is somewhat agitated and scolding.

6: Therapist is moderately agitated and scolding.

7: Therapist is very agitated and scolding.

APPENDIX C

Confrontation Suggestion Scale

1	2	3	4	5
No suggestion	Implied suggestion	Some suggestion	Explicit suggestion	Explicit, directive, and forceful suggestion

1: No suggestion.

2: Implied suggestion.

3: Some suggestion.

4: Explicit suggestion.

5: Explicit, directive, and forceful suggestion.

APPENDIX D

Client Confrontation Response Scale

1	2	3	4	5	6	7
No Under-standing & No Acceptance	Minimal Under-Standing & No Acceptance	Some Under-standing but No Acceptance	Seems to Under-stand but No Evidence of Acceptance	Clear Under-standing but Not Clear Acceptance	Clear Under-standing & Mostly Accepting	Clear Under-standing and Clear Accepting

1: Clearly does not understand or accept / No understanding and no acceptance

2: Minimal understanding, No acceptance.

3: Some understanding, No acceptance.

4: Seems to understand but no evidence of accepting.

5: Clearly understands but does not clearly accept

6: Clearly understands and mostly accepts

7: Clearly understands and clearly accepts

APPENDIX E

Change in Core Problem Dynamic Scale

1	2	3	4	5	6	7
Significant negative change	Slight negative change	No change	Slight positive change	Moderate positive change	Significant positive change	Significant and manifest change

1: A destructive session that may threaten either the continuation of treatment or family relationship, or both.

2: Clients disagree with the therapist over the problem dynamic and show marked resistance.

3: Things seem to get no better or worse; clients may accept or at least consider the therapist's interpretations but show little evidence of change.

4: Clients seem to accept therapist's interpretations.

5: Clients begin to communicate about problem dynamic; indicate a willingness to work on changing; accept and acknowledge a need for change.

6: Clients show understanding of problem dynamic and accept personal responsibility; may begin to take steps to change behavior in the session.

7: Clients understand and accept therapist's interpretations and begin to make clear behavioral changes in the session; clients accept their own role in problems and begin to interact more effectively in the session.

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