

5-2012

Caring Confrontation with Involuntary Chemical Dependency Clients

Faith Clark
St. Catherine University

Recommended Citation

Clark, Faith, "Caring Confrontation with Involuntary Chemical Dependency Clients" (2012). *Master of Social Work Clinical Research Papers*. Paper 13.
http://sophia.stkate.edu/msw_papers/13

This Clinical research paper is brought to you for free and open access by the School of Social Work at SOPHIA. It has been accepted for inclusion in Master of Social Work Clinical Research Papers by an authorized administrator of SOPHIA. For more information, please contact ejasch@stkate.edu.

Caring Confrontation with Involuntary Chemical Dependency Clients

Submitted by Faith M. Clark LSW, MHP, LADC

May 2012

MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

School of Social Work

St. Catherine University & University of St. Thomas

St. Paul, Minnesota

Committee Members:

David Roseborough, Ph.D (Chair)

Natalie Solga MSW, LGSW

Phoenix Lyn Walker, LADC

Abstract

The purpose of this study was to research the benefits of caring confrontation with 24 involuntary chemically dependent clients. The researcher created a survey which contained 11 variables that measured the benefits of caring confrontation and type of caring confrontation with the demographics of age, gender, and amount of time in treatment. The survey was distributed at a Midwestern chemical dependency facility. The results of the survey showed a positive mean score in the area of benefits of caring confrontation for the entire sample and when factoring in the demographics of age, gender, and amount of time in treatment. The results of the survey also showed a positive mean score in the area of type of caring confrontation for the entire sample, and when controlling for the demographics of age, gender, and amount of time in treatment. Although there were positive results regardless of demographics measured, the research yielded the most positive results for benefits of caring confrontation for individuals in treatment from one to two months with a mean score of 18.44 (on a scale of 4 to 20) versus individuals in treatment from three months to aftercare with a mean score of 14.56. The conclusions of this research are that caring confrontation is perceived as beneficial to involuntary, chemically dependent clients in this sample in the areas of relapse, recidivism, and bio-psycho-social health, while in treatment, regardless of demographics included in this study. The results of this research find that incorporating caring confrontation in the treatment process with involuntary chemically dependent clients is beneficial and practitioners should consider receiving training and supervision in the correct practice of this treatment modality.

Acknowledgements

The researcher would like to acknowledge her friends and family for support received in completing this research. The researcher would also like to acknowledge Francis McGiffert and Carry A. Nation for their pioneering work in social work and chemical dependency.

Table of Contents

Abstract.....	ii
Acknowledgements.....	iii
Introduction.....	1
Literature Review.....	3
Importance to Social Work.....	3
What is Caring Confrontation & How to Use Caring Confrontation.....	4
Involuntary Clients.....	7
Chemical Dependency Treatment Modalities.....	8
Harm Reduction.....	8
Motivational Interviewing.	9
Cognitive Therapy.....	11
Alcoholics Anonymous.....	12
Improper Use of Caring Confrontation.....	15
Previous Research in Confrontation.....	16
Conceptual Framework: Reality Therapy.....	20
Methods.....	22
Measure.....	22
Time Frame, Setting & Protection of Human Participants.....	23

Data Collection.....	23
Design.....	25
Strengths & Weaknesses.....	27
Findings.....	28
Demographic Findings.....	28
Table 1. Frequency Distribution of Demographics.....	29
Central Tendency Analysis.....	29
Table 2. Benefits of Caring Confrontation With Entire Sample (Question 12).....	30
Table 3. Importance of Type of Caring Confrontation With Entire Sample (Question 13).....	31
Table 4. Female Perceptions of the Benefits of Caring Confrontation (Question 12).....	31
Table 5. Female Perceptions Regarding Type of Caring Confrontation (Question 13).....	32
Table 6. Male Perceptions of the Benefits of Caring Confrontation (Question 12).....	33
Table 7. Male Perceptions of Type of Caring Confrontation (Question 13).....	33
Table 8. Less Than a Month to Two Months: Benefits of Caring Confrontation (Question 12).....	34
Table 9. Less than a Month to Two months: Type of Caring Confrontation (Question 13).....	35
Table 10. Three Months to Aftercare: Benefits of Caring Confrontation (Question 12).....	35
Table 11. 3 Months to Aftercare: Type of Caring Confrontation (Question 13).....	36
Table 12. Ages 20 to 36: Benefits of Caring Confrontation (Question 12).....	37
Table 13. Ages 20 to 36: Type of Caring Confrontation (Question 13).....	37
Table 14. Age 37 to 72: Benefits of Caring Confrontation (Question 12).....	38
Table 15. Age 37 to 72: Type of Caring Confrontation (Question 13).....	39
T-test Analysis.....	39
Table 16. T-test: Male & Female Reports of Benefits of Caring Confrontation (Question 23).....	40
Table 17. T-test Regarding Male & Female Perceptions Regarding Type of Caring Confrontation (Question 13).....	41

Table 18. T-test for Less than a month to two months vs. 3 months to Aftercare for Benefits of Caring Confrontation (Question 12).....	42
Table 19. T-test for Less than a month to 2 months vs. 3 months – Aftercare: Type of Caring Confrontation (Question 13).....	43
Table 20. T-test for age 20-36 vs. Age 37-72: Type of Caring Confrontation (Question 13).....	44
Table 21. T-test Age 20-36 vs. Age 37-72: Benefits of Caring Confrontation (Question 12).....	45
Standard Deviation Analysis.....	45
Table 22. Range of Standard Deviations. (Question 13).....	46
Qualitative Analysis.....	46
Table 23. Qualitative Questions 10 & 11.....	47
Discussion.....	48
Overview.....	48
Demographics & Statistical Significance.....	48
Demographic Significance.....	50
Qualitative Responses.....	52
Strengths, Weaknesses, & Further Research.....	53
Summary.....	55
References.....	56
Appendix.....	58
Participant consent form.....	58
Participant Survey (not coded).....	59
Participant Survey (coded).....	61
Approval Letter from Institutional Review Board.....	63

“Confrontation exists in every human transaction. Any question, no matter how benign, is also a confrontation by virtue of the process of reflection and reaction. Confrontation is thus synonymous with awareness” (Bratter, Esparat, Kaufman, & Sinskeimer, 2008, p. 13). This research examines the human transaction of confrontation in the therapeutic setting with involuntary chemically dependent clients.

Many social workers, counselors, and other practitioners are assigned clients that are court ordered to treatment- otherwise known as involuntary clients. This leads to a multitude of frustrations as the client does not necessarily want to work with the practitioner and the practitioner has a limited amount of time to facilitate change from a person in a Precontemplation Stage (does not intend to take any action) to a person in Action Stage (someone who has made a commitment to change) and moving toward Maintenance Stage (sustaining new behavior & confident with change) (Robbins, Powers, & Burgess 2005).

This research explored caring confrontation as a potentially beneficial treatment modality with involuntary, chemically dependent clients to facilitate positive bio-psycho-social changes. McGuire-Bouwman (2006) states that “caring confrontation is another way of increasing [the] experience[e] level. I [McGuire-Bouwman] see low experiencing as actually being a variety of behavior patterns learned by the person as a child as ways of avoiding feeling feelings, or experiencing. Caring confrontation enables the person to step around these learnings and right down into experiencing, or the feelings that are there” (p. 4). A better understanding of caring confrontation can lead to more effective use of the technique with involuntary, chemically dependent clients. In exchange, this may result in decreasing the frustration of practitioners

working with involuntary clients, increase the clients' ability to be successful in their recovery and decrease the court's need to become involved in the client's life in the future.

To examine caring confrontation in the therapeutic setting, this research discusses its importance to social work, the increasing presence of chemical dependency issues in North American society, and the social workers part in the change process. The literature review examines what caring confrontation is- defining the concept and proper use of the treatment modality. Next, the concept of involuntary clients will be discussed and the challenges that come in working with this population. Other treatment modalities that are similar and dissimilar to caring confrontation will be discussed as well in terms of how they relate to practice with involuntary clients. A brief history of addiction treatment and confrontation approach is presented to include the improper use of confrontation with clients. Finally, the literature review discusses previous research on confrontation in the therapy setting.

The methods section includes discussion on how this study will measure the benefits of caring confrontation in one particular therapeutic setting. This study measures perceived risk of lapse/relapse and recidivism, program participation, bio-psycho-social health, amount of time spent in chemical dependency treatment, and demographic information such as age of the client, and gender of the client in regards to the benefits of using caring confrontation.

Literature Review

Importance to Social Work

The Minnesota Association of Resources for Recovery and Chemical Health (MARRCH) (2011) estimates the total economic costs of alcohol for 2007 in Minnesota as \$5,062,000,000- this includes health care expenditures, productivity, and other impacts on society such as criminal justice, fire, destruction, motor vehicle crashes and social welfare programs. MARRCH reports that Minnesota is higher than the national median of all states for binge drinking. MARRCH (2010) reports alcohol as the most harmful drug followed by heroin. The Duluth News Tribune reports “Judges, teachers and others realize it, as the columns on today’s page make plainly clear. They live, everyday, with the dangers and evils of alcoholism and alcohol abuse; they see how drinking destroys families, clogs courts, dominates police time, bloodies highways, endangers communities and raids everyone’s pocketbook” (2010, p. B1).

Social workers encounter the destruction of families and communities because of drugs and alcohol. As social workers continue their education and experience and become clinical social workers, they will often be in the situation of diagnosing and treating chemical dependency disorders and the majority of these clients will be involuntary. At the time of referral, many thoughts go through the social worker’s mind including- how do I work effectively with someone who doesn’t necessarily want to be here, follow legal guidelines, and present a treatment modality that will decrease relapse and recidivism all within a limited time frame. It is a heavy responsibility and to work effectively in these situations the social worker

must be educated and experienced in different chemical dependency treatment modalities especially in the modality of caring confrontation.

What is Caring Confrontation & how to use Caring Confrontation

McGuire-Bouwman (2006) defines caring confrontation as "...a method for presenting clients with ways of looking at themselves of which they may not yet be aware, without losing the respect for each person's inner experience..." (p. 2). Sheafor & Horejsi (2006) further describe confrontation as respectful and gentle efforts that help clients recognize their deceptions, denials, distortions, and manipulations. In order to practice this correctly, Sheafor and Horejsi have some basic principles of practice: Do not challenge the client when angry as this may be seen as punishing. Do not confront a client if you do not intend to take time to help the client understand the message. The client and social worker must respect each other in order for the message to be beneficial. Be sure to follow the confrontation with positive observations. Use descriptive examples of the client's behavior that are non-judgmental. When presenting observations, use "I statements".

Bratter, Esparat, Kaufman, & Sinsheimer (2008) discuss the use of confrontational psychotherapy as observed by William Glasser. Glasser attended a group session with adolescents and observed participants confronting one of their peers regarding burning rice in the kitchen. At first, Glasser thought this was a trivial discussion and not worth the confrontation; however, as he continued to listen to the group, Glasser was stunned by the excuses the boy was coming up with for burning rice and began to see the dishonesty within him that the group was confronting him about. Glasser then stated,

Confrontation, I have come to understand, is necessary to pierce the armor of denial and rationalization with which these dysfunctional souls are to surround themselves. Facing the truth is the first step towards long-lasting change...when delivered with care, even the harshest sounding confrontation results in the student feeling better as well as doing better... Caring Confrontation also generally results in a closer relationship between confronter and confronted. The message is simple: I care enough about you to tell you the hard truth, even if it hurts in the short term (p. 20).

Polcin (2003) discusses in his research that in order to properly analyze the use of caring confrontation, a practitioner must look at several contextual factors including: The clinical environment- Is the environment inpatient, outpatient, or correctional? This can determine the need and intensity of caring confrontation. Do other clients role model caring confrontation? This would facilitate acceptance of confrontation. What is the client's relationship with the confronter? This determines whether the client considers the confrontation a personal attack or constructive criticism from someone who cares about them. How long has the client been in treatment? Clients at the beginning of treatment are less adjusted to programming and are more likely to be reactive to caring confrontation. Does the client have a psychiatric disorder? A client with antisocial personality disorder may need more caring confrontation where a person with major depression may need very little. What is the timing of the confrontation? Practitioners who practice caring confrontation when angry have less positive results and confronting a client who is upset or angry creates distrust. Are the practitioners trained; what is the level of clinical skill? Without ongoing training and consultation, the practitioner is less likely to practice effectively. What is the client's commitment to the program? The more a

client is committed to programming, the more they are committed to working with the practitioner. McGuire-Bouwman (2006) offers a good example of caring confrontation:

I (McGuire-Bouman) have been with a client for several sessions, using all manner of reflection of feelings and invitations to go deeper through focusing in an attempt to deepen her experiencing level. Still, each time I invite this kind of slowing down of her rapid-fire, highly intellectualized style of talking, she immediately pops back up to this speedy way of being. Finally, I point this out, gently and out of some knowledge that we have already established warm connection that she has already received my client-centered message of loving and accepting her no matter how she is being. I offer my analysis tentatively: “I have a sense that, every time I invite you to go quietly inside, you run away as fast as can be, never staying quiet for more than a split second, then returning to a fast-as-can-be way of talking. I’m thinking that this is a way that you have learned of avoiding feelings, of staying away from the hurt and anger, and I’m wanting you to know that I believe that getting ‘better’ means going through these feelings, not jumping away from them. Does this make any sense to you?” and then I respond in a listening way (through reflection) to whatever impact this sharing has had upon her (p.3).

In conclusion, caring confrontation is a method of working with clients on their logic errors without losing sight of their needs, individual qualities and respect for one another. When using caring confrontation, the practitioner must be aware of environmental factors before using the treatment modality such as type of treatment, diagnoses, and length of time in treatment.

Involuntary Clients

Ritchie (1986) defines an involuntary client as one that is "...referred to counseling by a third party" (p.516). A third party could be a judge, social services, principal, employer, probation, or other court services. The third party with involuntary chemically dependent clients is usually the judicial system, such as a judge sentencing a client to chemical dependency treatment after being convicted of three Driving While Intoxicated (DWI) violations. Reluctance is defined as a client who would choose not to have treatment, perhaps because of feeling uncomfortable about talking about self around others. Resistance is defined as "...the client's unwillingness to change" (Richie, 1986, p. 516). Ritchie also states reasons for resistance could be not admitting there is a problem, not wanting change, not knowing how to change, and being afraid of change.

Another area Ritchie (1986) discusses is that practitioners are often taught how to work with clients that are already motivated to change. However, this is a problem as the social worker who works in chemical dependency, prisons, schools, and hospitals may or will often have a caseload that is primarily compromised of involuntary clients.

To work with involuntary clients effectively Ritchie describes the importance of earning client trust, starting where the client is at and to avoid confrontations at the beginning of the client/counselor relationship. Mitchell (2007) adds to this stating that while working with resistant clients it is important to time the confrontation appropriately as a confrontation that is too early may risk injuring the therapeutic process. Ritchie (1986) also reports the importance of clearly explaining concepts, purposes, and rules of the treatment process. Some important areas are explaining why the person has been sent to treatment, confidentiality, and time limits of

counseling. It is also important to talk about expectations and limits within the treatment process and these areas "...should be repeated, clarified, and renegotiated according to the needs of the individual client as the relationship develops" (p. 517). Osborn (1999) adds to this stating that to increase the involuntary client's willingness to participate, the practitioner should discuss "...the parameters or terms of the counseling process" (p. 9). This includes the expectation that the client maintain contact with the referral source (such as a probation officer), attendance expectations, referral policies, and participation expectations. Osborn (1999) also discusses the importance of reminding the involuntary client that they have choices even if that choice was to go to jail or to go to treatment. The client should be commended on choosing treatment. Baird (1996) as cited by Mitchell (2007) gives some of the best wisdom for working with involuntary clients; "If you do not want to learn to use words carefully and accurately, you should probably consider another profession" (p. 131).

An involuntary client is one that is referred to treatment by a third party and would otherwise not choose treatment. Researchers discuss how practitioners are not trained in working with involuntary clients; confrontation is beneficial with involuntary clients but must be timed appropriately and a mutual respect between client and counselor must occur. It is also important to discuss rules and expectations in treatment and to also encourage choice when able to.

Chemical Dependency Treatment Modalities

Harm Reduction

Wormer & Davis (2003) as cited by Kirst-Ashman & Hull, Jr. (2006) define harm reduction as "...a treatment approach emphasizing means to reduce the 'harm caused' by the

addiction...to help people help themselves by moving from safer use, to managed use, to abstinence, is so desired” (p. 245). When discussing harm reduction it is important to remember that different practitioners use different definitions/models of harm reduction. Some use a more conservative form of harm reduction. For instance, in order for the client to remain sober, he/she is allowed to smoke cigarettes, drink coffee, and eat candy. Some use a more liberal method of harm reduction. For example, in order for the client to become sober, he/she is allowed to reduce their intake of alcohol.

How does this method incorporate working with involuntary, chemically dependent clients? The conservative method does fit the treatment modality of the involuntary chemically dependent client as before the client is sent to treatment he/she is seen before a judge and when the judge sentences the client to chemical dependency treatment and probation, the judge also sentences the client to remain clean and sober. This practitioner has seen over their practice that the more liberal form of harm reduction is not suggested for working with involuntary, chemically dependent clients as this method does not focus on abstinence (which is required by the judicial system for their probation) and it is difficult for clients to understand the message being presented to them while their minds and bodies are still drug affected. However, the more liberal form of harm reduction may have better outcomes within the mental health system with voluntary clients where there are not judicial restrictions and more time is allowed for the treatment process.

Motivational Interviewing

Miller & Rollnick (1991;2002) developed motivational interviewing and define the technique as “a client-centered, directive method for enhancing intrinsic motivation to change

by exploring and resolving ambivalence” (as cited by Austrian, 2005, p. 138). Austrian reports there are two phases of motivational interviewing. Phase one includes building motivation for change through open ended questions, affirming and supporting, reflective listening, summarizing, and reinforcing material, and stating how current patterns of behavior have disadvantages and what the advantages would be of changing the behavior. Phase two consists of strengthening the change commitment by summarizing work done in phase one, such as reporting what the client plans to do, the practitioner only gives advice and information when the client asks for or gives permission to do so, and sets goals, considers options, and coaches for commitment. Austrian (2005) states “[t]his ends the process of Motivational Interviewing. The client may not want or need further intervention in another form, although many do” (p. 139).

In working with involuntary chemically dependent clients, motivational interviewing has some beneficial tactics; however, it also has some short falls. With involuntary chemically dependent clients the practitioner should primarily use open ended questions, listen carefully, give support, summarize and reinforce the material, and recognize disadvantages of current behavior. However, there are two major problems with this treatment modality in this setting. The first major difficulty with this model is only giving advice when the client asks for it. Doing this is making an assumption that each client is able to logically decipher right from wrong. As social workers in the chemical dependency field know, many of the clients referred have difficulty making safe, logical decisions. Before a client can safely make choices again, the practitioner and client need to work together on healthy decision making. The second major difficulty with this model is considering long-term treatment effectiveness. If the practitioner only gives advice to the client when they ask for it, and knowing that the client and practitioner have a limited amount of time to work together in an outpatient chemical dependency treatment

setting, how can a practitioner be certain that at the end of treatment the client is not still in the beginning stages of recovery? How can a practitioner accurately document stability? Not only would this be ineffective for the client but would also not be cost effective for payment sources. If a client is in an extended residential setting or seeking services with an outpatient mental health therapist the time frame might be more appropriate.

Cognitive Therapy

Cognitive therapy is defined as "...a system of psychotherapy that attempts to reduce excessive emotional reactions and self-defeating behavior by modifying the faulty or erroneous thinking and maladaptive beliefs that underlie these reactions...As applied to substance abuse, the cognitive approach helps individuals to come to grips with the problems leading to emotional distress and to gain a broader perspective on their reliance on drugs for pleasure and or relief from discomfort" (Beck, 1976; Beck, Rush, Shaw, and Emery, 1979 as cited by Beck, Wright, Newman, and Liese, 1993, p. 27). Beck et al. describe that cognitive therapy for substance use focuses on two major areas: 1. Identifying underlying beliefs to reduce frequency and intensity of urges. 2. Teaching specific techniques for managing or controlling urges. To carry out cognitive therapy, the therapist works with the client to examine the events that led to drug use and what is the client's value of using drugs. The practitioner also works to have the client identify "faulty thinking" and to gain a better handle on thought behaviors by using role playing and rehearsal techniques. Beck et al, 1993, p. 77 describe confrontation in the cognitive therapy process as "...therapists must be prepared to confront their drug-abusing patients when they break therapeutic ground rules (Frances & Miller, 1991), but a tone of respect and concern must prevail (Newman, 1988)."

With this practitioner's history in the chemical dependency field, using cognitive therapy with involuntary chemically dependent clients has been seen to be largely effective. This model looks at logic errors, offers education on ways of coping, practicing coping skills, and careful and respectful techniques for working with chemical dependency clients who have mental illness. One area to consider when using cognitive therapy is to add the element of caring confrontation when the client gets stuck on identifying problem situations and to have consideration of time restraints within the chemical dependency treatment process. Another area to consider is that successfully practicing cognitive therapy requires clinical skill, education, supervision, and experience.

Alcoholics Anonymous

We are average Americans. All sections of this country and many of its occupations are represented, as well as many political, economic, social, and religious backgrounds. We are people who normally would not mix. But there exists among us a fellowship, a friendliness, and an understanding which is indescribably wonderful. We are like the passengers of a great liner the moment after rescue from shipwreck when camaraderie, joyousness and democracy pervade the vessel from steerage to Captain's table. Unlike the feelings of the ship's passengers, however, our joy in escape from disaster does not subside as we go our individual ways. The feeling of having shared in a common peril is one element in the powerful cement which binds us. But that in itself would never have held us together as we are now joined (Wilson & Smith 1939;2001, p. 17).

Alcoholics Anonymous (A.A.) was founded in 1935 and the first edition of the text "Alcoholics Anonymous" was printed in 1939 from the minds and inspiration of co-founders Bill

Wilson (Bill W.) and Dr. Bob Smith (Dr. Bob) both chronic Alcoholics. Alcoholics Anonymous follows 12 Steps toward Recovery:

1. We admitted we were powerless over alcohol- that our lives had become unmanageable.
2. Came to believe that a power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs (Wilson & Smith, 1939;2001, p. 59).

Many practitioners have moved away from A.A. stating it is old, religious, and ridged. However, it is important to always respect the perspectives of those who experience the pain of disease. Bill W. and Dr. Bob spent many years dealing with the pain of alcoholism and wrote about their experiences and this should be respected. Another way to look at this is to use the example of Schizophrenia. If a person wants to truly understand the unique experience of Schizophrenia, would they talk to a specialist or would they talk to a person who has experienced Schizophrenia for many years? This practitioner's history in chemical dependency treatment has shown A.A. groups as excellent for guidance, socialization, and understanding. A.A. helps to get those who isolate to get out and be with people again.

This practitioner recommends these areas to consider when using A.A. philosophy: remember that A.A. is a spiritual program, not a religious program and whatever a client describes as their higher power needs to be respected including an Atheistic view point. Also, the practitioner should be careful with some A.A. terminology as it could be misconstrued- specifically the words "powerless," "insanity," and "character defects." With certain populations, such as the Mental Illness & Chemical Dependency (MICD) population, these words may be confusing and misrepresenting. The practitioner then should not steer the client away from 12 Step philosophy; rather, allow the client to find their own word that represents their situation or their story. In working with involuntary chemically dependent clients, this practitioner has found A.A. philosophy as largely beneficial; however, with resistant, precontemplative clients or clients with dual diagnoses, other forms of treatment modalities should be used as well such a cognitive therapy and caring confrontation with reality therapy. The most important part of having the involuntary chemically dependent client involved in A.A. groups is that the client's time with the practitioner is very limited but their relationship with their peers is lasting.

There are many different approaches to working with chemically dependent clients including harm reduction, motivational interviewing, cognitive therapy, Alcoholics Anonymous, and reality therapy. In working with involuntary chemically dependent clients and choosing a treatment modality, some important areas to remember are time constraints, court order to remain abstinent, diagnoses, history, and chronicity. This researcher found through chemical dependency experience that a combination of cognitive therapy, Alcoholics Anonymous, reality therapy and use of caring confrontation as successful approaches with research behind them.

Improper Use of Confrontation

An interview was conducted with a chemical dependency professional in July 2011 regarding improper use of confrontation in chemical dependency treatment and provides concrete examples of improper usage. The interviewee reported seeing improper use of confrontation when they first started in the chemical dependency field over 23 years ago. The interviewee reported that clients were required to turn in all street clothes and wear “pajama type bottoms” without shoes. This was followed by hours of yelling at the individual and degrading them for being an addict and withholding their ability to contact family stating that family did not want to talk to the client because of his/her actions and would never forgive them. The interviewee reported another incident they considered to be inappropriate use of confrontation- stating a time when a client was confronted by the other individuals in a residential unit and by a counselor due to coming back to the facility intoxicated. However, it was later discovered that the woman had received a call stating that her children had been killed in a car accident and the client had drank because they thought it would be better than suicide (Anonymous, personal communication, July 12, 2011).

Another setting in which inappropriate confrontation is alleged in chemical dependency treatment is the Synanon Therapeutic Community. The Synanon, developed by Charles Dederich, started by following A.A. principles but later abandoned A.A. philosophy and became what some have called an abusive, dictatorship. “The story of the man and the institution are the story of the rise and fall of Synanon as a pioneering force in addiction treatment. As this story unfolded, no one could have imagined that Synanon would later be depicted as a paramilitary cult and that Charles Dederich would be charged with conspiracy to commit murder” (White, 1998, p. 241). The Synanon was a therapeutic community turned commune in Ocean Park, California. Dederich used abusive confrontation techniques on his followers such as ridiculing, humiliating, and yelling profanity in the individual’s face.

The three previous examples of confrontation are abusive and are not characteristic of caring confrontation. In the three examples, there is missing a respect for the client, gaining trust, looking at timing, consideration of diagnoses, starting where the client is at, and clinical skill and experience which are crucial to caring confrontation as stated earlier in the literature review.

Previous Research in Confrontation

Mainord, Burk, and Collins (N.D.) researched the use of confrontation vs. “diverting” as therapeutic modalities for clients with schizophrenia in an Inpatient treatment center. For their research, they chose 36 male patients with schizophrenia at the Veterans Administration Hospital, American Lake, Washington. The 36 patients were put into three groups of 12 patients. The first group received three months of confrontation therapy followed by three months of diverting therapy. Mainord, Burk, and Collins define diversion therapy as “diverting”

the client from anything personal, anything that might cause strong emotion to something bland-like the weather. For confrontation, if the patient wanted to talk about something personal or emotionally charged they were encouraged to do so. The second group received three months of confrontation therapy, followed by three months of diversion therapy. The third group received no treatment. To analyze the benefits of either treatment, the researchers use the inpatient hospitals Positive Incident Documentation which measured the categories of:

1. Increased privileges, including initial granting of pass from the hospital.
2. Trial visit, home care, maximum hospital benefits.
3. Improved work performance- detail, education, etc.
4. Formulation of plan for future, good or bad; improvement in plan.
5. Self-initiation of hospital-approved activities.
6. Requests for interview with physician, psychologist, etc., implementing decisions, or in general, visible increase in cooperativeness.
7. Better socialization, including spontaneity, sensitivity, directness, all outside the group sessions.
8. Seeks outside employment.
9. Accepts and acts on reasonable suggestions from others in contrast to passive or overt resistance.
10. Improvement in mood (sad to cheerful, hostile to friendly, etc.).
11. Such things as returned sense of humor, increased frustration tolerance, more reality oriented (pgs. 223-224).

The results of this study report 95 positive incidents for the confrontation approach, 35 for the diversion approach, and 24 for the no-therapy approach with a p-value of .02; show that the confrontation approach had the best results.

Arninen and Haloner (2007) conducted research on confrontation in a chemical dependency inpatient center in Finland. Their focus was on how to use laughter and humor in

confrontation. Arninen and Haloner used conversation analysis to decipher the use of laughter in confrontation. Arninen and Haloner looked at three specific areas: “The Therapist Provokes Laughter: The Socratic Method of Laughing Off the Problem” (p. 493), “Mirroring: Pointing Out a Problem the Patient has Not Recognized by Laughing at it” (p. 500), and “Softening the Confrontation Afterwards: Responsive Laughter” (p. 504). For example, Arninen and Haloner describe how they will conduct conversational analysis in the first area of provoking laughter as: “We will first analyze the therapist’s use of the ‘Socratic’ question-answer sequence technique to resolve a complaint or a problem introduced by the patient. The therapist poses strategically designed questions to achieve question-answer pairs that eventually lead to the solution to the trouble that is seen in a humorous or non-serious light. The answer may also function as a remedy for the complaint, but not automatically” (Arninen & Haloner, 2007, p. 493). Arninen and Haloner completed 7.5 hours of conversation analysis with chemically dependent clients and humor in confrontation. In conclusion, Arninen & Haloner found laughter in confrontation effective stating:

...[L]aughter is a crucial part of therapeutic processes and critical for managing confrontations in group therapy. The nature/function of laughter is not unified, but differs depending on the context and type of therapeutic intervention. Laughter can be the goal of intervention... laughter can also be responsive in that the therapist may respond with laughter to a failed confrontation and use it as a way out of an impasse (p. 508).

Just as the Mainord, Burk, and Collins study researches self-determination with clients who have mental illness, shouldn’t chemically dependent clients be given the same respect of talking about and experiencing emotions that they have been “diverted” from showing

or were hiding with use of chemicals? With Arminen & Haloner's research, shouldn't the practitioner know that a confrontation does not have to be restricting but can be done together with laughter and humor? This research will analyze the beneficial role of Caring Confrontation in the treatment of involuntary, chemically dependent clients.

Conceptual Framework

This research uses a conceptual framework of reality therapy. This type of therapy was developed by William Glasser, M.D. Glasser (1965) states "...the denial of some or all of reality is common to all patients. Therapy will be successful when they are able to give up denying the world and recognize that reality not only exists but that they must fulfill their needs within its framework...[t]o do Reality Therapy the therapist must not only be able to help the patient accept the real world, but he must then further help him fulfill his needs in the real world so that he will have no inclination in the future to deny its existence" (pgs. 6-7). Glasser discusses that reality therapy is about helping the client to see where they are responsible for current situations rather than external sources, but he also reports the importance of the client and practitioner identifying needs to move forward with healthy change. In identifying needs, Wubbolding & Brickell (2009) report that reality therapy incorporates concepts from Choice Theory. The critical needs identified are survival, love & belonging, power/self-worth, freedom, and fun & enjoyment. Wubbolding & Brickell (2009) state:

The helper's task is to assist them to get what they want, and to choose behaviors that are truly more effective than those chosen in the past. Finally, some clients, such as those addicted to drugs, do not have an 'out-of-balance scale.' They do not see the need for change. They believe everyone else has a problem. They often think they are getting what they want. The helper's function is, in this case, to help them get their scales out of balance and thus develop more effective behaviors for fulfilling their needs. The helper's job is at times to 'comfort the afflicted' and at other times to 'afflict the comfortable'(p. 10).

In the last sentence of the previous quote, we see the words “afflict the comfortable” this is where caring confrontation comes into play. Caring confrontation is derived from reality therapy and in this practitioner’s experience has been seen as effective in working with involuntary chemically dependent clients but must be done with respect for one another.

An important aspect to remember when using reality therapy is that Glasser looks primarily at how the self causes dysfunction. This is true; however, social workers are aware that dysfunction is caused by both nature and nurture. Yet, reality therapy can be used when nature or environment is seen as the major problem. In this case, the practitioner can work with the client on the reality that, for example, certain people may not apologize, a death happened, a fire occurred, or the body has changed.

This study is focused on the benefits of caring confrontation (derived out of reality therapy) with involuntary, chemically dependent clients that are part of the correctional system and receiving their treatment within a chemical dependency outpatient setting. This research used a primarily quantitative survey to draw on the insights of involuntary, chemically dependent client’s currently in chemical dependency treatment. With this information, this research hopes to educate chemical dependency practitioners in better practices with involuntary chemically dependent clients and to show a brighter, healthier, and healing side of caring confrontation.

Method

To analyze the helpfulness of caring confrontation from the perspective of involuntary, chemically dependent clients, this research used a quantitative design and the Survey of Caring Confrontation in Chemical Dependency (see appendix) developed by the researcher using the conceptual framework of reality therapy.

Measure

The *Survey of Caring Confrontation in Chemical Dependency* has 11 variables pertaining to how helpful caring confrontation is in the treatment of involuntary, chemically dependent individuals. The survey includes demographic information such as how long the client has been in chemical dependency treatment, gender, and age. The *Survey of Caring Confrontation in Chemical Dependency* utilizes likert scales to label the participants' responses. The scales go from 1-5 with one labeled as "Not Helpful" and five labeled as "Very Helpful." To research the participants' perspective of the helpfulness of caring confrontation, the survey asked the questions: How helpful has caring confrontation been in helping you to participate in group activities and interacting with your peers? How helpful is caring confrontation in reducing your possibility of relapse? How helpful is caring confrontation in reducing your possibility of reoffending? How helpful has caring confrontation been in helping you come to terms with the severity of your addiction and how it is negatively affecting your environment? To research the participants' perspective of helpfulness of the type of caring confrontation, the survey asked the questions: how helpful is caring confrontation to your recovery when you receive it from your peers? How helpful is caring confrontation to your recovery when you receive it from your counselors? The survey also asked two questions that require a written response: What do you

find most helpful with caring confrontation? What do you find least helpful with caring confrontation? The purpose for the written response questions is to give the participants the ability to write personal feedback that may not be representative of the likert scales. The researcher also looked for words or phrases in the written questions that would lead to a better understanding of the helpfulness of caring confrontation. These responses were compiled to illustrate any emerging patterns. The survey, itself, is included in the appendix on pg.

Time Frame, Setting, & Protection of Human Participants

After the study was approved by The University of St. Thomas Institutional Review Board (IRB), the survey was used to collect data from December 2011-January 2012. Data was collected at a Midwestern outpatient chemical dependency treatment center with a broad sample where in a sample was taken from a men's chemical dependency group, a women's chemical dependency group, and aftercare treatment groups. However, the sample was based on whomever was willing to volunteer to fill out the survey. Individuals invited for participation in the research were adult, male and female, involuntary, chemically dependent clients that are in outpatient treatment groups that utilize Reality Therapy in the treatment process. It should be noted that this research did not use samples from the researcher's own treatment groups in order to secure anonymity. This research attempted to survey at least 30 participants. Completion of a survey took about 10 minutes. The survey was anonymous and participation in the survey was also voluntary.

Data Collection

Before the individuals filled out the survey, a coversheet/consent form (see appendix) was given to them and explained by their primary counselor. The coversheet/consent form

explained the purpose of the study, that it was anonymous, and how to contact the University of St. Thomas IRB if there were any further questions. The researcher gave directions and trained the counselor of each treatment group on how to complete the survey so that the counselor would be able to distribute the survey rather than the researcher in order for the survey to stay anonymous. The primary counselors for each group distributed the surveys at the beginning of their group sessions. Before the surveys were completed, the counselors explained to the participants what the consent letter/cover sheet means- that completing the survey was voluntary, anonymous, did not impact their treatment at this site, and may stop taking the survey at any time. The primary counselor asked that those who chose to participate in the survey to put their completed surveys in a small, white envelope and then place them into a manila envelope entitled "returned surveys" that was left in the room with the participants as they completed the survey. Participants who wished not to participate in the survey placed their blank surveys in a small, white envelope then into the manila envelope as well. The survey took about 10 minutes to complete and the counselor was not in the group room while the surveys were being completed. The counselor returned 10 minutes later to retrieve the manila envelope and give it to the researcher. The researcher conducted all analysis of the surveys. The counselors were not involved in conducting the analysis. The surveys were kept in a locked cabinet at this site that only the researcher had access to. After completion of the research project and successful presentation of its data in May 2012, the surveys will be shredded. Also, any electronic data will be stored on an USB drive that is only accessible to the researcher. This de-identified data will be kept for future analysis.

Design

Data from the surveys were used to complete a statistical analysis of the helpfulness of caring confrontation and the helpfulness of type of confrontation from the perspective of involuntary chemically dependent clients and amount of time in treatment, gender, and age. This research had two primary goals and asked: 1. What is the perspective of involuntary, chemically dependent clients of the helpfulness of caring confrontation in their treatment? 2. What type of caring confrontation do involuntary, chemically dependent clients find most helpful?

To analyze the involuntary, chemically dependent client vs. helpfulness of the caring confrontation treatment modality in recovery, this research used as its independent variable- question (7) “How long have you been in chemical dependency treatment,” independent variable- question (8) “What is your gender,” and independent variable-question (9) “What is your age” with dependent variable- question (12) “Helpfulness of caring confrontation Scale.” In the *Survey of Caring Confrontation in Chemical Dependency*, question (7) asked for the person filling out the survey to indicate their current length in chemical dependency treatment with the options of: less than a month - two months and three months - aftercare. Question (8) asked the person to identify their gender. Question (9) asked for the person to identify what their age is by writing in their age in the space provided. In the *Survey of Caring Confrontation in Chemical Dependency*, question (12) is the sum of questions 1-4. Question (1) asked how helpful you feel caring confrontation is in helping to participate in group activities and interact with peers from a scale of 1= Not Helpful to 5= Very Helpful. Question (2) asked how helpful you feel caring confrontation is in reducing possibility of relapse with a scale of 1-5. Question (3) asked how helpful you feel caring confrontation is in reducing possibility of reoffending on a scale of 1-5. Question (4) asked how helpful you feel caring confrontation is in helping to come to terms with

the severity of addiction on a scale of 1-5. A frequency distribution was used to illustrate the survey answers for question (7) “How long have you been in chemical dependency treatment.” A frequency distribution was used to illustrate the survey answers for question (8) “What is your gender.” A frequency distribution was also be used to illustrate the survey answers for question (9) “What is your age.” A measure of central tendency in the form of mean, median, mode was used to illustrate the survey answers for question (12) “Helpfulness of caring confrontation Scale.” An independent sample t-test was used to test the hypothesis that there is a difference between length of time in chemical dependency treatment and the perceived helpfulness of caring confrontation. A t-test was used to test the hypothesis that there is a difference between gender and perceived helpfulness of caring confrontation. A t-test was also be used to test the hypothesis that there is a difference between age and perceived helpfulness of caring confrontation.

To analyze the involuntary chemically dependent client vs. helpfulness of type of caring confrontation, this research used question (7) “How long have you been in chemical dependency treatment” with question (13) “Helpfulness of type of caring confrontation.” In the *Survey of Caring Confrontation in Chemical Dependency*, question (13) is the sum of questions 5 & 6. Question (5) asked how helpful caring confrontation is when delivered by a peer from a scale of 1= Not Helpful to 5= Very Helpful. Question (6) asked how helpful caring confrontation is when delivered by a counselor on a scale of 1-5. A measure of central tendency in the form of mean, median, and mode was used to illustrate the survey answers for question (13). A t-test was used to test whether there is a difference between the independent variable of length of time in treatment and the dependent variable of helpfulness of type of caring confrontation. A t-test was used to test the hypothesis that there is a difference between the independent variable of gender

and the dependent variable of helpfulness of type of caring confrontation. A t-test was used to test whether there is a difference between the independent variable of age and the dependent variable of helpfulness of type of caring confrontation.

To analyze the two qualitative questions, the researcher listed the answers for the two written questions side by side to look at the difference of likes and dislikes in responses. The researcher looked for any correlation between scores, demographics and written response. The researcher provided possible explanations for responses and applications for future research.

Strengths and Weaknesses

The strengths of this study consist of using a sample from a Midwestern outpatient chemical dependency treatment center which is one of the oldest human service agencies in Northern Minnesota and uses reality therapy as one of the primary methods of chemical dependency treatment. Also, the majority of the clients being served at this outpatient center are involuntary clients, in the legal system, with various chemical dependency difficulties. Another strength is that the survey is anonymous and voluntary which allows the client to have freedom in answering the questions. The survey was written to be easily understandable and easily completed. A definition of caring confrontation was given at the top of the survey for the participant to reference when answering the questions. A limitation of this study is the goal of having at least 30 participants for the study was not met; however, the survey participants in this study are involuntary, chemically dependent clients and participation in the study is voluntary and anonymous. Therefore, it was unknown how many participants would volunteer to be in the study.

Findings

This research is concerned with the benefits and types of caring confrontation specifically as they pertain to the demographics of amount of time in treatment, gender, and age. In this section, the researcher discusses the findings of the *Survey of Caring Confrontation in Chemical Dependency* in regard to the research question starting with descriptive findings and followed by inferential analyses.

Distribution

Before the survey was distributed, the researcher had a training with the primary counselors in how to distribute, explain, and collect the surveys in a successful and anonymous fashion. The *Survey of Caring Confrontation in Chemical Dependency* was distributed in January 2012 over a two week period. Surveys were distributed to primary chemical dependency groups of adult males and females and to aftercare chemical dependency groups of adult males and females. Respondents were given 10 minutes to complete the survey, seal it in a small, white envelope, and then place it into the large manila envelope labeled “returned surveys.” Altogether, over 40 surveys were given to the primary counselors to distribute. Twenty-five of the surveys came back with writing on them; however, one of the surveys was not used for analysis as the respondent only answered one numerical question. The choice was made to not use the partially completed survey in order to preserve the validity of the statistics.

Demographic Findings

Independent variable #1 in this research is amount of time in chemical dependency treatment, independent variable #2 in this research is gender, and independent variable #3 is age. A total of 24 participants completed the *Survey of Caring Confrontation in Chemical*

Dependency: nine participants reported having been in treatment less than a month to two months, nine participants reported having been in treatment three months to aftercare. Six participants chose not to answer this question. Twelve participants were male, nine participants were female and three participants chose not to answer this question. Eight participants were between the ages of 20 to 36, seven participants were between the ages of 37 to 72, and nine chose not to answer the question. This is illustrated by a frequency distribution (see table 1).

Table 1. Frequency Distribution of Demographics

Demographic	Count	Count	Did not answer	Total
Time in Treatment	Less than a month to two months = 9	Three months to aftercare = 9	6	24
Gender	Male = 12	Female = 9	3	24
Age	Ages 20 to 36 = 8	Ages 37 to 72 = 7	9	24

Central Tendency Analysis

The researcher analyzed question 12 (benefits of caring confrontation scale) which is the sum of questions 1-4. Questions 1-4 ask the participant to rate the benefits of caring confrontation between one and five with one meaning not helpful and five meaning very helpful (with a range of scores between 4 and 20). The researcher also analyzed question 13 (benefits of type of caring confrontation scale) which is the sum of questions 5 & 6. Questions 5 & 6 ask the participant to rate the benefits of type of caring confrontation between one and five with one meaning not helpful and five meaning very helpful (with a range of scores between 1 and 10). To do this statistical analysis, the researcher used two online statistics programs: easycalculation.com and GraphPad Software QuickCalcs (graphpad.com).

Analysis of the entire sample size for benefits of caring confrontation (question 12), regardless of demographics, showed a mean score as 15.08 (with a range of 4 to 20) and a median of 16 with the lowest score of four, a highest score of 20 out of 20 and a mode of 20. These findings show that, regardless of demographics, the sample found caring confrontation as beneficial to their chemical dependency recovery. This is illustrated in table 2 below by several measures of central tendency (see table 2).

Table 2. Benefits of Caring Confrontation With Entire Sample (Question 12).

Results:

Total Numbers:	24
Mean (Average):	15.08
Standard deviation:	4.59

Median: 16

Mode: 20

Ascending Order: 4, 4,10,11,11,12,13,14,14,15,16,16,16,17,17,18,19,19,19,20,20,20,20

An analysis of the entire sample for type of caring confrontation (question 13), regardless of demographics, shows a mean score as 8.04 and a median of 8 with the lowest score of one, highest score of 10 out of 10 and mode of 8 & 10. These findings show that, regardless of demographics, the sample size found caring confrontation from both peers and counselors as beneficial to their chemical dependency recovery. This is illustrated in table 3 below.

Table 3. Importance of Type of Caring Confrontation With Entire Sample (Question 13).

Results:

Total Numbers:	24
Mean (Average):	8.04167
Standard deviation:	2.45798

Median: $8+8/2 = 8$

Mode: 8 & 10

Ascending Order: 1,1,6,7,7,8,8,8,8,8,8,8,8,9,9,9,10,10,10,10,10,10,10

This researcher analyzed the response of females in the survey as it pertains to benefits of caring confrontation (question 12). This analysis shows a mean score for females of 15.56 and a median of 17 with the lowest score of 10, highest score of 19 out of 20 and mode of 17. These findings show that females in this sample size found caring confrontation as beneficial to their chemical dependency recovery. This is illustrated in table 4 below.

Table 4. Female Perceptions of the Benefits of Caring Confrontation (Question 12)

Results:

Total Numbers:	9
Mean (Average):	15.56
Standard deviation:	2.96

Median: 17

Mode: 17

Ascending Order: 10,12,14,16,17,17,17,18,19

An analysis of the responses of females in the survey as it pertains to type of caring confrontation (question 13) was completed. This analysis shows a mean score for females as 8.33 and a median of 8 with the lowest score of 6, highest score of 10 out of 10 and mode of 8. These findings show that females, as a group, in this sample size found caring confrontation from both peers and counselors as beneficial to their chemical dependency recovery. This is illustrated by a central tendency (see table 5).

Table 5. Female Perceptions Regarding Type of Caring Confrontation (Question 13).

Results:

Total Numbers:	9
Mean (Average):	8.33
Standard deviation:	1.32
Median:	8
Mode:	8
Ascending Order:	6,7,8,8,8,9,9,10,10

This researcher analyzed the responses of males in the survey as they pertain to benefits of caring confrontation (question 12). This analysis shows a mean score for male as 15.75 and a median of 17.5 with the lowest score of 4, highest score of 20 out of 20 and mode of 20. These findings show that males, on average, in this sample size found caring confrontation as beneficial to their chemical dependency recovery. This is illustrated by a central tendency (see table 6).

Table 6. Male Perceptions of the Benefits of Caring Confrontation (Question 12).

Results:

Total Numbers:	12
Mean (Average):	15.75
Standard deviation:	5.08
Median:	$16+19/2= 17.5$
Mode:	20
Ascending Order:	4,11,11,13,16,16,19,19,20,20,20,20

This research analyzed the responses of males in the survey as they pertain to type of caring confrontation (question 13). This analysis shows a mean score for male as 8.33 and a median of 8.50 with the lowest score of 1, highest score of 10 out of 10 and mode of 8 & 10. These findings show that males in this sample size found caring confrontation from both peers and counselors as beneficial to their chemical dependency recovery. This is illustrated by a central tendency (see table 7).

Table 7. Male Perceptions of Type of Caring Confrontation (Question 13).

Total Numbers:	12
Mean (Average):	8.33
Standard deviation:	2.49
Median:	$8+9/2= 8.5$
Mode:	8 & 10
Ascending Order:	1,8,8,8,8,8,9,10,10,10,10,10

This researcher analyzed the responses of participants who have been in chemical dependency treatment less than a month to two months as they pertain to benefits of caring confrontation (question 12). This analysis shows a mean score for less than a month to two

months as 18.44 and a median of 19 with the lowest score of 16, highest score of 20 out of 20 and mode of 20. These findings show that participants in treatment for less than a month to two months found caring confrontation as beneficial to their chemical dependency recovery. This is illustrated by a central tendency (see table 8).

Table 8. Less Than a Month to Two Months: Benefits of Caring Confrontation (Question 12).

Results:

Total Numbers:	9
Mean (Average):	18.44
Standard deviation:	1.50
Median:	19
Mode:	20
Ascending Order:	16,17,17,18,19,19,20,20,20

An analysis of the response of participants in treatment less than a month to two months as it pertains to type of caring confrontation (question 13) was completed. This analysis shows a mean score for less than a month to two months as 9.22 and a median 10 with the lowest score of 8, highest score of 10 out of 10 and mode of 10. These findings show that males in this sample size found caring confrontation from both peers and counselors as beneficial chemical dependency recovery. This is illustrated by the measures of central tendency listed below (see table 9).

Table 9. Less than a Month to Two months: Type of Caring Confrontation (Question 13).

Results:

Total Numbers:	9
Mean (Average):	9.22
Standard deviation:	0.97
Median:	10
Mode:	10
Ascending Order:	8,8,8,9,10,10,10,10,10

The researcher analyzed the responses of participants who have been in chemical dependency treatment three months to aftercare as it pertains to benefits of caring confrontation (question 12). This analysis shows a mean score for three months to aftercare 14.56 and a median of 14 with the lowest score of 10, highest score of 20 out of 20 and mode of 11. These findings show that participants in treatment three months to aftercare found caring confrontation as beneficial to their chemical dependency recovery. This is illustrated by a central tendency (see table 10).

Table 10. Three Months to Aftercare: Benefits of Caring Confrontation (Question 12).

Results:

Total Numbers:	9
Mean (Average):	14.56
Standard deviation:	3.64
Median:	14
Mode:	11
Ascending Order:	10,11,11,13,14,16,17,19,20

The researcher analyzed the responses of participants in treatment three months to aftercare as it pertains to type of caring confrontation (question 13). This analysis shows a mean score for

three months to aftercare as 8.44 and a median of 8 with the lowest score of 7, highest score of 10 out of 10 and mode of 8. These findings show that participants that have been in treatment for three months to aftercare found caring confrontation from both peers and counselors as beneficial to their chemical dependency recovery. This is illustrated by a central tendency (see table 11).

Table 11. 3 Months to Aftercare: Type of Caring Confrontation (Question 13).

Results:

Total Numbers:	9
Mean (Average):	8.44
Standard deviation:	1.01
Median:	8
Mode:	8
Ascending Order:	7,8,8,8,8,9,10,10

An analysis of the responses of participants between the ages of 20 to 36 as they pertain to benefits of caring confrontation (question 12) was completed. This analysis shows a mean score for ages 20 to 36 as 16 and a median of 17 with the lowest score of 11, highest score of 20 out of 20 and mode of 17 & 20. These findings show that participants in treatment ages 20 to 36 found caring confrontation as beneficial to their chemical dependency recovery. This is illustrated by a central tendency (see table 12).

Table 12. Ages 20 to 36: Benefits of Caring Confrontation (Question 12).

Results:

Total Numbers:	7
Mean (Average):	16
Standard deviation:	3.46
Median:	17
Mode:	17,20
Ascending Order:	11,13,14,17,17,20,20

The researcher analyzed the responses of participants between the ages of 20 to 36 as they pertain to type of caring confrontation (question 13). This analysis shows a mean score for ages 20 to 36 as 8.88 and a median of 8.5 with the lowest score of 8, highest score of 10 out of 10 and mode of 8. These findings show that participants ages 20 to 36 found caring confrontation from both peers and counselors as beneficial to their chemical dependency recovery. This is illustrated in table 13 below.

Table 13. Ages 20 to 36: Type of Caring Confrontation (Question 13).

Results:

Total Numbers:	8
Mean (Average):	8.88
Standard deviation:	0.99
Median:	$(8+9)/2 = 8.5$
Mode:	8
Ascending Order:	8,8,8,8,9,10,10,10

An analysis of the responses of participants between the ages of 37 to 72 as they pertain to benefits of caring confrontation (question 12) was completed. This analysis shows a mean score for ages 37 to 72 of 17.42 and a median of 19 with the lowest score of 10, highest score of 20 out of 20 and mode of 19 & 20. These findings show that participants in treatment ages 37 to 72 found caring confrontation as beneficial to their chemical dependency recovery. This is illustrated by the measures of central tendency (see table 14).

Table 14. Age 37 to 72: Benefits of Caring Confrontation (Question 12).

Total Numbers:	7
Mean (Average):	17.42
Standard deviation:	3.55
Median:	19
Mode:	19,20
Ascending Order:	10,16,18,19,19,20,20

The researcher analyzed the responses of participants between the ages of 37 to 72 as they pertain to type of caring confrontation (question 13). This analysis shows a mean score for ages 37 to 72 of 9 and a median of 10 with the lowest score of 7, highest score of 10 out of 10 and mode of 10. These findings show that participants ages 37 to 72 found caring confrontation from both peers and counselors as beneficial to their chemical dependency recovery. This is illustrated by a central tendency (see table 15).

Table 15. Age 37 to 72: Type of Caring Confrontation (Question 13).

Results:

Total Numbers:	7
Mean (Average):	9
Standard deviation:	1.29
Median:	10
Mode:	10
Ascending Order:	7,8,8,10,10,10,10

T-test Analysis

This researcher used the independent variable of gender with the dependent variables of both the benefits of caring confrontation and the type of caring confrontation. This researcher used t-tests to analyze these variables. For t-test analysis, the researcher has abbreviated caring confrontation as C.C. and aftercare as A/C.

This researcher used an independent samples t-test to analyze gender and question (12) on the Survey of Caring Confrontation in Chemical Dependency regarding benefits of caring confrontation using a p-value of $\leq .05$. The results show a mean female score for benefits of caring confrontation as 15.56 and a mean male score for benefits of caring confrontation as 15.75. The difference between these two means was not statistically significant.(See table 16). The results show that the benefits of caring confrontation in chemical dependency are experienced by most as high regardless of gender.

Table 16. T-test: Male & Female Reports of Benefits of Caring Confrontation (Question 23)

P value and statistical significance:

The two-tailed P value equals 0.9198

By conventional criteria, this difference is considered to be not statistically significant.

Confidence interval:

The mean of Female Benefits C.C. minus Male Benefits C.C. equals -0.19

95% confidence interval of this difference: From -4.18 to 3.79

Intermediate values used in calculations:

$t = 0.1021$

$df = 19$

standard error of difference = 1.905

Group	Female Benefits C.C.	Male Benefits C.C.
Mean	15.56	15.75
SD	2.96	5.08
SEM	0.99	1.47
N	9	12

A t-test was also used to analyze gender and question (13) on the Survey of Caring Confrontation in Chemical Dependency type of caring confrontation using a p-value $\leq .05$. The results show a mean female score for type of caring confrontation as 8.33 and a mean male score for type of caring confrontation as 8.33 with a p- value of 1.00. These are identical scores and thus are not statistically significantly different. The data show that the perceived benefits of receiving caring confrontation from peers and counselors are high regardless of gender. See table 17.

Table 17. T-test Regarding Male & Female Perceptions Regarding Type of Caring Confrontation (Question 13).

P value and statistical significance:

The two-tailed P value equals 1.00

By conventional criteria, this difference is considered to be not statistically significant.

Confidence interval:

The mean of Female Type C.C. minus Male Type C.C. equals 0.00

95% confidence interval of this difference: From -1.92 to 1.92

Intermediate values used in calculations:

t = 0.01 df = 19

standard error of difference = 0.920

Group	Female Type C.C.	Male Type C.C.
Mean	8.33	8.33
SD	1.32	2.49
SEM	0.44	0.72
n	9	12

This researcher used a t-test to analyze amount of time in treatment and question (12) on the Survey of Caring Confrontation in Chemical Dependency regarding benefits of caring confrontation using a p-value of $\leq .05$. The results showed a mean less than a month to two months score for benefits of caring confrontation of 18.44 and a mean three months to aftercare score for benefits of caring confrontation as 14.56 with a p-value of 0.01. See table 17. This is a statistically significant difference in means. The results show that the benefits of caring confrontation are high for clients in treatment less than a month to two months and clients in treatment three months to aftercare; however, the benefits of caring confrontation in chemical dependency are perceived as even higher for clients that are in treatment from less than one month to two months.

Table 18. T-test for Less than a month to two months vs. 3 months to Aftercare for Benefits of Caring Confrontation (Question 12).

P value and statistical significance:

The two-tailed P value equals 0.01

By conventional criteria, this difference is considered to be statistically significant.

Confidence interval:

The mean of <1 mo.- 2 mo. Benefits C.C minus 3 mo.- A/C- Benefits C.C. equals 3.89

95% confidence interval of this difference: From 1.10 to 6.68

Intermediate values used in calculations:

t = 2.96

df = 16

standard error of difference = 1.32

Group	<1 mo.- 2 mo. Benefits C.C	3 mo.- A/C- Benefits C.C.
Mean	18.44	14.56
SD	1.51	3.64
SEM	0.50	1.21
n	9	9

A t-test was used to analyze amount of time in treatment and question (13) on the *Survey of Caring Confrontation in Chemical Dependency* (regarding type of caring confrontation) using a p-value $\leq .05$. The results show a mean score for those in treatment less than a month to two months score for type of caring confrontation as 9.22 and a mean three months to aftercare score for type of caring confrontation as 8.44 with a p- value of 0.12. This is not a statistically significant difference. The data show that the benefits of receiving caring confrontation from peers and counselors is considered high regardless of amount of time in treatment. See table 19.

Table 19. T-test for Less than a month to 2 months vs. 3 months – Aftercare: Type of Caring Confrontation (Question 13).

P value and statistical significance:

The two-tailed P value equals 0.12

By conventional criteria, this difference is considered to be not statistically significant.

Confidence interval:

The mean of <1-2mo. Type C.C. minus 3mo.-A/C Type C.C. equals 0.79

95% confidence interval of this difference: From -0.21 to 1.77

Intermediate values used in calculations:

t = 1.66

df = 16

standard error of difference = 0.468

Group	<1-2mo. Type C.C.	3mo.-A/C Type C.C.
Mean	9.22	8.44
SD	0.97	1.013
SEM	0.32	0.33
n	9	9

This researcher used a t-test to analyze age and question (13) on the Survey of Caring Confrontation in Chemical Dependency:, type of caring confrontation using a p-value $\leq .05$. The results show a mean ages 20 to 36 score for type of caring confrontation of 8.89 and a mean ages 37 to 72 score for type of caring confrontation as 9.00 with a p- value of 0.84. This is not statistically significant. The data show that the benefits of receiving caring confrontation from peers and counselors is perceived as high regardless of age. See table 20.

Table 20. T-test for age 20-36 vs. Age 37-72: Type of Caring Confrontation (Question 13).

P value and statistical significance:

The two-tailed P value equals 0.84

By conventional criteria, this difference is considered to be not statistically significant.

Confidence interval:

The mean of Age 20-36 Type C.C. minus Age 37-72 Type C.C. equals -0.13

95% confidence interval of this difference: From -1.40 to 1.15

Intermediate values used in calculations:

t = 0.21

df = 13

standard error of difference = 0.59

Group	Age 20-36 Type C.C.	Age 37-72 Type C.C.
Mean	8.88	9.00
SD	0.99	1.29
SEM	0.35	0.49
n	8	7

A t-test to analyze age and question (12) on the Survey of Caring Confrontation in Chemical Dependency regarding benefits of caring confrontation using a p-value of $\leq .05$. The results show a mean ages 20 to 36 score for benefits of caring confrontation as 16.00 and a mean ages 37 to 72 score for benefits of caring confrontation as 17.43 with a p-value of 0.45. See table 21. This is not statistically significant. The results show that the benefits of caring confrontation are high for clients regardless of age.

Table 21. T-test Age 20-36 vs. Age 37-72: Benefits of Caring Confrontation (Question 12).

P value and statistical significance:

The two-tailed P value equals 0.45

By conventional criteria, this difference is considered to be not statistically significant.

Confidence interval:

The mean of Age 20-36 Benefits C.C. minus Age 37-72 Benefits C.C. equals -1.4285700

95% confidence interval of this difference: From -5.35 to 2.49

Intermediate values used in calculations:

t = 0.80

df = 13

standard error of difference = 1.81

Group	Age 20-36 Benefits C.C.	Age 37-72 Benefits C.C.
Mean	16.00	17.43
SD	3.46	3.55
SEM	1.22	1.34
n	8	7

Standard Deviation Analysis

The standard deviation of each demographic was analyzed for question 13 to decipher whether there was a major difference in preference of type of caring confrontation: receiving it from peers or from counselors. The standard deviations were low showing that there was little descriptive difference between the spread in answer choice indicating that regardless of demographic that both caring confrontation from a peer and from a counselor was equally beneficial. The standard deviations and range of answers for question 13 (which is the sum of questions five and six) is illustrated in table 22.

Table 22. Range of Standard Deviations and Answers. (Question 13).

Demographic	Male	Female	Age 20 to 36	Age 37 to 72	1 to 2 months treatment	3 months to aftercare treatment	All demographics combined
Standard Deviation	2.50	1.32	0.99	1.29	0.97	1.01	2.46
Question 5- caring confrontation from peers	1, 1,3, 3, 4, 4,4,4,4,4, 4,4,4,4,5,5,5,5,5,5,5,5, 5,						
Question 6- caring confrontation from counselors	3,3, 3,3,4,4,4,4,4,4,4,5,5,5,5,5,5,5,5,5,5,5						

Qualitative Questions

Two qualitative questions were asked in the *Survey of Caring Confrontation in Chemical Dependency*. The first question was question (10) on the survey “What do you find most helpful with caring confrontation?” The second question was question (11) on the survey “What do you find least helpful with caring confrontation?” Many of the participants chose to not answer the qualitative questions; however, of those who did answer the questions, there were more positive comments towards caring confrontation than negative comments which is also consistent with the above statistical information. Five participant comments were omitted from the analysis. The omitted comments were neither descriptive of what they liked about caring confrontation or disliked about caring confrontation. In table 23 below, the researcher has listed the qualitative participant responses separated by question.

Table 23. Qualitative Questions 10 & 11

<p>What do you like about caring confrontation?</p>	<p>What do you dislike about caring confrontation?</p>
<ul style="list-style-type: none"> • <i>I'm basically with this type of personality and like others to show me the same respect.</i> • <i>The concept that this person does care about you, however sees this negative behavior.</i> • <i>It's good to hear a second opinion.</i> • <i>Helps people (me) look at my life from angles, so I can see just how harmful my using was to me and others.</i> • <i>Feedback from my peers.</i> • <i>Information I learn and receive from other people to help me.</i> • <i>To know you are not alone.</i> • <i>Talking about issues.</i> • <i>I feel it is a better approach that is non-judgmental.</i> • <i>That I'm held accountable, it's nice that people care about me.</i> • <i>Everyone is in the same wrecked boat.</i> • <i>Refresh my mind of past treatment and present.</i> • <i>Let's you free yourself.</i> • <i>Being able to meet new people who share in the same addiction.</i> • <i>It was very helpful on keeping me sober and got me where I am today.</i> • <i>Good insight and good information in my recovery from my counselor and peers. I feel this treatment very good and helpful to me.</i> • <i>Hearing what others see in me that I can't see in myself.</i> • <i>The knowledge of information from counselors.</i> 	<ul style="list-style-type: none"> • <i>If the person making the comments backs the credibility.</i> • <i>This survey is not applicable to this treatment class- there is no therapeutic value here.</i> • <i>When someone truly believes in the things they are or will do in their future and even the people's feedback can't change their mind because they strictly feel that way.</i> • <i>That sometimes it feels people are too much in my business.</i> • <i>Looking back through the lens of an active user.</i> • <i>When it's not caring.</i>

Discussion

Overview

The focus of this research was to explore the benefits of caring confrontation with involuntary, chemically dependent clients. The discussion section will review the research question by relating the statistical data to the literature. The researcher will first discuss the statistics that showed a favorable outcome, however did not show statistical significance when tested with demographic factors and what these findings might suggest for practice. The researcher will then discuss the statistics that showed positive results and showed statistical significance when tested with demographic factors and what these might suggest in terms of implications for practice. Next, the researcher will discuss the results of the qualitative questions and how they reflect on the research question and potential implications for practice. Finally, there will be a discussion of strengths and weaknesses of the research, and recommendations for future research.

Demographics and Statistical Significance

When the female survey responses were compared to the male survey responses and when the responses of participants ages 20 to 36 were compared to the responses of participants ages 37 to 72, the research found the demographics of gender and age to be not statistically significant for benefits of caring confrontation. Moreover, the research found the average score and maximum score to be high (positive) for benefits of caring confrontation and type of caring confrontation regardless of the demographic tested. In relation to the conceptual framework of reality therapy, the flexibility of caring confrontation is also noted by William Glasser (1965)

Reality Therapy is an effective psychiatric treatment different from that generally accepted today. Based on psychiatric theory which also differs greatly from conventional or traditional psychiatry, it is applicable to all people with psychiatric problems...juvenile delinquents, chronic mental hospital patients, private psychiatric patients, and disturbed children in the school classroom...do these widely different behaviors indicate different psychiatric problems requiring a variety of explanations, or are they manifestations of one underlying difficulty? We believe that, regardless of how he expresses his problem, everyone who needs psychiatric treatment suffers from one basic inadequacy; he is unable to fulfill his essential needs...in their unsuccessful effort to fulfill their needs, no matter what behavior they choose, all patients have a common characteristic: they all deny the reality of the world around them (pgs. 3, 5-6).

This research suggests that caring confrontation is a treatment approach that can be used with this population with a positive outcome. For practice implications, this research shows that chemical dependency practitioners should be aware of the significant benefits of caring confrontation with the involuntary chemically dependent population and to read and understand how reality therapy with caring confrontation works. However, in implementing more caring confrontation in the treatment of chemical dependency a practitioner should have training, supervision, and, as the qualitative data suggest, consultation as this treatment modality requires mature clinical skill. It is necessary to have training in delivery of this type of treatment as evidenced by White's (1998) description in the literature review regarding individuals who practiced confrontation without training and supervision and their approach became abusive.

Demographic Significance

This research shows that when comparing the responses of participants in treatment less than a month to two months to the responses of participants who have been treatment from three months to aftercare, the demographic of amount of time in treatment is statistically significant, supporting the benefits of caring confrontation. Although, both categories of amount of time in treatment had high scores for benefits of caring confrontation, the category of less than a month to two months mean score (18.44) was higher than the mean score for the category of three months to aftercare (14.56) with a p-value of .01. This result suggests that participants starting chemical dependency treatment in this setting had the best response to caring confrontation where participants farther along in treatment find caring confrontation beneficial, however, not as beneficial as those starting treatment.

This researcher and practitioner hypothesizes that one explanation for this outcome is due to the enhanced amount of structure that is needed/wanted by chronic chemical dependency clients as they enter treatment; however, as the clients “dry out” or live prolonged periods without drugs and alcohol and their bodies and minds begin to correct themselves biochemically, they require less structure, less reality therapy as they begin to regain control of their lives and at that time the practitioner moves more towards cognitive/behavioral therapy and person centered therapy using caring confrontation when needed but less than at the start of treatment. This result also follows the structure of The 12 Steps of Alcoholics Anonymous. As in Step One, the client reports how they have become powerless and life has become unmanageable because of addiction or how they have lost structure in their lives. The client then works on restoring structure by finding and working with their higher power and making amends internally and externally. What is also very interesting with this result, is that it is in direct

contrast with current accepted practices of working with the chemically dependent population. Current teachings state that one should not confront the client either initially or not at all as this may be detrimental to recovery. Mitchell (2007) has an example of how this result goes against modern teachings:

A significant amount of resistance comes from poor timing. The most common timing mistakes center on introducing new ideas prior to your client being ready to accept those ideas. Anytime you are experiencing resistance ask yourself, am I getting ahead of my client? If you find that you are ahead of your client, slow your pace, back up, and take smaller steps. Explaining before the client is ready to accept, confronting too soon, and moving too quickly to an action phase are all common forms of bad timing (p. 23).

The American Society of Addiction medicine (ASAM) (2010) reports “The neurobiology of addiction encompasses more than the neurochemistry of reward. The frontal cortex of the brain and underlying white matter connections between the frontal cortex and circuits of reward, motivation and memory are fundamental in the manifestations of altered impulse control, altered judgment, and the dysfunctional pursuit of rewards...” (p. 1). With this information, it would also be important for chemical dependency practitioners to consider that addiction affects the areas of judgment in the brain, so it may be very difficult for the chronically addicted client in the beginning stages of treatment to logically understand and work with other types of treatment perspectives other than that of caring confrontation and reality therapy which creates the structure needed.

Qualitative Responses

Referring to page 46 where the qualitative answers are noted, the research shows 18 positive statements regarding caring confrontation and six negative statements regarding caring confrontation. The researcher will take a few examples from the positive comments and from the negative comments to analyze.

On the negative comment side, one of the responses was *When it's not caring*. This is an important response that is a good reminder that the practitioner remembers how they are being perceived by their client. Again, this takes much clinical skill and supervision but it is also crucial to the recovery process. For example, a practitioner's caring confrontation response to one client may be completely misread by another client such as an individual with Borderline Personality Disorder where emotions and boundaries are often distorted. Another comment on the negative side was *If the person making the comments backs the credibility*. This comment is a good reminder of what Sheafor & Horejsi, (2006) report as important aspects of practicing confrontation. They report that a practitioner should not confront a client if they do not intend on helping the client understand the message. What is important to remember in practicing caring confrontation is that the understanding of the message does not necessarily have to come from the practitioner. The caring confrontation itself along with the meaning of it can and should be encouraged to come from peers.

On the positive comment side, one of the responses was *That I'm held accountable, it's nice that people care about me*. This respondent's message is important to practice as it is likely saying- I have not been able to hold myself accountable. I need your structure and when you give me this accountability and structure you are showing me that you care enough about me to

not let me hurt myself any longer. This statement also strengthens Glasser's (1965) comment "...I care enough about you to tell you the hard truth, even if it hurts in the short term" (p. 20). To practitioners, this is a reminder that the practitioner is a helper, not an enabler, and not addressing a major presenting concern to a client sets the stage for future difficulties. Another positive statement was *Let's you free yourself*. This is a short yet telling statement. This researcher and practitioner finds that often times in addiction, the client becomes bogged down with dishonesty and manipulation which becomes tiring as the client can no longer keep straight which lies they said to whom and whether they can continue to keep up the lies. What this respondent may be saying is- I have confronted my dishonesty and manipulation and therefore no longer carry unwanted baggage. This statement is likened to Step Four of Alcoholics Anonymous (2001) which states "Made a searching and fearless moral inventory of ourselves" (p. 57).

Strengths, Weaknesses, & Future Research

A major strength of this study is that the participants invited to be a part of the study were clients of a chemical dependency facility that works directly with involuntary clients where caring confrontation and reality therapy is used on a regular basis. Another strength was that the survey distributors went through a survey distribution training held by the researcher to aid in distributing and explaining the survey as well as answering any questions that may have arose during survey distribution. The counselors that distributed the surveys reported no difficulties in participant understanding which also creates a strength of using the tool to replicate the study. The survey was also created to be easily understandable and easily completed. There is also the strength of adding the qualitative questions at the end of the survey as these questions allowed for the participants to have a voice other than a numerical value and in the end these qualitative

statements helped to support the already positive statistical outcomes. The research had 24 completed surveys returned out of 40+ distributed this is a strength as it shows how the nature of this survey was completely voluntary without coercion. However, the research had hoped for at least a return of 30 surveys to further support the statistical analysis. Although it was a positive having qualitative questions, it was a negative needing to interpret the meaning of some of them. Another negative was having to omit five participant responses in the qualitative section as these respondents' answers were neither specific to what they liked or disliked regarding caring confrontation. To clarify this for respondents, the researcher recommends adding a statement on the qualitative questions that this space is specifically for comments on caring confrontation.

For further research, this researcher would suggest using the same survey tool, with the clarifying comment for qualitative questions, to see if same or similar responses are given and it would be interesting to have the primary counselors/distributors extend a (voluntary) invitation to speak with the researcher regarding responses. This would lead to less hypothesizing of what the qualitative responses meant. Should a participant be willing to be interviewed, the researcher suggests asking the following questions during an interview: Can you tell me what specific caring confrontation technique worked best for you? What do you consider confrontation that is not caring? What was your perception of caring confrontation going into treatment versus how you feel about it today? When was caring confrontation most beneficial? Does caring confrontation help with a need for structure? Was your need for structure different after you had remained clean and sober for a period of time?

Summary

This research explored the bio-psycho-social benefits of caring confrontation with involuntary chemically dependent clients. The research explored and compared different types of chemical dependency treatment modalities with the treatment of involuntary clients. The research used the conceptual framework of reality therapy to illustrate the benefits of caring confrontation. Forty or more surveys were distributed to adult men and women at a chemical dependency treatment facility researching the benefits of caring confrontation. Twenty-five surveys were returned with an overall positive response for caring confrontation as well as positive responses in the demographic areas of age, gender, and amount of time in treatment; however, the statistical analysis shows that for the demographic of amount of time in treatment that those who are in treatment one month to two months have an even greater perception of benefit to caring confrontation than those who have been in treatment three months to aftercare. The results of the research show the importance of incorporating caring confrontation and reality therapy in treating involuntary chemically dependent clients in this setting and potentially in others; however, in doing so, practitioners should receive training and supervision to accurately implement caring confrontation as a treatment modality.

References

- Arminen, I., Halonen, M. (2007). Laughing with and at Patients; The Roles of Laughter in Confrontations in Addiction Group Therapy. *The Qualitative Report*, 12 (3), 484-513.
- American Society of Addiction Medicine. (2010). Public Policy Statement: Definition of Addiction. Retrieved from <http://www.asam.org/for-the-public/definition-of-addiction>.
- Austrian, S. G. (2005). *Mental Disorders, Medications, and Clinical Social Work* (3rd ed.). New York, NY: Columbia University Press.
- Beck, A. T., Wright, F.D., Newman, C. F., Liese, B. S. (1993). *Cognitive Therapy of Substance Abuse*. New York, NY: The Guilford Press.
- Bratter, T. E., Esparat, W., Kaufman, A., & Sinsheimer, L. (2008). Confrontational Psychotherapy: A Compassionate and Potent Therapeutic Orientation for Gifted Adolescents Who are Self-Destructive and Engage in Dangerous Behavior. *International Journal of Reality Therapy*, XXVII (2), 13-25.
- Floerke, S., R. (2010, December, 12). Alcohol: The Often Overlooked Demon Drug. *Duluth News Tribune*.
- Glasser, W. (1990). *Reality Therapy: A New Approach to Psychiatry* (3rd ed.). New York, NY: Harper and Row.
- Kirst-Ashman, K. K., Hill, Jr., G. H. (2006). *Understanding Generalist Practice* (4th ed.). Belmont, CA: Thomson Higher Education.
- Minnesota Association of Resources for Recovery and Chemical Health. (2010). Alcohol Ranked Most Harmful Drug. *One Voice*, November, 13.
- Minnesota Association of Resources for Recovery and Chemical Health. (2011). Minnesota DOH Updates Cost of Alcohol Estimates. *One Voice*, May, 12-14.
- Mainord, W. A., Burk, H. W., & Collins, L. G., (n.d.). Confrontation Versus Diversion in Group Therapy with Chronic Schizophrenics as Measured by a "Positive Incident" Criterion. *Journal of Clinical Psychology*, 222-225.
- McGuire-Bouwman, K. (2006). Caring Confrontation in Experiential Psychotherapy. Retrieved from <http://www.cefocusing.com/pdf/2F2cCaringConfrontationinExperientialTherapy.pdf>
- Mitchell, C. W. (2007). *Effective Techniques for Dealing with Highly Resistant Clients: Innovative Ideas and Approaches to Prevent, Avoid, and Resolve Resistance* (2nd ed.). Johnson City, TN: Clifton Mitchell.

- Osborn, C. (1999). Solution-Focused Strategies with Involuntary Clients: Practical Applications for the School and Clinical Setting. *Journal of Humanistic Education and Development*, 169-181.
- Polcin, D. L. (2003). Rethinking Confrontation in Alcohol and Drug Treatment: Consideration of the Clinical Context. *Marcel Dekker, Inc.*, 38 (2), 165-184.
- Ritchie, M. H. (1986). Counseling the Involuntary Client. *Journal of Counseling and Development*, 64, 516-518.
- Robbins, G., Powers, D., Burgess, S. (2005). *A Wellness Way Of Life* (6th ed.). New York, NY: McGraw Hill.
- Sheafor, B. W., Horejsi, C. R. (2006). *Techniques and Guidelines for Social Work Practice* (7th ed.). Boston, MA: Pearson, Allyn and Bacon.
- White, W. L. (1998). *Slaying The Dragon: The History of Addiction Treatment and Recovery in America*. Normal, IL: Chestnut Health Systems.
- Wilson, B., Smith, B. (2001). *Alcoholics Anonymous* (4th ed.). New York, NY: Alcoholics Anonymous World Services, Inc.
- Wubbolding, R., E. (1999). *Counseling With Reality Therapy*. Bradwell Abbey, UK: Speechmark Publishing Ltd.

Appendix

Survey of Caring Confrontation in Chemical Dependency Treatment Consent Form

You are being invited to participate in a research study about caring confrontation in chemical dependency treatment. This research project is being conducted by Faith Clark LSW, MHP, LADC and student at St. Catherine University/University of St. Thomas in the Master of Social Work Program. The objective of this research project is to better understand caring confrontation and its benefits in the chemical dependency treatment process.

The survey should take about 10 minutes to complete. There are no known risks if you decide to participate in this research study. This survey is anonymous. If you choose to participate, do not write your name on the survey. No one will be able to identify you. Your participation in this survey is entirely voluntary. Your decision whether or not to participate will in no way affect your current or future relations with this treatment center, your chemical dependency treatment, and current or future relations with St. Catherine University/University of St. Thomas. The results of the survey will be used in a statistical analysis of the benefits of caring confrontation in chemical dependency treatment. You may stop taking the survey at any time.

If you choose to participate, please place your completed questionnaire in the small- white envelope, seal it, and then place it in the large manila envelope marked “returned surveys.” If you choose not to participate, please place your blank survey in the small- white envelope, seal it, and then place it in the large envelope marked “returned surveys.” You may keep the consent form for your own reference.

If you have any questions regarding this survey, you may contact me at 218-740-3763 or by e-mail at fclark@duluthbethel.org, my chairperson Dr. David Roseborough at 651-962-5804 or by e-mail at djroseboroug@stthoma.edu, or the University of St. Thomas Institutional Review Board at (651) 962-5341 with any questions or concerns.

Completion and submission of a survey implies your consent to be in this study. Completed surveys will be kept in a locked cabinet that only the researcher has access to. The surveys will be destroyed in May 2012 after data analysis and presentation of analysis has been successfully completed. Digital, de-identified, spread sheet data from surveys will be kept on a secure USB device.

*Please place your completed or incomplete surveys in the small- white envelope, seal it, and place it in the large manila envelope labeled “returned surveys” that your counselor has placed in the room.

Thank you for your participation.

Faith M. Clark LSW, MHP, LADC

Principal Investigator

Survey of Caring Confrontation in Chemical Dependency

Please do not write your name on this survey; it is anonymous

Caring Confrontation is defined as: a method for presenting clients with ways of looking at themselves of which they may not yet be aware, without losing respect for each other.

McGuire-Bouwman (2006)

Please circle the number that best fits your answer to each question:

1. How helpful has caring confrontation been in helping you to participate in group activities and to interact with your peers?

Not Helpful Very Helpful
1 2 3 4 5

2. How helpful is caring confrontation in reducing your possibility of relapse?

Not Helpful Very Helpful
1 2 3 4 5

3. How helpful is caring confrontation in reducing your possibility of reoffending? (Such as: Driving While Intoxicated, burglary, selling drugs, or dishonesty).

Not Helpful Very Helpful
1 2 3 4 5

4. How helpful has caring confrontation been in helping you come to terms with the severity of your addiction and how it is negatively affecting your environment?

Not Helpful Very Helpful
1 2 3 4 5

(Over)

5. How helpful is caring confrontation to your recovery when you receive it from your peers?

Not Helpful

Very Helpful

1

2

3

4

5

6. How helpful is caring confrontation to your recovery when you receive it from your counselors?

Not Helpful

Very Helpful

1

2

3

4

5

Please circle the response that best defines you:

7. How long have you been in chemical dependency treatment?

Less than a month – 2 months

3 months - Aftercare

8. What is your gender?

Male

Female

9. What is your age?

10. What do you find most helpful with caring confrontation? (See definition for caring confrontation on other side of survey)

11. What do you find least helpful with caring confrontation? (See definition for caring confrontation on other side of survey)

Survey of Caring Confrontation in Chemical Dependency (Coded)

Please do not write your name on this survey it is anonymous

Caring Confrontation is defined as: a method for presenting clients with ways of looking at themselves of which they may not yet be aware, without losing respect for each other.

McGuire-Bouwman (2006)

Please circle the number that best fits your answer to each question:

1. How helpful has caring confrontation been in helping you to participate in group activities and to interact with your peers?

Not Helpful Very Helpful
1 2 3 4 5

2. How helpful is caring confrontation in reducing your possibility of relapse?

Not Helpful Very Helpful
1 2 3 4 5

3. How helpful is caring confrontation in reducing your possibility of reoffending? (Such as: Driving While Intoxicated, burglary, selling drugs, or dishonesty).

Not Helpful Very Helpful
1 2 3 4 5

4. How helpful has caring confrontation been in helping you come to terms with the severity of your addiction and how it is negatively affecting your environment?

Not Helpful Very Helpful
1 2 3 4 5

(Over)

5. How helpful is caring confrontation to your recovery when you receive it from your peers?

Not Helpful

Very Helpful

1

2

3

4

5

6. How helpful is caring confrontation to your recovery when you receive it from your counselors?

Not Helpful

Very Helpful

1

2

3

4

5

Please circle the response that best defines you:

7. How long have you been in chemical dependency treatment?

Less than a month – 2 months (1)

3 months - Aftercare (2)

8. What is your gender?

Male (1)

Female (2)

9. What is your age? (1) (2)

10. What do you find most helpful with caring confrontation?

11. What do you find least helpful with caring confrontation?

12. *Helpfulness of Caring Confrontation Scale, the sum of items 1-4.*

13. *Helpfulness of type of Caring Confrontation, the sum of items 5&6.*

Institutional Review Board Approval Letter

DATE: January 11, 2012

TO: Faith Clark

FROM: University of St. Thomas Institutional Review Board

PROJECT TITLE: [284751-1] Caring Confrontation with Involuntary Chemically Dependent Clients

REFERENCE #:

SUBMISSION TYPE: New Project

ACTION: APPROVED

APPROVAL DATE: January 3, 2012

EXPIRATION DATE: December 6, 2012

REVIEW TYPE: Expedited Review

REVIEW CATEGORY: Expedited review category # *[enter category, or delete line]*

Thank you for your submission of New Project materials for this project. The University of St. Thomas Institutional Review Board has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on applicable federal regulations. Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document. Please note that any revision to previously approved materials must be approved by this committee prior to initiation. Please use the appropriate revision forms for this procedure. All UNANTICIPATED PROBLEMS involving risks to subjects or others (UPIRSOs) and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. Please use the appropriate reporting forms for this procedure. All FDA and sponsor reporting requirements should also be followed. All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office. This project has been determined to be a Minimal Risk project. Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of December 6, 2012. Please note that all research records must be retained for a minimum of three

years after the completion of the project. If you have any questions, please contact at 651-962-5341 or e9roulis@stthomas.edu. Please include your project title and reference number in all correspondence with this committee.

Best wishes as you begin your research. Thank you for all of your modifications.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within University of St. Thomas Institutional Review Board's records.