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Therapist Directiveness and Client Reactance in the Administration of Homework in Therapy: An Analog Study

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THERAPIST DIRECTIVENESS AND CLIENT REACTANCE IN THE ADMINISTRATION OF HOMEWORK IN THERAPY: AN ANALOG STUDY

By

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Abstract

This study examined the relationship between client reactance and therapist directiveness in the administration of homework in therapy. Research has shown significant matching effects for client reactance and therapist directiveness on treatment outcome (Beutler, et al., 2011) however, this relationship has not been explored in the field of homework in therapy, an important factor to treatment outcome (Kazantzis, Deane, and Ronan, 2000). The present study used an analog design with three vignettes portraying homework administrations at three levels of therapist directiveness (Low, Medium, and High) and the Therapeutic Reactance Scale to measure participant reactance. Participants read the vignettes and following each vignette, responded to four different measures: Homework Completion Scale (HCS), Counseling Continuation Scale (CCS), Counselor Rating Form-Short (CRF-S) Attractiveness subscale, and CRF-S Expertness subscale.

Three multivariate analysis of variance (MANOVA) were conducted, one for each vignette. Results showed significant differences between low and high reactant groups on the HCS and CCS for the High and Medium directiveness homework administrations. No significant differences were found for the low directiveness vignette, or the CRF-S Attractiveness and Expertness subscales for any vignette. These results suggest that therapist directiveness does interact with client reactance in the administration of homework.
Chapter 1
Introduction

This chapter focuses on research in client reactance, therapist directiveness, and homework in therapy. First, the concept of reactance is explained and defined for the purpose of the present study. Next, measures of reactance are described and the reasoning for the selection of the Therapeutic Reactance Scale for this study is presented. Literature pertaining to the construct of therapist directiveness, related measures, and empirical research is also summarized. The use of homework and its contribution to the effectiveness of therapy is then explored and related to the present study’s hypothesis. Finally, literature relevant to the interaction between therapist directiveness and client reactance is examined concluding with the hypothesis for the present study.

Client Reactance in Therapy

Outcome in therapy has long been noted to be moderated by a variety of variables. Both client and therapist contribute unique individual differences to the therapeutic process that have measurable effects on the success or failure of therapy. Psychological reactance, originally defined by Brehm (1966) as an oppositional state aroused by a perceived threat to one’s personal freedom, is widely recognized as a factor to have strong implications to therapy outcome. This definition however has ignited a debate on whether client reactance is a state or a stable trait, which is discussed below.

Client Reactance as a State

Shoham, Trost, and Rohrbaugh (2004) examined research on the construct of reactance as a state or trait and suggested that, although reactance does correlate with personality variables
(Dowd, Wallbrown, Sanders, & Yesenosky, 1994) it does not display stable trait attributes. Shoham-Salomon, Avner, & Neeman (1989), produced one of the few empirical studies in which reactance was considered only as a state. In their study, reactance was aroused in the clients before the administration of self-controlled interventions or paradoxical interventions, in which change is instigated by discouraging it. Clients high in state reactance responded more positively to the paradoxical interventions. However, more recently researchers began attempting to link reactance to personality variables and define it as a client trait.

**Client Reactance as a Trait**

The majority of research has focused on client reactance as a trait. This approach has utility in that clients can be labeled as “reactant” and self-report measures can be administered to gage a client’s reactance level (Shoham, et al., 2004). Reactance has been linked to a variety of personality variables. The Therapeutic Reactance Scale (TRS), developed by Dowd, Milne, and Wise (1991), is self-report measure of client reactance based on a trait conceptualization. The TRS, when correlated with the California Psychological Inventory shows significant positive correlations to personality variables such as dominance, achievement via independence, and independence (Dowd, Wallbrown, Sanders, & Yesenosky, 1994). The authors also report significant negative correlations with personality variables good impression, tolerance, and psychological mindedness. The TRS has also shown a strong correlation with subscales of the Personality Research Form (PRF) (Dowd & Wallbrown, 1993).

**State-Trait Construct**

Recent research and opinion has lead researchers to settle on a state-trait definition of reactance (Beutler, Harwood, Michelson, Song, & Holman, 2011). Measures such as the
Therapeutic Reactance Scale and subscales of the Minnesota Multiphasic Personality Inventory 2, used to measure reactance, approach it as a trait-like feature that is aroused through environmental states occurring in therapy sessions. Beutler et al. (2011) distinguished reactance from resistance by defining reactance as considering the environment rather than only the intrinsic properties of the client. Further, reactance is the state-like act of a person possessing a resistant trait. The present study will use the state-trait conceptualization of client reactance.

Client Reactance and Multiculturalism

Psychological reactance occurs when events in the therapeutic environment induce resistance in the client to therapy and intervention. Reactance has been shown to appear on some level across all cultures, ages, ethnicities, and genders (Woller, Buboltz, & Loveland, 2007). Results from this study, which included a sample of university students, indicated that participants identifying themselves as African American, Asian, or Native American scored higher on both the verbal and behavioral scales on the TRS than did Caucasians. The authors of this study suggested that there is indication that younger and older participants scored higher than middle-aged participants in both subscales. However, further research should be conducted on the relationship between age and reactance.

Measures of Client Reactance

A variety of instruments have been developed to measure clients’ reactance in order to predict clients’ behavior in therapy and thus improve the likelihood of positive therapy outcomes. Beutler and colleagues (1991) have developed a combination of subscales of the Minnesota Multiphasic Personality Inventory 2 (MMPI-2) called Resistance Potential (RP) by combining items relating to dominance, control, and defensiveness to create a measure of
Client Reactance in Homework

resistance potential. This measure, however, used face validity in selecting items and only used an internal sample for confirming its constructs which the authors recognized as a weak procedure.

Perhaps the most well-known and widely used measure of reactance is the Therapeutic Reactance Scale (TRS) developed by Dowd, Milne, and Wise (1991). The TRS is a 28 item self-report measure composed of verbal and behavioral subscales. The TRS has shown moderate construct, convergent and divergent validity and is perhaps the best measure of reactance currently available. Validity studies consistently show that clients scoring high in reactance achieve more negative outcomes in therapy than do clients low in reactance (Dowd, Milne, & Wise, 1991). Baker, Sullivan, and Marszalek (2003) compared both the TRS and RP finding that the two measures show a weak correlation even though they are supposed to measure the same construct. However, the TRS displayed more internal consistency and stronger relationship to measuring the construct of reactance than the RP.

**Therapist Directiveness**

Outside of client factors in therapy, therapists also play a significant role in the direction and effectiveness of therapy. Therapist directiveness has been characterized as the therapist leading the client and controlling the therapy agenda (Karno & Longbaugh, 2005a). Beutler et al. (2011) define therapist directiveness as “the degree to which the therapist is the primary agent of therapeutic process or change through the selection of specific techniques and/or the adoption of a specific interpersonal demeanor” (p. 135).

*Measures of Therapist Directiveness*
Most recent research in therapist directiveness in therapy has utilized theoretical orientation as an approximate measure of therapist directiveness. A variety of studies (Karno & Longabaugh, 2005b; Beutler et al., 1991; Karno, Beutler, & Harwood, 2002) have used Cognitive Behavioral Therapy (CBT) as a measure of high directiveness due to the typically high activity level of the therapist in assigning homework, directing cognitive restructuring, and leading the client. In contrast, measures of low directiveness in these studies consisted of theories such as Focused Expressive Therapy (Beutler, Engle et al., 1991), Family Systems Therapy (Karno, Beutler, & Harwood, 2002), and Motivational Interviewing (Karno & Longabaugh, 2005b). These theories differ from CBT and are consistent with nondirectiveness due to less involvement of the therapist in areas such as, intervention structure and therapy direction.

**Client Reactance and Therapist Directiveness in Therapy**

If client reactance occurs in response to a perceived threat to one’s personal freedoms and therapist directiveness, if a therapist is leading the client and controlling the therapy agenda, one can easily predict that these two variables will adversely affect one another. Research has shown this to be the exact case. Beutler et al. (2011) provide a meta-analysis examining the interaction between client reactance and therapist directiveness. Although the studies varied in methods of measuring reactance and directiveness, the study provided strong evidence to support the hypothesis that reactant clients respond poorly to directive therapies.

In the literature reviewed for this study, no research examining the interaction of client reactance and therapist directiveness used the TRS as a measure of reactance. More variable is the method of measuring therapist directiveness. Beutler et al. (2011) acknowledge that this inconsistency in methodology has a limiting effect on effect size found in the meta-analysis.
Homework in Therapy

Homework in therapy provides a way for the client to engage in a therapeutic activity outside of the therapy session. It also provides content for the therapist and client to collaboratively examine and discuss during sessions. In CBT, homework plays a vital role. In fact, Kazantzis and Daniel (2008) assert that effective CBT cannot occur without homework. Burns and Spangler (2000) studied homework compliance and therapy outcome in participants seeking treatment for depression. They found that compliance to homework activities played a strong role in positive therapy outcomes with patients who complied with homework improving significantly greater in depression than those who did not comply.

In another study, Kazantzis et al. (2008) studied compliance to homework and cognitive restructuring in depressed outpatients. Compliance to homework and cognitive restructuring accounted for a positive correlation between homework compliance and reduced symptomology. Kazantzis, Deane, and Ronan (2000), in an authoritative meta-analysis of 27 studies (mostly CBT), confirmed that homework indeed plays a vital role in the outcome of therapy.

Conclusion and Statement of Purpose

As previously stated, homework plays a vital and necessary role in cognitive behavioral therapy. Even though we know that high client reactance does not produce positive therapeutic results when matched with high therapist directiveness in treatment in general (and the opposite), this hypothesis has not been tested in the specific area of homework administration. Since cognitive behavioral therapy and its administration of homework require a certain level of directiveness on the part of the therapist, which may evoke reactance in a client, one may then wonder if this could possibly undermine the process and outcome of therapy. This study aims to
answer the question of whether there are differences between low and high reactant participants in homework compliance, continuation in counseling, and view of the counselor when provided different levels of directiveness in the administration of homework.

**Hypotheses**

Based on the literature discussed above, it is evident that clients range in their level of reactance and that this attribute can have implications for outcome and compliance in therapy. Based on previous findings from the field of client-therapist matching research in terms of directiveness and reactance, it is hypothesized that similar effects will be observed as it concerns the use of homework in therapy. Specifically:

1. Clients higher in reactance, compared to those lower in reactance, will be more likely to comply with homework in therapy, continue with therapy, and view their counselor more positively when paired with a less directive counselor.

2. Clients lower in reactance, compared to those higher in reactance, will be more likely to comply with homework in therapy, continue with therapy, and view their counselor more positively when paired with a more directive counselor.
Chapter 2

Review of the Literature

This chapter offers a critical review of literature related to eclecticism and matching client variables to treatments in order to improve therapy outcome. Reactance, a client variable, and its effect on therapy outcome are then reviewed as well as measures used in measuring reactance. Similarly, the concept of therapist directiveness and methods of measuring therapist directiveness are reviewed. Studies focused on the relationship between therapist directiveness and client reactance are examined. Finally, homework in psychotherapy and its effect on therapy outcomes is examined, along with possible relations to therapist directiveness and client reactance.

Eclecticism in Psychotherapy

Therapeutic eclecticism is a concept which dates back to the 1930’s. Especially since the 1990s psychotherapy has progressed beyond rigid theoretical structures and more towards integration. With the emphasis currently on evidence-based practice, therapists acknowledge the need to look beyond their preferred theoretical framework and adopt a variety of perspectives and interventions that elicit the greatest change for their clients.

Psychotherapy integration is most commonly achieved four different ways (Norcross, 1990). First, integration can be reached through theoretical integration. Theoretical integration involves synthesizing two or more theoretical structures to maximize the empirical benefits of all theories involved. Users of this form of integration adhere to the conceptual foundations of the theories being used, not only the technical methods. Secondly, technical eclecticism, which incorporates selecting the best treatments for the client’s specific needs, can be used without
subscribing to the theoretical foundations from which the techniques are derived. Therapists working from a technical eclectic perspective do not describe themselves as atheoretical, but instead they borrow techniques that may be most useful based on their clients’ unique situation. Thirdly, a common factors approach can be taken to join together a variety of theories based on congruous factors shared. The fourth route of psychotherapy integration is assimilative integration. Therapists working from this perspective have a firm foundation in a single particular theory but select certain concepts and practices from other perspectives.

For the purpose of this study the focus will be on technical eclecticism and how therapists can more accurately match clients to the most effective interventions or techniques.

**Systematic Treatment Selection**

Systematic Treatment Selection (STS), developed by Beutler and colleagues (1990), is an empirical approach to matching client variables to treatments that would presumably provide optimal opportunities for positive outcomes. From its early stages of development, STS has had a strong foundation in empirical research. Beutler (1979) first began the procedure of developing an empirically founded integration process by examining literature related to comparing therapy outcomes of different theoretical modalities. Through this process, six variables were found to have significant effects on that outcome of therapy. These six variables are problem complexity, chronicity, level of functional impairment, coping style, resistance level, and distress.

STS directly addresses prior empirical design problems with previous literature (Norcross, 1995) by proposing that clients are assessed preceding treatment and then assigned, according to their individual factors, to treatments that have been shown to be most effective. STS assumes the technical eclectic approach by using treatments without the need to assume the
entire theoretical framework from which it is drawn. Norcross (1995) states that research conducted from the STS or aptitude treatment interaction (ATI) perspective demonstrates significant interaction effects between client variables and specific treatments and therapist styles.

Beutler (1979) identified four therapeutic attributes that interact with themselves: coping style, reactance/resistance potential, insight vs. behavior change objectives, and high vs. low therapist authoritative/directiveness. The former two are client dimensions while the latter two are procedural characteristics of therapy. These four characteristics would eventually, after further research and examination, comprise the foundation of STS.

The STS approach to treatment acknowledges the previously stated question posed by Gordon Paul (1967) in which he declared that prescriptive therapy focuses on “What treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances?” (p. 111). This could be said to be the aim of eclecticism as well as the focus of the present study.

**Research using the STS approach**

Due to the fact that STS’s dimensions were developed after several extensive literature reviews (Beutler, 1979; Beutler & Consoli, 1993; Beutler & Clarkin, 1990), it already possesses empirical support. Since its development and subsequent revision due to new research, the STS approach has been used as a foundation of research focused on examining treatment matching to client attributes.

For example, Karno, Beutler, and Harwood (2002) examined the interactions of therapeutic procedures and client attributes using the STS approach. Their study contained 47
adult subjects meeting DSM-IV criteria for alcohol dependency. Subjects were split into two therapy groups for outpatient treatment. The first group contained 19 subjects and received manualized Cognitive Behavioral Treatment (CBT). The second group contained 28 subjects that received manualized Family Systems Therapy (FST).

Two subject attributes were found to be significant predictors of drinking behavior after treatment. Once baseline drinking and treatment modality effects were accounted for, the first subject attribute was emotional distress and therapist focus on affect which accounted for 14.8% of the variance. The second significant interaction between subject attributes and therapeutic process was psychological reactance and therapist directiveness. We will return to discuss these two variables in greater depth later as they are the topic of the present study. When treatment modality and baseline drinking were taken into account it was found that 7.9% of the variance was attributed to this interaction. In subjects high in reactance, higher therapist directiveness was associated with more drinking.

The STS approach and research using STS provide substantial evidence that client reactance and therapist directiveness interact to create a moderating effect on positive therapy outcomes. Other studies have adopted similar approaches to examine if different therapies elicit different outcomes. One major study to assume this approach is Project MATCH.

**Project MATCH**

Project MATCH (Project MATCH Research Group, 1997), a research project conducted at five clinical sites across the United States, aimed to identify client variables that could assist in the assignment of clients to different treatments for clients seeking therapy for alcoholism. In total, 952 outpatients participated in the study.
The three treatment groups for this study were: Cognitive-Behavioral Therapy (CBT), Twelve-Step Facilitation (TSF) therapy, and Motivational Enhancement Therapy (MET). All were delivered on an individual therapy basis. At follow-up, subjects were given a battery of tests to measure such factors as Alcoholics Anonymous (AA) attendance, psychosocial functioning, consequences of drinking, etc. Drinking was measured using only two independent variables: Percentage of Days Abstinent (PDA) and Drinks per Drinking Day (DDD).

Results revealed that no particular treatment displayed superior outcome results over another across all client variables. Subjects whose social network was more supportive of drinking and received TSF treatment had higher PDA and lower DDD than subjects receiving CBT or MET. Client anger also proved to be a moderating variable depending on treatment type. Clients high in anger produced better outcomes when receiving MET treatment than TSF and CBT treatments pooled together. The authors attributed part of MET success with clients high in anger to its nondirective approach to therapy. Both TSF and CBT tend to require more directiveness on the part of the therapist which can elicit reactance in the client, an attribute closely related to anger (Karno & Longabaugh, 2004).

These results suggest that client attributes can have a moderating influence on the effectiveness of various treatments. That is, attributes that the clients possess and carry with them into the therapeutic setting affect outcomes in therapy. Further, when matched to treatment types more conducive to individual attributes, better outcomes can be achieved. For the purpose of the present study, a major client attribute identified in STS, client reactance and resistance in therapy, is discussed next.

**Client Reactance in Therapy**

In the aforementioned literature, one can see that client resistance, or reactance, plays a
central role in the moderating of treatment effectiveness. Clients that are higher in reactance are more likely to drop out of therapy or achieve worse results (Beutler, Clarkin, & Bongar, 2000). Reactance has some of its original foundations in the psychoanalytic explanation of resistance. Clients were said to use defense mechanisms in order to protect their Ego or unconscious. Psychoanalysts believe that the resistance to therapy is an indication of the unconscious avoidance or ego defense (Arnow et al., 2003). For example, if a client where to arrive late to an appointment, one could interpret it as an avoidance or resistance to the therapeutic process. Brehm (1966) originally defined reactance as an oppositional state aroused in therapy in response to a perceived threat to one’s personal freedom. Brehm considered the client level of reactance to have an enormous role in the effectiveness of treatment. Much debate has persisted about its true nature ever since Brehm’s inception of reactance as a defined construct. 

*Reactance as a State*

Reactance in its original conceptualization as a state holds some theoretical value. For one, it describes the variable nature of reactance. A client displaying reactance in therapy is not always reactant in all situations. Also, a client who becomes reactant in therapy may be reacting to events that occurred in the session. In other words, events in the session may provoke a person with a resistant personality trait to become reactant. Thus, the state conceptualization describes the variable nature of reactance.

Because of the advantages of the trait conceptualization of reactance, which will be discussed later, little research has been conducted on reactance as a state. One of the few studies using reactance as a state, conducted by Shoham-Salomon, Avner, and Neeman (1989), used 45 university student participants who attended treatment for procrastination. Subjects were screened for level of procrastination and divided into two treatment groups: paradoxical
interventions and self-control interventions. Paradoxical interventions are treatments prescribed to the client to engage in the exact actions or symptoms of their problem. It is theoretically perceived that if engaging in the symptoms does not change the behavior then attribution of the therapist prescribing the symptom will change the client’s perception into a controlled event.

Reactance for this study was measured by graduate students ratings of fluctuations in the client’s voice pattern. The authors reason that voice inflection is one of the most difficult behaviors for people to monitor. Their reasoning followed that when someone becomes reactant during treatment their voice inflection will change and produce their genuine feelings about the corresponding intervention. Interjudge effective reliability was correlated at .77 when measuring how spiteful, uninhibited, and active their vocal tone was.

Results did show that participants high in nonverbal reactance did increase their effective study time when paired with paradoxical, rather than self-control, treatments. This would indicate that reactance level plays a substantial part in the effectiveness of paradoxical interventions.

This study is unique in its attempt to measure reactance as a state. However, its ability to accurately measure spontaneous client reactance falls short and should be questioned. Using tone of voice to measure reactance is not a common or objective measure. Although interrater reliability showed moderate to strong correlation, one could question whether the attributes of vocal tone used actually comprise reactance. This study did occur before other measures of reactance, such as the Therapeutic Reactance Scale (TRS) and the Resistance Potential scale, which measure trait aspects of reactance in a self-report format, were developed. Had these measures existed, the authors could have provided the subjects with such measures in conjunction with the observer rated state reactance and conclude a level of validity attributed to
the vocal intonation measure.

*Reactance as a Trait*

Originally conceptualized as a motivational state, reactance quickly developed into a trait like feature (Shoham, Trost, & Rohrbaugh, 2004; Woller, Buboltz, & Loveland, 2007). Therapists began to speak of reactant clients instead of stating that the client was engaged in reactant behavior. This conceptualization quickly found utility because it allowed therapists to label a client as reactant and could then address the client and their problems appropriately (Shoham, Trost, Rohrbaugh, 2004). It also permitted therapists the opportunity to measure reactance with enough reliability to establish valid measures. It is often difficult to measure spontaneous occurrences in therapy, which as mentioned earlier, was a weakness in previous studies (Shoham-Salmon, Avner, & Neeman, 1989). With reactance viewed as a trait, therapists could test clients in advance and prepare appropriately for treatment sessions or on occasion, refer to other services.

In the attempt to establish reactance as a trait, several efforts have been committed to correlating reactance with personality variables. One such study (Dowd, Wallbrown, Sanders, & Yesenosky, 1994) administered the California Psychological Inventory (CPI), Frageborgen sur Messung der psychologischen Reactanz (Questionnaire for the Measurement of Psychological Reactance[QMPR]), and Therapeutic Reactance Scale (TRS) to a sample of 326 undergraduate and graduate students. The CPI consists of 20 “folk scales” which are designed to measure personality in descriptions used by lay people. The TRS is a 28 item self-report measure with verbal (TRS:V) and behavioral (TRS:B) subscales that comprise a total reactance score (TRS:T). The QMPR, which has been adapted into English from the original German, is an 18 item self-report measure that provides a total reactance score.
Results from this study showed that 29% of the variance in the TRS:T is accounted for by the scales on the CPI. When the TRS scores were compared to scores on the QMPR a moderate correlation of .53 was found. Four of the CPI folk scales were found to have significant beta weights in relation to the TRS. These scales were: Good Impression, Tolerance, Independence, and Dominance. Subjects scoring higher in reactance on the TRS were less concerned about making good impressions, were less tolerant, more independent, and more dominant than those scoring low in reactance. This indicates that reactance, as measured by the TRS, demonstrates trait-like qualities evidenced by the significant amount of variance accounted for by all of the CPI scales. In addition, the four CPI scales that demonstrated significant beta weights are closely related to the original constructs of reactance on the TRS (Dowd, Wallbrown, Sanders, & Yesenosky, 1994).

Reactance has also been examined across age, ethnicity, and gender variables. Woller, Buboltz, & Loveland (2007) administered the TRS to a sample of 3,499 undergraduate students and gathered demographic information on each participant. Notable findings from this examination included racial differences with African Americans scoring significantly higher in reactance than Caucasians and Native Americans. Hispanic/Latinos also scored significantly higher than Caucasians but lower than African Americans, although not significantly lower. The authors of this study also concluded that most studies consider reactance as a stable trait.

Gender differences were also evident on the TRS:T, TRS:V, and TRS:B scales with males scoring significantly higher than women on all scales. Furthermore, age also displayed significant differences with younger adults scoring significantly higher on TRS:T and TRS:B than middle-aged and older adults. Evidence involving differences in reactance based on stable traits such as age, gender, and ethnicity further provide evidence of trait-like qualities of
Client Reactance in Homework

reactance, especially reactance measured by the TRS. These findings are also important when answering the aforementioned question of “which treatment for which client”. Cultural differences are to be expected when working with a diverse range of clients. These results can offer important information for practicing therapists. Evidence for trait qualities of reactance is evident but still do not fully explain the complete nature of reactance.

State-Trait Construct

More recently research and opinion has suggested that reactance contains both state and trait like qualities (Beutler, Harwood, Michelson, Song, & Holman, 2011). Beutler et al. (2011) makes this distinction by pointing out that reactance is the state like act of a person possessing a resistant trait. The authors posit that their preference of the term reactance stems from the term’s implication that the psychotherapy environment plays a role in inducing noncompliance. This definition can then help explain why some variance in measuring reactance is attributed to personality variables (Dowd, Wallbrown, Sanders, & Yesenosky, 1994) and trait variables such as age, gender, and ethnicity (Woller, Buboltz, & Loveland, 2007) while recognizing that events in therapy arouse these traits and produce client reactance (Shoham-Salomon, Avner, and Neeman, 1989; Shoham, Trost, & Rohrbaugh, 2004).

Measures of Reactance

Therapeutic Reactance Scale

Although long recognized as a significant client variable contributing to therapy outcome, reactance lacked a reliable and valid measure. Perhaps the first reliable and valid self-report measure of reactance was the Therapeutic Reactance Scale (TRS). This self-report measure is a 28 item Likert scale ranging from “strongly agree” to “strongly disagree”, that provides a total
reactance score (TRS:T), verbal reactance score (TRS:V), and behavioral reactance score (TRS:B). The TRS is viewed as the most widely used measure of psychological reactance (Buboltz, Thomas, & Donnell, 2002). The theoretical basis for the TRS is in the psychodynamic approach to reactance.

Psychometric examinations of the TRS have shown that the TRS possesses moderate test-retest reliability. Test retest reliability is reported to be .59 (TRS:T), .60 (TRS:B), and .57 (TRS:V). Internal consistency has been reported as .84 (TRS:T), .81 (TRS:B), and .75 (TRS:V). Convergent validity was established by correlating scores from the TRS with the K scale of the Minnesota Multiphasic Personality Inventory (MMPI) as well as the Rotter Internal external Locus of Control Scale. Divergent validity was established by comparing the Counselor Rating Form-Short (CRF-S) as well as the State-Trait Anxiety Inventory. These comparisons produced no significant correlations.

When the TRS is compared with other accepted measures of reactance it has been found to be superior. Mallon (From Dowd et al. 1994) compared the TRS to the Hong Reactance Scale which is an English adaptation of the QMPR, a German self-report measure of reactance. Results showed that the TRS was superior in measuring psychological reactance in a community college student population. Baker, Sullivan. And Marszalek (2003) compared the TRS and the Resistance Potential (RP) scale in a sample of 98 participants diagnosed with depression. The RP, which is examined in more detail later, is a combination of two scales from the original MMPI and is a self-report measure. They found that the TRS and RP did not show a significant correlation even though they supposedly measure the same theoretical construct. The RP lacked internal consistency whereas the TRS displayed strong internal consistency. The RP also produced a low but significant correlation with the Hopkins Symptom Checklist suggesting that
the items on the RP may be measuring some level of symptomology. The TRS in this study demonstrated adequate convergent, divergent, and construct validity further contributing to its reputation as a solid measure of reactance.

The validity of the TRS has been called into question by some researchers (Shen & Dillard, & James, 2007). They point to moderate convergent and divergent validity established during the normative process. While debate on the state or trait nature of reactance has persisted, validity studies do show that clients who score high in reactance on the TRS have more negative outcome in therapy, a result that is theoretically sound. Some researchers still show preference for other measures of reactance.

**Resistance Potential**

Beutler, Engle, et al. (1991) developed the Resistance Potential (RP) scale using items from the original MMPI. They combined two subscales from the MMPI, the Taylor Manifest anxiety and Edwards Social Desirability subscales, which they considered related to reactance. Items from these subscales still remain relevant even though there is a new version of the MMPI. Its relevance relies on the fact that 44 of the 50 items of the RP were retained on the MMPI 2.

The RP has been successfully used in research to predict differential effects in psychotherapy. When comparing therapist directiveness and client reactance, a topic discussed in further detail later, the RP has been successfully used to measure reactance and predict the client’s response to directive or nondirective therapeutic styles (Karno, Beutler, & Harwood, 2002).

As previously mentioned, convergent and divergent validity for the RP is less than optimal (Baker, Sullivan, & Marszalek, 2003). Baker, Sullivan, and Marszalek found that the RP
did not correlate highly with the TRS and other measures of reactance. In addition, significant correlations with measures of psychopathology on the Hopkins Symptom Checklist and Edwards Social Desirability demonstrate that the RP measures some pathology which is considered not a part of the definition of reactance. This is related to the operational definition of reactance used to develop the RP which says that clients high in reactance would be high in anxiety and low in social desirability. The fact that items for the RP are taken from the MMPI, an instrument used to measure pathology, further contributes to the RP’s lack of divergent validity and correlation with pathological measures. Research using the RP to measure reactance will be discussed later in this review.

**Therapist Directiveness and its Measurement**

Client factors are not the only elements that have an effect on therapy outcomes; therapist’s factors can interact with client factors as well. Therapist directiveness has been shown to activate client reactance and moderate the effectiveness of therapy (Beutler, Harwood, Michelson, Song, & Holman, 2011; Beutler, Moleiro, & Talebi, 2002b). Therapist directiveness can be defined as:

- “extent to which a therapist dictates the pace and direction of therapy” (p. 135; Beutler et al., 2011)
- “degree to which the therapist is the primary agent of therapeutic process or change” (p. 135; Beutler et al., 2011)
- “(Counselor) imposes a constraint on the recipient’s available options or his or her freedom—the very conditions that elicit reactance.” (p. 135; Beutler et al., 2011)
• “controlling the agenda during treatment sessions” (from Rogers, 1942; Karno & Longabaugh, 2005)

• “leading the client” (from Ashby et al., 1957; Karno & Longabaugh, 2005)

Although there are paper and pencil forms of measuring therapist directiveness, like the Therapist Orientation Questionnaire (Howard, Orlinsky, & Trattner, 1970), and observer rating forms, like the Therapy Process Rating Form (Karno and Longabaugh, 2004), the most common method of measuring or manipulating therapist directiveness is therapeutic theory. Certain psychotherapy theories are considered to be more directive than others. For instance, cognitive behavioral therapy (CBT) is considered more directive because of the high activity level of the therapist leading the client through interventions such as cognitive restructuring and homework administration. Other theories like Rogerian person centered therapies are less directive because the therapist acts as a sounding board and the client controls the direction of the therapy process.

The Therapy Process Rating Scale (Fisher, 1998) is a rating form for observers of therapy sessions consisting of six items scored on a five point Likert scale. Factor analysis of the six items revealed three items to be significantly related to confrontation while the other three were related to structure (Karno & Longabaugh, 2005). An example of an item related to confrontation was, “How often did the therapist interpret resistance, or suggest any other meaning or motive to the way the client behaves toward the therapist?” An example of an item related to structure was, “How often did the therapist provide information to or teach the client?” Structure and confrontation could be considered theoretically important factors related to the construct of directiveness.
In a recent meta-analysis by Beutler et al. (2011) of 12 studies examining the relationship between therapist directiveness and client reactance, all but two studies used psychotherapy theory as a measure of therapist directiveness. There is a deficit however in current research on measures of therapist directiveness. Future research should focus on comparing varying methods of measuring directiveness whether it be by self-report, observation, analogue vignette, or theoretical orientation. This would provide valuable understanding into the construct of therapist directiveness and researchers’ ability to isolate its moderating effects on the therapeutic process.

**Therapist Directiveness and Client Reactance in Therapy**

The aforementioned research on therapy outcome suggests that client reactance or resistance to therapy intervention is one of the most substantial moderating factors (Beutler & Consoli, 1993). Bischoff and Tracey (1995) note that reactance is not a spontaneous phenomenon that occurs in therapy but instead is the direct result of events occurring in the therapeutic environment. Events that occur in the therapeutic environment activate the reactance in the client. This view supports the state and trait conceptualization that was previously discussed and is the view commonly held by researchers on the topic today (Beutler et al. 2011). Due to the significant nature of these two variables on therapy outcome, a substantial amount of research has been conducted on the topic, although it is far from exhaustive.

Beutler et al. (2011) provide a recent meta-analysis of research focused on the interaction between client reactance and therapist directiveness. From their original sample of more than 30 studies, the authors identified 12 studies that included 1,103 psychotherapy patients meeting their established criteria for inclusion into the meta-analytic review. Results from this review
confirmed the previous hypothesis that client reactance and therapist directiveness produce more positive outcomes when they are inversely matched.

In 10 of the 12 studies, direct measures of therapist directiveness and client reactance were taken. This ensured that these variables would be independent of other factors. It was found that these studies combined to have a Cohen’s $d$ of .82 indicating that 15% of the variance in therapy outcome is related to the interaction between therapist directiveness and client reactance. The authors note that variance in effect size ranges from .14 to 1.41 across all studies indicating that other factors are moderating the results of these studies. This could be due to differences in methodologies of the studies included in the review. Differences in method of measuring reactance, measuring directiveness, client pathology, and therapist skill are just some of the possible areas of variance in methodology. This does not include the difficulty of measuring the variable nature of constructs such as reactance and directiveness. Variability in therapist directiveness alone is difficult to consistently measure. Even if a therapist is working from a CBT perspective and including homework in therapy, the level of directiveness in the administration of that homework could be variable.

**Homework in Psychotherapy**

Recently, with the proliferation of CBT as a therapeutic approach of choice, homework in psychotherapy has become more prevalent. Many practitioners find that homework, when using CBT, is a crucial element. Kazantzis and Daniel (2008) posit that effective therapy using the CBT approach cannot be achieved without the use of homework. Homework is viewed as an important tool that allows therapy to occur outside the therapist’s office. Homework can help in the generalizability of skills learned in therapy because clients have to apply skills in real life
situations (Kazantzis & Lampropoulos, 2002). Further, Kazantzis and Lampropoulos (2002) assert that homework should be a central feature to therapy and not a second hand addition. Clients can engage in activities and behaviors that are therapeutic and allow them to practice specific techniques learned in sessions. Homework can occur in an array of different forms. Therapeutic homework could include engaging in a social situation or conversation, using worksheets, bibliotherapy, workbooks, etc.

The effectiveness of homework depends strongly on client compliance with homework completion (Kazantzis, Deane, Ronan, 2004). Kazantzis, Deane, and Ronan (2000), in a meta-analytic review of 32 studies, found that compliance with homework assigned in CBT was a strong predictor of positive overall therapy outcomes. The more homework that clients completed during the process of therapy the better their therapy outcomes were. The authors did, however, find that all of the studies in their review focused on the quantity of homework compliance rather than the quality of compliance or the level of learning from completing homework. In other words, the amount or percentage of homework completed to the amount assigned rather than the level of depth achieved in each completed homework assignment. Based on these results they concluded that the assessment of homework compliance has been a deficit in psychotherapy research. Future research using real client samples should not only measure the amount of homework completed but also the level of depth and quality of therapy gained from the completion of homework.

In a review of literature on the effect of homework and therapy outcome, Kazantzis and Lampropoulos (2002) make several important observations about the previous research. First, they identified 30 different outcome studies examining the effect of homework on treatment outcome. The authors also observe that some of the methodologies used to examine the
interaction between homework and treatment outcomes are not sensitive enough to identify statistically significant differences between groups receiving homework during therapy and control groups without homework during therapy. Some studies did not examine if subjects engaged in their own therapeutic homework outside of therapy. One study, by Kornblith, Rehm, O’Hara, and Lamparski (1983), did not produce any significant differences between homework and therapy groups and control groups receiving therapy without homework. Upon termination of the study clients were asked about their activities outside of therapy and it was revealed that several of the clients in the control group created and used their own homework regimen in conjunction with their therapy. Situations like these underscore the importance of strong experimental control and the confounding effects of poor research methodology. As discussed earlier in this section, the lack of measurement in the quality of homework completion rather than only the quantity is again highlighted in this review.

**Therapist Directiveness in the Use of Homework**

The present study focuses specifically on therapist directiveness in the administration of homework, therefore literature on homework administration in different theories was also evaluated. Psychotherapy theory has been used as a measure of directiveness (Beutler et al., 2011) thus differences in how homework is administered in theories considered explicitly directive or nondirective were examined.

Kazantzis and L’Abate (2007) provide a theory by theory review of homework in psychotherapy. Theories considered to be nondirective included emotion-focused experiential therapy and client centered therapy. The role of homework in emotion-focused experiential therapy was described as: “Homework is offered in a non-imposing tentative manner, as
‘experiments,’ ‘activities,’ ‘exercises’ to try, rather than as expert pronouncements of what should be done.” (Ellison and Greenberg, 2007, p. 68). This describes the tone in which homework is presented to the client- with a sense of curiosity and tentatively. Client centered therapy is described as committed to nondirectiveness and assumes the “nondirective attitude” (Witty, 2007).

Cognitive behavioral therapy (CBT) is considered to be directive (Beck & Tompkins, 2007; Kano & Longabaugh, 2004; Beutler, et al., 1991). Beck and Tompkins describe the assignment process as collaborative with the therapist suggesting particular assignments. The therapist suggesting particular assignments or techniques and doing so in different ways highlights the variation in directiveness that can occur even within a single theory. Thus, the previously mentioned attributes of the therapist directiveness such as limiting choice, tone, and leading the client are then important distinguishing factors in various formats of homework administration.

**Statement of Purpose and Conclusion**

This research emphasizes the importance of the effect that both client reactance and therapist directiveness can have on treatment process and outcome. With homework being an integral part of CBT and CBT considered and used as a directive form of therapy, one wonders what the experience would be for a resistant client during the administration of homework in therapy. This is especially important when the assumption is made that different therapies and interventions do produce better outcomes when paired with specific client variables.

The present study aims to measure the interaction between client reactance and therapist directiveness in the administration of homework. As discussed earlier client reactance has large
implications as a moderating variable for treatment outcome and its nature in relation to homework administration in therapy has not been directly explored. Information gathered from this study can provide guidance in the method of administering homework, an already directive aspect in therapy.

**Hypotheses**

This study focused on two different client and therapist variables in an analogue therapy setting focused on homework administration. The client variable is reactance with participants rating high or low in reactance as measured by the TRS. The therapist variable is directiveness in the administration of homework as determined by the content of the vignette. The hypotheses are as follows:

1. Participants in the high reactance group will be more likely to complete the discussed activity in a less directive approach to homework administration when compared to participants in the low reactance group.
2. Participants in the low reactance group will be more likely to complete the discussed activity in a more directive approach to homework administration when compared to the high reactance group.
3. Participants in the high reactance group will be more likely to continue working with a less directive counselor, rate them as more attractive, and higher in expertness compared to the low reactance group.
4. Participants in the low reactance group will be more likely to continue working with a more directive counselor, rate them as more attractive, and higher in expertness compared to the high reactance group.
Chapter 3

Methods

The purpose of this study was to examine the interaction between client reactance and therapist directiveness in the administration of homework in therapy. The previously reviewed literature provides evidence of an inverse relationship between client reactance and therapist directiveness. Although previous studies have indicated that this inverse relationship may have some effect on homework administration in therapy, this relationship has not been directly explored. The goal of this study is to examine directly the relationship between client reactance and therapist directiveness in the administration of homework and the possible implications it has for therapy, using an analog methodology.

Research Design

This experiment was an analog study using vignettes. The research question explored in this study was, “What is the relationship between client reactance level and therapist directiveness in the administration of homework in therapy?” The main independent variables for this study were client reactance and therapist directiveness. Clients were either considered high or low in reactance while vignettes represented high, medium, and low directiveness levels. The dependent variables were motivation towards working with the counselor, motivation to complete the described assignment, and counselor attractiveness and expertness, as measured by the CRF-S Attractiveness and Expertness scores. Motivation to continue working with the counselor and to complete the assignment described in the vignette were rated on five point Likert scales, with items ranging from 1 (Not at all) to 5 (Completely). Therapist directiveness was manipulated by using vignettes that each represented different levels of directiveness (low,
medium, and high). Client reactance was measured using the Therapeutic Reactance Scale (TRS; Dowd, Milne, & Wise, 1991).

**Hypotheses**

1. Participants in the high reactance group will be more likely to complete the discussed activity in a less directive approach to homework administration when compared to participants in the low reactance group.

2. Participants in the low reactance group will be more likely to complete the discussed activity in a more directive approach to homework administration when compared to the high reactance group.

3. Participants in the high reactance group will be more likely to continue working with a less directive counselor, rate them as more attractive, and higher in expertness compared to the low reactance group.

4. Participants in the low reactance group will be more likely to continue working with a more directive counselor, rate them as more attractive, and higher in expertness compared to the high reactance group.

**Variables**

The independent variables for this study were client reactance and therapist directiveness. Client reactance was measured using the TRS and scores were split into two groups of low and high reactance at the median total score of 65 in the present sample. Therapist directiveness was manipulated using vignettes portraying three different levels (low, medium, and high) of therapist directiveness in the administration of homework. Dependent variables
were scores on the Homework Completion Scale, Counseling Continuation Scale, CRF-S attractiveness subscale, and CRF-S expertness subscale.

**Measures**

**Vignettes**

Vignettes describing directive and nondirective homework administrations in therapy were created and reviewed by experienced counseling practitioners. The theoretical basis of therapist directiveness was established based on definitions found in the literature and rating forms such as the Therapist Orientation Questionnaire (Howard, Orlinsky, Trattner, 1970). Each vignette was rated based on how accurately it described directive and nondirective homework administrations. Ratings from the experts were compared and vignettes meeting the necessary criteria were used.

The theoretical basis for the vignettes was designed to portray therapist directiveness based on dialog that occurs in a common therapeutic session with homework administration. Care was taken to replicate likely dialog that was not extremely directive or nondirective and thus unrealistic to a typical therapeutic setting. Vignettes aimed to resemble homework administrations that could happen in a typical counseling session to increase their generalizable effect to real counseling situations. At the same time, vignettes were created to be distinguishable from each other so that nondirective and directive vignettes were discriminable.

The basis for the directiveness construct was formed on a careful examination of the literature on therapist directiveness and theoretical directiveness— that is, theories that are considered to be more directive than others. Directiveness has been previously defined as “leading the client”, “controlling the agenda during treatment sessions”, (Karno & Longabaugh,
2005), “the extent to which a therapist dictates the pace and direction of therapy,” and “imposes a constraint on the recipient’s available options” (Beutler et al., 2011). In addition, recommendations for homework administration for either directive therapies (CBT; Beck & Tompkins, 2007) or nondirective therapies (Emotion-focused therapy; Ellison and Greenberg, 2007; or Client Centered; Witty, 2007) were also reviewed. Tone and recommended verbiage were adapted for the vignettes to further contribute to an accurate portrayal of directive and nondirective dialog in therapy (Tompkins, 2002). Structure and confrontation were found to be related to therapist directiveness (Karno & Longabaugh, 2005). These concepts were used in developing two main principles the author found to be valuable in developing vignettes that represent therapist directiveness.

Availability of options and the therapist leading the client were determined to be the two most important and homework-related principles that could be presented and manipulated to develop both directive and nondirective homework vignettes. These two principals were determined to have three levels of directiveness. The three levels related to availability of options listed in order of most directive to least directive would be (a) giving only one option, (b) offering two to three options, or (c) leaving the assignment open ended and up to the client to develop an activity, thus the options are theoretically infinite. The three levels related to the therapist leading the client in order of most directive to least directive would be (a) the therapist prescribing an assignment to be done by next session, (b) proposing that the client might try an activity, or (c) suggesting that there may be something to be done between the current and future session and the client consider what it may be.

In order to create vignettes that were distinct from each other, it was decided to incorporate both principles into a single vignette and match one principle with the other on the
same level of directiveness. Thus, the most directive limitation of options was matched with the most directive form of the therapist leading the client. This matching was used to create the most distinct vignettes and limit the possible options to a manageable number of three. Figure 1 shows how matching was conducted. Thus, vignettes of three different levels were created: high directiveness (HD), medium directiveness (MD), and low directiveness (LD).

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<th>HD</th>
<th>MD</th>
<th>LD</th>
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<tr>
<td>Therapist leading process and content.</td>
<td>Therapist leading process and some content</td>
<td>Therapist leading some process and no content</td>
</tr>
<tr>
<td>Giving one option</td>
<td>Giving two to three options</td>
<td>Giving an open number of options</td>
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Three experienced therapists and three advanced masters level mental health counseling students were used to validate the vignettes. Experienced therapists were comprised of two university professors with counseling experience and a masters level counselor with more than 30 years of counseling experience. The three 2nd year masters students also had counseling experience using homework in therapy both in practica and internship settings. Vignettes were to be rated on how well they represented actual homework administrations, overall directiveness, level to which the therapist leads the client, and availability of options. Raters were asked to rate each vignette on a five point (1-5) Likert scale ranging from “Not at all” to “Completely” according to the clinical representation of the vignette, degree to which the counselor lead the client, the degree to which the counselor restricted options, and the overall directiveness of the vignette (see Appendix G).
Table 1 provides the means of the ratings of each vignette. The lower the average score on questions two through four represent a less directive approach. One can see that the average rating of each vignette decreased from the most directive to the least directive, as expected. These ratings, and particularly the ones on question #4 (overall directiveness) confirmed the correct categorization of the three vignettes as high, medium, and low directiveness, with respective mean ratings of 4.3, 3.1, and 1.5 (on a scale 1-5, ranging from “Not at all” to “Completely”).

The LD vignette was rated somewhat lower on clinical representativeness than the other vignettes, but still at an acceptable range. Raters pointed to the lack of direction or the fact that they would not use this style as the reason for lower ratings. The LD vignette assumed a humanistic approach to homework administration as described by Ellison and Greenberg (2007) and Witty (2007). This approach may be unfamiliar to even experienced counselors because homework is normally administered using a CBT approach. This vignette was still included because there is substantial theoretical evidence for the approach it portrays (see Ellison & Greenberg, 2007).

**Therapeutic Reactance Scale**

The TRS (see Appendix F; Dowd, Milne, & Wise, 1991) was developed as a self-report measure of client reactance consisting of 28 items that are split into two subscales, verbal (TRS:V) and behavioral (TRS:B) that form a combined total reactance score (TRS:T). The TRS is the most widely used and accepted self-report measure of client reactance (Buboltz, Thomas, & Donnell, 2002) and is considered a valid measure of psychological reactance (Dowd, Milne, & Wise, 1991).
Normative data is based on a sample of 211 educational psychology students from a large Midwestern university. Although this provides a sizable sample, its reliance on university students is not representative of the general population. Other researchers have used the TRS in examining the demographic differences of reactance providing further data which was discussed in more depth earlier (Woller, Buboltz, & Loveland, 2007). The present study also uses a sample of university students which concurs with the TRS’s normative sample. The mean score for the present study was 68.5 with a standard deviation of 6.1. This mean is higher than the original normative data which resulted in a mean of 66 (Dowd, Milne, Wise, 1991) and lower than the mean of 70 found on an even larger sample (Woller, Buboltz, & Loveland, 2007). Variance in means can be related to a variety of demographic reasons which are explored in the literature (see Woller, Buboltz, & Loveland, 2007).

The test retest reliability for the TRS ranged from .57 to .60 for a period of 3 weeks (Dowd, Milne, & Wise, 1991). Another study, using a different participant pool found a 1-week test retest reliability of .76 on the TRS:T (Lukin, Dowd, Plake, & Kraft, 1985). Internal consistency reliability ranged from .75-.84 (Dowd, Milne, & Wise, 1991) while Baker, Sullivan, and Marszalek found a Cronbach’s alpha rating of .89. In the present study reliability coefficient was .65, much lower than in the previous literature.

Convergent validity was established by correlating scores from the TRS with scores on the K scale of the Minnesota Multiphasic Personality Inventory (MMPI) as well as the Rotter Internal-External Locus of Control Scale. Comparison of the TRS:T and the K scale found an expected negative relationship of -.48 ($p<.005$) and -.43 ($p<.0005$) on the TRS:B and the K scale. A significant correlation (.21) with Scale 4 of the MMPI which is related to nonconformity and
with the Authority Conflict Scale ($r=.305, p<.05$) also had a significant correlation with the TRS (Baker, Sullivan, and Marszalek, 2003).

Divergent validity was established by correlating scores from the TRS with scores from the Counselor Rating Form-Short (CRF-S), State-Trait Anxiety Inventory (STAI), and Beck Depression Inventory (BDI). These measures were chosen because reactance is considered a client attribute not a pathology (Dowd, Milne, Wise, 1991). When compared to the CRF-S no significant correlations were found between subscales of Expertness and Trustworthiness on the CRF-S. However, a significant correlation ($r=-.21, p<.05$) between Attractiveness and the TRS:B was found (Dowd, Milne, Wise, 1991). When the TRS was correlated with STAI nonsignificant correlations of .11 and .06 were found on the State and Trait subscales respectively. Comparisons with the BDI also produced a nonsignificant correlation of .11 while in an additional study this correlation was found to be .085 (Baker, Sullican, & Marszalek, 2003). Baker, Sullivan, and Marszalek (2003) also correlated the TRS with other divergent measures such as the Hamilton Rating Scale for Depression, Edwards Social Desirability, and Hopkins Symptom Checklist. All produced nonsignificant correlations.

A factor analysis of the items composing the TRS was conducted by the original author (Dowd, Milne, Wise, 1991). Two main factors were chosen for the item analysis, Behavioral and Verbal. Items were rated based on these two main factors producing factor loadings ranging from .35 to .60 with a minimum criterion for inclusion of .35 (Dowd, Milne, Wise, 1991).

Counselor Rating Form-Short

The Counselor Rating Form-Short (CRF-S; Corrigan & Schmidt, 1983), is a 12 item measure of client’s perceptions of their therapist on three different factors: expertness,
attractiveness, and trustworthiness (see Appendix E). The CRF-S was adapted from the Counselor Rating Form (CRF) which has 36 items. CRF-S was constructed by conducting a factor analysis of the items from the original CRF and selecting those with the highest rating from all three constructs. The CRF-S was validated using a multiple models method using all three constructs. The CRF-S was found to be a valid and reliable instrument at measuring client’s perceptions of their therapist (Corrigan & Schmidt, 1983; Epperson & Pecnik, 1985; Tracey, Glidden, & Kokotovic, 1988). The CRF-S has three subscales: attractiveness, expertness, and trustworthiness.

For the purposes of this study, it was determined that two subscales of the CRF-S would be most appropriate for participants to rate the counselor in the vignettes. The Attractiveness and Expertness subscales were selected because of their relevance to the hypotheses and applicability of use by the participant in rating the described therapy situation in the vignettes. The CRF-S subscale of trustworthiness was deemed inappropriate for use to rate the counselors in the homework vignettes, as the information provided would not allow participants to meaningfully rate the therapist in the trustworthiness dimension. Attractiveness for the CRF-S was defined as the level to which the client likes the counselor and perceived similarity to the counselor (Strong, 1968). Expertness is defined as the perception that the counselor is a valid source of information (Strong, 1968).

Cronbach’s Alphas were calculated using data from the present study. Alphas of .94, .92, and .93 were found for the CRF-S Attractiveness subscale on the LD, MD, and HD vignettes respectively. For the CRF-S Expertness subscale, Cronbach’s alphas of .96, .92, and .91 were found for the LD, MD, and HD vignettes respectively.
**Homework Completion Scale and Counseling Continuation Scale**

Two scales were developed by the experimenter to measure the likelihood that participants would complete the assignment described and continue to work with the counselor represented in the vignette. Two scales, Homework Completion Scale (HCS) and Counseling Continuation Scale (CCS), were comprised each of three items (see Appendix D). Questions focused on how *likely*, *committed*, and *willing* the participant would be to either complete the assignment or work with the counselor described in the vignette. The three items of the HCS are: “How likely are you to complete an out of session activity this week as discussed by your therapist?”, “How willing are you to engage in the activity proposed by your counselor?”, and “How committed are you to completing an out of session activity?” The three items for the CCS are: “How willing are you to work with this counselor?”, “How likely are you to continue working with this counselor?”, and “How committed are you to continue working with this counselor?” The scales were scored on a five point Likert scale ranging from “Not at All” to “Completely”.

Reliability coefficients were calculated using data from the present study. The HCS produced Cronbach’s Alphas of .92, .91, and .93 for the LD, MD, and HD vignettes respectively. The CCS resulted in Cronbach’s Alphas of .95, .92, and .91 for the LD, MD, and HD vignettes accordingly.

*Pilot Study* Because these items were developed by the experimenter they were pilot tested on a sample of two undergraduate students and 15 graduate students for a total of 17 participants attending a large university in the southeastern United States. The sample consisted of 13 females and four males. The pilot study was conducted using the Qualtrics online survey
which was designed for the actual experiment. HCS and CCS questions were pilot tested to examine descriptive and reliability data. Alpha’s for HCS in the pilot data ranged from .78 to .96 across the three vignettes. Alpha’s for CCS in the pilot data ranged from .87 to .97 across the three vignettes.

In addition to supporting the internal consistency of the HCS and CCS, the pilot study served as a trial run for the whole study, testing for any problems. The pilot administration included open questions soliciting feedback from the 17 pilot participants about any problems completing any parts of the study. None were reported.

**Participants**

*Study Participants*

Participants were 299 students from undergraduate and graduate courses at a large university in the southeastern United States ranging from age 18 to 40 with the average being 21.2 years (SD =2.3). Of the sample, 62.2% of participants were female while 37.5% were male. The sample was composed of 223 (74.6%) Caucasians, 32 (10.7%) African Americans, 28 (9.4%) Hispanic, 5 (1.7%) Asian, and 10 (3.3%) identified themselves as other or multiracial. Participants were primarily undergraduate students (294 or 98.3%).

**Data Analysis**

An *a priori* power analysis was conducted using GPower 3.1 computer software. *F* test and “MANOVA: Global Effects” were selected with effect size set to $f^2(V)=.10$, $\alpha$ error probability set at 0.05, Power equal to 0.95, number of groups set to two (low and high reactance), and response variables set to four. Results from the analysis revealed a critical $F=2.41$ and a required sample size of $N=192$. Based on this analysis, the sample size of $N=299$
in the present study is well above the required size to reveal statistically significant results with a small effect size.

To examine between group means, three independent MANOVAs, one for each presentation of the DVs across the vignettes, were conducted using SPSS 20. To ensure the theoretical integrity of the analysis was met, test for heteroscedacity and Levene’s test for equality of error variances were performed. Means and standard deviations (SD) were calculated and correlations between DVs were analyzed using Pearson’s $r$.

**Procedure**

*Survey*

An online survey was created using the Qualtrics survey system to present the informed consent (see Appendix A), vignettes, HCS and CCS, CRF-S in that order; and finally the TRS and collect demographic information. At the end of survey for the study, participants were redirected to a separate site with spaces to enter a password given to them at the completion of the study to unlock another area where they could enter their student ID number, professor’s name, and class they were receiving extra credit for participation. Because this information was entered on a separate site, participant’s responses on the study were kept separate from their identifying information and thus anonymous.

The order of vignettes was randomized for each participant to protect against a response effect based on the order of presentation. Both the dependent variable questions and CRF-S followed each vignette on the same page. Items were forced response to guard against incomplete data, but participants could leave the survey and return later to complete it at their leisure, or abandon it, if they wished.
Recruitment Procedure

Participants were recruited using a university research pool and undergraduate classes. The university research pool was available to students and faculty conducting research in the College of Education. Potential participants registered with the research pool and complete studies to earn research credits which can be redeemed for extra credit in classes. Undergraduate professors were contacted by the researcher via email to inquire about their possible participation in the study. Three professors responded offering a total of four classes. Two classes were offered extra credit as an incentive for participation in the study. Participants from both sources were provided a link to the online survey and could complete the survey at their leisure.
Chapter 4

Results

This chapter presents the findings of the study. Descriptive statistics of the independent variables (client reactance and therapist directiveness) and the dependent variables (HCS, CSS, and attractiveness and expertness subscales of the CRF-S) are presented. Correlations of the dependent variables and results of the three independent multivariate analysis of variance (MANOVA) are also presented and discussed.

Multivariate analysis of variance

Table 2 provides the means and standard deviations for each of the dependent variables as they were measured across all three vignettes varying in levels of directiveness (LD, MD, and HD). Three separate between-groups multivariate analysis of variances (MANOVA), one for each presentation of the four dependent variables (DVs), were conducted on the four DVs: HCS score, CCS score, CRF-S attractiveness subscale, and CRF-S expertness subscale. The MANOVAs were conducted using SPSS 20 inserting the coded low and high reactance scores as a fixed factor and counselor directiveness lying in the dependent variable measurements. A Levene’s test of equality of error variances revealed no significant heterogeneity in variances across all measurements of the DVs. This confirms the theoretical assumptions of MANOVA (Tabachnick & Fidell, 2007).

Tables 3-5 provides a correlation matrices of the dependent variables for each measurement across each presentation following the vignettes. For the HD vignette Pearson’s $r$ ranged from .27 to .81 representing a moderate to strong positive relationship. For the MD vignette Pearson’s $r$ ranged from .41 to .78 representing a moderate to strong positive
relationship. The LD vignette also demonstrated moderate to strong positive Pearson’s \( r \) correlations ranging from .39 to .81.

**Results from High Directiveness Vignette**

As seen in Table 6, the multivariate analysis revealed a significant main effect between the low and high reactant groups for the HD vignette (\( \Lambda F(4, 294)= 3.0, p < .02 \)). One can see in Table 6 that the HD HCS score and the CCS score revealed a significant difference (\( F= 9.9, p < .01; F= 5.6, p < .05 \)) between the low and high reactant groups, in the expected direction. Specifically, the Low reactance group showed higher likelihood of completing the homework assignment and continuing working with the counselor, compared to the High reactance group. The low and high reactant groups were not significantly different on the attractiveness and expertness subscales of the CRF-S.

**Results from Medium Directiveness Vignette**

In Table 6, multivariate analysis of MD vignette for main effects between the groups on all four DVs showed a significant difference between the low and high reactant groups (\( \Lambda F(4, 294)= 2.7, p < .05 \)). Univariate tests of between-subjects effects for individual measures revealed significant differences for the HCS score and the CCS score (\( F=9.4, p < .01; F=5.3, p < .05 \)) respectively. Specifically, the Low reactance group showed higher likelihood of completing the homework assignment and continuing working with the counselor, compared to the High reactance group. There were no significant differences between the two groups on the attractiveness and expertness subscales of the CRF-S.

**Results from Low Directiveness Vignette**
For the LD vignette, multivariate main effects were not significant ($\Lambda, F(4,294)=1.7, \ p > .05$). The tests of between-subjects effects of the individual DVs confirmed that no measurement produced any statistically significant differences between the low and high reactant groups.
Chapter 5

Discussion

This chapter offers a critical analysis of the results of the study and their relation to the literature discussed in chapter 2. First, the findings from the analysis of the data collected in the experiment are discussed followed by a discussion of the limitations of the findings. Then, a discussion about areas for future research is presented.

Discussion of results

Previous studies have shown that there are significant effects between client reactance and therapist directiveness on outcome in therapy (Beutler et al., 2011). Research also demonstrates the importance of homework in psychotherapy in general and in cognitive behavioral therapy in particular (Kazantzis, Deane, & Ronan, 2000), a theoretical approach which is more directive in its administration of homework (Kazantzis & L’Abate, 2007). Results from this analog study revealed significant differences between low and high reactant groups on two of the dependent variables for the HD vignette and the MD vignette, but not the LD one. Although not comprehensive, the findings indicate that an interaction between client reactance and therapist directiveness does occur in the setting of homework administration as suggested in the prior literature (Beutler et al., 2011). Specifically, low reactance participants are more likely to comply with a homework assignment and continue working with a therapist when homework is assigned in a high or moderate directiveness fashion, compared to highly reactant participants. However, there were no differences between groups when homework was assigned in a low directiveness fashion.
The HCS and CCS were the only measures that produced significant results, but not the CRF-S. This means that therapist directiveness didn’t produce any between group differences in terms of the likeability of the counselor. This is a reasonable finding, given that the CRF-S is only an indirect measure of participant’s intention to comply with homework, and could be affected by other factors. On the contrary, the HCS and the CCS address more directly compliance with a proposed activity and continuation in counseling with a particular counselor. Lastly, the effect sizes produced were relatively small (between .018 and .032), according to Cohen’s guidelines of .01 = small; .06 = medium; .14 = large (Pallant, 2007). This could be attributed to the study’s focus on the administration of homework only and not the larger therapy session as a whole.

**Clinical Implications**

Results from this study have utility in a clinical setting for counselors using homework as a part of their therapy. These results indicate that therapist can increase the likelihood that their clients will comply with a homework activity and continue in therapy if they meet the client reactance level with an inverse level of directiveness. If working with a client who displays higher reactant behavior or attributes to therapy, a counselor can be less directive in their homework administration by offering the client more options and letting the client decide the activity. If a client presents as lower in reactance or is assessed as such, the counselor can administer homework using a more directive approach. A more directive approach could be the counselor more firmly guiding the homework process or describing a single activity as an option. These recommendations are consistent with those from the broader literature on matching client reactance with therapist directiveness in therapy in general (Beutler et al., 2011), and could be
implemented either in a Cognitive behavior therapy context or within other theoretical frameworks.

**Limitations**

The results could have been moderated by limitations in the design. First, the TRS collects data on a continuous scale which was transformed into a categorical scale by using a median split. This division may not entirely capture the entire nature of low and high reactant group. Given a larger sample size, high and low reactant groups could be determined by categorizing participants in the lowest third scores on the TRS as “low reactance” and those scoring in the highest third on the TRS as “high reactance”. This may create more heterogeneity between groups and produce more significant differences.

Another limitation in the study is the use of an analog design in conjunction with the CRF-S subscales and the brevity of the homework vignettes. The vignettes presented in this study were intended to be brief and focused only on the instance of the administration of homework in a therapy setting. Information in the vignettes may have been too brief in order for participants to accurately rate the described counselor on how likable and valid the counselor’s suggestions were, both definitions of Attractiveness and Expertness constructs for the CRF-S subscales (Corrigan & Schmidt, 1983; Strong, 1968). This could have affected the lack of statistical significance in the comparisons involving the CRF-S. The relative brevity of the vignettes may have also affected the magnitude of the effect sizes found on the other measures. Reliability for the TRS in this study was lower than in other studies using the TRS. A Cronbach’s alpha of .66 was found for the TRS total score in the study. Previous examinations of the internal consistency of the TRS total score found coefficients ranging from .75-.84 (Dowd,
Milne, & Wise, 1991) and .89 (Baker, Sullivan, and Marszalek, 2003). This lower internal consistency could have some effect on the results.

Participants could have been asked if they would ever consider seeking counseling services. This information could be used to increase the generalizability into actual clinical settings because clients who said they would consider seeking counseling services would be considered potential clients. Lastly, the analog nature of the study suggests that these results may not generalize in real therapy contexts, and should be treated as preliminary until replicated in such settings.

**Future Research**

This study raises further questions for examination. Future research could focus on demonstrating this interaction between client reactance and counselor directiveness in homework administration in an actual counseling setting. Using an actual setting may increase the effect size of the interaction because the reality of the setting may activate the state like features of reactance more than an analog setting. It may also aid in the ability to accurately measure therapy compliance and continuation in therapy, the two concepts which revealed significant differences. Corroborating findings from an actual clinical setting would increase the generalizability of the present results.

Beutler and colleagues (2011) found the 15% of the variance in treatment outcome can be attributed to the matching effect between client reactance and therapist directiveness. This same examination could be conducted using the setting of homework administration in order to estimate the size of effect the interaction between therapist directiveness and client reactance in homework administration has on overall therapy outcome.
This study only examined between group differences while nesting one independent variable, therapist directiveness, in the repetition of dependent variables. Future examinations of the data collected during this study could examine within group differences for the low and high reactant groups. This information could produce results that indicate which level of therapist directiveness participants in each group prefer or increased their compliance and continuation in counseling. Because some significant differences between groups were found in this study, it may suggest that there may be significant within group interactions between client reactance and therapist directiveness which could be isolated using more in-depth statistical analysis. Examining this data for within group differences would further provide clarity into the matching effect of client reactance and therapist directiveness in a clinical setting. Such results could be better generalizable and have more utility for practitioners.
APPENDIX A

IRB APPROVAL MEMORANDUM
APPROVAL MEMORANDUM

Date: 1/17/2012

To: William Branagan

Address: 4673 Inisheer Dr. Tallahassee, FL 32309
Dept.: EDUCATIONAL PSYCHOLOGY AND LEARNING SYSTEMS

From: Thomas L. Jacobson, Chair

Re: Use of Human Subjects in Research

Client reactance and therapist directiveness in the administration of homework in psychotherapy: an analog study.

The application that you submitted to this office in regard to the use of human subjects in the proposal referenced above have been reviewed by the Secretary, the Chair, and one member of the Human Subjects Committee. Your project is determined to be Expedited per per 45 CFR § 46.110(7) and has been approved by an expedited review process.

The Human Subjects Committee has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval does not replace any departmental or other approvals, which may be required.

If you submitted a proposed consent form with your application, the approved stamped consent form is attached to this approval notice. Only the stamped version of the consent form may be used in recruiting research subjects.

If the project has not been completed by 1/15/2013 you must request a renewal of approval for continuation of the project. As a courtesy, a renewal notice will be sent to you prior to your expiration date; however, it is your responsibility as the Principal Investigator to timely request renewal of your approval from the Committee.

You are advised that any change in protocol for this project must be reviewed and approved by the Committee prior to implementation of the proposed change in the protocol. A protocol change/amendment form is required to be submitted for approval by the Committee. In addition, federal regulations require that the Principal Investigator promptly report, in writing any unanticipated problems or adverse events involving risks to research subjects or others.
By copy of this memorandum, the Chair of your department and/or your major professor is reminded that he/she is responsible for being informed concerning research projects involving human subjects in the department, and should review protocols as often as needed to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

This institution has an Assurance on file with the Office for Human Research Protection. The Assurance Number is FWA00000168/IRB number IRB00000446.

Cc: Georgios Lampropoulos, Advisor
HSC No. 2011.7466
APPENDIX B

INFORMED CONSENT FORM
Florida State University Consent Form

Therapist directiveness and client reactance in the administration of homework in therapy.

You are invited to be in a research study that examines the relationship between therapist directiveness and client reactance in the administration of homework in therapy. You were selected as a possible participant because you are a student at Florida State University and are at least 18 years of age. We ask that you read this form and contact the researchers if you have any questions about the study. By proceeding to the next page, you are acknowledging that you are at least 18 years of age and that you consent to participate in the study.

This study is being conducted by Tyler Branagan, a masters student in the Mental Health Counseling Program in the Department of Educational Psychology and Learning Systems at Florida State University.

Background Information:

The purpose of this study is to investigate how therapist directiveness interacts with client reactance in the administration of homework in psychotherapy

Procedures:

If you agree to be in this study, we would ask you to do the following things:

1. Take a self-report rating scale of reactance.
2. Read vignettes portraying a therapy session and answer corresponding questions.

The total amount of time expected for full participation in this study is about 20 minutes.

Risks and Benefits of being in the Study:

There is no risk associated with the study. The study has several possible benefits, such as the opportunity to think about preference in counselors and types of therapy. Participants who wish to consult with a counselor are encouraged to contact the University Counseling Center (see address below).

Compensation:

Compensation is not being offered for completion of this study.

Confidentiality:

You will not be asked for your name, contact information, or any personally-identifying information. Your IP address will not be tracked, and there will not be any connection between your identity and the information you provide. If you are completing this survey for class credit,
you will be asked at the end of the survey to provide your FSU ID. Your instructor will be given a list of student’s IDs who have completed the survey and will apply the credit. Your FSU ID will not be linked to your responses to the survey in anyway. Your responses are confidential to the extent allowed by law.

**Voluntary Nature of the Study:**

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with the University.

**Contacts and Questions:**

Please feel free to share any concerns you have. The researchers conducting this study are Tyler Branagan, B.S., and Georgios Lampropoulos, PhD. If you have any questions later, you are encouraged to contact them:

Tyler Branagan  
850-345-0522  
tbranagan@gmail.com  

Dr. Georgios Lampropoulos  
Stone Building 3206-B  
850-645-1293  
glampropoulos@.fsu.edu

If you have any questions or concerns regarding this study and would like to talk to someone other than the researchers, you are encouraged to contact the FSU IRB at 2010 Levy Street, Research Building B, Suite 276, Tallahassee, FL 32306-2742, or 850-644-8633, or by email at humansubjects@magnet.fsu.edu.

If you would like to talk to a counselor, we would encourage you to contact the Florida State University Counseling Center (UCC).

**LOCATION / HOURS:**  
201 SLB  
Askew Student Life Building  
942 Learning Way  
Open M-F 8:00 a.m. to 5:00 p.m.

**CONTACT:**  
Phone: (850) 644-2003  
Fax: (850) 644-3150

By proceeding to the next page, you are acknowledging that you consent to participate in the study.
APPENDIX C
VIGNETTES
Vignettes

Instructions for vignettes

In the following vignette, please assume you are a client seeing a counselor. Please answer the questions following the vignette based only on the information provided in the vignette.

High Directiveness Vignette

You have been visiting a counselor for a couple weeks for some problems you have been experiencing. It has been helpful and you are beginning to feel like it is making a difference. At the end of your third session your counselor says to you, “I have an activity that I would like you to do. It has worked well with some of my other clients and takes about half an hour to complete. I would like you to complete it before our next session and bring it back so that we can discuss it during our next session.” Your counselor then explains the activity to be completed.

Medium Directiveness Vignette

You have been visiting a counselor for a couple weeks for some problems you have been experiencing. It has been helpful and you are beginning to feel like it is making a difference. At the end of your third session your counselor says to you, “I think that it might help if you could do some kind of activity between now and our next session. I have a few ideas of some activities that you could try.” The counselor explains three different activities that have been helpful for past clients and take about 30 minutes to complete. Your counselor then says, “If you want to try one of these we can discuss it during our next session to see how it worked for you.”

Low Directiveness Vignette

You have been visiting a counselor for a couple weeks for some problems you have been experiencing. It has been helpful and you are beginning to feel like it is making a difference. At the end of your third session your counselor says to you, “Some people find it helpful to do an activity between sessions that relates to their counseling. I wonder if there is anything you could do outside of our session that could be helpful to you? If you try something, we could talk about it.”
APPENDIX D

HOMEWORK COMPLIANCE SCALE AND

COUNSELING COMPLETION SCALE
**Homework Compliance Scale**

**Instructions:** Please respond to the following questions according to the previous vignette.

1. How likely are you to complete an out of session activity this week as discussed by your therapist?
   
   Not at all 1----------------2----------------3----------------4----------------5 Completely

2. How willing are you to engage in the activity proposed by your counselor?
   
   Not at all 1----------------2----------------3----------------4----------------5 Completely

3. How committed are you to completing an out of session activity?
   
   Not at all 1----------------2----------------3----------------4----------------5 Completely

**Counseling Continuation Scale**

**Instructions:** Please respond to the following questions according to the previous vignette.

1. How willing are you to work with this counselor?
   
   Not at all 1----------------2----------------3----------------4----------------5 Completely

2. How likely are you to continue working with this counselor?
   
   Not at all 1----------------2----------------3----------------4----------------5 Completely

3. How committed are you to continue working with this counselor?
   
   Not at all 1----------------2----------------3----------------4----------------5 Completely
APPENDIX E

COUNSELOR RATING FORM-SHORT

ATTRACTIVENESS AND EXPERTNESS SUBSCALES
Counselor Rating Form-Short

We would like you to rate several characteristics of the counselor depicted in the above vignette. For each characteristic on the following page, there is a seven-point scale that ranges from "not very" to "very." Please mark an "X" at the point on the scale that best represents how you view the counselor depicted in the above vignette. For example:

FUNNY
not very ___:___:___:___:___:___:____ very

WELL DRESSED
not very ____:___:___:___:___:___:____ very

These ratings might show that the therapist does not joke around much, but dresses wisely.

Though all of the following characteristics are desirable, therapists differ in their strengths. We are interested in knowing how you view these differences.

FRIENDLY
not very ____:___:___:___:___:___:____ very

EXPERIENCED
not very ____:___:___:___:___:___:____ very

WARM
not very ____:___:___:___:___:___:____ very

LIKABLE
not very ____:___:___:___:___:___:____ very

EXPERT
not very ____:___:___:___:___:___:____ very

SKILLFUL
not very ____:___:___:___:___:___:____ very
SOCIABLE
not very____:____:____:____:____:____:very

PREPARED
not very____:____:____:____:____:____:very
APPENDIX F

THERAPEUTIC REACTANCE SCALE
The Therapeutic Reactance Scale

Instructions: Please answer each item by marking the appropriate letter. Use the following categories to record your answer.

A= strongly disagree       B=disagree                  C=agree                D=strongly agree

1. If I receive a lukewarm dish at a restaurant, I make an attempt to let that be known.
2. I resent authority figures who try to tell me what to do.
3. I find that I often have to question authority.
4. I enjoy seeing someone else do something that neither of us is supposed to do.
5. I have a strong desire to maintain my personal freedom.
6. I enjoy playing “Devil’s Advocate” whenever I can.
7. In discussions I am easily persuaded by others.
8. Nothing turns me on as much as a good argument!
9. It would be better to have more freedom to do what I want on a job.
10. If I am told what to do, I often do the opposite.
11. I am sometimes afraid to disagree with others.
12. It really bothers me when police officers tell people what to do.
13. It does not upset me to change my plans because someone in the group wants to do something else.
14. I don’t mind other people telling me what to do.
15. I enjoy debates with other people.
16. If someone asks a favor of me, I will think twice about what this person is really after.
17. I am not very tolerant of others’ attempts to persuade me.
18. I often follow the suggestions of others.
19. I am relatively opinionated.
20. It is important to me to be in a powerful position relative to others.
21. I am very open to solutions to my problems from others.
22. I enjoy “showing up” people who think they are right.
23. I consider myself more competitive than cooperative.
24. I don’t mind doing something for someone even when I don’t know why I’m doing it.
25. I usually go along with others’ advice.
26. I feel it is better to stand up for what I believe than to be silent.
27. I am very stubborn and set in my ways.
28. It is very important for me to get along well with the people with whom I work.
APPENDIX G
VIGNETTE RATING QUESTIONS
Vignette Rating Questions

1. Please rate the degree the above vignette represents an administration of homework as it could happen in a clinical setting.

   Not at all  1----------------2----------------3----------------4----------------5 Completely

2. Please rate the degree to which the therapist leads the client through the administration of homework.

   Not at all  1----------------2----------------3----------------4----------------5 Completely

3. Please rate the degree of restriction of options for homework tasks in the above vignette.

   Not at all  1----------------2----------------3----------------4----------------5 Completely

4. Please rate the overall degree of the therapist directiveness in the homework administration in the above vignette.

   Not at all  1----------------2----------------3----------------4----------------5 Completely
References


TABLES
Table 1

*Means of vignette ratings by experienced counselors*

<table>
<thead>
<tr>
<th></th>
<th>High Directiveness Vignette</th>
<th>Medium Directiveness Vignette</th>
<th>Low Directiveness Vignette</th>
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<td>Question 4</td>
<td>4.3</td>
<td>3.1</td>
<td>1.5</td>
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Note: Question 1= “Please rate the degree the above vignette represents an administration of homework as it could happen in a clinical setting.”, Question 2= “Please rate the degree to which the therapist leads the client through the administration of homework.”, Question 3= “Please rate the degree of restriction of options for homework tasks in the above vignette.”, Question 4= “Please rate the overall degree of the therapist directiveness in the homework administration in the above vignette.” Rating scale 1-5, ranging from “Not at all” to “Completely”.
Table 2
Mean Scores and Standard Deviations for Low and High Reactant Groups Across Vignettes

<table>
<thead>
<tr>
<th>Group</th>
<th>Homework Compliance Scale</th>
<th>Counseling Continuation Scale</th>
<th>CRF-S Attractiveness Subscale</th>
<th>CRF-S Expertness Subscale</th>
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<tr>
<td></td>
<td>$M$</td>
<td>SD</td>
<td>$M$</td>
<td>SD</td>
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<td>Low Reactance</td>
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<td>HD</td>
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Note: HD= High Directiveness vignette, MD= Medium Directiveness vignette, LD= Low Directiveness vignette
Table 3

Correlations Among Dependent Variables for HD Vignette.

<table>
<thead>
<tr>
<th>Measure</th>
<th>HCS</th>
<th>CCS</th>
<th>CRF-S Attractiveness</th>
<th>CRF-S Expertness</th>
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<td>.81</td>
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Note: HCS = Homework Compliance Scale, CCS = Counseling Compliance Scale
<table>
<thead>
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<th>Measure</th>
<th>HCS</th>
<th>CCS</th>
<th>CRF-S Attractiveness</th>
<th>CRF-S Expertness</th>
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<td>CRF-S Expertness</td>
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Note: HCS = Homework Compliance Scale, CCS = Counseling Continuation Scale
Table 5

Correlations Among Dependent Variables for LD Vignette

<table>
<thead>
<tr>
<th>Measure</th>
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<th>CRF-S Attractiveness</th>
<th>CRF-S Expertness</th>
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<tr>
<td>HCS</td>
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</table>

Note: HCS = Homework Compliance Scale, CCS = Counseling Continuation Scale
Table 6
Multivariate and Univariate Analysis of Variance for Low and High Reactant Groups Across Vignettes

| Source | Multivariate | HCS | | CCS | | CRF-S Attractiveness | | CRF-S Expertness | |
|--------|--------------|-----|-----------------|-----------------|-----------------|-----------------|-----------------|
|        |              | F\(^{a}\) | p   | \(\eta^2\) | F\(^{b}\) | p   | \(\eta^2\) | F\(^{b}\) | p   | \(\eta^2\) | F\(^{b}\) | p   | \(\eta^2\) |
| HD     |              | 3.06 | .017 | .040 | 9.95 | .002 | .032 | 5.66 | .018 | .019 | .150 | .699 | .001 | .010 | .920 | .000 |
| MD     |              | 2.72 | .030 | .036 | 9.43 | .002 | .031 | 5.36 | .021 | .018 | .592 | .442 | .002 | .409 | .523 | .001 |
| LD     |              | 1.75 | .137 | .023 | .449 | .503 | .002 | .035 | .852 | .000 | 2.98 | .085 | .010 | 3.36 | .068 | .011 |

\(^{a}\)Multivariate \(df = 4, 294.\) \(^{b}\)Univariate \(df = 1, 297.\)

Note: HD= High Directiveness Vignette, MD= Medium Directiveness Vignette, LD= Low Directiveness Vignette. HCS= Homework Compliance Scale, CCS= Counseling Continuation Scale.