ADOLESCENT CLIENT PERCEPTIONS OF AND REACTIONS TO REFRAME AND SYMPTOM PRESCRIPTION TECHNIQUES

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Submitted to the Faculty of the
Graduate College of the
Oklahoma State University
in partial fulfillment of
the requirements for
the Degree of
DOCTOR OF PHILOSOPHY
December, 1995

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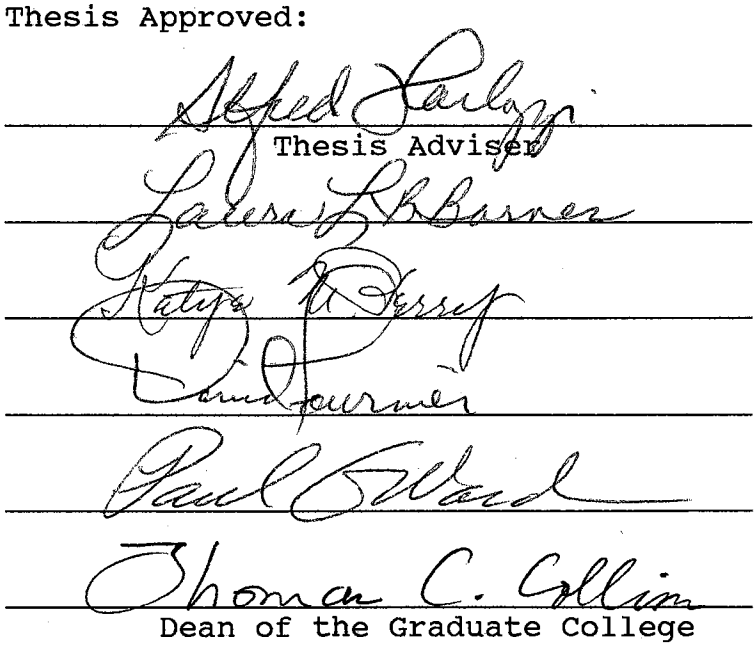
Thesis Approved:



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ACKNOWLEDGEMENTS

I would like to thank my committee members for their feedback and guidance in the completion of this project. I am grateful to Laura Barnes for her extra technical support and valuable critiques of this work. I would also like to express special appreciation to Katye Perry for her warmth, humor, and guidance throughout my graduate training and this research. I am especially indebted to Al Carlozzi who, for the past six years, has been not only a mentor but also an admired friend and colleague.

I owe special thanks to several people who have assisted in the completion of this dissertation: Cheryl Nelson and Suzanne Koenig were extremely helpful with their editorial comments and encouragement. The staff at Green Country Mental Health assisted in data collection and endured my constant presence and cajoling. Greg Eells provided invaluable help with the statistical analysis of the results.

I am particularly grateful to Dean Williams, CEO at Green Country Mental Health, for providing me with the opportunity and financial support to complete my doctoral training. I look forward to a continued working relationship with someone who I respect a great deal.

I wish to acknowledge Del Morgan, for her friendship and professional support; Margaret and Marshall Olson, for their emotional support and encouragement; and Tom and Barbara Mohn for their love, concern, and succor for the past fifteen years.

Finally, I wish to express my greatest appreciation to my family. To my children, Emily, Seth, Maggie, Noah, and Olivia I am thankful every day for their love, hugs, and smiles. They have made my life more happy than I could ever imagine. To my wife, Becky, a true "soul-mate" and treasured light in my life, I wish to say thanks for loving me, believing in me, standing by me, and pushing me through the completion of this degree.

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CHAPTER I

INTRODUCTION

Counseling the resistant client poses a particularly difficult challenge for the experienced, as well as beginning, clinician. This challenge is reflected in the description of such clients as the "Achilles heel" of clinicians (Hartman & Reynolds, 1987). Counselors are likely to work with at least some resistant clients, and in some situations such clients may represent a major proportion of a therapist's caseload (Fremont & Anderson, 1986; Ritchie, 1986). The effects on therapists working with such clients are often frustration and anger. This can typically lead to some degree of distancing, with clients continuing problematic behavior patterns and clinicians rationalizing failure through blaming the client (Hartman & Reynolds, 1987).

The concept of resistance has been a difficult one to define. This is evidenced in discussions of resistance in the professional literature. Amatea (1988) posits there are different types of client resistance, ranging from the overtly oppositional to the therapeutically inert client. Nelsen (1975) observes that resistance is identified by the client "holding back, disengaging, or...subverting change

effort whether knowingly or not...." (p. 587). Ritchie (1986) distinguishes resistance from reluctance. The former refers to the client's general unwillingness to change, including active efforts by the client to circumvent the process of change. The latter term is defined by the individual who, by choice, would prefer not to be in counseling and is exemplified by the client referred by others and uninterested in counseling. It would appear, however, that these may not be as clearly delineated as the author defines them. In the author's discussion of techniques to deal with resistance, the description of clients who assign blame to others and/or those who react against being told what to do could easily characterize the reluctant client as well as the resistant one.

From a social-psychological perspective, resistance has been defined and researched by J.W. Brehm (1966). Brehm postulates that psychological reactance, or resistance, can result from a perceived or real threat to freedom or autonomy. When personal autonomy is threatened with elimination, the individual whose freedom may be restricted or threatened by some external authority (or "social entity" [p. 13]) will employ resistance as a protective maneuver. Resistance, then, is viewed as a motivational state aroused in the individual, to restore what is perceived as a loss, or threat of a loss, of autonomous or "free behaviors." These behaviors are those which the client is free to engage in at any moment in the present or future. If the

importance of these behaviors is great, the level of resistance will also be great. This aroused state will induce the individual to attempt to regain the loss by whatever means available. The individual will likely experience feelings that s/he can do what s/he wants and doesn't have to do what s/he doesn't want. The individual may also experience hostile or aggressive feelings.

Applying these concepts to the therapeutic relationship, the concept of perceived threat is most salient. This threat suggests that a power relationship exists between the threatener (therapist) and threatened (client). If the threatener has some possibility of carrying out the threat or is likely to do so, the threat becomes meaningful. The threat includes the threatener having some control over the other's behavior or control over rewards/punishments which would lead to control over the other's behavior. If the threat is perceived as meaningful, resistance will be relatively high, and the individual or client is hypothesized to exhibit little or no compliance, perhaps even demonstrate anti-compliant behavior. This is not unlike Ruppel & Kaul's (1982) formulations that oppositional "forces" (p. 232) will be aroused through an attempt to influence behavior. Brehm (1966) also notes that this resistance will often occur in social influence situations. As previously suggested, these influence situations are easily related to the therapeutic endeavor, or therapist-client relationship.

From the preceding discussion, it may appear obvious that there are some types of clients who fairly consistently exhibit resistance in a counseling context. One such type is the adolescent client. Adolescents are often referred for therapy by a third party (parent, teacher, court or juvenile system) (Prout, 1983). Typical attitudes and responses elicited from the adolescent are not wanting to be present, inhibition in talking about self or problems, or, if talking about problems, attributing blame to others with either active or passive reactivity to being told what to do. Adolescents required to attend counseling or being requested to change their behavior would be expected to display resistance due to a perceived threat to personal autonomy (Brehm, 1966). The belief that resistance in adolescents is considered commonplace can be better understood by considering the developmental issues encountered by adolescents.

While there are several developmental tasks faced by adolescents, developing autonomy within the family with eventual separation from the family of origin is a chief task (McHolland, 1985). This task has also been defined as the achievement of emotional independence of parents (Prout, 1983) and "emancipation from parental attachments" (Berkovitz & Sugar, 1975, p. 3). This task, together with the development of intimate relationships, is considered to be central to identity formation (McHolland, 1985). The successful negotiation of these tasks depends at least

partially on the social contexts in which adolescents operate. The most significant of these is, of course, the family (Carter & Orfanidis, 1976). In achieving autonomy for the adolescent, the family must establish and negotiate an appropriate hierarchy with clear boundaries entailing the when, the how, and the how much of suitable levels of autonomy (McHolland, 1985). When this autonomy is threatened, one may expect negative and/or oppositional behavior (Bow, 1988; Goldstein & Myers, 1986). When a parent or other "agency" requires that an adolescent attend counseling, this is viewed as a common infringement on autonomy and is expected to produce resistance. One of the therapist's tasks, then, is to deactivate this resistance which could prevent the client (adolescent and/or family) from effective problem solving (McHolland, 1985).

Deactivation of resistance requires that the therapist develop and employ an effective strategy in countering or reducing the resistance which would interfere with the therapeutic process. The strategies identified in the literature as most consistently used in dealing with client resistance are paradoxical interventions. Indeed, Katz (1985) indicates that paradoxical injunctions should be used with a resistant population and includes in his description of such individuals those who do not wish to change because they do not feel they have a problem, such as the acting out adolescent.

Paradoxical tactics are those which seem in apparent opposition to the goals of therapy, but in actuality are designed to achieve them (Rohrbaugh, Tennen, Press, & White, 1981). These strategies include prescribing the symptom and encouraging resistance. The reframe technique, although seldom used alone, is also classified as a separate paradoxical intervention (Dowd & Milne, 1986; LaClave & Brack, 1989).

What is noteworthy about the use of these interventions is that clinicians, varying across theoretical orientations, are utilizing these techniques with different rationales. Mozdzierz, Lisiecki, & Macchitelli (1989) identify that paradox appears to be used universally, under a diversity of names. It has been pointed out that a behavior therapist may instruct a patient to practice a symptom, explaining this technique as negative practice or extinction. Existentialists use the tactic emphasizing the absurdity and humor in order to change the client's perspective, overcoming the sense of uncontrollability of the symptom and achieving some distance from it. Strategic therapists use paradox to prevent the symptom from functioning as it has in an interpersonal context (Rohrbaugh et al., 1981; Wathney, 1982).

In the selection of a paradoxical method, two factors need to be considered. The first is for the therapist to determine whether the potential for resistance is high or low. In other words, what is the likelihood that the

individual will resist or defy the therapist's interventions? The second factor is concerned with whether the individual perceives his/her problem to be under voluntary control (free) or whether the problem is perceived to have occurred spontaneously (unfree). It should be noted that some problem behaviors may be considered free even though the client does not believe s/he has control over them. These two parameters have been conceptualized as representing a completely crossed design with two levels of resistance (high and low) and two levels of symptom freedom (free and unfree) (Rohrbaugh et al., 1981). The design is displayed in Figure 1 below.

Figure 1

Assessment Parameters for Using Paradoxical Techniques

REACTANCE POTENTIAL	PERCEIVED FREEDOM OF "TARGET" BEHAVIOR	
	Free	Unfree
High	1	3
Low	2	4

Adolescent clients in general are perceived by many therapists to fall into category 1, exhibiting high

reactance, with behavior under voluntary control. Strategies designed to address this will be, according to the model, defiance-based. There are many different ways an effective intervention could be formulated. Rohrbaugh et al. (1981) suggest the therapist frame a defiance-based directive or suggestion in a way which is incongruous with the way a client would prefer to see him/herself. An additional criterion in constructing a successful intervention involves inclusion of ideas or prescriptions which represent variations of the client's own self or world view.

While these authors delineate paradoxical interventions into three categories, elsewhere (Seltzer, 1986) these tactics have been classified as being included in either reframing or symptom prescription categories. Seltzer points out that both techniques, depending upon their use, can be either compliance-based or defiance-based. The former refers to those interventions with which the therapist expects the client to comply, while the latter refers to interventions the therapist expects the client to defy.

The reframe technique involves alteration of the meaning attributed to a situation or problem by changing the way in which the problem has been defined or by altering the emotional context in which the situation is experienced. Accomplishing this requires the therapist to first accept the client's frame of reference (McDonald, 1992). The

subsequent "interpretation" made by the therapist is contrived in such a way as to fit the facts of the problem situation so well that the client is induced to react to it in a new way, one in which the situation is likely to be changed (Watzlawick, Weakland, & Fisch, 1974). The expectation is that if the problem can be viewed from an alternative standpoint, it must be reduced or eliminated, since its existence is closely connected to how it is perceived (Seltzer, 1986). McDonald (1992) suggests the reframe will free the client to broaden his/her personal frame and expand on existing strategies, leading to positive change. Likewise, Mozdzierz and Greenblatt (1992) suggest reframing a problem in positive terms can lead to preferences for positive outcomes, leading to greater self-esteem and/or social interest, which are particularly salient issues for adolescents.

While conceptually separate, reframe is often employed as a rationale for a paradoxical injunction or symptom prescription. An important distinction between the two is that reframe is more implicit in its message about change, while symptom prescription is explicit in its direction of behavior. Symptom prescription involves encouraging or instructing clients to maintain their problem behavior. The intent behind the directive is that problems can be eliminated by intentionally adhering to the directive, with control for the problem being placed back into the client's hands (Seltzer, 1986; Stone, 1994).

Statement of the Problem

Adolescents are viewed as generally resistant as a group. However, it is a somewhat surprising finding that a paucity of research exists which specifically addresses techniques which would be effective in reducing or countering adolescent resistance (Dowd & Milne, 1986). Those studies which are directed toward a child or adolescent client population typically examined the effects of paradoxical strategies alone or against other techniques in bringing about a change in behavior. Further, these studies were aimed at applying paradoxical strategies in a family therapy context. While these strategies were developed and are typically used within a family framework, their utility as an intervention useful in individual counseling should not be ignored, particularly with older adolescents.

There have been a number of studies (Beck & Strong, 1982; Lopez & Wambach, 1982; Wright & Strong, 1982) which have examined client ratings of counselors employing paradoxical versus non-paradoxical directives or paradoxical interventions alone. One study (LaCrosse, 1980) noted a relationship between counselor rating and counseling outcome, suggesting the value of examining reactions to paradoxical techniques.

While the importance of examining outcome as evidenced by responses to type of intervention is unquestioned, others

(Kazdin, 1980; Wolf, 1978) have suggested that additional criteria be considered in evaluating treatment techniques. Acceptability of treatment is suggested as one such criterion and refers to the judgments about treatment procedures made by nonprofessionals, including clients and other possible consumers of mental health services. Such judgments include appropriateness of the procedure for the problem, fairness, reasonability, and consistency with common sense about what treatment should be, among others (Kazdin, 1980a, 1980b). Using acceptability as a criterion for evaluation provides a means to help identify variables that affect client reactions to treatment (Kazdin, 1980b). If particular treatment procedures are viewed as more acceptable than others, there is a higher likelihood that clients will positively respond to therapist interventions, thus leading to problem reduction or resolution (Kazdin, 1980a).

Previous experimental research and case studies in the use of reframe and symptom prescription techniques have typically explored the utility of a combination of both rather than separate techniques. Since both can be employed in similar circumstances (i.e., with defiance-based clients), the question of whether clients react equally or differentially depending on level of resistance seems to be worth studying.

The perceptions of adolescent clients, exhibiting differing levels of resistance, toward a reframe technique

versus a symptom prescription technique were examined in this study. One intent of this study is to answer whether one strategy might be superior to the other at the initiation of therapy, as evidenced by client perceptions of the use of such techniques. Specifically, do resistant adolescent clients perceive the use of a reframe intervention differently than the use of a symptom prescription technique?

Significance of the Study

Ritchie (1986) has noted that client resistance to counseling is "negatively correlated with client satisfaction and improvement and positively correlated with premature termination" (p. 516). Premature termination could be potentially detrimental to the client and also have deleterious effects for the counselor as previously discussed.

To assist in reducing the client's level of resistance, paradoxical strategies are believed to be the most effective. Some evidence exists that the level of resistance exhibited by a client may mediate the effectiveness of paradoxical as well as nonparadoxical techniques (Dowd & Milne, 1986). The belief that paradoxical strategies might be useful in reducing resistance is suggested by these authors, and they argue that such strategies may be particularly useful to those who

are working in situations or with populations where high resistance is common (i.e. in correctional institutions or with adolescents). As Kazdin (1980a) notes, although paradoxical techniques may be effective in such situations, their use may not be viewed as acceptable by clients, possibly contributing to drop-out. More research in this area is needed, and this study reflects an attempt to begin to address that need.

Dowd & Milne (1986) also point out the need to focus on disorders that are typically manifested by children and adolescents. Some controlled research in this area may be able to validate what is typically being expressed in anecdotal reports or case studies.

This study may provide information on the appropriateness or acceptability of using paradoxical interventions in countering resistance with adolescent clients, as judged by client responses to those techniques. This approach is based on the assumption that acceptable treatments are more likely to be effectively implemented, that acceptability as a construct may serve as a significant variable in determining the optimal match of client with treatment and be useful in predicting compliance and attrition (Cross-Calvert & Johnston, 1990). A clinician, regardless of theoretical orientation, working with a resistant population could employ such techniques to reduce resistance and effect change or at least remove barriers so

that the s/he could more effectively utilize techniques within his/her own theoretical framework.

Definition of Terms

Definitions of terms used in this study are as follows:

Paradoxical intervention is defined as any tactic, strategy, or intervention which is "perceived by the client, at least initially, as contrary to therapeutic goals, but which is yet rationally understandable and specifically devised by the therapist to achieve these goals" (Seltzer, 1986, p. 10).

Resistance is defined as the motivational state aroused in the individual and directed toward reestablishing autonomy, or free behavior, when that behavior has been lost or threatened with loss (Brehm, 1966). Level of resistance will be operationally defined by the score obtained on the Therapeutic Reactance Scale (TRS; Dowd, Milne, & Wise, 1991).

Reframe is defined as a paradoxical intervention which consists of a message given by the therapist to the client which alters the meaning attributed to a situation or problem by changing the conceptual and/or emotional context in which the situation or problem is experienced. The message is delivered in a manner which is consistent or compatible with the client's frame of reference (Watzlawick et al., 1974).

Symptom prescription is defined as a paradoxical directive which involves encouraging or instructing clients to maintain symptomatic or problem behavior. A symptom prescription typically involves a reframe component given as a rationale for continuing symptomatic or problem behavior (Seltzer, 1986).

Limitations

The following limitations are inherent in this study:

1. The study will include subjects who voluntarily agree to participate in this study. Results will not be generalizable to all adolescent clients. In fact, refusal to participate may be due to high levels of resistance which is an important variable in this study; therefore, the group may not include some subjects important to this study.

2. Because only one mental health clinic will be utilized, results cannot be generalized to all similar settings. It is possible that some other variable other than the independent variable, and inherent in this group, may account for observed differences.

Organization of the Study

The present chapter includes an introduction to the study, a statement of the problem, significance of the study, definition of terms, and limitations. Chapter II contains a review of the research literature pertinent to this study and null hypotheses. Chapter III describes the

subjects, selection of subjects, instrumentation, procedure, design of the study, and statistical procedures. Chapter IV contains an analysis of the data and Chapter V includes the summary, conclusions, and recommendations.

CHAPTER II

REVIEW OF THE LITERATURE

This chapter contains a review of the literature relevant to this study. Theoretical formulations for strategies in dealing with adolescent resistance, experimental studies utilizing paradoxical techniques, experimental and case studies specifically addressing paradoxical techniques with adolescents, and treatment acceptability research will be discussed.

Theoretical Formulations

As previously noted, adolescents who are not really interested in seeking counseling are often seen in therapists' offices. The "true" client in these cases is generally a third party. The counselor is then expected to provide services which are not really wanted. Several authors have proposed some ways in which to approach this difficult situation.

It has been suggested that adolescents are not really as resistant to change as to being changed (Hurley, 1984), implying a necessity in developing alternative intervention strategies to approaching client problems over the more "traditional" ways of intervening in the counseling

situation. Hurley identifies the appropriate intervention techniques in these cases to be the paradoxical methods (i.e. reframe, restraining, and prescribing the symptom).

Ritchie (1986) bases his formulations on similar suppositions, or that theories and techniques of counseling are generally based on the premise of the cooperative client. He proposes that a counselor distinguish between the reluctant and the resistant client and suggests that different techniques are more appropriate for one over the other. In dealing with the reluctant client, efforts at structuring the parameters of the counseling contract should be more of the focus. With the resistant client, or where there is more of a reaction against being told what to do, Ritchie suggests paradoxical techniques be employed. In general, the counselor accepts the behavior and encourages the individual to continue in the same patterns even though these patterns have not worked. The premise behind this is that the client will then become motivated to try something new (Fisch, Weakland, & Segal, 1982). Ritchie (1986) also notes that in employing these strategies, or any intervention for that matter, the therapist needs to exhibit a great deal of patience, as building trust in the relationship cannot be minimized.

Amatea (1988) discusses her proposed strategies out of a dissatisfaction with the typical approaches to dealing with resistant clients, which have included perceiving the resistant client as unworkable and terminating with the

client until interest in counseling is shown by the client. She indicates that brief therapy approaches are aimed at helping to motivate the client to change. Strategies she proposes to accomplish this include renegotiating the counseling contract with the client, bringing in the "true" client (typically the one who referred the adolescent), and contaminating the client's position (Fisch et al., 1982; Watzlawick et al., 1974). Each of these strategies is aimed at the counselor aligning him/herself with the client in order to reduce the opposition. The third strategy is essentially a reframe technique, in that the counselor takes the client's position but does so in a way which makes the position less acceptable to the client. The counselor changes the meaning of the problem by placing it in a different context.

Another case for the use of reframe with resistant clients is made by LaClave and Brack (1989). They contend that this technique has been used to treat a variety of problems and that research has supported its efficacy. Using case examples, the authors show how reframe is not only useful in moving the client toward change, but also in assisting treatment personnel to deal with difficult clients in a more positive and productive manner. This can be of great value in fostering the treatment relationship between helper and client.

Wathney (1982) has also observed that paradoxical methods are used with resistant clients. Specifically, they

are used extensively with adolescent offenders (noting their tendency for rebelliousness). Using case examples, Wathney attempts to support his contention that these techniques are particularly useful when being applied to adolescents who "rebel against advice or suggestions" (p. 188). He suggests the counselor accept the problem presented by the client, encourage aspects of the problem while reframing intent, and then prescribe the behavior. The author contends that, when such behavior is prescribed, the behavior is no longer taking place in its old context, fostering more client control over the behavior through awareness that if the client can purposely produce the behavior, the client then has the ability to not produce it.

McHolland (1985) addresses the issue of developing strategies for dealing with resistant adolescents in a more comprehensive manner than those previously discussed. Initially, he challenges the reader to think of resistance in a more productive manner, much as other authors, but develops this idea around understanding the resistant adolescent within a developmental context. He also addresses the importance of the treatment relationship in beginning to "deactivate" the resistance more fully than other authors to this point.

McHolland (1985) details a model of delineating the different expressions of resistance, postulating that not all resistance is the same. In this model, adolescent resistance ranges from the "coerced" client to the

"cooperative resistant" client. Depending on the type of resistance expressed by the client, different strategies are proposed for dealing with the resistance. Like other authors, McHolland suggests that the clinician needs to recognize the positive elements or function of resistance and to "go with the resistance, not against it" (p. 357). This task typically involves a positive connotation or reframe of the resistance.

For purposes of this study, the strategies which are suggested for dealing with the coerced client seem most salient. In dealing with specific behaviors as expressions of the resistance, McHolland includes reframing the behavior or prescribing it. He gives specific examples of these interventions which could be useful in attempts to empirically validate the effectiveness of these strategies.

Experimental validation of these techniques with this specific population and in specific situations, much as McHolland (1985) outlines, is the most glaring deficiency in the literature in this area. There are, however, experimental studies using paradoxical interventions with other populations which can serve as a starting point to validating the use of these techniques with resistant adolescent clients.

Experimental Studies Utilizing Paradoxical Techniques

In the literature, experimental studies examining reframe and/or symptom prescription techniques to date appear to focus on either comparing different paradoxical techniques or examining how these techniques impact resistance or symptom behavior. Those comparing techniques will be addressed first.

Three of the studies discussed are aimed at evaluating the utility of paradoxical directives in treating procrastination difficulties. Lopez & Wambach (1982) compared the effects of paradoxical and self-control counselor directives on change in subjects over a four-week period. Subjects consisted of 32 introductory psychology students self-identified as having a serious, recurrent problem with procrastination. The paradoxical condition consisted of telling students to deliberately practice their procrastination behavior daily in order to better understand that behavior. In the other condition, students were given directives to engage in specific study habits to overcome their problem. Dependent measures included weekly ratings of problem frequency, perception of control over the problem, and the expectation of change. Using a repeated measures ANOVA, the authors found students improved significantly in both conditions. Interestingly, subjects who were exposed to the paradoxical directive did not report perceptions of more controllability over their symptom.

Limitations of the study were offered as explanation for this, as this finding is contrary to the theory underlying paradoxical directives. Of note is that the intervention failed to reframe the nature of the problem. Without this, attitudes and thoughts about the problem would remain unchanged. Basic assumptions and beliefs about the problem would remain intact.

Wright & Strong (1982) also explored the use of compliance-based versus defiance-based directives. Thirty introductory psychology students were placed into either one of two experimental conditions or a control group. One experimental group was offered a choice to continue doing as they had with respect to certain behaviors, while the other group was told to continue doing exactly as before. Again, both treatment conditions resulted in a decrease in procrastination while no such decrease occurred in the control group. Differences between the experimental groups were noted in their descriptions of how their behavior came to change. The students in the "choose" condition viewed change occurring under their own volition. Students in the "exactly" condition tended to perceive improvement in more spontaneous terms.

One of the difficulties in this study is that in both experimental conditions phrasing both directives with "what I <u>insist</u> that you do...." may have confounded the results. Using this "resistance" term may have counteracted possible differences in the attitudes or behaviors of the students.

In both conditions, the subjects' sense of personal behavioral freedom can be viewed as similarly threatened, diminishing the differences between the conditions. The differences in attribution could be due, as pointed out by the authors, to the different demand characteristics between the two directives. The fact that the authors fail to provide the reader with the amount of time elapsed between the second interview and the posttest is a troublesome omission from this study.

Shoham-Salomon, Avner, and Neeman (1989) examined reactance and sense of self-efficacy with paradoxical interventions applied to the problem of procrastination. They randomly assigned college students to a paradoxical intervention condition or self-control intervention and looked at effective study time and perceived self-efficacy measures at pre and posttreatment. In their first study, the authors assessed initial reactance and experimentally manipulated reactance in a second study. In the paradoxical intervention, subjects who were high on initial reactance received more benefit from treatment than did subjects who were low in reactance. The nonreactant subjects did not increase in effective study time, although they did improve in perceived efficacy to control procrastination. In the self-control intervention condition, subjects increased study time accompanied by increased self-efficacy. The authors suggested that some clients experienced a reduction in symptoms as a function of reactance while other clients

experienced more of a cognitive change, which would be expected to lead to eventual behavior change. As with other studies, the use of college students rather than clients seeking help through a mental health setting limits generalizability of the findings.

In a study of sleep onset delay problems, Horvath and Goheen (1990) randomly assigned 41 subjects to a symptom prescription or stimulus control treatments and to one of two levels of therapist contact. Level of reactance was assessed prior to initiation of treatment. The dependent variables were sleep onset delay time, quality of rest, and total time asleep which were assessed at baseline, treatment, and followup. The authors found that both treatments were equally effective in reducing sleep onset delay and increasing amount of sleep. The symptom prescription group rated their quality of rest as more improved than the other treatment group. Additionally, they found that the more reactant clients exposed to paradoxical intervention continued to improve beyond active treatment while the low reactant clients lost some of their initial gains. The opposite pattern to this was noted with the stimulus control group. The authors concluded that while paradoxical intervention is not necessarily superior to other treatment for high reactant individuals, it does seem to have a better long-term effect for sleep onset delay problems.

Several other studies involve the application of paradoxical directives in the treatment of depression. The first of these (Beck & Strong, 1982) compares positive and negative connotative interpretations in how they influence change. This study attempts to elucidate that different kinds of therapist interpretations may serve to interfere with the utility of the symptom in interpersonal transactions, thereby producing change. It is hypothesized by the authors that both positive and negative connotations will produce change, but in different ways.

To test their hypotheses, the authors provided 20 of 30 "student-clients" (identified on the basis of scores on a depression inventory) two weekly 30-minute interviews during which time they received six interpretations connoting their depression either positively or negatively. The students in the control condition were not given interviews. The authors found that, as expected, both conditions resulted in change; however, long-term effects were different. Changes in the positive condition tended to persist whereas changes in the negative condition deteriorated over time. The control group reported some worsening of depression. This is consistent with Strong's (1984) finding in a review of experimental studies that positive and negative interpretations in paradoxical interventions both resulted in greater therapeutic change than in no treatment conditions, but positive interpretations resulted in significantly greater and longer lasting therapeutic change

than the negative interpretations. While Beck and Strong (1982) report results of their study in support of their hypothesis, it is possible that change may have occurred in a condition with no interpretation, only directives, which is an alternative the authors did not seem to consider. Reliance on self-report measures, short treatment time, and the use of students are considered weaknesses of this study and may have limited generalizability.

A study by Feldman, Strong, and Danser (1982) attempts to examine the comparative effects of consistent and inconsistent combinations of paradoxical and nonparadoxical directives and interpretations. This study used a similar subject pool (students) as the others, with a total of 50 participants. There were four interview conditions and a no-interview control condition. Students across all interview conditions experienced remission of depressive symptoms. One of the findings, not in support of the authors' hypotheses, was that paradoxical interpretations (regardless of directive) were superior to conditions not containing such interpretations. Nature of directives did not appear to make a difference with respect to change as suggested by the Lopez and Wambach (1982) and the Wright and Strong (1982) studies. Similarly, Boettcher (1984) found that symptom prescription interventions, regardless of rationale given, produced decreases in students' experiences of performance anxiety.

In a study by Swoboda, Dowd, and Wise (1990) effects of a reframe technique and restraining technique were compared. Level of psychological reactance was also considered. From 116 clients in a mental health center who met the study's criteria for inclusion (depressive symptomatology and diagnosis of depression), 74 completed the study. The paradoxical reframe condition positively connoted the clients' symptoms while the restraining condition focused on the disadvantages of changing and a directive to go cautiously in attempting change. A pseudotherapy control group was utilized, where the therapist talked about different theories of depression.

Results of this study showed improvement across all conditions, however, the reframe technique displayed greater efficacy than either the restraining technique or the control condition. These findings are consistent with other findings reported in a literature review by Dowd and Milne (1986) indicating the effectiveness of reframing for depression. Level of resistance did not appear to make a difference with respect to improvement as found by Morgan (1986) in a mental health setting.

Limitations of this study include the differences between the treatment and control condition (different counselors were used in the control). Also, not noted by the authors as potentially affecting results is the differential timing of interventions in the treatment conditions. Due to the setting, some control was

sacrificed, however, this was balanced by the use of an actual clinical population versus student subjects. The authors have taken a much needed positive direction in exploring the impact of interventions where they are more greatly used, with actual clients in a mental health setting, exhibiting more severe pathology.

Another study which found for the superiority of reframe was conducted by Kraft, Claiborn, and Dowd (1985). The authors compared the effects of a reframe statement, no-reframe statement with a paradoxical directive, non-paradoxical directive condition. While all subjects improved, subjects who received positive reframe statements showed greater improvement in negative emotions than those who received no reframe statements. It is unfortunate that the authors do not indicate whether the paradoxical directive included a reframe component as a rationale. If not, its lack may have created some misunderstanding on the part of the subjects and affected the nonsignificant finding for this effect.

Reframe was compared with a treatment of self-control directives using 57 undergraduate volunteers in a study by Conoley and Garber (1985). Results indicated that reframe produced more significant reduction in depression than in self-control or control groups. No treatment was found to be more effective than another in reducing loneliness and no differences were found for controllability. Findings were consistent with previous research on the use of reframe with

depression, and overall there is evidence that reframe can be more effective than rationally directive therapy in reducing depression at the beginning of therapy. Nonsignificant findings are possibly due to the fluctuations in experience of loneliness.

Several meta-analyses have been conducted to examine the validity of claims regarding the efficacy of paradoxical interventions. Hill (1987) analyzed 15 outcome studies and found that, on average, clients who received paradoxical treatment were better off than untreated and placebo groups. In comparisons with nonparadoxical treatments, paradoxical treatments were found to be significantly more effective. He also found that paradoxical intervention appeared to be most indicated when the presenting problem was relatively severe and resistant to other forms of treatment.

Similarly, Shoham-Salomon and Rosenthal examined 12 data sets and found that paradoxical intervention was as effective (although not more so) than the typical treatment modality and showed greater effectiveness than others at one month after termination of treatment and with more severe cases. As previously mentioned, a significant treatment effect was found for positive connotation. Symptom prescription was found to be less effective when it was not used with a positive connotation. Shoham-Salomon and Rosenthal also reported that while resistance is hypothesized as a mediator for the effectiveness of paradox, little attention has been given this in the literature.

In a more recent meta-analysis, Hampton and Hulgus (1993) analyzed 29 studies and discovered the outcomes of paradoxical treatment to be superior to those of other treatments at posttest and followup. The treatment effects for paradoxical interventions were greatest when compared to untreated control groups at posttest. Symptom prescription tended to show greater durability of effects than other treatments.

Experimental/Case Studies with Adolescents

From the previous discussion of the literature on the use of paradoxical techniques, it is clear the focus on the use of these techniques has been in limited settings, with limited populations and types of problems (procrastination, insomnia and depression). While some of these studies have examined the level of resistance, none address resistance related to the client being coerced into treatment. This would most likely occur with a child or adolescent population.

An individually oriented case study of the use of symptom prescription using a clinical patient, five years old with cerebral palsy, was reported by Zarske (1982). Following a five-day baseline period, during which the parent was instructed to chart frequency, duration, and location of child tantrums, an "encouraging the symptom" strategy was implemented in two phases. In the first phase, a dramatic decline was noted. This improvement continued

until tantrums were totally absent. One and two month follow-ups revealed no recurrence of tantrums.

Because all charting was done by the parents or other caretaker, there was a lack of experimenter control. Also, because only one treatment approach was used, it cannot be evaluated in relation to other treatment approaches. Generalizability is also extremely limited, particularly with the nature of the family dynamics and the child's physical limitations.

Burgess and Hinkle (1993) report a case study involving an adolescent girl referred by the courts for chronic school avoidance. Paradoxical interventions were used within a strategic family therapy context. The authors report a discontinuation of avoidance of social situations. Despite its limitations as a case study and that level of reactance was not objectively assessed, this study represents a positive effort to examine the utility of paradoxical interventions in a situation (court referral) where situational reactance is likely to be high.

In an examination of the use of paradox in treating disturbed adolescents and their families, Derman (1985) presents three cases in which a paradoxical approach was used. In two of the cases, the author reports that the prescription resolved the problem. In the other case, the paradox served as a step toward the adolescent's parents taking greater charge of their child. Similarly, Williams and Weeks (1984) present seven cases in which paradoxical

interventions were successful in treating behavior problems in a school setting (7th and 8th grades). The authors comment that these techniques are especially suited for oppositional students and that they place adolescents in control of their own behavior.

In response to the uncontrolled case studies and analogue research in the utility of paradoxical directives, Kolko and Milan (1983) undertook "an empirical evaluation of the utility of reframe and paradoxical instruction with a clinical population" (pp. 655-656). The authors utilized a multiple baseline analysis (across clients) on the treatment of three delinquent adolescents. All were referred by the juvenile court system and all displayed school-related difficulties. All clients were given a symptom prescription, with a reframe component, to maintain their truancy or tardiness problem behaviors following collection of baseline data. Measures of class attendance and grades were used to evaluate the effects of intervention. Reliability of measurement was established, but the authors did not report this.

Improvement in class attendance was reported to be "dramatic" during the paradoxical intervention. Progress was maintained at followup. The authors use these results to offer "preliminary support to the therapeutic use of reframing as a means of reactance induction with inert clients or highly refractory problem behaviors" (p. 659). The authors used an appropriate design for their study,

including the minimum number of subjects needed for this design (Gay, 1987). Although cumbersome for the researcher, studies involving the direct application of paradoxical interventions on adolescent consumers of mental health services, using a large number of subjects, need to be undertaken.

Research on Treatment Acceptability

The foregoing review has focused on the utility of paradox as it impacts on specific behavioral and emotional problems. The conclusions drawn from these studies is that paradox is indicated in certain treatment situations, such as with highly resistant clients or when there is a history of past treatment failure (Tennen, Rohrbaugh, Press, and White, 1981); however, it has also been noted that outcome research should be expanded to include measures of how consumers of mental health services react to or perceive the use of treatment techniques because this has bearing on client behavior and satisfaction with treatment (Cross-Calvert and Johnston, 1990).

Conoley and Beard (1984) compared paradoxical and nondirective interventions along core therapeutic conditions (empathy, warmth, genuineness) and therapist-client relationship issues. The variables examined were counselor attractiveness, expertness, and trustworthiness. It was hypothesized that higher ratings on these dimensions

indicated that a client would be more involved in therapy and would be more likely to experience behavior change.

The authors used four audiotapes, two of which presented paradoxical interventions (one high and one low in core conditions), and two which presented non-directive interventions (high and low in core conditions). Undergraduate students were randomly assigned to one of four conditions and completed the Counselor Rating Form (Barak & LaCross, 1975). Results showed that interventions high in core conditions received higher ratings on all dependent variables than those low in core conditions. Paradoxical intervention was rated significantly higher on the Expertness subscale of the CRF than the nondirective intervention. The conclusion drawn from the study was that paradoxical interventions could be designed strong in core conditions, thus challenging the notion that paradoxical interventions are contraindicated because of properties specific to them which might undermine the therapeutic process.

The view clinical psychologists take toward the acceptability of paradoxical techniques was the focus of a study by Hunsley and Lefebvre (1991). Eighty-eight clinical psychologists were asked general questions about paradoxical methods and questions about the use of these strategies in four vignettes presented to them. Results indicated a significant relationship between theoretical orientation and the acceptability of paradoxical techniques, although it was

noted that many psychologists, regardless of orientation, perceived paradoxical techniques to be acceptable. No differences were found in psychologists' ratings of compliance-based versus defiance-based rationales or of treatment failure history versus no treatment history.

A similar finding was reported by Hunsley (1993) upon examining acceptability ratings of university students when comparing compliance-based rationales with defiance-based rationales and type of treatment history. Further, Hunsley found no relationship between psychological reactance and acceptability ratings. A second study researched the acceptability of compliance-based symptom prescription with a behavioral intervention. While the symptom prescription was rated as acceptable, it was less acceptable than the behavioral intervention.

Using a simulation methodology to address some of the limitations with written case vignettes, Betts and Remer (1993) recruited undergraduate students to role play family conflicts associated with an acting out adolescent. The "family" then received a letter from the therapist with one of two types of directives (paradoxical and non-paradoxical). The paradoxical directives did not negatively influence perceptions of counselor attractiveness, expertness, or trustworthiness. While the paradoxical directives were judged less acceptable than the nonparadoxical, neither were considered unacceptable.

The common difficulty with these studies on treatment acceptability concerns the use of students rather than actual clients involved in treatment. The type of reactance that may be exhibited by college students is qualitatively different from the type of resistance shown by an individual experiencing negative emotions or behavior problems and coerced into treatment. These studies all agreed that future research should focus on acceptability ratings from actual consumers of mental health services.

With a focus on parent-adolescent conflict, Mittl and Robin (1987) examined acceptability ratings by students (ages 17 to 30) and their mothers of varying treatment procedures, including paradox. Four different treatments (problem-solving communication training, paradoxical intervention, behavioral contracting, and medication) were evaluated by all participants after having read one of two family vignettes describing parents and adolescents in conflict and in need of treatment. Using a modified version of the Treatment Evaluation Inventory (Kazdin, 1980a), the authors found that subjects rated problem-solving communication training as the most acceptable procedure while paradox was rated as the least acceptable and most negatively evaluated treatment technique. Likewise, Cavell, Frentz, and Kelley (1986) discovered that teachers gave similar negative ratings to descriptions of the use of paradoxical interventions to treat school problems. Kolko and Milan (1986) have critiqued this study on the basis of

the way in which the interventions were described as well as providing inadequate information in the description of how the paradoxical intervention was introduced. Other difficulties with these studies include the fact that ratings were completed by individuals who were not clients and who were not identified as currently involved in conflict with one another. Acceptability of treatment may be viewed differently by those actually involved in treatment (Cross-Calvert and Johnston, 1990). Further, the student subjects were not adolescents themselves which may also have affected the findings. The authors suggest further studies be undertaken to investigate the acceptability of treatment by client populations. Finally, the authors acknowledge that ratings by the professionals in assessing content validity for the paradoxical technique were lower for that intervention, suggesting that condition may not have been appropriately representative of a paradoxical intervention. How paradoxical interventions are constructed and delivered can have an impact on how they are received and accepted.

Summary

The literature covered in this review is consistent with respect to the utility of paradoxical interventions. Much of the literature concerns the use of paradoxical techniques in an academic setting with procrastination, depression, insomnia, and other problems of subclinical

severity. Seltzer (1986) suggests that exploration is needed in answering the question of with what populations and under what circumstances are different paradoxical strategies differentially effective. Research obviously needs to broaden in this area, particularly with clinical populations. Martinez-Taboas (1990) has critiqued the research in this area, finding that the research to date has questionable relevance for the clinician due to the narrow field of problems it addresses. He asserts there is a need to emphasize research with clinical populations presenting with a greater diversity of disorders. Additionally, in keeping with Kazdin's (1980b) and Wolf's (1978) observations on evaluating treatment procedures, the criteria for evaluation needs to expand beyond only outcome.

Consistently, adolescents in treatment are described in the literature as a highly reactant, oppositional group. Paradoxical interventions are invariably being identified as the common strategies for dealing with resistance. Yet, little is being accomplished in the research to address this. Adolescent client resistance, increased by being forced to seek therapy, as well as the underlying message to change, is qualitatively different from the resistance that is being defined in the research on undergraduate students.

Those studies which do address the use of paradoxical strategies with adolescents are being carried out in the context of family treatment. This is consistent with the theory behind, and development of, paradoxical strategies;

however, it has also been noted that these strategies can be effectively employed in an individual context as well (L'Abate & Weeks, 1978).

While the efficacy of paradoxical strategies has been addressed relative to outcome on client problems or complaints, there is a need for research to expand beyond outcome only and begin to look at how the consumer evaluates and reacts to treatment procedures. Such perceptions can provide valuable information when measuring outcomes. Recognizing this need for broader criteria to judge the appropriateness of therapeutic interventions, this study is undertaken to examine how specific paradoxical interventions are perceived by adolescent clients, and to what degree, if any, the level of reactance may mediate those perceptions.

Null Hypotheses

The following null hypotheses will be tested at the .05 level of significance:

1. There is no significant interaction between intervention conditions (reframe or symptom prescription techniques) and reactance level (high versus low) on adolescent clients' ratings of the counselor, using the Counselor Rating Form-Short Version (CRF-S; Corrigan & Schmidt, 1983), and their ratings of intervention techniques, using the Treatment Evaluation Inventory (TEI; Kazdin, 1980a).

2. There is no significant difference between adolescent clients identified as high reactant and those identified as low reactant on their ratings of a counselor, using the CRF-S, and on their ratings of intervention techniques, using the TEI.

3. There is no significant difference between the reframe and symptom prescription interventions on adolescent client ratings of a counselor, using the CRF-S, and on their ratings of the intervention techniques, using the TEI.

CHAPTER III

METHODOLOGY

This chapter will discuss the procedures for selection of subjects for the study. A description of the research instrumentation and procedure for administration will be followed by the research design and statistical procedure to be used in analysis of the data.

Subjects

Eighty-six subjects participated in this research study. All of the subjects were selected from a community mental health agency in a rural community with a population of approximately 45,000, located in the midwestern United States. They were obtained by enlisting individuals who had been referred (e.g. by parent, school, social agency, or self) for mental health services and had been accepted and were receiving services as clients by the clinic. Presenting problems of the clients who participated in this study were varied. While there were many who were referred due to problems with depression, the majority of clients were being seen due to a history of oppositional behavior, school and legal difficulties, and anger control problems. Most were experiencing conflicts with parents which were

displayed as primarily oppositional behaviors. Many clients were also identified either by self-report or through the use of random drug screens as experiencing substance abuse problems. Severity of problems ranged from moderate to severe and a high percentage of clients were identified as Seriously Emotionally Disturbed.

While the clinic serves clients and families ranging in age from infancy to older adulthood, for purposes of this study, only those clients whose ages ranged from 13 to 20 were asked to participate. Of the total, seven subjects (8%) could not be identified with respect to demographic variables (age, gender, and ethnic background). Of the remainder, 32 (37%) of the subjects were male and 47 (55%) were female. The mean age was 16 (SD=1.84) with all ages represented. Clients who seek services with this clinic fall within all socioeconomic levels, although the agency provides services predominantly to individuals and families receiving public assistance. While all ethnic groups are served, the prevailing ethnic group seeking services is Caucasian. The largest percentage (58%) of the subjects in this study was Caucasian. African-American (21%), Native American (12%), and Asian American (1%) were the other ethnic groups represented.

Instrumentation

The instruments used in this study to collect the data were the Therapeutic Reactance Scale (TRS), the Treatment Evaluation Inventory (TEI), and the Counselor Rating Form - Short Version (CRF-S). A free response questionnaire was utilized as well.

The Therapeutic Reactance Scale

The TRS (Dowd, Milne, & Wise, 1991) was developed to measure the construct of psychological reactance, or resistance (Brehm, 1966) as used in this study. The TRS is constructed of 28 items. Each item is designed to be rated by subjects using a four-point Likert scale. Scoring is straightforward by assigning a value of 4 to Strongly Agree, 3 to Agree, 2 to Disagree, and 1 to Strongly Disagree. Scoring is reversed for reverse-keyed items. Minimum and maximum attainable scores on the TRS total scale are 28 and 112. The nine items which are reverse-keyed are #7, #11, #13, #14, #18, #21, #24, #25, and #28. Reverse-keyed items were developed to eliminate effects of acquiescence response sets. To eliminate any bias in responses due to the term "reactance," the scale to be completed by subjects will be labeled "Personal Attitude Inventory."

Dowd, Milne, & Wise (1991) performed a factor analysis on the TRS and found a two factor solution to be the most interpretable. Thus, the TRS can yield a behavioral reactance score, a verbal reactance score, and a total

reactance score; however, for the purposes of this study, only the total reactance score will be considered.

Reliability of the TRS. Dowd et al. (1991) report internal consistency reliability for a sample of 130 subjects. The majority of the subjects were in their early 20's with about 75% of the sample being women. Cronbach's alpha reliability coefficients are reported for Behavioral Reactance (.81), Verbal Reactance (.75), and for Total Reactance (.84).

Test-retest reliability, using a three week interval, is also reported (Dowd et al., 1991). Reliability coefficients were computed for Behavioral Reactance (.60), Verbal Reactance (.57), and Total Reactance (.59).

Convergent validity of the TRS. Duckworth (1979) indicates that the K scale of the Minnesota Multiphasic Personality Inventory (MMPI) is associated with a desire to impress and be socially appropriate. Theoretically, the TRS should correlate negatively with the K scale. Morgan (1986) computed a negative correlation of -.48 ($p<.0005$) between K and the Behavioral Reactance subscale. High TRS scores seem to be related to a lessened desire to impress and to be socially appropriate (Dowd, Milne, & Wise, 1991).

Evidence for convergent validity has also been found by correlating TRS scores with the Rotter Internal-External Locus of Control Scale. A significant positive relationship between different measures of psychological reactance and internal locus of control has been found (Brehm & Brehm,

1981). Morgan (1986) found a significant positive correlation (.27, $p<.005$) between the TRS Total Score and internality on the Rotter scale. The Behavioral Reactance subscale and internality on the Rotter scale correlated positively (.35, $p<.0005$).

Divergent validity of the TRS. Partial support for divergent validity was found when comparing the TRS to the Counselor Rating Form-Short version, a measure of counselor social influence. Because these two instruments measure theoretically different constructs, no relationship would be expected. Indeed, no significant correlations between the Expertness and Trustworthiness subscales of the CRF-S and the total scale and two subscales of the TRS were found. A significant negative correlation ($r=-.21$, $p<.05$) between the Attractiveness subscale of the CRF-S and the TRS Behavioral Reactance subscale indicated that as counselor attractiveness increases, behavioral reactance decreases.

Elsewhere (Lukin, Dowd, Plake, & Kraft, 1985), correlating the TRS total score with State and Trait scales of the State-Trait Anxiety Inventory (Spielberger, Gorsuch, and Lurshene, 1970) and with the Beck Depression Inventory (Beck, 1967) revealed nonsignificant correlations. Therefore, the TRS appears to measure a separate construct from anxiety and depression as well as counselor social influence.

Construct validity of the TRS. In a study of client resistance on efficacy of different paradoxical directives,

Dowd et al. (1988) found that low resistant clients had higher scores in their expectation to change and perceived controllability of symptom than did high reactant clients. Furthermore, low reactant clients were found to have fewer external excuses for their problem than did high reactant clients. In contrast, Swoboda, Dowd, and Wise (1990) found no mediating effects due to level of reactance potential.

In a study on counseling supervision (Tracey, Ellickson, & Sherry, 1989), in noncrisis counseling situations, counselors who had low experience and low reactance were found to be more extreme in their preference for structured supervision than counselors who were matched on experience but high in reactance. High reactant counselors identified as high in experience preferred unstructured supervision, whereas high experience counselors who were low in reactance had a slight preference for structured supervision.

The TRS was also used in a study involving efficacy of physician advice to stop smoking (Graybar, Antonuccio, Boutilier, & Varble, 1989). Because high amounts of advice would be perceived, theoretically, as a threat to freedom, the hypothesis that high reactant clients would comply less than they would to low amounts of advice was tested. Low reactant clients were found to have reduced smoking more with high amounts of advice. Another finding revealed that high reactant subjects receiving low amount of negatively toned advice reduced smoking the most.

Morgan (1986) found that the no show rate at a mental health center was significantly higher for high reactant subjects. Another significant finding in this study was a longer duration of treatment for high reactant clients.

The Counselor Rating Form - Short Version

The CRF-S (Corrigan & Schmidt, 1983) is a revised version of the Counselor Rating Form (CRF; Barak & LaCrosse, 1975; LaCrosse & Barak, 1976). The CRF consists of 36 pairs of bipolar adjectives, with each of the pair anchoring the ends of a 7-point Likert scale. There are 12 items for each of these attribute dimensions: attractiveness, expertness, and trustworthiness. One adjective is a positive indication of the attribute it measures, with the other adjective representing the opposite. For the CRF-S, the negative adjective was eliminated and the 7-point scale reflects a range from not very (1) to very (7). This was done to increase the variability in ratings. Twelve of the 36 original items were then selected on the basis of high factor loadings for each item as reported in previous factor analyses and whether the items could be understood at an eighth grade reading level.

Each of the attribute dimensions is represented by four items, resulting in a total score range of 4 to 28 for each of the attributes. Expertness, attractiveness, and trustworthiness items are alternated and items within each scale are arranged alphabetically.

Reliability of the CRF-S. In developing the CRF-S, Corrigan and Schmidt (1983) utilized two samples. The first sample consisted of 133 college student subjects while the second sample included 155 clients from several community mental health centers. College students were asked to rate three 15 minute taped interviews of three different therapists. In the outpatient sample, clients were asked to rate counselors (n=22) following regularly scheduled interviews.

Mean split-half reliabilities across student and client populations were .90 (Expertness), .91 (Attractiveness), and .87 (Trustworthiness). The interitem reliabilities for the CRF-S were compared against expected reliabilities as calculated by the Spearman-Brown correction of the split-half reliabilities for the scales in the CRF. Not only did the reliabilities exceed what was expected but in most cases equaled or exceeded the interitem reliabilities reported by LaCrosse and Barak (1976) for the CRF.

Construct validity of the CRF-S. To determine the underlying factor structure of the CRF-S, a confirmatory factor analysis with simultaneous groups was used. The authors found that a three-factor oblique model, with separate expertness, attractiveness, and trustworthiness dimensions, fit the data better than did four competing two and three-factor oblique and orthogonal models. Most factor loadings for the best fitting model exceeded .75. The authors assert that expertness, attractiveness, and

trustworthiness should be considered distinct but interdependent dimensions (Corrigan & Schmidt, 1983).

The Treatment Evaluation Inventory

The TEI (Kazdin, 1980a) was developed to measure an individual's overall evaluation of a treatment procedure for children. Initially, 45 items were generated, but 16 were finally selected due to their relevance to treatment with children. Sixty introductory psychology students were used in the pilot and were administered the questionnaire after hearing one of four treatments as applied to a clinical case. Additionally, the students rated 15 bipolar adjectives from the Semantic Differential (Osgood, Suci, & Tannenbaum, 1957) covering Evaluative, Potency, and Activity dimensions.

Individual item responses were then subjected to a principal components factor analysis, resulting in 15 of the 16 items producing high loadings on a single principal component before rotation (range is reported from .67 to .94) and on the first factor after varimax rotation (range .61 to .95). In the rotated factor analysis, items loaded highly on a single factor and did not load highly (with the exception of one item, less than .40) on other factors. Interitem correlations, ranging from .35 to .96 (median r=.67), were reported for items of the first factor. Additionally, loadings from the Evaluative dimension of the

Semantic Differential were high for this first factor, indicating the TEI assessed an overall evaluative reaction.

For purposes of this study, a slightly modified version of the TEI, as reported by Mittl and Robin (1987), was used to rate interventions. The authors omitted three items from the original inventory because they were not amenable to being used with family conflict as presented in the case vignettes of the present study. Mittl and Robin provided no reliability information for this modified version. Kuder-Richardson reliability (KR 21) was calculated for the modified version of the TEI used in this study, with a value of .92.

Questionnaire

A free response questionnaire was formulated to assist in further clarifying reactions to and perceptions of the counselor described in each vignette. Three of the questions are based on concepts in the Counselor Effectiveness Rating Scale (CERS; Atkinson & Carskaddon, 1975). The questions address perceptions of the counselor's ability to help the client, willingness to help the client, and comprehension of the client's problems. An additional question addresses the issue of a change in the subject's attitude toward his/her own parents as a result of the counselor's intervention. Finally, a manipulation check was added to the questionnaire to determine whether the subject read and understood the case vignette.

Case Vignettes

The treatment conditions, differentiated by intervention technique, are two written vignettes of a counselor-client interview. The interview is a summary of a "counseling session" focusing on a parent-child conflict. The client in the vignette indicates presence at the session to be at parental demand and that, while acknowledging there is a problem, the problem exists with the parents rather than self. The client asserts parents to be unfair, not allowing the client appropriate freedom.

In the reframe condition, the counselor ends the session with a reframe suggested by McHolland (1985) for dealing with coerced clients. In this intervention, the counselor reframes the "symptoms" as the client's way of standing up for personal beliefs, to further develop independence. In the symptom prescription condition, the counselor ends the session with the same reframe (as a rationale) but gives the client a directive to schedule times for arguments/conflicts with parents in order to maintain and further develop that sense of independence and autonomy.

The vignettes were constructed by the researcher based on professional experience in working with such clients. The gender of the client and therapist is ambiguous to control for any possible gender effect. To assure that

clients would be able to read and understand the vignettes, two reading specialists in the community where the study was undertaken were consulted. Both indicated the vignettes would be readable by the clients solicited for the study.

To address content validity, the vignettes were given to eleven master level practitioners, in a mental health clinic, with a minimum of one year experience providing direct care. Each clinician was asked to read the vignette and give a rating on 1) representativeness of the description of the client and symptoms, 2) representativeness of the intervention as an appropriate reframe and 3) representativeness of the intervention as an appropriate symptom prescription. The clinicians were asked to use a Likert scale, with 1 = not at all representative and 7 = very representative. For the client and symptom description, a mean rating of 6.68 and standard deviation of .46 was obtained. For the reframe and symptom prescription interventions, respective mean ratings of 6.45 and 6.81, with standard deviations of .52 and .34, were obtained.

Procedure

Adolescent clients, ranging in age from 13 to 20, who were admitted for services to the community mental health center were solicited to participate in the study. The primary clinician assigned to each client was enlisted and instructed in proper procedure to assist in administering the instrumentation. Because numerous clinicians were

involved in the collection process, a written solicitation form (Appendix A) was used to help standardize administration of the instruments. The instruments were administered in locations where clients received services. These locations included client homes, alternative school day treatment facilities, and the mental health agency. Each subject was informed s/he was being asked to evaluate counselors, and techniques that counselors sometimes use, to help improve services to agency clients. It was believed this approach was more likely to reduce the probability that the more resistant clients would refuse to participate. Consent forms were obtained from the clients as well as from the parent/guardian.

Each subject was informed s/he would be evaluating a written case vignette describing an interview between a counselor and an adolescent client and would be completing evaluation forms on the counselor after reading the vignette. Each client was requested to complete a form (TRS) on personal attitudes to assess characteristics of those who participate. The TRS was administered before any other questionnaire. Subjects were classified in either high or low reactant groups on the basis of the median split for the total group. The median value of the TRS for client subjects was 74.00.

The intervention conditions were randomly administered to each subject. After reading the vignette, the client completed the TEI, the CRF-S, and the free response

questionnaire. The forms were stapled together in counterbalanced order to control for possible order effects.

The intervention condition was randomly administered to all clients prior to subjects being classified as high or low reactant. This was necessary due to the nature of the setting and type of subjects used. No show rates and what is often a brief "length of stay" would have meant a loss of subjects and collection difficulties if the TRS had been administered (and reactant scores calculated) initially and separately from the dependent variables. Consequently, while the number of subjects in each intervention condition was approximately equal, there was no experimenter control over the number of subjects in each reactant group, producing unequal cell sizes.

Design of the Study

The independent variables for this study were level of reactance (high and low) and type of intervention (reframe and symptom prescription), producing a 2 x 2 factorial design. The dependent variables were the total score on the Treatment Evaluation Inventory and the total score on the Counselor Rating Form-Short Version. A free response questionnaire was also included.

Statistical Procedures

Because this was a factorial design with more than one dependent variable, a multivariate analysis of variance

(MANOVA) was performed on the data to determine if there was a significant interaction effect between the groups on the dependent measures. The dependent variables were the group mean scores for the Treatment Evaluation Inventory and the Counselor Rating Form-Short Version. The independent variables in this study were the level of reactance (high versus low) and the treatment condition (reframe versus symptom prescription).

Responses to the first three questions on the free response questionnaire are reported in percentages. Additionally, a content analysis was conducted on these items to assist in interpretation of the quantitative data. Responses to the fourth item on the questionnaire produced three categories of responses and these are also reported in percentages. A percentage of agreement is reported for the fifth item, or manipulation check on this questionnaire.

CHAPTER IV

RESULTS

In this chapter, the statistical analysis used to test the three hypotheses and the results, together with an analysis of the qualitative measure, are presented. The purpose of this study was to examine the relationship between the dependent variables, the scores on the Counselor Rating Form-Short version and Treatment Evaluation Inventory, and the independent variables, high/low reactance and reframe/symptom prescription techniques.

Descriptive Statistics

The cell means and standard deviations for the CRF-S and the TEI, according to reactance level and intervention type, are presented in Table 1. The mean values suggest that, in general, both groups rated the counselor and treatment positively. This finding is based on defining acceptable ratings as those achieving mean scores greater than the midpoint on a particular acceptability measure (Cross-Calvert & Johnston, 1990). For this study, the midpoint value was defined as the midpoint of the potential range for each instrument. Except for the high reactant

group rating on the TEI for symptom prescription, all dependent measure means exceeded this midpoint value (42).

Table 1

Group Means and Standard Deviations for Dependent Variables by Intervention and Reactant Group

	Reframe		Symptom Prescription	
Reactant Level	CRF-S	TEI	CRF-S	TEI
High				
M	60.00	49.68	48.70	37.95
SD	16.95	13.17	16.12	15.51
n	25		16	
Low				
M	52.56	43.75	60.74	46.72
SD	17.08	12.61	17.99	18.51
n	20		25	

Because there is an assumption that the dependent variables in a MANOVA are correlated, a Pearson r correlation coefficient for the CRF-S and the TEI was computed to determine the extent of this relationship. The correlation between the CRF-S and the TEI is .52. This correlation is significant, $p < .05$.

Test of the Null Hypotheses

Null Hypothesis 1

The first null hypothesis states there is no significant interaction between intervention conditions and level of reactance on adolescent clients' ratings of the counselor, using the CRF-S, and their ratings of intervention technique, using the TEI. The hypothesis was tested at $p<.05$ level of significance.

The multivariate analysis of variance revealed a significant interaction effect, Hotellings trace=.096, between intervention condition and reactance level (See Table 2).

Table 2

Multivariate Test of Significance

Variable	DF	F	Probability
Reactance Level	1	.195	.823
Intervention Type	1	.882	.418
Reactance X Intervention	1	3.89	.024*

* $p<.05$

This interaction is graphically displayed for each dependent variable (See Figures 2 & 3).

Figure 2

Interaction Effect for the
Counselor Rating Form - Short Version

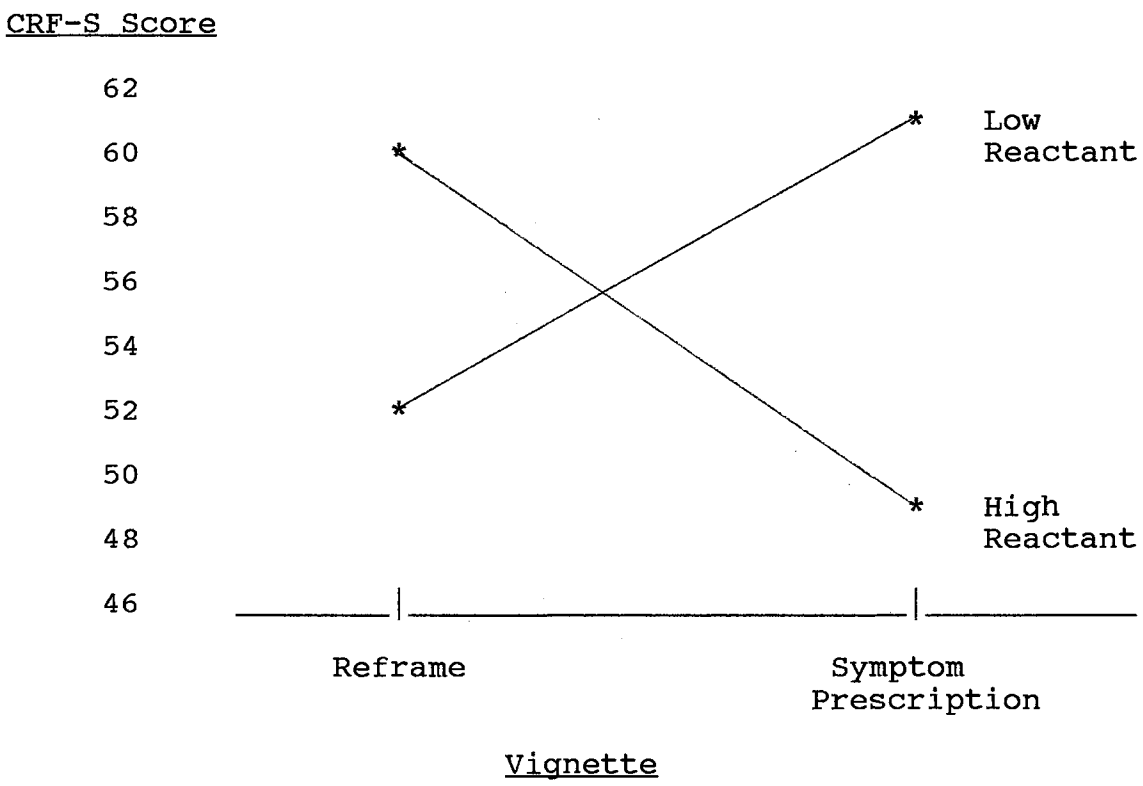
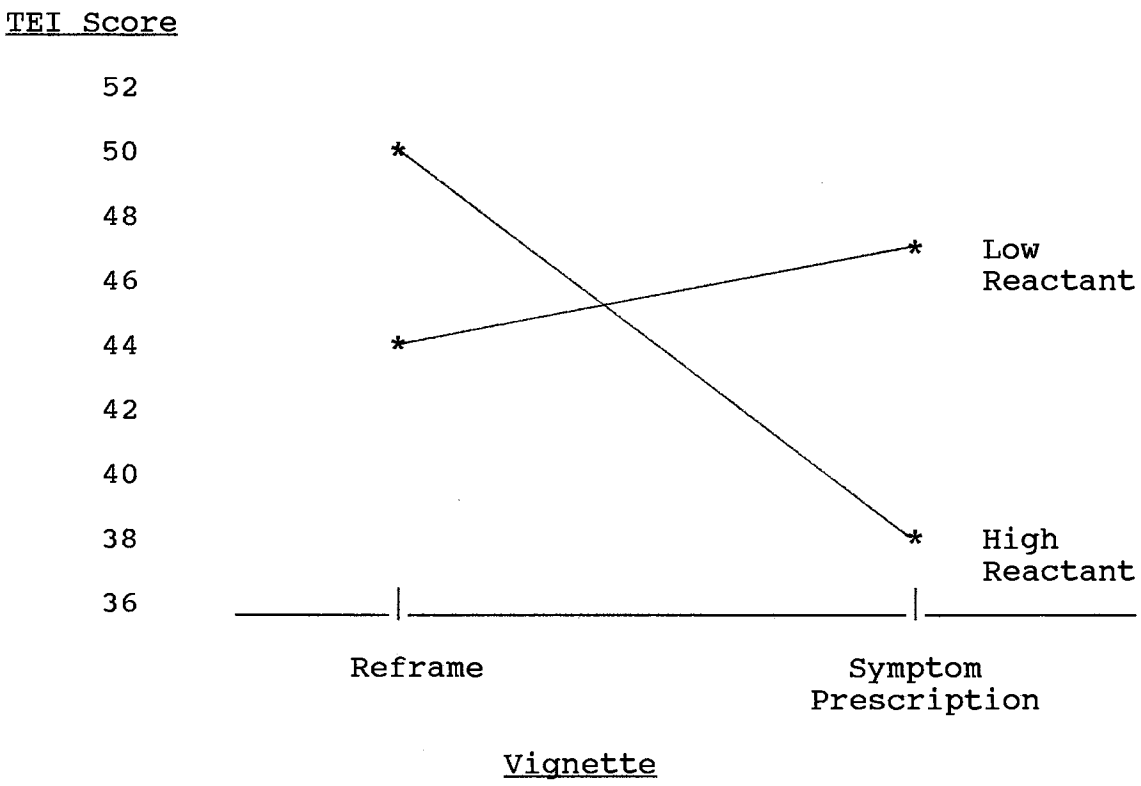


Figure 3

Interaction Effect for the
Treatment Evaluation Inventory



Results of univariate analyses revealed significant effects for both the Counselor Rating Form - Short Version and the Treatment Evaluation Inventory (See Table 3).

Table 3

Univariate Analysis for Interaction Effect - Reactance X Intervention

Dependent Variable	MS	F	Significance of F
CRF-S	1973	6.71	.011*
TEI	1122.7	4.84	.031*

df=1, 82; $p<.05$

These results suggest that level of reactance does play a mediating role in how paradoxical interventions are perceived. Counselor ratings and ratings of treatment acceptability depend on the level of client reactance and the intervention being used. Specifically, high reactant clients rated the reframe intervention and the counselor using it higher than the low reactant client. Low reactant clients, on the other hand, rated the symptom prescription technique and the counselor using it more favorably than the high reactant client. It is therefore concluded to reject Null Hypothesis 1.

Null Hypothesis 2

The second null hypothesis states there is no significant difference between adolescent clients identified as high reactant and those identified as low reactant on their ratings of a counselor, using the CRF-S, and on their

ratings of intervention techniques, using the TEI. Results of the MANOVA failed to find a significant main effect for level of reactance (Hotellings trace=.005), indicating no significant difference between high and low reactant subjects on the dependent variables. The means for this main effect are presented in Table 4 and reflect little difference between high and low reactant clients' ratings when controlling for intervention type. The conclusion based on this finding is to fail to reject the null hypothesis.

Table 4

Group Means for Main Effects - Reactant Level and Intervention Condition

Reactant Level	CRF-S Mean	TEI Mean
High	54.35	43.82
Low	56.65	45.24
Intervention Condition		
Reframe	56.28	46.71
Symptom Prescription	54.72	42.34

Null Hypothesis 3

The third null hypothesis states there is no significant difference between the reframe and symptom

prescription interventions on adolescent clients' ratings of a counselor, using the CRF-S, and on their ratings of the intervention techniques, using the TEI. Results of the MANOVA indicate a non-significant effect for intervention condition (Hotellings trace=.021), suggesting no significant difference between reframe and symptom prescription techniques on the dependent variables. The means for the two intervention conditions are presented in Table 4. Their is little difference between the two means, indicating that counselor ratings and technique ratings for the two intervention conditions, when controlling for level of reactance, are essentially equal. The conclusion from this finding is to fail to reject the null hypothesis.

Questionnaire

Responses to the items on the questionnaire were first evaluated based upon the level of reactance. The first item asked whether the counselor was able to help the client. The second item asked whether the counselor seemed willing to help the client. The third item asked the subject if the counselor seemed to understand the client's problem. Each of these items also asked the subject to explain his/her response. A summary of the responses to these first three items is reported according to intervention type in Tables 5 and 6.

Table 5

Summary of Responses to Questionnaire Items 1 - 3

Reactance Level	Item	Symptom Prescription Yes	No/ No Response
High	1	56% (n=9)	44% (n=7)
	2	69% (n=11)	31% (n=5)
	3	50% (n=8)	50% (n=8)
Low	1	56% (n=14)	44% (n=11)
	2	76% (n=19)	24% (n=6)
	3	64% (n=16)	36% (n=9)

Table 6

Summary of Responses to Questionnaire Items 1 - 3

Reactance Level	Item	Reframe Yes	No/ No Response
High	1	56% (n=14)	44% (n=11)
	2	80% (n=20)	20% (n=5)
	3	68% (n=17)	32% (n=8)
Low	1	60% (n=12)	40% (n=8)
	2	75% (n=15)	25% (n=5)
	3	55% (n=11)	45% (n=9)

The results indicate there is a general tendency for subjects to perceive that the counselor is able and willing

to help and that the counselor seems to understand the client's problem. These numbers correspond to the higher than average ratings that all subjects, regardless of level of reactance, gave on the CRF-S (see Table 1).

The fourth item of the questionnaire asked the subject how, if the counselor had said to the subject what the counselor said to the client, that would change the subject's attitude toward his/her own parents. The responses were separated into three categories: change for the better, change for the worse, or no change at all. A summary of the responses to this item is provided in Table 7.

Table 7

Summary of Responses to Questionnaire Item 4

Reactance Level	Pos (+)	Neg (-)	No Change	Not Know/ No Response
		Reframe		
		Type of Change		
High	40% (n=10)	8% (n=2)	44% (n=11)	8% (n=2)
Low	30% (n=6)	35% (n=7)	15% (n=3)	20% (n=4)
		Symptom Prescription		
High	25% (n=4)	31% (n=5)	31% (n=5)	13% (n=2)
Low	28% (n=7)	20% (n=5)	28% (n=7)	24% (n=6)

For the reframe intervention, a high percentage of high reactant clients identified that the intervention would lead to positive changes for themselves with a large number stating no changes. The low reactant group was close to evenly split on positive and negative changes, with a leaning toward the negative.

Regarding the symptom prescription intervention, more high reactant clients reported either negative or no changes. The majority of low reactant clients perceived themselves to change for the positive or experience no change at all. Assuming that no change is a rather benign response to an intervention, these numbers parallel the statistical results in that the high reactant clients exhibited more favorable (or benign) responses to the reframe intervention while the low reactant subjects responded more favorably to the symptom prescription intervention.

Content Analysis

To further evaluate the responses to the first three items of the questionnaire, a content analysis was undertaken. For the first question, subjects who responded yes to this item in both the Reframe and Symptom Prescription conditions identified a number of characteristics of the counselor as reasons for the counselor's ability to help the client. Twenty one percent of subjects who responded yes attributed the counselor's

ability to help to the counselor's expertness or experience. This was reflected in such comments as the counselor gave "good advice," because the counselor "is experienced," "is trained," "is expert," or that the counselor "knows what he's talking about" and "knows what to do." Similarly, 12% of the subjects perceived the counselor as able to help due to certain positive attributes of the counselor, such as being "cool," "friendly," "smart," and "nice." Ten percent of the subjects provided reasons associated with the counselor establishing the conditions to assist the client such as "spending time with him," "getting to know him better," "taking the side of the client," and "helping him to see his faults." Four subjects perceived the counselor as able to help due to certain characteristics possessed by the client. These were identified as the client's "ability to change," and being in need of help, i.e. "if he wants help then he can receive it." Two respondents saw the counselor as able to help but qualified it. One believed the counselor was able to help but "not doing a good job" while the other thought the client did "not need that much freedom."

Those subjects who expressed the belief that the counselor was not able to help gave reasons associated with characteristics of the client and the counselor. Nine percent of the subjects believed the counselor was not able to help because the "client did not want to be helped" or could "change only if he wants to." Two subjects believed

the client was "in the wrong" and was only "getting his way," thus preventing the counselor from being able to help.

Seventeen percent of the subjects believed the counselor was giving the client "bad advice," and could not be helpful because the advice was "stupid" and would make the situation worse because the client would continue to keep doing what he was doing which was the problem. The counselor was seen by eight percent of the subjects as unable to help because of lack of preparation and that the counselor did "not have everything" in the way of information.

For item two on the questionnaire, 43% of the responses in both Reframe and Symptom Prescription conditions identified positive characteristics of the counselor as reasons for the counselor's willingness to help. These responses included statements such as "friendly," "cares," "concerned," "sweet," and "trying to hear both sides." Ten percent of the subjects perceived the counselor as willing because it is the counselor's job to help. Seven percent said the counselor seemed willing because the counselor provided a response to the client. Two subjects indicated the counselor seemed willing because the client needed help.

Twelve percent of the subjects did not perceive the counselor as willing to help because the counselor provided the client with bad advice. Statements to this effect included "the counselor is telling the client to do what he needs help with" and "what the counselor said does not seem

right." Six percent perceived that the counselor did not seem to care, that he "just wants money" and "should have told the truth." One subject stated the therapist did not seem willing to help because the counselor "did not get the whole story."

For the third item of the questionnaire, 16% believed the counselor understood the client because the counselor seemed to identify the correct definition of the problem, i.e. the counselor "sees Chris's need to feel independent" and "says a lot to relate to the client." With statements such as "some counselors have been through the same problem" and "has been through it," 12% perceived the counselor's ability to understand on the basis that the counselor has shared similar kinds of experiences as the client. Ten percent of the subjects believed in the counselor's ability to understand the client because of things the counselor said to the client, i.e. "the counselor said things to describe Chris's actions," "the counselor was using reverse psychology," and "the counselor tried to give somewhat of a solution." Three subjects identified personal characteristics of the counselor (e.g. "because he's smart") to justify the counselor's ability to understand the client.

Of the subjects who did not perceive the counselor as able to understand the client's problem, ten percent thought the counselor did not have enough information or the "full background" to be able to understand. Others (eight percent) saw the counselor as giving the client bad advice

and not helping the client with the problem. Another eight percent made statements regarding the counselor not acting like he understood, that the counselor "has problems too" and "must be crazy," not "realizing the damage it's doing." Two subjects perceived problems with the client as the reason the counselor was not able to understand the problem. One perceived the client as "lazy" and the other believed the client was "not willing to share the problem."

From this analysis, clients perceived the counselor as able to help because of attributing expertise or experience to the counselor. Similarly, clients tended to attribute positive personal characteristics to the counselor contributing the perception that the counselor was able to help. This also appeared to be a trend in the responses regarding why the counselor seemed willing to help. These positive responses are likely a function of the way in which the counselor's responses to the client were described, suggesting that certain counselor behaviors can mediate the reactions clients have to paradoxical interventions due to their counterintuitive nature (Conoley & Beard, 1984; Newton & Dowd, 1990).

Those who did not see the counselor as able to help perceived the intervention would worsen the situation or that the counselor was giving bad advice. These same statements were reflected in the reasons the counselor was not willing to help or able to understand the client as well. These responses are likely a reaction to the

counterintuitive nature of paradoxical interventions and may be responses on the basis of limited information about the background of the "client" in the case vignette. A number of subjects perceived the counselor as not understanding the client because of a lack of information or background. With more information about the reasons for intervening paradoxically, these negative responses might change.

Another interesting finding in the analysis was that subjects attributed the counselor's ability to understand the "client" because of sharing similar experiences with the client, even though this was not indicated in the vignette. This response is likely a function of the beliefs that individuals have about what counselors are supposed to be like, rather than what is actually the case.

For item five, 65% of those reading the symptom prescription intervention vignette correctly identified the vignette they had read. Fifty-five percent of those reading the reframe intervention vignette made the correct identification. The discrepancy between the two is most likely accounted for by the similarity between the two choices. Also, the reframe intervention carries an implicit directive, thus creating the potential for some to interpret the reframe intervention as explicitly requesting the client to continue the behaviors, which is the intent of the symptom prescription intervention.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The treatment literature is replete with identifying the treatment of choice for countering client resistance. Typically, this involves a consideration of the client who seeks treatment voluntarily but who "resists" efforts from the therapist to assist in resolving symptoms or complaints. Less considered has been the client whose resistance takes the form of a lack of desire or willingness to attend or engage in treatment and who exhibits a strong motivation toward self-direction, autonomy, and independence. Turning attention toward the developmental life-span, the most striking example of the potentially "resistant" client is the adolescent.

The treatment approaches most often identified as appropriate in countering client resistance have been the paradoxical interventions. There is little argument that, when a clinician encounters a highly resistant client, a paradoxical approach seems most appropriate; however, empirical studies of this claim have been, at best, ambiguous in their findings, with a glaring deficiency in

the empirical investigation of the use of such techniques with the adolescent population.

When considering the use of such techniques, the practitioner should be primarily concerned with the efficacy of such techniques. More specifically, will the use of such a technique produce a positive outcome? While there is little empirical support for any one technique producing client change, some research has pointed to the necessity of examining client reactions to therapeutic techniques as a measure of outcome. Clients who perceive their treatment and clinician in a positive manner are believed to be in a better position to make positive changes and thus achieve positive outcomes (Cross-Calvert & Johnston, 1990). Conversely, negative perceptions may lead to problems in the therapeutic relationship or, at worse, premature termination with the perception of a negative outcome of treatment.

The literature on paradoxical interventions has separated them into two classes: reframe interventions and symptom prescriptions. It has been theorized that the use of either is contingent on the level of resistance or reactance displayed by the client. The purpose of this study was to investigate the perceptions of adolescent clients toward these two paradoxical approaches, with a focus on differences as a function of level of reactance.

The following null hypotheses were formulated and tested in this study at the $p<.05$ level of significance:

H1. There is no significant difference between intervention conditions (reframe or symptom prescription techniques) and reactance level (high versus low) on adolescent clients' ratings of the counselor, using the Counselor Rating Form - Short Version, and their ratings of intervention techniques, using the Treatment Evaluation Inventory.

H2. There is no significant difference between adolescent clients identified as high reactant and those identified as low reactant on their ratings of a counselor, using the Counselor Rating Form - Short Version, and on their ratings of intervention techniques, using the Treatment Evaluation Inventory.

H3. There is no significant difference between the reframe and symptom prescription interventions on adolescent client ratings of a counselor, using the Counselor Rating Form - Short Version, and on their ratings of intervention techniques, using the Treatment Evaluation Inventory.

Data were collected from 86 adolescent clients (ages 13 to 20) of a rural community mental health center. Subjects were solicited for participation through the primary clinicians working with them. Each subject was administered the Therapeutic Reactance Scale and randomly administered either a case vignette with a reframe intervention or a

vignette with a symptom prescription intervention. Each subject was then requested to complete the Counselor Rating Form - Short Version, the Treatment Evaluation Inventory, and a free response questionnaire (administered in counterbalanced order).

Multiple and univariate analyses were used to analyze the data and test the three hypotheses. The independent variables were the intervention conditions (two levels) and the reactance level (two levels). The dependent variables were the scores on the Treatment Evaluation Inventory and the Counselor Rating Form - Short Version.

Multivariate analysis revealed a significant interaction effect but no significant main effects. This finding indicates that client perceptions of counselor and technique used differ on the basis of intervention type and level of reactance. The high reactant adolescent clients rated the counselor using the reframe intervention higher than the counselor prescribing the symptom. The low reactant clients, on the other hand, gave higher ratings to the counselor prescribing the symptom than the counselor using the reframe. The high reactant group rated the reframe technique more positively than did low reactant adolescent clients while the low reactant group rated the symptom prescription technique more favorably than the high reactant subjects.

Univariate analyses revealed a significant relationship of both dependent variables to the independent variables.

There were no significant main effects for the level of reactance or intervention conditions on the dependent variables.

Examination of the free response questionnaire shows that in both treatment conditions, high and low reactant groups tended to view the counselor as able and willing to help the client. Additionally, both groups tended to perceive that the counselor understood the client's problem. In addressing changes that the subject would make in response to the counselor's intervention, high reactant responded more favorably or neutrally to the reframe condition. The low reactant group responded both favorably and negatively, with a trend toward negative change, to the reframe. To the symptom prescription technique, high reactant clients identified worse or no changes while the low reactant group perceived themselves to make positive or no changes.

Conclusions

Analysis of the data showed both dependent variables to be significantly related to the two independent variables. This finding supports the notion that adolescent clients do respond differentially to paradoxical techniques depending on the level of reactance. Based on the results of this study, the following conclusions can be drawn:

1. High reactant adolescent clients rate a counselor using a reframe technique more positively than do low

reactant adolescent clients responding to the same counselor.

2. High reactant adolescent clients perceive the use of a reframe technique as more favorable and more acceptable than do low reactant adolescent clients.

3. Low reactant adolescent clients rate a counselor who uses symptom prescription techniques more positively than do high reactant clients.

4. Low reactant adolescent clients rate the use of a symptom prescription technique as more acceptable than do high reactant adolescent clients.

The first two conclusions are interesting findings given the research that indicates symptom prescription should be used with high reactant clients. Due to the nature of reactance as defined in this study, though, this finding makes sense. High reactant clients are viewed as responding more favorably to messages which affirm their self-direction and autonomy. The reframe intervention affirms this personal sense of identity and poses no obvious threat to autonomy. This would "free up" the high reactant client to stop reacting to authority in negative ways and allow for opportunities to change behavior in more positive directions.

The low reactant client, on the other hand, by nature of responding more favorably to other-direction, may perceive the counselor using a reframe technique as not taking an active role by leaving the message to change an

implicit one. The low reactant client may perceive a greater possibility for negative things happening without the directive guidance of a counselor. This is suggested in the higher percentage of low reactant clients expecting their attitude to worsen toward their parents as a result of the reframe.

Conversely, the high reactant client would react more strongly to interventions which are directive, even if this directive is to continue doing the same behaviors. The stronger the directive, the more this is expected to activate the client's resistance to the directive (Tennen, et al., 1981). The low reactant client would perceive the counselor using the symptom prescription technique more favorably, because of its directive nature, even if the intervention seemed incongruous initially.

Limitations

There are several limitations in this study to consider when interpreting the data. While the population used involved actual clients in a mental health setting, only one mental health center, located in a rural community, was used. Consequently, generalizations to other client populations in other centers are restricted. Samples from other centers, including those in metropolitan areas, could result in different findings.

Measures of self-report were used in this study and involved asking clients to report on perceptions and

judgments about individuals in a written vignette. Because such perceptions and judgments are easily changed or influenced by extraneous variables, the reliability of the subject's responses must be approached cautiously.

A median split on the TRS was used to place subjects in a high or low reactant group. It is unknown at this point whether those who fell near the split on either side could actually be considered "high" or "low" in reactance. Using extreme scores, while providing more accurate information, would have reduced power by eliminating subjects.

It should also be noted that the TRS was administered to all subjects together with the dependent variables. Random assignment to treatment condition after reactance level had been determined would have been preferred, but as previously discussed, not feasible. It is unknown what effect this may have had on the results.

The vignettes in this study described behaviors which fall under the category of "free" behaviors, or those which are perceived to be under the voluntary control of a client. The results cannot be generalized to behaviors which are considered to be "unfree" or not under the voluntary control of a client. Ratings on the dependent variables may be affected by descriptions of behaviors which are considered to be "unfree."

Finally, there are a number of contextual variables (e.g. nuances in counselor non-verbal behaviors, the type of relationship formed) which have an effect on the delivery of

any intervention. While efforts were made to include positive counselor characteristics in the scenarios, these variables are easily overlooked or impossible to see in a written vignette. The absence of these variables in the written scenarios may have affected how clients responded to the vignettes.

Implications

The findings from this study have several implications for clinicians who work with an adolescent population. A reframing intervention which focuses on the central issue of self-direction and autonomy will likely help create an environment and/or therapeutic relationship where the highly reactant client has the opportunity to feel heard and respected. The reframe intervention allows the clinician to keep him/herself from being "pulled into" an oppositional, frustrating and losing struggle with the reactant adolescent client. Not only will this prove to be more beneficial to the client and to the therapeutic process in the long run, but will aid in preventing burn out among clinicians who find themselves working with large numbers of reactant youths.

The finding that high reactant adolescent clients responded more favorably to the reframe than to the symptom prescription does not necessarily rule out the use of symptom prescription with this population. The negative reaction to the symptom prescription technique may be the

very catalyst for moving the client toward behavioral change. This is the reason that some researchers (Weeks & L'Abate, 1982; Tennen et al., 1981) suggest that paradoxical directives should be delivered to highly reactant individuals by coming on strong or acting in an authoritarian or controlling manner. The results suggest that such a strong stance may not be necessary in raising reactance, as highly reactant adolescent clients react negatively to a symptom prescription technique but still perceive the counselor in a positive manner. Taking a strong, authoritative stance may also raise reactance but at the cost of undermining the perceptions of the client toward the counselor. It would appear that a symptom prescription can be used without damaging the perceptions of therapist attractiveness, expertness, and trustworthiness (Newton & Dowd, 1990).

It should be emphasized that, based on questionnaire responses, a large number of both high and low reactant clients attributed expertness to the counselor. This is consistent with Conoley and Beard's (1984) finding that the directive nature of paradoxical intervention affects ratings of expertness on the Counselor Rating Form. This may help to account for the significant difference found between high and low reactant clients on counselor and treatment ratings in the symptom prescription intervention. It may be that adolescent clients perceive counselors to be expert because of a general societal belief that counselors have extra

training and should therefore be expert. This places a great deal of responsibility on the clinician to respond to clients and formulate interventions with respect for the client's trust in the counselor to behave in an appropriate and professional manner and with consideration for the client's world view.

It should be noted that for all therapeutic techniques there are indications and contraindications for their use. General guidelines for the use of paradoxical interventions suggest they should not be used in situations where the client or others may be at risk of harm (such as with suicidal and homicidal ideations). As with any other technique, its use with minors should be accompanied with the consent and involvement of parent and/or guardian.

Recommendations

The following recommendations are offered as a result of this study:

1. Determination of reactance level was made on the basis of a median split of the TRS. Because this would mean a greater number of "average" reactant subjects, further research should increase the number of subjects so that extreme scores could be used without a loss of power.

2. Contextual variables are considered to be important in the delivery of any intervention or technique. Despite the advantages to written case scenarios, research which explores client reactions to such techniques delivered

directly to the client would yield more precise information. Including family members in the delivery of the interventions would also allow for those contextual variables to be considered more thoroughly. Direct contact with a therapist would allow clients to make a more accurate assessment.

3. Further research including other centers from varying geographical locations would allow for greater sampling of clientele and thus broader generalization of results.

4. Identification and use of other objective measures of perception or reaction, such as changes in client response or verbalizations, when techniques are delivered directly to the client is recommended to minimize problems with reliability of self-report.

5. All subjects involved in this study were active clients in the mental health center where the study was conducted. The amount and quality of contact with their respective clinicians may have influenced ratings of the clinician in the vignette. It is recommended that further study involve consumers who are initially entering treatment so that possible effects due to contact with a therapist could be controlled.

6. This study considered a symptom prescription and reframe technique, more positively framed. There are other ways to construct and deliver such techniques. It is recommended that research continue to explore the responses

adolescent clients have toward different types and styles of paradoxical interventions.

7. While actual adolescent clients were used in this study, ratings of counselor and technique were still based on vignettes read by the client. A study utilizing therapists delivering paradoxical techniques directly to adolescent clients and obtaining counselor and technique ratings would provide valuable and relevant information for the practitioner.

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APPENDIXES

APPENDIX A

SOLICITATION TO PARTICIPANTS

Solicitation to Volunteer Participants

Dear Participant,

I am interested in getting your perceptions of certain treatment interventions which are sometimes used with clients of mental health services. To do this, I am asking that you read a description of a case of a parent and adolescent conflict and the treatment intervention provided by the therapist. I would like for you to complete a questionnaire, giving me your judgments about the treatment plan that was used in the case and a questionnaire giving me your perceptions of the counselor. To help understand your responses, I am also asking that you complete an attitude inventory which asks you to respond to items which people might use to describe themselves. I will also be asking you to complete a survey form which helps to clarify some of your judgments about what the therapist did in the case example. I recognize this sounds like a lot of forms to fill out, however, it should not take more than a total of 30-40 minutes. The information you provide can be useful in helping therapists improve the delivery of their services, which will ultimately be of value to potential clients of those services.

You will not be asked to reveal any personal information about your own family situation or possible conflicts you might experience at home. If you do have any negative feelings after reading the case example, you will certainly have the opportunity to discuss these with your counselor.

Your participation, which is entirely voluntary, will not only be useful but greatly appreciated.

Thanks

Bryan K. Blankenship

APPENDIX B

PERSONAL ATTITUDE INVENTORY

PERSONAL ATTITUDE INVENTORY

Instructions: Please answer each item by circling the appropriate answer.

SD = Strongly disagree D = Disagree
A = Agree SA = Strongly agree

1. If I receive a lukewarm dish at a restaurant, I make an attempt to let that be known.	SD	D	A	SA
2. I resent authority figures who try to tell me what to do.	SD	D	A	SA
3. I find that I often have to question authority.	SD	D	A	SA
4. I enjoy seeing someone else do something that neither of us are supposed to do.	SD	D	A	SA
5. I have a strong desire to maintain my personal freedom.	SD	D	A	SA
6. I enjoy playing "Devil's Advocate" whenever I can.	SD	D	A	SA
7. In discussions, I am easily persuaded by others.	SD	D	A	SA
8. Nothing turns me on as much as a good argument!	SD	D	A	SA
9. It would be better to have more freedom to do what I want on a job.	SD	D	A	SA
10. If I am told what to do, I often do the opposite.	SD	D	A	SA
11. I am sometimes afraid to disagree with others.	SD	D	A	SA
12. It really bothers me when police officers tell people what to do.	SD	D	A	SA
13. It does not upset me to change my plans because someone in the group wants to do something else.	SD	D	A	SA
14. I don't mind other people telling me what to do.	SD	D	A	SA

15. I enjoy debates with other people.	SD	D	A	SA
16. If someone asks a favor of me, I will think twice about what this person is really after.	SD	D	A	SA
17. I am not very tolerant of others' attempts to persuade me.	SD	D	A	SA
18. I often follow the suggestions of others.	SD	D	A	SA
19. I am relatively opinionated.	SD	D	A	SA
20. It is important to me to be in a powerful position relative to others.	SD	D	A	SA
21. I am very open to solutions to my problems from others.	SD	D	A	SA
22. I enjoy "showing up" people who think they are right.	SD	D	A	SA
23. I consider myself more competitive than cooperative.	SD	D	A	SA
24. I don't mind doing something for someone even when I don't know why I'm doing it.	SD	D	A	SA
25. I usually go along with others' advice.	SD	D	A	SA
26. I feel it is better to stand up for what I believe than to be silent.	SD	D	A	SA
27. I am very stubborn and set in my ways.	SD	D	A	SA
28. It is very important for me to get along well with the people I work with.	SD	D	A	SA

APPENDIX C

WRITTEN CASE VIGNETTES

Case Vignette - SYMPTOM PRESCRIPTION

Chris is 15 years old and was told to come to counseling by the school principal and Chris's parents, Mr. and Mrs. Brown. For the last two years, Chris has been having trouble at school and home. The school has suspended Chris on three occasions for such things as smoking on school grounds, arguing with teachers, and fighting with other students. The teachers have sent Chris to the principal's office several times and to the school counselor to try to find out what the problem is. Nothing seems to have worked.

At home, Mr. and Mrs. Brown say that Chris does not do what is asked, including cleaning Chris's room, washing the dishes, and taking out the trash. The first time Mr. and Mrs. Brown tell Chris to do something, Chris usually ignores them. Mr. and Mrs. Brown then repeat what they ask and Chris says "O.K." but still does not do it. After Mr. and Mrs. Brown repeat themselves a number of times, they usually get angry and yell at Chris. Chris also becomes angry and yells back. The arguments usually end up with Chris name-calling and slamming doors. Mr. and Mrs. Brown say they are very upset and do not know how to deal with Chris's behavior and "bad attitude." They have tried "everything" including talking to Chris, grounding, and taking away Chris's privileges. Mr. and Mrs. Brown say that nothing has worked so far and that Chris needs to talk to a counselor one on one.

When talking with the counselor, Chris said, "I don't need to be here, I'm not crazy." The counselor agreed that Chris did not appear crazy and that many people who come for counseling feel this way. The counselor also said it would be hard for anyone to talk to a stranger about personal things and did not blame Chris for not wanting to come.

Chris and the counselor then talked about the conflicts between Chris and Mr. and Mrs. Brown. Chris said that they are too strict and that they treat Chris like a little kid. Chris believes the things they ask are unfair, that the brother and sisters in the home do not have to do the same things Chris does. Chris said, "I don't know why I have to make changes just to make them happy, when they're the ones who need to change." The counselor said it seemed as if Chris felt upset and angry because Mr. and Mrs. Brown did not understand what Chris needed or how Chris felt.

In ending the session, the counselor made the following statement:

"It seems to me you have become really good at standing up for your right to be independent. It's also clear that you have a lot of strong feelings about not messing up your life with changes others want you to make. You seem to really know your mind and stand up for what you believe and it appears that your conflicts with your parents have really helped you to become good at this. At your age, your main job is to work on becoming independent. So, what I would

suggest you do is continue to do what you've been doing. I think it would even be a good idea if you made time each evening to argue with your parents about something so that you could make sure you got enough practice at becoming independent."

Case Vignette - REFRAME

Chris is 15 years old and was told to come to counseling by the school principal and Chris's parents, Mr. and Mrs. Brown. For the last two years, Chris has been having trouble at school and home. The school has suspended Chris on three occasions for such things as smoking on school grounds, arguing with teachers, and fighting with other students. The teachers have sent Chris to the principal's office several times and to the school counselor to try to find out what the problem is. Nothing seems to have worked.

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In ending the session, the counselor made the following statement:

"It seems to me you have become really good at standing up for your right to be independent. It's also clear that you have a lot of strong feelings about not messing up your life with changes others want you to make. You seem to really know your mind and stand up for what you believe and it appears that your conflicts with your parents have really helped you to become good at this."

APPENDIX D

COUNSELOR RATING FORM - SHORT VERSION

Counselor Rating Form - Short Form

Instructions

We would like you to rate several characteristics of the therapist you just read about. 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 therapist. For example:

FUNNY

not very _X_:___:___:___:___:___:___ very

WELL DRESSED

not very ___:___:___:___:___:_X_:___ 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. Remember, your responses are totally anonymous. No attempt will be made to associate you with the ratings you make.

FRIENDLY

not very ___:___:___:___:___:___:___ very

EXPERIENCED

not very ___:___:___:___:___:___:___ very

HONEST

not very ___:___:___:___:___:___:___ very

LIKEABLE

not very ___:___:___:___:___:___:___ very

EXPERT

not very ___:___:___:___:___:___:___ very

RELIABLE

not very ___:___:___:___:___:___:___ very

SOCIABLE

not very ___:___:___:___:___:___:___ very

PREPARED

not very ___:___:___:___:___:___:___ very

SINCERE

not very ___:___:___:___:___:___:___ very

WARM

not very ___:___:___:___:___:___:___ very

SKILLFUL

not very ___:___:___:___:___:___:___ very

TRUSTWORTHY

not very ___:___:___:___:___:___:___ very

APPENDIX E

TREATMENT EVALUATION INVENTORY

TREATMENT EVALUATION INVENTORY

Please complete the questions listed below. Place a check mark on the line that best shows how you feel about what was done to help the client. Please read very carefully.

1. How right was what the counselor said for the client's problem behavior?

___ ___ ___ ___ ___ ___ ___

not at all right — OK — completely all right

2. If you were the therapist, would you say this yourself to the client?

___ ___ ___ ___ ___ ___ ___

definitely not — maybe — definitely would

3. Would this be OK to use on clients with different problems?

___ ___ ___ ___ ___ ___ ___

not at all — maybe — yes

4. If clients had to get the treatment without wanting it, how bad would it be to give it to them anyway?

___ ___ ___ ___ ___ ___ ___

very bad — not too bad — not bad at all

5. How mean does this treatment seem to you?

___ ___ ___ ___ ___ ___ ___

very mean — mean — not mean at all

6. Does this plan seem like something that should be done?

___ ___ ___ ___ ___ ___ ___

not at all — maybe it should be done — definitely it should be done

7. Do you think this plan treats the client nicely?

___ ___ ___ ___ ___ ___ ___

not at all nice — kind of nice — treats client very nicely

8. Do you think this treatment could be harmful to the client?

not harmful at all	___	___	___	___	___	very harmful

9. How much do you like the things said to the client?

do not like them at all	___	___	___	___	___	like them very much

10. How well would this plan work? (That is, how well will this intervention help the client overcome the problems?)

not at all	___	___	___	___	___	very well

11. What are the chances that this plan will make the client better for a long time?

none at all	___	___	___	___	___	excellent chance

12. How many bad things will happen when this plan is used?

many bad things	___	___	___	___	___	no bad things

APPENDIX F

QUESTIONNAIRE

QUESTIONNAIRE

Please respond to the following questions about the case example you just read by circling your response and then writing your reasons:

1. Do you believe this counselor has the ability to help the client? Yes or No

   Why or why not?

2. Does the counselor seem willing to help the client? Yes or No

   Why or why not?

3. In your opinion, based on what the counselor said, does the counselor seem to understand the client's problem? Yes or No

   Why or why not?

4. If a counselor had said to you what the counselor said to the client in the case example, how would that change your <u>attitude</u> toward your parent(s)?

5. Which of the following best describes the case example you just read? Please circle the appropriate letter.

   A. The counselor said the client's behaviors were attempts to increase independence.

   B. The counselor said the client's behaviors were attempts to increase independence and that the client should continue to do those behaviors.

APPENDIX G

CONSENT FORMS

CONSENT FORM
PARENT/GUARDIAN

I,_____, hereby authorize or direct Bryan K. Blankenship or assistants of his choosing, to perform the following procedure:

This study is interested in obtaining information about certain types of treatment interventions and how they are perceived by actual adolescent clients of a mental health agency. The purpose of this research is to add to our understanding of treatment procedures so that we can evaluate what we do as treatment providers. Ultimately, our hope is to inform counselors/therapists about the utility of certain treatment techniques.

To give us some information about your child, he or she will be asked to complete a Personal Attitude Inventory, which should take about 10 minutes to complete. After completing this inventory, he or she will then read a description of a typical conflict between a parent and adolescent who are seeking counseling services. The treatment intervention of the therapist will follow. Your child will then be administered a form, the Treatment Evaluation Inventory, which asks questions about the intervention used in the case example. An additional survey form will be given to clarify some of your child's perceptions of the technique used. Completion of these forms is expected to take about 20 minutes. Confidentiality of this information will be maintained as no names will be placed on these forms. Your child will not be personally identified with the forms he or she completes.

There are minimal risks to your child in participating in this study. He or she will not be asked to reveal or discuss any information about his or her own family conflicts. Any discomfort that may arise would be negative feelings which could be provoked from reading about family conflict and relating this to his or her own situation. If this does occur, your child will be able to discuss these feelings with his or her counselor to help resolve the discomfort.

The potential benefits include providing information to treatment providers about certain procedures which are used in the counseling process. Obtaining evaluative information from actual consumers of counseling services has been lacking in this field. Such information can be used by treatment providers to improve their services to their clients, helping to reduce negative treatment experiences of consumers of mental health services.

This is accomplished as part of an investigation entitled Adolescent Perceptions and Reactions to Reframe and Symptom Prescription Techniques.

I understand that participation is voluntary, that there is no penalty to my child for refusal to participate, and that I am free to withdraw my consent for my child's participation in this project at any time without penalty.

For answers to my questions or should I wish further information about this project, I may contact Bryan K. Blankenship at telephone number (918) 682-8407 or Dr. Al Carlozzi, Department of Applied Behavioral Studies, Oklahoma State University, at (405) 744-6036. If you have questions about the rights of research participants, please contact Ms. Jennifer Moore at the OSU University Research Services (405) 744-5700.

I have read and fully understand the consent form. A copy of this form has been provided to me.

Date:_____

Signed:_____
(signature of parent/guardian)

CONSENT FORM
PARTICIPANT

I,_____, hereby authorize or direct Bryan K. Blankenship or assistants of his choosing, to perform the following procedure:

This study is interested in obtaining information about certain types of treatment interventions and how they are perceived by actual adolescent clients of a mental health agency. The purpose of this research is to add to our understanding of treatment procedures so that we can evaluate what we do as treatment providers. Ultimately, our hope is to inform counselors/therapists about the utility of certain treatment techniques.

To give us some information about yourself, you will be asked to complete a Personal Attitude Inventory, which should take about 10 minutes to complete. After completing this inventory, you will then read a description of a typical conflict between a parent and adolescent who are seeking counseling services. The treatment intervention of the therapist will follow. You will then be administered a form, the Treatment Evaluation Inventory, which asks questions about the intervention used in the case example. An additional survey form will be given to clarify some of your perceptions of the technique used. Completion of these forms is expected to take about 20 minutes. Confidentiality of this information will be maintained as no names will be placed on these forms. You will not be personally identified with the forms you complete.

There are minimal risks to you in participating in this study. You will not be asked to reveal or discuss any information about your own family conflicts. Any discomfort that may arise could be negative feelings which would be provoked from reading about family conflict and relating this to your own situation. If this does occur, you will be able to discuss these feelings with your counselor to help resolve the discomfort.

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I have read and fully understand the consent form. A copy of this form has been provided to me.

Date:_____

Signed:_____
(signature of participant)

2

VITA

Bryan K. Blankenship

Candidate for the Degree of

Doctor of Philosophy

Thesis: ADOLESCENT CLIENT PERCEPTIONS OF AND REACTIONS TO REFRAME AND SYMPTOM PRESCRIPTION TECHNIQUES

Major Field: Applied Behavioral Studies

Area of Specialization: Counseling Psychology

Biographical:

Personal Data: Born in Oklahoma City, Oklahoma on September 9, 1958, the son of Darrell and Nolly Blankenship. Married to Rebecca A. Blankenship; father of Emily Anne, Seth Thomas, Margaret Grace, Noah Paul, and Olivia Jane Blankenship.

Education: Graduated from Skiatook High School, Skiatook, Oklahoma in May, 1976; received Bachelor of Arts degree, cum laude, from Oral Roberts University, Tulsa, Oklahoma, in May, 1980; received Master of Arts degree, with high honors, from Wheaton Graduate School, Wheaton, Illinois, in May, 1984; completed requirements for the Doctor of Philosophy degree at Oklahoma State University in December, 1995.

Professional Experience: Senior Counselor, Shadow Mountain Institute, May, 1980 to May, 1982. Psychological Assistant, Mental Health Services of Southern Oklahoma, December, 1984 to February, 1987; Outpatient therapist, Green Country Mental Health Services, March, 1987 to August, 1992 and August, 1993 to July, 1994; Psychology Intern, Sedgwick County Mental Health, Wichita, Kansas, August, 1992 to August, 1993. Director of Clinical Services, Green Country Mental Health, July, 1994 to present.

Professional Memberships: Clinical Member, American Association of Marital and Family Therapists; Licensed Marital and Family Therapist

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
HUMAN SUBJECTS REVIEW

Date: 12-15-94 **IRB#:** ED-95-035

Proposal Title: ADOLESCENT CLIENT PERCEPTIONS OF AND REACTIONS TO REFRAME AND SYMPTOM PRESCRIPTION TECHNIQUES

Principal Investigator(s): Alfred Carlozzi, Bryan Blankenship

Reviewed and Processed as: Expedited

Approval Status Recommended by Reviewer(s): Approved

APPROVAL STATUS SUBJECT TO REVIEW BY FULL INSTITUTIONAL REVIEW BOARD AT NEXT MEETING.
APPROVAL STATUS PERIOD VALID FOR ONE CALENDAR YEAR AFTER WHICH A CONTINUATION OR RENEWAL REQUEST IS REQUIRED TO BE SUBMITTED FOR BOARD APPROVAL.
ANY MODIFICATIONS TO APPROVED PROJECT MUST ALSO BE SUBMITTED FOR APPROVAL.

Comments, Modifications/Conditions for Approval or Reasons for Deferral or Disapproval are as follows:

Signature:  Date: January 24, 1995

Chair of Institutional Review Board