



Psychological reactance in psychiatric patients: Examining the dimensionality and correlates of the Hong Psychological Reactance Scale in a large clinical sample



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ARTICLE INFO

Article history:

Received 4 April 2014

Received in revised form 11 June 2014

Accepted 16 June 2014

Available online 17 July 2014

Keywords:

Factor structure

Hong Psychological Reactance Scale

Psychiatric outpatients

ABSTRACT

This study investigated the factor structure and psychometric properties of the Spanish version of the Hong Psychological Reactance Scale (HPRS) in psychiatric outpatient care, and how socio-demographic and clinical variables are related to this measure of trait reactance proneness. We carried out a cross-sectional survey involving seven hundred and ten consecutive psychiatric outpatients that completed the HPRS, health locus of control, self-efficacy and drug attitude scales, in addition to a questionnaire including socio-demographic and clinical variables. A confirmatory factor analysis to test the dimensionality of the HPRS was performed. Results supported that the best-fitting model of reactance processes was a two-factor structure including affective and cognitive dimensions whose understanding and interaction appear essential to develop effective persuasive clinical messages. Further analyses yielded significant results with age, educational level, number of drugs prescribed, health locus of control dimensions and attitudes toward psychiatric treatment but not with sex, self-efficacy or psychiatric diagnoses. Psychological reactance is a longstanding but still promising construct. Our results confirm that a two-factor structure is reasonable for assessing psychological reactance in psychiatric patients and provides an opportunity to understand patients' health behavior.

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1. Introduction

Patients actively involved in their health and healthcare tend to have better outcomes and, some evidence suggests, lower costs (Hibbard & Greene, 2013). Nevertheless, some factors attributable to patients and their characteristics and proclivities need to be overcome to carry out effective patient engagement.

In this sense, psychological reactance is an aversive motivational state that functions to restore an individual's perceptions of autonomy in response to regulations or impositions that impinge on freedom and autonomy (Brehm, 1966, 1972; Brehm & Brehm, 1981), particularly when individuals feel obliged to adopt a particular opinion or engage in a specific behavior. Although initially investigated as a state phenomenon, it has become evident

that individuals are likely to vary as regards their trait propensity to experience reactance (Shen & Dillard, 2005).

The Hong's Psychological Reactance Scale (HPRS; Hong & Faedda, 1996) was devised for use in the general population to measure the individual difference in reactance proneness, that is, a person's trait propensity to experience psychological reactance. Although psychometric properties of the scale have been subject to extensive study and the scale has been used in several studies (Dillard & Shen, 2005; Hellman & McMillin, 1997; Hong, Giannakopoulos, Laing, & Williams, 1994; Joubert, 1990, 1992), there is little agreement in terms of the factor structure of this measure, which has ranged from an initial four-factor structure to a one-dimensional solution (Hong, 1992; Donnell, Thomas, & Buboltz, 2001; Jonason, 2007; Shen & Dillard, 2005).

Prior research has revealed a considerable amount of negative consequences resulting from psychological reactance (Steindl & Jonas, 2012). Within the field of mental health, patients' perceptions of limiting or threatening freedoms or control may induce nonadherence with prescribed treatments so that recommendations to follow a drug regimen have the potential to elicit reactance

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and, as a result, lead individuals to ignore the recommended treatment (Fogarty & Youngs, 2000; Hong, 1992; Moore, Sellwood, & Stirling, 2000), as well as play a role in boosting the efficacy of psychotherapy and dealing with client resistance to this (Carver, 1991; Dowd, 1990, 1993; Horvath & Goheen, 1990). Although psychological reactance has been present in the field of psychology for over 50 years, this potentially useful construct is rarely used in psychiatric clinical practice and is not even cited in many textbooks.

The aim of this study was to assess the factor structure and psychometric properties of the Spanish version of the Hong Psychological Reactance Scale in psychiatric outpatient care, and to investigate how socio-demographic and clinical variables are related to this measure of trait reactance proneness.

2. Material and methods

2.1. Sample

From October 2013 to January 2014, nine hundred and ten consecutive psychiatric outpatients seen in the Community Mental Health Services on Tenerife Island (Canary Islands, Spain) were invited to participate in a cross-sectional study; a total of 710 accepted. Patients were eligible for inclusion in the study if they were aged 18 and over and were diagnosed by their psychiatrists with psychiatric disorders using the International Classification of Diseases, Tenth Edition (ICD-10) codes F20 (schizophrenia), F31 (bipolar affective disorder), F32–33 (depressive episode and recurrent depressive disorder), F40–48 (obsessive–compulsive disorder and other neurotic, stress-related and somatoform disorders), and F60–69 (Disorders of adult personality and behavior). Each participant received a full explanation of the study, after which they signed an informed consent document approved by the clinical research ethics committee of Nuestra Señora de Candelaria University Hospital in Santa Cruz de Tenerife. Each participant then filled out a brief socio-demographic survey and the remaining questionnaires.

2.2. Measures

2.2.1. Socio-demographic characteristics and clinical variables

Age, sex, educational level, psychiatric patient history, and class of psychoactive drugs currently taken were assessed. For assessment purposes the drugs were split into the common groups of psychotropic drugs: antidepressants, benzodiazepines, antipsychotics and mood stabilizers. For statistical analysis purposes, a new variable (number of different drugs) was drawn up as an indirect measure of treatment complexity. We also recorded how long patients had been under psychiatric treatment (in months), the number of different psychiatrists treating them during that time, and the number of psychiatric admissions specifying their voluntary or involuntary character. Psychiatrists responsible for patient mental health care were asked about patient diagnosis.

2.2.2. Hong Psychological Reactance Scale (HPRS)

The Hong Psychological Reactance Scale (Hong & Faedda, 1996; Pérez García, 1993) is a 14-item self-report questionnaire designed to measure the individual difference in reactance proneness, that is, a person's trait propensity to experience psychological reactance. Psychological Reactance (Wallston, 1992) assumes that, when an individual's freedom is threatened, the individual will be motivated to restore the perceived loss of freedom. Participants indicated the extent to which they endorsed each statement on a five-point Likert scale (ranging from 1 = strongly disagree to 5 = strongly agree).

2.2.3. Multidimensional Health Locus of Control (MHLC) Form C Scale

Form C of the multidimensional health locus of control (MHLC) scale (Wallston, Stein, & Smith, 1994) is an 18-item, general purpose, condition-specific locus of control scale that could easily be adapted for use with any medical or health-related condition. There are four subscales of the form C of the MHLC: (1) internal health locus of control (IHLC), which is the belief that one's own behaviors affect one's health status; (2) chance health locus of control (CHLC), which is the belief that one's health condition is a matter of fate, luck or chance; (3) doctors (DHCL) health locus of control, which is the belief that it is doctors who determine the outcomes of patient health; and (4) other people health locus of control (PHLC), which is the belief that other people, such as family and friends have control over one's health status. Internal and chance subscales are comprised of six items, while doctors and other people subscales are comprised of three items, totaling 18 items on the questionnaire. Patients are asked to rate, on a six-point Likert scale, the degree to which they agree or disagree with each statement. Higher scores on each subscale indicate a stronger belief in that kind of control.

2.2.4. General Perceived Self-Efficacy Scale

The General Perceived Self-Efficacy Scale (GSE) (Schwarzer & Jerusalem, 1995) is a 10-item self-report scale that measures general self-efficacy as a prospective and operative construct. In contrast to other scales designed to assess optimism, this scale explicitly refers to personal agency, i.e., the belief that one's actions are responsible for successful outcomes. Each item is scored from 1 (not at all true) to 4 (completely true). The summary score ranges from 10 to 40, with the highest score indicating high self-efficacy.

2.2.5. Drug Attitude Inventory

The Drug Attitude Inventory (DAI-10) (Hogan, Awad, & Eastwood, 1983) is a 10-item self-report scale devised to measure the subjective responses and attitudes of psychiatric patients towards their treatment by revealing whether patients are satisfied with their medications and assessing their understanding of how the treatment is affecting them. Items represent subjective experience presented as self-report statements with which the patient agrees or disagrees. These are based on actual recorded and transcribed accounts of patients, and response options are true/false only. Each response is scored as +1 if correct or –1 if incorrect. The final score is the grand total of the positive and negative points and ranges in value from –10 to 10, with higher scores indicating a more positive attitude towards medication. A positive total score means a positive subjective response; a negative total score means a negative subjective response.

2.3. Data analysis

Frequency was analyzed to describe the sample. An initial exploratory factor analysis (EFA) was performed to identify the empirical structure of the Hong Psychological Reactance Scale. To perform this analysis, a random sample (approximately 50% of those participants without missing data) was used. To obviate the confounding variable of related factors, an oblique rotation was carried out. Factors with an eigenvalue equal or higher than 1.0 were considered. To assign items to factors, loading coefficients equal or higher than .30 were taken into account. When one item loaded in more than one factor, the item was assigned to a factor with a higher loading coefficient. Confirmatory factor analysis (CFA) was performed to test this empirical structure and other structures derived from previous studies. Once again, to avoid tautologic errors with EFA, a random sample representing 50% of participants was generated. Convergent validity and the relationship with socio-demographic variables were analyzed with the Pearson

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