Why, Why, Why?: Reason-Giving and Rumination as Predictors of Response to Activation- and Insight-Oriented Treatment Rationales

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This study examines the relationships among the reasons a person offers for depression, the tendency to ruminate in response to depression, and reactions to activation-oriented (AO) or insight-oriented (IO) treatment rationales. Adults from the community ($N = 51$) completed self-report measures of reason-giving and rumination and rated the credibility of, and personal reactions to, AO and IO rationales presented in written and videotape formats. Participants who gave more reasons for depression also tended to ruminate more in response to depressed mood. Reason-giving and rumination predicted lower credibility ratings and more negative personal reactions to the AO rationale. Although no relationship was found between these variables and response to the IO rationale, specific reasons were associated with different reactions to the two rationales. We discuss the roles of reason-giving and rumination in predicting responses to psychotherapies for depression. © 1999 John Wiley & Sons, Inc. J Clin Psychol 55: 881–894, 1999.

Psychotherapists typically assume that clients who agree with the rationale underlying an intervention will have better outcomes than those who disagree. This clinical observation has been empirically supported in areas as diverse as depression (Addis & Jacobson, 1996; Fennel & Teasdale, 1987; Ilardi & Craighead, 1994), pain management (Spence & Sharpe, 1993), and medical treatment (Becker et al., 1977; Centers for Disease Control, 1990; DeGood, 1983). What is less clear is exactly why different clients agree or disagree

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natural dialogue). In psychotherapy, reason-giving may serve to avoid a therapist's inducements to change a client's behavior (Addis & Jacobson, 1996). To the degree that a client enters treatment offering multiple reasons for problems, he or she may be less likely to collaborate with a therapist on changing specific behaviors. Because different treatments vary in their degree of emphasis on behavioral change, reason-giving may be an important individual difference variable in determining responses to specific rationales.

Second, reason-giving may be a private attempt, a public attempt, or both to solve a problem by discovering its causes. We all have long learning histories in which stating reasons for problems (to ourselves or to others) helps to identify what needs to be changed. If our car won't start, we can't solve the problem until we know why it isn't starting. However, the process may be less productive when it comes to human experiences such as depression and anxiety.[1] Drawing on a history of reason-giving as problem solving can lead to rumination, or continuous representation[2] of problems as opposed to solutions. Lyubomirsky and Nolen-Hoeksema (1993) found that experimentally induced rumination led participants to report less likelihood of engaging in pleasant activities. Participants felt it would interfere with their efforts to understand themselves (see also Hayes, 1989, and Hayes & Wilson, 1993, for a thorough discussion of the role reason-giving may play in maintaining behavioral problems). Thus, an additional purpose of this study was to examine the associations between (a) reason-giving and the tendency to ruminate and (b) rumination and response to a treatment rationale emphasizing the importance of understanding the causes of depression.

To summarize, reason-giving may predict response to different psychotherapies in ways not addressed by previous research on causal attributions and beliefs. Because it can serve to justify or exonerate behavior, reason-giving should predict a negative response to treatment rationales emphasizing a client's role in changing behavior. Second, if reason-giving reflects a tendency to try to solve problems by discovering causes, it should predict negative reactions to change-oriented treatment rationales and positive reactions to those focusing on insight as a change mechanism. In the present study we sought to replicate and extend these hypotheses by examining the relationships among reason-giving, rumination, and response to activation-oriented (AO) versus insight-oriented (IO) treatment rationales.

We used an analogue design to evaluate reactions to treatment rationales presented in video and written format. Although the study did not involve actual psychotherapy clients and treatments, there is consistent evidence that acceptance of particular treatment rationales is associated with positive treatment outcomes (Addis & Jacobson, 1996; Fennel & Teasdale, 1987; Spence & Sharpe, 1993). Thus, variables affecting reactions to rationales are worth investigating in their own right (e.g., Rokke, Carter, Rehm, & Veltum, 1990). We were interested in exploring two types of reactions to each rationale. The first was the perceived credibility of a rationale as presented in written form. The second was an individual's personal reaction to the same rationale presented in a video format. Although we did not have a firm basis from which to predict differences between the two types of

[1]There are obviously times when it can be helpful to determine the causes of emotional and behavioral problems. However, it is not always necessary. Regardless of why one is depressed, engaging in pleasant activities, exercising, combating pessimistic thinking, or taking medication all can be helpful. Nonetheless, most of us continue to assume that it is necessary to delve deeply into the causes of distress before treatment can effective. Presumably, this tendency is due to a strong history of reason-giving being functional in solving problems in the physical world, and our culture's tendency to reinforce offering private events (e.g., thoughts and feelings) as causes of behavior. Hayes (1988) and Hayes and Wilson (1993) have discussed this issue in more detail.

[2]We are referring here not to symbolic representation as a cognitive process but to re-presentation: the act of continuing to think and talk (privately or publicly) about distressing events and their causes.

Video Treatment Vignettes. Vignettes of a therapist presenting an AO and an IO treatment rationale were created for participants to watch and respond to. The first author served as the therapist in each vignette. An actor or actress played the client in both treatments. Thus, there were four videotaped vignettes with either a man or woman client and an AO or IO rationale. Women participants saw the actress in both the AO and the IO treatment. Men participants saw the actor in both treatments. We chose to match the sex of the participant and the client to maximize the likelihood that the former would identify with the latter. The actor and actress were asked to play the role indicated in a written paragraph (presented subsequently). They were instructed to appear depressed and to describe their problems briefly, but to let the therapist have the floor when presenting the rationale or making interventions. Finally, they were told not to endorse either treatment in any way (e.g., head nodding, or saying, "That sounds really good.").

The order of presentation of the treatments was randomized. Each tape showed a split-screen image with head and torso profiles of the therapist on the left and the client on the right. Each tape lasted approximately 10 minutes (M = 10.4 minutes, SD = 49 seconds). Several steps were taken to insure that that the vignettes differed only with respect to the treatment rationale and the type of interventions utilized by the therapist. The particular issues discussed were matched in each tape. Prior to viewing the first tape, participants were given a brief written paragraph and told that it would give them some background information on the client they were about to see. Women participants were given the following paragraph:

> This client is a married woman in her mid-thirties who has sought psychotherapy for feelings of depression. She feels deeply sad most days, has difficulty sleeping, difficulty remembering things, and is tired most of the day. The client has recently moved to Massachusetts from the Midwest where she was born, and where her family and friends still live. She recently started a new job that she finds challenging and enjoyable, although at times the stress is overwhelming. Her primary difficulty at work is that she often feels incompetent and is very self-critical of her performance. Her self-critical tendencies continue despite consistent positive feedback from her employer.

Men participants were given an identical paragraph describing a male client. These particular issues were chosen because they represent common and credible life events associated with depression.

Participants were asked to imagine that they were experiencing the type of therapy described in each tape and to think about how helpful it would be for them if they were feeling depressed. On each tape, the therapist spent approximately the first 2 minutes describing an AO or an IO treatment rationale after which the image faded out.[4] The therapist then spent approximately 4 minutes focusing on symptoms of depression related to the recent move and missing friends and family, followed by a fade-out. The final 4 minutes were spent discussing the client's feelings of incompetence at work and perceived criticism from his or her employer. The latter two segments were intended to show how the different treatment rationales would be implemented in concrete interventions.

In the AO treatment, the therapist approached the issue of moving to a new city and missing family by suggesting that the client increase pleasurable activities, exercise, and phone extended family more frequently. The difficulties at work were approached by focusing on concrete ways to decrease stress and manage time more effectively. In the IO

[4]The rationales were virtually identical to those presented in the written treatment descriptions. The AO rationale focused on the importance of increasing pleasurable activities, solving problems, and getting more active as an effective way to combat depression. The IO rationale emphasized the importance of understanding the unconscious causes of depression, the specific feelings involved, and possible past events that may be contributing to current feelings.

How complete does this therapy seem to you? In other words, do you think this therapy covers all the types of people who become depressed? To what extent would this therapy help an individual in other areas of his or her life? How likely would you be to go into this therapy if you were depressed? How effective do you think this therapy would be for most people? If a close friend or relative were depressed, would you recommend this therapy to them? These seven items, adapted from Borkovec and Nau (1972), have demonstrated good internal consistency and have been used to assess young adults' perceptions of the credibility of different treatment for depression (Rokke et al., 1990).

Personal Reactions to the Rationales (PRR). After watching each treatment vignette, participants answered the following five questions on a 7-point scale from 1 (*not at all*) to 7 (*extremely*): If you were depressed and went to see a therapist, how helpful do you think this therapy would be for you? To what extent do you think that this therapy would help you to understand the causes of your depression? To what extent do you think that this therapy would help you learn effective ways to cope with feeling depressed? If you were to seek therapy for depression, how likely would you be to choose this type of therapy? If you were to try this type of therapy, how effective would it be in treating your depression? In contrast to the credibility items for the written descriptions, these items were chosen for their more personal focus (i.e., do you think this treatment will be effective for you?)

Results

Individual item ratings on the PRR were highly intercorrelated within the AO (mean r = .75, α = .94) and IO (mean r = .78, α = .95) treatments. Due to the high degree of intercorrelation among the items we chose to sum the individual item ratings for each video to create single PRR scores for the AO and IO rationales. These scores had a possible range of 5 to 35 (mean AO = 24.1, SD = 7.0, mean IO = 22.0, SD = 7.1) with higher scores indicating more positive reactions.

Total ratings for the credibility items following the written descriptions of the AO (mean r = .49, α = .87) and IO (mean r = .65, α = .93) rationales were computed in the same fashion. These scores had a possible range of 7 to 49 (mean AO = 29.0, SD = 7.5, mean IO = 31.6, SD = 8.0) with higher scores indicating higher credibility ratings. Credibility and PRR ratings of the same rationale were moderately to highly correlated (r(AO) = .53, $p < .001$, r(IO) = .62, $p < .001$). The correlations between credibility and PRR ratings of contrasting rationales were less than .20 and nonsignificant.

Order Effects and Comparisons of the Rationales

We conducted a paired t-test to test for possible order of presentation effects on PRR ratings of each video vignette. The results indicated significantly higher average scores for the second vignette ($t(50) = 2.82$, $p < .01$). Comparisons of differences between AO and IO ratings depending on order of treatment presentation revealed that PRR scores were higher for the AO vignette when it was presented second ($t(49) = 2.1$, $p = .03$). PRR ratings for the IO vignette did not differ depending on presentation order. The order of presentation of the vignettes was dummy-coded and treated as a covariate in the remaining analyses involving PRR ratings.

Table 1 shows the means and standard deviations for all variables. The mean BDI score of 10.4 (SD = 8.7, range = 0–42) suggests that the sample as a whole was not

rumination to be associated with depressed mood in a nonclinically selected sample (Addis et al., 1995), we wanted to see whether or not the relationship between these two variables was completely accounted for by current depressed mood. Partialling out the BDI resulted in a smaller, but significant, correlation ($r(49) = .36, p < .01$) between the RFD and the RSQ. Thus, the relationship between the RFD and the RSQ was not completely accounted for by current depressed mood.

We performed a series of hierarchical multiple regression analyses to determine whether RFD and RSQ-R scores predicted PRR and credibility ratings for the two rationales. PRR or credibility ratings served as the criterion in each analysis. The order of treatment presentation was entered first in all analyses involving PRR ratings as a criterion. BDI scores were also entered first in all analyses to determine the unique contribution of reason-giving and rumination to predicting responses to the rationales. As Table 2 indicates, both RFD and RSQ-R scores were significant predictors of responses to the AO rationale, accounting for between 6% and 13% of the variance in PRR and credibility ratings. Participants scoring higher on these measures tended to have more negative reactions to the AO rationale and to rate it as less credible. We found no significant relationships between the RFD and RSQ-R scores and response to the IO rationales.

We conducted an additional series of hierarchical regressions to test for mediational effects between reason-giving or rumination and response to the rationales. Table 2 shows that RFD scores continued to be a significant predictor of lower PRR and credibility ratings for the AO rationale, even when controlling for RSQ-R scores. Scores on the RSQ-R did not mediate the relationship between the RFD and response to the AO rationales. The relationship between RSQ-R scores and PRR ratings of the AO rationales became nonsignificant when RFD scores were entered first into the equation. However, the difference in partial correlations when controlling ($r(48) = -.22$) versus not controlling for RFD scores ($r(48) = -.30$) was nonsignificant (Z(difference) = .43, *ns*). Table 2 shows that similar results were obtained for credibility ratings. Although the

Table 2
Partial Correlations, Beta Weights, and Percentage of Variance Accounted for by Regressions of Treatment Rationale Ratings on RFD and RSQ-R Scores

	Activation Oriented			Insight Oriented		
Predictor[a]	Partial *r*	β	R^{2b}	Partial *r*	β	R^2
PRR Ratings						
RFD	−.31*	−.48	.09	−.01	.02	.00
RSQ-R	−.30*	−.37	.08	−.06	−.07	.00
RFD (controlling for RSQ-R)	−.24*	−.37	.05	−.03	.05	.00
RSQ-R (controlling for RFD)	−.22	−.27	.04	−.07	−.09	.01
Credibility Ratings						
RFD	−.35**	−.54	.13	−.02	−.03	.00
RSQ-R	−.24*	−.31	.06	.13	.16	.01
RFD (controlling for RSQ-R)	−.29*	−.46	.08	−.07	−.11	.00
RSQ-R (controlling for RFD)	−.13	−.17	.02	.14	.20	.01

Note. RFD = Reasons for Depression Total Score; RSQ-R = Response Styles Questionnaire − Rumination Subscale.
[a]All regression equations with PRR ratings as the criteria have the order of treatment presentation and BDI scores entered prior to the variables in the table. Equations with credibility ratings as criteria have BDI scores entered first.
[b]R^2 represents the proportion of variance for each variable beyond that accounted for by others in the equation.
*$p < .05$. **$p < .01$.

rationales (video and written presentation) differs from the more typical context in which a treatment rationale is presented (i.e., within a therapy session). At the same time, there are characteristics of the participants and the methodology that help to increase the generalizability of the findings. First, given that BDI scores of greater than 9 are thought to reflect dysphoria in nonclinical populations, the mean score of 10.4 for our sample suggests a greater severity of depressed mood than would be found in a strictly normal population. Twenty-seven percent of the sample had BDI scores in the dysphoric range and 16% scored above the typical cutoff for major depression (Kendall et al., 1987). Thirty-one percent of the sample had seen a psychotherapist in the past year (69% lifetime). These figures are higher than those found in large-scale studies of normal populations not selected for any type of psychopathology or treatment history (cf. Howard et al., 1996). With regard to the treatment rationales, it is increasingly common for written psychoeducational materials to be used in conjunction with psychotherapy (e.g., Burns, 1980; Craske, Meadows, & Barlow, 1994). Moreover, as psychotherapy treatments become increasingly structured, therapists necessarily become more explicit in their presentation of the rationale behind treatment. Thus, although the present study is analogue in nature, it is not entirely dissimilar to a real-world clinical context.

The most salient finding from this study is that individuals who endorse more reasons for depression have a less positive reaction to an AO treatment rationale. The relationship holds for personal reactions to a video vignette and credibility ratings in response to a written treatment rationale. Together with a previous study demonstrating similar findings (Addis & Jacobson, 1996), these results suggest that clients who offer more reasons for depression will be more likely to resist an activation-oriented rationale for treatment. Given that acceptance of a rationale is associated with positive treatment outcomes (e.g., Fennel & Teasdale, 1987; Ilardi & Craighead, 1994; Spence & Sharpe, 1993), high scores on the RFD may be considered a negative indicator for an activation oriented treatment.

Precisely why such an association exists is less clear. One possibility is that reason-giving is often functioning to justify behavior; in this case depressed behavior. If an individual feels the need to justify his or her behavior, she or he should be more likely to resist inducements to take personal responsibility for change. It also may be that people who perceive the causes of their depression to be complex, and therefore give multiple reasons, will resist the apparently simple approach of changing specific behaviors. This interpretation is consistent with the finding from the current study that the tendency to ruminate is associated with a more negative reaction to a behavior change rationale (see also Lyubomirsky & Nolen-Hoeksema, 1993). However, our results suggest that rumination is not the pathway through which reason-giving is associated with resistance to a behavioral rationale. Although, as one would expect, reason-giving and rumination are correlated, they appear to have separate effects on receptiveness to a behavior change–oriented treatment rationale. Future studies might explore in an open-ended format people's reasons for rejecting or accepting various treatment options.

Contrary to what we had predicted, we found no evidence of an association between either reason-giving or rumination and responses to a treatment rationale emphasizing the role of insight in treating depression. This was true regardless of whether participants were rating their personal reactions to a video vignette, or the credibility of a written description. The tendency to give multiple reasons for a problem may not necessarily make one more receptive to an insight-oriented rationale. However, characterological and childhood reasons specifically predict positive personal reactions to an insight-oriented rationale. In contrast, both characterological and childhood reasons are associated with a more negative personal reaction to an activation-oriented rationale. It appears

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