THERAPY EXPECTATIONS AND MOTIVATION: PRELIMINARY EXPLORATION AND MEASUREMENT IN ADULTS WITH INTELLECTUAL DISABILITIES.

Major Research Project & Clinical Research Portfolio

Part One

(Part Two bound separately)

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Submitted in partial fulfilment of the requirements for the degree of

Doctor of Clinical Psychology.

August 2008

UNIVERSITY
of
GLASGOW

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SYSTEMATIC REVIEW

MAJOR RESEARCH PROJECT

This portfolio is dedicated to the memory of my loving and proud grandparents Elsie, Bill, Norma and my darling Grandpa Joe.

ALR August 2008

SYSTEMATIC REVIEW

Title: What is the Relationship between Expectations and the Process and Outcome
of Psychological Interventions for Adult Mental Health Problems?

Running Title: Therapy Expectancy and Motivations

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To be submitted to: *Psychology and Psychotherapy: Theory, Research and Practice*

(see Appendix A).

Purpose: Expectancy beliefs are a common change factor believed to influence both the process and outcome of therapy. The current review addresses the relationship between therapy expectancy and the process and outcome of psychological interventions. **Methods:** PsychInfo, Medline, Cinahl and Embase databases were searched electronically. Searches were conducted using the key search term 'expect$'; cross-referenced with various permutations of the terms 'patient', 'therapy', 'process' and 'outcome'. Twelve studies published from 2000, and exploring the relationship between expectancy and indices of psychological therapy process and outcome, were identified and included in this review. Each study was reviewed using a structured rating scale. **Results:** The majority of reviewed studies reported positive associations between therapy expectancy and indices of therapy process and outcome. Therapeutic alliance and the level of engagement during therapy were significant partial mediators of the relationship. Methodological weaknesses relating to expectancy conceptualisation, measurement and sampling remained features of this literature. **Conclusions:** Studies published since 2000 suggest that therapy expectancy is positively associated with indices of therapy process, which in turn partially mediates the relationship between expectancy and therapy outcome. Criticisms relating to sample characteristics and expectancy measurement are reformulated in acknowledgement of the challenge posed by studying a dynamic index of individual experience. It is proposed that expectancy theory will offer the greatest contribution to clinical work when explored at different points in therapy with individual clients. This approach will enable clinicians to identify ways to promote active participation for any individual and positively influence their pathway through therapy.

Introduction

Quoting from Lewis Carroll "At last the Dodo said, *'Everybody* has won, and *all* must have prizes', Rosenzweig (1936) posited that the unrecognised and unintentional factors present in any therapeutic situation may be more important influences on therapeutic success than those intentionally applied in the name of particular theoretical orientations. With this proposition, the concept of common change factors was born.

In a review of 40 years of psychotherapy outcome literature, Lambert (1992) reported that expectancies were the third most influential class of common factors after patient variables and therapeutic relationship. Therapy expectancies are anticipatory beliefs about will happen during or because of therapy. Garfield (1994) separated the expectancy construct into outcome, process and role categories. Client outcome expectations are those beliefs about whether therapy will be beneficial and will result in change. Process expectations refer to those beliefs about the procedures, experience and duration of therapy. Role expectations are beliefs about what behaviours the client and therapist will engage in during therapy.

Interest in the expectancy construct has gone beyond simple theoretical musings to consideration of the role it plays clinically. Drawing links between motivation to engage in therapy and the subsequent process and outcome of that intervention, have now become the focus of the expectancy literature.

Expectancy and Motivation

Readiness to engage in any therapeutic activity requires both the ability and the motivation to take part (Rollnick, 1998; Keijsers et al., 1999; Krause, 1966). Goal

Theory (Locke and Latham, 1984) would suggest that an individual's beliefs about how helpful therapy is going to be and what they will be expected to do, may be linked to how much the individual is motivated to engage. Similarly, the Theory of Planned Behaviour (Ajzen, 1988) would suggest that intention to engage in therapy will be determined by beliefs about expected outcome, sense of self-efficacy about fulfilling the necessary 'client role' behaviours and motivation to achieve improvement.

Bandura (1977) proposed that an individual's sense of self-efficacy about being able to perform an action will largely determine their motivation to engage in it. This sense of self-efficacy will be influenced by appraisals of past experience in comparable situations. In the context of therapy, an individual is required to develop a working relationship with the therapist in order to achieve shared therapeutic goals. Therefore, appraisal of past relationship experiences may be an important influence on what an individual expects of him or herself within the therapeutic relationship. According to the Attachment Internalisation Hypothesis (Bowlby, 1984), early caregiving experiences are internalised into a cognitive model that guides what a person expects of and does within their subsequent relationships. Less secure attachment styles may be characterised by higher levels of interpersonal distrust, difficulty in depending on another person for support, or preoccupation with concerns about possible abandonment. Researchers such as Weinberger (1995) and Mischel and Shoda, (1995) have identified that development and maintenance of the therapeutic relationship may be particularly challenging for individuals with less secure attachment.

Expectancy and Therapy Process and Outcome

Reviews of the expectancy literature have almost consistently found a significant and positive relationship with indices of therapy process and outcome (Arnkoff et al., 2002; Noble et al., 2001; Dew and Bickman, 2005; Deisgnore and Schnyder, 2007; Greenberg et al., 2006). This trend was also evident for reviewed studies that used pre-therapy interventions to modify expectations. Methodological concerns largely related to the conceptualisation and measurement of expectancy. Specifically, the literature has been criticised for confusing expectancy with other constructs such as beliefs about the credibility of the intervention offered or preference for a particular type of intervention. Another common criticism has been the widespread failure to use expectancy measures supported by psychometric evidence of reliability and validity. The implication was that it is not always possible to draw conceptually sound and generalisable conclusions from the expectancy literature.

The current review returns to the relationship between expectations and the process and outcome of psychological interventions, in adult mental health. It will seek to chart progress toward the methodological rigour and conceptual clarity previously called for. It will aim to build on the review by Delsignore and Schnyder (2007) by making a specific examination of the literature on the expectancy-process relationship and on variables that mediate the effect of expectancy. It will also follow up the adult psychotherapy review of Arnkoff et al. (2002) and consider the studies published since 2000.

<div align="center">Objectives</div>

The current review will address the following questions:

    i.   What relationship is reported between therapy expectancy and the process and outcome of psychological interventions for adult mental health problems in the literature published from 2000 onwards?

    ii.   How do the findings of this more recent literature relate to that published prior to 2000?

    iii.   Are there consistent ways in which future studies of therapy expectancy can still be strengthened?

Methodology

Search Strategy

Search terms were initially drawn up by identifying the key components of the review questions and generating all possible permutations. The resultant search terms were then used to conduct a pilot search using Ovid MEDLINE (R) <1996 to November Week 2 2007>, CINAHL – Cumulative Index to Nursing & Allied Health Literature <1982 to December Week 1 2007>, EMBASE <1996 to 2008 Week 1> and PsychINFO <2000 to December Week 3 2007>. This process highlighted terms that offered optimal sensitivity and adequate specificity. An electronic search was completed using these terms. The key search term *expect$* was combined with *therapy, therapist, patient, client, role behaviour, process, outcome, positive, improvement, effects, congruence, recovery, change, therapeutic alliance, duration, symptom, psych$,* in addition to combinations of *common change factors, treatment, therapy, rationale, credibility, motivation, patient, client, characteristics, psychotherapy, beliefs, preferences, predict$, pre-therapy, information, preparation, outcome, process.* The search strategy also involved setting parameters to include only studies published in English language from 2000 onwards. An examination of

titles and abstracts was used to initially filter potential studies. All studies filtered into the inclusion category were then examined at full-text level prior to inclusion.

Hand-searches of *Journal of Consulting and Clinical Psychology* (January 2000 to October 2007), *The Journal of Psychotherapy Practice and Research* (January 2000 to October 2007), *Psychotherapy Research* (January 2000 to October 2007) and *Psychotherapy: Theory, Research, Practice, Training* (January 2000 to October 2007) were conducted to identify additional articles and ensure sensitivity of the electronic search strategy. The reference sections of articles included in the review were examined, in addition to a non-systematic literature review (Greenberg et al., 2006) and existing systematic reviews with similar objectives (Dew and Bickman, 2005; Arnkoff et al., 2002; Noble et al., 2001; Delsignore and Schnyder, 2007). Personal communication with Dr Mike Constantino, University of Massachusetts, provided an indication of search strategy sensitivity.

Inclusion and Exclusion Criteria

Criteria for inclusion-

1. Studies published in English language during or after 2000.

2. Studies using adult participants aged 16-65 years old (inclusive) referred for or receiving a psychological intervention for a psychological difficulty.

3. Studies that adhere to the definition of expectation as an individual's cognitive anticipation of what will happen during or as a result of psychological intervention.

4. Non-experimental studies that collect and report data about client expectations and the relationship between such expectations and therapy process and/or outcome variables, or quasi-experimental studies, which

examine the effect of an intervention to alter expectation on therapy process and/or outcome variables.

5. Studies designed to delineate the effect of the expectancy variable from other variables on therapy process and/or outcome variables.

Criteria for exclusion:

1. Studies published prior to 2000 and/or not published in English.

2. Studies using participants other than adults aged 16 to 65 years (inclusive) e.g. children, older adults or studies of parental expectations about psychological interventions for their children.

3. Studies that did not involve the provision of a psychological intervention e.g. medication only, or which were targeted at physical health conditions, substance abuse or offending behaviours only.

4. Studies of insufficient quality to determine the following:

    i.   which constructs were being measured

    ii.   the participant characteristics, or

    iii.   the nature of the intervention being provided.

5. Studies using qualitative methodology only.

6. Articles published in the format of a systematic or non-systematic review of the literature.

7. Unpublished dissertations or single case research designs.

Results of Literature Search

The search and exclusion process is presented in Figure 1. Electronic database searching using the specified terms and hand-searching of the stated journals and citation lists initially produced a total of 167 potentially relevant studies. Of these studies, 110 were excluded following application of the inclusion and exclusion criteria filter and a further 41 duplications were also excluded. One study was removed due to poor quality. On this basis 12 studies were included in the current review. The reasons for exclusion are presented in Table 1.

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Quality Ratings

In considering the most appropriate means of assessing quality, it was critical to acknowledge the varying design methodologies within which expectancy has been explored. The structured rating scale developed to assess the quality of studies under review is presented in Table 2.

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INSERT TABLE 2 ABOUT HERE

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Scale construction was informed by detailed examination of methodological critiques presented within previous systematic and non-systematic reviews within this area (Arnkoff et al., 2002; Noble et al., 2001; Dew and Bickman, 2005; Deisgnore and Schnyder, 2007; Greenberg et al., 2006). Further key dimensions were identified from a review of methodological issues in process research outlined by Hill and Lambert (2004) and guidance on quality assessment of experimental and non-experimental studies presented by Cochrane Collaboration (2008) and Centre of Reviews and Dissemination (Khan et al., 2003). To determine item relevance and reliability of ratings, two independent reviewers piloted the scale on expectancy studies from pre-2000.

Each study was given a percentage score based on the number of general items achieved, number of key expectancy literature specific items achieved and combined total items achieved. Items not applicable to the design of the study were not scored or included in the percentage calculation. In order to be classified as high quality, studies were required to achieve a score of at least 70% across all quality items plus at least 70% on the key expectancy specific items. These studies have achieved adequate methodological quality to assume that the results have acceptable internal and external validity. On this basis these studies may be considered to be of high quality in relation to the other literature in the expectancy field. A moderate quality classification was applied to studies where total quality score fell between 40 and 69%. Moderate ratings indicate that attempts were clearly made to achieve internal and external validity, but that a number of methodological issues were identified and interpretation of results should be made with more caution. Poor quality studies achieved total quality scores of 39% and below, and were removed

from the review on the basis that the results could not be deemed internally or externally valid.

The rating scale was used to provide the author with a standardised method of achieving a broad indication of internal and external validity and thus how much weighting should be applied to the study findings in drawing broader conclusions to the review questions. Cohen's kappa coefficient was calculated in order to assess the level of rater agreement between two raters on quality categorisation of studies. A co-efficient of k = 1.0 was achieved. A summary of each reviewed study with the quality rating is presented in Table 3.

INSERT TABLE 3 ABOUT HERE

Results

The results of the review are considered in three sections as defined by the review questions. Firstly, the results relating to the relationship between expectancy and therapy process and outcome are presented. Secondly, these results will be considered in relation to the literature published in this field before 2000. Finally, the ways in which future expectancy literature can be strengthened will be discussed.

Therapy Expectancy and Outcome

As indicated in Table 3, nine papers reported on the relationship between therapy expectancy and indices of outcome. In elucidating the evidence for the expectancy-

outcome relationship, a useful starting point is to consider the results of those papers rated as being of high quality.

Using a quasi-experimental design, Westra and Dozois (2006) reported that a pre-therapy motivational interviewing intervention for individuals with anxiety disorders significantly increased beliefs about therapy being effective. A pre-therapy belief that the intervention was going to be helpful was significantly and positively associated with early response to CBT and later symptom improvement. In another high quality paper, Abougeundia et al. (2004) measured pre-therapy ratings of expected improvement on therapy targets selected by individuals with complicated grief reactions. Aggregated expectancy ratings were significantly and positively associated with client rated improvement in target areas, general symptoms, life satisfaction and specific grief symptoms at post-therapy.

A particular strength of these two studies was that participants were largely comparable in terms of the clinical variables which may be predicted to cause systematic variation in expectancy e.g. nature and severity of presenting problems. Achievement of this one quality criterion marked a clear distinction from the other high quality papers.

Another two of the reviewed expectancy-outcome studies were rated as being of high quality, but reported mixed results depending on the outcome measure used or clinical characteristics of the sample. Joyce et al. (2003) reported that in a mixed sample of psychotherapy referrals, combined ratings of expected outcome for self-selected therapy targets were significantly and positively associated with client and therapist reported improvement in these target areas. However, outcome expectancy was not significantly associated with therapist rated residual gain scores on a

measure of symptom severity. Westra et al. (2007) found that a pre-therapy expectancy of being able to improve control over anxiety predicted change in symptoms after two sessions of CBT. This relationship was found in individuals with generalised anxiety disorder and panic disorder, but not social phobia.

These mixed results may be ascribed to the fact that these otherwise high quality papers used participants less comparable at baseline in terms of factors that may influence expectancy and/or outcome. For example, Joyce et al. (2003) used a sample of individuals with various Axis I and a higher proportion of concurrent Axis II diagnoses than other papers (e.g. Abougeundia et al., 2004). The relevant literature would suggest that Axis I treatment response may be lower in the presence of a concurrent Axis II difficulty (Benjamin and Karpiak, 2002). Interpretative versus supportive therapies may also have different outcomes depending on the interpersonal schemata associated with specific types of personality disorder (Ogrodniczuk and Piper, 2001). Despite collecting the relevant data, the study did not analyse how the specific Axis II diagnoses or quality of object relations (QOR) related to initial therapy expectancy. QOR refers to an individual's internal and persistent tendency to develop a particular type of relationship with others. Beliefs about self and others held by this subset of the overall sample may have confounded the measurement of expectations. It may also have influenced how they responded to the experience of a therapeutic relationship and thus affected therapist ratings of change in the severity of disturbance.

The remaining five expectancy-outcome papers were rated as moderate quality. Three of these presented mixed findings. Murray et al. (2003) reported that individuals with bulimia nervosa were significantly more likely to take up a self-directed intervention whilst waiting for psychological therapy if they expected it to

be helpful. However, those who accepted or refused the intervention did not differ in expectations of the intervention increasing control over cravings or negative thoughts. Mussell et al. (2000) reported that levels of binging at post-therapy, but not follow-up, in bulimia nervosa were predicted by pre-therapy expectations about changes in ability to control the behaviour. Meyer et al. (2002) found that post-therapy improvement in depression was predicted by pre-therapy expectancy about the effectiveness of therapy, but not by global expectancy about their outcome in general.

The final two moderate papers reported no significant relationship between expectancy and outcome. Vogel et al. (2006) reported that early therapy expectancy of benefit from Exposure and Response Prevention (ERP) for Obsessive Compulsive Disorder (OCD) was not associated with subsequent outcome. Constantino et al. (2007) found no significant relationship between early therapy expectation of change and subsequent outcome for a group CBT intervention for sleep disorder.

The moderate papers were typically characterised by a combination of the sample issues described above *and* non-standardised expectancy measurement. They were also more likely to raise more than one concern by the reviewers about the method in each of these domains. Only two papers (Constantino et al., 2007; Mussell et al., 2000) used a psychometrically evaluated expectancy measure. However, Murray et al. (2003) did use qualitative data to triangulate their numerical ratings of expectancy. As a group, the moderate papers all revealed problems with sample comparability and intervention appropriateness. Two studies asked participants to rate how much they expected benefit from interventions that may not have been appropriate. In the first, Murray et al. (2003) offered a self-help intervention unlikely to meet the needs of individuals requiring specialist eating disorder intervention due

to severity of their symptoms. In a similar way, Constantino et al. (2007) offered an insomnia specific group intervention to individuals with diverse undiagnosed sleep disorders. Hence, in this context, it is hard to imagine what benefit these people would expect from these interventions. Indeed, the initial expectations reported by Murray et al. (2003) were generally low. As Constantino et al. (2007) did not report on how positive or negative initial expectations were, it is not possible to assess the impact of beliefs about the suitability of the intervention on expectancy.

Therapy Expectancy and Process

As indicated in Table 3, nine of the reviewed papers examined the expectancy-process relationship. Once more, Westra and Dozois (2006) reported that expectancy was significantly and positively associated with the subsequent level of engagement in CBT for anxiety. A further two of the high quality papers described in the previous section also reported a significant and positive association between expectancy and quality of therapeutic alliance (Joyce et al., 2003; Abougeundia et al., 2004). Westra et al. (2007) again found that expectancy was significantly and positively associated with engagement in homework tasks in clients presenting with generalised anxiety and panic disorders, but not social phobia.

The remaining five papers were rated as being of moderate quality. Joyce et al. (2000) reported that beliefs about ability to fulfil expected therapy role behaviours were significantly associated with both the quality and pattern of the therapeutic alliance. This relationship was mediated by quality of object relations (QOR). Expectations of own behaviour in individuals with high QOR was inversely associated with change in the therapeutic alliance. In another moderate paper, Constantino et al. (2005) reported that outcome expectancy was significantly

associated with therapeutic alliance in early therapy for bulimia nervosa and mid therapy, controlling for initial symptom improvement. Constantino et al. (2007) reported that expectations were significantly associated with subsequent ratings of affiliation with the therapist.

The other two moderate papers reported mixed findings. Connolly Gibbons et al. (2003) found that the beliefs of a mixed sample of psychotherapy referrals about the outcome of therapy, predicted the quality of the early therapeutic alliance in supportive-expressive, but not cognitive behavioural therapy. This treatment specific effect was absent at mid-therapy. As with the expectancy-outcome analysis, Meyer et al. (2002) concluded that treatment specific, but not global outcome expectancies, predicted therapeutic alliance.

Process Variables as Mediators of the Expectancy-Outcome Relationship

Examination of Table 3 indicates that five of the reviewed papers also analysed and confirmed the mediating role of process variables in the expectancy-outcome relationship. Three of these studies were rated as high quality. Two reported that the expectancy-outcome relationship was partially mediated by the quality of the therapeutic alliance (Joyce et al., 2003; Abougeundia et al., 2004). The third found a significant partial mediation by early compliance with homework in CBT (Westra et al., 2007). Two moderate studies also reported a significant partial mediation role for therapeutic alliance (Meyer et al., 2002; Constantino et al., 2007).

The preliminary conclusion to be drawn is that an expectation of improvement in or enhanced control over specific, self-selected therapy targets was significantly associated with positive experiences of therapy process and better clinical outcome. The quality of the therapeutic alliance and level of active participation were found to

mediate the expectancy-outcome relationship. Significant results were evident across patients with different presenting problems. There is also robust evidence that motivational interviewing techniques provided before therapy can enhance therapy expectancies. The presence of some mixed or non-significant results may be related to use of samples with high levels of clinical heterogeneity and failure to use standardised measures of expectancy.

Relation of recent expectancy research to studies published pre-2000

The second objective of the current review was to consider how the expectancy literature since 2000 relates to that published prior to this date. Arnkoff et al. (2002) provided an appropriate source of comparison, as their review used very similar search parameters and objectives to the current review. These authors reviewed 61 studies. Twenty four of the studies measured outcome expectancies and thirty seven studies measured role expectancies. At first glance, the studies under current review showed a very different pattern with only one study examining role expectancies compared to the eleven studies addressing outcome expectancies. However, the pattern indicated in the current review may be representative of an overall trend over time. Arnkoff et al. (2002) noted that none of the role expectancy studies reviewed were published after 1996. Indeed, twenty-seven of these studies were published prior to 1980. Therefore, it would appear that published research into role expectancies has been in decline for a number of decades now. This is interesting when one considers the growing body of evidence suggesting that therapeutic alliance is a significant mediator in the expectancy-outcome relationship and that personality variables (e.g. QOR, interpersonal difficulty) moderate the expectancy-outcome and expectancy-process relationships. It might be predicted that beliefs about who will be responsible for carrying out particular therapy roles (e.g. listening,

disclosing, providing emotional containment) may be significantly influenced by these personality variables.

Arnkoff et al. (2002) discussed the issue of mediating and moderating influences on the expectancy effect and concluded that the mechanisms remained largely unexplored. In contrast, just under half of the papers in the current review examined the effect of mediating variables, with therapeutic alliance being the dominant focus.

Strengthening the future of expectancy research.
Heterogeneous clinical samples are ecologically valid in the context of clinical practice. However, drawing a clear link between expectancy and outcome or process requires that the samples do not differ significantly on variables that may systematically influence them. Measuring and controlling for such variables will make it easier to draw clear conclusions for clinical practice. Existing knowledge about the key issues surrounding particular clinical presentations and consideration of what this may mean for engagement and prognosis may inform the design of future studies. For example, studies of expectancy in individuals with Obsessive Compulsive Disorder might consider evidence that links higher levels of rigidity of obsessional beliefs (Steketee and Shapiro, 1995; cited in Roth and Fonagy, 2005) and co-morbid depression (Keisjers et al., 1994; cited in Roth and Fonagy, 2005) to poorer treatment outcome. The importance of making repeated measurements of expectancy at different points is also highlighted by the nature of recommended interventions for this group e.g. ERP. In ERP, the individual is exposed to anxiety provoking situations and asked to desist from engaging in the previous compulsive behaviours used to reduce that anxiety. Early therapy information about what is actually involved in this challenging form of therapy may alter the outcome expectations of an individual who strongly believes it is their responsibility to

engage in such compulsive behaviours. Furthermore, ERP may put a particular strain on the alliance at different points during therapy as the individual is asked to engage in behavioural tasks that may temporarily increase anxiety levels.

The current review identified subtle, but important, variations in the conceptualisation of expectancy across studies. The main distinction was between those that asked clients to rate their expected level of control over symptoms following the intervention and those that required a prognostic rating of how useful or beneficial they expected therapy to be. Ratings of expected control may represent self-efficacy in relation to the presenting problem. This measure may have different meanings for those seeking to control overt behaviours, such as bingeing or purging in bulimia nervosa, compared to those struggling with more internalised symptoms such as depressive thinking patterns or anxious rumination. These issues are also likely to interact with individual appraisal of the intervention proposed and previous experience with professional help for the issue. Future studies should carefully consider how conceptualisation influences interpretation of results.

Only three of the studies reviewed used a standardised measure of expectancy with reported psychometric properties. The remaining nine studies threatened the internal and external validity of their results by using a variety of approaches including extraction of single items from standardised measures or development of idiosyncratic approaches for their study.

There were a number of other recurring methodological issues. Firstly, there was a consistent failure by all reviewed studies to make any justification for their sample sizes. Secondly, only one of the studies reviewed (Murray et al., 2003) attempted to

triangulate their quantitative expectancy measurements with any qualitative data. Hill and Lambert (2004) proposed that use of such triangulation could be considered an indicator of quality in process research. They argued that the credibility of findings is increased by checking numerical ratings against what the individual is actually saying about an issue. Finally, there continued to be an over-reliance on self-report measures of outcome with only a minority of studies incorporating therapist and/or independent observer ratings of outcome or process.

Non-experimental, observational designs continued to dominate the expectancy literature. One study in the current review used a quasi-experimental, longitudinal design to explore the effect of an expectancy manipulation intervention on subsequent indicators of therapy process and outcome. The remaining eleven studies adopted a non-experimental design and used correlational analyses to explore the direction and strength of association between therapy expectancies and subsequent process and outcome. Future expectancy literature should both work to improve methodology as described above, in addition to exploring more causal relationships using longitudinal designs.

Discussion

Similar to the literature published before 2000, the majority of reviewed studies reported modest, but significant associations between expectancy and therapy process and outcome. They also suggested that therapy expectancy can be improved through pre-therapy interventions. The expectancy-outcome relationship was most consistent when people were asked to rate how much they anticipated that an intervention would result in increased control over the difficulties that they wanted therapy to target. There is a clear implication for the importance of working closely with clients to develop collaborative treatment goals at the outset of therapy. This

will enable the therapist to utilise the expectancy-outcome link to positive effect. The mediating role of process in the expectancy-outcome relationship represented the most robust set of findings in the current review. Specifically, it showed that the quality of the therapeutic alliance and the level of engagement during therapy were significant mediators of the relationship between pre-therapy expectancy about outcome and the subsequent outcome. The levels of mediation reported for therapeutic alliance were 19-52% (Abougeundia et al., 2004) and 33.5% (Joyce et al., 2003). The implication is that other mediating variables are yet to be identified.

The replication of the expectancy effect across different clinical populations adds weight to its reliability. However, the review indicated that the literature is systematically failing to consider how disorder specific and personality related trait factors may influence expectancy, process and outcome in therapy. Contextual issues such as previous experience of formal and informal support with the problem, the characteristics of the therapist and specific aspects of the intervention may further complicate these influences. There were examples of studies of this type in the current review (Joyce et al., 2000; Constantino et al., 2005; Connolly-Gibbons et al., 2003). The more sophisticated insights of these studies contrasted with the others reviewed. However, it is clear that no one combination of factors will suffice across all expectancy research and as such, they must be considered for each individual study.

Drawing a clear conclusion based on the reviewed papers is somewhat limited by the continuing failure of the literature to acknowledge the subtle variations in how expectancy can be conceptualised (e.g. locus of control in relation to symptoms compared to anticipated effectiveness of therapy) and to measure it in a psychometrically robust manner. A clear strand of evidence was available for

expectancy of symptom control and outcome for self-selected therapy targets. Therefore, conceptualising expectancy in terms of locus of control or self-efficacy may have greater clinical utility than measuring direct predictions of how effective the specific mechanisms of the intervention will be. Future research must also acknowledge how the timing of expectancy measurement will influence what is being tapped into. Trait levels of self-efficacy and previous experiences of helping relationships may heavily influence outcome expectancy measured prior to any therapeutic contact. In contrast, expectancy measured after meeting the therapist and after provision of therapy rationale may be coloured by how positively or negatively these have been experienced. The implication is that expectancy is a dynamic variable that will be most informative for clinical practice when measured across different points in therapy.

The points made above may considered in the context of Constantino et al. (2007) and Vogel et al. (2006). Both of these papers failed to find a significant expectancy-outcome relationship. In contrast to the other studies, both of these papers measured expectancy after therapist contact and provision of therapy rationale. It may be that expectancy measurement in this context captured a state response to the information or therapist, rather than an indication of prognostic beliefs or self-efficacy about achieving change. The interventions offered in both of these studies required high levels of active participation. As such, a more direct measurement of control or self-efficacy in relation to change may have produced a stronger relationship with engagement and outcome.

Process research seeks to understand those aspects of therapy that are alive, dynamic and an inherent source of curiosity for clinicians across all theoretical orientations. However, reviewing the literature in this theoretically and clinically interesting area

can be experienced as a somewhat lifeless process. The reader is often left without a clear sense of how the dynamic nature of expectancy can be captured in a clinically meaningful way and used to provide insight into what it means for an individual client. Engaging in expectancy research presents authors with an opportunity to harness some aspect of this construct and use it to guide clinical practice. It should guide the clinician in making a clinically meaningful consideration of what may be potential barriers to therapeutic engagement and improvement for a particular individual offered a particular intervention. This provides therapists with an opportunity to optimise the experience and outcome of the intervention for the individual.

Limitations of the current review

The current review did not report on findings relating to the relationship between therapist expectancy and subsequent process and outcome. Whilst the review has highlighted the need for increased consideration of the relational aspects of therapy in expectancy research, incorporation of this variable was beyond the scope of the current review. Secondly, the review utilised a quality rating scale developed for the purpose of the current review and which applied percentage scores to each study. An important consideration in the use of quality ratings based on percentages is that a study may fail to achieve only one quality criterion and yet still achieve a high percentage. However, that one failed criterion may have highly significant implications for the internal and external validity of results. Whilst the current review specified and rated both general and field specific quality criteria, in order to place greater emphasis on expectancy specific threats to validity, this caveat in interpretation of the quality percentages remains. Finally, the current review was designed and conducted within a framework that emphasised scientific and

methodological rigour. This was driven by an attempt to extract general conclusions. Reflection on the completed process suggests that future reviews of the expectancy literature should place greater weight on the extent to which studies attempt to capture the individual experience and context of participants.

Conclusion

It is no longer disputed that therapy expectations held by clients hold some relationship with the process and outcome of that therapy. Client beliefs that that an intervention will result in increased control over self-selected therapy targets are positively associated with the quality of therapeutic alliance developed. This, in turn, will mediate the effect of expectancy on therapy outcome. Whilst the reviewed studies displayed theoretical progression by increasing the focus on the mechanisms of the expectancy effect, they unfortunately continued to fail in addressing conceptual and methodological flaws relating to sample characteristics and robust expectancy measurement. Indeed, it may be argued that the only clear conclusion to be drawn is that expectancy is a partial mediator of therapy process and outcome. A myriad of other as yet unspecified clinical, interpersonal and contextual variables are likely to interact with clients' expectancies.

Completion of the current review raises the question as to what value exists in pursuing a single conceptualisation of such a dynamic and idiosyncratic variable. This construct perhaps only achieves meaning when it captures the nuances of an individual's past experiences and current context as they enter psychological therapy. The evaluative beliefs that the individual holds about the process and outcome of that therapy will then continue to respond to ongoing experience of the therapist and therapeutic process. As such, there is an inherent tension between

effectively capturing the dynamic feelings and beliefs of an individual, and achieving psychometrically robust and standardised approaches across groups of participants for scientific rigour.

 The outcome of the current review would suggest that research effort would be most fruitfully applied to developing valid methodologies that combine quantitative and qualitative approaches to study the influences on and mediators of an individual's expectancy in therapy. Regardless of the level of rigour applied in such studies, the generalisation of results will always be restricted by the individual nature of expectancy. This should not be viewed as a limitation, but an invitation for clinical audiences to creatively apply the findings in individual contexts. Expectancy theory will offer much to clinical practice when further knowledge of the relevant clinical, interpersonal, personality and contextual factors is used to guide exploration of expectancy at different points in therapy with individual clients. This approach would enable clinicians to identify what may promote or prevent active participation for any individual and positively influence their pathway through therapy.

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Table 1. Summary of Study Exclusion Categories

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Reason for exclusion	Number of studies (%)
Study did not use the same definition of expectancy as the current review.	43 (38)
Study did not involve a psychological intervention.	15 (13)
Study did measure expectancy, but did not examine it in relation to therapy process or outcome AND/OR did not conduct expectancy manipulation/intervention.	13 (12)
Study treatment target was physical health or substance misuse.	13 (12)
Unpublished dissertations.	12 (10)
Review paper.	4 (3.5)
Study only used qualitative methodology.	4 (3.5)
Study participants were outwith demographic criteria specified for review.	3 (2)
Study 'in process' or unavailable on basis of publisher restrictions on full-text access.	3 (2)
Study was not published in English language.	2 (2)
Excluded due to poor methodology.	1 (<1)

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Table 2. Quality Rating Scale

Generic Items	Item	Yes	No	N/A to design
1	Demographic and baseline clinical characteristics of participants described.			
2	Sample representative of the population and appropriate to the study question.			
3	Sample size justified.			
4	Expectancy manipulation intervention/therapeutic treatment reliably ascertained.			
5	Dependent variable measurement from various sources.			
6	Measures administered by an individual independent to the individual's therapy provision.			
7	Outcome measured by investigators blind to intervention/baseline measurements.			
8	Appropriate analysis to address the research question and for which the conditions of use can be confirmed.			
9	Reports all relevant exact p values, confidence intervals, effect sizes, change score and the associated standard errors.			

Table 2 continued. Quality Rating Scale

Key Quality Items	Item	Yes	No	N/A to design
1	Sample comparable in terms of eligibility criteria, basic characteristics and specific characteristics which may be **prognostic or influential in terms of expectancies**?			
2	Expectancy variable explicitly operationalised and differentiated from similar but distinct variables.			
3	Expectancy variable has been measured using a tool which is in line with the variable conceptualisation/operationalisation in the study and which delineates the variable from similar/related constructs.			
4	Expectancy Measurement tools supported by psychometric evidence of validity, reliability and sensitivity to change within the population.			
5	Measures used at appropriate time points in relation to the design and focus of the study.			
6	Drop-out/attrition adequately described and examined in relation to expectancy variable.			
7	Manipulation checks made to determine whether the expectancy manipulation group did demonstrate a change in expectations prior to therapy and did differ from any control groups in terms of expectations as a result.			
8	Combined methodologies used to triangulate the data obtained from standardised tools.			
9	Analysis incorporates methods which permit an examination of a causal or correlational relationships between expectancies and process/outcome measures, examines and reports the role of mediator variables **where examined**.			

Table 3. Summary of Reviewed Papers

Study	Participants	Type of expectancy and how measured.	Dependent Variable	Results	Generic Quality	Key Quality	Total Quality % and Category	Quality Issues
Westra and Dozois (2006)	N=55 with diagnosis of an anxiety disorder.	Pre-expectancy intervention expectations of effectiveness and post-expectancy intervention. Anxiety Change Expectancy Scale (ACES: Dozois and Westra, 2005)	PROCESS and OUTCOME. Change in expectancy, CBT engagement/ retention, CBT response, symptom levels.	Significant interaction of time (baseline, pre-CBT) and group (MI, NPT) F(1,34) = 4.82, p<.05 (effect size, d=.60). Change in ACES scores from baseline to post pre-treatment (M ACES change = 4.94, SD = 6.51; M ACES change in NPT = 0.93, SD=2.89, t (29) = 2.28, p<.05). Effects sizes across diagnostic groups (ranged from .38 PDA, .54 for GAD, 1.65 for SP). Homework completion F (1,31) = 7.74, p<.05 (effect size, d = .33). Principal Outcome T(30) = 2.69, p<.05 (sig)	78%	89%	83% High	No sample size justification. Lack of combined methodologies. Expectancy construct conceptualisation.
Abougeun dia et al. (2004)	N=107 with diagnosis of complicate d grief reaction.	Pre-therapy outcome expectations for patient identified therapy targets. Single item Likert 'expected improvement as a function of treatment' aggregated across 3 objectives for	PROCESS and OUTCOME. PROCESS AS MEDIATOR. Outcome on individually identified treatment targets and other symptom measures. Therapeutic Alliance as mediating variable.	Patient outcome expectancy was significantly and directly associated with improvement on the General Symptoms (r=.31, p<.001) and Target Objectives/Life Satisfaction factors (r=.32, p <.001); it was also associated with improvement on the Grief Symptoms factor (p< .10). The mediation provided by the patient-rated alliance accounted for 19%–52% of the direct effect of patient expectancy on therapy outcome.	83%	75%	80% High	No sample size justification. Outcome measurements not blind. Expectancy measure not psychometrically evaluated. Attrition not described in relation to expectancy variable.

		therapy.						
Joyce et al. (2003)	N=144 (various Axis I and II diagnosis referred for short- term individual therapy)	Pre-therapy outcome expectations for patient identified therapy targets. Single item Likert 'expected improvement as a function of treatment' aggregated across 2-5 objectives for therapy.	PROCESS and OUTCOME. PROCESS AS MEDIATOR. Outcome as measured by ratings of severity and improvement made by patient, therapist and independent observer. Therapeutic alliance as mediator. Rated by patient and therapist.	Patient outcome expectancy significantly associated with patient rated observed improvement post-therapy (r=.24, p=.006) and therapist rated improvement post-therapy (r=.32, p=.003). Patient outcome expectancy significantly associated with therapeutic alliance as rated by patient (r=.27, p=.001) and therapist (r=.30, p=.001).	71%	88%	77% High	No sample size justification. Lack of combined methodologies to triangulate quantitative ratings. Outcome measurements not blind to baseline/group. Expectancy measure had no reported psychometric properties. Comparability of sample at baseline.
Westra et al. (2007)	Adults with an anxiety disorder. N=67. Panic Disorder N=23; GAD N=26; Social Phobia N=18.	Ability to control own anxiety symptoms. Measured pre-therapy. Anxiety Change Expectancy Scale (ACES: Dozois and Westra, 2005) Homework compliance (investigated as a mediator of the expectancy-	PROCESS and OUTCOME. PROCESS AS MEDIATOR. Initial and total cognitive symptom change.	Panic Disorder: ACES score significant predictor of homework compliance (R² = .26, p<.05) and early symptom change (R² = .74, p<.01). Generalised Anxiety Disorder: ACES score significant predictor of homework compliance (R² = .37, p<.001) and early symptom change (R² = .51, p<..05). Social Phobia: ACES did not significantly predict homework compliance (p>.05).	67%	88%	80% High	No sample size justification. Lack of combined methodologies to triangulate quantitative ratings. Reliance on self-report.

			initial outcome effect).					
Murray et al. (2003)	N=81 adults with BN.	Pre-intervention expectations. Expectations of outcome. Self-report questionnaire on expectation of treatment package. Designed for purpose of study. Likert scales and qualitative sections. Expectations of usefulness and self-efficacy about intervention.	OUTCOME. Uptake of an intervention.	Participants who accepted the self-help intervention were significantly more likely to hold positive expectations prior to uptake, p = 0.02 . No significant differences between groups on expectations of challenging negative thoughts or controlling cravings.	73%	63%	68% Moderate	Participants not comparable at baseline. Sample size not justified. Reliance on self-report. Expectancy measurement not supported by psychometric evidence. Attrition not examined in relation to expectancy variable.
Mussell et al. (2000)	Adult females with Bulimia Nervosa (BN) (N=143)	Expected success/difficulty in quitting BN behaviours. Modified version of the Thoughts About Abstinence Scale (TAAS; Hall et al., 1990).	OUTCOME. Symptom remission at treatment completion, post-treatment and one month F/U.	End of Treatment: Expectancy significantly contributed to model of variance in symptom remission (p<.001) Follow-up: Expectancy did not significantly contribute to model.	46%	63%	52% Moderate	Comparability of participants at baseline. No sample size justification. Lack of combined methodologies to triangulate quantitative ratings. Reliance on self-report. Administrator of measures not independent to therapy.

								Expectancy conceptualisation and measurement.
Meyer et al. (2002)	N=151 adults with diagnosis of major depressive disorder.	Pre-therapy outcome expectancies. Treatment specific and global improvement. Single item Likert scale for both treatment specific outcome and global improvement.	PROCESS and OUTCOME. PROCESS AS MEDIATOR. Symptom improvement and Therapeutic Alliance as mediator.	Treatment specific expectancy significantly associated with alliance (r² = .27, p<.01) and symptom level at outcome (r² = .22, p<.01). Expectancy outcome effect no longer significant when alliance ratings taken into account indicating significant mediation.	64%	50%	59% Moderate	Participant comparability at baseline. No sample size justification. Lack of combined methodologies to triangulate quantitative data. Expectancy measurement.
Vogel et al. (2006)	N=37 adults with OCD.	Outcome expectation following provision of rationale pre-therapy. Based on Borkovec and Nau (1972). Rating of confidence in intervention achieving desired outcome (0-100).	OUTCOME. Post-treatment outcome on Y-BOCS.	Expectancy not significantly associated with outcome.	54%	38%	48% Moderate	Did not examine the relationship between expectancy and therapeutic alliance. Conceptualisation of expectancy. No sample size justification. No combined methodology. Measurement not blinded.
Constantino et al. (2007)	N=110 with sleep difficulties. No formal	Pre-therapy expectations. Measured after session 2.	PROCESS and OUTCOME. PROCESS AS MEDIATOR.	Significant negative interaction between expectations and perceived therapist affiliation, r= -.23, p<.05. This interaction was significantly	46%	88%	62% Moderate	Participants not comparable at baseline.

	diagnostic process.	Expectancy items from the Expectancy/Cr edibility Questionnaire (Devilly and Borkovec; 2000) .	Symptom outcome measures and therapeutic alliance as mediator.	related to change in total wake time during the night, part r= -.34, β= -.34, p<.05. Expectations did not significantly predict change in perceived daytime interference.				Sample size not justified. Lack of combined methodologies. Reliance on self-report.
Joyce et al. (2000)	N=64 adults with various Axis I and Axis II referred for out-patient psychother apy.	Pre-therapy role expectations (self and therapist) and therapist expectations after first two sessions. Scale developed for purpose of study. 12 role behaviour items rated on Likert scale of perceived contribution through that role.	PROCESS. Average therapeutic alliance over therapy and growth in therapeutic alliance.	High QOR cases – Expectancy of contributing to therapy and pattern of change in the patient related alliance, t= -3.77, df=30, p<.001 and slope of patient rated alliance, r= -.55, p<.001 (sig). Low QOR – Expectancy of contributing to therapy and the average level of the alliance , r= .42, p<.05 (sig). Low QOR cases – greater patient-therapist congruence regarding expectancies of a Supportive Therapist Role was significantly and directly associated with the pattern of change in the therapist rated immediate impression of the alliance, (t= -4.27, df=30, p<0.0001).	60%	75%	67% Moderate	Comparability of participants at baseline. No sample size justification. Lack of combined methodologies. Attrition not analysed in relation to expectancy variable.
Constantin o et al. (2005)	N=220 females with diagnosis of Bulimia Nervosa (BN).	Outcome expectancy after session 1. Two single item ratings of potential benefit and suitability of treatment (Agras et al.,	PROCESS. Therapeutic Alliance in early and middle phases of either CBT or IPT.	Early Therapy: Expectancy significantly associated with patient rated therapeutic alliance (Part r = .43, p<.001) Middle Therapy: CBT group – Expectation significantly associated with patient rated therapeutic alliance when controlling for initial symptom improvement (Part r =.39, p<.001). IPT group –	77%	38%	62% Moderate	Patient comparability at baseline. Lack of combined methodologies to triangulate quantitative data. Reliance on self-report. Expectancy

		2000). Ratings combined into one score.		Expectation significantly associated with patient rated therapeutic alliance when controlling for initial symptom improvement (Part r =.25, p<.05).				conceptualisation and measurement. No analysis of attrition by expectancy variable.
Connolly Gibbons et al. (2003)	N=141 adults with various diagnoses.	Pre-therapy outcome expectancy. Single item measure used by Elkin et al. (1989). Expected improvement as a function of intervention from -3 to +3.	PROCESS. Therapeutic Alliance at session 2 and 10 and growth across CBT or Supportive-Expressive Dynamic Therapy.	Outcome expectancy and patient rated alliance at Session 2 (controlling for symptom improvement from intake to Session 2) Semi-partial r = .35, Beta = .37 (p<.001) (sig). Outcome expectancy and treatment type on session 2 alliance (semi-partial r = .42, beta 1.29, p< .05). Greater expectations of improvement were significantly related to alliance for patients in SE t(129) = 3.36, p<.001, but not cognitive therapy. Expected improvement did not significantly predict alliance at session 10.	54%	50%	52% Moderate	Participants not comparable at baseline. Sample size not justified. Lack of combined methodologies. Reliance on self-report. Conceptualisation of expectancy construct. Expectancy measure not supported by psychometric evidence. Attrition not analysed in relation to expectancy variable.

Figure 1. Flowchart of Search Strategy and Results.
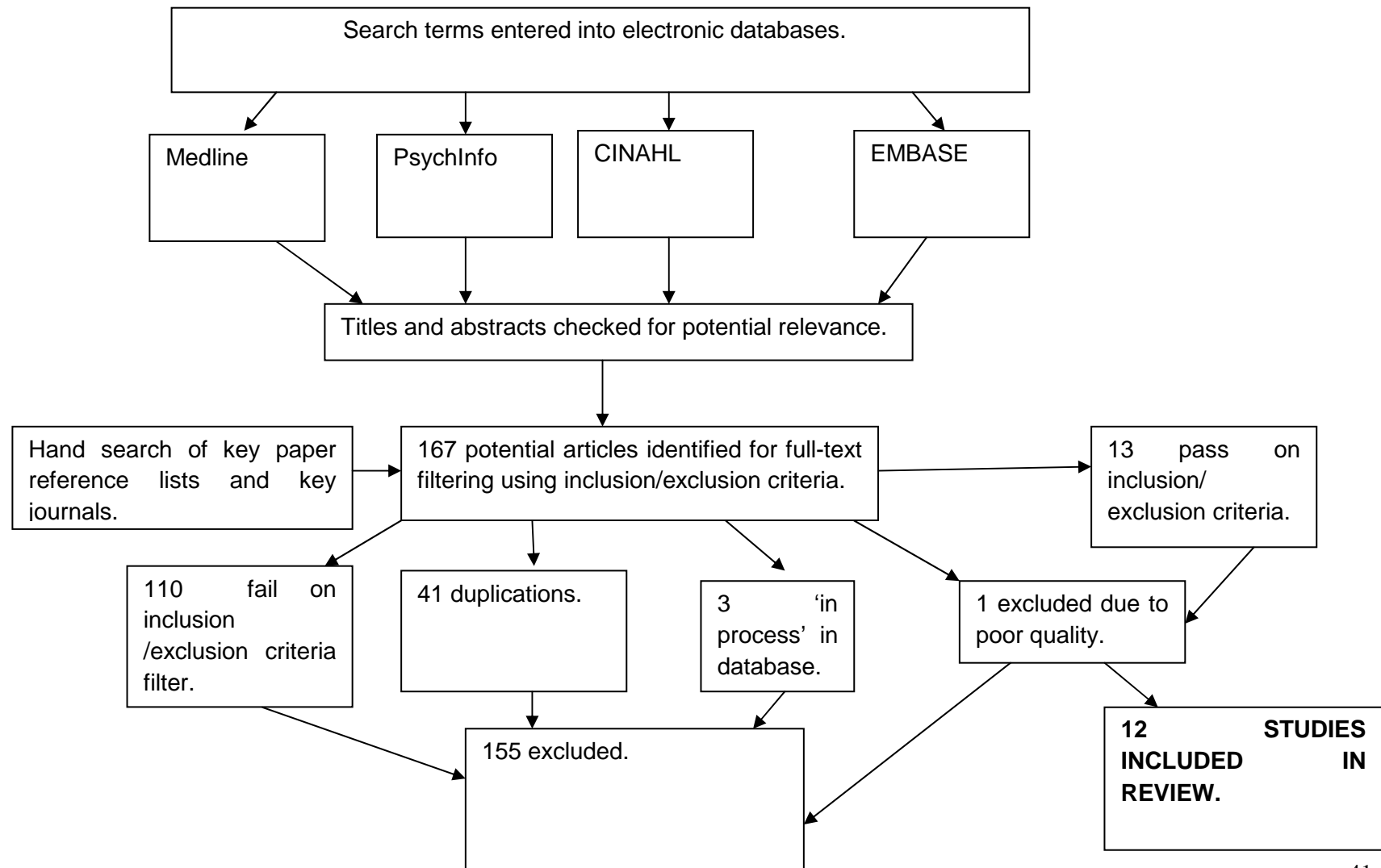
MAJOR RESEARCH PROJECT

Title: Therapy Expectations and Motivation: Preliminary Exploration and Measurement in adults with intellectual disabilities.

Running Title: Therapy Expectancy and Motivations

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To be submitted to: *Psychology and Psychotherapy: Theory, Research and Practice* (see Appendix A).

Objectives: To carry out a preliminary exploration and measurement of therapy expectancy and motivation in adults with intellectual disabilities through the development and psychometric evaluation of the Therapy Expectation and Motivation Measure (TEAMM). **Design:** The initial scale development phase combined top-down theory driven and bottom-up data driven processes to identify TEAMM items and format. The subsequent scale evaluation phase piloted the TEAMM and used correlational analyses to evaluate reliability and validity. **Method:** Six adults with intellectual disabilities took part in semi-structured interviews about therapy expectancy and motivation in order to identify TEAMM items. A further 22 participants piloted the measure for psychometric evaluation. **Results:** Preliminary psychometric evaluation confirmed that the TEAMM has acceptable test-retest reliability and internal consistency. Assessment of construct validity found a strong and positive relationship with a measure of general self-efficacy. Client expectations of therapy were largely positive and congruent with therapy as a goal-oriented process in which they will be an active participant. However, a number of individuals were unclear about the reason for referral and felt a low level of involvement in the process. Client and carer perceptions of referral understanding were significantly different. **Conclusions:** The TEAMM may help clinicians to identify potential barriers to engagement in therapy and find ways of enhancing the therapeutic experience of adults with an intellectual disability. Further psychometric evaluation of the TEAMM with larger samples is required to confirm the factorial structure of the scale and enhance its clinical utility.

Introduction

An expansion in the use of individual psychotherapeutic techniques, such as Cognitive Behavioural Therapy (CBT), for emotional difficulties in adults with Intellectual Disabilities (ID) has been evident across clinical and academic spheres (Nagal and Leiper, 1999; Linington, 2002). This shift has been welcome in light of the recognised vulnerability of this population to psychological problems (Richards et al., 2001; Dosen and Day, 2001). This growth has been paralleled by a body of work producing clinically informative results regarding the abilities required to participate in approaches such as CBT (Willner, 2005; Dagnan et al., 2000; Reed and Clement, 1989; Dagnan and Chadwick, 1997).

The general adult mental health literature has shown that readiness to engage in any therapeutic activity depends, however, on motivation as well as ability (Rollnick, 1998; Keijsers et al., 1999; Krause, 1966). Motivation may be intrinsic or extrinsic depending on the individual's level of self-determination in relation to resolving or changing the problem (Deci and Ryan, 2000; Vansteenkiste and Sheldon, 2006). Determinants of motivation may be remote, such as external pressure, or internal factors, such as problem recognition and expectancies about treatment (Drieschner et al., 2004).

Client expectations about what will happen when they attend therapy and whether they can perform the required tasks are positively associated with treatment outcome and process (Arnkoff et al., 2002; Greenberg et al., 2006). Indeed, therapy expectancy was found to be the third most influential pan-theoretical change factor in psychotherapy, after patient factors and the therapeutic alliance (Lambert, 1992). It is the premise of the current study that certain characteristics of the ID population and their pathway to psychological interventions may make their expectations of

therapy and motivation to attend sessions particularly potent influences on therapy process and outcome.

Referral Involvement and Understanding

Within the context of therapeutic work with adults without ID, it is not an unreasonable assumption that most presenting individuals have in some way initiated the help-seeking process and have some level of motivation, or expectation of change. In contrast, Willner (2003) found that the role of the Psychologist had not been explained to half of the adults with ID attending a Clinical Psychology service, and a higher number were unaware that the referral had been made. This result would suggest that individuals with ID may have restricted opportunities to show self-determination in this area of their lives. Indeed, a recent qualitative study with adults with an ID in the early stages of therapy revealed a sense of powerlessness in previous contacts with services, uncertainty about service access and a desire to have more control over access to professional help (Jahoda et al., 2006). In addition, many clients did not comprehend that therapy was time-limited and oriented towards the achievement of specific goals.

Outer-directedness and Locus of Control in Intellectual Disabilities

The CBT that may follow a referral is an interactive and goal-focused process occurring within the context of a therapeutic relationship or alliance. Observations made in the literature about the relational characteristics of people with an ID may become particularly relevant in this context. Zigler and Balla (1972) reported that individuals with ID may develop lower autonomy across development by retaining a higher dependency on reinforcement from others and a greater reliance on external cues rather than internal cognitive resources – referred to as outer-directedness. This

may also result in an increased desire for social reinforcement and a motivation to prolong interactions with individuals who offer this. In a similar vein, Rotter (1966) labelled the perception of a connection between one's action and its consequences as the locus of control (LOC). With the exception of Mamlin et al. (2001), most studies have suggested that individuals with ID are more likely to display a more external LOC (Wehmeyer, 1994; Wehmeyer and Palmer, 1997; Langdon and Talbot, 2006), feeling that they can exert little influence through their own actions.

Cognitive approaches in particular require active involvement and shared responsibility for therapy progression. Therefore, for an individual with ID, the therapeutic relationship may be inconsistent with the expectations that have arisen from previous experiences. Specifically, the therapeutic relationship requires the individual to work with the therapist and then gradually make greater use of internal resources as a source of motivation and reinforcement. An individual with ID who has high levels of outer-directedness and external LOC could be motivated to attend sessions for the level of individual social interaction available with the therapist, who may be experienced as warm and supportive, but not necessarily for the purpose of actively engaging in therapeutic work.

Self-efficacy in Intellectual Disabilities

In addition to beliefs about interactions with others, it is also important to consider beliefs about self. Bandura (1977) proposed that self-efficacy is the conviction that one can successfully execute the behaviour required to produce the desired change or outcome and is a specific form of therapy expectancy. Hence, he argued that self-efficacy would effect the nature and persistence of pro-therapy behaviours. Zigler and Balla (1977) further posited that individuals with ID might have lower self-

efficacy because of experiencing multiple failures across the life span. A small number of studies have indicated that this group does indeed have lower self-efficacy expectations in relation compared to a non-ID comparison group (Slemon, 1998; Gresham et al., 1998). Thus, self-efficacy potentially represents a specific form of therapy expectation that may be inherently lower in people with an ID, with implications for engaging and participating constructively in the therapy process.

Expectancy beliefs have an established link to therapy process and outcome in non-ID populations (Arnkoff et al., 2002; Greenberg et al., 2006). However, there has been less consideration of such common change factors in therapy for adults with ID. The current study sought to address this gap.

The aim of the study was to make a preliminary attempt at conceptualising and measuring therapy expectancy and motivation in adults with ID through the development of a self-report measure. Field-testing of the Therapy Expectancy and Motivation Measure (TEAMM) explored whether these constructs can be measured in a valid and reliable way in clinical settings. Therapy expectations and motivation were predicted to show a significant association with the level of general self-efficacy and direction of control orientation. Therapy expectancy and motivation was also expected to show a significant association with contextual factors associated with the referral, and, in particular the extent to which the individual feels that they understood the referral process and were actively involved in it.

Method and Results

Design

The current study utilised a two-phase design. The aim of the first phase was to establish a conceptual framework and measurement tool (TEAMM) for therapy expectancy and motivation in ID. Figure 1 shows the processes of development of the TEAMM. As the study was the first known direct exploration of therapy expectancy in ID, a top-down theory driven review of the general expectancy literature was combined with bottom-up data driven approaches exploring people's experiences. The aim was to establish a valid population specific measure of therapy expectancy and motivation. This combined approach has been used by other published research studies to develop self-report measures for the ID population (Mindham and Espie, 2003). The aim of the second phase was to field test the TEAMM and carry out a preliminary psychometric evaluation of validity and reliability. In order to clarify the process, the methodology and results are presented for each phase of the TEAMM development and evaluation in turn.

INSERT FIGURE 1 ABOUT HERE

Phase 1. Scale Development Phase

Recruitment and Participants

Following ethical approval from NHS Greater Glasgow and Clyde and NHS Lanarkshire, six participants were initially recruited from Intellectual Disability Psychology Service waiting lists. Two females and four males with a mean age of 28

years participated in this phase. All had been referred for emotional difficulties of low mood, anxiety and anger. Three of the participants had seen a Clinical Psychologist before. Inclusion criteria were that individuals should be aged 16-65 years with a mild or moderate ID, and be referred for individual psychological therapy for emotional problems of anger, anxiety or depression. Individuals with dementia or other cognitive disorders that may have impeded informed consent or participation were excluded. Individuals with autism were also excluded due to the potential for specific social interaction and communication issues to confound the data.

Procedure

A systematic review of the literature and analysis of existing transcripts from a previous study (Jahoda et al, 2006) concerning the therapy experiences of individuals with ID were used to guide the structure and content of the semi-structured interview guide. Interviews were then carried out with three of the participants recruited for the scale development phase. The emergent themes from the interviews were then combined with the themes emerging from the previous study, to develop a model of therapy expectancy and motivation and to derive the item pool for the TEAMM. The item pool was then refined through consultation with an expert panel and a further three scale development participants. Each stage will now be described in turn.

Systematic Review of the Expectancy Literature

A systematic review of the expectancy literature identified theoretical conceptualisations of expectancy and existing measures developed for the non-intellectually disabled population (Ramsay, unpublished).

Review of study on therapy experiences in intellectual disabilities.

Ten pre-therapy transcripts from a qualitative study of therapy experiences in adults with ID (Jahoda et al., 2006) were examined using the principles of Interpretative Phenomenological Analysis (Smith and Osborn, 2006). This did not represent a secondary analysis of this data, but a transcript review with a more specific focus on identifying emergent themes relevant to therapy expectancy and motivation. Potentially relevant textual units were identified prior to the establishment of more general themes. The potential connections between the emergent themes were then mapped out and checked against the original transcripts. The themes were also checked against those used to cluster the same textual units by Jahoda et al. (2006). As advised by Smith and Osborn (2006), a second researcher reviewed the analysis process and confirmed that the proposed themes were derived from the data, as evidenced by use of appropriate examples from transcripts. The combined emergent themes from the transcripts and the subsequent semi-structured interviews used to develop the measure are presented in Table 1.

INSERT TABLE 1 ABOUT HERE

Semi-structured interviews with adults with ID awaiting psychological therapy.

Interviews were conducted with the first three consecutive scale development participants. The semi-structured questions displayed in Appendix B were used to open up discussion about therapy expectancy and motivations. All interviews were

audiotaped and transcribed verbatim. These new transcripts were analysed using the same IPA methodology described in the previous section. As indicated in Table 1 emergent themes were combined with the existing transcript themes.

Preliminary Modelling of Therapy Expectancy and Motivation in ID.

The emergent themes from the analysis of existing transcripts and semi-structured interviews were combined with the conceptual framework from the existing literature to produce a preliminary model of therapy expectation and motivation in individuals with an ID at the point of referral to Psychology. This model is presented in Figure 2.

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INSERT FIGURE 2 ABOUT HERE

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On the left hand side of the model are those factors that represent the individual, interpersonal and situational context of the individual as they presented for therapy. The model proposes that these contextual factors form the frame of reference and expectation that the individual has for future helping relationships. It is proposed that this frame of reference then determines engagement in therapy. The specific determinants of engagement proposed are the potential of an individual to engage in a therapeutic relationship with shared therapeutic goals, and the existence of motivations to drive that engagement in therapy.

Refinement of item pool and response format through consultation with expert panel and client pilot.

The model and interview transcripts were used to generate an initial pool of 141 potential items. Five individuals working within the ID Speciality participated in a focus group aimed at refining this item pool (two Consultant Clinical Psychologists, two Clinical Psychologists, one Trainee Clinical Psychologist). Panellists considered the items in terms of conceptualisation of expectancy in ID and consistency with the model. They also considered potential comprehension of items based on wording and length. This process led to the identification of 36 final items. Panellists also consulted on the presentation of response formats.

A further three scale development participants were then consulted on the items and response formats. Three items were removed as none of the participants could understand them. Different response formats using Likert scale and visual supports were piloted (Hartley and MacLean, 2006). All three participants made appropriate use of a four point Likert Scale. They agreed that the use of 3D visual supports for the Likert scale were more useful than pictorial supports. There was also complete agreement that the use of 'posting boxes' for categorising therapy role items was easier to use than verbal or 2D visual presentation of categories. The process described resulted in the creation of a 33 item measure.

Phase 2. Scale Evaluation

Recruitment and Participants

A total of 135 recruitment packs were sent out over a five month recruitment period. Twenty-two adults with an ID and 22 individuals involved in their care or support

were recruited. This represented a recruitment uptake of only 16%. Eleven women and eleven men with a mean age of 38 years (SD = 17 years) participated in the study. The mean Full-Scale IQ (two subtest) score of the sample on the Wechsler Abbreviated Scale of Intelligence (WASI - Psychological Corporation, 1999) was 61 (SD = 6). The mean scores on the Adult Nowicki-Strickland Internal-External Control Scale (ANSIE; Nowicki and Duke, 1987) and the General Self-Efficacy Scale (GSES; Sherer et al., 1982; Woodruff and Cashman, 1993) were 11 (SD = 3) and 39 (SD = 10) respectively. The referral and support characteristics of the population are summarised in Table 2. As shown in Table 2, most of the sample had been referred for depression or anxiety and were most frequently referred by support workers or care providers. The majority of the sample resided in their own tenancy with support, in group care settings or with family members. Half of the individuals who participated had no current work or training placement, with most of the other half attending a resource centre or college placement. Eleven of the participants (50%) had seen a Clinical Psychologist in the past.

INSERT TABLE 2 ABOUT HERE

Client Measures

The Therapy Expectancy and Motivations Measure (TEAMM)

The TEAMM is a thirty-three item measure. Prior to administration of the TEAMM, the individual is engaged in general conversation to build rapport and identify items for socialisation to the Likert response format e.g. likes and dislikes in music,

television programmes or food. These items are then used to assess reliability of responding on the four-point Likert scale with 3D-visual supports. Following this check, thirty-one expectancy and motivation items are presented on flashcards with verbal support. These items explore issues such as previous experience of helping relationships, self-efficacy and control, perceptions about current difficulties, beliefs about therapy process and beliefs about the likely outcome of therapy. Examples include 'When I talked to people like <insert name of person who provided help in the past> about <insert name of problem>, I felt listened to' , 'I will be able to keep on seeing the Psychologist as long as I want to' and 'It's going to be hard work to make <insert name of problem> better'. Participants indicate their level of agreement with each statement using a four point Likert scale with 3D-visual supports. The additional role expectation item asks participants to allocate thirteen therapy roles to themselves, the Psychologist or both by posting it into an appropriately labelled box. Examples of the therapy role items include 'telling feelings', 'doing good listening' and 'sorting out the problem'. The final item is an open-ended question that asks the individual their reasons or motivations for attending therapy. The complete TEAMM and administration manual are presented in Appendix C.

Adult Nowicki-Strickland Internal-External Control Scale (ANSIE; Nowicki and Duke, 1987)

The ANSIE assesses internal versus external control attributions using 23 self-report yes or no items. Higher scores indicate a more external locus of control and lower scores denote a more internal locus of control. Psychometric evaluation with non-intellectually disabled samples has indicated split-half reliability figures from .74 to .86 and test-retest reliability ranging from .63 to .76. Exploration of factor structure

and construct validity by Wehmeyer (1993a) confirmed the factor structure and construct validity in adolescents and adults with intellectual disabilities (n=409).

General Self-Efficacy Scale (GSES; Sherer et al., 1982; Woodruff and Cashman, 1993)

This scale was developed by Sherer et al., (1982) and refined to 12 items by Woodruff and Cashman (1993). The scale is reported to have an internal consistency Cronbach alpha of .69 (Bosscher and Smit, 1997) with factor analysis indicating that the data fits best with a unidimensionsal general self-efficacy construct. This scale has previously been used in studies with ID population (Payne and Jahoda, 2004).

Client perception of understanding and involvement in referral process

Participants completed a two-item Likert scale measure developed for the purpose of the proposed study. The first item asks to what extent the individual felt that they understood the reason for referral. The second item asks to what extent the individual felt that they had been involved in the process. Responses were made using the same visual four point Likert scale used for the TEAMM. A copy of the measure is presented in Appendix D.

Wechsler Abbreviated Scale of Intelligence (WASI - Psychological Corporation, 1999).

In order to control for the effects of cognitive ability in the analysis each participant completed the two-subtest version of Wechsler Abbreviated Scale of Intelligence (WASI - Psychological Corporation, 1999). This provides an estimate of general intellectual ability in approximately 15 minutes. The two-subtest version of the WASI includes Vocabulary – a measure of verbal comprehension and Matrix

Reasoning – a measure of perceptual reasoning. The WASI normative IQ scores range from 50 to 160. Psychometric evaluation of the WASI showed test-retest reliability of the IQ scales ranging from .87 to .92 (Psychological Corporation, 1999). The IQ scales correlated highly with the WAIS-III (.84 to .92).

Carer Measures

Carer perception of client understanding and involvement in referral process

Carer perception of client understanding and involvement in the referral process was measured separately. A two-item Likert scale was developed for the purpose of the current study. The first item asks to what extent they felt the individual understood the reason for referral. The second item asks to what extent they felt the individual was involved in the decision to make a referral for psychological intervention. The same response format as the client version described above was used. A copy of the measure is presented in Appendix E.

Psychiatric Assessment Schedule for Adults with Developmental Disability Checklist (PAS-ADD Checklist; Moss et al., 1997).

This measure was designed for use by those with or without training in psychopathology to screen for mental health problems in adults with intellectual disabilities. It consists of a life-events checklist and 29 symptoms items. Measurement of referral reason was standardised by asking carers to complete the PAS-ADD Checklist.

Procedure

The researcher met with participants on two occasions for hour long sessions in a familiar environment of their choice e.g. resource centre, college, social work building. The TEAMM was administered on both occasions. The administration of all other measures was counterbalanced across participants. Carers completed their measures at the same time in another room.

Psychometric Evaluation

Correlational analyses were initially used to identify the most central and reliable items. The retained items were analysed for test-retest reliability, internal consistency and construct validity. Due to the exploratory nature of the study, it was a priority in analysis planning that the likelihood of Type II errors was minimised. On this basis Bonferroni adjustments were not conducted (Perneger, 1998). However, the significance of all results was assessed using more conservative two-tailed testing and significance level of .01.

The mean score on the TEAMM was 59.7 (SD = 10.9). Histograms and boxplots of all data distributions showed no evidence of significant skew or outliers. The ratios of skew and kurtosis to relative standard errors supported the assumption of normality in the data distributions. This was confirmed by calculation of the One-Sample Kolmogorov-Smirnov Test for Normality.

Correlations between each item and the TEAMM total score assessed the reliability of individual items. Items were removed if the corrected item-total correlation was less than Pearson's r = 0.3 *and* removal of the item resulted in an increase in reliability as indicated by calculation of Cronbach's alpha (α) if item deleted (Kline,

2000; Hinton et al., 2004). This ensured a balance between developing a concise and internally reliable measure, whilst not reducing the content validity by eliminating large numbers of items that were meaningful and relevant to clients. This process resulted in the exclusion of five items (Items 5, 19, 30, 31 and 32). Table 3 displays the remaining corrected item-total correlations and alpha if item deleted. Individual item pairs were also checked for correlations exceeding Pearson's r = 0.70. No item pairs exceeded this cut-off, indicating that none of the items were affected by singularity or multi-collinearity. Therefore, this process resulted in the retention of 26 Likert items plus the therapy role and open-ended motivation items. As sample size precluded the use of Principal Component Analysis to confirm the factor structure of any subscales, only the TEAMM total score was further analysed as summarised in Table 4.

INSERT TABLE 3 ABOUT HERE

INSERT TABLE 4 ABOUT HERE

Evaluation of Response Format

Only one participant provided a 'don't know' response in the current study and did so on four of the items. Another one participant responded with the most positive response option on more than 90% of the items.

Test Retest Reliability and Internal Consistency

The TEAMM was re-administered to participants after a minimum of one week. The mean test-retest period was 11 days (SD = 5.2). This was naturally constrained by the need to re-administer the measure prior to contact with the therapist. As indicated in Table 4, the test-retest reliability of the TEAMM total score, as assessed by the Intra-Class Correlation (two-way mixed effects) was .82 (95% CI = .58-.93), F = 3.8, p = .002. The TEAMM total score was found to have acceptable internal consistency (Cronbachs alpha α = 0.80, N=22). Cronbach's Alphas if item deleted ranged from α = .75 to .79.

Construct Validity

The construct validity of the scale was explored by examining the partial correlations between the TEAMM total score and scores on the GSES and the ANSIE when controlling for intellectual ability as measured by the WASI. The TEAMM Total Score showed a large and positive significant association with GSES (Pearson's r = .70, p < .001, two-tailed), but no significant relationship with the ANSIE (Pearson's r = -.28, p = .22, two-tailed). TEAMM Total Scores showed small and non-significant associations with both client perception of referral understanding (Pearson's r = .18, p >.05, two tailed) and referral involvement (Pearson's r = .20, p >.05, two tailed).

Ratings of referral understanding and involvement are presented in Table 5. Due to missing carer data for six participants, it was necessary to compare percentages rather than frequency of ratings across the categories. Table 5 suggested some discrepancy between client and carer ratings across the categories of perceived referral understanding. Specifically, 63.6% of clients rated their level of

understanding as 'big', in comparison to the 25% of carers who felt the client had this level of insight. In contrast, the most frequent carer rating of client understanding (43.8%) was 'little', whereas only 9.1% of clients placed themselves in this category. Pearson Chi-Square analysis confirmed that there was a significantly different pattern of referral understanding ratings between clients and carers for 'little' and 'big' categories, χ^2 (1, N= 22) = 7.67, p< .01. As the analysis indicated that one cell (25%) had an expected count of less than five, Fisher's Exact Test was examined and confirmed the result at p = .01. Examination of Table 5 indicated a more even distribution of client ratings of level of referral involvement and less discrepancy with the ratings made by carers. Overall, roughly equal proportions of the client sample rated themselves as having been involved in the referral a 'little' (N=7), 'quite a bit' (N=7) and 'a big bit' (N=6), with only a minority feeling that they had had no involvement (N=2).

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INSERT TABLE 5 ABOUT HERE

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Exploration of Client Role Expectations

Client beliefs about responsibility for particular therapy roles are presented in Figure 3. As would be expected, most participants (N=17) said that giving help and advice was predominantly the role of the Psychologist. More than half (N=14) also felt that providing simple explanations of the emotional difficulties was also the role of the Psychologist. Whilst talking was seen as a shared task, participants allocated more specific aspects of communication to either themselves or the therapist. Fifteen

participants stated that talking specifically about feelings in therapy was predominantly their job. Asking questions, explaining issues, giving help and explaining the difficulties to family and support workers were typically seen as Psychologist roles. Overall, most participants appeared to have an expectation of active participation in terms of generating ideas, learning and trying out new things and doing homework tasks. However, they tended to see overall responsibility for resolving the problem lying either with them (N=8) or the Psychologist (N=11) alone. Only a small number (N=3) expected this to be a shared role.

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INSERT FIGURE 3

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Exploration of Therapy Motivation

The TEAMM also included a qualitative section in which participants were asked to indicate their reasons for going to see the Psychologist. These responses were categorised according to the Therapy Motivation Type model (Deci and Ryan, 1985). The reliability of coding was assessed by calculation of inter-rater reliability between two independent reviewers. Calculation of Cohen's Kappa indicated a high level of agreement with κ = .93. The number of participants reporting the different therapy motivation types and exemplar statements are presented in Table 6.

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INSERT TABLE 6 ABOUT HERE

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Ten participants gave therapy motivation reasons consistent with 'Extrinsic/Identified Regulation' (Deci and Ryan, 1985). These clients made statements about therapy being consistent with the goals they had for themselves at this time. Examples included "Help me to get things out of my mind...like the suicidal thoughts. Psychologist might help me to get them out of my head" and "to feel better...stop the mad thoughts and that...get rid of the anger". The next most frequent category of responding indicated 'Amotivation' (Deci and Ryan, 1985). These clients (N = 5) made statements indicative of not knowing why they were going to see a Psychologist and being unable to specify any particular reasons or hopes for attendance. Small numbers of clients gave reasons consistent with the remaining therapy motivation types. Three participants gave motivation statements consistent with 'Extrinsic/External Regulation'. Two participants made statements consistent with 'Extrinsic/Introjected Regulation' and another two with 'Extrinsic/Integrated Regulation'. No participants gave motivations that would be categorised by Deci and Ryan (1985) as 'Intrinsic'.

Discussion

The current study has shown that most adults with a mild intellectual disability are able to reflect on and discuss therapy expectancy and motivation at the point of referral to psychological services. Development of the TEAMM has provided preliminary evidence that these constructs can be measured in way that demonstrates reliability, content validity and initial indication of construct validity. Field-testing of the TEAMM revealed that many adults with ID have a frame of reference for helping relationships that is congruent with therapy as an active goal-oriented process and hold positive expectations for its process and outcome. However, it also revealed evidence of incongruency of carer and client beliefs about the individual's

understanding of the referral process and an indication that some individuals still had limited opportunity to display self-determination in relation to the help-seeking process.

In terms of construct validity, as predicted, the TEAMM shows a large and positive correlation with general self-efficacy as measured by GSES. This suggests that higher scores on the TEAMM indicate that the individual believes they can be an effective and active participant in therapy and has positive anticipations about process and outcome. Contrary to the initial hypothesis, the TEAMM is not significantly correlated with control orientation on the ANSIE or self-reported referral understanding and involvement. It is perhaps important to consider that the GSES items are self-referent statements of efficacy and perhaps more closely related to beliefs about being an effective participant in therapy. Indeed, the non-ID literature has indicated that expectancy beliefs hold the most robust relationship to process and outcome when they relate to anticipated changes in control over specific, self-selected therapy targets (Ramsay, unpublished). In contrast, the items of the ANSIE address global beliefs about the ability of others generally to be efficacious. As such, it may be insensitive to the control attributions relevant to therapy expectations and motivation in ID.

The TEAMM demonstrated high internal consistency of 0.80. This is comparable to existing general adult therapy expectancy measures such as the expectancy subscale of the Credibility Expectancy Questionnaire (Devilly and Borkovec, 2000). Given the content validity and probable construct validity of the TEAMM total score, it is likely to be a reliable measure of therapy expectancy and motivation. However, examination of individual items would also prove helpful in determining expectancy and motivation for therapy for any one individual. For example, a clinician could

glean clinically useful information from individual items measuring whether an individual with ID believes that therapy will be time-limited and goal-focused.

The test-retest reliability of the TEAMM total score after an average of 11 days was 0.82 indicating high stability of the measure over short time periods (Kline, 2000). This was identical to the test retest reliability coefficient achieved by Devilly and Borkovec (2000). It may reasonably be argued that correlation is inflated by the short test-retest period. However, it is anticipated that the time between clinical administration of the TEAMM and implementation of any expectancy interventions indicated by its administration is likely to be similarly short. Administering the TEAMM over longer time periods one would also expect greater variation due to the dynamic factors that are likely to influence therapy expectancy. Further exploration of these factors with larger samples will represent an interesting development to the current study.

In contrast to the results of Jahoda et al. (2006), the current study suggested that most individuals with ID expected therapy to be time-limited and goal oriented. Whilst most individuals thought therapy would lead to a positive outcome, they anticipated that it would take a long time for their problem to be improved. Congruent with therapies such as CBT, most participants expected to be active participants in therapy. This has positive implications for therapy in that higher congruency of role expectancy is significantly associated with the subsequent development of a higher quality of the therapeutic alliance and outcome (Joyce et al., 2000). However, responsibility for the overall solving of the problem was only viewed as a collaborative process by a minority of participants. Most felt that this task was the responsibility of either himself or herself or the Psychologist alone.

The majority of individuals were motivated by clear goals for therapy. Whilst none of the statements indicated intrinsic motivation as defined by Deci and Ryan (1985), most related to the internal reinforcement provided by achieving symptom reduction through increased emotional coping. Overall, these results indicate a frame of reference for therapy as a goal focused process. This suggests that the established relationship shown between positive expectancy and self-selected therapy goals (Joyce et al., 2003) can also be used to therapeutic benefit in ID. However, the participants who did not know why they were attending a Psychologist, whose motivation was externally controlled and who evidenced little self-determination in the process also highlight the importance of directly discussing therapy goals with all individuals. Indeed, the lack of agreement between clients and carers about referral understanding suggests that systemic attributions about individuals with ID having a lower capacity for self-determination in relation to treatment decisions may persist in support and care provision.

The current study had a number of limitations. Firstly, the study recruited a small number of participants (N=22). Due to the exploratory nature of the study, Bonferroni adjustments were not made in order to reduce the likelihood of Type II errors. Whilst all the positive effects reported were large and significant at a more conservative two tailed testing level and significance level of $p \leq .01$, the inflated risk of Type I errors in the current study must be acknowledged. Therefore, the reported results will be preliminary in relation to our understanding of therapy expectancy and motivation in ID and will require confirmation with larger sample sizes. A further implication of the small sample size is that it was not possible to carry out any factor analysis on the TEAMM data in order to confirm the variables present and permit interpretation of any subscales. Further refinement of the

TEAMM using such procedures will require a larger sample. A second limitation of the current study is the existence of a potential sampling bias. The conditions of ethical approval may mean that the current sample represented individuals whose environment provided higher levels of opportunity for self-determination. This potential bias suggests that generalisation across all adults with ID should be tentative at this point. Thirdly, the different presenting problems in the sample may influence responding on many of the TEAMM items. For example, negative self-evaluative and social comparative beliefs in depression (MacMahon and Jahoda, 2008; Dagnan and Sandhu, 1999) may influence expectations of making an effective contribution to successful therapeutic relationships.

Despite these limitations, the results of the current study have a number of applications for clinical practice. Higher TEAMM total scores may be interpreted as an indication of more positive beliefs about personal and therapeutic efficacy in relation to the process and outcome of psychological intervention. Examination of individual items may also be used to capture the nuances of expectancy and motivation for each individual. The current study would also suggest that reflection is required on the part of academic, clinical research governance and care provider systems on the issue of self-determination of adults with ID. Attributional biases may continue to reduce environmental opportunities for this group to develop optimal levels of self-determination in relation to their treatment decisions and participation in research. The current study provides evidence that individuals with ID can be engaged in a meaningful dialogue about their feelings and beliefs regarding impending psychological interventions. The gap between client and carer perceptions would suggest that many support providers and referring agencies would benefit from the provision of informative training on effective communication with

clients at the stage of referral. This may support these agencies to enhance the opportunities they offer for individuals with ID to be more active participants in treatment decisions.

Amidst the expanding use of individual psychological interventions with adults with an intellectual disability, the current study represents a further endeavour in facilitating this group to report on and discuss a key influence on the process and outcome of the therapy they receive. The current study indicates that the TEAMM is a clinically useful tool that may help clinicians to engage in collaborative discussion of expectancy and motivation as an individual enters therapy, and thus significantly enhance the therapeutic experience of adults with an intellectual disability.

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Table 1.   Emergent Themes and Exemplar Statements from Existing Transcripts and Semi-Structured Interviews.

_____

Theme	Description	Exemplar
Outcome Expectations	Statements of expected outcome.	*Things might not change...might not help.*
	Reasons why unable to predict outcome.	*It will depend on whether that person can get to know me. I don't know which Psychologist it will be so I can't really comment on that.*
Process Expectations	Positive and negative experiences of communication in previous relationships.	*We had this meeting and they were going 'blah, blah, blah'. I was like a tennis person going back and forwards...felt like I was in a French film or something.*
		Therapist X explained things to me that I didn't understand...simple words.
	Expectations of future communication	*Doctors and nurses will use all the medical language and I'll have to tell them they're talking in a foreign language.*
		Psychologist will help me to think things and then I tell her and she translates back.
	Trust and Safety	*I like to build up my relationships. I don't like just going in there if I don't know them.*
		Like a brother and sister to me...but on the outside. Psychologists are on the outside, so it's good. Like talking to a pal.

_____

Table 1 (continued). Emergent Themes and Exemplar Statements from Semi-Structured Interviews

_____

Theme	Description	Exemplar Statement
Therapy Duration	Beliefs about duration and endings.	*Hopefully I'm not going to see them for long.*
		We'll be caught up for a while.
		There is no limit how long you see the person...you might be seeing them all your life.
		I might be well enough to stop. Or the Psychologist might say you are ready to get on with your life.
		I might get fed up and stop….depends how long the talking lasts.
Role Expectancy	References to therapy role behaviours.	*Explain things in easy words.*
		Help staff/family to understand better.
		I thought it was for bad people. I thought what Therapist X is doing is for people who are not well and that people who take pills are bad.
		They'll want to know what's been wrong with me all my life..I might tell some of it.
		Ask the Psychologist what I should do. Ask questions.

_____

Table 1 (continued). Emergent Themes and Exemplar Statements from Semi-Structured Interviews

_____

Theme	Description	Exemplar Statement
Self-Efficacy and Control	Beliefs about level of agency and control in general life circumstances.	*I can have a lot of control...but the workers said they need to do it for me. It's frustrating.* *I don't know where to start with things. It's do with how I'm feeling, not what I can do.*
Motivation	Emotional or interpersonal difficulties.	*I was getting angry and aggressive. Nobody had wanted to listen to me at all.* *I feel like my head is a volcano, building up, building up, like a big bubble and I don't know where to start.*
	Causal attributions about the problem.	*It came from in my head. People around me make me annoyed...I feel guilty and upset after.* *I think probably other people... they think people in wheelchairs are daft.*
	Motivations for attending therapy	*Start talking...wouldn't be scared..being able to cope again. Help me understand when I'm angry.* *Make staff happy. Get a centre.*
Referral Understanding & Involvement	References to perceived understanding and involvement in referral.	*Someone should have told me because it is my future.* *It was <Care Manager>'s idea. It was a good idea. I was able to say what was right for me.*

_____

Table 2. Referral and Support Characteristics of the Scale Evaluation Participants.

Referral or Support Characteristic	Number	of	Participants	(%)
Referral Reason				
Low mood or depressive disorder	7	(31)		
Anxiety	5	(23)		
Anger	4	(18)		
Self-injurious behaviours	3	(15)		
Complicated bereavement reaction	2	(9)		
Emotional issues arising from abuse	1	(4)		
Referral Source				
Care Provider/Support Worker	9	(41)		
Psychiatrist	5	(23)		
Community Nursing Team	4	(18)		
Family member via GP	2	(9)		
Social Worker	2	(9)		
Living and Support Situation				
Own tenancy with daily support	8	(36)		
Group care setting with 24 hour support	6	(27)		
Living with parents	5	(23)		
Living with spouse/partner without support	2	(9)		
Living with spouse/partner with support	1	(5)		
Work and Training				
No current work or training placement	11	(50)		
College	5	(23)		
Resource centre placement	4	(18)		
Voluntary work	2	(9)		

PAS-ADD	Mean Score (SD)
Life Events	3 (2)
Organic Subscale	0.9 (2)
Affective-Neurotic Subscale	4 (1)
Psychotic Subscale	0.9 (1)

Table 3. Corrected Item-Total Correlations and Cronbach's Alpha if Item Deleted for retained items.

Item	Corrected Item-Total Correlation	Cronbach's Alpha if item deleted
1	.30	.78
2	.47	.77
3	.48	.77
4	.36	.77
6	.31	.78
7	.24	.78
8	.19	.78
9	.54	.77
10	.04	.79
11	.24	.78
12	.28	.78
13	.38	.77
14	.05	.79
15	.44	.77
16	.46	.77
17	.06	.79
18	.51	.76
20	.76	.75
22	.13	.78
23	.57	.76
24	.34	.77
25	.25	.78
26	.53	.76
27	.35	.77
28	.53	.77
29	.38	.77

Table 4. Reliability and Validity Analysis of the TEAMM Total Score.

	Reliability			Construct Validity			
	Test Retest	Internal Consistency		GSES	ANSIE	Und[1]	Inv[2]
	Intra-class correlation	Cronbach's Alpha	(a)	Pearson r	Pearson r	Pearson r	Pearson r
TEAMM	.82 (F = 5.7), p<.001**	.80		.70, p<.001**	-.28, p=.22	.18,p=.42	.20,p=.36

**Indicates two-tailed significance at p < 0.01

[1]Client perception of referral understanding.   [2]Client perception of referral involvement.

Table 5. Frequency Counts and Proportions of Client and Carer Ratings of Referral Understanding and Involvement.

		Perception of Referral Understanding			Perception of Referral Involvement		
		Client	Carer	Total	Client	Carer	Total
None	Count	4	2	6	2	2	4
	Expected Count	3.5	2.5	6	2.3	1.7	4
	% within Position	18.2%	12.5%	15.8%	9.1%	12.5%	10.3%
A little	Count	2	7	9	7	2	9
	Expected Count	5.2	7	9	5.2	3.8	9.0
	% within Position	9.1%	43.8%	23.7%	31.8%	12.5%	23.7%
Quite a bit	Count	2	3	5	7	6	13
	Expected Count	2.9	2.1	5	7.5	5.5	9.0
	% within Position	9.1%	18.8%	13.2%	31.8%	37.5%	34.2%
Big bit	Count	14	4	18	6	6	12
	Expected Count	10.4	7.6	18	6.9	5.1	12.0
	% within Position	63.6%	25%	47.4%	27.3	37.5	31.6
Total	Count	22	16	38	22	16	38
	Expected Count	22	16	38	22	16	38
	% within Position	100%	100%	100%	100%	100%	100%

Table 6. Therapy Motivations of Adults with Intellectual Disabilities

_____

Therapy Motivation Type	Participants N(%)	Exemplar Statement
Intrinsic Individual is motivated to attend for the pleasure and/or satisfaction of therapy.	0	-
Extrinsic/External Regulation The individual's motivation to attend is controlled by external sources e.g. material gains, constraints imposed by others.	3(14)	I'm going so that the Psychiatrist will put my tablets down. Staff said I might get the tablets stopped.
Extrinsic / Introjected Regulation The individual's formerly external motivation has now been internalised and is reinforced by internal pressures.	2 (9)	To make me feel better and change what I've been doing. It's no good for my partner..it's not fair on him.
Extrinsic / Identified Regulation Going to therapy is congruent with the individual's values or goals.	10 (46)	Might help me to get things out of my mind...like the suicidal thoughts.
Extrinsic / Integrated Regulation Attendance is congruent with self-identity	2 (9)	To get professional help for my frustrations. To talk to me about my problems and give me advice...so that I can sort things out by myself in the future. I want to be able to cope better by
Amotivated Unsure why going and may refer to feeling out of control.	5 (22)	I don't know..not sure really. Think maybe my Grandad knows why. They told him.

_____

Figure 1. Summary of TEAMM Development Processes

```
┌─────────────────────┐        ┌─────────────────────┐
│ Systematic  review  │        │ Review           of │
│ of       expectancy │        │ transcripts    from │
│ literature      and │        │ Jahoda    et    al. │
│ existing expectancy │        │ (2006).             │
│ measures.           │        │                     │
└─────────────────────┘        └─────────────────────┘
            ＼                        ／
             ＼                      ／
          ┌─────────────────────┐
          │ Semi-structured     │
          │ interviews     with │
          │ clients    awaiting │
          │ psychological       │
          │ therapy (N=3).      │
          └─────────────────────┘
                     │
                     ▼
          ┌─────────────────────┐
          │                     │
          │ Development      of │
          │ Therapy             │
          │ Expectancy      and │
          │ Motivation Model.   │
          └─────────────────────┘
                     │
                     ▼
          ┌─────────────────────┐
          │ Derivation of initial│
          │ item    pool   (141 │
          │ items).             │
          └─────────────────────┘
                     │
                     ▼
          ┌─────────────────────┐
          │ Expert   Panel   to │
          │ refine item pool (36│
          │ items).             │
          └─────────────────────┘
                     │
                     ▼
          ┌─────────────────────┐
          │ Piloting of item pool│
          │ for           further│
          │ refinement     with │
          │ clients    awaiting │
          │ psychological       │
          │ therapy (33 items). │
          │ (N=3)               │
          └─────────────────────┘
                     │
                     ▼
          ┌─────────────────────┐
          │ Therapy             │
          │ Expectation     and │
          │ Motivation Measure. │
          └─────────────────────┘
```

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Figure 2. Proposed model of therapy expectations and motivation in adults with an intellectual disability.

Individual, interpersonal and situational context ⇨ Expectations ⇨ Engagement / Motivation

Previous experience of helping relationships.	Understanding of the nature, process and potential costs and benefits of helping relationships.
Previous communication experiences.	

Nature of any therapy hopes, expectations about therapy jobs (role expectations), potential outcome (outcome expectations), relationship with therapist (process expectations) and own self-efficacy within therapeutic relationship/situation.

Potential for development of shared therapeutic goals within a therapeutic relationship.

Perception of control and self-efficacy in current life situation including involvement in referral.

Reasons/motivations for going to see the Psychologist.
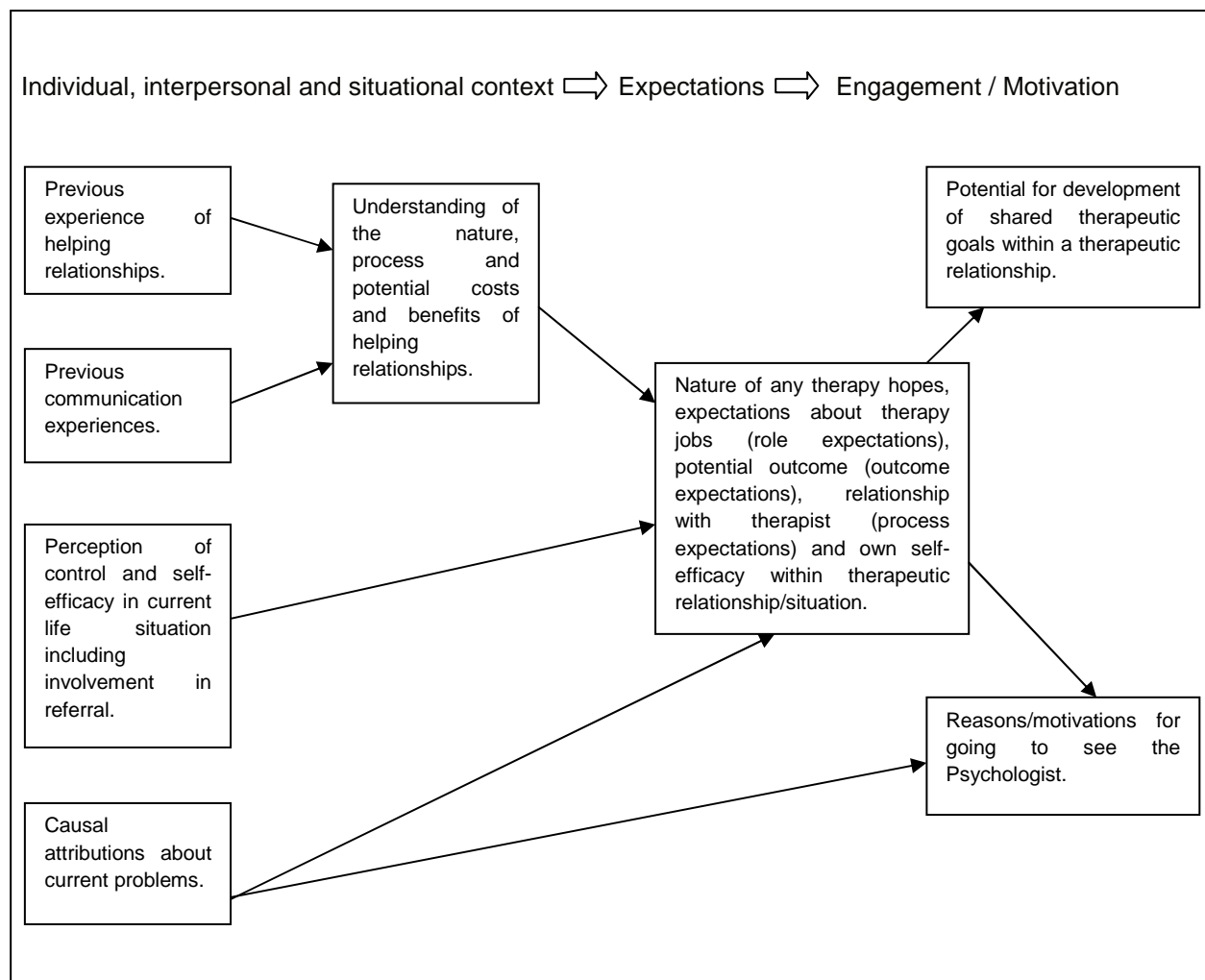
Causal attributions about current problems.

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Figure 3. Therapy Role Categorisations by adults with intellectual disabilities.

Appendix A. Requirements for submission to Ps*ychology and Psychotherapy:Theory, Research and Practice.*

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Psychology and Psychotherapy (PAPTRAP)
Notes for Contributors

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 5000 words, although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Submission and reviewing

All manuscripts must be submitted via our online peer review system. The Journal operates a policy of anonymous peer review.

4. Manuscript requirements

> ► Contributions must be typed in double spacing with wide margins and on only

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one side of each sheet. All sheets must be numbered.

- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.
- All articles should be preceded by an Abstract of between 100 and 200 words, giving a concise statement of the intention, results or conclusions of the article.
- For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions. For further details please see the document below:

    Psychology and Psychotherapy: Theory, Research and Practice – Structured Abstract Information

- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.

For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.

5. Brief reports

These should be limited to 1000 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. A summary of not more than 50 words should be provided.

6. Publication ethics

All submissions should follow the ethical submission guidelines outlined the the documents below:

    Ethical Publishing Principles – A Guideline for Authors

    Code of Ethics and Conduct (2006)

7. Supplementary data

Supplementary data too extensive for publication may be deposited with the British

Library Document Supply Centre. Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The material should be submitted to the Editor together with the article, for simultaneous refereeing.

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Appendix B.   Topic Guide for Semi-Structured Interviews

1. Can you tell me the names of people who have helped you with problems in the past?

2. What did you think/feel about the help they gave you?

3. What was helpful about what they <insert each of the names provided>?

4. Was there anything that wasn't helpful or didn't feel good about the help?

5. You are going to see a Psychologist soon. How did that happen?

    a. Who decided it would be helpful for you to go?

    b. Was there any talking about it first?

6. How do you think this problem <insert client selected word for problem> started?

    a. Who/what will need to be different for it to get better?

7. What do you think will happen when you see the Psychologist?

    a. What kind of things/jobs do you think the <u>Psychologist</u> will do?

    b. What kind of things/jobs do you think <u>you</u> will be doing when you go?

8. How do you think you'll get on with your jobs?

9. What do you hope will happen when you see the Psychologist?

    a. Is there anything you hope the Psychologist will help you with?

    b. If they do a good job, who will notice a difference? What will they notice?

10. How long do you think you will keep on seeing the Psychologist? <Use anchors e.g. festivals and holidays, birthdays, seasons>.

11. When you will stop seeing them?

    a. How will you/Psychologist decide that you don't need to meet any more?

    b. Why might you finish seeing the Psychologist?

12. Do you feel that you get a lot of control / say over what happen in your life everyday?

    a. How do decisions get made about what happens in your life?

    b. What's that like for you?

Appendix C. Therapy Expectation and Motivations Measure and Manual

Therapy Expectations and Motivations Measure (TEAMM) - Manual

What you need:

Item cards.

Four point Likert scale with visual supports.

Three posting boxes labelled 'Me', 'Psychologist' and 'Both'

Therapy Job Cards.

Response sheets.

Administration Instructions 1: Engagement and Rapport Building.

Start the session by engaging the participant in general conversation in order to build rapport. This conversation should also be used to identify idiosyncratic items for Likert scale socialisation e.g. interests and hobbies, activities that are liked/disliked, types of films or music that are liked or disliked. Try to identify things that vary in degree of desirability e.g. like a little bit, like a lot.
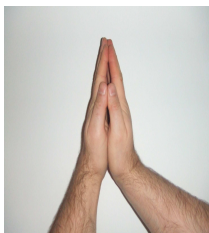
Administration Instructions 2: Scale Socialisation.

"Today I am going to be talking to you about going to see a Psychologist. I am going to show you some cards. I would like you to tell me how much the cards are right (true) for you. You can use this ruler to show me".

Place the ruler in front of the participant with the visual supports in place.

Participant view

"On this ruler, this bit means 'none....not right at all' <simultaneously point to the 'none' section>*, this bit means 'little...little bit right'* <simultaneously point to the 'little' section>*, this bit means 'quite a lot...quite a lot right'* <simultaneously point to the 'quite a lot' section> *and this bit means 'a lot.....a lot right'*<simultaneously point to the 'a lot' section>*".* Read through the sections again slowly and simultaneously indicate an increasing amount using hand gestures.
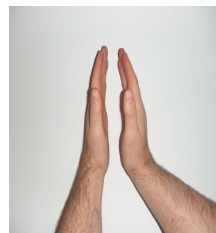
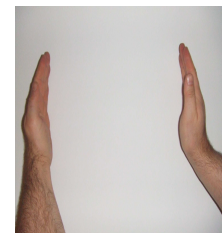
None   Little   Quite a lot   A lot

Administration Instructions 3: Likert Scale Practice

*"Let's have a practice first. I am going to say some things and I want you to show me on the ruler how right they are for **you**. You might think some of them are a bit funny, but they're just for practice."*

Practice item cards should be used with the relevant items written on a 'wipeable' surface. Each card should be placed in front of the person and should be read out followed by *'How much is that right for you? None, little, quite a lot or a lot right?'* <Simultaneously point to scale>. If the person does not respond after a few moments then repeat. The individual should be given

ongoing encouragement and positive reinforcement/reassurance as required. If the individual is unsure about responding, then encourage them to have a go and choose the one they think is best for them.

If the individual clearly indicates the incorrect section of the scale during pretesting, then re-administer the scale socialisation script and then ask again *'Where is e.g.'quite a lot' on the ruler?'*. If the individual indicates the correct area, then re-administer the item. If the individual responds appropriately then proceed with the remaining items. If the individual continues to respond inappropriately, then the administrator should re-consider the use of the measure with the individual.

Administration Instructions 4: Therapy Expectations and Motivation Scale:

Each item card should be placed in front of the individual and read out loud. The administrator should then say *'How much is that right is that for you? None, little, quite a lot or a lot? <Simultaneously point to scale>'*. If the person does not respond after a few moments then repeat the item. The administrator should alternate the direction that the responses are read out in after every 2 or 3 items to prevent development of a response set. If the individual still does not respond or indicates that they do not understand the item, then say *'Another way to say it is..."* <insert alternative standardised script which is printed in italics in the manual>. The individual should be given ongoing encouragement and positive reinforcement/reassurance as required. If the individual is unsure about responding, then encourage them to have a go and choose the one they think is best for them.

Therapy Role Expectancy (Item 21)

Item 21 relates to role behaviour expectancy. The administrator should place the three posting boxes in front of the individual. The label on each box should be read out and simultaneously pointed to (ME, PSYCHOLOGIST, BOTH). The administrator should then point out that each box has an opening on the top *"like a post box"*.

The administrator should then introduce this section of the TEAMM by saying *"I have some new cards here. On the cards are the names of some things that might happen when people see a Psychologist. Some of them are jobs that you might be doing. Some of them are jobs that the Psychologist might be doing. Some of them are jobs that **both** of you might be doing. "*

I would like you to tell me who you think will be doing each one. You can show me by posting the card into the box.

Introduce each role by saying *"When you go to see the Psychologist, whose job will it be to <insert therapy role>?* The administrator should then provide the response options by pointing to each box and indicating 'whose' box it is e.g. me, Psychologist, both of us. The ordering should be altered each time to reduce the likelihood of response sets being established.

<u>Therapy Motivations (Item 33)</u>

Scoring of Item 33 is qualitative and so it is crucial that the individuals responses are recorded as close to verbatim as possible. Responses are coded according to the Therapy Motivation Types Model (Deci and Ryan, 1985).

Scoring Instructions:

Scores for each item range between 0 and 3. The administrator should be careful to reverse score where indicated. Psychometric evaluation only supports interpretation of the TEAMM total score at this time. The total possible score for Likert response items is 93. The analyses conducted on the TEAMM to date indicate that higher scores can be interpreted as a general indication that the individual believes they can be an effective and active participant in therapy and has positive anticipations about process and outcome. The mean score of a small sample of adults with mild intellectual disabilities (N=22) awaiting psychological therapy balanced for previous psychological intervention was 60 (SD 11).

Responding on Item 21 can be used to explore the individual's therapy role expectancies and will provide qualitative information about their expectations

of active, collaborative or passive participation. It can also be used to highlight beliefs about therapy roles that may be incongruent with the therapy being offered.

Responding on Item 33 can be used to explore the nature of the individual's motivations for attending therapy. It can also be used to inform collaborative goal-setting at the outset of therapy.

Motivation Type	Description	Examples
Intrinsic	Individual is motivated by the enjoyment or self-development that arises from therapy. There are no external gains.	I want to get to know myself better.
Extrinsic/External Regulation	Motivation is controlled by external demands, pressures or contingencies.	I am only going to keep my partner/Social Worker happy.
Extrinsic/Introjected Regulation	Motivation was previously external, but has now been internalised and is reinforced by internal motivators e.g. guilt, worry, self-esteem. Individual feels that they *should* go.	I should go because I feel guilty about my children having a mother who is sad all the time.
Extrinsic/Identified Regulation	Motivation is based on therapy being consistent with the individuals goals.	It will help me to cope better which is really important to me right now.
Extrinsic/Integrated regulation	Motivation is based on a recognised value of therapy, but also a consistency with the individual's self-identity.	I saw a Psychologist before and it really helped me to work through things. I want to build on that progress.
Amotivated	Individual does not see a relationship between their behaviour (attending therapy) and an outcome (getting better).	I don't even know why I am going. There is nothing I or anyone else can do about this.

Therapy Expectations and Motivations Measure

Name:_____   Age:_____   Gender: Female/Male

Therapist name: _____   Date: _____

*Indicates items removed following psychometric evaluation.

Item		Score (please circle)
		None Little Quite a bit Big
"Now that you know how to use the ruler, we'll talk about some different things".	*"I would like to start by talking to you about when you have had problems in the **past**.*	*Can you tell me the names of people who have helped you with problems in the past?*
	*I'm going to show you some cards. Tell me how much each card is right(true?) for **you**."*	
1	**I've had help before.** *People have helped me with problems before.*	0 1 2 3
2	**People haven't helped me with problems.** *I haven't had good help with problems.*	0 1 2 3 (reverse score)
	*"These cards are about talking with people who have helped you, like <insert names>. Tell me how much each card is right (true) for **you**."*	
3	**I can understand what other people like _____ are talking about.** *I know what other people are saying.*	0 1 2 3
4	**People like ____ don't understand me when I talk.** *People like ____ don't know what I'm saying.*	0 1 2 3 (reverse score)
*5	**I feel stupid when people don't understand what I'm**	0 1 2 3 (reverse score)

	saying. *I feel bad when people don't know what I'm saying.*				
6	**I can speak up for myself when I don't understand what people are talking about.** *I can say when I don't know what people are saying.*	0	1	2	3
7	**When I talked to people like _____ about my (problem), I felt safe.** *I felt safe when I talked to _____.*	0	1	2	3
8	**When I talked to people like _____ about my (problem), I felt listened to.** *_____ didn't really listen to me.*	0	1	2	3
9	**People like _____ knew how I was feeling.** *People like _____ knew what was wrong with me.*	0	1	2	3
10	**Nobody really wanted to help me.** *People didn't help me.*	0	1	2	3 (reverse score)
	*I'd like to find out more about what things are like for you in your life. We're going to use this ruler again <indicate the Likert scale>. I'm going to show you some cards <each item on card>. Tell me how much each card is right(true?) for **you**.*				
11	**I get a lot control over what happens in my life.** *I have get a lot of say about*	0	1	2	3

	what happens in my life.	
12	**I don't feel in control of what happens in life.** *I don't get any say in what happens in my life.*	0 1 2 3 (reverse score)
13	**I'm happy with how much control I have over my life.** *I'm happy with how much say I have.*	0 1 2 3
14	**I need help from other people to make things happen in my life.** *I need help to do what I want to do.*	0 1 2 3 (reverse score)
15	**It was my idea to see a Psychologist.** *I said that I needed to see a Psychologist.*	**0 1 2 3**
16	**I should have had more say in it.** *I should have been talked to about it more.*	**0 1 2 3**
		I would like to talk a bit about the problems you've been having recently. <Place down three 'Responsibility for Change' cards in a row in front of the participant>. 'Mostly me'
17	**Who needs to change to make the problem better?**	**Me Both Others** **2 1 0**
	*"Let's go back to the ruler again. I'm going to show you some cards <each item on card>. Tell me how much each card is right(true?) for **you**.*	
18	**How much do <u>you</u> need to change to make the (problem) better?**	0 1 2 3

	How much changing will you need to do?	
*19	**How much do <u>other people or things</u> need to change to make the (problem) better?** *How much changing will other people need to do?*	0 1 2 3 (reverse score)
20	**I can make my (problem) better.** *I can do things to make the (problem) go away.*	0 1 2 3
	"You are going to see a Psychologist soon/ You have just started seeing the Psychologist <delete as applicable>. I would like to talk about what you think will happen." *"I have three boxes here. One box says 'Me', one box says 'The Psychologist' and one box says 'Both of us' <point to each in turn>. Here are some cards that have 'jobs' on them. Tell me who you think will be doing these jobs when you go to see the Psychologist and post it in the right box."*	
21	**When you go to the Psychologist, whose job is _____<insert therapy job>? Will it be you, the Psychologist or both of you?**	Use TABLE 1 for individual items.
	"Let's go back to the ruler again. I'm going to show you some cards <each item on card>. Tell me how much each card is right(true?) for you.	
22	**I will be good at my jobs.** *I will do my jobs well.*	0 1 2 3
23	**The Psychologist will be good at their jobs.** *The Psychologist will do their jobs well.*	0 1 2 3

24	**I will be able to keep on seeing the Psychologist for as long as I want to.** *I can just keep on seeing the Psychologist if I want to.*	0	1	2	3
25	**I will stop seeing the Psychologist when my (problem) gets better.** *The Psychologist will stop when the problem gets better.*	0	1	2	3
26	**It won't take long to sort out my (problem).** *The problem will be sorted quickly.*	0	1	2	3
27	**I can say when I've had enough for that day.** *I can tell the Psychologist when I want to stop for that day.*	0	1	2	3
28	**Things will change when I see the Psychologist.** *The problem will change when I see the Psychologist.*	0	1	2	3
29	**It's going to be hard work to make my (problem) better.** *It is going to be difficult to make the problem better.*	0	1	2	3 (reverse score)

*30	**Show me on this ruler how big the problem is for <u>you</u>?** *How much is the _____ a problem for **you**?*	0	1	2	3
*31	**Show me on this ruler how big the problem is for <u>other people</u>?** *How much is the _____ a problem for **other people**?*	0	1	2	3
*32	**How much on this ruler do you <u>want</u> to go and see the Psychologist?** *How happy are you about going to see the Psychologist?*	0	1	2	3
33	**Can you tell me why?**	**Record verbatim reasons and refer to categories later. This item is used qualitatively and not scored as previous items. See manual.**			

Therapy Jobs (Item 21)

Job	Mostly Me	Mostly Psychologist	Both of us
Ask questions			
Talk about upsetting things.			
Talking			
Do good listening			
Come up with good ideas			
Sort out the problem			
Learn new things			
Do jobs before the next meeting			
Tell feelings			
Give help and advice			
Explain things in an easy way			
Try out new things to make problem better			
Help your family/support workers to understand px.			

Appendix D. Client Perception of Referral Understanding and Involvement Measure

Understanding
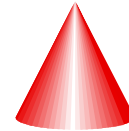
I understand why I am going to see a Psychologist.

Not at all   A little   Quite a bit   A lot

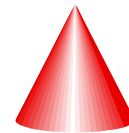**Involvement**

I was spoken to about it first / I helped decide to get a Psychologist.

Not at all   A little   Quite a bit   A lot

Appendix E. Carer Perception of Referral Understanding and Involvement Measure
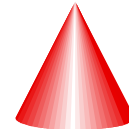
Understanding

How much do you feel the individual understands why a psychologist has been asked to meet with them? Circle most appropriate answer.

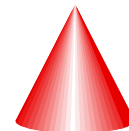| Not at all	A little	Quite a bit	A lot

Involvement

How much involvement do you think the individual had in the decision to make a referral to psychology? Circle most appropriate answer.

Not at all	A little	Quite a bit	A lot

APPENDIX F: MAJOR RESEARCH PROPOSAL

Title: Therapy Expectations and Motivations: Preliminary Exploration and Measurement in Adults with intellectual disabilities.

Running Title: Therapy Expectancy and Motivations

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Abstract

Background: The beliefs that an individual has about therapy and their sense of efficacy within that process represent significant influences on treatment motivation, therapy process and outcome. Certain characteristics of the Intellectually Disabled population and the systemic context of the pathway by which they arrive at psychological intervention assign a particular significance to expectancies and motivation within this population at the point of referral. **Aims:** The proposed study will conduct an initial exploration of therapy expectations and motivations in adults with Intellectual Disabilities who are referred for psychological therapy. Through the development of a preliminary assessment measure, the extent to which this construct can be measured in a valid and reliable way will be determined. **Methods:** A content analysis on existing transcripts and from semi-structured interviews will be combined with a systematic review of the expectancy literature to construct a measure of therapy expectancy and motivation. This measure will be piloted on an independent sample of clients and will undergo psychometric evaluation of reliability and validity. **Applications:** The proposed study will contribute to the larger research focus on increasing the accessibility and effectiveness of psychological therapies for the Intellectually Disabled population by making the first population specific investigation of this key influence on process and outcome. Development of a measure of therapy expectation and motivation for this population will offer clinicians the opportunity to easily assess these variables within clinical practice and potentially instigate appropriate pre-therapy interventions to optimise the experience and effectiveness of psychological therapies for this population.

Introduction

A positive shift towards the adoption of individual psychotherapeutic techniques with adults with Intellectual Disabilities (ID) is occurring. A body of work exploring the basic ability requirements has started to emerge with promising indications for the use of various therapies with ID adults (Willner, 2005; Dagnan et al., 2000; Reed and Clement, 1989; Dagnan and Chadwick, 1997). However, it is a critical consideration that readiness to engage in any activity requires a combination of both ability and motivation (Rollnick, 1998) and there have been calls for research addressing the latter in the ID population (Willner, 2006).

Based on the premise that therapy requires active participation, it is critical to both process and outcome that the individual is motivated to engage (Keijsers et al., 1999; Krause, 1966). A vast array of common change factors have been proposed as potential internal and external determinants of motivation to engage in therapy. Recent reviews of common change factors in psychotherapy confirm expectancies have positive associations with indicators of both treatment outcome and process (Arnkoff et al., 2002; Noble et al., 2001; Greenberg et al., 2006). Therapy expectancies are defined as anticipatory cognitions about will happen during or because of therapy. The link to motivation to engage in therapy is clear within the framework of goal theory in that individuals will strive towards achieving a goal as long as they expect that goal to be achievable. Individuals who believe in the efficacy of therapy and themselves within that process may be more likely to develop a collaborative and affiliative bond with the therapist and engage constructively in the treatment process. (Greenberg et al., 2006)

Consideration of therapy expectancies clearly overlaps with research efforts around related constructs such as self-efficacy and locus of control. Bandura (1977) proposed that self-efficacy is the conviction that one can successfully execute the behaviour required to produce the desired change or outcome. In the context of any form of psychotherapy he argued that this will impact on the nature and persistence of therapy related behaviours and the individual's estimate that the desired change or outcome will follow from these behaviours. Thus it may be argued that self-efficacy represents a specific form of therapy expectation. Zigler and Balla (1977) argued that individuals with ID may have lower self-efficacy as a result of experiencing multiple failures and being exposed to an environmental expectation of failure. There are a small number of studies, which have shown that this group does indeed have lower self-efficacy in relation to cognitive tasks. (Slemon, 1998; Gresham et al., 1998)).

A related construct is locus of control, defined by Rotter (1966) as the perception of a connection between one's action and its consequences. Individuals with an internal locus of control view themselves as being able to exert control over the consequences through their own actions. In contrast, individuals with a more external locus of control believe that others primarily control reinforcement and outcome. Bandura (1977) argued that locus of control represents a causal belief about the outcome of action and thus represents a significant influence on self-efficacy in therapy. Indeed, Page and Scalora (2004) reported that a more internal locus of control pre-therapy may provide some indication of treatment amenability.

Research into the characteristics of the relationships developed by individuals with Intellectual Disabilities also gains a particular significance in this context. Zigler et al. (1968) and Yando and Zigler (1971) proposed that individuals with ID have high levels of outer-directedness. They proposed that this manifests in a higher need for

external approval and less reliance upon internal resources to determine effectiveness. A number of studies have suggested that individuals with ID do tend to have a more external locus of control, (Wehmeyer, 1994; Wehmeyer and Palmer, 1997; Langdon and Talbot, 2006). The implication is that the therapeutic relationship would represent a social interaction that is very different to those previously experienced in that it will require a greater use of internal resources as a source of motivation and reinforcement. This has significant implications for engagement in therapy in that cognitive approaches require active involvement and shared responsibility for therapy progression.

Within the context of therapeutic work with adults, it is assumed that most presenting individuals have initiated the help-seeking process and have some expectation of what will happen during therapy. This assumption is arguably less reasonable with adults with an Intellectual Disability. Willner (2003) found that 50% of a sample taken from a Clinical Psychology service had not had the role of the psychologist explained to them and in a higher number of cases it was not clear that the individual had even consented to the referral. A recent qualitative study with adults with an ID in the early stages of therapy revealed a number of important and related findings that say much to the current argument (Jahoda et al., 2006). A number of individuals indicated a sense of powerlessness in previous contacts with services, not knowing how to access services and a desire to have more control over access to professional help. This piece of work also highlighted the presence of common expectations about therapy that may be considered incongruent with the intervention being offered. Many of the clients did not comprehend that therapy was time-limited and oriented towards the achievement of specific goals. Instead, they saw therapy as the development of an ongoing source of support.

Whilst the specific relationship between expectancies, self-efficacy, locus of control and treatment motivation requires further delineation, it is indisputable that the beliefs and understanding an individual holds about therapy have a pan-theoretical role in mediating therapeutic process and outcome. It is the premise of the current proposal that certain characteristics of the ID population and the systemic context of the pathway by which they arrive at psychological intervention assign a particular significance to many of the common change factors which are posited to determine therapy process and outcome.

Aims and Hypotheses

The overall aim of the proposed study is to contribute to the wider research focus on increasing the accessibility and effectiveness of psychological therapies for adults with Intellectual Disabilities. The specific objectives of the proposed study are as follows:

i. To conduct an initial exploration and measurement of therapy expectations and motivations in adults with Intellectual Disabilities who are referred for psychological therapy.

ii. To explore the relationship between this construct and state factors such as locus of control and self-efficacy and referral context factors.

The following hypotheses are made in relation to the proposed study:

i. Therapy expectancy and motivation for adults with ID will show a significant association with the level of general self-efficacy and direction of control orientation.

ii. Therapy expectancy and motivation will be also be significantly associated with perceived level of understanding involvement in referral process.

Methodology

Design

The proposed study will incorporate a scale development and a scale evaluation phase.

Phase 1: Scale Development

The item pool development phase will incorporate four key procedures. Firstly, a review of relevant literature on treatment expectancy and motivation will be used to generate potential items. Secondly, a content analysis will be conducted on transcripts from a recent qualitative study on the experiences of adults with intellectual disabilities in the early stages of therapy (Jahoda et al., 2006) to generate potential items. Ten pre-therapy interviews will be analysed for the purpose of this study. The constructs of interest are client expectations about therapy, motivations for therapy, understanding of the therapy process and indication of the extent to which they felt control over the process of referral. The material from these interviews will examined using a relevance sampling method for the purpose of item pool derivation in the proposed study. Thirdly, the item pool will be passed to an expert panel of Clinical Psychologists experienced in the Intellectual Disabilities field and Trainee Clinical Psychologists who have completed their core Learning Disabilities training. Based on clinical experience the expert panel will be asked to provide detailed feedback on the content and clarity of items with modifications and item addition and elimination made where indicated. Finally, semi-structured

interviews will be conducted with clients currently in the early stages of psychological therapy. The interviews will be conducted within an essentialist framework on the assumption that each participant will have their own cognitions about the topic under consideration and which may be elicited in the course of the discussion (Krippendorff, 2004). The schedule will be designed to enable bottom-up modifications and to facilitate expression of both positive and negative perspectives and experiences. This process will aim to identify items that capture the individual's expectations and experience of being referred, the therapy process and outcome, how expectations may be incongruent with experience and what motivates their level of engagement in therapy. The final set of items will be piloted on a sample of individuals who are clients currently in the early stages of psychological therapy to assess clarity and comprehension of items. The final item pool will be used to construct a pilot measure of therapy expectancy and motivation.

Phase 2: Scale Evaluation

The scale will be field tested on a sample of individuals from the waiting list who meet the original inclusion and exclusion criteria. The developed scale will be re-administered prior to the commencement of therapy with a minimum one week test-retest delay. The new scale will then undergo psychometric evaluation as detailed below in the Analysis section.

Participants

The population of interest is adults with a mild-moderate intellectual disability referred to NHS Lanarkshire and NHS Greater Glasgow & Clyde Learning Disability Services for individual psychological intervention for emotional problems of anger, anxiety or depression.

Inclusion and Exclusion criteria

Inclusion criteria are individuals aged 16-65 years with a mild-moderate intellectual disability and who have been referred for individual psychological therapy for anxiety, depression or anger. Ability to consent to participate in the study and communicate their beliefs and opinions about helping relationships and therapy will be necessary. Individuals with dementia or other cognitive disorder, a history of psychosis or autism will be excluded. Whilst it is recognised that presence and quality of previous therapeutic experience have a clear potential to influence both expectations and motivation, there are a number of pragmatic reasons not to include only first referrals. Anecdotal evidence from clinicians in both localities suggests that rates of re-referral are high. Exclusion of individuals on this basis may reduce recruitment rates and research participation opportunities for a significant proportion of this clinical population. Furthermore, exclusion on this basis would also assume that all participants would be able to discriminate between previous psychological input from other professional supportive relationships e.g. Social Work.

Recruitment Procedures

Recruitment will be from NHS Lanarkshire and NHS Greater Glasgow and Clyde Learning Disability Services Psychology waiting lists. There will be two phases to the recruitment process for the purpose of item pool derivation and subsequent piloting and psychometric evaluation of the scale. Using the specified exclusion/inclusion criteria and a conservative assumption of 50% uptake on participation, a feasibility analysis based on retrospective examination of referral rates projected a recruitment rate of approximately 55 participants over a 6 month data collection period. Information about study purpose and requirements will be provided in an accessible format. Direct contact with the individual and their

identified other will not occur until a consent form has been determined. However, the researcher will be available by telephone if necessary to answer any remaining questions during the recruitment process.

Power Calculation

There are no known previous studies of therapy expectations and motivation in adults with Intellectual Disabilities. As the central focus of the proposed study is to examine the reliability and validity of therapy expectations and motivations measurement in this population, it is argued that a study by Payne and Jahoda (2004) represents an important point of reference. This study reported a test retest reliability coefficient of r = .9 and an internal consistency α = .78 for the Glasgow Social Self-Efficacy Scale (GSSES). Exploration of the validity of the social self-efficacy construct in adults with ID found significant correlations between social self-efficacy and the expected variables of social support (r = .35, p<0.05) and depression (r = .31, p<0.05). It is argued that these results represent a good estimate of potential effect size in the current study. To achieve power of 0.8 and assuming a significance level of p<0.05, a sample size of eight will be needed based on the expectation of a large effect size for test-retest and internal consistency analyses. However, to achieve a power of 0.8 and assuming a significance level of p<0.05 a sample size of 39 will be needed based on the expectation of a medium effect size for construct validity assessment. This calculation was made using the methodology of Cohen and Cohen (1983, p. 59) and was confirmed using G*Power software (Erdfedler et al., 1996).

Sampling

The proposed study will use waiting lists of referrals for Learning Disability Psychology in NHS Lanarkshire and NHS Greater Glasgow and Clyde as the

sampling framework. All individuals referred during the data collection period and who meet with inclusion and exclusion criteria will be included in the sample for potential participation.

Procedures

Settings and Equipment

Client participants will be met in a familiar and regularly attended location for data collection e.g. day placement or work placement. It will be necessary to identify a location within each setting that will enable optimal data collection in terms of minimal distraction and comfort and will reassure participants of privacy. Equipment required will be recording equipment for the semi-structured interviews and copies of the assessment measures to be administered.

Measures

Cognitive Ability

In order to control for the effects of cognitive ability in the analysis each participant will be administered the 2-Subtest Version of Wechsler Abbreviated Scale of Intelligence (WASI - Psychological Corporation, 1999). This provides an estimate of general intellectual ability and can be administered in approximately 15 minutes. The 2-Subtest version of the WASI includes Vocabulary – a measure of verbal comprehension and Matrix Reasoning – a measure of perceptual reasoning.

Locus of Control Orientation

Locus of control orientation will be measured using the 23 Item Adult Nowicki-Strickland Internal-External Control Scale (ANSIE; Nowicki and Duke, 1974). The

ANSIE assesses internal versus external attributions using self-report yes or no items. When summed these items are reported to indicate externally controlled attributions with higher scores indicating a more external locus of control and lower scores denoting a more internal locus of control. For the purpose of the proposed study it was argued that this is an appropriate measure for a number of reasons. The scale has been shown to be unrelated to social desirability and was also designed using language appropriate across the developmental span. Psychometric evaluation with non-intellectually disabled samples has indicated split-half reliability figures from .74 to .86 and test-retest reliability ranging from .63 to .76. Exploration of factor structure and construct validity by Wehmeyer (1993a) with adolescents and adults with intellectual disabilities (n=409) indicated a comparable result to the non-intellectually disabled sample. This scale has been used in a number of studies with intellectually disabled individuals (Langdon and Talbot, 2006; Rose et al., 2005; Hall et al., 2002; Wehmeyer, 1994; Wehmeyer and Palmer, 1997).

Self-Efficacy

General self-efficacy will be measured with the 12-Item General Self-Efficacy Scale (GSES). This scale was originally developed by Sherer et al., (1982) using the self-efficacy theory proposed by Bandura (1977). Subsequent work by Woodruff and Cashman (1993) led to the refinement of the original scale to the 12 item GSES-12. This revised scale is reported to have internal consistency Cronbach alpha of .69 (Bosscher and Smit, 1997) with factor analysis indicating that the data fits best with a unidimensionsal general self-efficacy construct. This scale has previously been used in studies with ID population (e.g. Payne and Jahoda, 2004).

Client perception of understanding and involvement in referral process

Client evaluation of how much they understand the reason for referral and have felt involved in the process will be measured using a 2 – item Likert scale developed for the purpose of the proposed study. This scale will ask two key questions. Firstly, to what extent the individual feels that they understand the reason for referral. Secondly, to what extent the individual feels that they have a choice about whether they see the psychologist. The response format will be a 4 point Likert scale (not at all, a little bit, quite a lot, a lot) with pictorial representations of response options. A copy of the proposed scale is presented in Appendix D.

Referrer perception of understanding and involvement in referral process

Referrer evaluation of how much they perceive the referred individual to understand the reason for referral and have been involved in the process will be measured using a 2 – item Likert scale developed for the purpose of the proposed study. This scale will ask two key questions. Firstly, to what extent they feel the individual understands the reason for referral. Secondly, to what extent they feel the individual was involved in the decision to make a referral for psychological intervention. The response format will be a 4 point Likert scale (not at all, a little bit, quite a lot, a lot). This will be used to triangulate the responses provided by the client and to potentially identify any consistent patterns of incongruency between client and referrer perceptions. A copy of the proposed scale is presented in Appendix E.

Reason for Referral

Reason for referral will be measured by asking referrers to complete the Psychiatric Assessment Schedule for Adults with Developmental Disability (PAS-ADD) (Moss

et al., 1997). This measure was designed for use by those with or without training in psychopathology to screen for mental health problems in adults with intellectual disabilities. It consists of a life-events checklist and 29 symptoms items.

Engagement

Prior to data collection it is proposed that the researcher will arrange to meet briefly with participants in order to establish some familiarity and rapport with the individual prior to the data collection date. Whilst the purpose of this meeting will not be to provide information about the study, it is recognised that individuals may wish to use this opportunity to ask questions. Responses to queries about the study will be standardised and will provide no more information than was presented in the original information sheet. During this meeting preferred times for the data collection meeting will be discussed to avoid arranging this at a time that co-inside with particular activities or commitments that the individual would understandably be reluctant to miss.

Data Collection

During the scale development phase the researcher will meet with participants on one occasion to carry out a semi-structured interview. During the scale evaluation phase the researcher will meet with participants on two separate occasions. The developed measure will be administered on both occasions. Administration of all other measures will be counterbalanced across participants and sessions. A significant other chosen by the participant will be invited to complete the carer measures during this time. It is estimated that the data collection procedure will be completed with each individual in a maximum time period of 1 hour. A second session for re-administration of the developed measure is planned to take place prior

to the commencement of therapy. This second session is anticipated to take a maximum of 15 minutes. Individuals will be provided with the opportunity for rest-breaks as appropriate. The data collection procedure has been designed to be as interesting and interactive as possible using self-report measures and individuals will be encouraged to develop any responses as desired and talk about their experiences.

Debrief

At the end of data collection, there will be an opportunity to debrief and talk about any particular concerns that the individual has raised about the referral and therapy process. To ensure reciprocity of activity all individuals who participate in the study will be provided with the opportunity to receive feedback on the outcomes of the study. This will be provided in a format that is accessible to both the participant and their peer group e.g. accessible text with pictorial support where necessary.

Analysis

Scale Development

For the purpose of developing an item pool the transcripts from a previous and related study (Jahoda et al., 2006) and the semi-structured interview transcripts will be subjected to a content analysis. The initial step will be to conduct a content analysis on the transcripts from Jahoda et al. (2006). The analysis will utilise a relevance or purposive sampling framework that involves selecting all textual units that contribute to answering the questions of interest. The thematic sampling units will be defined as references to therapy process and outcome, experiences of the referral process and motivations for attending therapy. A set of recording instructions will be made explicit and an independent clinician will be asked to apply the

recording instructions to a random sample of transcriptions to determine the reliability of the coding system. The emergent themes will be combined with existing literature on therapy expectations and motivations to develop topic guides for the semi-structured interviews. The transcripts of the semi-structured interviews will be analysed using the same procedure. The emergent themes from all of these processes will be used to identify an initial item pool, which will undergo refinement through consultation with an expert panel and an independent sample of participants.

Scale Evaluation

A psychometric evaluation of the developed measure will assess the extent to which the derived expectation and/or motivation construct can be measured in a valid and reliable way.

Reliability

The reliability of individual items will be assessed by examining corrected item-total correlations and the impact on Cronbach's Alpha if the item is deleted. Items will be deleted if the corrected item-total correlation is less than $r = .3$ and deletion of item increases Cronbach's alpha. This enables an optimal balance between reliability and measure length to be achieved. This process is guided by the need to produce a scale that acknowledges the cognitive ability of the target population and which can be easily incorporated into clinical practice. Inter-item correlations will be also be examined for evidence of multi-collinearity or singularity. Test-retest reliability will be assessed by calculation of the correlation co-efficient between scores at Time 1 and Time 2. Cronbach's Alpha will be calculated to assess internal consistency.

Validity

Face and content validity will be assessed by means of feedback from the expert panel and the scale development sample at an earlier stage of analysis. The construct validity of the scale will be assessed by examining the Pearson correlation coefficients between the score on the developed scale and scores on the GSES, ANSIE and the referral understanding and involvement measure, controlling for cognitive ability. Due to the exploratory nature of this study, it is not anticipated that the pilot scale will necessarily be unifactorial. However, it will be beyond the scope of the proposed study to recruit an adequate number of participants for a factor analysis.

Health and Safety

The study does not pose any significant risk to the participants in that the procedures and topic under consideration are not normally associated with the production of significant distress. The current study does not pose any significant risk to the researcher. Any risk associated with carrying out an interview with an individual referred for aggression will be assessed on a case-by-case basis through discussion with the referrer and a qualified clinician within the relevant service. Individuals who have been referred for aggression problems will be seen in familiar and regularly attended environments where the procedures in place to minimise risk to staff are considered adequate in the context of the proposed study.

Ethical Issues

In accordance with NHS COREC framework an ethics approval application will be made to one LREC in each Health Authority. Information about study purposes and

participation requirements in addition to clear statements of the voluntary nature of involvement and the right to withdraw at any time will be provided in a format accessible to both the potential participant and their closest worker or family member. The researcher will not approach individuals until consent has been given. Consent will be revisited during each contact with the participant. All data will be stored securely and each participant will be assigned a linked anonymisation code for the purpose of data storage and analysis. All measures will be anonymous and assigned the same linked anonymisation code as above. The codes will be stored separately to raw data and transcriptions.

The researcher will meet with participants prior to therapy starting and it is recognised that that this raises certain ethical issues. Whilst it will be made explicit that the purpose of the study is to talk about the experience of being referred and expectations of therapy, the subtle boundary between this and discussing the specific problem may represent a particular difficulty for this population. The occurrence of this situation will be handled by reassurance that the individual will have the opportunity to discuss this with the allocated clinician shortly and provision of sensitive redirection to the study focus. In the event that a participant discloses clinical material that indicates risk to the individual, the researcher will use clinical judgement to determine if it is necessary to breach confidentiality and will consult with either Dr Andrew Jahoda (Research Supervisor) or Dr Rachel Wright (Field Supervisor) in line with professional supervision practice.

<div align="center">Financial Issues</div>

The costs associated with the proposed study are as follows:

a. Printing and postage of initial information sheets and consent forms estimated at approximately £38.

b. Photocopying of measures estimated at £5.

c. Purchasing of 2 x 25 pack of record forms for WASI @ £41.13 (including VAT) totalling £82.26.

Timetable

Application to the relevant LRECs for ethical approval and to local Research and Development Departments for management approval will be made in May 2007. Relevant services will be visited between May and July 2007 to discuss protocol for identification and approach of potential participants. Dependent on relevant LREC and R&D procedure timescales it is anticipated that data collection will take place between November 2007 and April 2008. The proposed timescale is deemed realistic on the basis of the following-

a. Data collection within the specified period will be for the purpose of scale evaluation. Transcription of qualitative data from Jahoda et al. (2006) is complete and ongoing content analysis will be complete by mid-September 2007. This timescale will then allow up to 2 ½ months (mid September – November 2007) for item pool development.

b. Projections of recruitment rates indicate that 6 months will permit recruitment of the proposed sample size. This timescale allows for extension of the data collection period to 7 months without any adverse effect on the timetable for analysis and write-up.

It is anticipated that psychometric evaluation of the scale will be completed during May 2008.

Practical Applications

Through achievement of the identified objectives, it is proposed that this study will have a number of important practical applications:

a. Contribution to the larger research focus on increasing the accessibility and effectiveness of psychological therapies for the Intellectual Disabled population by investigating a key influence on process and outcome.

b. Preliminary development of an assessment scale that measures the expectancy and motivation construct in a valid and reliable way in this population and can be easily applied within clinical practice.

c. Development of a framework within which clinicians are given an opportunity to positively influence therapy process and outcome with the Intellectually Disabled population. Identification of expectations, which may represent threats to optimal therapy process and outcome, can be addressed by pre-referral or pre-therapy interventions such as pre-therapy information sessions to socialise the individual to the therapy process, self-efficacy and expectations enhancement work during early stages of therapy or even identification of situations where a systemic intervention would be more appropriate.

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Appendix G. Ethical Approval

Acute Services Division

NHS
Greater Glasgow and Clyde

West Glasgow Ethics Committee 1
Western Infirmary
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Glasgow G11 6NT

Tel: 0141 211 6238
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15 November 2007

Miss Amy L Ramsay
Department of Psychological Medicine
Division of Community Based Sciences,
Academic Centre,
Gartnavel Royal Hospital,
1055 Great Western Rd,
GLASGOW
G12 0XH

Dear Miss Ramsay

Full title of study: Therapy Expectations and Motivation: Preliminary Exploration and Measurement in Adults with Intellectual Disabilities.

REC reference number: 07/S0703/112

The REC gave a favourable ethical opinion to this study on 02 October 2007.

Further notification(s) have been received from local site assessor(s) following site-specific assessment. On behalf of the Committee, I am pleased to confirm the extension of the favourable opinion to the new site(s). I attach an updated version of the site approval form, listing all sites with a favourable ethical opinion to conduct the research.

R&D approval

The Chief Investigator or sponsor should inform the local Principal Investigator at each site of the favourable opinion by sending a copy of this letter and the attached form. The research should not commence at any NHS site until approval from the R&D office for the relevant NHS care organisation has been confirmed.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

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40389

07/S0703/112   Please quote this number on all correspondence

Yours sincerely

Andrea Torrie, Manager - West Glasgow LREC's

Email: andrea.torrie@northglasgow.scot.nhs.uk

Enclosure: Site approval form

Copy to: Dr Mary Fraser

West Glasgow Ethics Committee 1

LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION

For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.

REC reference number:	07/S0703/112	Issue number:	2	Date of issue:	15 November 2007

Chief Investigator:	Miss Amy L Ramsay

Full title of study:	Therapy Expectations and Motivation: Preliminary Exploration and Measurement in Adults with Intellectual Disabilities.

This study was given a favourable ethical opinion by West Glasgow Ethics Committee 1 on 02 October 2007. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.

Principal Investigator	Post	Research site	Site assessor	Date of favourable opinion for this site	Notes (1)
Dr Rachel Wright	Principal Clinical Psychologist / Local Collaborator for current proposal.	NHS Lanarkshire	West Glasgow Ethics Committee 1	19/10/2007	
Professor Andrew Jahoda	Consultant Clinical Psychologist	NHS Greater Glasgow and Clyde Learning Disability Directorate	Glasgow & Clyde Primary Care, Community & Mental Health	19/10/2007	
Dr Rachel Wright	Principal Clinical Psychologist / Local Collaborator for current proposal.	NHS Lanarkshire	Lanarkshire Local Research Ethics Committee	15/11/2007	

Approved by the Chair on behalf of the REC:

ADVANCED CLINICAL PRACTICE I:

REFLECTIVE CRITICAL ACCOUNT (Abstract only)

Title: Being a Good Enough Mother in the Dark Swamps – A

Developmental Reflection on Managing the Balance in

Forensic Practice.

Authors: Amy L Ramsay[1]

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Abstract

Introduction: The process of selecting a reflective focus is described in the context of previous supervisory and developmental experiences, in addition to the influence of works by Freud (1927) and Casement (1985). The identified focus is the experience of managing the balance of complex process issues within therapeutic interactions with the ethical demands of the legal and medical systems surrounding assessment in forensic work. A reflective framework is identified in the Reflective Practioner Model (Schon, 1983; 1987), the work of Winnicott on being a 'Good Enough Mother' (Winnicott, 1958) and the National Occupational Standards for Clinical Psychologists. **Reflective Review:** The experience of developing and maintaining a balance between attention to therapeutic process issues and directive assessment in a forensic setting is reflected on using a framework of reflection in action, reflection on action, reflection on impact on others and impact on self development as a professional. The role of supervision in the process of development is explored and the nature of future developmental needs identified.

ADVANCED CLINICAL PRACTICE II:

REFLECTIVE CRITICAL ACCOUNT (Abstract only)

Title: Flowing with Mozart's Tide? A Developmental Reflection on

Reflective Practice and Rigour in Service Evaluation.

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Abstract

Introduction: The process of selecting a reflective focus is considered in the context of developing clinical experience in different aspects of the multifaceted Clinical Psychologist role. Experience of Acceptance and Committment Therapy (Eifert et al., 2005) and the Tidal Model of Mental Health Recovery (Barker, 2002) combine with the works of Freud (1927) and Casement (1985) to focus the reflective process. The reflective focus is the relationship between reflective practice and rigour in the context of establishing frameworks for gathering evidence for evaluation of psychological services for adults with severe and enduring mental illness (SEMI). A reflective framework is identified in the Reflective Practioner Model (Schon, 1983; 1987) and the National Occupational Standards for Clinical Psychologists. **Reflective Review:** The compatability of reflective practice and rigour in the gathering of evidence for service evaluation is considered through a process of reflecting in action, reflecting on action and impact on others, and reflection on impact on self. The influence of policy directives, systemic organisational influences and the individual experience at the heart of a person centred recovery process, on the conceptualisation and measurement of evidence are explored. The future trajectory of development in both individual and service level reflection are identified.