Therapeutic relationship and concordance of client- and clinician-rated motivational goals in treatment of people with psychosis: An exploratory study

ABSTRACT

Addressing motives determining behaviour and experiences of people in treatment for psychosis could improve the therapeutic relationship. This pilot study explored the association between the concordance of clients and clinicians ratings of clients' motivational goals and the therapeutic relationship in the treatment of psychosis.

Twenty in- and outpatients with a psychotic disorder in a general psychiatric setting answered measures addressing motivational goals and the therapeutic relationship. Fifteen clinicians rated their clients' motivational goals and psychopathology.

The concordance between clients' and clinicians' ratings of approach goals was not associated with clients' ratings of the therapeutic relationship. However, a higher concordance in avoidance goals ratings was significantly correlated with less satisfaction with the therapeutic relationship.

This finding might be understood in light of explicit (i.e., conscious) and implicit (i.e., non-conscious) avoidance goals: The more difficulties clinicians had in recognizing their clients' implicit goals, the more they may have only rated and considered the clients' explicit goals. This could have resulted in both a higher concordance rating between clients and clinicians, and less clients' satisfaction with the therapeutic relationship (because of unintended threats for implicit avoidance goals). Future studies with larger samples are needed that separately examine explicit and implicit motivational goals of people in treatment for psychosis.

Keywords: Therapeutic alliance, schizophrenia, motivational goals, motives

1. Introduction

Psychotic disorders can be effectively treated by antipsychotic medication and psychosocial interventions, but the effects of these treatments are only moderate (Leucht, Arbter, Engel, Kissling, & Davis, 2009; Turner, van der Gaag, Karyotaki, & Cuijpers, 2014). There is increasing evidence that treatment outcomes for people with severe mental disorders do not only depend on the treatment form (e.g., medication or psychosocial treatment), but also on the therapeutic relationship (Orlinsky, Roonestad, & Willutzki, 2004), defined as the affective and collaborative bond between the client and the clinician (Bordin, 1979). There is increasing evidence indicating that the therapeutic relationship also plays an important role for treatment outcomes of people with psychosis (Berry, Gregg, Lobban, & Barrowclough, 2016; Farrelly et al., 2014; Priebe, Richardson, Cooney, Adedeji, & McCabe, 2011; Shattock, Berry, Degnan, & Edge, 2017). For instance, Goldsmith, Lewis, Dunn, & Bentall (2015) demonstrated that the therapeutic relationship has a causal effect on symptomatic outcomes of psychological treatment for people with non-affective psychosis, and that a poor therapeutic relationship is actively detrimental. In addition, a good therapeutic relationship was found to be pivotal when people with psychosis decided to engage with mental health services (Tindall, Francey, & Hamilton, 2015), and to adhere to medication (Sendt, Tracy, & Bhattacharyya, 2015). Engagement and adherence are preconditions for any treatment to take effect. Thus, the therapeutic relationship is a promising target to improve the effectiveness of treatments for psychosis.

While establishing a therapeutic relationship is a challenge for treatment in general, there are specific challenges when working with clients with psychosis (Hasson-Ohayon, Kravetz, & Lysaker, 2016). These include, but are not limited to, (1) the divergent opinions hold by clients and clinicians about the role of the mental health system (e.g., a client's understanding of the mental health system as the primary threat to their wellbeing, a clinician's understanding of the mental health system as benevolent, offering assistance to people in need); (2) the divergent conceptualizations by clients and clinicians of the problems that the client is confronted with (e.g., whether certain experiences such as hearing voices are symptoms of a mental disorder that requires treatment, which is sometimes labelled as "lack of insight" by clinicians, as well as a clinician's theoretical perspective on mental disorders); and (3) the stigmatizing beliefs hold by both clients and clinicians about people with mental disorders that can result in the opinion that clients are not an equal party in making sense of their experiences and taking responsibility for treatment decisions. Such challenges make it difficult for clients and clinicians to agree on goals and procedures in treatment (Moritz, Berna, Jaeger, Westermann, & Nagel, 2016), which is one of the core ingredients of a successful therapeutic relationship (Bordin, 1979).

Given the significance of the therapeutic relationship for treatment outcome on the one hand, and the specific challenges to build a therapeutic relationship with clients with psychosis on the other hand, the question arises how a therapeutic relationship with clients with psychosis can be best established. Motive-oriented therapeutic relationship (MOTR) is a framework that helps clinicians to offer a custom-

tailored therapeutic relationship based on the client's individual motives (Caspar, 2011; Westermann, Cavelti, Heibach, & Caspar, 2015). MOTR is based on the case formulation method of Plan Analysis (see Figure 1 for an examplary excerpt; Caspar, 2009; Grawe, 1980). Deducted from a client's verbal and nonverbal behaviour as well as from other sources of information (e.g., reports from relatives), clinicians generate hypotheses about a client's Plans, which encompass motivational goals and means to achieve these goals and can be both conscious (i.e., *explicit*) or non-conscious (i.e., *implicit*) (Miller, Galanter, & Pribram, 1960). They can be further divided into *approach goals* (e.g., *seek affiliation*), which are based on basic motives and refer to the generation of desired transactions with the environment, and a*voidance goals*, which result from the violation of basic motives, and imply the prevention of averse transactions with the environment (e.g., *avoid being patronized*; Grawe, 1998). Plans are hierarchically ordered in the Plan structure, which reflects the instrumental function of concrete behaviour (depicted at the bottom) for superordinate motives (depicted at the top). A central tenet of MOTR is that even the most problematic client behaviour (e.g., *refuses taking medication*) serves superordinate motives (e.g., *stay self-determined*), which in themselves are acceptable. Proactively addressing acceptable motives using MOTR is a profound and individualized way of being empathic, and eliminates the need for lower-level problematic behaviour, because the client already gets what he or she needs. Challenging therapeutic interventions (e.g., the prescription of a new antipsychotic medication) become less threatening, because important motives are satisfied and do not have to be particularly protected. This fosters collaboration and proactively prevents therapeutic alliance ruptures (Grosse Holtforth & Castonguay, 2005). MOTR is not a distinct treatment form, but a set of therapeutic principles, which determine how to best build a therapeutic relationship and conduct therapeutic interventions, and can be added to any (pharmacological or psychosocial) treatment form (Kramer, Berthoud, Keller, & Caspar, 2014). While MOTR has been a demonstrated utility in the treatment of affective disorders (Caspar, Grossmann, Unmuessig, & Schramm, 2005; Kramer, Berger, & Caspar, 2009; Kramer, Rosciano, et al., 2011), post-traumatic stress disorder (Kramer, 2009), and personality disorders (Caspar & Ecker, 2008; Kramer, Berger, et al., 2011; Kramer, Berthoud, et al., 2014; Kramer, Caspar, & Drapeau, 2013; Kramer, Fluckiger, et al., 2014; Kramer, Kolly, et al., 2014; Kramer et al., 2015), it has not been examined in the treatment of psychosis so far.

As a first step towards MOTR in the treatment of psychosis (Westermann, et al., 2015; Westermann, Moritz, Caspar, & Cavelti, 2016), the current pilot study aimed at assessing motivational goals of people with psychosis and exploring, for the first time, the correlations between the concordance of clients' and clinicians' ratings of clients' motivational goals and the therapeutic relationship. In accordance with the assumption of MOTR that clinicians who are aware of their clients' motivational goals are able to offer a more individualized therapeutic relationship (Caspar & Grosse Holtforth, 2009), which positively affects clients' satisfaction with treatment, we hypothesized that a higher concordance of

motivational goals as rated by clients and clinicians is associated with a better client-rated therapeutic relationship.

2. Methods

2.1. Participants and study procedure

Between April 2015 and February 2016, 21 in- and outpatients from the University Hospital of Psychiatry and Psychotherapy in Bern, Switzerland, were recruited. The inclusion criteria were that they were aged between 18 and 65 years, diagnosed with a schizophrenia spectrum disorder according to ICD-10 (Organization, 1992) and DSM-IV (Association, 2000), and had had five or more treatment sessions with the same clinician. Exclusion criteria were their insufficient knowledge of German, an organic psychosis or learning disability, an acute risk for self or others, or severe disturbances, which interfered with the ability to give consent or adhere to the study procedures. All participants were informed by a member of the study team about the aims, risks, benefits, and procedures of the study, and gave written informed consent. They were asked to answer questionnaires addressing their motivational goals and the therapeutic relationship. In addition, the participants' clinicians were asked to rate the psychopathology, illness severity and motivational goals of their clients. The study was approved by the local ethics committee.

2.2. Measures

The Inventory of Approach and Avoidance Motivation (IAAM; Grosse Holtforth & Grawe, 2000) was used to assess clients' motivational goals. Ninety-four items address 14 approach goals (item examples: "having friends", "being respected and valued by others", "being autonomous") and 9 avoidance goals (item examples: "being lonely", "being embarrassed", "being overwhelmed by emotions") and are rated on a 5-point Likert scale (approach goals: 1 = not at all important, 5 = very important; avoidance goals: 1 = not bad at all, 5 = very bad). The mean scores of the 14 approach goals and the 9 avoidance goals constitute the second-order subscales Approach Motivation and Avoidance Motivation, respectively. The IAAM was rated by both patients (IAAM-P) and clinicians (IAAM-C). Notably, the patient version only acquires clients' *explicit* motivational goals. At the end of the IAAM-C, clinicians were asked to estimate how often their ratings of clients' motivational goals differed from the ratings of their clients (4-point Likert scale from 0 = never to 3 = often). This additional question takes into account that clinicians' and clients' ratings may differ, because clients are unaware of some of their motivational goals. IAAM-P and -C demonstrated acceptable to good Cronbach's alpha and retest-reliability scores as well as clinical validity (i.e., meaningful differences between patients and healthy controls, and substantial correlations with different measures of distress and well-being) in outpatients with affective and anxiety disorders and healthy controls (Grosse Holtforth & Grawe, 2000).

The 12-item Scale to Assess the Therapeutic Relationship-Patient Version (STAR-P; McGuire-Snieckus, McCabe, Catty, Hansson, & Priebe, 2007) was administered to assess clients' estimates of their relationship with clinicians. The items are rated on a 5-point Likert scale (0 = never, 4 = always). A higher sum score indicates a better therapeutic relationship. In contrast to the measures of therapeutic

relationship traditionally used in conventional psychotherapy settings (e.g., the Working Alliance Inventory; Hatcher & Gillaspy, 2006; Mallinckrodt & Tekie, 2016), the STAR was specifically developed to assess the relationship between mental health professionals in multidisciplinary teams and clients with severe mental illness in psychiatric settings. Cronbach's alpha in the current study was .90, indicating excellent internal consistency (Cohen, 1988).

Psychotic symptoms were evaluated by clinicians based on a 9-item questionnaire developed for daily monitoring of psychopathological change (German: Tagesbogen zur Einschätzung der Psychopathologie, TEP; Tschacher & Kupper, 2009). The items are rated on a 7-point Likert scale (1 = not present, 7 = extremely severe), addressing hallucinations, delusions, formal thought disorder, excitement, hostility, depressiveness, ambivalence, anxiety, blunted affect, and apathy, and have been found to be moderately to highly correlated with the Positive and Negative Syndrome Scale (Tschacher & Kupper, 2002). A higher sum score indicates a more severe psychopathology. Cronbach's alpha in the current study was .72, indicating sufficient internal consistency (Cohen, 1988).

The Clinical Global Impression – Severity (CGI-S) scale (Guy, 1976) is a 7-point scale (1 = not at all ill, 7 = most extremely ill) that requires clinicians to rate the current severity of clients' illness.

2.3. Statistical analyses

An index of the concordance between clients' and clinicians' ratings of clients' motivational goals was established as following: Firstly, we calculated Spearman correlations between clients' and clinicians' ratings for each IAAM item. Secondly, the correlation scores were converted into z values using Fisher's Z transformation. Afterwards, associations between the concordance index and clients' ratings of the therapeutic relationship (STAR-P) were examined using Pearson correlations.

3. Results

3.1. Sample characteristics

One of the 21 participants withdrew from the study before the assessment took place, reducing the sample size to $N = 20$. Fourteen (70%) were females. The mean age was 36.2 years ($SD = 12.88$). The majority were Swiss citizens ($n = 19$, 95%), and declared German as their first language ($n = 19$, 95%). Most of the participants were not in a current relationship ($n = 16$, 80%). Three participants (15%) lived with their partners, while the others lived by themselves ($n = 9$, 45%), with parents ($n = 4$, 20%), friends ($n = 3$, 15%), or children ($n = 1$, 5%). On average, participants reported that they had had 14.3 years ($SD = 3.46$) of education. Ten participants (50%) had paid work, 5 (25%) were unemployed, 3 ($n = 15$%) were in sheltered employment, and 2 (10%) were students. Seven participants (35%) earned their own living, 3 (15%) were financially supported by their family, and 9 (45%) received a governmental annuity. Five participants (25%) were diagnosed with schizophrenia (ICD-10 F20, DSM-IV 295), 4 (20%) with schizoaffective disorder (ICD-10 F25, DSM-IV 295.70), 3 (15%) with delusional disorder (ICD-10 F22, DSM-IV 297.1), and 8 (40%) with brief psychotic disorder (ICD-10 F23, DSM-IV 298.8). The majority of participants were treated in the inpatient setting ($n = 12$, 60%), and received antipsychotic medication ($n = 18$, 90%) at the moment of the research assessment. The mean age of first psychotic episode was 26.1 years ($SD = 10.02$). On average, patients had had 2.3 psychiatric hospitalizations over their lifetime ($SD = 2.41$). The mean score of the TEP was 19.45 ($SD = 6.63$) and the median of the CGI-S was 5 ($IQR = 4\text{-}6$), indicating that the participants had low levels of symptoms and were seen as moderately ill by their clinicians.

The clinician group ($N = 15$) included 11 women (73.3%). The mean age was 36.13 years ($SD = 10.12$). Ten clinicians were psychologists (66.7%) and 5 (33.4%) were physicians. On average, they had been working in psychiatry for 7.03 years ($SD = 8.42$). Most of them stated that they had a knowledge of MOTR ($n = 11$, 73.3%). On average, clinicians and clients had met 18.6 times ($SD = 19.49$) for treatment sessions of 20 minutes or longer.

3.2. Concordance in motivational goals and therapeutic relationship

Table 1 displays means, standard deviations, and Cronbach's alpha's of the IAAM patient and clinician versions. For both the patient and clinician version, the second-order subscales Approach Motivation and Avoidance Motivation showed sufficient internal consistency ($\alpha = .78\text{-}.90$). While for most of the first-order subscales internal reliability was adequate ($\alpha \geq .70$), for some it was insufficient ($\alpha \leq .70$). Thus, we used the IAAM second-order subscales for further analyses. Notably, the mean values for Approach Motivation and Avoidance Motivation of the clinician and client versions indicate that clinicians generally underestimated their clients' motivational goals, and that this was more pronounced in the domain of approach goals ($t(38) = 3.30$, $p = .002$) than in the domain of avoidance goals ($t(38) = 0.60$, $p = .55$). The mean score of the STAR-P was 3.26 ($SD = 0.62$).

The majority of the clinicians believed that their ratings of clients' motivational goals sometimes (40%) or often (45%) differed from their clients' ratings, because clients were aware of some, but unaware of other motivational goals (cf. explicit and implicit motivational goals).

The average concordance between clients' and clinicians' IAAM ratings was $z_r = 0.33$ ($SD = 0.19$) for Approach Motivation, and $z_r = 0.14$ ($SD = 0.24$) for Avoidance Motivation. The concordance in avoidance goals was significantly correlated with clients' ratings of therapeutic relationship (STAR-P), with $r = -.45$, $p < .050$. In contrast, the concordance in approach goals was not significantly associated with clients' ratings of therapeutic relationship ($r = .25$, $p > .296$). These results indicate that a higher concordance between clinicians' and clients' ratings of clients' avoidance goals was associated with lower clients' ratings of therapeutic relationship.

4.   Discussion

As a first step towards MOTR in the treatment of psychosis (Westermann, et al., 2015; Westermann, et al., 2016), the current pilot-study aimed to assess – for the first time – motivational goals in a convenient sample of 20 people with non-affective psychosis in a public psychiatric setting and to explore the correlations between motivational goals and the therapeutic relationship.

The main finding of the current study was that, in contrast to our hypothesis, a higher concordance between clients' and clinicians' ratings in avoidance motivation was significantly correlated with lower ratings of the therapeutic relationship by clients. This finding is in contrast to a study reporting a positive effect of MOTR on therapeutic relationship (Kramer, Berger, et al., 2011), and can be interpreted in three different ways. First, clinicians may have *intentionally* worked on relevant avoidance goals, but in an *inadequate way*. Avoidance motivation constitutes a significant target for therapeutic interventions, since a reduction of avoidance motivation has been found to be associated with better satisfaction of motivational goals and, thus, to a better treatment outcome (Berking, Grosse Holtforth, & Jacobi, 2003; Holtforth, Grawe, Egger, & Berking, 2005). Activating avoidance goals can be highly aversive, as they are accompanied by negative emotions. Without sufficient support by clinicians (e.g., motivational attunement to approach goals, resource activation), this can lead to emotional overload and alliance ruptures (Grosse Holtforth & Castonguay, 2005).

Second, clinicians may have *incidentally* violated important avoidance goals of clients (e.g., *avoid being patronized*) during treatment (e.g., by providing a prescription for a potentially more effective medication without involving the client in the decision process), resulting in both the clinician's gain of knowledge about client's avoidance goals and the disruption of the therapeutic relationship. Alliance ruptures can be divided into two groups according to their motivational basis (Ackerman & Hilsenroth, 2001; Grosse Holtforth & Castonguay, 2005): Alliance ruptures due to the therapist's failure to satisfy the patient's approach goal and alliance ruptures due to therapist's activation of the patient's avoidance goals. Our second interpretation corresponds to the second group of alliance ruptures.

Third, the inverse relationship between the concordance in avoidance motivation and the therapeutic relationship ratings may indicate that, on the one hand, the more difficulties clinicians had in recognizing their clients' *implicit* avoidance goals, the more they may have only rated their clients' *explicit* avoidance goals in the IAAM. This could have resulted in a higher concordance rating between clients and clinicians. On the other hand, the more difficulties clinicians had in recognizing clients' *implicit* avoidance goals, the less they may have offered an individually tailored therapeutic relationship. This could have led to lower client satisfaction with the therapeutic relationship. This interpretation is supported by the fact that the majority of the clinicians in the current study believed that their ratings of clients' motivational goals sometimes or often differed from what they thought their clients rated. According to the motivational attunement approach, the therapist should attempt to satisfy approach goals while activating avoidance goals no more than necessary in order to foster the

therapeutic relationship and therapeutic outcome. Thus, it is essential to clinicians to be aware of both the client's approach goal in order not to miss important expectations or needs, and of the client's avoidance goals in order not to commit interactional blunders that fit the client's individual vulnerabilities (Grosse Holtforth & Michalak, 2012). This might be particularly important for the treatment of people with psychosis (Westermann, et al., 2015). In contrast to the primarily nomothetic approach of previous research that has examined universally valid predictors of the therapeutic relationship in schizophrenia (symptoms and lack of insight: Shattock, et al., 2017), our study results highlight the importance of an idiographic, person-centred approach while improving the therapeutic alliance in people with psychosis (Westermann, et al., 2015).

However, which interpretation is most appropriate cannot be determined, based on the current study. Future studies should separately assess explicit and implicit approach and avoidance goals in people with psychosis, and examine their distinct associations with therapeutic strategies and the therapeutic relationship in more detail. Plan Analysis (Caspar & Grosse Holtforth, 2009) may be a helpful tool to assess implicit motivational goals informed by behaviour and experiences. It can also be used in clinical training to teach mental health professionals how to better recognize and utilize implicit motivational goals in order to establish a successful therapeutic relationship.

The current study has a number of limitations. First, the small sample size was acceptable for the purpose of piloting, but limited the statistical power and prevented to take into account the nested data structure (level 1: client-clinician dyads, level 2: clinicians) in the analyses. Second, diagnoses were made by experienced clinicians, but not confirmed by a structured clinical interview. Also, a remarkable number of participants (40%) were diagnosed with a brief psychotic disorder, questioning the generalizability of the results to psychotic disorders of longer duration. Third, the treatment sessions of the clients and clinicians who participated in the study may be representative in terms of frequency, duration, and content (e.g., psychopathology, risk assessment, medication) for a general psychiatric setting, but may have contributed to the assumed difficulties of clinicians to recognize clients' implicit avoidance goals, as there was not enough time for a more thorough assessment of motivational aspects. Fourth, the therapeutic relationship was only assessed from the clients' point of view, but not from the clinicians' point of view. Fifth, we did not consider other factors that may influence the client-rated therapeutic relationship, such as insight into illness and therapists' qualities (e.g., perceived genuineness, empathy, and trustworthiness; Shattock, et al., 2017), in our study. Also, future studies should investigate if the concordance measure explains additional variance of the therapeutic relationship over and above that of the motivational goals alone. Sixth, the IAAM patient version only assesses explicit motivational goals that the client is aware of, and the IAAM clinician version does not differentiate between explicit and implicit motivational goals. Last, the concordance measure used says nothing about the degree to which clinicians over- and/or underestimated their clients' motivational goals. A better understanding of the difficulties clinicians face while estimating their clients'

motivational goals is required to inform strategies for clinicians regarding the therapeutic relationship building with clients with psychosis.

Overall, the current study revealed preliminary evidence that avoidance goals play a crucial role for the therapeutic relationship in the treatment of people with psychosis, and that clinicians should consider both explicit and implicit motivational goals. This finding needs further examination in larger study samples, which take both explicit and implicit motivational goals into account.
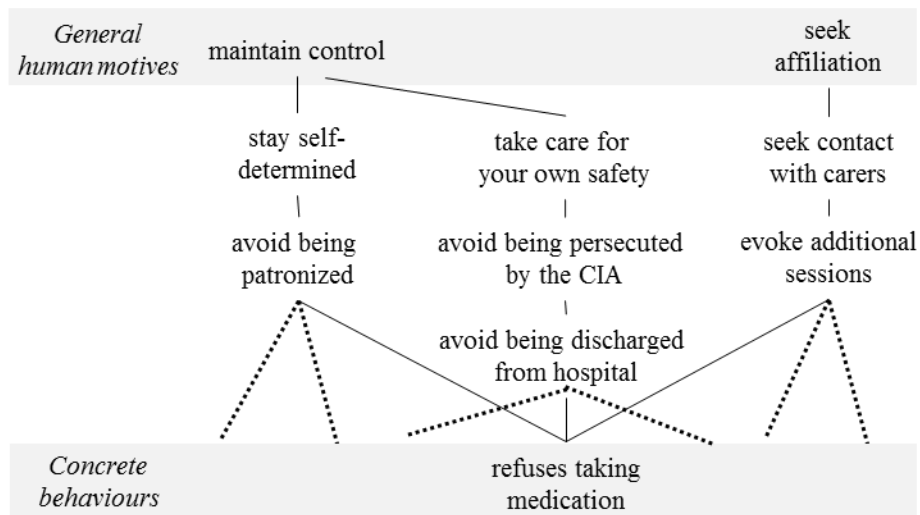
FIGURES AND TABLES

Figure 1. Excerpt of an exemplary Plan Analysis for a client with psychosis.

Table 1. Inventory of Approach and Avoidance Motivation (IAAM)

	Patient version (*N* = 20)			Clinician version (*N* = 15)		
	M(*SD*)	Range	α	*M*(*SD*)	Range	α
Approach motives						
Intimacy	3.75 (0.84)	2.20-5.00	.88	3.18 (0.76)	1.60-4.40	.82
Affiliation	3.10 (0.94)	1.75-5.00	.88	2.49 (0.73)	1.25-4.00	.89
Altruism	3.63 (0.85)	2.00-5.00	.92	2.96 (0.86)	1.50-4.75	.89
Help	3.63 (0.81)	1.75-5.00	.86	3.04 (0.62)	2.00-4.25	.69
Appreciation	3.85 (0.59)	2.70-5.00	.68	3.65 (0.50)	2.75-4.50	.67
Status	2.84 (0.91)	1.00-5.00	.86	2.36 (0.57)	1.25-3.75	.67
Autonomy	4.24 (0.56)	3.25-5.00	.68	3.65 (0.99)	1.25-5.00	.88
Achievement	3.51 (0.84)	2.25-5.00	.84	3.29 (0.79)	1.75-4.00	.79
Control	4.16 (0.57)	3.00-5.00	.59	3.66 (0.64)	2.75-5.00	.68
Education	3.68 (0.78)	2.00-5.00	.77	3.09 (0.82)	1.25-4.75	.75
Belief	3.23 (1.02)	1.75-5.00	.81	2.91 (0.67)	1.75-4.50	.55
Variation	3.65 (0.90)	1.60-5.00	.89	2.99 (0.87)	1.80-4.75	.88
Self-confidence	4.15 (0.67)	2.75-5.00	.85	3.87 (0.59)	2.75-4.75	.73
Self-rewarding	4.13 (0.65)	3.00-5.00	.73	3.32 (0.61)	2.00-4.30	.64
Avoidance motives						
Loneliness	3.66 (0.88)	2.20-5.00	.78	3.19 (0.53)	2.20-4.00	.61
Depreciation	3.75 (0.75)	2.00-5.00	.84	3.44 (0.68)	2.20-4.80	.89
Humiliation	3.44 (0.79)	2.00-5.00	.69	3.16 (0.90)	1.50-4.75	.82
Accusations	3.45 (0.77)	2.33-5.00	.58	3.83 (0.64)	2.67-5.00	.59
Autonomy loss	4.06 (0.72)	2.40-5.00	.81	3.67 (0.77)	2.20-5.00	.83
Hostility	3.51 (0.91)	1.75-5.00	.84	3.53 (0.65)	2.75-4.75	.75
Vulnerability	2.68 (0.83)	1.33-4.00	.50	3.03 (0.70)	1.00.-4.50	.44
Helplessness	3.95 (.74)	2.50-5.00	.69	3.74 (0.52)	3.00-4.50	.47
Failure	3.54 (0.68)	2.25-5.00	.70	3.63 (0.64)	2.25-4.75	.74
Approach Motivation	3.68 (0.53)	2.71-4.95	.95	3.18 (0.36)	2.45-3.65	.90
Avoidance Motivation	3.56 (0.60)	2.40-4.89	.95	3.47 (0.34)	2.75-4.04	.78

Notes. α = Cronbach's alpha, *M* = mean, *SD* = standard deviation

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