THERAPEUTIC ALLIANCE AND MOTIVATION: THE ROLE OF THE RECREATIONAL THERAPIST AND YOUTH WITH BEHAVIORAL PROBLEMS.

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THERAPEUTIC ALLIANCE AND MOTIVATION: THE ROLE OF THE RECREATIONAL THERAPIST AND YOUTH WITH BEHAVIORAL PROBLEMS.

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Title of Study: THERAPEUTIC ALLIANCE AND MOTIVATION: THE ROLE OF THE RECREATIONAL THERAPIST AND YOUTH WITH BEHAVIORAL PROBLEMS.

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Abstract: The purpose of this study was to expand on the limited body of knowledge that exists on motivation and therapeutic alliance for recreational therapy programs. This study examined motivation with youth living with behavioral problems (BP) in an inpatient setting. In order to identify the type of motivation patients had for recreational therapy the Client Motivation for Therapy Scale (CMOTS) was utilized. The Working Alliance Inventory- Short form (WAI-S) was used to identify the therapeutic alliance between patients and recreational therapist. The researcher found that intrinsic motivation and therapeutic alliance were positively correlated.

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CHAPTER I

INTRODUCTION

Self-determination theory (SDT) suggests that the needs for competence, autonomy, and relatedness are integrally involved in intrinsic motivation and that contextual events such as the offer of a choice or reward, the provision of positive feedback, or the imposition of a deadline are likely to affect intrinsic motivation to the extent that they are experienced as supporting versus thwarting satisfaction of these needs (Deci, 1975). When an event prompts a change toward a more internal perceived locus of control, intrinsic motivation will be enhanced (Deci, 1975).

SDT proposes that when an activity is not intrinsically motivating, behaviors are guided by extrinsic motivation. Intrinsically motivated behaviors are those whose motivation is based in the inherent satisfaction of the activity or task rather than in contingencies or reinforcements that are operationally separable from those activities (Deci & Ryan 2000). Youth who are intrinsically motivated will engage in activities freely, being sustained by the experience of interest and enjoyment as well as engaging in them for a longer lasting change (Deci & Ryan, 2000).

When youth are intrinsically motivated they are motivated to do something for pure enjoyment and fun versus extrinsically motivated they are doing something for a reward. Intrinsic motivation promotes a focus on short-term goals and yields energizing emotions such as interest and excitement (Deci, Eghrari, Patrick, & Leone, 1994). Deci et al. (1994) suggested that intrinsic motivation is only partially responsible for psychological adjustment. Perhaps intrinsic motivation is most important for regulation of short-term goals related to interesting activities that youth living with BP would be involved in (Deci et al. 1994). Within SDT, intrinsic motivation arises from the needs for self-determination and competence (Deci & Ryan, 1985a). SDT supports youth autonomy by requiring an array of interpersonal skills for intrinsic motivation and self-determination. These skills include taking the perspective of the youth with behavioral problems (BP), acknowledging their feelings, providing rationale for request, and communicating with non-controlling language (Deci, 1995). Youth may acquire the capacity to direct their own behavior, inhibit actions, focus attention, regulate emotional arousal, and maintain social relations in response to the demands of their social environment.

Autonomy supportive environment revolves around giving youth freedom to make their own personal decisions pursue their own agendas under therapeutic guidelines that will not alter their behavioral treatment process and with guidance from an authority figure. An autonomy supportive environment should better support the use of socially appropriate behaviors to obtain desired outcomes in an efficient and effective manner, thus reducing the youths need to engage in BPs during an intervention (Conroy, Brown, & Olive, 2008).

Along with the autonomy supportive environment for youth there is a therapeutic alliance that is formed between patient and therapist during treatment. This alliance plays an important role in autonomy supportive environments for youth living with BPs. The therapeutic alliance can be defined as the feelings and attitudes that a therapist and youth have towards each other while working together towards the agreed upon goal (Bachelor & Horvath, 1999). The most common definition of therapeutic alliance refers to the development of an affective bond, agreement on tasks, and agreement on goals between therapist and youth (Bordin, 1979). The affective bond is how much the youth likes the therapist, how much youth look forward to therapy sessions, and considers the therapist to be a peer. Agreement on tasks refers to how well the youth and therapist work together to solve problems. Finally, agreement on goals is agreeing on goals together for therapy outcomes.

A strong therapeutic alliance is an important component to any therapy session because it suggests that intrinsic quality is an active factor, contributing to the success of therapy (Gaston, Marmar, Thompson, & Gallagher, 1991). Youth do not continue to attend therapy only because it is helpful but also because of the positive relationship they in return receive from their therapist (Bachelor & Horvath, 1999). Through a strong therapeutic alliance and autonomy supportive environment youth living with BPs are able to make a positive behavioral change.

Statement of the problem

When the environment does not have sufficient activities to satisfy and please youths' needs and desires, it could make them unhappy, which could make behavioral problems (BP) more evident (Cooper, 1996). Negative affect that BP may bring about are

defined by a high level of negative emotions, including anger, sadness, and fear. BPs are not usually manifested on a random basis; the probability of a specific action occurring varies according to the surrounding environmental cues. These environmental cues are people, places, times, and situations that align with the basic needs being either fulfilled or thwarted by contextual factors (Cooper, 1996).

It is important to encourage independence and autonomy for youth who are involved in therapeutic groups. Autonomy support and structure are two different elements that can be facilitated during a therapeutic group, which have different aims and different effects on youth (Connell & Wellborn, 1991). Structure of interactions and the environment revolves around giving youth clear expectations, optimal challenges, and timely and informative feedback as they attempt to make progress in living up to expectations and challenges (Deci, 1995). Autonomy support is described as the degree of freedom that the authority figure provides to allow youth to experiment, make judgments, choose activities, and express ideas. Autonomy is central to the intervention planning process that influences youth lives, and opportunity suggests that more than a single option needs to be available if a positive choice is to be realized.

Often when allowed reasonable choices (e.g., sharing with peers, being on a team with others, and/or taking turns), youth will choose between one of the reasonable choices rather than engaging in BPs because they were given the chance to choose and not forced into a decision (Conroy et al., 2008, p. 217). Youth living with BP need autonomy supportive environments to allow for a positive behavioral change. An autonomy supportive environment should better support the use of socially appropriate behaviors to obtain desired outcomes in an efficient and effective manner, thus reducing

the youths need to engage in BP during an intervention (Conroy et al., 2008, p. 208). Reaching autonomy and having the option to choose may be influenced when the authority figure provides information, or through rewarding wanted behavior and not rewarding unwanted behavior.

Along with autonomy supportive environments, therapeutic alliance needs to be present between youth living with BPs and the therapist. There needs to be a connection made between the youth and therapist that is supportive and strong. The connection between youth and therapist is made by creating a bond between each other, coming up with goals, and developing a specific task together. With this bond and an autonomy supportive environment youth will feel more intrinsically motivated to participate in therapy and feel more in control of their own actions.

Purpose of the study

The purpose of this study is to identify if there is a correlation between motivation and therapeutic alliance between recreational therapist and youth with BPs. The cornerstone of this study is Self-Determination Theory (SDT). Greater self-determination leads to higher levels of intrinsic motivation and better performance, thus leading to lasting positive behavioral change. SDT (Deci & Ryan, 2000) is concerned with why people engage in specific behaviors and focuses on the degree to which people's motivation towards engagement in specific activities that are more or less self-determined or controlled by external or internal pressures. SDT proposes that when an activity is not intrinsically motivating, behavior is guided by a variety of extrinsic

regulations, which are assumed to lie on a self-determination continuum (Ryan & Deci, 2002).

The definition of intrinsic motivation hypothesizes that people who have greater freedom to choose what they will do and how they will do it should have more intrinsic motivation for the activity than people who do the exact same activity without having had choice (Zuckerman, Porac, Lathin, Smith, & Deci, 1978). To the extent that an activity is inherently rewarding, such as recreational activities, it is likely that processes related to intrinsic motivation will energize and direct a person's involvement with the specific recreational activity (Deci & Ryan, 2000).

With an environment that supports intrinsic motivation also comes an environment that offers a therapeutic alliance, which refers to the youth's ability to join in the accomplishment of the therapy task, meaning the therapist and the youth work together to achieve positive outcomes (Horvath, Del Re, Fluckiger, & Symonds, 2011). Therapeutic alliance is formed by the bond developed between the youth and therapist, and also, formed through trust and freedom during treatment environment. The therapist, in an autonomy supportive environment, provides a supporting and caring environment for the youth to also form this therapeutic alliance (Horvath et al., 2011). Having a therapeutic alliance should have a positive effect on youth with BP. Therefore, environments that support intrinsic motivation through therapeutic alliance are considered important for optimal physical and psychological health and well-being of youth living with BPs (Rouse, Ntoumanis, Duda, Jolly, & Williams, 2011).

Research question

To identify if there is a relationship between therapeutic alliance and motivation for recreational therapy treatment among youth ages 13-17 with behavioral / mental health diagnosis receiving inpatient mental health treatment.

Hypotheses:

1) A stronger therapeutic alliance is related to more intrinsic motivation for recreational therapy.
2) A weaker therapeutic alliance is related to more extrinsic motivation for recreational therapy.

Null Hypothesis:

1) There will be no correlation in motivation and therapeutic alliance.

Significance of the study

Rates suggest that anywhere from 8% - 25% of youth with BP is severe enough to impede their social competence (Conroy et al., 2008). BP interferes with youths learning, development, and behavioral competence (Conroy et al., 2008). BPs are described as those behaviors that result in injury to self or others, cause damage to physical environment, interfere with skill acquisitions, or isolate youth and are displayed in a variety of forms and include both externalizing (noncompliance, disruption, tantrum, aggression, self-injurious behaviors, and stereotype) and internalizing (withdrawal, avoidance) behaviors (Doss & Reichle, 1991). BP occurs across different people, settings, and circumstances, and often produces similar problematic outcomes (Asmus,

Franzese, Conroy, & Dozier, 2003). Occurrence of BPs are directly related to the consequences that follow inappropriate behaviors (Conroy et al., 2008). Identifying the functions of BPs and linking behavioral change strategies to those functions often increases the effectiveness of interventions. Youths environments should be arranged to better support the use of socially appropriate behaviors to obtain desired outcomes in an efficient and effective manner; thus reducing the youths need for engaging in BPs and facilitating their emerging social competence (Conroy et al., 2008).

Youth with a BP diagnosis exhibit behavioral and /or emotional characteristics that appear to interfere with their own learning, and in some cases the learning and security of their peers (Cooper, 1996). These problems can take the form of disruptive and/or aggressive behaviors, or withdrawn uncommunicative behaviors (Cooper, 1996). A few reported problems may include overanxious disorders, conduct disorders, oppositional disorders, and depression and dysthymia (Barbarin & Soler, 1993).

Allowing youth to make choices when appropriate is a relatively easy antecedent-based intervention strategy that has been effective in decreasing youth with BPs. Designing choice-making interventions begins with having an environment that supports the basic needs of autonomy, competence, and relatedness (Conroy et al., 2008). Embedding highly preferred or relatively easy interventions into non-preferred or difficult activities is an antecedent-based intervention that may decrease the probability of BPs.

Definition of the terms

For clarification of the terms stated in the introduction a list of terms is provided below:

Intrinsic motivation – Satisfactions inherent in action, refers to the innate energy that people demonstrate when they purpose an activity because it is interesting or fun (Deci & Ryan, 2000).

Extrinsic motivation – Focused toward and depended on contingent outcomes that are separable from the action and comes from outside yourself (Deci & Ryan, 2000).

Autonomy –Being the perceived origin or source of one's own behaviors (Ryan & Deci 1985b). Degree of freedom, which the adult provides to allow the child to experiment, make judgments, choose activities, and express ideas.

Self-determination - Determination by oneself or itself, without outside influence (Deci & Ryan, 2000).

Competence –Feelings of one's ongoing interactions with the social environment and experiencing opportunities to exercise and express one's capacities of doing something successfully or efficiently (Deci, 1975).

Relatedness – Feelings of being connected to others, to caring for others, to having a sense of belongingness with both other individuals and with one's community (Ryan, 1995).

Amotivation – People do not act at all or they act passively- that is they go through the motions with no sense of intending to do what they are doing, unable to achieve

desired outcomes because of a lack of contingency (Deci, 1975) or that they do not value the activity or the outcomes it would yield (Ryan, 1995).

Therapeutic alliance –The quality and the strength of the collaboration between patients and therapists and a sense of partnership between therapist and their patients and included three categories of task, goal, and bond (Hovarth, 2001).

Bond- The personal attachment between patients and therapist including trust, acceptance, and confidence in the therapy process (Horvath & Greenberg, 1989).

Goal – The outcomes targets of the therapy process (Horvath & Greenberg, 1989).

Task – Behaviors and cognitions of the patients and therapist during the therapy session (Horvath & Greenberg, 1989).

Introjected regulation – Involves taking a stand but not fully accepting it as one's own action and avoiding outside forces (Deci & Ryan, 2000).

Integrated regulation – Behavior that is performed not only because an individual values its significance, but also it is consistent with their self-identity (Deci & Ryan, 1985a).

External regulation – Focused towards rewards and avoiding punishment and behaviors that are controlled by external sources (Deci & Ryan, 1985a).

Identified regulation - Behavior that an individual chooses to perform because it is congruent with his or her values and goals (Dec & Ryan, 1985a).

Challenging behaviors (behavior problems)- A global term used to describe those behaviors that result in injury to self or others, cause damage to physical environment, interfere with skill acquisition, or isolated children (Doss & Reichle, 1991).

Assumptions of the study

1. Youth have different motivational styles when participating in activities because of varying developmental and environmental interactions.
2. Not all youth with BP will react the same way when stimulated during an activity.
3. Youth with BP may be affected in situations where they have to follow an authority figure.
4. Some youth will already have a strong alliance with their recreational therapist.
5. Recreational therapy will motivate any youth to make healthy behavioral changes.
6. Youth with BP who have already received treatment will have a stronger therapeutic alliance with the recreational therapist

Limitations of the study

1. The background of the youth participating in the study; the youths home life and the upbringing.
2. The reasoning the youth were admitted to the hospital.
3. Varying lengths of hospitalization.
4. The behaviors youth may have already learned through treatment.

5. Techniques youth may have already learned during their stay at the hospital or another treatment.
6. Recidivism and other similar hospitalizations youth may have already experienced.
7. Other therapy sessions youth have attended while at the hospital.
8. Influence from staff members at the hospital; the relationships they have made with staffing at the hospital.
9. Youths' attitude towards their therapist and groups they attend.
10. Youth refusing to participate in recreational therapy.
11. Youth being unable to make that alliance with therapist.

CHAPTER II

REVIEW OF LITERATURE

Self-determination theory (SDT) (Deci & Ryan, 1985b) provides a humanistic approach to human motivation and a method of understanding the development between behavioral and cognitive theories. SDT begins by identifying that all humans have basic needs to develop their own sense of self. Each basic need is vital for integrating a variety of experiences enlightened by different events. These three basic needs are competence, relatedness, and autonomy, which are supporting factors in a youth's environment. Deci and Ryan (2000) stress the importance of the personal or social environments for youth as a way to develop a greater sense of self.

SDT suggests that social situations support the basic needs for autonomy, competence, and relatedness that help youth uphold intrinsic motivation, orientations and goals of life, which in return will enhance mental health and well-being (Deci & Ryan, 2000). At the same time, humans are working towards the satisfaction of three basic needs; autonomy, competence, and relatedness.

Autonomy reflects the need to feel capable of making one's choices, to fully decide one's behaviors, and be the originator of their own behaviors. The need for competence leads people to seek challenges that are best for their capabilities and to repetitively maintain and enhance those skills and capabilities by participating in activities. Finally, relatedness goes beyond the tendency to connect with others and to be accepting of others and accepted by others, but also about a sense of belonging (Patrick, Knee, Canevello, & Lonsbary, 2007, p. 434).

SDT suggests that when an activity is not intrinsically motivating, behaviors are guided by extrinsic motivation. Intrinsically motivated behaviors are those done without an external drive, the drive comes from within and for self-achievement and does not require reinforcement to partake in those activities (Deci & Ryan, 2000). When youth are intrinsically motivated they will engage in activities freely, based on interest, and for the enjoyment as well as engaging in them for a longer periods of time (Deci & Ryan, 2000). Whereas extrinsic motivation is focused toward outcomes separate from one's action (Deci & Ryan, 2000).

SDT suggests that the needs for competence and autonomy are involved in intrinsic motivation and use youths perspectives and feelings, gives rationale when a request is made, and supports youths choice and self-regulation (Amoura, Berjot, Gillet, Caruana, & Finez, 2015). Autonomy supportive environments need to nurture inner motivational resources, provide rationale, rely on non-controlling and informational language, and display patience acknowledging and accepting expressions of negative affect (Amoura et al., 2015). These environments are likely to affect intrinsic motivation to the extent that they are experienced as supporting factors of the basic needs (Deci &

Ryan, 2000). Contextual factors either improve or negatively affect intrinsic motivation. Contextual Factors are characteristics of the ecology/environment that are related to the effectiveness of collaboration. Contextual factors are facts or statistics that play into the way therapy is conducted. There are two types of contextual factors: the community and the environment. Contextual factors change often and it is up to authority figure, in this study the recreational therapist, to identify them before planning.

Deci and Ryan (1980) suggest that there are two primary thinking processes through which contextual factors affect intrinsic motivation; change in perceived locus of causality (relation of cause and effect) and a change perceived competence (the quality of being competent). A change in perceived locus of causality relates to reaching a state of autonomy during an activity. By reaching a state of autonomy youth are to be given the freedom they need in group settings to make choices on their own. By doing so, autonomy will be reached during an activity for youth. By being more intrinsically motivated reaching a state of autonomy is easier to achieve. A change in perceived competence relates to competence and the quality of being competent in an activity. When youth are intrinsically motivated they are more likely to be competent in the activities they chose to partake in because they have the skills and abilities to do that activity they intrinsically chose to do.

During activities it is important that people find them interesting, challenging, or pleasing. Activities that do not reach these requirements will not be intrinsically motivating and are unlikely to be pursued unless there is an extrinsic reason for doing so. Within SDT, autonomy means to reach a state of being in control of one's self and actions (Ryan, 1993). Its opposite, heteronomy, refers to being under the control of and

outside force other than one's self. "SDT specifically distinguishes autonomy from independence, noting that one can, for example, be autonomously dependent, or forced into independence" (Ryan & Deci, 2006, p. 1562).

Mini-theories of Self-Determination Theory

SDT is broken down into five mini theories, Cognitive Evaluation Theory (CET), Organismic Integration Theory (OIT), Causality Orientation Theory (COT), Basic Psychological Needs Theory (BPNT), and Goal Context Theory (GCT). Each theory was developed to explain a set of motivationally based events that began from further research and either addresses one side of motivation or one side of personality functioning that is important to the development of self-determination.

Cognitive Evaluation Theory (CET) describes the effects of social framework on people's intrinsic motivation (Deci & Ryan, 1980). This mini theory was explained in two ways. First, it was suggested that rewards, deadlines, and positive feedback had significant influence on decision making. Second, CET is concerned with internal events, suggesting that people can start and regulate their own actions. Therefore, it addresses the effects of social contexts on intrinsic motivation, or how factors such as rewards, personal controls, and ego impact intrinsic motivation and interest (Ryan & Deci, 2002).

Organismic Integration Theory (OIT) (Deci & Ryan, 1985a) concerns internalization and combination of values and guidelines, and was created to explain the development of extrinsic motivation. The more internalized the extrinsic motivation the more autonomous the person will be. OIT highlights autonomy and relatedness as critical to dealing with an emotion or conflict by thinking about it instead of showing it openly to others (Ryan & Deci, 2002).

Causality Orientation Theory (COT) “describes individual differences in people’s tendencies to orient towards the social environment in ways that support their own autonomy, control their behaviors, or are amotivating” (Ryan & Deci, 2002, p.10). A person orienting autonomously toward an environment acts out of interest for the activity in that environment. Focusing on the rewards, gains, and approval of others is part of COT. “People are oriented to some extent to interpret (e.g., to seek, create and evaluate) events as informational, to some extent to interpret them as controlling, and to some extent to interpret them as amotivating” (Deci & Ryan, 1985a, pp. 152-153). Deci and Ryan (1985a) suggest that the three orientations lead people to regulate themselves as if they were in an informational environment, a controlling environment, or an amotivating environment. These orientations have been labeled as autonomy orientation, control orientation, and impersonal orientation. “Autonomy orientation describes the tendency for behavior to be initiated and regulated by events internal to one’s sense of self and by events in the environment that are interpreted as informational” (Deci & Ryan, 1985a, p. 153). “The control orientation describes the tendency for behavior to be initiated by events in the person that are external to one’s integrated sense of self and by events in the environment that are interpreted as controlling” (Deci & Ryan, 1985a, p. 153). Impersonal orientation is characterized as the extent to which a person believes that attaining desired outcomes is beyond his or her control and that achievement is largely a matter of luck or fate (Dei & Ryan, 1985a).

Basic Psychological Needs Theory (BPNT) (Ryan & Deci, 2000) was formulated to explain the relation of motivation and goals to health and well-being. This mini theory argues that psychological well-being and optimal functioning is based on autonomy,

competence, and relatedness. It argues that all three basic needs are essential for health and well-being (Ryan & Deci, 2000).

Goal Context Theory (GCT) (Ryan & Deci, 2000) grows out of distinctions between intrinsic and extrinsic goals, and the impact on motivation and wellness. Goals can also be seen as some basic needs but are differently associated with well-being. Goals are set and reached by wants and needs whereas basic needs are required for survival. Extrinsic goals such as financial, appearance, and popularity have been compared with intrinsic goals such as community, close relationships, and personal growth, with the former more likely associated with lower wellness and greater ill-being. Goals can be extrinsically and intrinsically motivating depending on the overall goal. Extrinsic goals will focus more on the external outcomes of one's life and intrinsic goals will focus more on the internal and personal goals for one's life.

Intrinsic motivation

When youth are intrinsically motivated, they engage in behaviors and activities that are naturally interesting and appealing to them. For this reason, satisfaction of the need for autonomy is said to be vital for the development of intrinsically motivated activities (Vansteenkiste & Ryan, 2013). Autonomy and competence satisfaction is also vital for the intrinsic enjoyment of an activity, especially if the activity is undertaken by choice (Vansteenkiste & Ryan, 2013). A vital part for youth to feel intrinsically motivated is that they need to be in control of and feel competent in the decisions they make. Feelings of competence will not improve intrinsic motivation if autonomy is not present (DeCharms, 1968) because the feeling of independence and freedom to make choices is one of the most contributing factors when youth are intrinsically motivated.

Youth who are intrinsically motivated to make decisions based on what they feel inside with no external factors are more capable to reach a state of autonomy then youth who are extrinsically motived to participate in something. When youth follow their interests, and are being themselves, contributing to a sense of autonomy and truthfulness also contributes to their health and well-being (Kernis & Goldman, 2006).

Research has shown that choice is related to adaptive outcomes such as increased intrinsic motivation, greater task perseverance and performance, and higher levels of positive satisfaction (Cordova & Lepper, 1996). The proposed means behind these effects are that the delivery of choice is inspiring and provides individuals with a sense of personal action and control (DeCharms 1968) “Contexts and social agents that provide choice are therefore more likely to enhance intrinsic motivation by promoting the understanding of autonomy” (Hagger, Rentzelas, & Chatzisarantis, 2014, p. 217). Choice, acknowledgement of feelings, and opportunities for self-determination were found to enhance intrinsic motivation because they allow people a greater feeling of autonomy (Deci & Ryan, 1985a). Hagger et al. (2014) identified that not having choice will undermine and reduce intrinsic motivation.

Events in the environment that promote increased choice, competence or personal agency promote intrinsic motivation (Ryan, 1982). Remember, however, that people will be intrinsically motivated only for activities that hold intrinsic interest for them, for example activities that appeal to have originality, be challenging, or hold value (Ryan & Deci, 2000). Youth are said to be intrinsically motivated when they engage in an activity in the absence of extrinsic rewards. Koestner, Ryan, Bernieri, and Holt, (1984) showed that limit setting will have a significantly different effect depending on whether the

personal setting is informational or controlling. These studies consisted of reporting that youth who expected rewards produced poor quality in activities than those who did not expect a reward. White and Owen (1970) found that creativity of elementary school boys in a self-evaluation group were significantly better than those that were in a peer-evaluation group

Extrinsic Motivation

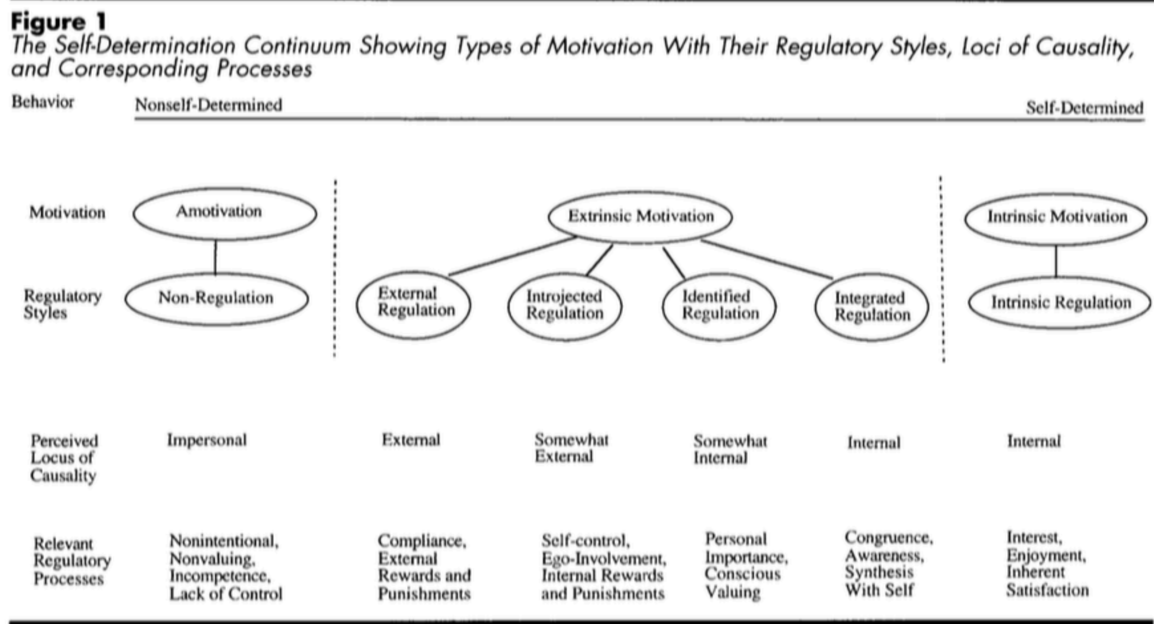


Figure 1
The Self-Determination Continuum Showing Types of Motivation With Their Regulatory Styles, Loci of Causality, and Corresponding Processes

Figure 1. adapted from Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being by Ryan and Deci (2000). Highlights the SDT motivation continuum with type of motivation and internalization of the features within an activity.

Extrinsic motivation is identified as motivation that is controlled by specific external forces and demands (Deci, 1975). Within SDT extrinsic motivation occurs along a continuum, with the extrinsic continuum moving from amotivation toward intrinsic motivation. The most extrinsic motivation is external regulation, followed by introjected regulation, identified regulation, and integrated regulation, which is the closest to

intrinsic motivation. On either side of the continuum is amotivation and intrinsic motivation.

External regulation occurs when individuals show less interest, value, and effort toward achievement the more they tended to disown responsibility for negative outcomes, and blame others for their situation. External regulation is more focused towards rewards, avoiding punishment, and behaviors that are controlled by external sources, such as material rewards or constraints imposed by another person (Deci & Ryan, 1985b). For example, the patient who enters therapy because their parents have given them an ultimatum to work on their problems with assistance from a healthcare professional or be kicked out of the home (Pelletier, Tuson, & Haddad, 1997).

Introjected regulation involves taking a stand but not fully accepting it as one's own action and avoiding the outside forces (Deci & Ryan, 2000). Behaviors are performed to avoid guilt, anxiety, or to maintain one's ego (Deci & Ryan, 2000). Introjected regulation was positively related to applying more effort, but is also related to feeling more anxiety and coping poorly with failures because one does not want to perform poorly and wants to succeed. Instead, these behaviors are reinforced through internal pressure such as guilt, anxiety, or emotions related to self-esteem (Ryan & Connell, 1989). For example, a client who has been abused seeks out therapy because they are overwhelmed with feelings of shame for having done nothing to improve their situation (Pelletier et al., 1997).

Identified regulation is associated with more interest and enjoyment of learning and with more positive coping styles and applying more effort (Deci & Ryan, 2000). Also, identified regulation is defined as behavior that an individual chooses to perform

because it is congruent with his or her values and goals (Dec & Ryan, 1985). For example, a patients struggling with a difficult friendship who makes a personal decision to enter therapy because seeking professional help is congruent with her value of trying everything possible to hold a friendship together (Pelletier et al., 1997).

Integrated regulation, the closest to intrinsic motivation, occurs when identified regulations are fully enhanced, which means they have been evaluated and brought into one's values and needs (Deci & Ryan, 2000). This type of regulation refers to behavior that is performed not only because an individual values its significance, but also is consistent with their self-identity (Deci & Ryan, 1985a). Youth may be motivated this way because of other feelings they may have towards what is motivating them. This type of motivation is the most fully self-determined among the group of extrinsic motivation types. For example, a patient who had previously completed therapy but now wishes to see a therapist to help them maintain the changes brought about in the course of that therapy would be motivated by integrated regulation (Pelletier et al., 1997).

The last aspect in relationship to the extrinsic motivation continuum is amotivation, a state in which people lack the intention to behave, and also lack motivation. Within SDT, people are likely to be amotivated when they lack either a sense of efficacy or a sense of control with respect to a desired outcome (Deci & Ryan, 2000). Individuals are amotivated when they do not distinguish a relationship between their actions and the outcomes of those actions. This is a similar feeling of being incompetent and having a lack of control (Deci & Ryan, 1985b). This type of motivation happens when someone engages in an activity without having a clear understanding of why they are doing it; there is no real sense of purpose. For example, the client who enters therapy

consumed with a sense of hopelessness, believing that therapy will undoubtedly prove to be a waste of time (Pelletier et al., 1997).

Autonomy supportive environments

Within SDT the issue of autonomy is a key to understanding the quality of behavioral regulation (Ryan & Deci, 2006). Research in SDT has highlighted the positive influence that autonomy supportive environments can have healthy behavior changes as well as physical and psychological benefits (Deci & Ryan, 1985b). Autonomy supportive environments have features of social environment created by other(s), such as prompting and acknowledging perspectives (e.g., viewpoints and outlooks), supporting self-initiative (e.g., supporting one's intentions to act, readiness, and supporting one's personal decisions), choice, providing related information to each individual, and minimizing pressure and control to individuals in group settings (Williams et al., 2000). Autonomy supportive environments have been shown to be an important factor in promoting intrinsic motivation (Reeve & Deci, 1996).

In an autonomy supportive environment making choices freely without external forces will lead to youth being more intrinsically motivated to participate because of the fact that they themselves chose to participate and were not forced or done so because of an external reward or pressure. This type of environment also refers to socializing agents encouraging independent problem solving and decision making (Grolnick & Ryan, 1989) and supports youth's intrinsic motivation and internalization processes. "Autonomy supportive environments provide meaningful choice or deliver effective feedback, facilitate intrinsically motivated behaviors through the satisfaction of the needs for autonomy and competence" (Vansteenkiste & Ryan, 2013, p. 266). An autonomy

supportive environment is not defined by the absence of external influences but rather by intrinsic influences or inputs.

Autonomy supportive environment promotes more joy in learning, enhanced persistence in the face of difficulty, and richer levels of engagement (Deci & Ryan 2008). Autonomy is not the same thing as independence. Autonomy means to act volitionally, with a sense of choice, whereas independence means to function alone and not rely on others (Deci & Ryan, 2008). Autonomy supportive environments involves one individual (often an authority figure) relating to target individuals by taking their perspective, encouraging initiation, supporting a sense of choice, and being responsive to their thoughts, questions and initiatives (Deci & Ryan, 2008). "Autonomy is not restricted to independent initiatives but also applies to acts reflecting wholehearted consent to external inputs or inducements" (Ryan & Deci, 2006, p. 1560). These analyses identify that for an act to be autonomous and for an environment to be autonomy supportive it must be approved by youth themselves.

An autonomy supportive environment revolves around giving youth with BP freedom to make their own personal choices while still following the rules of the activity and still participating because they chose to do so (Deci & Ryan, 2000). Within a treatment setting for youth, an autonomy supportive environment may include tasks that allow youth to decide exactly what they want to participate in by giving them choices throughout the activity and allowing them to make specific decisions about what they would like to use throughout the treatment, thus eliminating the pressure to participate in a one specific activity with no other choices. Autonomy supportive environments requires youth to enter into relationships willingly, encourage initiative, nurture competence, and

communicate in ways that are not controlling (Deci & Ryan, 2000) and they also create choices without requiring pressure to participate willingly without controlling their decisions. This type of environment also involves recognizing and acknowledging feelings (e.g., express appreciation and gratitude towards feelings), providing reasoning for uninteresting activities (e.g., providing proof for uninteresting activities and a conclusion for reasoning), and recognizing others interest (Deci & Ryan, 2000).

Supporting youth's autonomy requires not only a respect and a valuing for their intrinsic motivation and self-determination, but it also requires a range of personal skills (Deci & Ryan, 2000). These skills include taking the perspective of the youth, acknowledging their feelings, providing reasoning for request, and communicating without controlling (Deci, 1995). High levels of autonomy supportive environments are important to promote successful self-determination in youth living with BPs (Deci & Ryan, 2000). When youth autonomy is supported in these types of environments they often feel free to follow their interest and consider the relevance and importance for themselves of social values (Deci & Ryan, 2008).

The research shows that youth in more autonomy supportive environments display greater curiosity and more independent mastery attempts, and higher self-esteem (Deci, 2004). Mastery is a psychological force that motivates youth to persist at developing proficiency for completing a task (Roemmich et al, 2012). Mastery rather than competition increases intrinsic motivation for recreational therapy activities. By increasing intrinsic motivation in a given task, mastery may promote increased loyalty to that task. This could enhance the need for choice during autonomy supportive environments. When mastery and choice are both present in autonomy supportive

environments this combination could be most efficacious at increasing intrinsic motivation during an activity (Roemmich et al, 2012).

Summary

To be autonomous does not mean to be a part from or independent of others. Autonomy can be positively associated with relatedness and well-being, being willing, acting from one's inner sense of self, and supporting one's actions. Basic principles of SDT are that human motivation varies in the extent to which it is autonomous (self-determined) or controlled, and that promoting long term behavior change implies an understanding of the initialization process, which refers to the inherent tendency, possessed by all humans, to integrate the regulation of extrinsically motivated activities (Silva et al., 2010).

Therapeutic Alliance

Most treatment of youth with BP occurs through interventions with a healthcare professional, generally a therapist, in this study a recreational therapist. The relationship developed between the therapist and patients can be termed therapeutic alliance. "Alliance refers to the quality and nature of the interaction between the patient and therapist, the collaborative nature of that interaction on the tasks and goals of treatment, and the personal bond or attachment that emerges in treatment" (Kazdin, Marciano, & Whitley, 2005, p. 726). Horvath and Bedi (2002) suggested the stronger the alliance the greater the therapeutic change. The literature suggests that the therapeutic alliance is an important common factor to make a lasting therapeutic change (Missirlian, Toukmanian, Warner, & Greenberg, 2005). A therapeutic alliance may enhance treatment experience and reduce barriers (Kazdin et al., 2005).

According to Fitzptrick, Stalikas, and Iwakabe (2001) the therapeutic alliance was first conceptualized from the psychodynamic approach, and has since been adopted by several other approaches including cognitive therapy and emotionally focused therapy. Bordin (1979) also stated that the concepts of task, goal, and bond represent a need for collaboration between therapist and patients and that these alliance factors apply to all therapy approaches. Norcross (2001) also discussed the importance for therapist to collaborate with their patients regarding task and goals in therapy, and the importance of the development of a positive bond or alliance between therapist and patients.

Bordin (1979) proposed that the alliance between the patient and therapist is vital and necessary for any successful therapeutic experience. It is also hypothesized that the alliance contains three key factors: the bond between the patient and therapist, agreement on goals for therapy, and agreement on tasks used to reach their goals (Bordin, 1979). Therapeutic bond is described as an experience the youth has with the therapist. The youth feel the therapist is someone they count on for help (Shirk, Karver, & Brown, 2011). The bond enables youth to work purposefully on the tasks during therapy and appears to be a core component of the therapeutic alliance with youth living with BPs (Shirk et al., 2011). For the therapist to create this bond appropriately they must make an appropriate personal attachment with the patients, trust that person, accept their past without judgment, and have confidence the therapy process will be helpful (Horvath & Greenberg, 1989). Tasks are formed when both patient and therapist agree on terms and methods to use during therapy (Bordin, 1979). Agreement on goals is the third component of the therapeutic alliance, it consists of agreeing on treatment goals and the methods to achieve those goals (Shirk et al., 2011). These goals were set and agreed on

by the patient and their therapist. Goals are set in treatment setting for youth to have an end result to be working towards. Goals should be set by the person and not for the person, this is why goals need to be agreed on by therapist and youth.

Treatment acceptability is likely to be influenced by the therapeutic alliance. Acceptability refers to the judgments by patients about the degree to which treatment procedures are appropriate, fair, and reasonable for each diagnosis. Acceptability focuses on the procedures, treatment components, and what is actually being done to achieve change (Kazdin et al., 2005). Treatment acceptability may consider assessment of the appropriateness of a treatment for a particular problem; whether the treatment is suitable, rational, and likely to be effective; and whether the treatment coincides with customary notions of the nature of treatment (Jones, Eyber, Adams, & Boggs, 1998).

Anna Freud (1946) noted that the youth relationship with the therapist could arise from a number of ways, not all of them develop the same. For many youth, the relationship with a therapist is an opportunity to fulfill needs not available in other settings. Rogers (1957) work suggests that therapy is an opportunity for growth for youth living with BPs. "The therapeutic alliance between patient and therapist has been established as a universal agent of change and is significant with treatment outcomes" (Tatman & Love, 2010, p. 165).

Summary

Utilizing SDT framework during recreational therapy with youth with BPs will help make youth feel more in charge of themselves and in return may make better decisions and set more attainable goals. During the recreational therapy group when the therapeutic alliance is also present alongside with the SDT youth will begin to feel like they are in charge of their own actions and can make a longer lasting behavioral change.

With the therapeutic alliance being present youth will trust the recreational therapist more and feel more comfortable working with them to make that lasting behavioral change.

Behavioral Problems (BP)

The more learned about (BP) the more the definition changes. BPs can be defined "by four parts; A) a developmental change in behavior; B) influenced by the internal processes of the individual; C) it is something whole individuals does; D) it is a response to a stimulus either internal or external" (Baum, 2013, pp. 284-285). Because BP consists of interactions with one's environment, they cannot develop overnight however problems develop and change overtime.

Youth is a critical period in development when numerous changes occur that affect mental, social, physical, and emotional well-being (Hunter & Stanford, 2014). This period is marked by extensive brain development and growth, and individuals are especially receptive to environmental changes (Hunter & Stanford, 2014). Taken together, the shifts that occur during this transitional phase can increase youth's vulnerability to mental health issues and risky behavior (Hunter & Stanford, 2014). For this study only youth was defined between ages 13-17.

Youth mental health difficulties including anxiety and depression, conduct problems including individual and group or gang, violence, alcohol and drug misuse, eating disorders, and so on (Briggs, 2009). Media has led society to believe that youth are getting worse and behavioral health is deteriorating (Briggs, 2009).

BPs affect a significant amount of youth in the United States. Youth BPs can be grouped as healthy, extreme (e.g., dangerous or life threating to self or others), or less extreme (e.g., kicking, screaming, and defiance) (Ackard, Neumark-Sztainer, Story, &

Perry, 2006, p. 60). Research indicated that attention deficit/hyperactivity disorder, aggression and relational violence, antisocial disorder, substance abuse, depression, suicide, eating disorders, mood disorders, sexual disorders, conduct disorder, anxiety disorders, and mood disorders are just a few of the most common BPs youth may have (American Psychiatric Association, 2013). When youth with BPs do not receive treatment, they are at increased risk of later conduct problems, antisocial behaviors, delinquency, and serious mental health problems within their adult life (Caspi, Henry, McGee, Moffit, & Silva, 1995).

Risk factors for behavioral problems

Historically, society has been largely concerned about the negative aspects of youth development such as BPs and risk behaviors; with little attention being paid to promoting healthy youth development (Burt, Resnick, & Novick, 1998). Youth represents an important developmental link between childhood and adulthood. During one's youth they encounter changes in emotions, social experiences, physical attributes, and intellectual development, making youth a very diverse population.

During the youth period, they are trying to find who they are and who they want to be and look more towards their friends for answers rather than their families. There is a connection between family relationships and the development of BPs. Ackard et al. (2006) found significant connections between parent-youth relationships and the behavioral and emotional health of youth. Youth who valued their friend's opinions over those of their parents, and those who felt that they could not talk to their mother or father about their problems reported greater prevalence of health risk behaviors than youth who reported being about to talk to their parents (Ackard et al., 2006). Family relationships in

general and the parent-youth relationship in particular have a pervasive influence on the psychological, physical, social, and economic well-being of youth. Many significant mental health, social, and economic problems are linked to disturbances in family relationships. A lack of a warm positive relationship with parents, insecure attachment, harsh, inflexible, rigid, or inconsistent discipline practices, inadequate supervision of youth, marital conflict, and parental psychopathology increase the risk that youth could develop major behavioral and emotional problems (Ackard et al., 2006).

Middle school is the time in youths' life where they are highly influenced. Youth who develop positive social bonds are more likely to perform better in school and refrain from BPs. It has been postulated that interventions that provide opportunities and rewards for success in school and increase the educational attainment of low achievers should also improve youths' school behavior and inhibit BPs (Hawkins & Weis, 1985). Students who perform badly in school have a greater risk for developing problem behaviors. Specific BPs identified in this study can be found under Appendix A.

Treatment for Behavioral Problems

There are several ways to treat BPs. Along side using recreational therapy as treatment, family intervention, primary prevention, cognitive behavioral therapy, and person-centered therapy have all been utilized in treatment setting to help youth develop and make positive behavioral change(s). This section identifies those treatment options more clearly.

Family Interventions. Family interventions and group activities with youth living with BP may benefit from early family behavioral interventions. Increased family partnership in family groups serve to increase outcomes, satisfaction, and self-advocacy

through building parent support (Alexander, Robbins, & Sexton, 2000). Youth's risk for developing severe BPs is reduced by teaching parents to use natural occurring daily interactions to teach youth language, social skills, developmental skills, and problem-solving skills in an emotionally supportive way (Alexander, Robbins, & Sexton, 2000). Positive family relationships, including being able to discuss problems with parents, and in return has a lower chance for engaging in bad behaviors during youth (Alexander, Robbins, & Sexton, 2000).

Primary Prevention. Findings provide empirical support for further research and practice in primary prevention (Durlak & Wells, 1997). Primary prevention is not a new idea; primary prevention has been present in the U.S. for more than a century. There is the difficulty in demonstrating that a negative outcome has not occurred, that is, that a clinical disorder has not developed. Research is only beginning to articulate the specific developmental course of major youth problems, such as conduct disorder, that would permit preventionists to time interventions and assess their impact most effectively. Furthermore, the specific etiologies of BP are unknown and probably multiply determined, suggesting the need for complex, multicomponent programs. It is not known exactly how or when currently healthy children eventually develop specific BPs, making it difficult to plan interventions to prevent future specific dysfunctions. Many researchers have widened their goals beyond the prevention of specific disorders to include the general modification of emotional and BPs. Prevention over the long term may be the ultimate goal, in the interim it is important to document that the intervention has an immediate positive impact.

Preventive interventions may also seek to enhance protective factors, which, in general, are positive behaviors or features of the environment that lessen the likelihood of negative outcomes or increase the possibility of positive outcomes. Currently, there is considerable interest in modifying the risk status and enhancing protective factors for the target populations (Coie et al., 1993). Over the past several years primary prevention has expanded from a focus on preventing specific problems to include the prevention of emotional and behavioral disorders in general and the promotion of mental health.

Cognitive Behavioral Therapy. Cognitive Behavioral Therapy (CBT) is the most studied nonpharmacolgic intervention for the treatment of youth with BP with more than 80% of published psychotherapy trials testing the effects of CBT protocols (Weersing & Brent, 2006). These treatment programs acknowledge the biologic, behavioral, and environmental basis of BPs. This type of therapy draws heavily from the behavioral technique domain (Weersing & Brent, 2006). Techniques in CBT for youth with BP targets those hypothesized as cognitive distortions and behavioral deficits to improve current mood and prevent future episodes (Weersing & Brent, 2006).

Programs attempt to teach youth with BP specific CBT mood regulation skills, encourage practice of skills within and between sessions, and treat skills acquisitions as an experiment in which youth are coached by their therapist to make changes in their lives and then collaboratively assess the extent to which these chances lead to positive affective outcomes (Weersing & Brent, 2006). The core techniques of CBT may not be a development fit for youths' less developed abstract reasoning and perspective taking skills and limited control over their personal environments (Weersing & Brent, 2006). Some common techniques and sequences are;

> psychoeducational and mood monitoring; teaching youth to monitor their moods, thoughts, and behaviors to begin and see patterns, pleasant activity scheduling and behavioral activation; promoting engagement in activities that provide opportunities for mastery and pleasure, also creating a rewarding, non-stressful, and mood elevating environment, cognitive restructuring; helping youth to examine their automatic thoughts, teaching youth to engage in rational thinking about themselves, the world and their possibilities for the future, and skill-building techniques used in many programs; teaching relaxation techniques to cope with continuing environmental stressors, providing social skills and conflict resolution training to enhance youth adaptive repertoire and teaching general problem solving skills. (Weersing & Brent, 2006, p. 942)

CBT's general focus is on fostering the development of personal coping strategies and mastery of emotional and cognitive processes (Benjamin et al., 2011). When using CBT for youth with BP focus is on incorporating an increased attention on contextual issues and the development their own environment (Benjamin et al., 2011). The theory emerged as a treatment with the most empirical support for numerous internalizing disorders in youth (Benjamin et al., 2011). CBT is known as a well-established treatment for youth living with BP (Benjamin et al. 2011). Often CBT considered the first line of defense in the treatment setting with behavioral disorders in youth (Benjamin et al., 2011). There are multiple target areas in CBT; cognitive, behavioral and affective and provides avenues of interventions (Benjamin et al., 2011). "CBT is considered the treatment of choice for behavioral health problems in youth" (Benjamin et al., 2011, p.185).

Person-Centered Therapy. Person-centered therapy is based on the assumption that the practicing therapist can help patients overcome negative effects that some past experiences have had on their attitudes, feelings, and behaviors (Cepeda & Davenport, 2006). Rogers (1961) views the role of the therapist as a listener who is supportive, accepting, and caring to their patients. In person-centered therapy therapists help patients by facilitating here and now experiences within the therapeutic relationship that create the opportunity for patients to become aware of their true feelings (Cepeda & Davenport, 2006). The goal of person-centered therapy is to create the conditions that will encourage patients toward self-actualization, to become their most real and richest being (Brodley, 1986). This approach rests on three main conditions necessary for personal growth and change: genuineness or congruence, empathy, and warmth or unconditional positive regard (Rogers, 1967).

The relationship of person-centered therapy allows patients to become aware and to fully accept themselves and their diagnosis. The patient's awareness exposes the gap between the real and ideal self and serves to motivate the individual toward narrowing that gap. Patients then use this relationship to connect to the outside world and to become more open to experiences. The therapist and the patient perceive this change as the patient becomes able to see reality without distorting it to fit a fixed perception (Cepeda & Davenport, 2006). The assumption is that patients go from a belief system to one of process and change, with an enhanced interest for exploring new possibilities (Cepeda & Davenport, 2006). Patients may become less invested in their public images and more interested in understanding how they are becoming their true self.

Person-centered therapy has two phases; Phase I consists of the creation of a therapeutic alliance that will foster the patient's drive toward self- actualization and growth (Cepeda & Davenport, 2006). Phase I fosters autonomy and encourages patients to explore their inner choices rather than to rely on others for direction or evaluation (Cepeda & Davenport, 2006). Once patients begin to engage fully in the therapeutic process and exhibit signs of a stronger internal locus of control and a willingness to grow, the therapist should move to Phase II. Phase I is thus hypothesized as setting the background for effective, honest, open communication and accurate identification of the patient's needs, whereas Phase II consists of finding and implementing the procedures that the therapist and patients find most suitable and similar with the needs of the patient (Cepeda & Davenport, 2006). Phase II moves into an experiential and diverse process that allows therapists to respond more directly to the individual needs of their patients (Cepeda & Davenport, 2006). Therapists in Phase II use addition of other therapeutic approaches and techniques that widen the patient's journey to self-actualization. This idea of the therapeutic relationship has been generally incorporated by most approaches (Watkins & Goodyear, 1984). Corey (2001) was responsible for demonstrating that the therapist's delivery of genuineness, empathy, and acceptance within the therapeutic relationship is the most important tool for a lasting change.

Recreational Therapy. Problem solving activities gives recreational therapy (RT) its distinctive features, since there is no pressure for immediate solution to the problem, but fundamental to youth activities (Martin, 1963). This type of therapy provides wholesome and purposeful stimulation and enjoyment for youth living with behavioral problems and enjoyable and beneficial to youth's health and well-being.

Research shows that participation in RT builds youth's fine and gross motor skills. Active participation in recreational therapy also provides further opportunities for youth to build social skills with others. The promotion of mental health through use of recreational activities is an outgrowth of psychiatric utilization of recreation as therapy with BPs.

RT involves professionally organized and prescribed activities selected for the special needs of individual patients. Research has been found RT to be useful as therapy in many ways. Within RT music can be utilized for its therapeutic values; emotional release through dancing can be utilized, as well as art work such as painting and sculpturing for an emotional release and creative refreshment (Martin, 1963). These activities have been used for youth to develop insight into their own behavioral problems and also serve as a vital function of learning how to compete well with other youth with BPs. RT may also help with life's challenge, coping with stress, adapting to those life challenges, healing from trauma, and enhance the quality of life.

A considerable body of evidence now supports the contention that RT can be an important resource for coping with BPs (Hutchinson, Bland, & Kleiber, 2008). Generated social support in RT refers to the ways in which connections with others in recreation may provide youth with important emotional support and with the skills to use recreation as a way to handle and deal with their BPs (Hutchinson et al., 2008). For example, regular participation in hobbies and crafts, visiting friends, and swimming were all associated with better psychological well-being and lower levels of BPs (Dupuis & Smale, 1995). Hutchinson, Yarnal, Son, and Kerstertter (2007), found that girls who participated in social groups indicated that participation helped them deal with stress in

their lives. These studies provide evidence that recreational activities can be a positive resource across the life course (Hutchinson et al., 2008). Positive emotions and thoughts experienced during recreation provide youth with something to look forward to along with a way to manage the ongoing problems in their life (Hutchinson et al., 2008). RT activities tend to provide these benefits while being less physically, cognitively, or emotionally demanding (Hutchinson et al., 2008). Shared activity and peer support can also be important in a RT setting for youth (Hutchinson et al., 2008).

CHAPTER III

METHODOLOGY

Introduction

The purpose of this study was to identify a correlation between motivation for recreational therapy (RT) treatment and therapeutic alliance among youth living with BP. Framework for motivation occurs through Self-Determination Theory (SDT).

This study evaluated if youth (patients) feel they reach intrinsic motivation while in a RT setting and was measured using the Client Motivation for Therapy Scale (CMOTS) (Pelletier et al., 1997) (Appendix B). In addition, level of alliance with recreational therapist was conducted through the Working Alliance Inventory- Short Form (WAI-S) (Horvath, 1990) (Appendix C). Patients, ages 13-17, participating in RT at a Mental Health hospital in a Southern Plains state completed the CMOTS and the WAI-S after an RT group.

It was the goal of this research to identify if a strong therapeutic alliance has a relationship with intrinsic motivation for RT among patients ages 13-17 with behavioral / mental health diagnosis receiving inpatient mental health treatment.

This study addressed if;

1) A stronger therapeutic alliance was correlated to intrinsic motivation for recreational therapy.
2) A weaker therapeutic alliance was correlated to more extrinsic motivation for recreational therapy.

Selection of participants

A convenience sample of youth ages 13-17 receiving inpatient care at a Southern Plains state Mental Health Hospital were recruited for this study. Inclusion criteria for recruitment includes; 1) male and female; 2) youth ages 13-17; 3) Neurodevelopmental disorders as indicated in the DSM-5 (see Appendix A); 4) a dual diagnosis without active psychoses; 5) received previous psychiatric treatment; 6) first psychiatric admission; 6) IQ of at least 70; and 7) receive parent/guardian permission and youth assent.

Exclusion criteria 1) youth under age 13; 2) ages 18 and older; 3) Schizophrenia and Other Psychotic Disorders with Active Psychoses; 4) youth with a Dissociative Disorder; 5) Actively Psychotic; 6) an IQ below 70; and 7) parental/guardian permission or youth assent not provided.

Research Design

This study employed a non-experimental correlational survey research design. A convenience sample of youth was utilized in the data collection. After IRB (appendix D) approval, data collection occurred on-site with the principal investigator (PI) distributing two surveys to potential research subjects immediately after an RT group. In addition, the PI received demographic information from a manager from the agency. The manager accessed patients' medical record to retrieve diagnosis and admission date to calculate current length of stay.

This research used the Working Alliance Inventory- short form (WAI-S) (Horvath, 1990) and the Client Motivation for Therapy Scale (CMOTS) (Pelletier et al., 1997) to measure both patients' perspectives of their therapeutic alliance and type of motivation the patients have about RT treatment, respectively. Data analysis included

Spearman's Rho to determine correlation. This type of test is a non-parametric test used to measure the strength of association between two variables (Howell, 2004). The Mann-Whitney U test was utilized to determine patient's tendency towards a specific type of motivation (e.g. intrinsic motivation, integrated regulation, identified regulation, introjected regulation, external regulation, amotivation) based on a stronger or weaker therapeutic alliance.

Study procedures

Contact was made with a mental health hospital in a Southern Plains state regarding feasibility of this study. A proposal was provided to the hospital liaison that was presented to the leadership team for approval of the study, with approval granted.

The researcher obtained human subjects approval from respective IRBs (appendix D). After approval was obtained, the researcher trained primary therapists about the procedures and requirements of the study. Primary therapists were trained to assist in sharing information about the study with parents/guardians of potential study subjects. Primary Therapists also provided PI with schedule of family therapy appointments for the PI to solicit parent/guardian permission. The PI met with the patient's parents/guardians before a schedule primary therapy session. Parent/guardian consent was required prior to patients' participation in this study (Appendix E). After parents/guardians consent forms were signed, PI provided information to patient and requested assent (Appendix F). After assent was secured, patients were surveyed by the PI during allotted free time. Free time occurred shortly after RT groups.

The PI contacted the recreational therapist to determine if patients had attended at least one RT session before filling out the two surveys. Patients were surveyed during allotted free time. The researcher asked the patients that had parent/guardians permission to participate in the study if they would like to participate. If patient agreed, assent form (Appendix F) was provided to the patient and any questions were answered at that time. Upon completion of the assent, the researcher handed out the two modified surveys, CMOTS and WAI-S, to the patient. When the patient completed both surveys the researcher collected the two documents. All documents associated with this study remained with the PI until she reached a secured place. All documents were locked in a cabinet in the PI’s office.

Instrumentation

Two instruments were used in this study were the Client Motivation for Therapy Scale (CMOTS) and the Working Alliance Inventory Short Form (WAI-S). To determine motivation for recreational therapy, a modified version of the Client Motivation for Therapy Scale (CMOTS) was utilized (Pelletier, Tuson, & Haddad, 2010). Permission for modification was granted by the lead author of the CMOTS (L. Pelletier, personal communication, February 2, 2015). Therapeutic alliance was measured utilizing a modified version of the WAI-S. Permission was granted by lead author of the WAI-S (A. Horvoth, personal communication, March 6, 2015).

Client Motivation for Therapy Scale. The Client Motivation for Therapy Scale (CMOTS) is a 24-item self-report questionnaire designed to measure patients intrinsic

motivation, extrinsic motivation, and amotivation for therapy adapted from Deci and Ryan's (1985b) SDT.

The development of the 24- item CMOTS was based on the theoretical perspective of human motivation proposed by Deci and Ryan (1985a), who postulated the existence of six different types of motivation that are classified along a continuum of increasing autonomy; amotivation, four types of extrinsic motivation (external, introjected, identified, and integrated regulation), and intrinsic motivation (Pelletier et al., 1997). By using the CMOTS therapist and researches can identify clients with high and low levels of self-determination for therapy.

Development of the CMOTS consisted of two phases. The first phase was an interview conducted to identify why clients originally engage in therapy. A clinical psychology graduate student met with three therapists for a 2-hour interview to talk about reasons why they thought people attended therapy. During the second part of the interview the therapist were given a brief description of Deci and Ryan's (1985a) theoretical model of motivation and the different forms of motivation (e.g., intrinsic, integrated, identified, introjected, external regulation, and amotivation).

After the therapist understood the model the third part of the interview began. The third part of the interview therapists were asked to combine various therapy sessions into sections that would then fit along the motivation continuum. They were asked to identify which motivational type they believed each of their reasons represented. After the interview was completed the most frequently reported reasons for entering therapy were formulated into formal items for the questionnaire. The first version of the CMOTS

questionnaire consisted of 10 items with 60 questions. The scale was distributed along with other questionnaires to different facilities to test the items that would most reliably represent the motivation constructs. The facilities staff was asked to distribute this scale after the end of any therapy session of their choice. The questionnaire was to be answered quietly alone at home and mailed back into the university the psychology student attended.

This sample version of the CMOTS collected background information on clients and several measures of related to determinants and consequences of motivation and constructs related to motivation (Pelletier et al., 1997). The scale was used to assess four subscales: autonomy supportive, control, care, and competence feedback. This also measured constructs thought to represent feelings experienced by clients during therapy sessions and therapy outcomes; distraction, tension, importance clients ascribed to therapy, future intention to continue in therapy, and positive mood during therapy.

The analyses ran on the trial 10 item CMOTS scale were the Cattell's Scree test, eigenvalues, chi-square divided by degrees of freedom, internal consistency of the factors, and interpretability of the solution. A goodness of fit test was also run on the highest 6 remaining items.

An assessment of the construct validity of the CMOTS was performed in a three way correlation; (a) among the six CMOTS subscales; a Pearson correlation was computed among the six subscales. Integrated and Identified regulation have the highest positive correlations and the opposite ends of the continuum amotivation and intrinsic motivation have the most negative correlation, (b) between the CMOTS subscale and

motivational antecedents; the prediction that was seen was supported, that clients with more self-determined types of motivation would report working with therapist proving relatively more autonomy support, care, and competence feedback and less control than clients with les self-determined toward therapy, and (c) between the CMOTS subscale and motivation consequences; the hypothesis was supported with all the outcomes (Pelletier et al., 1997). Positive consequences associated with the therapy session and constructs associated with positive psychological functioning were correlated positively with the more self-determined forms of motivation and negatively with the less self-determined forms of motivation.

Good construct validity to support self-determination continuum with significant relations between its subscales (e.g., intrinsic motivation and integration, $r = .57$) and perceptions of therapist interpersonal behaviors (e.g., therapist interpersonal behavior and autonomy support $r = .21$) was demonstrated by the CMOTS. Significant correlations also were reported between the CMOTS subscale and motivation consequences (e.g., intrinsic motivation and distraction $r = -.18$; amotivation and distraction $r = .22$) (Pelletier et al., 1997). The CMOTS has fair to excellent internal consistency with alphas for the subscales that range from.70 for external regulation to .92 for intrinsic motivation (Pelletier et al., 1997).

The Working Alliance Inventory. The Working Alliance Inventory short form (WAI-S) is a 12- item self-report questionnaire to measure the level of alliance between a patient and their therapist; in this study the recreational therapist (Horvath, 1990). Therapeutic alliance was captured through three aspects 1) agreement in the tasks of therapy, 2) agreement on the goals of therapy, and 3) development of an affective bond.

Therapeutic alliance is generally conceptualized as consisting of three components: the bond or affective components of the relationship, agreement on the tasks or activities of the therapy, and shared agreement on the goals of the therapy (Bordin, 1979). Relationship building occurs between youth, parents, and therapists, who each have different roles within the therapeutic process. The more positive or stronger the therapeutic alliance between patient and therapists, the greater the therapeutic change in youth (Kazdin et al, 2005)

Horvath and Greenberg (1989) developed the Working Alliance Inventory (WAI), a 36-item instrument used to objectively measure the alliance between therapist and patient. Since publication of the WAI, it has undergone two major updates. Tracey and Kokotovic (1989) conducted factor analyses on the larger, 36-item WAI to develop the Working Alliance Inventory-Short (WAI-S), which is a 12-item version of the WAI (Tatman & Love, 2010).

The WAI-S questionnaire is originally derived from the WAI (Horvath & Greenberg 1986), which is the most commonly used therapeutic alliance measure in adult mental health research (Ross, Polaschek, & Wilson, 2011). The shortened 12-item version of the instrument, the WAI-S, was developed by selecting the four highest loading items of each of the three subscales; Goal, Task, and Bond (Tracey & Kokotovic, 1989). The WAI-S has shown good reliability ($\alpha > 0.80$) and convergent validity with the Helping Alliance Questionnaire ($r > 0.64$) (Munder, Wilmers, Leonhardt, Linster, & Barth, 2010). Horvath and Greenberg (1989) found the WAI-S reliability to range from .85 to .88.

Test retest reliability was run on both modified questionnaires because when one makes modification to a scale the original reliability may not hold with the modified scale and it is important to retest those scales (Creswell, 2009, p. 150).

Analysis of Data

Data from the questionnaires was input into SPSS 20.0 for windows. A Spearmen's Rho was conducted to determine if therapeutic alliance is correlated with motivation for recreational therapy. The researcher ran a Spearmen's Rho Correlation Coefficient to measure the strength of the relationship between alliance and motivation. The correlation coefficient is a measurement that will identify the strength of the correlation between two variables (Howell, 2004).

Using SPSS the researcher created a scatter plot diagram that plotted the responses of the alliance and motivation (Howell, 2004). Spearman Rho Correlation Coefficient analysis was utilized in this study because the first assumption of parametric tests was violated, therefore the Spearman Rho to test the strength of the relationship between the WAI-S and the CMOTS. A pre-determined alpha level of $p < .05$ will be utilized in this study.

CHAPTER IV

FINDINGS

Introduction

This survey research study used the CMOTS by Pelletier (1997) and the WAI-S by Horvoth (1990) to examine if there is a correlation between motivation for recreational therapy and the alliance made with the recreational therapist by patients. One hypothesis of this study states; that a stronger therapeutic alliance is related to more intrinsic motivation for recreational therapy. The other hypothesis of this study is a weaker therapeutic alliance is related to more extrinsic motivation for recreational therapy.

Date Screening

Prior to data analysis, a screening of the data was completed to confirm any missing data. In the event a patient did not fill out every question of the two questionaries' those research subjects would have been omitted from the data analysis.

Fortunately, no questions were missed on either questionnaire by the research subjects.

Reliability was tested on the calculated data to verify that the scales were still reliable after changing the wording to meet the needs of the patients. The CronsBach α.756 for the WAI-S and .753 on the CMOTS.

The mean score from the WAI-S was determined to assist in identifying two groups, those scoring higher than the mean were placed in one group labeled stronger therapeutic alliance, and those scoring lower than the mean were placed in another group, labeled weaker therapeutic alliance. All patients either scored above and below the mean.

Descriptive

Patients were recruited from a Southern Plains state inpatient mental health facility. Twenty patients were recruited and completed usable questionnaires for analysis. Thirty-five percent of participants were female and 65 percent of participants were male. The mean age of the participants was 13.85 with a standard deviation of 1.040, with the youngest participant being 13 and the oldest being 17. The mean length of stay was 62 days with a standard deviation of 67.813, with a range of 1 day to 252 days (Table 1). Tables 2 and 3 identify the frequency of each diagnoses (DX) used in this research. 45 percent of patients reported a Major Depressive Disorder as their primary diagnosis (Table 2). Twenty-five percent of patients reported having Conduct Disorder as a secondary diagnosis (Table 3). The alpha selected for this study was $p < .05$

Table 1:

Descriptive Statistics

	N	Range	Min	Max	Mean	Std. Deviation
Gender	20	1	1	2	1.65	.489
Age	20	4	13	17	13.85	1.040
LOS	20	251	1	252	62.00	67.813
Primary Diagnosis	20	14	1	15	6.95	4.174
Secondary Diagnosis	20	11	0	11	4.40	3.016

Table 2:

Primary Diagnosis

Diagnosis	Frequency	Percent	Valid Percent	Cumulative Percent
Disruptive Mood	3	15.0	15.0	15.0
Impulse Control	2	10.0	10.0	25.0
MDD	9	45.0	45.0	70.0
ODD	2	10.0	10.0	80.0
RAD	1	5.0	5.0	85.0
Disruptive Impulse Control	2	10.0	10.0	95.0
Bipolar I	1	5.0	5.0	100.0

Table 3:

Secondary Diagnosis

Diagnosis	Frequency	Percent	Valid Percent	Cumulative Percent
No Secondary DX	3	15.0	15.0	15.0
Impulsive Control	2	10.0	10.0	25.0
Conduct Disorder	5	25.0	25.0	50.0
Antisocial	1	5.0	5.0	55.0
ADHD	4	20.0	20.0	75.0
MDD	2	10.0	10.0	85.0
ODD	2	10.0	10.0	95.0
Intermittent Explosive Disorder	1	5.0	5.0	100.0

Findings / Conclusion

Spearman's Rho test was used for this study to determine a correlation between therapeutic alliance and motivation for recreational therapy. Spearman's Rho results indicated a moderate correlation between the therapeutic alliance and motivation for therapy. The correlation between the two questionnaires was .498 (table 4) with $p < .05$.

Table 4:

Correlations

		CMOTSTOT	WAITOT
CMOTSTOT	Correlation Coefficient	1.000	.498*
	Sig. (2-tailed)	.	.025
	N	20	20
WAITOT	Correlation Coefficient	.498*	1.000
	Sig. (2-tailed)	.025	.
	N	20	20

The scores for therapeutic alliance were split into two groups. The two groups were divided based on the mean. The patients scoring above the mean were in one group, stronger therapeutic alliance, and the patients scoring below the mean were in the other group, weaker therapeutic alliance. Nine patients scored in the stronger therapeutic alliance and 11 patients scoring in the weaker therapeutic alliance.

Table 5:

WAI Totals

	Frequency	Percent	Valid Percent	Cumulative Percent
<66.95	11	55.0	55.0	55.0
>66.96	9	45.0	45.0	100.0
Total	20	100.0	100.0	

Additional data was analyzed using the Mann-Whitney U. The Mann-Whitney U is a non-parametric test that is similar to parametrically comparing two independent samples. The Mann-Whitney U test was conducted on the calculated data because the data did not meet the assumptions of the T-test. The Mann-Whitney U (table 6) was run to identify where patients in each therapeutic alliance group score more frequently in the subscales of the CMOTS. The motivated scale falls on a continuum. This continuum ranges from intrinsic motivation to amotivation with a group of extrinsic motivation in the middle (e.g., external, introjected, identified, and integrated). External and introjected motivation are more closely related to extrinsic motivation with identified and integrated being more related to intrinsic motivation.

Table 6:

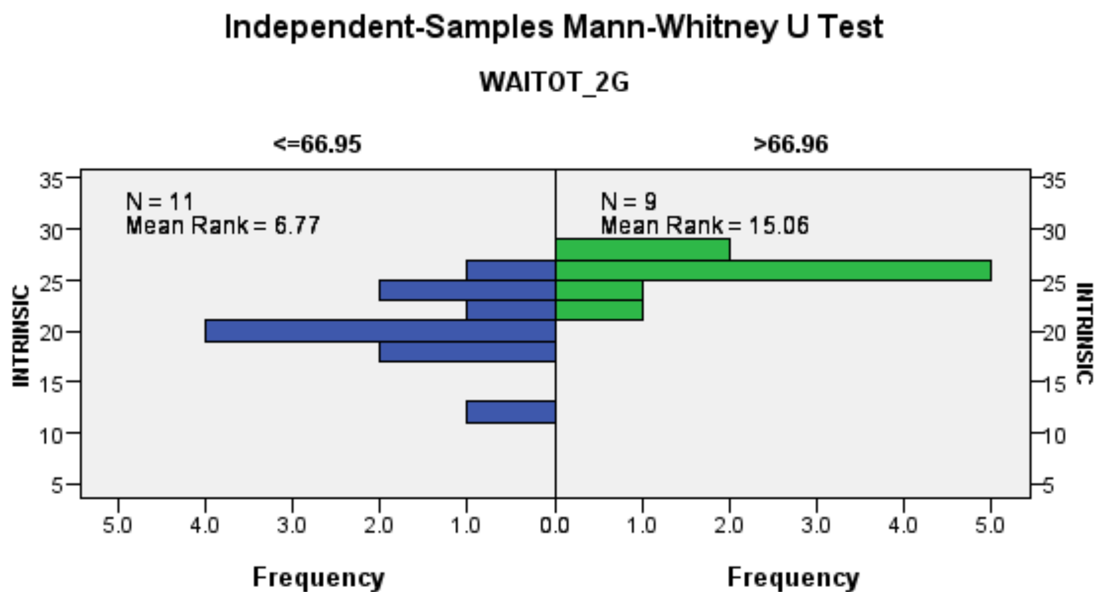
Mann-Whitney U Ranks

	Intrinsic	Integrated	Identified	Introjected	External	Amotivation
Mean	22.40	23.90	25.25	20.25	17.35	7.70
Sum	448	478	505	405	347	154

Intrinsic motivation

Based on the Mann-Whitney U intrinsic motivation was reported to reject the null hypothesis. Patients in the stronger therapeutic alliance group scored more frequently higher in intrinsic motivation than patients in the weaker therapeutic alliance group (Figure 2).

Figure 2:



Integrated Motivation

Based on the Mann-Whitney U integrated motivation was reported to reject the null hypothesis. Patients in the stronger therapeutic alliance group scored more frequently higher in integrated motivation than patients in the weaker therapeutic alliance group (Figure 3).

Figure 3:

Independent-Samples Mann-Whitney U Test

WAITOT_2G

<=66.95

>66.96

N = 11
Mean Rank = 6.95

N = 9
Mean Rank = 14.83

INTEGRATED

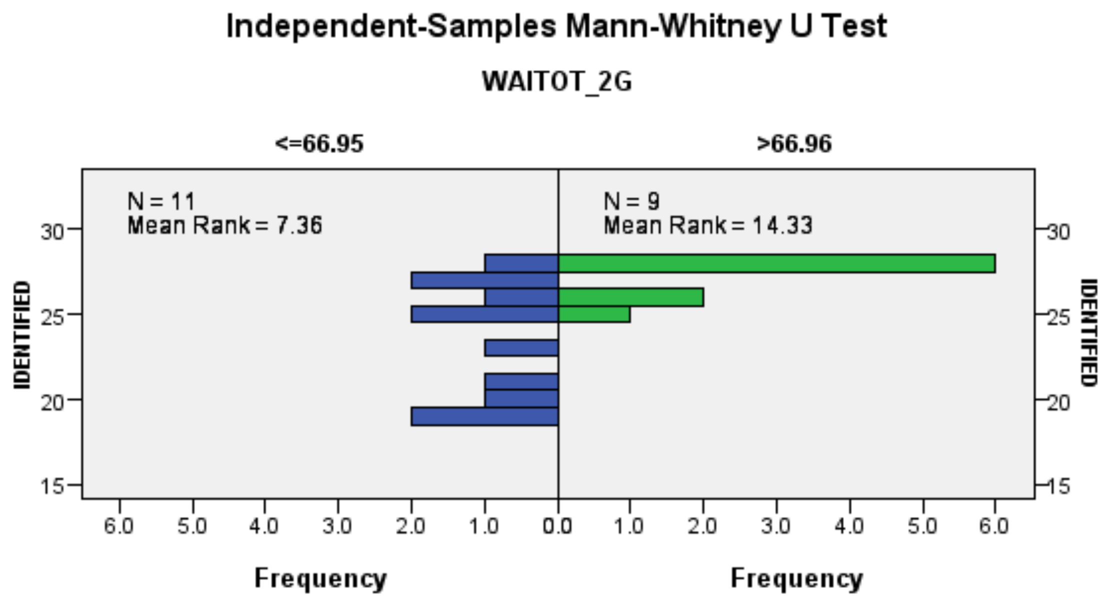
Frequency

Frequency

Identified Motivation

Based on the Mann-Whitney U identified motivation failed to reject the null. Patients in the stronger therapeutic alliance group scored more frequently higher in identified motivation than patients in the weaker therapeutic alliance group (Figure 4).

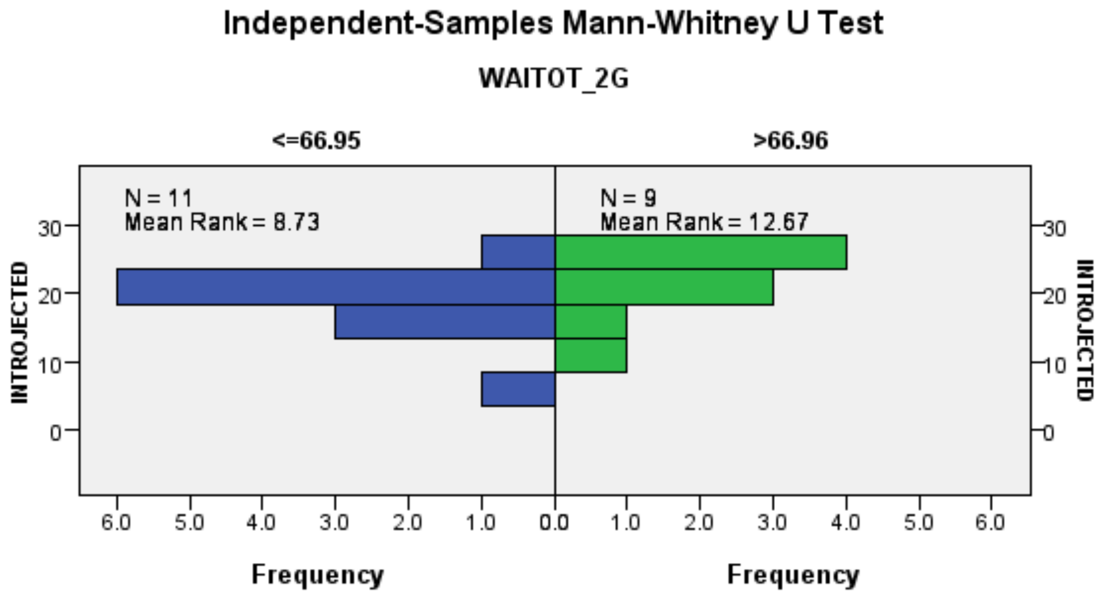
Figure 4:



Introjected Motivation

Based on the Mann-Whitney U introjected motivation was reported to reject the null hypothesis. Patients in the stronger therapeutic alliance group scored more frequently higher on introjected motivation than patients in the weaker therapeutic alliance group (Figure 5).

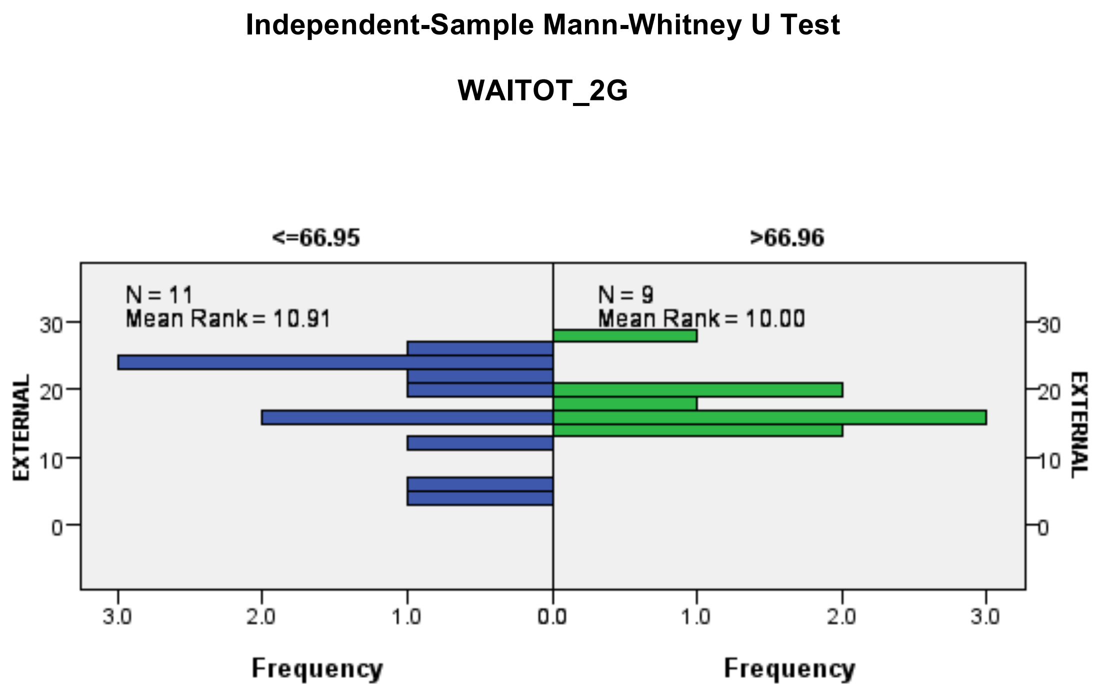
Figure 5:



External Motivation

Based on the Mann-Whitney U external motivation was reported to reject the null hypothesis. Patients in the weaker therapeutic alliance group more frequently scored higher on external motivation than patients the stronger therapeutic alliance group (Figure 6).

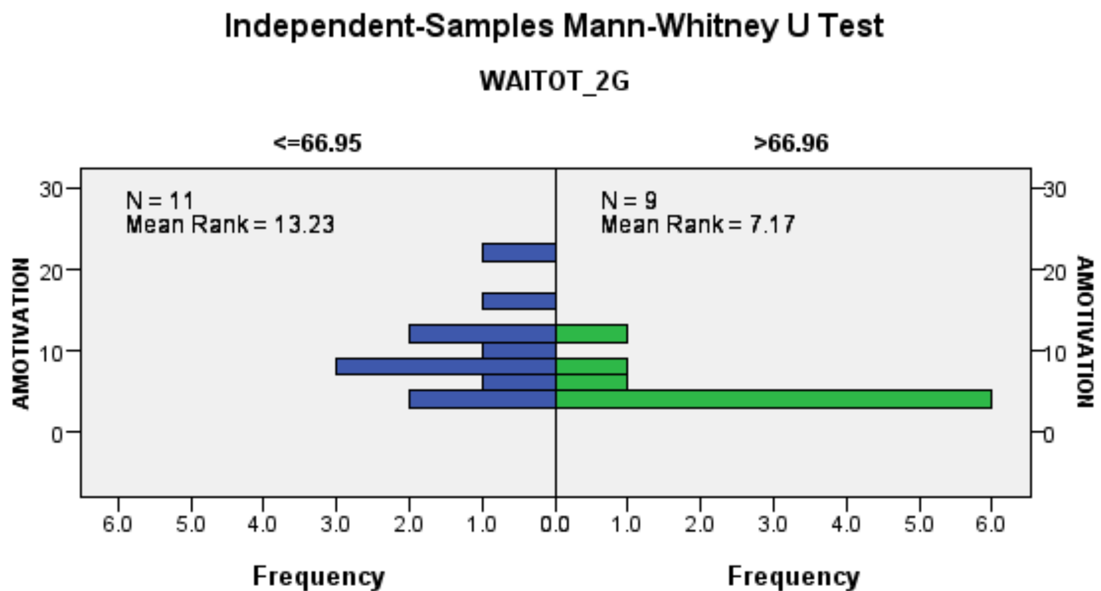
Figure 6:



Amotivation

Based on the Mann-Whitney U amotivation was reported to reject the null hypothesis for hypothesis 1 and retain the null hypothesis for hypothesis 2. Participants in the weaker therapeutic alliance group more frequently scored higher in amotivation than participants in the stronger therapeutic alliance group (Figure 7).

Figure 7:



Extrinsic Motivation

Participants who scored high in external motivation and amotivation reported to score in the weaker therapeutic alliance group. External motivation and amotivation are the closest types of extrinsic motivation on the continuum. Therefore hypothesis 2 was retained, reporting that participants in the weaker therapeutic alliance group were correlated to more extrinsic motivation.

Hypothesis

Two hypotheses were addressed in this study:

- Hypothesis 1: A stronger therapeutic alliance is related to more intrinsic motivation for recreational therapy.
- Hypothesis 2: A weaker therapeutic alliance is related to more extrinsic motivation for recreational therapy.
- Null Hypothesis: There will be no change with any subscale of motivation and therapeutic alliance.

Based on the results of the first hypothesis one therapeutic alliance and intrinsic motivation are correlated. Results of the second hypothesis confirmed that a weaker therapeutic alliance is correlated with more extrinsic motivation. After assessing the results of from Spearman Rho correlation testing this research fails to reject the null hypothesis because there were changes in the therapeutic alliance and motivation for therapy in a few subscales.

CHAPTER V

DISCUSSION

Introduction

The purpose of this study was to examine if motivation for recreational therapy was correlated with therapeutic alliance in patients living with BP. The CMOTS allowed for analysis of types of motivation identified by Pelletier (1997). The type of motivation identified by the CMOTS includes Intrinsic Motivation, four forms of Extrinsic Motivation (integrated, identified, introjected, and external regulation), and Amotivation. The WAI (Horvath, 1990) was used in this research to measure the therapeutic alliance made with patients with BP and their recreational therapist

Discussion

The research objective in this study was to examine how patients with BPs were motivated for RT and if therapeutic alliance was correlated with motivation.

This research examined if a stronger therapeutic alliance is correlated to more intrinsic motivation for recreational therapy or if a weaker therapeutic alliance is correlated to more extrinsic motivation for recreational therapy.

This study recognizes the need for RT to support intrinsically motivating interventions based on the results. This research found that patients with a strong therapeutic alliance more frequently reported to be intrinsically motivated during recreational therapy. Patients with a strong therapeutic alliance frequently scored higher on intrinsic motivation, integrated motivation, and identified motivation than patients with a weaker therapeutic alliance. A willingness to work with others and being intrinsically motivated for therapy comes from within and involves trusting someone else. With a strong therapeutic alliance between therapist and patients there will be trust involved resulting in forming a therapeutic alliance of some kind including three components: goals, bond, and agreement. All three components are important for a strong alliance between therapist and patient, the emotional connection is crucial for initial establishment of alliance (Castro-Blanco, & Karver, 2010). By building a strong therapeutic alliance is best practice for improving motivation for treatment and engaging and maintaining youth in mental health treatment facilities (Shirk & Karver, 2011). Having a strong therapeutic alliance between patient and therapist will support intrinsic motivation for patients and in return they should feel as though their therapist trust them and are supporting their own personal decisions.

Patients scoring in the stronger therapeutic alliance group scored more frequently higher in intrinsic motivation, integrated motivation, identified motivation, and

introjected motivation. Introjected motivation is a non-self-determined type of motivation on the extrinsic motivation continuum where individuals still have a somewhat external perceived locus of causality (Vlachopoulos, & Karageorghis, 2005). Thus, individuals see something outside themselves as a motivating factor and may explain why in this study patients in the stronger therapeutic alliance group more frequently scored high on introjected motivation. The extrinsic continuum forms a quasi-simplex structure, meaning that motivational sources located closer to each other (e.g., extrinsic and introjected) are more strongly correlated than motivational sources located further apart from each other (e.g., extrinsic and integrated) (Malmberg, & Little, 2007).

Patients that scored higher on amotivation more frequently scored in the weaker therapeutic alliance group. This study reported that patients scoring in the weaker therapeutic alliance group more frequently scored high on amotivation, this type of motivation is the closest form of extrinsic motivation. This may be because patients with low motivation (those falling on the end of the continuum) and scoring higher in extrinsic motivation are particularly sensitive to aspects of the therapeutic alliance (Miller & Rollnick, 2002). Another explanation may be that patients that enter therapy with high levels of withdrawal and extrinsic motivation for therapy make it difficult to establish a strong therapeutic alliance with their therapist (Michalak, Wiethoff, & Schulte, 2005). This could have played a role in those patients scoring high on external motivation and high on amotivation in the weaker therapeutic alliance group. Without a bond being present patients are less likely to form a therapeutic alliance and will withdrawal from therapy also resulting in no longer being intrinsically motivated but now being extrinsically motivated for therapy. Patient in the weaker therapeutic alliance reported to

be more frequently extrinsically motivated (e.g. external motivation and amotivated) for RT in this study. It is important to note that these findings are preliminary and more research is needed before concluding that a stronger therapeutic alliance caused patients to have high motivation for RT.

Limitations

As with any research, this study too had limitations. One of the primary limitations with this study is the generalizability of the results. Patient's family life was unknown and not addressed. Parents may create a controlling motivational environment that patients are used to responding to which is different from the hospital environment. Only patients who's parents signed the permission form for their child were allowed to participate in this study. This placed a limitation related to sampling. Including leaving out patients who were in the Department of Human Services (DHS) custody and patients who did not have family participation. This study is not generalizable to a bigger population because of the nature of the study and the participants in the study.

Surveys were given to patients in a one on one setting potentially making it easier for the investigator to influence the participant. Social desirability may have influenced patients to answer questions in a way the interviewer would have liked them to answer because the interviewer was in the room when patients were answering the surveys. Social desirability bias is a social science research term that describes the tendency of survey respondents to answer questions in a manner that will be viewed favorably by others (Fisher, 1983). The investigator was able to help the patients understand questions when they did not understand the meaning and encouraged them to answer honestly.

Only patients that did not have active psychosis were used in this study. This was not a good representation in the population of the hospital. In addition, some patients in this study had been receiving longer treatment than others. Admission dates varied from patient to patient. Some patients had already made a relationship with their recreational therapist and others had just met their recreational therapist. Patients who were admitted into programming earlier than others had a better rapport with their RT. Patients who were newly admitted to programming experienced confusion as a result of not being bonded with their RT. This leads to the need for additional research on the time frames involved in bonding processes between RT and patients, and that influence over intrinsic motivation.

Additional recommendations for further research

Implicit in this study results is the need for further empirical investigation on motivation for recreational therapy and the alliance between recreational therapist and patient; thus, the following recommendations are made.

Additional research should investigate the three different factors of alliance (e.g., task, bond, & agreement) that support therapeutic alliance. By identifying which factor has the most influence on the therapeutic alliance researchers may be able to use this information to improve therapeutic alliance and work on the areas that do not have a high connection.

Further research could be done to recognize if motivation changes depending on the length of stay at the facility. Motivation for treatment is affected by a variety of factors including; age, problem severity, peer deviancy, social support, family support,

pressure to enter treatment, multiple admissions, and education status (Webster et al., 2006). These factors may contribute to length of stay in different ways, thus impacting their motivation for therapy.

Research should identify specific factors that affect motivation for treatment and if these are more intrinsically motivating factors or extrinsically motivating factors. By looking at these factors investigators may be able to distinguish what influences motivation the most.

Potential research could be done utilizing patients with active psychosis. Patients with active psychosis may change the results based on how their symptoms and other relative problems because of their incompetence to participate and answer in the right state of mind. By using this group of patients their alliance made with RTs may be different than other patients without active psychosis. More research could be done to identify if patients with active psychosis portray a certain type of motivation towards recreational therapy.

Researchers could employ first time patients and comparing to patients that have been admitted numerous times. This research could examine the difference in motivation for patients who have attended the facility multiple times and the patients who have never been at the facility. Comparing the two should identify if repeat stays have any effect on motivation for treatment. Patients who have attended the facility multiple times could be burnt out on therapy sessions and not motivated to work on treatment. Patients may have the opposite attitude and only want to work on their treatment because they have been to the facility before and have already formed an alliance with the hospital staff.

Impending research ought to investigate why patients might have a strong alliance and intrinsic motivation at the same time. Some researchers have found positive associations between a strong therapeutic alliance and positive motivation for treatment. However there have been multiple studies examining the effects of alliance and motivation for treatment but have yet to be consistent (Garner, Godley, & Funk, 2008). Developing research in this area could be done identifying if strong alliance and intrinsic motivation happen very often or if it is a rare occurrence.

Continuing research could look at amotivation to see why patients are oriented in this way and how that affects their inpatient stay and treatment at a facility. By examining why patients are amotivated for different activities could be an identifying factor in why they are less likely to have a positive therapeutic relationship with recreational therapist. Future research could show why patients that had a weaker therapeutic alliance ranked amotivation to be the type of motivation they related to the most.

Additional research on different therapy sessions and motivation could be identified. Researchers could look at how patients are motivated for primary therapy, family session, and recreational therapy. With this research therapeutic alliance could also be studied by identifying which types of therapy groups have the best therapeutic alliance. Researchers could look into the components of each therapy type and why a therapeutic alliance is being formed.

Implications for Recreational Therapy

There is little to no recreational therapy (RT) research being done with youth in behavioral health facilities, specifically investigating patients and therapist relationship

on motivation for therapy. While it is clear that motivation has an important role in facilitating successful therapeutic outcomes in recreational therapy there needs to be more research identifying the importance of making a strong bond between therapist and patient. Therapeutic alliance is a factor that has been consistently found to have a significant influence on interventions and motivation (Clarke, Mun, Kelly, White, & Lynch, 2013). Recreational therapy interventions are positively affected by therapeutic alliance (Clarke et al. 2013). Patients tend to show more intrinsic motivation when there is a therapeutic alliance present during recreational therapy. It has been well established in other research that motivated patients have better treatment outcomes than those individuals who are not motivated to engage in therapy and they also develop a better relationship with their recreational therapist then those not motivated to make that bond (Clarke et al. 2013). This is significantly important to the recreational therapy field. Making and having an alliance with patients in an inpatient setting may have a stronger impact on them and will lead to helping them make a better and longer lasting behavior change.

Concluding Comments

Results of this study provide a foundation for further exploration into therapeutic alliance and patients in recreational therapy. This study recognizes the need for a therapeutic relationship with youth patients living with BP. With having that positive therapeutic relationship with the patients should encourage patients to be more intrinsically motivated for recreational therapy groups. This study also recognized that youth are more intrinsically motivated for recreational therapy when they have that strong therapeutic alliance with their recreational therapist. Recreational therapist need to

recognize that their patients treatment outcomes can be affected by the relationship they have with each other. Recreational therapists need to be aware of this and be working towards having a good therapeutic alliance with their patients. By having a high therapeutic alliance with patients recreational therapist may be able to foster more intrinsic motivation with patients with behavioral problems (BP). Recreational therapist may want to consider encouraging intrinsic motivation and therapeutic alliance in their programs.

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APPENDICES

Appendix A

Behavioral Problems Definitions

Diagnosis	**Description and symptoms**
Bipolar Disorder	"**Bipolar I** disorder criteria represents the modern understanding of the classic manic depressive disorder or affective psychosis describe in the nineteenth century. Necessary to meet the following criteria; manic episode may have been preceded by and may be followed by hypomanic or major depressive episode" (American Psychiatric Association, p.123, 2013). "**Bipolar II** disorder requiring lifetime experience of at least on episode of major depression and at least one hypomanic episode. Diagnosis is given for at least 2 years of both hypomanic and depressive periods without ever fulfilling the criteria for an episode of manic hypomania or major depression. Criteria; current or past hypomanic episode and the following criteria for current or past major depressive episodes" (American Psychiatric Association, p.123, 2013).
Depressive Disorder	"Most common feature of this disorder is the presence of sad, empty, or irritable mood, accomplished by somatic and cognitive changes that significantly after the individual's capacity to function. This disorder involves a two week period of a clear –cut change in affect, cognition, and neurovegetative functions and inter-episodes remission. When mood disturbance continues for at least two years" (American Psychiatric Association, p. 155, 2013). .

Anxiety disorders	"Includes disorders that share features of excessive fear and anxiety and related behavioral disturbance. Anxiety is the anticipation of future threats. These types of disorders differ from each other in the types of objects or situations that induce fear, anxiety, or avoidance behavior, and the associated cognitive ideation. Many of these disorders develop in childhood and tend to persist if not treated" (American Psychiatric Association, p. 189, 2013).
Trauma & stressor Disorders	"These disorders typically follow exposure to a traumatic or stressful event. Many individuals who have been exposed to a traumatic or stressful event exhibit a phenotype in which, rather than anxiety or fear based symptoms, the most prominent clinical characteristics are anhedonia and dysphoric symptoms, externalizing angry and aggressive symptoms, or dissociated symptoms" (American Psychiatric Association, p. 265, 2013).
Disruptive, Impulse-Control and Conduct Disorders	"Included conditions involving problems in the self-control of emotions and behaviors. These problems are manifested in behaviors that violate the rights of others (e.g., aggression, destruction of property) and that bring the individual into significant conflict with societal norms or authority figures. Many of the symptoms of this disorder can be result of poorly controlled emotions such as anger" (American Psychiatric Association, p. 461, 2013).

Personality Disorders	"Is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment" (American Psychiatric Association, p. 645, 2013).
Obsessive – compulsive Disorders	"This disorder is characterized by the presence of obsession and or compulsion. They are also characterized by preoccupations and by repetitive behaviors or mental acts in response to the preoccupations. Characterized primarily by recurrent body-focused repetitive behaviors and repeated attempts to decrease or stop the behaviors" (American Psychiatric Association, p. 235, 2013).
Eating Disorders	"These disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning" (American Psychiatric Association, p. 329, 2013).
Substance related and addictive disorders	"Drugs that are taken excessively that stimulate the brain in some kind of way, these drugs taken normally activate the system and produce feeling of pleasure, often referred to as a "high", These drugs produce such intense activation of the reward system that normal activities may be neglected" (American Psychiatric

	Association, p. 481, 2013).
Schizophrenia and other Psychotic Disorders	“These disorders are defined by abnormalities in one or more of the following five domains; delusion, hallucinations, disorganized thinking, grossly disorganized or abnormal motor behavior and negative symptoms” (American Psychiatric Association, p. 87, 2013).

Appendix B

Client Motivation for Therapy Scale

Why are you presently involved in Recreational Therapy?

Using the scale below, please indicate to what extent each of the following items corresponds to the reasons why you are presently *involved in recreational therapy by circling the appropriate number to the right of each item. We realize that the reasons why you are in recreational therapy at this moment may differ from the reasons that you initially began treatment. However, we are interested to know why you are in recreational therapy* at the present moment.

	Item	Not like me				Somewhat like me		Exactly lik[e] me
1.	Because other people think that it's a good idea for me to be in recreational therapy group.	1	2	3	4	5	6	7
2.	Honestly, I really don't understand what I can get from recreational therapy group.	1	2	3	4	5	6	7
3.	For the pleasure I experience when I feel completely absorbed in a recreational therapy group.	1	2	3	4	5	6	7
4.	For the satisfaction I have when I try to achieve my personal goals in the course of recreational therapy group.	1	2	3	4	5	6	7
5.	Because I would feel guilty if I was not doing anything about my problem.	1	2	3	4	5	6	7
6.	Because I would like to make changes to my current situation.	1	2	3	4	5	6	7
7.	Because I believe that eventually it will allow me to feel better.	1	2	3	4	5	6	7
8.	I once had good reasons for participating in recreational therapy group, however, now I wonder whether I should quit.	1	2	3	4	5	6	7
9.	Because I would feel bad about myself if I didn't continue with recreational therapy group.	1	2	3	4	5	6	7
10.	Because I should have a better understanding of myself.	1	2	3	4	5	6	7
11.	Because my friends think I should be in recreational therapy group.	1	2	3	4	5	6	7
12.	Because I experience pleasure and satisfaction when I learn new things about myself that I didn't know	1	2	3	4	5	6	7

before.

		1	2	3	4	5	6	7
13.	I wonder what I'm doing in recreational therapy groups; actually, I find it boring.	1	2	3	4	5	6	7
14.	I don't know; I never really thought about it before.	1	2	3	4	5	6	7
15.	Because I believe that recreational therapy groups will allow me to deal with things better.	1	2	3	4	5	6	7
16.	For the interest I have in understanding more about myself.	1	2	3	4	5	6	7
17.	Because through recreational therapy group I've come to see a way that I can continue to approach different aspects of my life.	1	2	3	4	5	6	7
18.	Because through recreational therapy group I feel that I can now take responsibility for making changes in my life.	1	2	3	4	5	6	7
19.	Because it is important for clients to remain in recreational therapy group until it's finished.	1	2	3	4	5	6	7
20.	Because I believe it's a good thing to do to find solutions to my problem.	1	2	3	4	5	6	7
21.	To satisfy people close to me who want me to get help for my current situation.	1	2	3	4	5	6	7
22.	Because I don't want to upset people close to me who want me to be in recreational therapy group.	1	2	3	4	5	6	7
23.	Because I feel that changes that are taking place through recreational therapy group are becoming part of me.	1	2	3	4	5	6	7
24.	Because I value the way recreational therapy group allows me to make changes in my life.	1	2	3	4	5	6	7

(Adapted with permission from: Pelletier, Tuson, & Haddad. (1997). Client motivation for therapy scale: A measure of intrinsic motivation, extrinsic motivation, and amotivation for therapy. *Journal of Personality Assessment*, *68*(2), 414-435)

Appendix C

Working Alliance Inventory-Short Form

Working Alliance Inventory

Short form ©

Instructions

On the following pages there are sentences that describe some of the different ways you might feel about your recreational therapist.

Below each statement there is a seven point scale

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

If the statement describes the way you always feel or think then circle the number 7; if the statement is something you never feel then circle the number 1. Use the numbers in between if you feel differently then never or always.

This questionnaire is confidential; neither your recreational therapist nor the agency will see your answers.

Please do not forget to respond to every item.

Thank you for your cooperation.

(Adapted from A. O. Horvath, 1981, 1982; Revision Tracey & Kokotowitc 1989).

1. My recreational therapist and I agree about the things I will need to do in Recreational therapy to help improve my issue.

1	2	3	4	5	6	7
Never	Rarely	Occasionall y	Sometimes	Often	Very Often	Always

2. What I am doing in recreational therapy gives me new ways of looking at my problems.

1	2	3	4	5	6	7
Never	Rarely	Occasionall y	Sometimes	Often	Very Often	Always

3. I believe my recreational therapist likes me.

1	2	3	4	5	6	7
Never	Rarely	Occasionall y	Sometimes	Often	Very Often	Always

4. My recreation therapist does not understand what I am trying to achieve in recreational therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionall y	Sometimes	Often	Very Often	Always

5. I trust my recreational therapist's ability to help me.

1	2	3	4	5	6	7
Never	Rarely	Occasionall y	Sometimes	Often	Very Often	Always

6. My recreational therapist and I are working to reach agreed upon goals.

1	2	3	4	5	6	7
Never	Rarely	Occasionall y	Sometimes	Often	Very Often	Always

7. I feel that my recreational therapist respects me.

1	2	3	4	5	6	7
Never	Rarely	Occasionall y	Sometimes	Often	Very Often	Always

8. We agree on what is important for me to work on.

1	2	3	4	5	6	7
Never	Rarely	Occasionall y	Sometimes	Often	Very Often	Always

9. My recreational therapist and I trust one another.

1	2	3	4	5	6	7
Never	Rarely	Occasionall y	Sometimes	Often	Very Often	Always

10. My recreational therapist and I have different ideas on what my problems are.

1	2	3	4	5	6	7
Never	Rarely	Occasionall	Sometimes	Often	Very Often	Always

y

11. We have agreed on the kind of changes that would be good for me.

1	2	3	4	5	6	7
Never	Rarely	Occasionall y	Sometimes	Often	Very Often	Always

12. I believe the way we are working with my problems is correct.

1	2	3	4	5	6	7
Never	Rarely	Occasionall y	Sometimes	Often	Very Often	Always

Appendix D

Integris IRB Letter

INTEGRIS Health
Institutional Review Board
3400 Northwest Expressway, Suite 806
Oklahoma City, OK 73112
Phone: (405) 949-4184
Fax: (405) 713-2713

July 22, 2015

Taylor Cudd
926 W. 11th
Stillwater, OK 74074

Dear Ms. Cudd:

The INTEGRIS Health, Inc. Institutional Review Board met on June 2, 2015 and reviewed the following protocol (as submitted) and consent form:

Motivation and therapeutic alliance with recreational therapy: an investigation of youth with mental health diagnosis. (Sponsor: , Protocol: 06/04/2015, Consent dated: 06/04/2015 , Total Number of Approved Subjects: 100) (15-015)

The IRB approved the protocol (as submitted) and subject consent form effective June 2, 2015 for a period not to exceed one year (365 days). This approval will expire June 1, 2016. Neither the Principal Investigator nor Sub-Investigators were present during the vote.

The following have been approved by the IRB:

- Protocol revised June 04, 2015
- Consent Form revised June 04, 2015
- Minor Assent revised July 20, 2015
- Patient/Guardian Consent for shared information
- Subject Questionnaire, undated
- Accrual goal of up to 100

The Board acknowledges the following:

- Approval letter from INTEGRIS Mental Health Spencer
- CMOTS modification approval letter
- WAI modification approval letter

A copy of the approved consent form is enclosed. You must provide the study subject with a copy of the consent form, keep a copy of the signed consent form with the research records, and place a signed copy in the study subject's hospital medical record (if applicable).

You must provide to the IRB an annual report prior to the anniversary date of this approval June 1, 2016 and/or a final report when the study closes. Unless your study is re-reviewed and re-approved within 12 months from the date of last approval by the IRB, federal regulations require the IRB to immediately suspend its approval and notification be sent to the FDA.

Any proposed changes in the approved protocol or consent form must be submitted to the IRB for review and approval before any new documents can be used. The IRB will determine whether the proposed changes are subject to full or expedited review. Unanticipated problems involving risks to the subjects or others must also be reported to the IRB as soon as possible, but no later than the following time frames:

1) Internal UPIRSO - within 10 days of the event

Appendix E

Informed Consent

INFORMED CONSENT

AND

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

(PARENT/GUARDIAN AUTHORIZATION)

OKLAHOMA STATE UNIVERSITY

PROJECT TITLE: Identifying if motivation for recreational therapy is influenced by the therapeutic alliance with a Recreational Therapist.

INVESTIGATOR(S):

Taylor Cudd

Oklahoma State University

117 Colvin Recreation Center

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Dr. Melissa L. Zahl, PhD, CTRS/L

Oklahoma State University

183 Colvin Recreation Center

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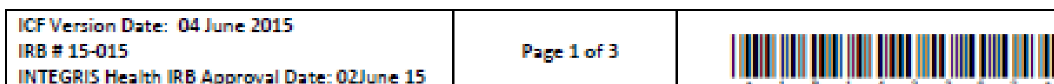
SITE:
INTEGRIS Mental Health Spencer
2601 Spencer Road
Spencer, OK 73084

PURPOSE:
The purpose of this research study is to determine if there is a relationship between how your child feels about their relationship with the recreational therapist and motivation for recreational therapy treatment during your child's hospitalization.

PROCEDURES:
Approximately 30-50 individuals will participate in this study. If your child participates, he or she will complete two questionnaires. One questionnaire will ask different questions about how they are motivated for recreational therapy here at INTEGRIS Mental Health Spencer. The other questionnaire will ask questions regarding alliance between your son or daughter and the recreational therapist. This study is designed to last approximately 20 minutes.

RISKS OF PARTICIPATION:
There are no known risks associated with this project which are greater than those ordinarily encountered in daily life.

ALTERNATIVE TO PARTICIPATION:
The only alternative is not to participate in this study. Choosing not to participate will not cause a loss of benefits to which you might otherwise be entitled.



BENEFITS OF PARTICIPATION:
There are no direct benefits to you or your child if they participate in this study. However, there is a benefit to understanding if the types of motivation youth living with a behavioral problem are related to how your child feels about their relationship with the recreational therapist. The results of this study will also help us better understand the role of the relationship between patient and therapist within the treatment environment.

HOW WILL MY PRIVACY BE PROTECTED?
The principal investigator, her employees and agents (collectively referred to as the "Principal Investigator") will collect and process certain personal health information about your child ("Protected Health Information" or "PHI"). The PHI will be kept on paper and/or in computers. PHI collected will be maintained in a confidential manner using passwords and encryption technology consistent with regulatory requirements.

Further, it may be necessary to send or transfer the PHI collected in this study to other companies or to government regulatory authorities. Once that occurs, the data may not be protected to the same degree.

By signing this patient informed consent and authorization form ("Authorization") on behalf of your child, you are authorizing the Principal Investigator to use your child's PHI in connection with this research study and to further disclose your child's PHI in connection with this protocol to:

(I) the Principal Investigator, study staff and authorized representatives of the Principal Investigator;

(II) the U.S. Food and Drug Administration (FDA), other government agencies in the United States and other countries;

(III) INTEGRIS staff;

(IV) the INTEGRIS Health, Inc. Institutional Review Board ("IRB");

(V) a public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, and conducting public health surveillance, investigations, or interventions; and

(VI) an individual or entity, without prior notice to you, in response to a valid court order by a court or other governmental or regulatory body or as otherwise required by law.

As further protection for your child's PHI, there will be no personally identifiable information about your child on the actual surveys. However, there will be identifiable information on the assent form that your child will be asked to sign. This will be removed once data is input and locked in a secured office. All records of this study will be kept private. Any written results will discuss group findings and will not include information that will identify you or your child. Research records will be stored on a password protected computer or a locked cabinet in a locked office and only researchers and individuals responsible for research oversight will have access to the records. Data will be destroyed three years after the study has been completed.

Any PHI collected based on this Authorization may be used by the Principal Investigator. If you withdraw permission for your child to be in the study, or withdraw permission for use of your child's PHI, the Principal Investigator will still be able to use the health information collected about your child before you withdrew your consent.

COMPENSATION AND COST:
There will be no compensation provided or cost to you or your child for participating in this research study.

CONTACTS:
You may contact any of the researchers at the following addresses and phone numbers, should you desire to discuss your participation in the study and/or request information about the results of the study: Taylor Cudd, MS student, Colvin, Dept. of Leisure Studies, Oklahoma State University, Stillwater, OK 74078, (580).591.3795. If you have questions about your rights as a research volunteer, you may contact the INTEGRIS IRB Office at 3400 N.W. Expressway Oklahoma City, OK 73112, (405)-949-4184, irb@integriok.com.

PARTICIPANT RIGHTS:
I understand that my child's participation is voluntary, that there is no penalty for refusal to participate, and that I am free to withdraw my permission for my child's participation at any time. If I wish to withdraw from participation in the study, I understand that I should contact the Principal Investigator listed on the first page of this Authorization form. Even if I give permission for my child to participate I understand that he/she has the right to decline. I also understand that any decision not to take part, stop study treatment or to leave the study will not affect the care my child receives now or in the future.

CONSENT DOCUMENTATION:
I have been fully informed about the procedures listed here. I am aware of what my child and I will be asked to do and the benefits of participation. I also understand the following statements:

I have read and fully understand this permission form and sign it freely and voluntarily. A copy of this form will be given to me. I hereby give permission for my child
____to participate in this study.

____ ___________________________

Signature of Parent/Legal Guardian Date

____

Nature of Relationship

I certify that I have personally explained this document before requesting that the participant sign it.

____ ___________________________

Signature of Researcher Date

Appendix F

Minor Assent Form

MINOR ASSENT FORM
OKLAHOMA STATE UNIVERSITY

PROJECT TITLE: Identifying if motivation for recreational therapy is influenced by the therapeutic alliance with a Recreational Therapist.

INVESTIGATOR(S):

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580.591.3795	405.744.3209
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My name is Taylor Cudd and I am interested in learning about your relationship with the recreational therapist and how this affects your motivation for recreational therapy. In order to understand this, I would like you to fill out two surveys. I will also need your permission to be a part of this research study. Your parent/guardian is aware of this project and has provided permission for you to do the study.

You may discuss anything in this form with your parents or friends or anyone else you feel comfortable talking to. You can decide whether to participate or not after you have talked it over. You do not have to decide immediately. There may be some words you don't understand or things that you want explained. Please don't be afraid to ask questions.

Do I have to participate?
Please understand that you do not have to do this, even if your parent provided permission. You do not have to answer any questions that you do not want to. If you do want to do this, you may stop at any time and return to the unit, bedroom, or dayroom. Whether you participate or not will not affect your treatment or relationship with any staff at INTEGRIS Mental Health-Spencer.

Will my participation be private?
We will not tell other people that you are in this research and we won't share information about you to anyone who does not work in the research study. Your name will not be on any other forms you fill out besides this one. This form will be kept in a locked cabinet in my advisor's locked office at Oklahoma State University. I will record the data using a computer software Oklahoma State University provides for us to use to compare and configure your responses. The data collected from these two surveys will not have your names on them and will also be kept in a locked cabinet in my advisors locked office at Oklahoma State University. If the data must be shared with anyone other than my advisor then it will be at your parents or guardians request.

Are there risks or benefits to me?

There are no known risks for participating in this study. There may not be any direct benefit to you from participating, but the results of this study will also help us better understand the role of the relationship between patient and therapist is within treatment.

I have read this form and have had all my questions answered and I agree to take part in the research project.

____

(Your name)

____

(Your signature)

____

(Date)

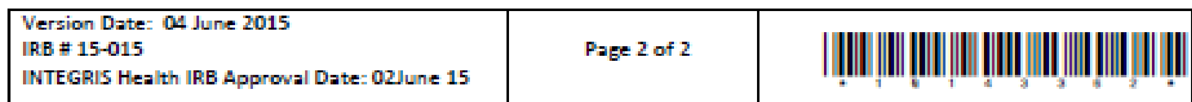
For researches use only:

Diagnosis: ____

Age: ____

Gender: ____

LOS: ____



VITA

Taylor Bryanne Cudd

Candidate for the Degree of

Master of Science

Thesis: THERAPEUTIC ALLIANCE AND MOTIVATION: THE ROLE OF THE RECREATIONAL THERAPIST AND YOUTH WITH BEHAVIORAL PROBLEMS.

Major Field: Leisure Studies

Biographical:

Education:

Completed the requirements for the Master of Science in Leisure Studies at Oklahoma State University, Stillwater, Oklahoma in December 2015.

Completed the requirements for the Bachelor of Science in Sports Management at Cameron University, Lawton, Oklahoma in May 2013.

Experience:

RT Internship at Comanche County Memorial Hospital, Lawton, OK.

RT Internship at Integris Mental Health Spencer, OK

RT Internship at Oklahoma City Veteran Affairs Medical Center, Oklahoma City, OK,

Professional Memberships:

Member of ATRA American Therapeutic Recreation Association

Member of TRAO Therapeutic Recreation Association Oklahoma

Rho Phi Lambda Honor Fraternity Oklahoma State University