

Young People’s Expectations, Preferences and Experiences of Seeking Help from a Youth Mental Health Service and the Effects on Clinical Outcome, Service Use and Future Help-Seeking Intentions

A dissertation by

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Abstract

Objective: Young people represent a vulnerable age group for mental health concerns and tend not to seek help. Client expectations and preferences related to roles, therapy processes and outcomes of therapy have been linked with engagement, help-seeking, and clinical outcomes for adults, however, very little is known regarding the effects of these factors on young people's help-seeking experience. This thesis by published works makes an original contribution to knowledge by comprehensively examining young people's expectations, preferences and actual experience of therapy and the effects of these factors on therapy outcomes and also addresses a number of methodological weaknesses in previous research. This thesis is comprised of five research papers: paper one aimed to qualitatively explore young people's pre-treatment expectations of therapy; papers two and three aimed to quantitatively examine relationships and differences between young people's expectations, preferences, and experience of therapy as well as age and gender effects; the fourth paper aimed to explore the effects of expectations, preferences and experience of therapy on clinical outcome, mental health service use, and future help-seeking intentions; and paper five aimed to examine the effects of disconfirmed expectations on these important outcome variables.

Method: The methodology involved a longitudinal multi-method design with qualitative, cross-sectional, and prospective components. Participants in the qualitative study included 20 young people aged 12-25 years who participated in a brief interview immediately prior to their initial assessment at a youth mental health care service, which was targeted at mild to moderate early presentations of mental health problems. Participants involved in the quantitative study included a total of 228 young people aged 12-25 years who completed an initial questionnaire on contact with the youth mental health care service, and of these, 102 who completed a follow-up questionnaire two months later.

Results: The most prominent theme that emerged from the qualitative study was that young people were unsure of what to expect from attending a mental health service. The quantitative study found that young people's preferences for therapy were very optimistic, whereas initial expectations and actual experience of therapy were significantly more pessimistic. Females were less likely to expect the therapist to like and accept them or expect the therapist to self-disclose when compared to males. Younger participants had lower preferences to be motivated, open, and personally responsible in therapy and were more likely to expect the therapist to be directive when compared to older adolescents and young adults. Young

people's actual experiences of therapy and their preference for personal commitment were positively associated with the outcome variables; however no significant associations were evident for initial expectations. Further, young people whose actual experience of therapy was more negative than their initial expectations related to the therapist's role and processes of therapy had a poorer clinical outcome and attended fewer sessions. Finally, young people who had a negative experience of their role as a client attended fewer sessions and those who had negative expectations and experience related to their outcome had a poorer clinical outcome.

Conclusions: Results indicate that young people require age appropriate education on what to expect from seeking help from mental health services and highlight a need for clinicians to help young consumers to have realistic expectations as well as a positive experience of therapy. Further, the client's level of personal commitment in the therapeutic relationship was strongly identified as a factor that needs to be promoted and maintained. It is important that clinicians work collaboratively with younger consumers, build a strong therapeutic alliance, and tailor psychological interventions to meet the clients' individual needs, desires and expectations as this will promote engagement and more positive clinical outcomes.

Key words: Client Expectations, Clinical Outcomes, Engagement, Preferences, Psychotherapy, Young People.

Submitted Manuscripts, Presentations, and Publications

This thesis by published works is comprised of five research papers. The first research paper is a qualitative study titled ‘Exploring Young People’s Expectations of a Youth Mental Health Care Service’ and presents the main themes that emerged from brief interviews which explored young people’s pre-treatment expectations for therapy. This paper has been peer-reviewed and published in the journal *Early Intervention in Psychiatry* in June 2012. A seminar presentation of these qualitative research findings was presented at the Australian Psychological Society Conference in Canberra, 2011.

The second research paper reports on the cross-sectional quantitative data set and is titled ‘What do Young People Seeking Professional Help Want and Expect from Therapy?’ and examines differences between expectations and preferences for therapy as well as age and gender differences. This paper has been peer-reviewed and published in the *World Academy of Science, Engineering, and Technology Journal* in June 2012. An oral presentation of this quantitative research was presented at the International Congress of Applied Psychology and Behavioural Sciences (ICAP-BS) in Paris, 2012.

The third quantitative research paper titled ‘Young People’s Expectations, Preferences, and Actual Experience of Youth Mental Health Care’ builds on paper three by examining the relationships and differences between expectations, preferences and actual experience of therapy and also explores age and gender effects. This paper has been peer-reviewed and published in the *International Journal of Adolescence and Youth* in April 2013.

The fourth quantitative research paper titled ‘Young People’s Expectations, Preferences and Experiences of Therapy: Effects on Clinical Outcome, Service Use and Help-Seeking Intentions’ examines the impact of expectations, preferences and actual

experience of therapy on the important outcome variables of engagement, clinical outcome and help-seeking. This paper has been peer-reviewed and accepted for publication in the journal *Clinical Psychologist* in November 2013 (Manuscript ID: CPAPS-2013-041).

The fifth quantitative research paper titled 'Disconfirmed Expectations of Therapy and Young People's Clinical Outcome, Help-Seeking Intentions, and Mental Health Service Use' examines the effects of expectancy confirmation and disconfirmation on clinical outcome, engagement and help-seeking intentions. This paper has been peer-reviewed and accepted for publication in the journal *Advances in Mental Health* in September 2013 (Manuscript ID: AMH4278).

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CHAPTER I

Introduction

Background

Young people aged 12 to 25 years represent a vulnerable age group for mental health concerns, with one in every four to five Australian young people diagnosed with a mental illness. Despite the high prevalence rates of mental illness, young people tend not to seek help from professional sources. It is crucially important that young people receive timely and appropriate mental health care, and given that young people represent a unique consumer group, youth-focused models for mental health care services have been developed and rolled out in an attempt to increase young peoples' likelihood of seeking professional help.

Two factors that have been identified as being influential to the help-seeking process are client expectations and preferences of therapy. Client's hold expectations and preferences related to their role as a client, the therapist's role, the processes of therapy, and the outcomes of therapy. These expectations and preferences have been linked with engagement in therapy, help-seeking intentions, and clinical outcomes for adult clients, however, very little is known about the effects of these factors on young people's experience of seeking professional help.

Moreover, discrepancies between a client's initial expectations for therapy compared to their actual experience of therapy have been associated with premature termination of therapy and poorer clinical outcomes for adult clients; however research has not yet examined the effects of disconfirmed expectations on outcomes for young consumers. Given that young people are a vulnerable population group for the burden of mental illness and also represent an age group that are reluctant to seek

help, exploring the effects of client expectations and preferences for therapy on young people's help-seeking experience is timely.

Significance

This thesis by published works makes an original contribution to knowledge by comprehensively examining young people's expectations, preferences and actual experience of therapy and the effects of these factors on clinical outcome, mental health service use, and help-seeking intentions, given that this is an area that has not been explored previously.

The thesis also addresses a number of methodological weaknesses in previous research by: exploring all four expectancy domains simultaneously using a reliable and validated measure of client expectations and measuring expectations prior to therapy commencing; directly comparing initial expectations, preferences and actual experience of therapy; and examining all four possible expectancy confirmation groups across the four expectancy domains on clinical outcome, mental health service use, and help-seeking intentions.

Aims

This thesis is comprised of five research papers and involved a longitudinal multi-method design with qualitative, cross-sectional, and prospective components. Paper one aimed to qualitatively explore young people's pre-treatment expectations of therapy related to their role, the therapist's role, the processes of therapy, and their expected outcomes.

Papers two and three aimed to quantitatively examine the relationships and differences between young people's expectations, preferences, and actual experience

of therapy as well as explore age and gender effects. The fourth paper aimed to explore the effects of expectations, preferences and actual experience of therapy on young people's clinical outcome, mental health service use, and future help-seeking intentions. Finally, paper five aimed to examine the effects of disconfirmed expectations in relation to roles, outcomes, and processes of therapy on these important outcome variables.

Thesis Outline

The second chapter of this thesis presents a review of the literature and firstly explores the research on young people's mental health, the developmental challenges facing young people, youth mental health care services, and highlights the common barriers and facilitators to help-seeking for this age group. The review then presents the previous research on client expectations for therapy related to roles, therapy processes, and outcomes, and explores the research findings from adult, youth, as well as children and parent population samples across the four expectancy domains. Subsequently, a presentation of the research on disconfirmed expectations and the literature on client preferences for therapy is explored. The literature review then notes the limitations of prior research, and will highlight the original contribution of this thesis and will conclude with a statement of the research aims of this thesis.

This thesis comprised a longitudinal multi-method design with qualitative, cross-sectional, and longitudinal components, and chapter three presents an overview and justification for the methodology utilised. Chapter three first summarises the methodology used for the qualitative component and then presents the cross-sectional and longitudinal quantitative component.

Following the methodology chapter, the five research papers that comprise this thesis by published works are presented. Specifically, chapter four presents the first qualitative paper titled ‘Exploring Young People’s Expectations of a Youth Mental Health Care Service’. The fifth chapter presents the second cross-sectional quantitative paper titled ‘What do Young People Seeking Professional Help Want and Expect from Therapy?’ Chapter six presents the third quantitative paper titled ‘Young People’s Expectations, Preferences, and Actual Experience of Youth Mental Health Care’. The seventh chapter comprises the fourth paper titled ‘Young People’s Expectations, Preferences and Experiences of Therapy: Effects on Clinical Outcome, Service Use and Help-Seeking Intentions’. Finally, chapter eight presents the fifth research paper titled ‘Disconfirmed Expectations of Therapy and Young People’s Clinical Outcome, Help-Seeking Intentions, and Mental Health Service Use’.

To conclude the thesis, chapter nine presents the discussion, beginning with a summary of the research findings. The discussion chapter then considers the clinical implications and recommendations resulting from the research findings, namely: the need for further education on client expectations for youth; promoting a positive therapy experience for young people; fostering and monitoring young consumers’ motivation and commitment to therapy; building strong therapeutic alliance; providing flexible psychological intervention; relieving psychological distress early; and lastly, the importance of youth-focused models of care. The discussion then presents the strengths and limitations of this thesis, offers suggestions for future research, and finally closes with a summary and conclusions section.

CHAPTER II

Literature Review

Young People's Mental Health

Adolescence and young adulthood represent a critical age period for both the onset of mental illness and the potential for early intervention to take place (Kessler et al., 2007; McGorry, Parker, & Purcell, 2007; Slade et al., 2009). The terms 'adolescence' and 'young people' have been defined in numerous ways, however more recently, together are understood to concern the ages from 12 to 25 years, as this covers the complete age range between childhood and early adulthood (McGorry, Parker, Purcell, 2006).

The transition through adolescence and young adulthood is a critical developmental period comprising major change in all developmental domains including psychological, social, cognitive, and on-going biological changes (Kessler et al.; McGorry, Purcell, Hickie, & Jorm, 2007; Slade et al., 2009). Across the lifespan, mental health problems represent the most significant burden of disease for young people, with anxiety, depression, and problematic substance use being most prevalent at this time (Kessler et al., 2007).

The vast majority of mental health problems have their onset before the age of 25, with approximately half of all lifetime mental disorders developing by the time individuals reach their mid-teens and three-fourths by their mid-20s (Kessler et al., 2007). One in every four to five young people could be diagnosed with a mental illness in a 12 month period (Slade et al., 2009), with one in every five adolescents experiencing a depressive episode by the age of 18 years (Lewinsohn, 1993), one in

every ten young people aged 18 to 24 years affected by an anxiety disorder (Australian Institute of Health and Wellbeing [AIHW], 2007), and 12.7 per cent of people aged 16 to 24 estimated to have a substance use disorder (Australian Bureau of Statistics [ABS], 2007).

The burden of mental illness is the greatest during the early years following illness onset, and the symptoms of mental illness can significantly impact on a young person's development and include social, emotional, and cognitive impairments that can persist into adulthood (Kessler et al., 2007). These impairments can negatively affect a young person's quality of life and can lead to academic underachievement, social exclusion, as well as high levels of psychological distress (Patel, Flisher, Hetrick, & McGorry, 2007).

Major mental disorders during adolescence and young adulthood can also have significant long-term effects, and can be disruptive to identity formation and the development of adult roles later in life (Raphael, 1986). Furthermore, there are high rates of self-harm, co-morbidity with other disorders, and suicide is a leading cause of death for adolescents and young adults (ABS, 2008; Catania, Hetrick, Newman, & Purcell, 2011; Kessler et al., 2007). Devastatingly, suicide accounts for 17.8 per cent of deaths in the 15 to 19 year age group and nearly a quarter of all deaths in the 20 to 24 year age group (ABS, 2008).

Early Intervention and Improved Outcomes

There is growing evidence to support the significance of mental health promotion, that is, initiatives aimed at promoting greater community understanding that mental illnesses are treatable, as this increased awareness encourages early entry to care, improved clinical outcomes, and can lessen the stigma and discrimination

related to mental illness. Moreover, early recognition of mental illness coupled with early and effective treatment can make a significant difference to outcomes for people with depression, anxiety and psychotic disorders (Herrman, 2001).

Given the substantial burden of disease associated with untreated mental illness, it is crucial that young people receive early and effective treatment. 'Early intervention' refers to interventions targeting people displaying the early signs and symptoms of a mental health problem or mental disorder and people developing or experiencing a first episode of mental disorder (Commonwealth Department of Health and Aged Care, 2000). There is growing evidence to support the significance of early intervention, in particular for adolescents and young adults, as early intervention is fundamental to reducing the burden of disease and preventing the progression of illness (Herrman, 2001; Hodges, O'Brien, & McGorry, 2007; Slade et al., 2009).

An important element of effective intervention is to engage consumers in treatment. 'Engagement in therapy' has been defined as consumers, as well as their families in the case of younger consumers, attending a minimal number of sessions, a certain number of hours of therapy or the proportion of appointments scheduled versus the number kept, as well as contributing to therapy sessions and building therapeutic alliance (McKay, Stoewe, McCadam, & Gonzales, 1998; Perrino, Coatsworth, Briones, Pantin, & Szapocznik, 2001; Tetley, Jinks, Huband, & Howells, 2011). Therapy engagement is fundamental to the success of treatment, yet, it is often a challenge to engage young people in psychological interventions, given that most models of treatment are developed for adults and may not be developmentally appropriate or translate well to engaging young people in therapy (Oetzel & Scherer, 2003).

A key factor in promoting engagement in therapy is the significance of building a strong therapeutic alliance between client and therapist. ‘Therapeutic alliance’ refers to the quality and strength of the collaborative relationship between client and therapist in therapy, as well as agreement between client and therapist on the goals of therapy, level of commitment, and how to achieve these goals (Horvath & Bedi, 2002).

Engagement in therapy and strong therapeutic alliance are crucial to enhancing the success of therapy and achieving clinical improvement for the client. The term ‘clinical improvement’ is defined as progressive improvement of subjectively experienced well-being, reduction in symptomology, and enhancement of life functioning (Howard, Lueger, Maling, & Martinovich, 1993). The ultimate goal of early and effective intervention is to engage consumers in treatment, to improve clinical outcomes and to reduce the burden of disease associated with mental illness.

Young Peoples’ Help-Seeking

Regrettably, despite the high prevalence rates of mental illness, the significant burden of disease for adolescents and young adults, as well as the established importance of early intervention, young people affected by mental illness tend not to seek help from professional sources (Barney, Griffiths, Jorm, & Christensen, 2005; Kessler et al., 2007).

The term ‘help-seeking’ is used to refer to the behaviour of actively seeking help from other people and involves communicating to others a need to gain help in terms of understanding, support, information, and/or treatment. Individuals can seek help from a variety of sources, with informal help-seeking sources including friends and family, and formal help-seeking sources including health professionals, teachers,

youth workers, and general practitioners (Rickwood, Deane, Wilson, & Ciarrochi, 2005).

Many young people have a preference to seek help from informal sources such as close friends and family rather than from formal help-seeking sources, with up to 90 per cent of adolescents confiding in their peers rather than a professional (Offer, Howard, Schonert, & Ostrov, 1991; Kalfat & Elias, 1995). Current research has revealed that the majority of young people indicate that they would prefer to seek help from their peers or from no-one rather than to seek help from adults or from health professionals for concerns related to mental illness and psychological distress (Rickwood et al., 2005).

For example, one large study with young people aged 16 to 24 years indicated that while only 10 per cent presented to their GP for psychological complaints, a quarter of the young people perceived they had a mental illness, suggesting that a number of young people may be aware of their mental health problems but may not be willing to seek related health care assistance (Haller, Sancu, Patton, & Sawyer, 2007).

The gap between prevalence of mental illness and service use is the highest in late adolescence and young adulthood (ABS, 2007), with young men more reluctant to seek professional help than young women (Rickwood, Deane, & Wilson, 2007). It is concerning that of those young people with a diagnosable mental disorder only 13.2 per cent of males and 31.2 per cent of females had made contact with a professional service in a 12-month period, from national survey figures (Slade et al., 2009). Further analyses from the 2007 Australian National Survey of Mental Health and Wellbeing (NSMHWB) showed that among young people aged between 16 and 24,

only 32 per cent of those with anxiety disorders, 49 per cent of those with affective disorders, and 11 per cent of those with substance use disorders had sought professional help in the previous 12 months.

Barriers and Facilitators of Help-Seeking

It is highly concerning that the vast majority of young people with a mental illness either delay or fail to get help from professional sources, given that early intervention is fundamental to reducing the burden of disease and preventing the trajectory of illness (Hodges et al., 2007; Slade et al., 2009). This raises the question as to why so many young people in need of help do not receive the support and psychological interventions that they require. It has been proposed that many young people resist seeking help from professional services because they face a number of barriers in the help-seeking process. In this process an individual must initially identify a need to seek help, decide to seek help, and then carry out that decision to seek help. However, at each point of the process, factors may interfere and act as a barrier and prevent the progression (Rickwood et al., 2005). A recent systematic review by Gulliver, Griffiths, and Christensen (2010) of both the qualitative and quantitative literature summarised the key perceived barriers and facilitators of help seeking in young people aged 12 to 25 years.

Help-seeking barriers. A number of barriers to seeking professional help have been identified as being particularly pertinent for young people. Firstly, the Gulliver and colleagues' (2010) review identified a major barrier for young people seeking help as the perceived stigma, shame, and embarrassment of mental illness and mental health service use. Many young people have significant fears of others finding out that they have mental health difficulties and worry about what others will think of them if they were to seek help.

Young people also commonly hold concerns related to trust and the confidentiality of professional services. These concerns are likely related to fears of stigma, with young people concerned that breaches of confidentiality may lead to others finding out that they had sought help (Gulliver et al., 2010; Hallett, Murray, & Punch, 2000; Rickwood et al., 2005). An Australian study of high school students aged 12 to 21 years revealed that perceived fear of stigma and breaches of confidentiality were identified as important barriers to professional help-seeking intentions for suicidal and non-suicidal problems, with higher barriers related to lower help-seeking intentions (Wilson, Rickwood, Ciarrochi, & Deane, 2002).

Low levels of emotional competence were also identified as a significant help-seeking barrier in the Gulliver and colleagues' review. When young people are low in emotional competence, they struggle with understanding and managing their emotions, have problems recognising symptoms, and feel less capable and have fewer skills to effectively seek help than those with greater emotional competence (Rickwood et al., 2005). A large mixed-method Australian study with young people aged 14 to 24 years found that many young people do not feel they have the skills to confidently express their emotions to others; in particular, low emotional competence was identified as a significant challenge for young men and boys (Rickwood et al., 2005). Furthermore, results found that young people low in emotional competence with difficulties identifying the symptoms of mental illness, with a lack of knowledge of available service options, and who were unwilling or who had difficulties expressing their emotions were far less likely to seek help for mental health difficulties (Rickwood et al., 2005). Another recent study by Reavley and Jorm (2011) assessed young people's understanding, recognition and beliefs about treatment for depression, anxiety disorders, and psychosis. This research showed that young people

had good recognition of depression, with 75 per cent of young people correctly recognising and labelling depression. However, it was noted that young people's mental health knowledge could be improved, in particular around recognition and treatment beliefs for all the mental disorders, given that only one third correctly identified psychosis/schizophrenia and post-traumatic stress disorder, and only three per cent accurately recognised social phobia. Of note, the young people were most likely to nominate seeking help from family members for the range of disorders, and help-seeking intentions were the lowest for social phobia.

Another key help-seeking barrier identified in the Gulliver and colleagues' review was difficulties with the accessibility of mental health services. For many young people, their access to mental health services is often reliant on other people, such as family, which can either impede or facilitate their access to services. Common difficulties and barriers that young people face related to the accessibility of professional services include: transport, distance to services, cost, long wait lists, inflexible opening hours, and time. Challenges with easy accessibility of mental health care services can be a particularly pertinent barrier for young people in rural regions, with services often more difficult to access than services in metropolitan areas (Gulliver et al., 2010; Rothi, 2006).

The review further showed that young people are less likely to seek help from professional sources because many young people have a preference for self-reliance and informal supports, or simply do not want help (Gulliver et al., 2010). This was demonstrated in a recent study by Reavley, Yap, Wright, and Jorm (2011) which examined help-seeking behaviours taken by Australian young people aged 12 to 25 years to deal with mental disorders. Results showed that young people with mental health problems were more likely to seek help from informal sources, such as close

friends and family (up to 77%), and to use self-help interventions than to access professional help from a psychologist (21%), although, over 50 per cent of survey respondents with a self-identified problem had visited a general practitioner.

In addition, research has demonstrated that suicidal thoughts have a significant negating effect on help-seeking behaviour, with results indicating that as young people's suicidal ideation increases their intentions to seek help from both informal and formal sources decreases (Rickwood et al., 2007; Rickwood et al., 2005).

Finally, the review identified that negative attitudes towards help-seeking in general, the belief that therapy will not help, and being unsure or misinformed about what therapy will involve represent important help-seeking barriers. Research has revealed that negative attitudes and beliefs about seeking help from professional sources, and the belief that seeking help will not be useful have been associated with lower help-seeking intentions and behaviours for young people (Gulliver et al., 2010; Rickwood et al., 2007; Wilson, Deane, & Ciarrochi, 2005). Moreover, results of the 1999 NSMHWB showed that the belief that seeking help would not be useful was a highly reported help-seeking barrier among young people (Andrews, Henderson, & Hall, 2001). Related to this, the adult literature has established that client expectations and preferences for mental health care are significant factors influencing the help-seeking process, engagement in therapy as well as clinical outcomes; typically finding pessimistic expectations and denied access to preferred treatments to be associated with lower help-seeking intentions, poorer engagement in therapy and decreased clinical improvement (Dew & Bickman, 2005; Glass, Arnkoff, & Shapiro, 2001; Joyce, Ogrodniczuk, Piper, & McCallum, 2003; Swift & Callahan, 2009; Thompson & Sunol 1995; Vogel, Wester, Wei, & Boysen, 2005).

Help-seeking facilitators. Conversely, there are also a number of factors that help to facilitate the help-seeking process; however, facilitators have been less well researched than barriers (Gulliver et al., 2010). A number of key facilitator themes were identified in the Gulliver and colleagues' review. Young people were found to be more inclined to seek help for mental health problems when they and their parents are able to identify and recognise that they have a mental health problem and when they know how and where to access help. Mental health literacy, which has been defined as 'knowledge and beliefs about mental disorders which aid in their recognition, management or prevention', has been associated with increased help-seeking behaviours (Jorm et al., 1997, p. 182). Having an awareness of the potential services and supports that are available, and perceiving the problem as serious are associated with greater help-seeking actions. Moreover, when young people are emotionally competent, that is, when they are able to identify, describe and manage their emotions in an effective manner, they are more inclined to seek help (Gulliver et al., 2010; Rickwood et al., 2005). Of significance, many young people rely on adults including their parents, teachers, or their family doctor to recognise their mental health problems and to initiate the help-seeking process, and as such, these key adults' level of mental health literacy and emotional competence also plays a significant role in the young person's help-seeking experience (Rickwood et al., 2005; Sayal, 2006).

The review further highlighted that young people are more likely to seek help from established, known and trusted sources. It is crucial that young people believe their personal disclosures will be treated with privacy and confidentiality from the potential source of help, as this helps to facilitate help-seeking behaviours (Gulliver et al., 2010). As such, young people tend to seek help from their peers, parents, or familiar adults such as teachers or family doctor rather than confide in health

professionals who they have not met before and have not yet formed a trusted relationship (Rickwood et al., 2005).

Another facilitator of help-seeking for young people is positive past experiences with help-seeking, with those who have had favourable past help-seeking experiences or who have previously been helped by a professional more likely to seek help again in the future. These positive experiences promote a greater understanding of the processes of professional help seeking and therefore may also contribute to increased mental health literacy (Gulliver et al., 2010; Rickwood et al., 2005).

Furthermore, when young people are provided with social support and encouragement from others they are more inclined to seek help for mental health issues (Gulliver et al., 2010; Rickwood et al., 2005). One qualitative study of young people aged 17 to 24 years who were accessing help from a youth mental health care service, identified that when their family members encouraged them and initiated the help-seeking process, it was easier for them to seek professional help (Medlow, Kelk, Cohen, & Hickie, 2010).

Finally, it is vital that professional sources such as mental health care services are youth-friendly, assessable, and affordable as this too promotes and facilitates help-seeking for young people (Hodges et al., 2007; McCann & Lubman, 2012; Medlow et al., 2010).

Youth Mental Health Services

Youth-focused models of care are an important facilitator of help-seeking, as it has been proposed that adult mental health service models are often perceived by young people to be less assessable and more stigmatising than youth-friendly models of care (Hodges et al., 2007; Tylee, Haller, Graham, Churchill, & Sanci, 2007).

Moreover, many young people are highly reluctant to seek help from primary care

services and often do not have easy access to such services (Hodges et al., 2007). For those few young people who do seek help from professional services, many fail to receive evidence-based psychological interventions (Andrews, Sanderson, Corry, & Lapsley, 2000). Consequently, it became apparent that there was a significant need to implement youth-friendly, community-based services across Australia to facilitate help seeking among young people.

In response to this, the Australian Government established a youth mental health service initiative, headspace, the National Youth Mental Health Foundation. Over 55 headspace sites have been rolled out across metropolitan, regional and remote areas of the country, with the target of scaling up to 90 sites by 2015 (Rickwood, Van Dyke, & Telford, 2013). headspace aims to promote and facilitate improvements in the mental health, social well-being and economic participation of young Australians aged 12 to 25 years. The objective is to intervene early in the development of mental health problems, as early intervention at the onset of disorder aims to prevent the progression of illness and reduce the damage to social, psychological, educational and vocational functioning (Hodges et al., 2007; Muir et al., 2009). headspace services are unique in that they were developed to increase young people's access to mental health services and to reduce the burden associated with mild to moderate mental health and substance use issues. The service offers consumers evidence-based interventions, access to physical and mental health assessment and treatment, as well as providing a multidisciplinary approach comprising, for example, general practitioners, psychiatrists, and nursing and allied health clinicians (Hodges et al., 2007; Muir et al., 2009).

Youth-focused initiatives such as headspace have been developed to promote help-seeking intentions and behaviours as well as positive experiences of mental

health service use for young people. These initiatives are imperative, given that young people have been identified as a unique and vulnerable age group in terms of mental illness and are reluctant to seek help. In consideration of this, it is essential to explore the key factors that affect young people's help-seeking experience. As previously noted, prior research with adults has demonstrated that client expectations and preferences for mental health services have a significant influence on decisions to seek help, engagement in therapy, and clinical outcomes (Dew & Bickman, 2005; Swift & Callahan, 2009). However, very little is known regarding young people's expectations and preferences for therapy and the possible effects of these factors on their help-seeking experience, and as such, this represents an area that warrants further investigation.

Client Expectations

Clients' expectations and beliefs about therapy have been identified as significant factors affecting the help-seeking process (Dew & Bickman, 2005). When an individual begins the process of seeking professional help, they commence with a set of expectations related to what they anticipate their experience of therapy may entail. There are four main domains of client expectations, as clients hold expectations related to their role as a client, the therapist's role, the processes of therapy, and the outcomes they will achieve (Dew & Bickman, 2005; Glass et al., 2001; Thompson & Sunol, 1995). Client expectations are classed as a pre-treatment psychological characteristic, as they are something a client brings with them on initial contact with a mental health service. These expectations can be positive, ambivalent, or negative (Dew & Bickman, 2005; Glass et al., 2001).

Over the past 50 years, there has been extensive research interest in examining client expectations and how these influence clients' help-seeking experience and

therapeutic encounter (e.g. Frank, 1958; Goldstein & Shipman, 1961). One argument for the relevance of studying client expectations is that expectations are adaptable and therefore can be targeted for interventions aimed at promoting more optimistic and accurate expectations (Dew & Bickman, 2005). Moreover, there is considerable interest in gaining a greater understanding as to how an individual's expectations influence their subsequent behaviour regarding engagement in treatment (Thompson & Sunol, 1995).

According to social learning theory, behaviour is explained by individuals having subjective expectations of the probability that a given behaviour will lead to a particular outcome (Bandura, 1977). Within this framework, expectations are theorised to be influenced by our past life experiences, such that the more often a behaviour has led to a certain outcome in the past, the stronger the person's expectancy that the behaviour will achieve that outcome again in the future. With respect to client expectations, a simple view is that optimistic expectations regarding therapy or help-seeking represent an important component of motivation to actually seek help or engage in therapy, while pessimistic expectations are likely to lead to an avoidance of these help-seeking behaviours (Bandura, 1977). Client expectations have been found to have an effect on a client's help-seeking intentions and behaviours, and may not only affect the help-seeking process initially, but also on a more on-going basis throughout the therapy process. Initially, these expectations can influence a client's decision to seek help, and following this, should they decide to seek help, they can influence participation in treatment as well as on their therapeutic outcomes (Dew & Bickman, 2005; Glass et al., 2001).

It has been proposed that individuals' expectations regarding therapy and help-seeking are likely to be inherently different across the lifespan (Dew & Bickman,

2005; Nock & Kazdin, 2001). Young people represent a unique age group in terms of help-seeking intentions and behaviours and, unlike adults who are significantly more likely to voluntarily seek professional help, young people are far less likely to independently seek help and are more likely to be encouraged by their family and friends to do so (Gulliver et al., 2010; Medlow et al., 2010). As such, many young people may find themselves in therapy despite not having formed clearly defined expectations or necessarily even wanting to engage in therapy. Likewise, therapy expectations differ again for children, who are even less likely to have well-defined expectations for therapy. As such, parents' expectations are significant, given that typically it is the parent who will initiate and promote the continuation of therapy for their child.

It is therefore likely that young people's expectations around mental health services are quite different from those of adults and children, and this may be an important factor influencing their engagement with services. Previously conducted studies exploring client expectations of mental health services have almost exclusively focused on adult clients. Few studies have examined children's expectations, where parent or caregivers' expectations are also relevant. Very few studies have explored young people's expectations of therapy, and this represents a major gap in the expectations literature. With the recent emphasis on the critical importance of adolescence and early adulthood for mental health care, it is timely that young people's expectations for therapy be investigated. Given that client's expectations regarding therapy differ across the lifespan, a review of the previous research on each expectation domain related to roles, therapy processes and outcomes for adults, young people, as well as children and their caregivers will subsequently be presented.

Role Expectations

Role expectations are defined as patterns of behaviour viewed as appropriate or expected of a person who occupies a particular position and refer to a client's expectations concerning their role as a client as well as their expectations around the therapist's role (Arnkoff, Glass, & Shapiro, 2002; Delsignore & Schnyder, 2007). A client's expectations regarding their role include how they expect to behave during counselling and how personally motivated or involved they expect to be in the therapeutic process. Expectations related to the therapist's role include how experienced, skilled, trustworthy, or empathetic the client expects the therapist to be (Arnkoff et al., 2002; Delsignore & Schnyder, 2007).

Adults' role expectations. Specifically related to the therapist's role, prior research has indicated that adult clients do not necessarily commence the help-seeking process with clear expectations in relation to the therapist's role. To demonstrate this, a study by Douglas, Noble, and Newman (1999) examined pre-treatment role expectations with a group of 19 adults prior to their first outpatient psychiatric appointment. Results indicated that many clients were confused about the psychiatrist's role and were unsure whether psychiatrists are medically qualified and were unclear about the difference between psychiatrists and psychologists.

With respect to the client's role, research has examined adult clients' expectations related to their own role in therapy, and the effects of these expectations on clinical outcomes. For instance, a study by Timmer, Bleichhardt, and Rief (2006) demonstrated that adult clients who begin therapy with high levels of personal motivation, openness to psychotherapy, and who expect to take on the role of an active member in the therapeutic encounter are significantly more likely to see long-term improvements in symptoms and psychological complaints than those with less

favourable expectations towards their role in therapy. Similarly, other research has found that clients with a preference for psychotherapy treatment and who expected to be actively involved in the therapy process saw greater clinical improvements and benefits from therapy than clients who related more to a medical model and who expected to be more passive (Schneider, Klauer, Janssen, & Tetzlaff, 1999).

Prior research has also investigated adult clients' expectations related to their own role as well as the therapist's role in regards to commitment and responsibility in therapy. For instance, a study of 203 adult clients seeking help from a university-based psychology clinic found that clients high in pre-contemplation (i.e., clients who were not ready for therapy nor intending to take action in the foreseeable future) had the lowest levels of personal commitment and the highest levels of expectations for what the counsellor would do in therapy when compared to clients with high levels of the three other stages of change (i.e. contemplation, preparation, or action) who were more willing to take action and personal responsibility in treatment (Robitschek & Hershberger, 2005).

Clients' expectations related to roles have also been found to have a significant effect on therapeutic alliance, with prior research showing that optimistic client role expectations tend to be associated with greater client-rated therapeutic alliance (Al-Darmaki & Kivilghan, 1993; Patterson, Uhlin, & Anderson, 2008). A US study by Patterson and colleagues (2008) investigated the relationship between pre-treatment role expectations and client-rated therapeutic alliance after three outpatient clinic therapy sessions with a cohort of 57 adult clients. Client role expectations accounted for 31 per cent of the variance in working alliance and 30 per cent of the variance in the clients' perceived bond with the therapist. Further, client's

expectations regarding their own personal commitment to therapy played a vital role in the development of alliance in treatment.

Similarly, other research by Al-Darmaki and Kivlighan (1993) examined role expectations for adult clients after three therapy sessions and found that client's expectations related to the therapeutic relationship were positively related to the client's working alliance rating. Furthermore, when clients and counsellors agreed on the expected level of client spontaneous self-disclosure, counsellors perceived more bond and agreement on therapeutic goals.

Related to this, a research review based on adult research studies indicated that incongruent role expectations between client and therapist can be harmful to the therapeutic relationship, while congruent role expectations can contribute to a stronger therapeutic bond and improved outcomes (Glass et al., 2001). This was demonstrated in a study by Joyce, McCallum, Piper, and Ogrodniczuk (2000) which found that when the client and therapist both had similar expectations in relation to the therapist's level of supportiveness in therapy, there was greater therapeutic alliance. Another qualitative study with 19 adult clients found that clients who experienced pleasant surprises related to the therapist's role in terms of the therapist being more collaborative and non-judgemental than initially expected had better clinical outcomes than those who were unpleasantly surprised (Westra, Aviram, Barnes, & Angus, 2010).

Adult clients' pre-treatment role expectations have also been linked with engagement in therapy and premature termination of treatment (Aubuchon-Endsley & Callahan, 2009; Dew & Bickman, 2005; Reis & Brown, 1999). For instance, pre-treatment role expectations were found to be an excellent measure of prospectively identifying clients who may be at risk for early termination of treatment in a training

clinic setting, with results showing that clients who obtained a score outside of the normative range on their role expectations were seven times more likely to prematurely terminate therapy (Aubuchon-Endsley & Callahan).

Young people's role expectations. To date, research exploring young people's role expectations is extremely limited. One qualitative study by Bury, Raval, and Lyon (2007) based in the United Kingdom explored the expectations and experiences of 36 young people aged 16 to 21 years undergoing individual psychoanalytic psychotherapy. The study highlighted that young people's hopes, aims, and expectations for therapy shaped and influenced their experience of seeking help. Results found that commencing the therapy process was identified as an anxiety provoking time for young people and feelings of ambivalence as well as fears of stigma were commonly expressed. The young people also expressed highly optimistic expectations of therapy, in particular that the therapist might hold all the answers. Many of the young people reported expecting to have to learn what was required of them as a client. In the beginning phases of therapy, the young people noted the significance of building a relationship with the therapist, and while some young people found this process easy and felt comfortable with the therapist, several young people expressed finding it difficult to relax and open up. Many young people felt a sense of power imbalance between themselves and the therapist, often feeling powerless and unable to challenge the therapist or to make decisions about their treatment. Moreover, many of the young people expected that the therapist would be the most important factor in facilitating the therapeutic process.

Furthermore, two studies have investigated the effects of young people's role expectations on service satisfaction. A Swedish study by Schedin (2005) compared the expected and perceived experience of the interpersonal behaviour between client

and counsellor, with 15 career counsellors and 15 students with a mean age of 18 years serving as the participants. Clients' positive expectations related to their own role in therapy in terms of autonomy and interpersonal behaviour were associated with feeling more secure after the session. Furthermore, the clients' perceived experiences of the counsellors' behaviour, in terms of understanding and helpfulness explained 40 per cent of the variance in the clients' satisfaction with the session.

A US study conducted by Garland, Aarons, Saltzman, and Kruse (2000) explored the relationship between young people's client role expectations and satisfaction of mental health services. The study surveyed 180 youth who were receiving help from out-patient mental health services. Results found significant positive correlations between young people's perceived level of personal choice and motivation for being in treatment and their total satisfaction with the mental health service.

Children and caregivers' role expectations. Prior research examining children and their caregiver's role expectations also remains a neglected area. Two studies identified that parents of children engaging in therapy held rather pessimistic expectations regarding the therapist's role in treatment. Firstly, a US study by Richardson (2001) examined parents' expectations about seeking and obtaining mental health care with a cohort of 235 parents with children between the ages of 5 and 19. Results revealed that the parents held a number of negative expectations about mental health help-seeking, in particular around the therapist's role. For instance, almost half of the parents expected the trustworthiness of the therapist to be questionable, and 41 per cent of the parents reported they would wonder whether or not they could trust mental health professionals. A number of parents also expected mental health professionals to be disrespectful (14.8%) and unfriendly (13.5%) to

their child. Interestingly, one-third of the parents reported a lack of knowledge about the role of the mental health professional. In regards to the parents' expectations regarding their child's role, almost half of the parents anticipated that their child would not want to see a mental health professional and 14.2 per cent expected that getting their child to actually see a mental health professional would be a problem.

Secondly, another US study by Garcia and Weisz (2002) quantitatively examined the expectations of 344 parents, with children aged 7 to 18 years, in relation to their child's engagement in therapy. Results indicated that parents who expected the therapist to lack involvement and investment in their child and who believed that the therapist was not competent or effective were at greatest risk of prematurely dropping out of therapy. The most commonly reflected concerns reported by the parents were related to the therapist's role and included that the therapist did not seem to be: doing the right things, talking about the right problems, talking enough with family members, helping the child, understanding or explaining the child's treatment clearly to the parents, or that the child or parent simply did not like the therapist.

However, a study by Bonner and Everett (1982) which explored client role expectations with a non-clinical sample of 72 children aged 6 to 12 years serving as participants yielded contrary results. This study showed that the children held optimistic expectations regarding the therapist, with most of the children expecting to be highly receptive and attracted to a psychotherapist and had a high desire to work with the therapist again in the future.

Finally, one study examined children's expectations related to their own level of personal control in therapy and how this influences their clinical outcomes. This study by Weisz (1986) explored the effects of role expectations in terms of the client's perceived level of control in therapy, on clinical outcomes with a cohort of 78

children and adolescents aged 8 to 17 years engaging in psychotherapy. The results indicated that children who believed that they had higher control in regards to solving their problems saw greater problem reduction and greater problem solving in therapy than those who believed their problems were uncontrollable.

Expectations of Therapy Processes

Expectations around the processes of therapy represent the least examined domain amongst the client expectations literature. This domain refers to what clients expect will happen during the therapeutic encounter, their anticipations about the type of therapy or interventions they will receive, treatment duration, and what psychological techniques will be used (Greenberg, Constantino, & Bruce, 2006). A client's expectations around psychotherapy procedures have been found to be significantly influenced by the mass media, and while psychotherapy has tended to move away from traditional psychoanalysis, the media still portrays psychological techniques in a typical psychoanalytic framework. The images portrayed in the mass media may limit a clients' perceptions and expectations around what therapy may be like for them and if it will be beneficial for them (Orchowski, Spickard, & McNamara, 2006).

Adults' expectations of therapy processes. Previous research utilising adult population samples has indicated that clients tend to commence the help-seeking process expecting a range of treatments to be effective, but are more likely to expect psychological or combined interventions to be more helpful than medication alone (Noble, Douglas, & Newman, 2001). More specifically, a randomised control study of 49 adult clients diagnosed with obsessive compulsive disorder found that clients were significantly more likely to hold the expectation that psychological interventions will be more helpful than drug treatments (Lax, Basoglu, & Marks, 1992).

Likewise, a study of adult clients seeking help from an outpatient university clinic for symptoms of depression found that the majority of clients (62%) held the initial expectation that a combined intervention approach of both psychological and medical treatments would be more effective than medication (8%) or talk therapy (24%) alone (Rapaport, Zisook, Frevert, Seymour, Kelsoe, & Judd, 1996).

Research has also indicated that adult clients do not necessarily commence the help-seeking process with clearly defined, optimistic, or accurate expectations related to the processes of treatment. For instance, an early study by Michaels and Sevitt (1978) examined the hopes, fears, and expectations of 30 new psychiatric outpatients prior to their first psychiatric consultation. Only half of the clients expected the psychiatrist would be able to help them, with half of these clients unsure how exactly this would occur. Moreover, half of the clients wanted some form of talk therapy with only one client wanting medication. Following the initial consultation, 52 per cent of the clients reported that they did not find it helpful talking to the psychiatrist and 20 per cent felt they were not understood.

Similarly, a study by Douglas, Noble, and Newman (1999) examined pre-treatment expectations with a group of 19 adults prior to their first outpatient psychiatric appointment. Results indicated that many clients were confused about the processes and structure of treatment, with clients commonly expecting a short interview of 15 to 30 minutes and did not expect to be questioned about their background, relationships or past medical history. Furthermore, most clients expected treatment was talking therapy, rather than medication, and expressed concerns about confidentiality and the stigma of mental illness.

Other research has explored the effects of clients' expectations of therapy processes on their help-seeking intentions and behaviours. One study by Deane and

Chamberlain (1994) indicated that fears around the processes of treatment were predictive of clients' likelihood of seeking professional psychological help. Specifically, results showed that greater expectations of being stigmatised or being pressured to think, do, or say things related to their problem in a new way during treatment were significant predictors of avoiding help-seeking from professional sources.

Related to the processes of therapy, prior research with adults has examined clients' expectations regarding treatment duration and the associations between expected and actual session attendance. One study found that both client and therapist expectations for the number of sessions to be attended predicted the actual number of sessions attended, with client expectations being the stronger predictor (Mueller & Pekarik, 2000). Other research by Owen, Smith, and Rodolfa (2009) explored clients' expected number of sessions over a year at a university counselling centre. The participants included 478 clients aged 17 to 50 years who were attending individual therapy sessions at the university counselling centre. Results revealed that 62 per cent of the clients expected and also wanted to attend more than 20 sessions if there were unlimited resources.

Young people's expectations of therapy processes. Previous research on young people's expectations related to the processes and structure of therapy is limited. One qualitative study explored the experiences and expectations of 36 young people aged 16 to 21 years undergoing individual psychoanalytic psychotherapy (Bury et al., 2007). The study revealed that in terms of expectations related to the processes of therapy, young people had very little knowledge of mental health issues or mental health services prior to seeking help and their expectations were greatly influenced by images portrayed in the mass media. Many of the young people

reported expecting to need to learn the rules of therapy and to build a greater understanding of what the therapeutic process entails. During the process of therapy, young people described the experience of therapy as physically and emotionally exhausting (Bury et al., 2007).

Other research has examined the accuracy of young peoples' expectations related to the therapeutic techniques and type of intervention they anticipate they will receive. Seligman, Wuyek, Geers, Hovey, and Motley (2009) examined expectations of psychological treatment and the effects of accurate versus inaccurate expectations with students undergoing either Cognitive Behavioural Therapy (CBT) or nondirective therapy for non-clinical academic problems. Participants included 94 undergraduate students with an average age of 19 years. Results indicated that the students presenting for psychotherapy, at best, presented with expectations that were not specific to CBT and, at worst, presented with expectations that were not consistent with CBT. Instead, the students' expectations tended to be more consistent with non-specific psychotherapies.

Finally, research with young people has shown associations between therapy processes expectations and participation in treatment. A study by Tinsley and Tokar (1994) examined expectations about the processes of counselling with a group of university students and found that clients with more positive expectations of counselling processes had higher levels of involvement in therapy than those with more negative expectations.

Children and caregivers' expectations of therapy processes. Research exploring children and their caregivers' expectations of the processes of therapy is also lacking, with only one study examining the accuracy of children's expectations regarding the structure of therapy. A study by Bonner and Everett (1982) found that

children who had an opportunity to be prepared for therapy by watching an educational video tape with a therapist held more appropriate expectations about the structure of psychotherapy when compared to those children who were not prepared. Not surprisingly, the older children aged 9 to 11 years showed significantly more appropriate expectations of the processes of therapy than the younger children aged 6 to 8 years. In addition, related to the structure of therapy, the children were asked to identify the expected length of treatment and their responses ranged from one to 100 sessions with the average length of treatment predicted by the children to be nine sessions.

Finally, a study by Richardson (2001) examined parents' expectations about seeking and obtaining mental health care with 235 parents of children aged 5 to 19. Results indicated that related to the processes of therapy, a quarter of the parents indicated that they did not have a clear understanding of how mental health interventions could help their children. Most of the parents expected mental health professionals to help their child by providing a talk based intervention (93.1%), and half of the parents expected mental health professionals would help by giving the child medicine.

Outcome Expectations

Outcome expectations refer to how strongly a client believes that therapy will help them to improve or get better. This can either reflect a general optimism about the effectiveness of the treatment or can refer to expectations of therapeutic change in specific domains. Outcome expectations are commonly assessed on a continuum ranging from the potential benefits of treatment through to the potential worsening of symptoms (Constantino, Arnkoff, Glass, Ametrano, & Smith, 2011; Delsignore & Schnyder, 2007).

Previously conducted studies have measured outcome expectations using variables such as pre-treatment expectations around a reduction in symptoms or improvement in functioning and expected number of sessions to be attended before seeing clinical improvements. Outcome expectations have tended to receive more attention than the other expectancy domains; however, prior research has almost exclusively focused on adult clients' outcome expectations and has failed to explore children or young people's anticipation of therapeutic outcomes. A recent meta-analysis of pre-treatment outcome expectations and post-treatment outcomes found that over 80 per cent of the studies included in the analysis were based on adult population samples (Constantino et al., 2011).

Adults' outcome expectations. Previous research has established that generally, adult clients are likely to commence the therapeutic encounter with positive initial expectations related to their anticipated outcomes of therapy (Rapaport et al., 1996; Greer, 1980; Lax, Basoglu, & Marks, 1992). For instance, one study found that 91 per cent of adult clients expected to get better after therapy (Bowden, Schoenfeld, & Adams, 1980) and another study found that 81 per cent of adult clients diagnosed with depression expected to see clinical improvements after therapy, with only eight per cent expecting therapy to not be helpful (Rapaport et al., 1996).

A wealth of research has supported the link between outcome expectations and clinical outcomes of therapy. A number of reviews based predominantly on adult population samples have indicated a significant relationship between outcome expectations and clinical outcomes of therapy; typically finding optimistic expectations to be associated with client improvement (Dew & Bickman, 2005; Glass et al., 2001; Joyce et al., 2003; Noble et al., 2001; Thompson & Sunol, 1995). More specifically, early research with adult clients engaged in psychotherapy found

evidence to support a significant but small positive linear relationship between outcome expectations and client-rated satisfaction and clinical improvement (Karzmark, Greenfield, & Cross, 1983; Richert, 1976).

More recently, a US study with 113 adult clients diagnosed with social phobia found that more pessimistic expectations about the effectiveness of treatment was modestly but significantly associated with greater severity and longer duration of social phobia, more severe depression as well as decreased benefits from cognitive behavioural therapy (Safren, Heimberg, & Juster, 1997). Similarly, for clients engaging in short-term cognitive behavioural therapy for anxiety management, results found that clients with more optimistic pre-treatment outcome expectations for change saw greater therapeutic outcomes post-treatment (Fromm, 2001). A US study of 143 women diagnosed with bulimia nervosa engaging in a 12 week CBT group program found that pre-treatment expectations of therapeutic success were predictive of a favourable treatment response ($OR = 1.09$) (Mussell, Mitchell, Crosby, Fulkerson, & Hoberman, 2000). A randomised controlled trial with 43 adults engaging in brief cognitive therapy for panic disorder found a moderate relationship that showed clients who reported at the end of the first session that they expected the treatment to be helpful showed greater improvement and decreased panic-anxiety post-treatment (Clark, Salkovskis, Hackmann, Wells, Ludgate, & Gelder, 1999). Another study by Price, Anderson, Henrich, and Rothbaum (2008) examined pre-treatment outcome expectations with actual treatment outcome from the beginning of therapy through 12-month follow-up in a clinical sample of inpatient adult clients undergoing exposure therapy. Results found that pre-treatment outcome expectancy predicted treatment gains made during therapy, such that higher outcome expectations were associated with stronger rates of symptom reduction, however, this result was not maintained at

the 12-month follow-up. Research based on adult clients engaging in psychotherapy revealed that the use of videotaped psycho-education on client expectations was effective in increasing the accuracy and knowledge of clients' pre-treatment expectations and was successful in reducing state anxiety in the short-term (Deane, Spicer, & Leathern, 1992). Finally, research has indicated that clients who are more likely to expect therapy to be beneficial for them make more persistent efforts towards therapeutic change and are more engaged in the processes of therapy than those with more pessimistic outcome expectations (Meyer, Pilkonis, Krupnick, Egan, Simmens, & Sotsky, 2002).

Other research utilising adult population samples have established associations between optimistic outcome expectations and greater client-rated therapeutic alliance. For instance, a study by Joyce and colleagues (2003) examined client's pre-treatment ratings of expected improvement for their own target objectives for 144 adult clients who were referred to an outpatient psychiatric treatment clinic. The study indicated that client outcome expectancy was moderately directly associated with the therapeutic alliance as rated by both the client and the therapist and was also moderately directly associated with treatment outcome assessed by the client, the therapist and an independent assessor.

Similarly, for 107 adults attending a group treatment program for complicated grief, client outcome expectations were found to be moderately directly associated with client improvement and therapeutic alliance, indicating that positive expectations assisted with the development of a strong alliance and enhanced treatment outcomes (Abouguendia, Joyce, Piper, & Ogrodniczuk, 2004). A study by Dearing, Barrick, Dermen, and Walizer (2005) with adult clients who were undergoing outpatient alcohol treatment found that client outcome expectations, therapeutic alliance and

session attendance jointly influenced client satisfaction with treatment and drinking related outcomes, such that more positive expectations lead to greater client satisfaction, and in turn better drinking related outcomes.

Prior research has also examined the effects of clients' outcome expectations on help-seeking intentions and behaviours. A study of 354 adult university students explored the effects of outcome expectations on help-seeking intentions and actions towards seeking help from professional services. Results found that expectations about the helpfulness of therapy were moderately positively associated with attitudes toward help-seeking, which, in turn, contributed to the participants' intent to actually seek professional help for interpersonal and drug issues (Vogel et al., 2005).

Finally, a body of research has examined clients' expectations regarding the anticipated number of sessions they will be required to attend to see clinical improvements. While there is considerable variation in findings from the literature, generally, research determining the actual rate of improvement for psychotherapy has indicated that 31 per cent to 46 per cent of clients will experience positive reliable change within 26 sessions (Callahan & Hynan, 2005; Kadera, Lambert, & Andrews, 1996).

However, research has demonstrated that the number of sessions a client expects to attend and actually attends is typically far fewer than that. For instance, one study found that 44 per cent of clients expected to attend and 57 per cent actually attended less than eight sessions and 71 per cent of clients expected to attend and 75 per cent actually attended fewer than 12 sessions (Mueller & Pekarik, 2000).

For instance, a study by Swift and Callahan (2008) examined the number of sessions clients expected they would need to attend before seeing significant clinical improvements. The study found that participants expected a two session treatment to

have a 25 per cent recovery rate; such that they expected that 25 per cent of clients would recover by Session two. Moreover, they expected four sessions to have a 44 per cent recovery rate, eight sessions a 62 per cent recovery rate, 15 sessions to have a 72 per cent recovery rate, and 26 sessions to have a 77 per cent recovery rate. These results indicate that clients' outcome expectations for therapy are greater than the actual rate of improvement as demonstrated in the psychotherapy literature.

Young people's outcome expectations. As for the other expectancy domains, there are few studies of young people's outcome expectations. A large Australian descriptive study by Jorm and Wright (2007) explored the beliefs of 3746 young people aged 12 to 25 years and their parents about the effectiveness of a variety of treatments for a range of mental disorders including psychosis, depression, depression with alcohol misuse, and social phobia. Results indicated that there was a high level of agreement between the young people and their parents regarding which interventions they expected would be the most helpful. Most young people and their parents expected that general interventions such as GPs, counselling, or support groups and informal sources of help such as family and friends, would be more helpful than specialist mental health services for the range of mental disorders. The young people and their parents expressed the most negative expectations regarding the helpfulness of psychiatric medication, admission to hospital, or dealing with the problem alone.

Other research has shown that outcome expectations are linked with service satisfaction for young people and their parents. A study conducted by Garland, Haine, and Lewczyk Boxmeyer (2007) explored the relationship between a group of US young people and their parents' satisfaction of outpatient youth mental health services. Participants included 143 youth aged 11 to 18 years who were entering

treatment for the first time for a new episode of care. The study conducted baseline interviews after the initial session and follow up interview six months later. The study found that pre-treatment expectations were associated with youth satisfaction, such that more positive pre-expectations were associated with higher satisfaction of the treatment six months later. Further, results indicated that while both youth and parent pre-treatment expectations were generally positive, they were only minimally correlated with each other.

Children and caregivers' outcome expectations. Relatively little research has focused on children and their caregivers' expectations of their therapeutic outcomes. Two studies have explored children's outcome expectations. The first, an early study by Bonner and Everett (1982) found that in a non-clinical sample of children aged 6 to 12 years, the children held highly optimistic prognostic expectations related to the outcomes of therapy, with high expectations regarding the helpfulness of treatment and a high level of expected satisfaction with treatment.

More recently, a study by Carlberg, Thoren, Billstrom, and Odhammar (2009) explored children's expectations about psychodynamic therapy using semi-structured interviews. Participants included 10 children aged 6 to 10 years, and assessed expectations pre and post-treatment in a psychodynamic child psychotherapy setting. Results indicated that the children expressed positive pre-treatment expectations and also reported having positive experiences of the psychotherapy after termination. Furthermore, pre-treatment outcome expectations were positively associated with client-rated post-treatment improvement.

Two other studies examined parents' outcome expectations related to their child's experience of therapy. Firstly, a study by Nock and Kazdin (2001) examined 405 parents' expectations for their child's (aged 2 to 15 years) experience of

psychotherapy and found that those parents who did not expect therapy to be effective experienced greater barriers to treatment participation and viewed therapy as less relevant, more work, and had a poorer relationship with the therapist. Interestingly, those parents whose expectations for their child's experience of therapy were either overly optimistic or overly pessimistic attended the greatest number of sessions and were least likely to terminate treatment prematurely.

Lastly, in another study Richardson (2001) interviewed 235 parents of children (aged 5 to 19 years) in need of mental health care. Results showed that overall the parents reported having positive treatment outcome expectations of mental health interventions and professionals, with 93 per cent of the parents expecting the mental health professional would help their child.

Disconfirmed Expectations

Researchers have not only been interested in exploring the effects of clients' initial expectations of therapy on clinical improvement and engagement in therapy, but have also examined, specifically, how disconfirmed expectations influence these important outcome variables. Expectancy disconfirmation refers to discrepancies between clients' initial expectations of therapy compared to their actual experience of therapy (Duckro, Beal, & George, 1979). For most clients, at least some of their initial expectations regarding therapy will not be congruent with what the service actually provides, and for some clients, many of these expectations will not be met (Horenstein & Houston, 1976).

A client can experience one of four possible combinations of therapy expectations and experience: (a) positive expectancy disconfirmation, where their experience of therapy is perceived to be more positive than their initial expectations; (b) negative expectancy disconfirmation, where their experience of therapy is

perceived to be more negative than their initial expectations; (c) positive expectancy confirmation, where their expectations and experience of therapy match and both are positive; or (d) negative expectancy confirmation, where their expectations and experience of therapy match and both are negative (Horenstein & Houston, 1979).

A limitation of previous research on disconfirmed expectations is that in general, most studies have not assessed all four expectancy confirmation groups on important outcome variables, and rather have tended to focus on any discrepancy and often not included the valence of the incongruence. Therefore, it is difficult to ascertain the potentially distinct impact that each expectancy confirmation group may have on clients' engagement and outcomes of therapy. Furthermore, research to date has neglected to simultaneously assess all four expectation domains across the expectancy confirmation groups on outcome variables, making it difficult to compare the unique effects of each expectancy type.

There are three proposed models to explain the relationship between expectations and actual experience on outcomes, as presented by Tracey and Dundon (1988). The first and most commonly applied model is the linear discrepancy model which posits a linear relationship between expectations and actual experience on outcomes, with the most positive outcome occurring when the client is able to act more in line with their expectations than expected, for example 'I expected to be moderately motivated and I was actually highly motivated.'

The second model, the curvilinear discrepancy model, postulates that the most positive outcomes occur only when the client's experience of therapy exactly matches their expectation, for example 'I expected to be moderately motivated and I was actually moderately motivated.' The key difference between these two models is that in the linear model the most positive outcome occurs if the client is able to act more in

line with their expectations than initially expected, whereas, in the curvilinear model, the most positive outcome occurs only when the behaviour exactly matches the expectation, regardless of direction.

Finally, the third and least referred to model is the bidirectional discrepancy model, which takes both expectations and preferences into account and posits that there will be a good outcome if the discrepancy between client expectations and subsequent experience is in the direction of the client's preference, for example 'I expect to be moderately motivated, but I would like to be more motivated, and I was actually highly motivated.' (Tracey & Dundon, 1988).

Adults' Disconfirmed Expectations

Prior research has linked adult clients' disconfirmed expectations to important outcome variables, namely, therapy engagement, clinical improvement, and therapeutic alliance. Research based on adult population samples has shown that the greater the discrepancy between a client's expectations of therapy and the reality of the therapeutic encounter, the less effective treatment will be and the more likely the client will be to disengage from the process of therapy (Duckro et al., 1979; Levitt, 1966).

Prior research has examined specifically how adult clients' disconfirmed expectations relate to engagement in therapy and premature termination of treatment. Early research has shown that the greater the discrepancy between adult client's pre-treatment expectations for therapy when compared to their actual experience of therapy, the less likely they were to return for treatment (Overall & Aronson, 1963).

A more recent review by Reis and Brown (1999) found that disconfirmed expectations were related to client dissatisfaction as well as higher therapy drop-out rates. Results further highlighted the importance of promoting congruence between

the therapist's and client's expectations of the processes of therapy to reduce drop-out rates. Research by Elkin, Yamaguchi, Arnkoff, Glass, Sotsky, and Krupnick (1999) found that 'treatment-fit' or congruence between a client's expectations of treatment and the intervention provided was associated with engagement in therapy. The study found that when clients' treatment assignments were congruent with their expectations related to the way in which they thought about the origin of their problems and what would be helpful for them, they were more likely to stay in treatment and to develop a positive therapeutic relationship. Other research has found that adult clients' expectations for treatment recovery rates were significantly higher than actual recovery rates and raised the issue that a large number of clients are at risk of discontinuing treatment before they have actually recovered when their initial expectations are not met (Swift & Callahan, 2008). Moreover, an early study by Horenstein and Houston (1976) examined the effects of expectancy disconfirmation on premature termination of therapy and found evidence to support a curvilinear rather than linear relationship between expectancy confirmation and drop-out rates. Specifically, results found a significant inverted-U relationship, such that clients who dropped out of therapy after their first session were the least likely to experience expectancy confirmation (i.e. initial expectations were not met) with those who dropped out after their second session exhibiting the greatest expectancy confirmation (i.e. initial expectations were met), while those clients who remained in therapy reported an intermediate degree of expectancy confirmation (i.e. initial expectations were mostly met).

Disconfirmed expectations have also been shown to be associated with poorer clinical outcomes of therapy. A review by Noble and colleagues (2001) found that when clients' expectations of the processes of care were incongruent with what the

service provided, their therapy outcomes were poorer. Similarly, research with a group of 120 elderly clients aged 60 to 80 years with major depressive disorder found that when adult clients' expectations related to therapy processes were confirmed they had less depressive symptoms at the end of therapy than when these expectations were disconfirmed (Gaston, Marmar, Gallagher, & Thompson, 1989). Moreover, a qualitative study of 18 adult clients found almost all of the clients rated their actual experience of cognitive behavioural therapy to be inconsistent with their initial expectations of therapy, with pleasant surprises more prevalent among clients who had favourable clinical outcomes, and disappointing experiences more common among clients with poorer therapy outcomes (Westra et al., 2010). In addition, a study with 22 male veterans seeking psychotherapy found that when pre-treatment expectations for the content of therapy were consistent with what actually happened in treatment, the clients were less depressed and less apprehensive (Rosen & Wish, 1980). Research exploring adult clients' expectations of therapy found that the majority of clients initially held moderate, rather than very high or low expectations of therapy, and also found that differences in expectations and actual experience of therapy were mainly in the positive direction (Dimcovic, 2001).

Associations between disconfirmed client expectations and therapeutic alliance have also been explored. For instance, research has shown that when there is a match between the therapeutic intervention provided and a client's expectations and preferences related to the processes of therapy to achieve their therapeutic goals, there tends to be greater therapeutic alliance and therapeutic gains (Bordin, 1979). It has further been suggested that a client's engagement in the processes of therapy and their trust in the therapist increases when there is a match between their expectations of therapy and the intervention provided (Duncan, Sparks, & Miller, 2000).

Additionally, research by Joyce and Piper (1998) found that discrepancies between adult clients' pre-treatment expectations for the typical therapy session and their actual experience of session usefulness and comfort were directly associated with therapeutic alliance, such that if the client found that sessions met or exceeded their initial expectations, the therapist's general perception of the therapeutic alliance was positive. Results further indicated that for most of the clients, the actual experience of therapy was generally in line with or exceeded their initial expectations, suggesting that for most of them, therapy was a positive experience. Finally, results showed that the higher the initial expectancy, the greater the likelihood of disconfirmation; that is, a failure of session evaluations to meet expectations.

Children and Young People's Disconfirmed Expectations

To date, research examining disconfirmed expectations with samples of children, adolescents, or young people is almost non-existent, with a few studies exploring parent's disconfirmed expectations. Previous research on parents' expectations related to their children's experience of therapy has focused on examining discrepancies between parents' expectations of the structure and focus of the therapy sessions compared to their actual experience of these factors. Similar to results from the adult literature, these studies have found that the greater the discrepancy between parents' expectations of the processes of therapy and their actual experience, the greater the likelihood of premature termination and drop out of treatment for children (Burck, 1975; Day & Reznikoff, 1980; Furey & Basili, 1988; Plunkett, 1984).

A major shortcoming of the disconfirmed expectancy literature is that research exploring expectancy disconfirmation has exclusively focused on adult client samples,

with no prior research examining disconfirmed expectations with adolescents and young adults. As such, this represents an area that warrants further investigation.

Preferences

A construct related to client expectations that has received comparatively less research attention is client preferences of therapy. There has often been a lack of differentiation between client expectations and preferences in previous research, with many studies using these terms interchangeably (Duckro et al., 1979; Tracey & Dundon, 1988). However, while client expectations and preferences have been found to be inter-related, they remain two distinct constructs that can affect the therapeutic process differently. For instance, research has demonstrated that clients do distinguish between their expectations and preferences for therapy, with preferences typically more optimistic than expectations (Tracey & Dundon, 1988).

Client preferences refer to characteristics of the therapeutic encounter that are desired, valued or wanted by the client (Arnkoff et al., 2002). What clients expect from therapy does not necessarily reflect what they want, for example, a client may *expect* that therapy will not be helpful, but they may *want* therapy to help them (Duckro et al.).

Clients' preferences for therapy have been assessed in a variety of different ways, though most commonly tend to be measured by directly asking clients to identify what conditions of therapy they most desire, for example 'would you prefer psychotherapy or medication?' Other studies have assessed clients' preferences for particular aspects of therapy on a rating scale and therefore allow the strength of the preference to be determined, for example 'how much would you like to receive psychotherapy and/or medication?' (Swift, Callahan, & Vollmer, 2011).

As with client expectations, four types of preferences have previously been identified: preferences for the roles that are played in therapy for both the client and the therapist (e.g., who will do more of the talking in session, and therapist gender, personality, or level of experience); preferences for the type of treatment that will be provided (e.g., cognitive behavioural therapy, medication, supportive counselling); and preferences related to the outcomes of therapy (e.g., reduction of symptoms, changes in specific areas) (Glass et al., 2001).

Client preferences have been recognised as a key component of evidence-based practice, with the American Psychological Association's (2006) evidence-based practice policy incorporating client preferences by stating that treatment decisions should be made in collaboration with the client with the goal of maximising client choice. Research has highlighted the significance of shared decision making during therapy and noted that clinicians should strive to explore, identify and acknowledge clients' preferences for therapy, allow clients to make choices regarding the decision-making process, and to respect and adhere to the client's wishes during the therapeutic encounter where possible (Charles, Gafni, & Whelan, 1997). However, clients are often hesitant to voice their therapy preferences because they may be unaware that it is appropriate to express these preferences, may not know that a variety of treatment interventions exist, or may have reservations around questioning the therapist's expertise or authority (Swift et al., 2011).

A review by Benbassat, Pilpel, and Tidhar (1998) examined client preferences for their participation in clinical decision making and found that clients expressed a strong desire to be informed about their disorder and wanted to know what treatment options were available to them. The review also noted that without openly discussing a client's preferences for treatment, therapists will not be informed about what the

client wants and therefore will not be able to consider these preferences during therapy (Benbassat et al., 1998). It is important, therefore, that clinicians actively assess and consider a client's individual preferences for therapy, as research has also indicated that not honouring the client's desires and preferences can have a significant impact on therapy processes and outcomes (Grantham & Gordon, 1986).

Adults' Preferences

It is crucially important that consumers are involved in the process of making decisions about their care, as receiving a preferred method of treatment has been linked to improved outcomes as well as better engagement in therapy. To illustrate this, a recent meta-analysis showed that adult clients who received their preferred treatment were half as likely to prematurely terminate therapy (odds ratio [*OR*] = 0.58) and were significantly more likely to show improvement in clinical outcomes of therapy ($r = .15$) compared to clients who received treatments incongruent with their preferences or whose preferences for treatment were not considered (Swift & Callahan, 2009).

More specifically, associations between client preferences for therapy and clinical outcomes have been explored. For instance, an early study by Devine and Fernald (1973) allowed clients to watch an educational video that informed them about a variety of treatment options to treat specific phobias and then, based on the client's preference to engage in each treatment type, assigned clients to either a preferred or non-preferred treatment. Results showed that the clients in the preferred treatment condition saw significantly greater symptom reduction than the clients in the non-preferred treatment condition.

Another exploration of treatment preferences for adult clients diagnosed with Generalised Anxiety Disorder found that a lack of congruence between preferences

and subsequent experiences in the undesired direction was correlated with a negative outcome, while a lack of congruence in the preferred direction was related to a positive outcome of therapy. The study also found that while the majority of clients experienced a lack of congruence between preferences and experiences in the positive direction, a number of clients experienced a lack of congruence in the negative direction and these differences had a clear relationship to therapy outcome in terms of decreased symptoms of anxiety (Berg, Sandahl, & Clinton, 2008).

Other research has explored the effects of client preferences on the development of therapeutic alliance. A randomised control trial of 75 adult clients diagnosed with Major Depressive Disorder examined the effects of treatment preference on therapeutic alliance. Results indicated that clients preferring and receiving psychotherapy reported significant increases in their rated therapeutic alliance over time, whereas clients preferring psychotherapy but receiving active medication or a placebo reported significant decreases in their rated alliance (Iacoviello, McCarthy, Barrett, Rynn, Gallop, & Barber, 2007).

Swift and Callahan (2010) explored whether clients had higher preferences for empirically supported interventions or therapy processes, roles, and therapeutic alliance. Results revealed that clients were willing to sacrifice receiving a significantly more effective evidence-based treatment to ensure that their preferences were met related to: (a) the therapist being empathetic and supportive, (b) having a strong therapeutic relationship, (c) that sessions were client directed, and (d) that the therapist was more experienced. These results indicate that client preferences are not solely based on the efficacy of possible interventions, but rather, clients place high value and desire on variables that may contribute to their experience of therapy, specifically related to the therapist and therapeutic relationship.

It is important to note, however, that not all research has supported the hypothesis that denying clients access to their preferred treatment mode leads to poorer clinical outcomes and alliance. For instance, one study compared antidepressant medication to cognitive therapy for moderately to severely depressed clients by randomly assigning clients to receive either cognitive therapy or pharmacotherapy for the treatment of depression. The study compared the treatment outcomes of clients who received their preferred treatment versus those who did not. Although the majority of clients stated a preference for one treatment over the other, there was no significant difference in the level of reduction in symptoms of depression between those who received their treatment of choice compared to those who did not (Leykin, DeRubeis, Gallop, Amsterdam, Shelton, & Hollon, 2007).

Moreover, Bedi and Colleagues (2000) utilised a partially randomised preference trial, with clients assigned to either antidepressants or counselling or given their choice of either treatment. Results indicated that there was no significant effect for clients' treatment preference of psychotherapy versus medication on outcome or satisfaction.

A study of homeless adults diagnosed with a severe mental illness found that the clients who were able to choose their preferred treatment mode were more likely to attend sessions with their case managers than clients who were not able to choose their treatment type, however, the study found no significant differences between the two groups on improvement in symptoms of mental illness (Calsyn, Winter, & Morse, 2000).

Furthermore, a study that randomly assigned clients with a primary diagnosis of mild to moderate alcohol dependence to one of three different forms of brief therapy and assessed client preferences for each treatment type, found that receiving a

preferred treatment did not have a significant impact on treatment outcomes related to drinking behaviour or general functioning, treatment process, client-rated satisfaction and effectiveness, clinician-rated rapport and engagement, nor on the number of sessions attended (Adamson, Sellman, & Dore, 2005).

Many studies confirm that adult clients are more likely to have a preference for psychotherapy and counselling compared to antidepressants or medication interventions (i.e., van Schaik et al., 2004). For instance, research by Riedel-Heller, Matschinger and Angermeyer (2005) examined help-seeking and treatment preferences of the general public and found that that in the eyes of the public, psychotherapy was the most frequently preferred and recommended primary treatment option for vignettes of both schizophrenia and depression, with drug treatment far less preferred as a first line treatment, but accepted as a second line option if psychotherapy was not successful. A study of 984 adult patients attending a general practice clinic for symptoms of depression found that counselling was reported as the preferred mode of treatment for depression with antidepressants being a less preferred treatment option (Churchill et al., 2000).

Similarly, a study of depressed older primary care patients found that 57 per cent had a preference for counselling compared to 43 per cent that preferred medication, with males and clients with severe depression more likely to prefer medication than females or clients with milder depression (Gum et al., 2006).

Other research has explored women's treatment preferences after a sexual assault and found that the women had a stronger preference for psychotherapy rather than medication and stated the rationale for this preference was a wariness that medication may simply cover up, or mask, symptoms whereas the psychotherapy

would help to get to the root of the problem and produce longer-lasting effects (Cochran, Pruitt, Fukuda, Zoellner, Feeny, 2008).

Another study found that adult clients diagnosed with major depression who were more severely depressed reported higher preferences for antidepressant medication, while clients with more mild depression expressed a greater preference for counselling (Bedi et al., 2000).

Finally, a study by Givens, Houston, Van Voorhees, Ford, and Cooper (2007) found that ethnic minority groups were more likely to have higher preferences for counselling and prayer for treating depression, and had a higher prevalence of negative beliefs about medication than non-minority group respondents.

Other research has explored client preferences related to the race and ethnicity of the therapist, with one study finding that clients attending an outpatient mental health clinic expressed greater preferences for a therapist of their same race. Of note, results found no evidence to support that dropout and satisfaction with treatment were related to the nature of clients' preferences regarding race and ethnicity or to the racial makeup of the client and therapist (Proctor & Rosen, 1981).

Children and Young People's Preferences

To date, very little is known about young people's preferences for therapy. Results from the few studies that have explored young people's preferences for therapy and help-seeking behaviours have typically used community samples and shown that young people have a preference to seek help from informal sources such as family and friends or to deal with the problem by themselves and have a lower preference to seek help from professional sources such as health professionals, psychologists, or psychiatrists (Gulliver et al., 2010; Reavley, Yap, Wright, & Jorm, 2011; Rickwood et al., 2005). However, as these studies are based on community

rather than clinical samples, they do not reveal what young people actually entering therapy prefer.

Congruent with results from the adult literature, research by Jaycox and colleagues (2006) that has examined the treatment preferences of young people aged 13 to 21 years found that the youth preferred counselling (50.2%) over medication (22.1%), with 27.6 per cent having a preference for seeing their GP once a month rather than actively engaging in treatment. In addition, females were more likely to have a preference for engaging in active treatment than males. Results further found that negative attitudes about treatment of depression in general, recent mental health care use, having used psychotropic medications previously, and more current anxiety symptoms all increased the odds of preference for medications over counselling.

With regards to children's therapy preferences, Bonner and Everett (1982) explored treatment preferences in a non-clinical community based sample of children aged 6 to 12 years, and found that 68 per cent of the children indicated no preference for the gender of the therapist, 28 per cent had a preference for a female therapist, with four per cent stating a preference for a male.

Finally, one study by Mendonca and Brehm (1983) explored the effects of treatment intervention preference choice on intervention outcomes with a group of children engaged in a behavioural weight control program. The children in the preference choice condition were led to believe that they had chosen to participate in a type of intervention program that they had a preference for, while children in the no-choice condition were led to believe that they were assigned to a type of program. In reality, all of the children received the same behavioural treatment intervention. The post-treatment results showed that the children in the preference choice condition saw

significantly greater improvements in terms of decreased weight compared to the children in the no-choice condition.

Given that little is known regarding young people's preferences for therapy and that previous research with adult clients has demonstrated the significance of clients' preferences on clinical outcomes, gaining a greater understanding of young people's preferences for therapy is important and timely.

Limitations of Prior Research

This review of the literature has revealed a number of significant limitations of previously conducted research on client expectations. Firstly, a major limitation of prior research is that the vast majority of studies have focused on adult clients and to a much lesser extent, children and their caregivers' expectations. Very few studies have examined young people's expectations related to therapy and seeking professional psychological help. Specifically, no prior research has simultaneously explored young consumers' expectations, preferences and actual experience of therapy related to their role as a client, the therapist's role, the processes of therapy, and their therapeutic outcomes.

The literature review highlights the significance of three important outcome variables that are especially relevant for younger consumers, namely, clinical outcome, engagement in therapy, and help-seeking intentions. To date, no prior research has examined the effects of young people's expectations, preferences and experience of therapy on these important outcome variables. Furthermore, no research has examined the effects of disconfirmed expectations across these four expectancy domains on outcomes for young people.

Given the links established among adult client populations between expectations and therapy outcomes, it is timely that this area be examined specifically for young people, as results from adult samples may not apply for younger clients. As most mental health problems and disorders emerge at this time, investigating the factors that engage and retain young people in mental health services and maximise their clinical outcomes is a vital area of investigation.

With the recent emphasis on the critical importance of adolescence and early adulthood for mental health care, it is possible that young people's expectations, preferences, and experiences around mental health service use are quite different from those of adults and children and may be important in their help-seeking process. Thus, this thesis aims to address this significant gap in prior research by comprehensively exploring expectations, preferences and actual experience of therapy and the effects of these factors on engagement, clinical outcome and help-seeking intentions in a clinical sample of young people.

Another significant limitation of previously conducted research on client expectations is that most studies fail to simultaneously assess and examine all four expectancy domains, and instead tend to focus on one or two expectation types or simply measure client expectations as one general construct (e.g., Garland et al., 2000; Tracey & Dundon, 1988). It is therefore a challenge to make accurate comparisons between each expectancy type and to identify the unique role each distinct domain may have on important outcome variables. This thesis aims to address this gap by measuring and examining all four expectancy domains and assessing the unique role each type plays on significant outcome variables.

There are also a number of major weaknesses in the measurement of expectations, with many prior studies failing to use reliable and validated measures of client expectations (e.g., Garland et al., 2000; Joyce et al., 2003). Furthermore, there are significant problems with the timing of measuring expectations in several studies, which should measure expectations prior to beginning therapy, yet in some cases fail to do so and instead measure expectations after the first session or even in some cases after several sessions or at termination (e.g., Al-Darmaki & Kivilghan, 1993; Clark et al., 1999; Joyce & Piper, 1998; Odell, Butler, & Dielman, 2005). Many studies have also neglected to measure client expectations at varying points of the help seeking process and instead typically only measure initial expectations, which does not allow for comparison between initial expectations and a client's actual experience of therapy (e.g., Aubuchon-Endsley, Swift, & Callahan, 2009; Garland et al., 2000; Hardin, Subich, Holvey, 1988; Nock & Kazdin, 2001). Thus, this thesis will address these significant design concerns by using a reliable and validated measure of client expectations and will measure initial expectations prior to commencing therapy, and will also assess actual experience of therapy at a later time point.

Research examining expectancy disconfirmation is extremely limited. Those studies that have explored expectancy disconfirmation have often failed to include all four expectancy confirmation groups, and rather have just focused on any incongruence between expectations and experience and often do not report the valence of the incongruence, and therefore cannot ascertain the potentially distinct impact of each expectancy confirmation group (e.g., Bordin, 1979; Gaston et al., 1989; Joyce & Piper, 1998). This thesis addresses this gap by examining all four possible expectancy confirmation groups across the four expectancy domains on important outcome variables in a sample of young consumers.

Moreover, while research has acknowledged that client expectations and preferences for therapy represent two distinct constructs (Duckro et al., 1979; Tracey & Dundon, 1988) prior research has often failed to distinguish between these two factors. Furthermore, no previous studies have measured client expectations, preferences and actual experience using a congruent measure, making direct comparisons between these constructs a challenge. As such, this thesis will assess preferences and expectations as well as actual experience of therapy using a corresponding measure to ascertain the unique role each factor may have on engagement, help-seeking intentions and clinical outcomes and to allow direct comparisons to be made.

Original Contribution

This thesis addresses limitations of prior research and makes an original contribution to knowledge by: comprehensively examining young people's expectations, preferences and actual experience of therapy as well as exploring the effects of these factors on engagement, clinical outcome, and help-seeking intentions; exploring all four expectancy domains simultaneously using a reliable and validated measure of client expectations and measuring expectations prior to therapy commencing; directly comparing initial expectations, preferences and actual experience of therapy; and by examining all four possible expectancy confirmation groups across the four expectancy domains on important outcome variables.

Research Aims

Aim one. The first aim of this thesis was to explore young people's pre-treatment expectations of therapy related to their role as a client, the therapist's role,

the processes of therapy, and their expected outcomes. The study addressing this aim is presented in paper one.

Aim two. The second aim of this thesis was to describe and compare young people's expectations and preferences for therapy regarding seeking professional psychological help, specifically related to the roles they and their therapist will play, the processes of therapy, and their clinical outcomes. Age and gender differences were examined. The results relevant to this aim are presented in paper two.

Aim three. The third aim was to examine relationships and compare differences between young people's expectations, preferences and actual experience of seeking professional psychological help, across the domains of roles, processes and outcomes. Age and gender differences were also examined; in particular, the differences between adolescents and young adults are of interest, given the usual demarcation between child and adolescent and adult mental health services. This study is presented in paper three.

Aim four. The fourth aim of this thesis was to examine the predictive effects of young people's expectations, preferences and actual experience of therapy on clinical outcome, level of mental health service use, and future help-seeking intentions. Associations between more positive initial expectations and preferences of therapy and better clinical outcomes, greater mental health care service use, and intentions to seek help in the future were hypothesised to be potentially mediated by the young people's actual experience of therapy. Age and gender effects were also investigated. Results are presented in paper four.

Aim five. Finally, the fifth aim was to examine the effects of all four possible expectancy confirmation groups (i.e., positive confirmation, negative confirmation,

positive disconfirmation, and negative disconfirmation) across the multiple domains of client, therapist, process and outcome expectations on young people's service engagement, help-seeking intentions and clinical outcome. It was hypothesised that disconfirmed expectations across all the domains, when there are positive initial expectations, will be associated with poorer clinical outcome, less service use and reduced help-seeking intentions. Such effects are expected to be stronger for young adults compared with adolescents, as expectations are anticipated to be more clearly defined for the older clients. Paper five presents these findings.

CHAPTER III

Methodology Overview

The purpose of this chapter is to provide an overview and justification of the methodology utilised in this thesis. A longitudinal mixed-method research design with an initial exploratory qualitative component and subsequent quantitative cross-sectional and prospective component was undertaken to address the five research aims of this thesis. A mixed-method design comprising both qualitative and quantitative methods was used to allow for a complex set of research questions to be tested.

The first aim of this thesis was to explore young people's pre-treatment expectations of therapy and seeking professional help. Given that prior research has not yet specifically addressed young people's expectations for therapy across the four expectancy domains, this thesis firstly aimed to address this significant gap by exploring young people's pre-treatment expectations for therapy regarding their role as a client, the therapist's role, the processes of therapy, and their expected outcomes. A qualitative research method was utilised to address this research aim, as an exploratory approach was deemed most appropriate due to the lack of prior research to date. This method involved the administration of brief interviews undertaken by a cohort of 20 young people aged 12 to 25 years immediately prior to their initial intake assessment commencing at a youth mental health care service. The strength of utilising a qualitative design was to explore a previously neglected area of research in more detail and to allow for a greater understanding and description of young people's personal experiences of seeking professional help to be identified and to determine what set of expectations they commence this journey with. Furthermore, a qualitative method allowed the participants an opportunity to express their

expectations of therapy without being restricted by responding to a set of pre-determined quantitative questions.

This thesis further aimed to build on the exploratory research findings by quantitatively examining young people's initial expectations and preferences for therapy, and to also examine their subsequent actual experience of therapy, and to determine the effects of these factors on clinical outcomes over time. Specifically, the second aim of this thesis was to describe and compare young people's expectations and preferences for therapy related to their role as a client, the therapist's role, the processes of therapy, and outcomes as well as to examine age and gender differences. The third aim was to compare differences between young people's expectations, preferences and their actual experience of seeking professional psychological help, across the four expectancy domains. This thesis fourthly aimed to examine the predictive effects of young people's expectations, preferences and actual experience of therapy on clinical outcome, level of mental health service use, and future help-seeking intentions. Finally, the fifth aim was to examine the effects of all four possible expectancy confirmation groups across the multiple domains of client, therapist, process and outcomes on young people's service engagement, help-seeking intentions and clinical outcome.

A quantitative research method, involving cross-sectional and prospective components was, therefore, most appropriate to address these four research aims. This method involved the administration of an initial questionnaire completed by a cohort of 228 young people aged 12 to 25 years immediately prior to their first intake assessment commencing at a youth mental health care service and a follow-up questionnaire completed on-line two months later. The strength of utilising a longitudinal research design was to follow the young people through their journey of

seeking professional psychological help and to test hypotheses around the effects of expectations, preferences and actual experience of therapy on clinical outcomes over time.

The specific methodology utilised for both the qualitative and quantitative components of this thesis will subsequently be presented in further detail.

Qualitative Component

Aim One

The first aim of this thesis was to explore young people's pre-treatment expectations of therapy related to their role as a client, the therapist's role, the processes of therapy, and their expected outcomes, as this is an area that has previously not been explored in detail. As such, it was deemed most appropriate to utilise an exploratory qualitative research method to address this first aim.

Participants

Participants involved in the qualitative research component included 20 young people (11 females and 9 males) aged between 12 and 24 years ($M = 17.25$, $SD = 12.62$) who were attending their initial intake appointment at headspace, an Australian youth mental health care service in the capital city of Canberra. The service is part of an innovation in mental health service delivery that transcends the usual child and adolescent versus adult service dichotomy and caters for young people aged 12 to 25 years presenting with mild to moderate mental health concerns (Hodges et al., 2007). Consistent with the early intervention focus of the service, most young people presented with emerging symptoms of high prevalence mood disorders, mostly anxiety and depression.

During the recruitment period, all young people who were attending the service for their initial intake appointment were approached to participate. A total of 23 young people were approached and 20 agreed to participate. Recruitment continued until there was representation across age and gender groups and saturation of key themes was achieved. While all of the participants were attending the specific service for the first time, most had prior contact with a counsellor or psychologist, with only three reporting that this was their first time ever seeking help.

Procedure

Prior to this study commencing, ethics approval was obtained from the University of Canberra Committee for Ethics in Human Research (Project Number. CEHR 10-126). It was a requirement that all participants who were approached to participate in the study were attending the service for their initial intake appointment. This was to ensure that expectations were assessed prior to therapy commencing, as failing to do this has been identified as a common expectation measurement flaw in prior research (e.g., Al-Darmaki & Kivilghan, 1993; Clark et al., 1999; Joyce & Piper, 1998; Odell et al., 2005). During the recruitment period, all young people booked in for an initial assessment were invited to participate. In order to initially identify participants to be approached, the service receptionist provided the principle researcher with specific appointment times for the intake assessments. The participants were approached by the principal researcher when they were in the waiting area of the youth mental health care service prior to their intake assessment commencing. Information and consent forms were provided to participants prior to the interviews beginning and for young people under the age of 16, parental consent was also obtained. The semi-structured interviews were conducted in a private room at the mental health service and were taped with a voice recording device. The

interviews ranged in length from 9.06 to 14.53 minutes ($M = 11.04$, $SD = 1.59$). Each participant was given a movie ticket at the conclusion of the interview to thank them for their time.

Measures

Based on the definitions of each expectancy type as outlined in the literature, a set of open-ended interview questions was developed targeting each expectancy domain. More specific prompts were also developed to initiate further responses from the participants which were designed to be asked after the responses from the open-ended questions had been obtained. The questions developed related to expectations around the client's role included: "Could you please tell me about what you think you will do, or what you will be like when you come to therapy sessions?" (Example of prompts: How involved and/or motivated will you be?); the questions related to expectations of the therapist's role included: "Could you please tell me about what you think your therapist will do in sessions and what they will be like?" (Examples of prompts: Who do you think you will be seeing? How involved will they be?); the questions related to therapy processes included: "Could you tell me about what you think will happen during your sessions – that is, what sort of things you will do, what will therapy be like?" (Examples of prompts: Will it be all talk based or will there be activities? How often will you come?); and finally for outcomes; "Could you please tell me about what you think will happen for you after coming to therapy for a while?" (Example of prompts: Will anything change or be different for you?). Refer to Appendix H for the semi-structured interview outline and questions.

Analyses

The 20 interviews were transcribed verbatim and analysed using NVivo 9 qualitative data analysis software (QSR International Pty Ltd, 2010). A thematic analysis approach was used to identify patterns or themes within the data (Braun & Clarke, 2006). Thematic analysis involves a system of coding text into theoretically defined categories using a systematic approach (Silverman, 2000). This process involved the 20 transcripts being read and re-read, looking for patterns in the data. Following this, data were organised into categories and these initial themes were considered in the context of the expectations literature and theory. Initial labels were given to these themes, and the data was again re-examined and re-ordered as required. Finally, the key themes were coded, described and given meaningful labels. This approach was sufficient as it was not appropriate to have the transcripts checked by the participants as initial perceptions were all that was required.

To test inter-rater reliability, four clean transcripts were coded by a second independent researcher and then coding was compared, based on pre-determined codes. Cohen's Kappa coefficient is a statistical measure of inter-rater agreement and corrects for the number of agreements that would occur by chance between coders. A Kappa of 1 indicates perfect agreement, whereas a Kappa of 0 indicates agreement equivalent to chance. The Kappa coefficient obtained for this thesis was .76; Kappas of .75 and above are considered excellent (Robson, 2002). Inter-rater disagreement was resolved by consultation with a third researcher.

Quantitative Component

Aim Two

The second aim of this thesis was to describe and compare young people's expectations and preferences for therapy related to their role as a client, the therapist's role, therapy processes and outcomes. Age and gender differences were also examined.

Aim Three

The third aim was to examine relationships and compare differences between young people's expectations, preferences and actual experience of seeking professional psychological help, across the domains of roles, processes and outcomes, as well as to explore age and gender effects.

Aim Four

The fourth aim was to examine the predictive effects of young people's expectations, preferences and actual experience of therapy on clinical outcome, level of mental health service use, and future help-seeking intentions. Again, age and gender effects were examined.

Aim Five

Finally, the fifth aim was to examine the effects of all four possible expectancy confirmation groups (i.e., positive confirmation, negative confirmation, positive disconfirmation, and negative disconfirmation) across the multiple domains of client, therapist, process and outcome on young people's service engagement, help-seeking intentions and clinical outcome. Age and gender effects were also examined.

In order to address these four research aims, a longitudinal research design with cross-sectional and prospective components was deemed most appropriate.

Participants

Participants involved in the quantitative component comprised a total of 228¹ young people who were seeking help from headspace, an Australian youth mental health care service in the capital city of Canberra. The service caters for young people aged 12 to 25 years presenting with mild to moderate mental health concerns. A total of 895 young people attended an initial assessment at the mental health service during the recruitment phase, and a total of 228 agreed to participate in the research project, signifying an overall response rate of 25.5%.

Most participants presented with emerging symptoms of high prevalence mood disorders, mainly anxiety and depression, and had sub-threshold symptoms or first diagnosis of a mood disorder. Participants covered the whole age range of the service, with a mean age of 17.24 ($SD=3.17$). Of the total participants, 158 (69.3%) were female and 70 (30.7%) were male. The vast majority of participants reported that this was not their very first time seeking help, with 80.7% having been in counselling before, even if for only one session. Participants were asked to identify which, if any, health professionals they had had prior contact. A total of 46% had had prior contact with two or more of the health professionals, with 65.8% having prior contact with a school counsellor, 32.5% a counsellor, 32.5% a psychologist, 14.5% a youth worker, and 11.4% a psychiatrist. The most commonly reported referral sources were General Practitioners (34.6%), parents or family (24.6%), health professionals

¹ The participant sample included in paper two comprised a subset of 188 young people from the total participant sample of 228, as this was the number of participants reached at the time this paper was written.

(13.6%), friends (10.5%), or self (4.4%). Most participants (68.9%) reported that they had not looked at the headspace website section ‘What to expect when coming to headspace’.

Of the 228 participants who completed the initial questionnaire, 102 (44.7%) agreed to also complete the follow-up questionnaire two months later. The follow-up participants had a mean age of 17.81 ($SD=3.16$) and 73 (71.6%) were female and 29 (28.4%) were male. No significant differences were found between the participants who completed the follow-up questionnaire when compared to those participants who chose to only complete the initial questionnaire on their age, gender, initial expectations or preferences for therapy.

Procedure

Ethics approval was obtained from the University of Canberra Committee for Ethics in Human Research prior to the study commencing (Project Number. CEHR 11-59). All young people attending an initial intake assessment during the recruitment period were approached to participate. The participants were recruited by the service receptionist while in the waiting area of the service immediately prior to their initial intake session. An information sheet with details of the study was provided to all participants and to their parents if present. Consent forms were signed by each young person if they chose to participate in the study and, for those young people under the age of 16, parental consent was also sought. Participants were informed that participation was voluntary and that their responses would be treated with privacy and confidentiality and that the researcher was independent of the health service. After consent forms were signed, the participants filled out the first questionnaire in the reception area while waiting for their intake session to commence. The initial

questionnaire asked the participants a series of questions around their expectations and preferences for therapy as well as demographic questions and assessed base-line psychological distress levels. Participants were informed that they would be contacted two months later to be invited to complete a follow-up questionnaire.

Two months after completing the initial questionnaire, the participants were emailed by the primary researcher and invited to complete an online follow-up questionnaire and a reminder email was also sent one week later. The follow-up questionnaire asked the participants questions around their actual experience of seeking help at the youth mental health care service as well as assessing follow-up psychological distress levels and future help-seeking intentions. Actual service use was obtained from service records documenting how many sessions were attended during the intervening two month period. The rationale for a two-month follow-up period being implemented was that while treatment approaches varied, they generally entailed brief evidence-based interventions delivered over three to six sessions completed within a two month timeframe. To thank the participants for their time, they were given the opportunity to go in the draw for a chance to win a \$250 gift voucher.

Measures

Table 1 presents an overview of the variables, measures, and timing of administration for the quantitative components of this thesis.

Demographics. As part of the initial questionnaire, participants were asked to identify their age, gender, referral source, if it was their first time at headspace, if they had looked at the headspace website section ‘what to expect when coming to headspace’ and if they had ever been in therapy or counselling before, even if for only

one session. Participants were also asked to provide their email address so that the researcher could contact them regarding participation in the follow-up survey. To assess age effects, age was categorised into four developmental age groups for the purpose of aim two (12-14, 15-17, 18-20, and 21-25), and age was categorised according to adolescence versus young adulthood for aims three, four and five (12-18 and 19-25).

Expectations. The Expectations about Counselling Brief Form (EAC-B) (Tinsley, Workman, & Kass, 1980) was used as part of the first questionnaire to quantitatively assess clients' expectations of therapy, as it is the only client expectations measure with good validity and reliability that also simultaneously measures all four expectancy domains. The EAC-B is a 66 item self-report questionnaire and items are measured on a seven-point scale ranging from (1) Not True, through to (7) Definitely True. Items are phrased as "I expect to..." and "I expect my counsellor to..." The EAC-B has 17 scales which measure four domains related to the participants' expectations of: (a) their role as a client, this factor is labelled *Personal Commitment* (Motivation, Openness, and Responsibility) and assesses the client's expectation to assume personal responsibility for working hard and achieving progress in counselling; (b) the therapist's role, labelled *Counsellor Expertise* (Acceptance, Confrontation, Directiveness, Empathy, Genuineness, Nurturance, Self-Disclosure, Attractiveness, Expertise, Tolerance, and Trustworthiness) which measures the client's expectation that the counsellor will be a skilled practitioner who will be capable of helping them; (c) the processes of therapy, labelled *Facilitative Conditions* (Concreteness, Immediacy) addresses expectations that therapeutic conditions that have been identified as being theoretically necessary for progress in counselling will be present; and (d) clinical outcomes of therapy,

labelled *Outcome Expectations* (Outcome) shows how much the client expects their mental health and wellbeing to improve. Domain scores are computed by averaging the relevant item scores, and can range from one to seven, with higher scores indicating more positive or optimistic expectations about therapy within that domain. The EAC-B has been found to have good internal consistency, with coefficient alphas ranging from .69 to .82, test-retest reliabilities of .60 or higher (Tinsley, 1982), and support for construct validity (Tinsley & Westcot, 1990; Tinsley, Holt, Hinson, & Tinsley, 1991). Using the present data, all expectancy scale scores showed good internal consistency with Cronbach's α values ranging from a low of 0.83 for the scale Outcome Expectations to a high of 0.94 for the scale Facilitative Conditions Expectations.

In order to address the research aims of this thesis, it was a requirement that clients' expectations, preferences and actual experience of therapy were assessed on a corresponding measure to allow for direct comparison between these factors. To achieve this, the EAC-B was utilised and adapted to not only assess the client's expectations of therapy i.e., "I expect this to occur", but to also assess preferences i.e. "I want this to occur", and their actual experience of therapy i.e. "this did occur". This approach was utilised by Tracey and Dundon (1988), which adapted a client expectations measure to allow participants to rate each item twice, once with respect to how the clients anticipated counselling to be and once with respect to how clients preferred counselling to be. For the purpose of this thesis, client expectations and preferences for therapy were assessed using the EAC-B as part of the first questionnaire and was completed by participants immediately prior to their initial intake session commencing to ensure that expectations and preferences were measured prior to therapy commencing. Actual experience of therapy was assessed

using the EAC-B as part of the second questionnaire two months following completion of the initial questionnaire.

Preferences. In order to differentiate between the participants' expectations and preferences regarding therapy, the 66 items on the EAC-B were adapted so that the items were phrased as "I would like to..." or "I would like my counsellor to..." Four corresponding scale scores were created which measured clients' preferences for Personal Commitment, Counsellor Expertise, Facilitative Conditions and Outcome. Again, total factor scores were computed as average scores and range from one to seven. Higher scores indicate that the client would prefer certain conditions to be present as part of therapy. All preference scale scores showed good internal consistency with Cronbach's α values ranging from a low of 0.79 for the scale Outcome Preference to a high of 0.91 for the scales Personal Commitment and Facilitative Conditions Preferences.

Actual experience. As part of the follow-up questionnaire, the participants were invited to complete an adapted version of the EAC-B to determine their actual experience of seeking help from the mental health care service. The 66 items were now phrased to assess actual experience of therapy, such as "In counselling I did..." or "The counsellor was...". Experience scores for each of the four domains of Personal Commitment, Counsellor Expertise, Facilitative Conditions and Outcome were computed, corresponding to those for expectations and preferences and ranged from one to seven. Higher scores indicate a more positive experience of therapy. All experience scale scores showed good internal consistency with Cronbach's α values ranging from a low of 0.76 for the scale Outcome Experience to a high of 0.95 for the scale Facilitative Conditions Experience.

Clinical outcome. To measure clinical outcome, the 10-item Kessler Psychological Distress Scale (K-10) (Kessler et al., 2003) was utilised. This scale yields a global measure of psychological distress based on questions about anxiety and depressive symptoms that a person has experienced in the most recent four week period. K-10 scores can range from 10 to 50, with higher scores reflecting higher levels of psychological distress. The K-10 was developed in 1992 by Kessler and has been widely used in the United States as well as in Australia, where it has been included in the Australian Survey of Mental Health and Wellbeing and the Australian National Health Surveys (ABS, 2007; Sawyer et al., 2001). The K-10 was chosen to measure psychological distress levels in this thesis as it is a simple self-report measure of psychological distress and a tool used to monitor progress following treatment for common mental health disorders such as anxiety and depression (Kessler et al., 2003). Furthermore, the K-10 is routinely administered at the youth mental health care service where recruitment took place. Participants completed a K-10 both as part of the initial questionnaire and the follow-up questionnaire. To create a clinical outcome score, the initial K-10 score was subtracted from the follow-up K-10 score to create a difference score, so that higher positive scores reflected an improvement in psychological functioning and higher negative scores showed a decline.

Future help-seeking intentions. To measure the young people's likelihood of seeking help from professional sources in the future, participants were asked to rate on a seven-point scale ranging from (1) Extremely Unlikely, through to (7) Extremely Likely "How likely is it that you would seek help from a mental health professional for a personal or emotional problem in the future?" This question was administered as part of the follow-up questionnaire and the item was taken from the General Help

Seeking Questionnaire (Wilson, Deane, Ciarrochi & Rickwood, 2005), a widely used and accepted measure of help-seeking intentions, which has been used in numerous studies with samples of young people. Scores range from one to seven, with higher scores indicating greater likelihood of seeking professional help in the future.

Level of service use. To measure level of mental health care service use, the number of sessions attended by each participant over the two month research period was recorded by the clinicians at the youth mental health care service.

Expectancy confirmation. Finally, to address aim five and to overcome a major gap in prior research which has not examined all four possible expectancy confirmation outcomes, it was important to group participants according to their expectancy confirmation across the multiple domains of client, therapist, process and outcome expectations. As mentioned previously, the expectation and actual experience factor scores across the four domains range from one to seven, with higher scores indicating more positive expectations and experiences of therapy within that domain. For the purpose of creating the expectancy confirmation groups, the expectation scores for each domain were categorised into two groups: negative expectations (scores < 4) or positive expectations (scores \geq 4). Likewise, the experience scores for each domain were categorised into two groups: negative experience (scores < 4) or positive experience (scores \geq 4). Based on participants' expectancy and experience scores, participants were then categorised into one of four expectancy confirmation groups: (a) Positive disconfirmation—participants whose actual experience of therapy was more positive than their initial expectations of therapy; (b) Negative disconfirmation— participants whose actual experience of therapy was more negative than their initial expectations; (c) Positive confirmation— participants whose actual experience and initial expectations of therapy were

congruent and both were positive; and (d) Negative confirmation—participants whose actual experience and initial expectations of therapy were congruent and both were negative.

Analyses

Analyses were undertaken using SPSS 21 statistical package (IMB Corp, 2012). Data were screened and assumptions were tested prior to conducting the analyses. Scale scores were first examined for reliability and psychometric properties.

To address the second research aim, a series of paired samples *t* tests were conducted to determine differences between young people's expectations and preferences for therapy. Furthermore, two two-way multivariate analyses of variance (ANOVA) were conducted to assess the effects of gender and age on young people's expectations and preferences for therapy.

To address the third research aim, a series of factorial ANOVAs were conducted to determine if males and females aged 12 to 18 and 19 to 25 years differ on their initial expectations, preferences, or actual experience of therapy. Further, a series of paired samples *t* tests were conducted to determine differences between young people's initial expectations, preferences, and actual experience of seeking help at the youth mental health care service. Subsequently, bivariate correlations were conducted to determine the relationships between initial expectations, preferences, and actual experience of therapy. Finally, to determine whether there were any significant differences between the follow-up participants sample when compared to the participants who chose not to complete the follow-up survey, a series of *t* tests were conducted with all the key variables.

To examine the fourth research aim, a series of two by four ANOVAs were initially conducted to determine the effects of gender and age group on young people's clinical outcomes, level of mental health service use, and future help-seeking intentions. Bivariate correlations were conducted to determine the relationships between initial expectations, preferences, and actual experience of therapy and young people's clinical outcomes, level of service use, and likelihood of seeking professional help in the future. A path analysis was conducted, using Amos 19, to determine if associations between initial expectations and preferences of therapy and clinical outcomes, mental health care service use, and future help-seeking intentions were mediated by actual experiences of therapy, as hypothesised and presented in paper four.

Finally to examine the fifth research aim, a series of Pearson's Chi-square tests of contingencies were used to examine age group and gender differences for each expectancy confirmation group. One-way ANOVAs were used to determine whether baseline psychological distress varied across the expectation confirmation groups. Further ANOVAs determined the effect of expectancy confirmation group for each of the four expectation domains on young people's clinical outcome, service use, and future help-seeking intentions.

Table 1. Variables, Measures, and Administration for Quantitative Components

| Variable | Measure | Administered |
|---|---|---|
| Age, gender, first time seeking help/seeing a therapist? | Yes/No questions (<i>circle one</i>) or fill in blank | Completed by participant at initial appointment. |
| Base-line psychological distress | Kessler Psychological Distress Scale (K-10) | Completed by participant at initial appointment. |
| Client Expectations: Role Expectations Outcome Expectations Therapy Processes Expectations | Expectations about Counselling Brief Form (EAC-B) | Completed by participant at initial appointment. |
| Preferences: Role Preferences Outcome Preferences Therapy Processes Preferences | Adapted version of the EAC-B. Items re-phrased to “I would like to...” and “I would like my counsellor to...” | Completed by participant at initial appointment. |
| Actual Experience: Role Experience Outcome Experience Therapy Processes Experience | Re-administered adapted version of the EAC-B with items re-phrased to “I did...” and “The counsellor did...” | Completed by participant two months after completion of initial survey. |
| Follow-up psychological distress | Re-administered K-10 | Completed by participant two months after completion of initial survey. |
| Likelihood of seeking professional help in the future | Question from the General Help Seeking Questionnaire | Completed by participant two months after completion of initial survey. |
| Mental health care service use | Number of sessions attended | Recorded by the service clinicians for the duration of the study. |

CHAPTER IV

Exploring Young People's Expectations of a Youth Mental Health Care Service

Paper One: Chapter Introduction

Chapter four presents the first research paper, a qualitative study titled 'Exploring Young People's Expectations of a Youth Mental Health Care Service'. This paper aimed to explore young people's pre-treatment expectations of therapy regarding their role as a client, the therapist's role, the processes of therapy, and their expected outcomes. Paper one presents the main themes that emerged from brief interviews with 20 young people who were accessing help from a youth mental health care service. This paper has been peer-reviewed and was published in the journal *Early Intervention in Psychiatry* in June 2012.



Original Article

Exploring young people's expectations of a youth mental health care service

Clare Watsford, Debra Rickwood and Thea Vanags

Abstract

Client expectations about mental health services relate to the client's and the therapist's role, the therapeutic process and therapeutic outcomes. Research with adults shows that such expectations affect service engagement and clinical outcomes.

Aim: The present study investigated expectations for adolescents and young adults, which have not been adequately investigated and may partly explain the reluctance of young people to seek professional help.

Methods: Participants included 20 young people aged 12–24 attending their initial session at a youth mental health service, who were interviewed immediately prior to their initial session. Data were analysed using qualitative methods to draw main themes around each of the four expectancy types.

Results: Overall, the strongest theme was that young people were unsure of what to expect from attending a mental health service. The key theme for expectations of their role as a client was readiness for therapy, and for the therapist's role the key themes were who they expected to see, the directiveness and likeability of the therapist, and the type of help they expected they would receive. The young people expected that the therapy process would involve simply talking and expected their engagement to be dependent on how much they liked their first few sessions. Outcome expectations were non-specific and the theme of hopefulness was most evident.

Conclusion: As unrealistic and unmet expectations can lead to poorer engagement and outcomes in therapy, the study highlights a need for young people to be better informed about what to expect when coming to mental health services.

Key words: adolescence, health knowledge, mental health service, therapy.

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INTRODUCTION

Adolescents and young adults aged 12 to 25 years represent a critical age group for both the onset of mental illness and the potential for early intervention. Approximately half of all lifetime mental disorders emerge by the time individuals reach their mid-teens and three fourths by mid-20s.¹ Yet despite the high prevalence of mental illness among adolescents, young people tend not to seek help from professional sources.² A large Australian survey found that only 22% of young people with a mental illness

had made contact with a professional service in the previous 12-month period.³ A potentially powerful influence on mental health service use may be client expectations of seeking professional help. Expectations can affect a client's decision to enter a mental health service as well as their ongoing engagement, and may therefore affect clinical outcomes.^{4,5} With so many young people choosing not to seek professional help, investigating the role of client expectations on young people's help seeking is vital.

Client expectations refer to a client's understanding of the likelihood that certain conditions or

processes will occur during therapy.^{5,6} There are four commonly referred to subtypes of client expectations about therapy: the client's role, the therapist's role, therapeutic processes and outcomes.^{4,7,8} Client expectations are a pretreatment client psychological characteristic, as a client brings them on initial contact with a service. Importantly, they are adaptable and could be the target of help-seeking interventions.⁴ The majority of research on client expectations of therapy comes from research with adults; therefore, further research is required on young people's expectations.

Role expectations refer to a client's expectations of their role and also their expectations around their therapist's role.^{4,5,7,8} Research with adults shows that clients with considerably high or low pretreatment role expectations are significantly more likely to prematurely terminate therapy.⁹ Pretreatment role expectations have also been found to be strong predictors of the client's perceived level of working alliance and bond with their therapist.¹⁰

Expectations around the processes of therapy represent one of the least examined areas. This expectation refers to what clients expect will happen during therapy and what techniques will be used.^{4,5,7,8} Therapy expectations are influenced by the mass media, which often portray therapy in a stereotypical psychoanalytic framework and can limit clients' perceptions of what therapy will involve and whether it will be beneficial for them.¹¹ Research has found that adult clients are often unsure of what to expect and many hold inaccurate expectations about evidence-based practices like cognitive behavioural therapy.^{12,13}

The most frequently studied expectancy is outcome expectations; this refers to how strongly clients believe that therapy will help them to improve or feel better.^{4,5,7,8} Research with adults shows positive expectations to be associated with client improvement.^{4,5,7} Unmet expectations may lead to premature termination of therapy, as well as poorer outcomes of and engagement in therapy.^{13,14} Pretreatment outcome expectations have been shown to predict treatment gains during therapy in adult clients.¹⁵ One study found that children who expressed positive pre-treatment expectations reported more positive experiences of the psychotherapy after completion and had greater post-treatment improvement.¹⁶

Limited studies have explored the expectations young people hold with regard to their expectations of therapy. The majority of prior research has examined expectations among college students in non-clinical samples.^{5,17} Research with adolescents has revealed positive correlations between expected

level of personal choice or motivation for treatment and their satisfaction with the service.¹⁸ In addition, a significant barrier for young people seeking professional help is a negative attitude or belief towards professional help seeking.¹⁹

Despite an established link between client expectations and clinical outcomes for adult clients, few studies have examined young people's expectations of mental health services. With the recent emphasis on the critical importance of adolescence and early adulthood for mental health care, the role of client expectations as a factor in their help-seeking process should be explored further. The current study aimed to explore what expectations young people aged 12–25 held regarding: their role as a client; their therapist's role; what they expected the processes of therapy to involve; and their expected outcomes.

METHODS

Participants

Participants were 20 young people (11 females and 9 males) aged between 12 and 24 years ($M = 17.25$, $SD = 12.62$) who were attending their initial intake session at a youth mental health service. The youth mental health service caters to young people aged 12 to 25 years presenting with mild to moderate mental health concerns. All young people who were attending the service for the first time were approached to participate. A total of 23 young people were approached and 20 agreed to participate. Recruitment continued until there was representation across age and gender groups and saturation of key themes was achieved. The young people presented with a range of problems that included depression, anxiety, obsessive-compulsive disorder, drug and alcohol problems, self-harm, school difficulties, work stress, anger, and relationship concerns. Although all the participants were attending the service for the first time, most had prior contact with a counsellor or psychologist, with only three reporting that this was their first service.

Procedure

Prior to the study commencing, ethics approval was obtained from the University of Canberra Committee for Ethics in Human Research. The participants were approached by the principal researcher when they were in the waiting area of the service. Information and consent forms were provided; for young people under the age of 16, parental consent was

also obtained. Semi-structured interviews were conducted in a private room, which ranged in length from 9.06 to 14.53 min (M = 11.04, SD = 1.59). Open-ended questions and prompts were asked around each of the four primary expectancy types; Box 1 contains the questions asked.

RESULTS

Interviews were transcribed verbatim and analysed using NVivo 9 qualitative data analysis software.²⁰ A thematic analysis approach was used to identify

Box 1 Questions asked during the interviews.

- 1 Could you tell me about what you think you will do or what you will be like when you come to therapy sessions? (Example of prompts: How involved and/or motivated will you be?)
- 2 Could you please tell me about what you think your therapist will do in sessions and what they will be like? (Examples of prompts: Who do you think you will be seeing? How involved will they be?)
- 3 Could you tell me about what you think will happen during your sessions – that is, what sort of things you will do, what will therapy be like? (Examples of prompts: Will it be all talk based or will there be activities? How often will you come?)
- 4 Could you tell me about what you think will happen for you after coming to therapy for a while? (Example of prompts: Will anything change or be different for you?)

patterns or themes within the data.²¹ Thematic analysis involves a system of coding text into theoretically defined categories using a systematic approach.²² To test interrater reliability, four clean transcripts were coded by a second independent researcher and coding was compared. Cohen's kappa coefficient corrects for the number of agreements that would occur by chance between coders and was .76; kappas of .75 and above are considered excellent.²³

A dominant overarching theme was evident, showing that overwhelmingly the participants were unsure of what to expect when seeking professional help for mental health concerns. This was despite the fact that the majority had been involved in some type of therapy before. Even after being asked probing questions, most of the young people remained unsure of what they expected therapy would be like. Figure 1 presents an overview of the key themes that emerged for each expectancy type.

Client role expectations

The theme of Not Knowing pervaded all four expectations, but emerged most clearly through client role expectations, as this area was probed first in the interview. There were 17 participants who stated that they did not know or were unsure of what to expect in their role as a client.

I don't even really know how I'm . . . what I'm meant to talk about. – Female, 21
 I don't know . . . tell them about what's up . . . – Male, 16

The other theme that was evident for client role expectations was about Readiness for therapy. Eight participants felt ready to engage in therapy and

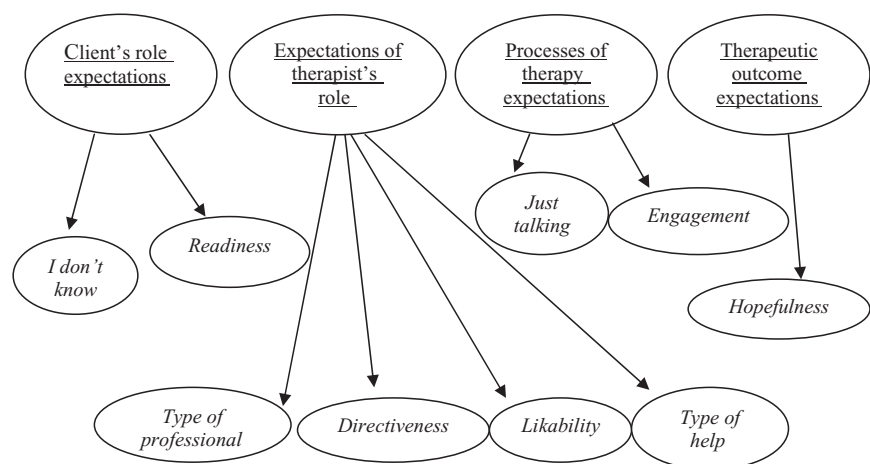


FIGURE 1. Key themes for each expectancy type.

Young people's expectations

made reference to feeling motivated to attend sessions and wanting to actively engage in therapy.

Um, pretty involved, coz like, I guess you've got to be if you want to help yourself. – Male, 18

Five stated strongly that they did not want to engage in therapy at the present time and felt pressured to attend by their loved ones.

Well I got made to come . . . I didn't want to go. – Female, 15

Not really . . . I came because she (mother) wanted me to . . . because she said if I didn't, I wasn't allowed to go anywhere for the rest of the holidays so I didn't have much of a choice! – Male, 16

Seven made reference to feeling unsure or ambivalent around their level of motivation and willingness to engage in therapy.

Yeah, I guess I'm kind of (motivated), I'm not quite sure . . . – Male, 16

Expectations of therapist's role

For therapist role expectations, four themes were evident. The first, labelled Type of Professional, revealed the labels the young people used to describe what type of health professional they expected they would see: 13 expected to see a counsellor, 2 a psychologist, 2 a psychiatrist, 5 a youth worker and 3 did not know. When prompted, half the participants did not know the difference between the types of health professionals.

Ah . . . I'm not too sure . . . I'm pretty sure they're (a psychologist) just like a counsellor but just with a special name . . . – Female, 14

The second theme, Type of Help, identified the type of behaviour they expected from the therapist. Most had vague expectations that the therapist would try to help them, six expected advice, another six expected the therapist to ask questions, six expected the therapist would offer them coping strategies and three expected that they would listen to them.

Um . . . write down everything I tell them, and then they will probably like analyze it later, and think of strategies and then next time I see them they will tell me, um, some strategies that they have thought of . . . yeah. – Female, 14

Um . . . I suppose they will ask me what my problem is and get me to tell them about it and then I don't know, hopefully offer me some ways to . . . cope. – Female, 22

The third theme was Likeability, as the majority of the participants commented on the likeability of the therapist: 14 expected them to be nice or friendly, 7 to be understanding, 5 to be outgoing and fun, 3 to be gentle and calm, and 2 expected them to be serious.

Oh! Friendly and receptive, they shouldn't be judgmental, you know, kind of um, calm. – Female, 18

The fourth theme, Directiveness, was around the therapist's level of involvement in the therapeutic process. More than half of the participants expected to enter into an equal relationship with their therapist, including contributing equally to therapy sessions and guiding topics of discussion.

Well, I think that maybe they will do quite a bit of the talking, but when they ask me questions then I will do a lot of the talking, so it's like, shared. – Female, 13

A total of six participants expected that the therapist would be more involved than themselves. Only one participant expected to be more involved than his/her therapist in the therapy process. Most young people felt it was part of the therapist's job to be more directive and involved in the process and develop an agenda for each session.

Oh, well they will be more involved (than me) because they're getting paid for it, we're paying them. – Male, 16

Interestingly, no strong expectations emerged regarding the therapist's age or gender: nine stated they did not know what to expect, five expected to see a female therapist and only one participant expected to see a male. Seven participants expected the therapist to be young, four expected them to be middle aged and only one participant expected to see an older therapist. When asked about their preferences, only three participants reported a preference to see a female, and one preferred to see a younger therapist.

Um, generally counsellor's tend to be female. – Female, 22

Therapy processes expectations

Expectations about therapeutic processes showed that the strongest theme was that over half the participants expected that therapy would involve simply talking; Just Talking.

I don't know, just talk to them. I don't think we're going to be playing a game of footy in there! To be honest with ya. – Male, 16

Participants were probed to determine whether they expected any specific activities, tasks or worksheets to be part of therapy. The majority of the participants replied they did not expect this, and importantly, many revealed that the suggestion of such activities sounded unusual and even anxiety provoking. Those young people who could refer to other therapeutic activities did not generally have a positive view of these.

I think breathing and cards and exercises and stuff, I have had to do before and I really hate it because it makes me feel like a little kid. – Female, 22

I haven't really read too much into the activities in counselling . . . I always saw counselling as a one-on-one talk, but I knew they did activities, but I only know of activities that they would do to a kid, like draw and stuff. – Male, 19

Participants were specifically probed about homework tasks; however, the word 'homework' was avoided and instead they were asked if they expected to do activities or tasks outside of sessions. Most of the participants had not expected to be required to do homework tasks as part of therapy. Again, homework was not highly regarded.

I'm not going to do homework or something, but if it's like try and change your personality, then I'll have a dig . . . If they're like 'write your name down a million times' I'm not going to do it. – Male, 16

Expectations regarding how long they expected a typical session would last were easier for the young people to consider: 11 expected a typical therapy session to go for 1 h, 4 expected 30 min, 2 for 15 min and 2 were unsure of what to expect. Fewer had thought about how often they expected they would attend sessions, with six young people expecting to come fortnightly, seven to come weekly, three expected to come once and four were unsure. The young people had the greatest difficulty expressing how long they expected they needed to come to sessions before they no longer needed to come, with half of the participants stating that they did not know what to expect; six expected it would take them a few months, two expected it to take over a year and three expected to attend once.

The young people's responses around the processes of therapy revealed a strong theme related to their expected level of engagement, with around half of the young people stating that their expected level of engagement with the service would be dependent on how they felt the first few sessions went. This theme was labelled Engagement.

I don't know, it kind of depends on how well this goes today. – Female, 14

Finally, most of the young people did not expect that their parents would join them in sessions and nothing was forthcoming regarding expectations of what the therapy room would be like, despite all participants being asked about this.

Outcome expectations

For outcome expectations, the most evident theme was called Hopefulness, as 17 participants reported believing that therapy would help them with their concerns and help them to get better.

I think it will be better, it will be something off my back. – Male, 19
um . . . I'll be a lot better . . . in how I think. – Female, 14

Only three participants reported that therapy would not help them with their problems.

I'm not really expecting that much to change. – Male, 16

DISCUSSION

The aim of this research was to explore young people's expectations around therapy and mental health services. The most prominent theme that emerged was that young people were unsure of what to expect from attending a mental health service. This was despite the fact that only three participants had not sought professional help before. The young people did not know what to expect with regard to their role as a client, who they would see and what that person would be like, or the format of sessions. Being unsure of what therapy would be like and what they as a client may be required to do in therapy sessions is likely to be anxiety provoking, suggesting that young people require age-appropriate, clear information on what accessing help from mental health services entails. Given that less than one in four young people with a mental illness seeks professional help,³ these findings highlight the importance of increasing young people's knowledge on what to expect around seeking professional help, which may reduce their anxiety levels and facilitate help seeking among this age group.

The majority of young people expected that therapy would involve simply talking to the therapist. Many evidence-based practices entail more than talking and typically involve homework tasks, worksheets as well as participating in therapeutic

activities.^{24–26} The majority of young people did not expect to do homework tasks or activities in session, and some interviewees stated that this idea was unappealing and/or anxiety provoking. This may impact on how they engage in therapy and may be an explanation for why so many young people do not complete homework tasks in therapy. This result highlights the need for therapists working with young people to be mindful of how they introduce homework tasks in therapy, given that prior research has found that half of the adolescents did not complete their homework tasks as part of cognitive behavioural therapy.²⁷

Although half of the young people in the study felt ready and willing to engage in therapy, it also showed that a quarter of the participants felt pressured, even bribed, to attend therapy. Research with adults has indicated that when clients feel pressured to attend therapy before they feel ready to engage in therapy, it can be harmful to treatment engagement and effectiveness.^{28,29} The participants varied in how ready they felt they were to participate in therapy and the majority of them were hopeful that therapy would help them feel better and most expected to like their therapist. Most of the participants expected to be involved equally in therapy sessions with their therapist. This is congruent with results from research into the experiences and beliefs about treatment decision making of young people.³⁰ They also thought that their future engagement with the service would be dependent on how well they felt their first few sessions went which highlights the importance of rapport building in the first session.

The study is limited because it involved young people from only one youth mental health service in one state of Australia. Furthermore, the interviews were relatively short as the majority of the young people were brief with their responses. Nevertheless, the information provided by these 20 young people showed that they were both unsure of what to expect and held some unrealistic expectations around engaging in therapy. The study has highlighted a need for young people to be better informed around what seeking help from mental health services entails. Increasing young people's awareness of what seeking help involves may promote engagement, reduce dropout rates and lead to better clinical outcomes.

Future research needs to determine whether these factors influence the therapeutic process for young people in terms of engagement and outcomes in therapy including their initial expectations, what their actual experience of the service is, and whether their initial expectations were perceived to be met or not.

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CHAPTER V

What do Young People Seeking Professional Help Want and Expect from Therapy?

Paper Two: Chapter Introduction

The fifth chapter presents the second research paper titled ‘What do Young People Seeking Professional Help Want and Expect from Therapy?’ This paper aimed to quantitatively examine differences between expectations and preferences for therapy across the domains of client and therapist roles, therapy processes, and outcomes, as well as to explore age and gender differences. Paper two presents the findings from the early quantitative data set with a sample of 188 young people who completed an initial questionnaire on contact with a youth mental health care service. This paper has been peer-reviewed and was published in the *World Academy of Science, Engineering, and Technology Journal* in June 2012.

What Do Young People Seeking Professional Help Want and Expect From Therapy?

Clare Watsford, Debra Rickwood

Abstract—Client expectations and preferences about therapy represent an important area of investigation as research shows they are linked to engagement in therapy and therapy outcomes. Studies examining young people's expectations and preferences of therapy remain a neglected area of research. The present study explored what expectations and preferences young people seeking professional help held regarding: their role as a client, their therapist's role, their therapeutic outcomes, and the processes of therapy. Gender and age differences were also examined. Participants included 188 young people aged 12-25 who completed a survey while attending their initial session at a youth mental health service. Data were analysed using quantitative methods. Results found the young people held significantly more pessimistic expectations around therapy when compared to what they had wanted therapy to be like. Few age and gender differences were found. Results highlight the importance of a collaborative therapy approach when working with young people.

Keywords—Client expectations, mental health services, preferences, young people

I. INTRODUCTION

YOUNG people aged 12 to 25 years represent a critical age group for both the onset of mental illness and the potential for early intervention to take place [1]. Approximately half of all lifetime mental disorders onset by the time individuals reach their mid-teens and three-fourths by their mid-20s [2]. The symptoms of mental illness can significantly impact on a young person's development and may include social, emotional, and cognitive impairments that can persist into adulthood [1]. Despite the high prevalence rates of mental illness amongst adolescents, young people tend not to seek help from professional sources [3], [4]. It has been proposed that young people often resist seeking help from professional services as they face a number of barriers in the help-seeking process [1]. Client expectations and preferences of therapy have been found to be influential factors that can affect an individual's decision to seek professional psychological help. Research indicates that client expectations and preferences can have a significant impact on a client's experience of seeking professional help and may not only affect the help-seeking process initially, but also have an on-going effect throughout the help-seeking process.

These expectations and preferences can influence a client's decision to enter a mental health service, and may also affect their clinical outcomes if they do choose to seek professional help [5], [6].

Client expectations refer to what conditions a client thinks or expects will occur during the course of therapy, whereas client preferences refer to attributes of therapy that are desired or wanted by the client [5]. There are four commonly referred to subtypes of client expectations and preferences around: 1) the client's role, 2) the therapist's role, 3) the processes of therapy, and 4) the outcomes of therapy [5], [6], [7]. Client expectations are classed as a pre-treatment client psychological characteristic, as they are something a client brings with them on initial contact with a mental health service [6]. One argument for the significance of studying client expectations and preferences as a pre-treatment client characteristic is that they are adaptable and can be targeted for interventions [6].

Client expectations and preferences of therapy can influence a client's willingness to seek professional help and have been found to play an important role in determining therapy engagement, premature termination of therapy and therapy outcomes [5], [6], [7]. Reviews based predominantly on adult literature have indicated a significant relationship between client expectations and outcomes of therapy, typically finding positive expectations to be associated with client improvement [5], [6], [7]. Client preferences have been recognised as a key component of evidence-based practice, with the American Psychological Association's evidence-based practice policy stating that treatment decisions should be made in collaboration with the client with the goal of maximising client choice [8]. It is fundamental that psychologists and other mental health care providers establish what their clients' expectations and preferences for therapy are early on in therapy in order to assess if these can be met by the therapist or the service [9] and to manage the expectations if they cannot be met.

Previously conducted studies on client expectations and preferences of mental health services have focused on adult clients with comparatively limited research examining young people's expectations and preferences. With the recent emphasis on the importance of adolescence and early adulthood for mental health care, investigating the role of client expectations and preferences on young people's help-seeking is vital. The present study aims to explore what expectations and preferences young people aged 12-25 hold regarding seeking professional psychological help, specifically related to their role as a client, their therapist's role, the

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processes of therapy, their clinical outcomes and whether their initial expectations differ to their preferences for therapy. The current study also aims to examine the effects of gender and age on young people's expectations and preferences for therapy.

II. METHOD

A. Participants

Participants included 188 young people who were seeking help from an Australian youth mental health care service in the capital city of Canberra. The youth mental health service caters for young people aged 12 to 25 years presenting with mild to moderate mental health concerns. Participants covered the whole age range of the service, with a mean age of 17.23 ($SD=3.18$). Of the participants, 125 (65.8%) were female and 63 (33.2%) were male. A total of 77.9% of the participants reported having been in therapy or counselling before.

B. Procedure

Prior to this study commencing, ethics approval was obtained from the University of Canberra Committee for Ethics in Human Research. The participants were recruited by the service receptionist immediately prior to their initial intake session commencing. An information sheet was provided to all participants and to their parents if present. Consent forms were signed by each young person if they chose to participate in the study. For those young people under the age of 16 who agreed to participate, parental consent was also sought. Participants were informed that participation was voluntary and that their responses would be treated with privacy and confidentiality and that the researcher was independent of the health service.

C. Measures

Demographics. Participants were asked to identify their age (12-14, 15-17, 18-20, 21-25), gender, and if they had ever been in therapy or counselling before, even if for only one session.

Client expectations. To measure expectations of therapy, participants completed the Expectations About Counselling-Brief form (EAC-B) [10] prior to their initial intake session. The EAC-B was designed to measure clients' expectations about counselling and has a total of 66 items. The self-report questionnaire items are measured on a seven-point scale ranging from (1) Not True, through to (7) Definitely True. Items are phrased as "I expect to..." and "I expect my counsellor to...", with an example item being "In counselling I expect to talk about my present concerns". The EAC-B has 17 scales, which measure four general areas: 1) *Client's Role Expectations* (Motivation, Openness, and Responsibility); 2) *Therapist's Role Expectations* (Acceptance, Confrontation, Directiveness, Empathy, Genuineness, Nurturance, Self-Disclosure, Attractiveness, Expertise, Tolerance, and Trustworthiness); 3) *Counselling Process Expectations* (Concreteness, Immediacy); and 4) *Outcome Expectations* (Outcome). Total scale scores are computed by averaging the

item scores, so each scale can range from one to seven. Higher scores indicate more positive or optimistic expectations about therapy, with lower scores indicating more negative or pessimistic expectations.

Preferences. In order to differentiate between the expectations and preferences of participants regarding therapy, the 66 items on the EAC-B were adapted so that the items were phrased as "I would like to..." or "I would like my counsellor to..." in order to assess preferences rather than expectations. An example item is "In counselling I would like to talk about my present concerns". Thus, 17 corresponding scale scores were created which measured clients' preferences for each expectancy attribute. Again, total scale scores are computed as average scores and range from one to seven. Higher scores indicate that the client would prefer certain conditions to be present as part of therapy, with lower scores indicating lower preference for the therapy characteristic.

D. Data Analysis

Analyses were undertaken using SPSS 19 statistical package. Data were screened and assumptions were tested prior to conducting the analyses. Two two-way multivariate analyses of variance (ANOVA) were conducted to assess the effects of gender and age on young people's expectations and preferences for therapy. A series of paired samples *t* tests were conducted to determine differences between young people's expectations and preferences for therapy.

III. RESULTS

A. Gender, Age and Expectations

A two-way multivariate ANOVA was conducted to investigate the effects of gender and age group on young people's expectations of therapy. The multivariate test revealed that across a combination of all the expectations there was a significant effect of gender, Wilks' Lambda=.849, $F(17,163)=1.711$, $p=.045$; a significant effect of age, Wilks' Lambda=.659, $F(51,486)=1.430$, $p=.032$; and a non-significant interaction of gender and age, Wilks' Lambda=.732, $F(51,486)=1.053$, $p=.381$.

Follow-up univariate tests revealed significant gender effects for acceptance, $F(1)=4.215$, $p=.042$, and self-disclosure, $F(1)=4.882$, $p=.028$; and a significant age effect for directiveness, $F(3)=6.411$, $p<.001$. No other significant univariate effects were evident. The gender effects showed that females had lower acceptance expectancies than males (Females: $M=4.40$, $SD=1.39$; Males: $M=4.76$, $SD=1.43$) and lower self-disclosure expectancies than males (Females: $M=3.92$, $SD=1.41$; Males: $M=4.31$, $SD=1.53$). The age effect showed a generally linear effect of age group with the younger participants having higher directiveness expectancies than the older participants (12-14 years: $M=4.99$, $SD=1.40$; 15-17 years: $M=4.34$, $SD=1.38$; 18-20 years: $M=3.96$, $SD=1.78$; 21-25 years: $M=3.49$, $SD=1.42$).

B. Gender, Age and Preferences

A two-way multivariate ANOVA was also conducted to investigate the effects of gender and age group on young

people's preferences for therapy. The multivariate test revealed that across a combination of all the preferences there was no effect of gender, Wilks' Lambda=.917, $F(17,163)=0.863$, $p=.618$; a significant effect of age, Wilks' Lambda=.633, $F(51,486)=1.580$, $p=.008$; and a non-significant interaction of gender and age, Wilks' Lambda=.715, $F(51,486)=1.137$, $p=.248$.

Follow-up univariate tests revealed significant age effects for motivation, $F(3)=5.562$, $p=.001$; openness, $F(3)=4.180$, $p=.007$; responsibility, $F(3)=6.495$, $p<.001$; immediacy, $F(3)=4.952$, $p=.003$; and outcome, $F(3)=4.867$, $p=.003$. Table 1 shows that there was a general linear trend whereby the older the participant the greater the preference for each of these attributes. Post-hoc tests showed that 12-14 year olds had significantly lower preferences for motivation, responsibility, immediacy and outcome compared with those aged 18-20 and those aged 22-25. For preference for openness, the 12-14 year olds and 21-25 year olds differed significantly from each other.

TABLE I
AGE GROUP DIFFERENCES IN PREFERENCES

| Measure | Age Group | | | |
|----------------|-------------|-------------|-------------|-------------|
| | 12-14 | 15-17 | 18-20 | 21-25 |
| Motivation | 4.22 (1.59) | 4.86 (1.73) | 5.28 (1.55) | 5.57 (1.28) |
| Openness | 5.12 (1.70) | 5.42 (1.26) | 5.80 (1.03) | 6.01 (0.96) |
| Responsibility | 5.06 (1.44) | 5.64 (1.14) | 6.09 (0.86) | 5.96 (0.80) |
| Immediacy | 4.98 (1.35) | 5.46 (1.24) | 5.73 (0.96) | 5.90 (1.00) |
| Outcome | 5.57 (1.36) | 5.90 (1.25) | 6.29 (0.77) | 6.30 (1.03) |

C. Expectations and Preferences

A series of paired samples *t* tests were conducted to test whether young people's initial expectations for therapy differed significantly to their preferences of therapy. Results revealed that there were significant differences between all 17 expectancy types when compared to their associated preferences at $p<.001$. Overall, the results found that young people held significantly lower and more pessimistic expectations of therapy when compared to what they wanted therapy to be like. Table II presents the results of the series of paired samples *t* tests comparing expectations to preferences.

Interestingly, the young people's highest rated preference for therapy was that the therapist would be genuine or a 'real' person and that they would be honest and respect them. The young people were least likely to want the therapist to self-disclose during therapy and had low preferences for their own level of motivation for therapy. One of the greatest discrepancies was between how much the young people wanted and expected to be able to trust their therapist, with them wanting to trust them much more than they expected to be able to.

D. Client Role Expectations and Preferences

Young people's expectations around their role as a client in therapy were significantly lower and more pessimistic when compared to what they wanted or would have preferred their

role to be like. More specifically, the young people held significantly more pessimistic expectations around their level of personal motivation for engaging in therapy when compared to their preferences. Furthermore, they held significantly lower expectations around their level of openness to discuss their emotions and thoughts in therapy when compared to how much they wanted to. Finally, the young people's expectations around their level of personal responsibility for making their own decisions in therapy and complete homework tasks outside of sessions were significantly more negative when compared to how responsible they would like to be.

Expectations and Preferences around the Therapist's Role

The young people's expectations around the therapist's role were also significantly lower and more pessimistic when compared to what they would have preferred their therapist to be like in therapy. The young people held significantly lower expectations that the therapist would like them and would accept them when compared to how much they wanted their therapist to be accepting of them. Further, their expectations around confrontation, that is, that the therapist would make them face up to differences between what they say and how they behave, were significantly lower when compared to how much they wanted their therapist to point out these differences. Interestingly, young people wanted their therapist to be more directive, offer advice and tell them what to do than they expected them to be. Furthermore, the young people's expectations that the therapist would be empathetic towards them and would know how they were feeling when they had difficulties expressing themselves were significantly lower when compared to their preferences.

The young people held significantly more pessimistic expectations that the therapist would be genuine or a 'real' person, and would be honest and respect them when compared to their preferences. Their expectations that the therapist would be nurturing and would encourage, support, praise, and reassure them were significantly more negative when compared to how much they wanted their therapist to nurture them. The young people's expectations that the therapist would self-disclose by talking openly about themselves were significantly lower and more negative when compared to how much they wanted their therapist to do this. The young people held lower expectations that they would like their therapist and would enjoy sessions with the therapist when compared to how much they wanted this. Their expectations around the counsellor's level of expertise were significantly lower and more negative when compared to their preferences around the expertise of their therapist. The young people's expectations around the counsellor's level of tolerance, that is, being easy-going and able to get along well with others were significantly lower and more negative when compared to their preferences around the tolerance of their therapist.

Finally, the young people's expectations around how much they would trust their therapist were significantly lower and more negative when compared to their preferences around the trustworthiness of their therapist.

E. Counselling Processes Expectations and Preferences

In terms of the concreteness and immediacy of the therapy

process, the young people's expectations that the therapist would help them to make their problem more concrete by identifying their feelings and particular aspects of their behaviour that are important to their problems were lower and more negative when compared to how much they wanted their therapist to do this. Similarly, expectations around the immediacy of therapy, which is about the therapist helping to identify problems they needed to work on in therapy and to develop skills within the counselling relationship to solve these problems was less than preferred.

F. Outcome Expectations and Preferences

Young people had a high level of preference for positive outcomes of therapy, but their expectations were significantly lower than this, although generally quite high. This difference in preferences and expectancies was quite large, however.

TABLE II
DIFFERENCES BETWEEN EXPECTATIONS AND PREFERENCES

| Measure | Mean Expectation | Mean Preference | 95% CI of the difference | <i>t</i> |
|-----------------|------------------|-----------------|--------------------------|----------|
| Motivation | 4.60 (1.50) | 4.94 (1.65) | 0.15 to 0.52 | 3.56* |
| Openness | 4.40 (1.46) | 5.54 (1.31) | 0.93 to 1.33 | 11.20* |
| Responsibility | 5.10 (1.21) | 5.67 (1.16) | 0.43 to 0.71 | 7.96 * |
| Acceptance | 4.52 (1.41) | 5.77 (1.20) | 1.05 to 1.45 | 12.59* |
| Confrontation | 4.92 (1.19) | 5.48 (1.32) | 0.37 to 0.75 | 5.88* |
| Directiveness | 4.26 (1.42) | 5.08 (1.45) | 0.62 to 1.02 | 8.25* |
| Empathy | 4.37 (1.41) | 5.53 (1.35) | 0.96 to 1.36 | 11.45* |
| Genuineness | 5.20 (1.37) | 6.27 (0.86) | 0.89 to 1.24 | 11.95* |
| Nurturance | 5.04 (1.25) | 5.61 (1.29) | 0.40 to 0.72 | 7.13* |
| Self-Disclosure | 4.06 (1.46) | 4.65 (1.67) | 0.39 to 0.79 | 5.85* |
| Attractiveness | 4.39 (1.36) | 5.78 (1.22) | 1.22 to 1.58 | 15.57* |
| Expertise | 4.91 (1.34) | 5.98 (1.11) | 0.90 to 1.25 | 12.14* |
| Tolerance | 5.05 (1.17) | 5.74 (1.13) | 0.56 to 0.82 | 10.55* |
| Trustworthiness | 4.86 (1.38) | 6.00 (1.11) | 0.96 to 1.33 | 12.32* |
| Concreteness | 4.94 (1.24) | 5.83 (1.22) | 0.70 to 1.07 | 9.56* |
| Immediacy | 4.80 (1.26) | 5.49 (1.21) | 0.54 to 0.83 | 9.04* |
| Outcome | 4.86 (1.36) | 5.98 (1.18) | 0.95 to 1.30 | 12.86* |

Notes. (SD), *df* = 187, **p* < .001

IV. DISCUSSION

The present study examined the expectations and preferences held by young people aged 12-25 regarding seeking professional psychological help and whether their expectations differed to their preferences of therapy. The study further explored the effects of gender and age on young people's expectations and preferences of therapy.

Results of the present study found some gender differences, showing that that females were less likely to expect that the therapist would self-disclose and that their therapist would like and accept them when compared to males. Furthermore, some age differences were found, which indicated that younger participants wanted to be less motivated, open, and personally responsible in therapy when compared to the older age groups.

In addition, the younger participants were more likely to expect the therapist to be directive and were less likely to want to have positive outcomes of therapy when compared to the older age groups. These results indicate that age and gender differences should be considered as factors that influence client expectations and preferences around therapy. Results also found that the young people were most likely to want the therapist to be genuine and they were least likely to want the therapist to self-disclose during therapy. Furthermore, the young people reported a low desire for being motivated in therapy. These results suggest that young people may face difficulties with motivation and personal responsibility for therapy. Health professionals working therapeutically with this age group should monitor motivation levels, given that low motivation may impact on engagement and therapeutic outcomes. Results revealed that the young people wanted to be able to trust their therapist much more than they expected to be able to trust them. This finding is clinically important, given that past research has found that young people show greater help-seeking intentions towards trusted sources [11]. These young people also held significantly more pessimistic expectations around their clinical outcomes of therapy when compared to their preferences, thus, fostering a sense of hopefulness that therapy will help them is crucially important in facilitating help-seeking and engagement.

Results found that overall the young people held significantly lower and more pessimistic expectations around therapy when compared to what they wanted therapy to be like. Discrepancies between expectations and preferences were found across the four domains of: 1) the client's role, 2) the therapist's role, 3) the processes of therapy, and 4) the outcomes of therapy. These results are consistent with prior research that has found young people often hold pessimistic attitudes towards therapy and mental health care providers, which can negatively impact on young people's help-seeking behaviours [11]. In order to promote help-seeking and engagement in therapy for adolescents and young adults, it may be beneficial for health professionals working with this age group to dedicate time in the initial session to discuss the client's individual expectations and preferences for therapy. It is important that mental health professionals work collaboratively with adolescent and young adult clients to determine which therapeutic interventions best suit their personal preferences, as this may promote engagement by maximizing client choice [8]. Health professionals should provide young people opportunities to be better informed about what to expect when coming to a mental health care service, given that past research has found that un-realistic or unmet expectancies can lead to poorer outcomes and engagement in therapy [6].

The study is limited because it exclusively involved young people from one youth mental health service in one state of Australia. Nevertheless, it is one of the first studies to systematically examine young people's expectations and preferences. Future research could explore whether client expectations and preferences influence the therapeutic process for young people in terms of engagement and outcomes in therapy.

Further, future research could examine what young people's actual experience of mental health care services are and whether their initial expectations and preferences for therapy are perceived to be met or not.

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CHAPTER VI

Young People's Expectations, Preferences, and Actual Experience of Youth Mental Health Care

Paper Three: Chapter Introduction

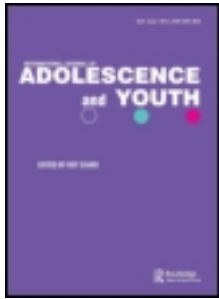
Chapter six presents the third research paper titled 'Young People's Expectations, Preferences, and Actual Experience of Youth Mental Health Care'. Paper three quantitatively examined the relationships and differences between young people's expectations, preferences and subsequent actual experience of therapy and also explored age and gender effects. This paper reports on the findings from the complete quantitative data set, with the participants consisting of a total of 228 young people and of these 102 who also completed the follow-up questionnaire. Paper three has been peer-reviewed and was published in the *International Journal of Adolescence and Youth* in April 2013.

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Young people's expectations, preferences and actual experience of youth mental health care

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Young people's expectations, preferences and actual experience of youth mental health care

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Understanding young people's expectations, preferences and actual experience of therapy is essential, given these factors are linked with engagement in therapy and clinical outcomes. This study examined differences between young people's expectations, preferences and actual experience of seeking professional help. Age and gender differences were also examined. Participants included 228 young people aged 12–25 who completed a survey on contact with a youth mental health care service; of these, 102 completed a follow-up survey two months later. The young people rated preferences for therapy very highly, whereas their initial expectations and actual experience of therapy were significantly lower. Furthermore, males and the 12–18 year age group had higher expectations around the counsellor's expertise, and the 19–25 year age group had higher preferences for their outcomes and personal commitment. Clinicians could tailor interventions to meet young people's preferences for therapy to promote engagement.

Keywords: adolescence; expectations; mental health; preferences; psychotherapy; youth

Introduction

Seeking professional help from mental health care services is a challenging decision for young people experiencing mental health problems. Research has indicated that young people aged 12–25 years are a highly vulnerable age group for the onset of mental illness, who are often reluctant to seek help from professional sources. At least one in four to five young people will experience a mental disorder in any given year and symptoms can persist into adulthood. Yet, a national Australian survey found that only 29% of young people with a mental illness had made contact with a professional service in a 12-month period (Slade et al., 2009). The burden of mental disorders for young people is substantial; there are high rates of self-harm and co-morbidity with other disorders, and suicide is a leading cause of death. Furthermore, mental disorders that onset in adolescence and young adulthood tend to persist into adulthood. Consequently, it is crucially important that young people receive timely and appropriate mental health care as young people represent a unique consumer group, and youth-focused models for mental health care services have been developed and rolled out in an attempt to increase young peoples' likelihood of seeking professional help (Patel, Flisher, Hetrick, & McGorry, 2007).

It has been proposed that young people often resist seeking help from professional services because they face a number of barriers in the help-seeking process. In this process, an individual must initially identify a need to seek help, decide to seek help and then carry out that decision. At each point of this process, there are barriers and facilitators to the

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help-seeking process (Rickwood, Deane, Wilson, & Ciarrochi, 2005). Help-seeking barriers include negative attitudes towards help-seeking in general, the belief that therapy will not help, and being unsure or misinformed about what therapy will involve (Gulliver, Griffiths, & Christensen, 2010).

Importantly, when individuals begin the process of seeking help, they commence with a set of expectations around what they think their experience of therapy will be like. These expectations can be positive, ambivalent or negative (Glass, Arnkoff, & Shapiro, 2001). Clients hold expectations related to the roles they and their therapist will play, the outcomes they will achieve and the processes of therapy. Prior research has established a link between optimistic initial expectations of therapy and positive clinical outcomes and engagement in therapy for adult clients (Dew & Bickman, 2005; Glass et al., 2001; Thompson & Sunol, 1995), but young people's expectations remain unexamined. Given that young people have been identified as a unique and critically vulnerable age group for mental health problem, exploring their expectations is essential.

Another area in the client expectations literature that has failed to receive adequate attention is the confirmation of initial expectations, i.e. whether a client's initial expectations regarding therapy match their actual experience of the therapeutic encounter (Burgoon & LePoire, 1993). The few studies that have explored the concordance of expectations and actual experience of therapy have found poorer clinical outcomes and higher dropout rates for adult clients whose expectations of therapy were disconfirmed (Baekeland & Lundwall, 1975; Duckro, Beal, & George, 1979; Noble, Douglas, & Newman, 2001; Webb & Lamb, 1975; Ziemelis, 1974). It is high time to examine whether young people have expectations of therapy that are congruent with their experience, as this area has not been investigated for youth and may comprise a salient point of intervention for innovation in youth mental health service delivery.

A construct related to client expectations that has received even less attention is client preferences of therapy. Client preferences refer to characteristics of the therapy encounter that are desired, valued or wanted by the client (Arnkoff, Glass, & Shapiro, 2002). Similarly to client expectations, clients can hold preferences related to their role as a client, their therapist's role, the processes of therapy and their clinical outcomes (Glass et al., 2001). While client expectations and preferences have been found to be interrelated, they remain distinct constructs that can affect the therapeutic process differently (Tracey & Dundon, 1988). Client preferences have been recognised as a key component of evidence-based practice, with the American Psychological Association Presidential Task Force's (2006) evidence-based practice policy stating that treatment decisions should be made in collaboration with the client with the goal of maximising client choice. Prior research with adults has demonstrated a relationship between client preferences and premature termination of therapy as well as clinical outcomes, typically finding that clients who received their preferred treatment were significantly less likely to prematurely terminate therapy and had better clinical outcomes (Swift & Callahan, 2008). Very little is known about young people's preferences for therapy. One recent study found that young people held significantly more positive preferences for therapy when compared to their expectations (Watsford & Rickwood, 2012). Gaining a greater understanding of young people's preferences for therapy is important, given the associations found with dropout rates and clinical outcomes for adults.

To date, no research has comprehensively examined the initial expectations, preferences and actual experience of therapy for young people, nor endeavoured to determine whether these factors correspond. To promote help-seeking and engagement in therapy among young people, it is essential to gain a greater understanding of young people's journey seeking professional help. We need better understanding of what young

people expect and want from therapy, and whether these match their actual experience of therapy and mental health service delivery. The present study aims to explore how young people expect, want and experience therapy at a youth mental health care service. It also compares young people's expectations, preferences and actual experience of seeking help – related to their role as a client, the therapist's role, processes of therapy and clinical outcomes. Age and gender differences are also examined. In particular, the differences between adolescents and young adults are of interest, given the usual demarcation between child and adolescent and adult mental health service.

Method

Participants

Participants included a total of 228 young people who were seeking help from an Australian youth mental health care service in the capital city of Canberra. The service caters for young people aged 12–25 years presenting with mild to moderate mental health concerns. Clinicians of the mental health service are registered psychologists, providing evidence-based psychological interventions. Participants covered the whole age range of the service, with a mean age of 17.24 (SD = 3.17). Of the total participants, 158 (69.3%) were female and 70 (30.7%) were male. Of the 228 participants who completed the initial survey, 102 (44.7%) agreed to also complete the follow-up survey two months later. The follow-up participants had a mean age of 17.81 (SD = 3.16), and 73 (71.6%) were female and 29 (28.4%) were male. A total of 895 young people attended an initial assessment during the recruitment phase, and the 228 who agreed to participate in the research project comprised a response rate of 25.5%.

Procedure

Prior to the commencement of the study, ethics approval was obtained from the University of Canberra Committee for Ethics in Human Research. The participants were recruited by the receptionist in the waiting area of the service immediately prior to their initial intake session. An information sheet with details of the study was provided to all participants and to their parents if present. Consent forms were signed by each young person if they chose to participate in the study, and for those young people under the age of 16 who agreed to participate, parental consent was also sought. After consent forms were signed, the participants filled out a brief questionnaire in the reception area while waiting for their intake session to commence. The initial survey asked the participants a series of questions around their expectations and preferences for therapy as well as demographic questions. Two months after completing the initial survey, the participants were emailed by the primary researcher and invited to complete an online follow-up survey and a reminder email was also sent. The follow-up survey asked the participants questions around their actual experience of seeking help at the youth mental health care service. Participants were informed that participation in the study was voluntary and that their responses would be treated with privacy and confidentiality and that the researcher was independent of the service.

Measures

Demographics

Participants were asked to identify their age, gender and if they had ever been in therapy or counselling before, even if for only one session.

Client expectations

To measure expectations of therapy, participants completed the Expectations About Counselling-Brief form (EAC-B) (Tinsley, Workman, & Kass, 1980). The EAC-B was designed to measure clients' expectations about counselling and has a total of 66 items. The self-report questionnaire items are measured on a seven-point scale ranging from (1) Not True to (7) Definitely True. Items are phrased as 'I expect to ...' and 'I expect my counsellor to ...' with an example item being 'In counselling I expect to talk about my present concerns'. The EAC-B measures four general areas around participant's expectations of: (1) their role as a client – *personal commitment*; (2) the therapist's role – *counsellor expertise*; (3) the processes of therapy – *facilitative conditions*; and (4) their clinical outcomes of therapy – *outcome expectations*. Total factor scores are computed by averaging the item scores, so each factor can range from 1 to 7. Higher scores indicate more positive or optimistic expectations about therapy.

Preferences

In order to differentiate between the participants' expectations and preferences regarding therapy, the 66 items on the EAC-B were adapted so that the items were phrased as 'I would like to ...' or 'I would like my counsellor to ...'. An example item is 'In counselling I would like to talk about my present concerns'. Four corresponding scale scores were created which measured clients' preferences for: (1) *personal commitment preferences*; (2) *counsellor expertise preferences*; (3) *facilitative conditions preferences*; and (4) *outcome preferences*. Again, total factor scores are computed as average scores and range from 1 to 7. Higher scores indicate that the client would prefer certain conditions to be present as part of therapy.

Actual experience

In the follow-up survey, the participants were requested to complete another adapted version of the EAC-B to determine their perceived experience of seeking help from the mental health care service. The items were now phrased as 'In counselling I did ...' or 'The counsellor was ...'. An example item is 'In counselling I did talk about my present concerns'. Again four corresponding factor scores were created which measured clients' actual experience for: (1) *personal commitment experience*; (2) *counsellor expertise experience*; (3) *facilitative conditions experience*; and (4) *outcome experience*. Factor scores range from 1 to 7, with higher scores indicating a more positive experience of therapy.

Data analysis

Data analysis was undertaken using SPSS 19 statistical package. Data were screened and assumptions were tested prior to conducting the analyses. Scale scores were first examined for reliability and psychometric properties. To determine whether there were any significant differences between the follow-up participants sample and that of the participants who chose not to complete the follow-up survey, a series of *t*-tests were conducted with all the key variables. A series of factorial analyses of variance were conducted to determine if males and females aged 12–18 and 19–25 years differ on their initial expectations, preferences or actual experience of therapy. Furthermore, a series of paired samples *t*-tests were conducted to determine differences between young people's

initial expectations, preferences and actual experience of seeking help at the youth mental health care service. Subsequently, bivariate correlations were conducted to determine the relationships between initial expectations, preferences and actual experience of therapy.

Results

Scale properties

All scale scores showed good internal consistency with Cronbach's α values ranging from a low of 0.76 for the scale *outcome experience* to a high of 0.95 for the scale *facilitative conditions experience*. Table 1 provides the means and standard deviations for young people's initial expectations, preferences and actual experience of therapy. It is interesting to note that, on average, the young people's initial expectations of therapy on all four factors were in the mid-range of the rating scale, indicating that they did not hold overly optimistic or pessimistic expectations for therapy on initial contact with the mental health care service. Across all the factors, the lowest mean score was for *counsellor expertise expectations*, which suggests that young people only held moderate expectations regarding their therapist's personal characteristics and level of skill. In contrast, the young people held very high preferences on all four factors, which were all near the top-end of the rating scale. The highest mean score was for *outcome preferences*, indicating that young people very much want to have positive clinical outcomes of therapy. Similarly to their expectations of therapy, the young people's actual experience of therapy was rated, on average, in the mid-range of the rating scale. Notably, the highest average actual experience score was for *facilitative conditions experience*.

Differences between initial and follow-up samples

A series of *t*-tests were conducted to determine if the participants who chose to complete only the initial survey differed significantly from the participants who agreed to complete the follow-up survey. Results revealed that there were no significant differences on age, gender or any of the measures of initial expectations and preferences for therapy. These

Table 1. Mean expectations, preferences and actual experience (SD) by age and gender.

| | Female | | Male | |
|-------------------------|--------------|--------------|-------------|--------------|
| | 12–18 years | 19–25 years | 12–18 years | 19–25 years |
| Expectations | | | | |
| Facilitative conditions | 4.86 (1.20) | 4.62 (1.05) | 5.07 (1.27) | 5.12 (0.897) |
| Personal commitment | 4.73 (1.13) | 4.65 (0.994) | 4.56 (1.23) | 5.08 (0.795) |
| Counsellor expertise | 4.46 (1.23) | 3.78 (0.988) | 4.63 (1.23) | 4.51 (1.17) |
| Outcome | 4.87 (1.43) | 4.84 (0.123) | 4.59 (1.55) | 5.24 (0.960) |
| Preferences | | | | |
| Facilitative conditions | 5.90 (0.952) | 5.78 (0.887) | 5.60 (1.24) | 5.89 (0.623) |
| Personal commitment | 5.52 (1.10) | 5.88 (0.803) | 5.14 (1.18) | 5.92 (0.816) |
| Counsellor expertise | 5.43 (1.18) | 5.02 (1.06) | 5.16 (1.23) | 5.42 (0.910) |
| Outcome | 6.00 (1.12) | 6.31 (0.882) | 5.50 (1.44) | 6.38 (0.639) |
| Actual experience | | | | |
| Facilitative conditions | 5.07 (1.47) | 5.46 (1.37) | 5.33 (1.56) | 5.70 (1.08) |
| Personal commitment | 4.57 (1.28) | 5.22 (1.28) | 4.92 (1.52) | 5.38 (1.28) |
| Counsellor expertise | 4.45 (1.69) | 4.53 (1.16) | 4.23 (1.42) | 4.29 (1.31) |
| Outcome | 4.35 (1.35) | 4.55 (1.45) | 4.40 (1.77) | 4.62 (1.54) |

results indicate that the follow-up sample was similar to the initial sample on all measured variables.

Age and gender differences

Table 1 presents the means and standard deviations for males and females aged 12–18 and 19–25 years for initial expectations, preferences and actual experience of therapy. A series of factorial analyses of variance were conducted to determine if males and females aged 12–18 and 19–25 years differed on their initial expectations, preferences or actual experience of therapy. Results revealed that males held significantly higher expectations of counsellor expertise when compared to females ($F(1, 224) = 6.37, p = 0.012$, partial $\eta^2 = 0.028$), and the 12–18-year-old age group held significantly higher expectations of counsellor expertise than the 19–25-year-old age group ($F(1, 224) = 5.14, p = 0.024$, partial $\eta^2 = 0.022$). Furthermore, the 19–25-year-old age group held significantly higher preferences for outcomes ($F(1, 224) = 12.51, p < 0.001$, partial $\eta^2 = 0.053$) and personal commitment ($F(1, 224) = 13.23, p < 0.001$, partial $\eta^2 = 0.056$) when compared to 12–18-year-old age group. No other significant main or interaction effects for age group or gender were found.

Expectations and preferences

A series of paired samples *t*-tests were conducted to test whether young people's initial expectations for therapy differed significantly from their preferences of therapy (see Table 2). Results showed that the young people's initial expectations around their personal commitment (Cohen's $d = -0.89$, large), their therapist's role (Cohen's $d = -0.88$, large), the processes of therapy (Cohen's $d = -0.90$, large) and their clinical outcomes (Cohen's $d = -0.96$, large) were all significantly lower and more pessimistic when compared to their preferences on these factors.

Expectations and actual experience

Further, a series of paired samples *t*-tests were conducted to test whether young people's initial expectations for therapy differed significantly from their actual experience of therapy. Results displayed in Table 2 show that the young people's initial expectations around their outcomes of therapy were significantly higher and more optimistic when compared to their actual experience regarding their outcomes of therapy (Cohen's $d = 0.27$, small). Furthermore, and on the contrary, the results indicated that the young people's initial expectations around facilitative conditions were significantly lower and more pessimistic when compared to their actual experience of the processes of therapy (Cohen's $d = -0.42$, small). Results found no significant differences between initial expectations and actual experience for counsellor expertise and personal commitment.

Preferences and actual experience

In contrast, the differences between preferences of therapy and actual experience were all found to be significant. Results presented in Table 2 show that the young people's preferences around their personal commitment (Cohen's $d = 0.57$, medium), their therapist's role (Cohen's $d = 0.68$, medium), the processes of therapy (Cohen's $d = 0.36$, small) and their clinical outcomes (Cohen's $d = 1.19$, large) were all significantly higher and more optimistic when compared to their actual experience on these factors.

Table 2. Differences between expectations, preferences and actual experience.

| Measure | Mean expectation | Mean preference | Mean experience | Expectation versus preference | | Expectation versus experience | | Preference versus experience | |
|-------------------------|------------------|-----------------|-----------------|-------------------------------|----------|-------------------------------|----------|------------------------------|---------|
| | | | | 95% CI of the difference | t | 95% CI of the difference | t | 95% CI of the difference | t |
| Facilitative conditions | 4.75 (1.18) | 5.75 (1.05) | 5.30 (1.41) | -1.05 to -0.82 | -16.31** | -0.83 to -0.27 | -3.89*** | 0.13 to 0.73 | 2.87* |
| Personal commitment | 4.68 (1.03) | 5.59 (1.01) | 4.91 (1.34) | -0.96 to -0.74 | -15.04** | -0.51 to -0.04 | -1.70 | 0.40 to 0.95 | 4.82*** |
| Counsellor expertise | 4.15 (1.20) | 5.21 (1.22) | 4.32 (1.39) | -1.07 to -0.80 | -13.69** | -0.46 to 0.12 | -1.17 | 0.59 to 1.20 | 5.81*** |
| Outcome | 4.82 (1.31) | 5.97 (1.07) | 4.45 (1.45) | -1.32 to -1.00 | -14.57** | 0.06 to 0.69 | 2.34* | 1.19 to 1.86 | 9.00*** |

Note: Values in the parentheses are standard deviations; df = 101 or 227.
 * $p < 0.05$, ** $p < 0.001$.

Relationships between expectations, preferences and actual experience

Table 3 presents the bivariate correlations between initial expectations, preferences and actual experience. This reveals that the majority of the variables were significantly interrelated, with the exception of the outcome factors, which were more likely to have non-significant correlations. There were particularly high correlations between (1) expectations of facilitative conditions and expectations of counsellor expertise, (2) experience of facilitative conditions, experience of counsellor expertise and experience of personal commitment and (3) expectations of personal commitment and expectations of outcomes.

Discussion

The present study explored young people's initial expectations and preferences and their subsequent actual experience of seeking help at a youth mental health care service. Age and gender differences were also examined. Results found that males and the 12–18-year-olds held significantly higher expectations around the counsellor's level of expertise and the 19–25-year-olds held significantly higher preferences for their outcomes and personal commitment. The results also revealed that the young people rated preferences for therapy very highly and had strong positive hopes for all aspects of therapy, whereas their initial expectations and actual experience were scored significantly lower. Initial expectations were found to be similar to actual experience, with most differences non-significant or yielding small effect sizes; thus, results indicate that young people's initial expectations of therapy are realistic and tend to be met. Furthermore, results found that expectations, preferences and actual experience were mostly significantly interrelated.

The results suggest that on initial contact with a youth mental health care service, young people strongly desired therapy to be a really positive experience. However, on average, the young people perceived their actual experience of the therapeutic encounter to be less favourable than they had initially hoped for. The results are congruent with the findings of quantitative research which found preferences of therapy to be more optimistic than initial expectations among young people seeking professional help (Watsford & Rickwood, 2012). The young people's positive preferences of therapy indicate that they feel a sense of hopefulness when commencing the help-seeking process and that they want to gain a lot out of therapy. It is important that young people are optimistic about therapy, as pessimistic beliefs about therapy have been found to be a barrier to help-seeking (Gulliver et al., 2010). Yet, these findings also highlight a need to provide education to young people in regard to what the therapeutic encounter involves in order to promote realistic hopes of therapy. It may be problematic that young people's preferences of therapy were not found to match their actual experience of therapy, given that prior research with adults has found clients who did not receive their preferred therapy mode had poorer clinical outcomes and higher dropout rates of therapy (Swift & Callahan, 2008). Thus, it would be important for clinicians to aspire to provide young consumers with psychological interventions that complement their individual desires. Future research could examine whether unmet expectations or preferences affect young people's clinical outcomes and engagement in therapy, as this has not been adequately explored to date.

Results of the present study indicate that the young people's initial expectations and actual experience of therapy were generally congruent with one another, but they are hopeful of something better. This finding suggests that young people hold relatively realistic expectations around the therapeutic encounter. For the facilitative conditions of therapy, however, young people's actual experiences exceeded their initial expectations.

Table 3. Bivariate correlations between expectations, preferences and actual experience.

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
|--|---|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| 1. Expectation facilitative conditions | | 0.69** (228) | 0.40** (102) | 0.83** (228) | 0.55** (228) | 0.38** (102) | 0.80** (228) | 0.51** (228) | 0.37** (102) | 0.72** (228) | 0.40** (228) | 0.33** (102) |
| 2. Preference facilitative conditions | | — | 0.27** (102) | 0.57** (228) | 0.80** (228) | 0.25** (102) | 0.64** (228) | 0.77** (228) | 0.25** (102) | 0.58** (228) | 0.64** (228) | 0.15 (102) |
| 3. Experience facilitative conditions | | | — | 0.30** (102) | 0.25** (102) | 0.86** (102) | 0.30** (102) | 0.31** (102) | 0.85** (102) | 0.24** (102) | 0.18 (102) | 0.69** (102) |
| 4. Expectation counsellor expertise | | | | — | 0.62** (228) | 0.36** (102) | 0.67** (228) | 0.35** (228) | 0.27** (102) | 0.63** (228) | 0.25** (228) | 0.27** (102) |
| 5. Preference counsellor expertise | | | | | — | 0.29** (102) | 0.49** (228) | 0.64** (228) | 0.19 (102) | 0.42** (228) | 0.48** (228) | 0.12 (102) |
| 6. Experience counsellor expertise | | | | | | — | 0.29** (102) | 0.24** (102) | 0.83** (102) | 0.16 (102) | 0.13 (102) | 0.70** (102) |
| 7. Expectation personal commitment | | | | | | | — | 0.69** (228) | 0.34** (102) | 0.83** (228) | 0.54** (228) | 0.30** (102) |
| 8. Preference personal commitment | | | | | | | | — | 0.30** (102) | 0.56** (228) | 0.82** (228) | 0.18 (102) |
| 9. Experience personal commitment | | | | | | | | | — | 0.27** (102) | 0.25** (102) | 0.73** (102) |
| 10. Expectation outcome | | | | | | | | | | — | 0.56** (228) | 0.33** (102) |
| 11. Preference outcome | | | | | | | | | | | — | 0.11 (102) |
| 12. Experience outcome | | | | | | | | | | | | — |

Note: Values in the parentheses are total numbers (N).
* $p < 0.05$, ** $p < 0.001$.

Their initial expectations of the processes of therapy were not well formed, as their scores were quite low on this factor, and their experience was generally more positive than they anticipated. It is important to note that the service where the research was undertaken is specifically set up to be youth friendly. Practitioners are selected and trained in youth-friendly practice, as well as providing evidence-based psychological interventions. Given the low rates of professional help-seeking among young people, it is encouraging to find that this age group is responsive to evidence-based psychological interventions in a youth-friendly mental health care service.

Importantly, the largest difference revealed was that the young people's initial expectations around their clinical outcomes were much more optimistic than their actual experience of their outcomes of therapy. Note that follow-up took place two months after commencement of therapy, however, and consequently, it is possible that therapeutic change may not have reached a level that was initially expected by the young people. Young people may need to be provided with more information regarding the processes of clinical improvement early in the therapeutic encounter and be aware that therapeutic change can take time, is a process to work towards and is not typically an immediate response to therapy. However, clinicians may also need to focus on alleviating psychological distress earlier in therapy with brief interventions, so that young people start to feel better sooner rather than emphasising assessment, given that research has demonstrated the efficacy of brief intervention among adolescents (Goti, Diaz, Serrano, & Gonzalez, 2010). It is important that young people are well informed about the processes of clinical outcomes, in order to promote realistic expectations and engagement in therapy, and encourage them to persevere until outcomes start to be evident. However, it is still important that young people are optimistic, given that past research has indicated that pessimistic beliefs around therapy are a barrier to help-seeking (Gulliver et al., 2010). Future research should explore the effects of initial expectations, preferences and actual experience of therapy on young people's clinical outcomes and engagement in therapy.

This study is limited in that it exclusively involved young people from one youth mental health care service in Canberra, Australia, and it is unknown how well these results may generalise to young people more widely. Furthermore, just under half of the original participant sample agreed to participate in the follow-up survey, and while results found no significant differences between these groups on the variables measured, it is likely the participants who dropped out of the study differed from those who did not in other meaningful ways. In addition, an overall response rate of 25.5% again suggests that caution should be taken with the representativeness of the sample. However, the study is the first to address a gap in prior research by comprehensively examining the initial expectations, preferences and actual experience of therapy for young people and, further, determining whether these factors match one another. Gaining a more detailed understanding of young people's expectations, preferences and actual experience of therapy may help clinicians working with these age groups to make more tailored and informed treatment decisions, which could lead to increased engagement in therapy and improved clinical outcomes.

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CHAPTER VII

Young People's Expectations, Preferences and Experiences of Therapy: Effects on Clinical Outcome, Service Use and Help-Seeking Intentions

Paper Four: Chapter Introduction

The fourth research paper titled 'Young People's Expectations, Preferences and Experiences of Therapy: Effects on Clinical Outcome, Service Use and Help-Seeking Intentions' is presented in chapter seven. This quantitative research paper examined the impact of expectations, preferences and actual experience of therapy on important outcome variables for youth, namely, service engagement, clinical outcome and help-seeking intentions. This paper has been peer-reviewed and was accepted for publication in the journal *Clinical Psychologist* in November 2013 (Manuscript ID: CPAPS-2013-041).

Young people's expectations, preferences and experiences of therapy: Effects on clinical outcome, service use and help-seeking intentions

Abstract

Background: Young people represent a vulnerable age group for mental health concerns and tend not to seek help. Exploring factors that influence young people's engagement in therapy and clinical outcomes is crucial. This study examined the relationships between young people's expectations, preferences and actual experience of therapy on their clinical outcome, mental health care service use, and help-seeking intentions. Gender and age effects were also explored.

Methods: A quantitative prospective research method was utilised. Participants included a total of 228 young people aged 12 to 25 years who completed an initial survey on contact with a youth mental health service and 102 who completed an online follow-up survey two months later.

Results: Results showed that young people's actual experiences of therapy and their preference to be personally committed to therapy were positively associated with the outcome variables. No significant associations were evident for initial expectations. No age or gender effects were found.

Conclusions: These initial findings suggest that initial expectations may not be well-formed for youth and appear to not be relevant to young people's engagement or outcomes, and are less important than motivation and actual experiences. Youth-focussed mental health services need to ensure a positive early experience to promote early intervention and relapse prevention.

Keywords: Client expectations, preferences, service use, therapy, young people.

Total word count: 6,291

Introduction

There is a high prevalence rate of mental disorders among young people aged 12 to 25 years (Slade et al., 2009). Symptoms of mental illness can significantly impact on a young person's development and may include social, emotional, and cognitive impairments that persist into adulthood (Costello, Foley, & Angold, 2006). Results of the US-based National Comorbidity Survey found that 75% of people with a mental disorder had an age of onset younger than 24 years. Australian national data show that one in four young people will experience a mental health problem in a 12 month period, with affective, anxiety and substance use disorders being the most common conditions (Slade et al., 2009). The transition from adolescence through young adulthood is a critical developmental period comprising major change in all developmental domains including psychological, social, and ongoing biological changes. Mental health problems among adolescents and young adults represent a concerning public health challenge, as the burden of mental illness on young people and the community is substantial (Patel, Flisher, Hetrick, & McGorry, 2007). However, the vast majority of young people experiencing mental illness will either delay or fail to seek help from professional sources (Slade et al., 2009), with young men being the least likely to seek help (Rickwood, Deane, & Wilson, 2007).

In an attempt to facilitate help-seeking and engagement in mental health care services for young people, youth-friendly models of care have been developed and implemented across developed countries (Patel et al., 2007). The importance of early intervention for emerging mental disorders has been widely recognized as a fundamental factor in effective treatment for young people (Bertolote & McGorry, 2005). It is vital that young people seek help from professional sources in a timely manner, as seeking appropriate treatment at the onset of disorder can minimise the damage to social, vocational, educational, and psychological functioning (Kessler et al.,

2007).

Many young people fail to seek help from professional sources because they face a number of barriers in the help seeking process. These barriers include problems recognising symptoms, a preference for self-reliance and informal support, and the perceived stigma, shame, and embarrassment of mental illness and mental health service use. Moreover, negative attitudes towards help-seeking in general, the belief that therapy will not help, and being unsure or misinformed about what therapy will involve represent important help-seeking barriers for young people (Gulliver, Griffiths, & Christensen, 2010; Rickwood, Deane, & Wilson, 2007). Related to this, the adult literature has established that client expectations and preferences for mental health care are significant factors influencing the help-seeking process, engagement in therapy as well as clinical outcomes; typically finding pessimistic expectations and denied access to preferred treatments to be associated with lower help-seeking intentions, poorer engagement in therapy and decreased clinical improvement (Dew and Bickman, 2005; Glass, Arnkoff, & Shapiro, 2001; Joyce, Ogradniczuk, Piper, & McCallum, 2003; Swift & Callahan, 2009; Thompson & Sunol 1995; Vogel, Wester, Wei, & Boysen, 2005).

Client expectations refer to the conditions a client thinks or expects will occur during the course of therapy (Dew & Bickman, 2005). Whereas client preferences refer to characteristics of the therapeutic encounter that are desired, valued or wanted by the client (Arnkoff et al., 2002). Clients can hold expectations and preferences related to their role as a client, the therapist's role, their clinical outcomes, and the processes of therapy (Dew & Bickman, 2005; Glass, Arnkoff, Shapiro, 2001; Thompson & Sunol, 1997). While research has indicated that client expectations and preferences are correlated, these constructs are distinct and can influence therapy differently (Tracey & Dundon, 1988). Prior research has found some age and gender differences for young people's expectations and preferences for therapy. Females have been found to be less

likely to expect the therapist will like and accept them and were less likely to expect the therapist to self-disclose when compared to males. Younger participants have been found to hold lower preferences to be motivated, open, and personally responsible in therapy and are more likely to expect the therapist to be directive when compared to older age groups (Watsford & Rickwood, 2012).

Research has examined the effects of client expectations on important outcomes, such as clinical improvements, premature termination of therapy, service satisfaction, and therapeutic alliance (Dew & Bickman, 2005). Based predominantly on adult samples, the literature reveals a significant association between client expectations and clinical improvement; typically finding that more optimistic expectations are associated with improved mental health and wellbeing (Dew & Bickman, 2005; Glass, Arnkoff, & Shapiro, 2001; Thompson & Sunol 1995). Research exploring associations between role expectations and therapeutic alliance shows that more optimistic client expectations are related to higher client-rated therapeutic alliance (Al-Darmaki & Kivilghan, 1993). More positive client expectations have also been found to be associated with higher satisfaction with mental health therapy (Garland, Haine, & Lewczyk Boxmeyer, 2007). Associations with premature termination of therapy reveal that both extremely positive and extremely negative expectations (Nock & Kazdin, 2001) or generally pessimistic expectations (Shuman & Shapiro, 2002) are linked with higher attrition rates.

Preferences are also relevant, with prior research showing that clients who received their preferred psychological treatment having better clinical outcomes and reporting greater therapeutic alliance than clients who did not receive a treatment congruent with their preferences (Berg, Sandahl, & Clinton, 2008; Iacoviello et al., 2007). Moreover, two meta-analyses report that clients who received their preferred treatments were significantly less likely to prematurely drop out from therapy and were significantly more likely to show improved clinical outcomes (when compared with

clients whose preferences were either not considered or not matched (Swift & Callahan, 2009; Swift, Callahan & Vollmer, 2011).

Clients' actual experiences of therapeutic encounters may mediate the effect of initial expectations and preferences of therapy on clinical outcomes, as proposed by the expectancy disconfirmation theory. Expectancy disconfirmation refers to discrepancies between clients' initial expectations of therapy compared to their actual experience of therapy (Duckro, Beal, & George, 1979). Research based on adult population samples has shown that the greater the discrepancy between a client's expectations of therapy and the reality of the therapeutic encounter, the less effective treatment will be and the more likely the client will be to disengage from the process of therapy (Baekeland & Lundwall, 1975; Duckro, Beal, & George, 1979; Webb & Lamb, 1975; Westra et al., 2010; Ziemelis, 1974).

To date, research into client expectations and preferences of therapy has been concentrated among adult client populations, and there has been little focus on younger people aged 12 to 25 years. Given that young people represent a unique and vulnerable age group for mental health concerns, it is important to determine whether the links found for the impact of adult client's expectations and preferences on clinical outcomes also apply to young people.

The present study aims to address this gap by examining young people's expectations, preferences and actual experience of therapy and the relationship of these factors with clinical outcomes, level of mental health service use, and future help-seeking intentions. Associations between more positive initial expectations and preferences of therapy and better clinical outcomes, greater mental health care service use, and intentions to seek help in the future were hypothesised to be potentially mediated by the young people's actual experience of therapy, as displayed in Figure 1. Age and gender effects were also investigated.

Method

Participants

Participants comprised a total of 228 young people who were seeking help from an Australian youth mental health care service in the capital city of Canberra. The youth mental health service is part of an innovation in mental health service delivery that transcends the usual child and adolescent versus adult service dichotomy and caters for young people aged 12 to 25 years presenting with mild to moderate mental health concerns (Hodges, O'Brien, & McGorry, 2007). The aim is to intervene early in the development of mental health problems, and so, effective engagement is essential. Consistent with the early intervention focus of the service, most young people present with emerging symptoms of high prevalence mood disorders, mostly anxiety and depression, and have sub-threshold or first diagnosis of a mood disorder. Treatments vary, but generally entail brief evidence-based interventions with 3-5 sessions of therapy. Participants covered the whole age range of the service, with a mean age of 17.24 ($SD=3.17$). Of the total participants, 158 (69.3%) were female and 70 (30.7%) were male. The age and gender profile of the participant sample is typical of the service users. Of the 228 participants who completed the initial survey, 102 (44.7%) agreed to also complete the follow-up survey two months later. The follow-up participants had a mean age of 17.81 ($SD=3.16$) and 73 (71.6%) were female and 29 (28.4%) were male.

No significant differences were found between the participants who completed the follow-up survey when compared to those participants who chose to only complete the initial survey on their age, gender, psychological distress, initial expectations or preferences for therapy. A total of 895 young people attended an initial assessment at the mental health service during the recruitment phase, and a total of 228 agreed to participate in the research project, signifying an overall response rate of 25.5%.

Procedure

Ethics approval was obtained from the University of Canberra Committee for Ethics in Human Research prior to the study commencing. The participants were invited to participate in the study while in the reception area of the mental health care service immediately prior to their initial intake session commencing. An information sheet with details of the study was provided to all participants and to their parents if present. Participants were informed that participation in the study was voluntary and that their responses would be treated with confidentiality and that the researcher was independent of the mental health service. Consent forms were signed by each young person and parental consent was also sought for those young people under the age of 16.

After consenting, the participants filled out a brief self-report questionnaire while waiting in the reception area. The initial survey asked the participants a series of questions around their expectations and preferences for therapy, demographics, and assessed baseline psychological distress levels. Two months after completing the initial survey, the participants were emailed by the primary researcher and invited to complete an online follow-up survey. This asked questions about their actual experience of seeking help at the youth mental health care service and measured follow-up psychological distress levels. Actual service use was obtained from service records showing how many sessions were attended during the intervening two month period.

Measures

Demographics. Participants were asked to identify their age range, gender, and to provide contact details so that the researcher could contact them regarding participation in the follow-up survey. Age was categorised into two age groups in order to assess differences between adolescents aged 12-18 years and young adults aged 19-25 years.

Client expectations. To measure expectations of therapy, participants completed the Expectations About Counselling-Brief Form (EAC-B) immediately prior to their initial

intake session commencing (Tinsley, Workman, & Kass, 1980). The EAC-B has been validated for use with adolescents and has been found to have good internal consistency, with coefficient alphas ranging from .69 to .82, test-retest reliabilities of .60 or higher (Tinsley, 1982), and support for construct validity (Tinsley & Westcot, 1990; Tinsley, Holt, Hinson, & Tinsley, 1991). The EAC-B was designed to measure clients' expectations about counselling and has a total of 66 items. The self-report questionnaire items are measured on a seven-point scale ranging from (1) Not True, through to (7) Definitely True. Items are phrased as "I expect to..." and "I expect my counsellor to..." with an example item being "In counselling I expect to talk about my present concerns". The EAC-B measures four general areas around the participants' expectations of: 1) their role as a client, this scale is labelled *Personal Commitment* and assesses the client's expectation to assume personal responsibility for working hard and achieving progress in counselling, for example "I expect to contribute as much as I can in terms of expressing my feelings and discussing them"; 2) the therapist's role, labelled *Counsellor Expertise* measures the client's expectation that the counsellor will be a skilled practitioner who will be capable of helping them, for example "I expect I will see an experienced counsellor"; 3) the processes of therapy, labelled *Facilitative Conditions* addresses expectations that evidence based therapeutic conditions that have been identified as being theoretically necessary for progress in counselling will be present, for example "I expect to gain some experience in new ways of solving problems within the counselling process"; and 4) clinical outcomes of therapy, labelled *Outcome Expectations* shows how much the client expects their mental health and wellbeing to improve. Total scale scores are computed by averaging the item scores, so each scale can range from one to seven, with higher scores indicate more positive or optimistic expectations about therapy.

Preferences. In order to differentiate between the participants' expectations and

preferences regarding therapy, the 66 items on the EAC-B were adapted so that the items were phrased as a preference, such as “I would like to...” or “I would like my counsellor to...”. An example item is “In counselling I would like to talk about my present concerns”. Four scales of preferences for personal commitment, counsellor expertise, facilitative conditions and outcomes were computed corresponding to those for expectations.

Actual experience. In the follow-up survey the participants were requested to complete another adapted version of the EAC-B to determine their actual experience of seeking help from the mental health care service. The items were now phrased to assess actual experience, such as “In counselling I did...” or “The counsellor was...”. An example item is “In counselling I did talk about my present concerns”. Four scales of experience of personal commitment, counsellor expertise, facilitative conditions and outcomes were computed corresponding to those for expectations and preferences.

Clinical outcome. The 10-item Kessler Psychological Distress Scale (K-10) (Kessler et al., 2003) was used as a clinical outcome measure. This scale yields a global measure of psychological distress based on questions about anxiety and depressive symptoms that a person has experienced in the most recent four week period. K-10 scores can range from 10 to 50, with higher scores reflecting higher levels of psychological distress. Participants completed the K-10 both as part of the first questionnaire to assess baseline psychological distress and as part of the second questionnaire to determine follow-up distress levels. To create a clinical outcome score, the initial K-10 score was subtracted from the follow-up score, so that higher positive scores reflect an improvement in psychological functioning and higher negative scores show a decline.

Level of service use. To measure level of mental health care service use, the number of sessions attended by each participant over the two month research period was recorded by the clinicians at the youth mental health care service.

Future help-seeking intentions. In order to measure the young people's likelihood of seeking help from professional sources in the future, participants were asked to rate on a seven-point scale ranging from (1) Extremely Unlikely, through to (7) Extremely Likely: "How likely is it that you would seek help from a mental health professional (e.g., school counsellor, psychologist, psychiatrist) for a personal or emotional problem in the future?" This question was administered as part of the follow-up survey and the item was taken from the General Help Seeking Questionnaire (Wilson, Deane, Ciarrochi & Rickwood, 2005). Scores range from one to seven, with higher scores indicating greater likelihood of seeking professional help in the future.

Results

Analysis

Analyses were undertaken using SPSS 19 statistical package. Data were screened and assumptions were tested prior to conducting the analyses. Scale scores were first examined for reliability and psychometric properties. A series of two by four ANOVAs were initially conducted to determine the effects of gender and age group on young people's clinical outcomes, level of mental health service use, and future help-seeking intentions. Bivariate correlations were conducted to determine the relationships between initial expectations, preferences, and actual experience of therapy and young people's clinical outcomes, level of service use, and likelihood of seeking professional help in the future. A path analysis was conducted, using Amos 19, to determine if associations between initial expectations and preferences of therapy and clinical outcomes, mental health care service use, and future help-seeking intentions were mediated by actual experiences of therapy, as hypothesised and presented in Figure 1. For each domain of expectations, preferences and outcomes, measures of the four

components of personally commitment, counsellor expertise, facilitative conditions and outcomes were included. To improve reliability of the standard error, a bootstrapping technique was utilised. A path analysis was used rather than multiple regression analyses to assess the effects of multiple dependant variables in one analysis.

Outcomes

Clinical outcomes in terms of improvement in psychological distress scores ranged from -15 to 27, with a mean of 3.26 ($SD=8.98$), indicating that on average the young people decreased in their level of psychological distress two months after completing the initial survey. Level of service use ranged from attending one session up to 10 sessions during the two month research period. The average number of sessions attended was 3.89 ($SD=2.78$). Young people rated their likelihood of seeking help in the future from professional services from one to seven, with a mean of 5.35 ($SD=1.62$), indicating that future help-seeking intentions were rated quite high.

Age and Gender

A series of ANOVAs were used to examine the effects of gender and age group on young people's clinical outcome, service use and help-seeking intentions. With a Bonferroni adjustment for inflated Type I error rate due to multiple comparisons p was set at .01. For clinical outcome, there were no significant effects of gender, $F(1,94)=4.79$, $p=.031$; age group, $F(3,94)=3.27$, $p=.025$; or the interaction of gender and age group, $F(3,94)=1.40$, $p=.248$. Similarly, for service use there were no significant effects for gender, $F(1,220)=0.13$, $p=.722$; age group, $F(3,220)=1.99$, $p=.116$; or the interaction term, $F(3,220)=0.09$, $p=.968$. Again, the results for help-seeking intentions were non-significant: gender, $F(1,94)=0.92$, $p=.341$; age group, $F(3,94)=1.50$, $p=.220$; and the interaction, $F(3,94)=1.05$, $p=.376$.

Expectations, Preference, Experience and Outcomes

Table 1 presents the bivariate correlations between young people's expectations, preferences and actual experience of therapy and their clinical outcomes, level of service use, and likelihood of seeking professional help in the future. No significant associations were evident between initial expectations of facilitative conditions, counsellor expertise, personal commitment, or outcomes and clinical outcomes, level of service use, or future help-seeking intentions.

For preferences, the only significant relationship was between preferences for personal commitment and clinical outcome, showing that as level of personal commitment preference increased so too did improvement in clinical outcome in terms of reduction in psychological distress. No significant relationships were found for any of the other preference measures and the outcome measures.

For actual experience of therapy, most of the factors were significantly related to the outcome variables. The more positive young people's actual experience of their therapy outcomes the greater the reduction in their psychological distress and the higher their level of service use. More positive experience of the facilitative conditions of therapy was also associated with better clinical outcome, more service use and greater likelihood of future help-seeking. More positive actual experience of personal commitment was associated with greater session attendance and higher likelihood of seeking professional help in the future. Finally, as actual experience of counsellor expertise was more positive, so were clinical outcomes and number of sessions attended.

Predicting Outcomes

The hypothesised model of multivariate relationships presented in Figure 1 did not fit the data $\chi^2 = 998.555$, $df = 81$, $p < .001$, GFI = .939, AGFI = .169, TLI = .072, RMSEA = .335. The model was subsequently modified by dropping non-significant paths, and examination of modification indices was used to obtain a better fitting model. A model that statistically fit the data containing all the variables of interest could not be found. Excluding all the expectation and preference variables was required to attain a well-fitting model as these variables did not demonstrate significant bivariate relationships as originally predicted, with the exception of preference for personal commitment which had a very weak bivariate association with outcome.

Figure 2 shows the model that was the best fit to the data, $\chi^2 = 13.182$, $df = 12$, $p = .356$, GFI = .962, AGFI = .911, TLI = .995, RMSEA = .032, along with standardised parameter estimates. All paths presented were significant at $p < .05$. This model explained 14% of the variance in clinical outcome, 31% of the variance in level of service use, and 7% of the variance in future intentions to seek help. All the parameters attaining significance in this multivariate model were consistent with their bivariate correlations.

In the multivariate model, the only direct predictor of clinical outcome was a moderately strong relationship with the young people's actual experience of their outcomes. The only direct predictor of level of service use was a strong relationship with actual experience of personal commitment. Finally, future help-seeking intentions were only directly predicted by a weak relationship with actual experience of facilitative conditions of therapy.

Discussion

This study examined the relationships between young people's expectations, preferences and actual experience of therapy and their clinical outcome, level of mental health care service use, and likelihood of seeking help from professional sources in the future. It also explored age and gender differences, none of which were found. The results provide some interesting preliminary findings in this area, showing that young people's initial expectations of therapy were not related to their clinical outcome, level of mental health care service use, or their future help-seeking intentions. Rather, results revealed that young people's actual experience of therapy and their preferences for being personally committed to therapy were related to these outcome variables. The only direct predictor of clinical outcome was a moderate relationship with the young people's actual experience of their outcomes. The only direct predictor of level of service use was a strong relationship with actual experience of personal commitment. Finally, future help-seeking intentions were only directly predicted by a weak relationship with actual experience of the processes of therapy.

Contrary to hypotheses, young people's expectations for therapy were not related to outcomes. This finding is not consistent with past research among adult samples, which has found client expectations to be linked with these outcome variables (Dew & Bickman, 2005; Glass, Arnkoff, & Shapiro, 2001; Thompson & Sunol 1995). This suggests that young people's initial expectations may not be as important in predicting therapy outcomes as they are for adult clients. Prior research has indicated that young people do not hold very firm expectations about therapy and have often not thought extensively about what therapy will involve (Watsford, Rickwood, & Vanags, 2012). Young people often initially make contact with mental health services because someone else, like a parent or caregiver, has facilitated this and they therefore may not have formed strong views themselves about the help-seeking process or the therapeutic

encounter (Rickwood, Deane, & Wilson, 2007). Based on these results it is speculated that the clinical implication for those young people with less formed expectations is that the first experiences of therapy are critical, as these may lay the foundation for future expectations, which as adults will then have an effect on outcomes.

Preference for personal commitment to therapy was the only preference variable to show an association with outcomes. Those young people who wanted to be more personally committed and involved in therapy were more likely to have positive clinical outcomes in terms of improved psychological functioning. This finding highlights the central role that the client's level of motivation and sense of personal responsibility in therapy plays in gaining improved clinical outcomes. Given that young people are reluctant to seek help, this finding highlights the importance of promoting self-motivation for young people which may, in turn, promote engagement in mental health service use.

Results show the importance of the actual experience of therapeutic encounters on clinical outcomes and engagement for young people. If young people have a negative experience of therapy, they are at greater risk of not seeking help again in the future and it is particularly important given the recurring nature of much mental health problems that younger clients perceive therapy as something they would be prepared to engage in again should they need it (Gulliver, Griffiths, & Christensen, 2010). Clinicians working with this age group need to ensure that early help-seeking for mental health care is positive in terms of: the processes of therapy, for example by providing evidence-based interventions; counsellor expertise, for instance by having a therapist that is experienced and empathetic and developing a strong therapeutic alliance; and promoting personal commitment and experienced outcomes, as these may be important as a predictor of future mental health care outcomes in adulthood. Positive expectations of therapy need

to be promoted in order to facilitate the likelihood of early engagement in mental health services upon experiencing signs of mental illness in the future.

A major strength of this study is that it is the first longitudinal study using a clinical sample to examine young people's expectations, preferences and actual experience of therapy and to explore the effect of these factors on clinical outcomes, and addresses an important gap in the literature. It has several important limitations, however. In particular, participants were recruited from one youth mental health care service in Canberra, Australia, and it is unknown how well these results may generalise to young people more widely. Notably, this service is specially set up to address the needs of young people, and more traditional forms of mental health service delivery may have quite different expectations and effects on young people. Further, just under half of the original participant sample agreed to participate in the follow-up survey, and while results found no significant differences between these groups on the variables measured, it is likely the participants who dropped out of the study differed to those who didn't in other meaningful ways. In addition, an overall response rate of 25.5% again suggests that caution should be taken with the representativeness of the sample. Furthermore, most of the data were self-reported, and it would improve validity to corroborate clinical outcomes with clinician measures. In particular, using change in K-10 scores provides only a rudimentary indication of improvement in clinical outcomes. While service use information was gathered by the service providers, this did not include service use from other service providers, nor show whether future help-seeking intentions were matched by future service use behaviour. Furthermore, for the purpose of this study, the EAC-B client expectations measure was adapted to measure preferences and actual experience, and as such, further analyses to determine the validity of these modifications would be warranted. In particular, possible order effects as a result of measuring both expectations and preferences at the same time were not

controlled. Moreover, determining the direction of causality is a challenge with cross-sectional data. Lastly, the clinical outcome measures were rudimentary and other indices of meaningful change might be more relevant for these age groups.

Future research could explore the expectancy disconfirmation theory with young people, as this has not adequately been examined before. The expectancy disconfirmation literature explores discrepancies between initial expectations of therapy when compared to the client's actual experience of therapy and how these differences influence clinical outcomes (Burgoon & LePoire, 1993; Duckro, Beal, & George, 1979). It is important to gain a greater understanding of the effect that unmet expectations may have on young people's clinical outcome, service use, and help-seeking intentions, as previous research has demonstrated this effect among adult samples (Baekeland & Lundwall, 1975; Webb & Lamb, 1975; Westra et al., 2010; Ziemelis, 1974).

Key Points

The current study has provided some interesting initial findings that highlight the critical importance of monitoring and promoting young peoples' motivation and personal commitment to therapy as well as fostering a positive therapy experience, which can lead to improved engagement and clinical outcomes for young mental health service users.

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Table 1
Correlations between Expectations, Preferences and Experience on Outcomes

| | Level of Service Use | Clinical Outcome | Future Help Seeking Intentions |
|-------------------------|-------------------------|---------------------|-----------------------------------|
| Expectations: | | | |
| Facilitative Conditions | .08 (228) | .06 (102) | .11 (102) |
| Counsellor Expertise | -.01 (228) | .10 (102) | -.04 (102) |
| Personal Commitment | .09 (228) | .07 (102) | .09 (102) |
| Outcome | .07 (228) | .13 (102) | .01 (102) |
| Preferences: | | | |
| Facilitative Conditions | .10 (228) | .08 (102) | .10 (102) |
| Counsellor Expertise | .05 (228) | .11 (102) | -.01 (102) |
| Personal Commitment | .11 (228) | .22* (102) | .15 (102) |
| Outcome | .09 (228) | .12 (102) | .07 (102) |
| Experience: | | | |
| Facilitative Conditions | .40** (102) | .38** (102) | .26** (102) |
| Counsellor Expertise | .37** (102) | .35** (102) | .15 (102) |
| Personal Commitment | .54** (102) | .32** (102) | .23* (102) |
| Outcome | .20* (102) | .35** (102) | .15 (102) |

Note. (Number of participants) ** $p < .001$, * $p < .05$.

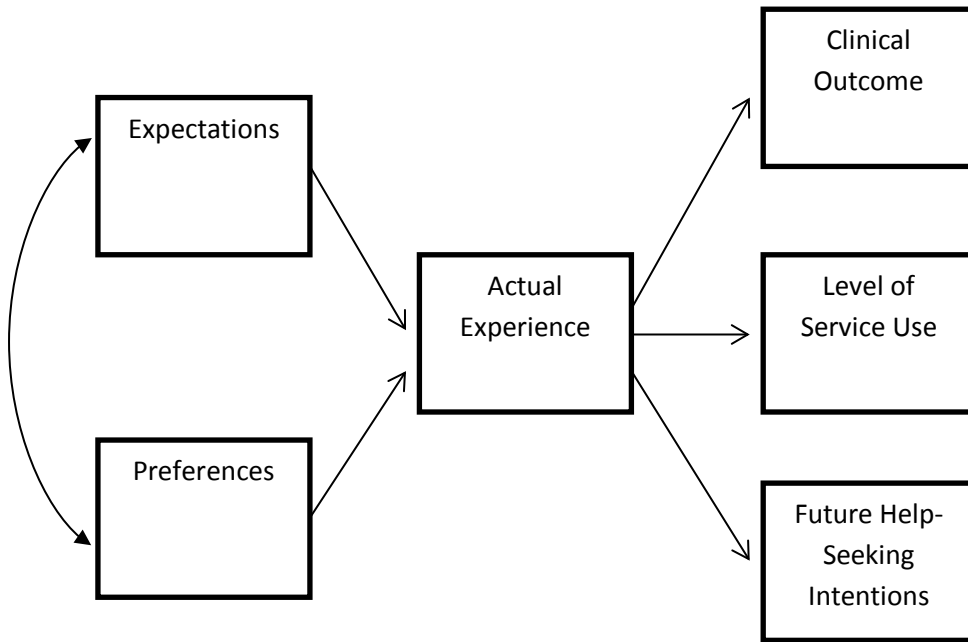


Figure 1. Hypothesised relationships of initial expectations, preferences and actual experience of therapy on clinical outcomes, mental health care service use, and future help-seeking intentions.

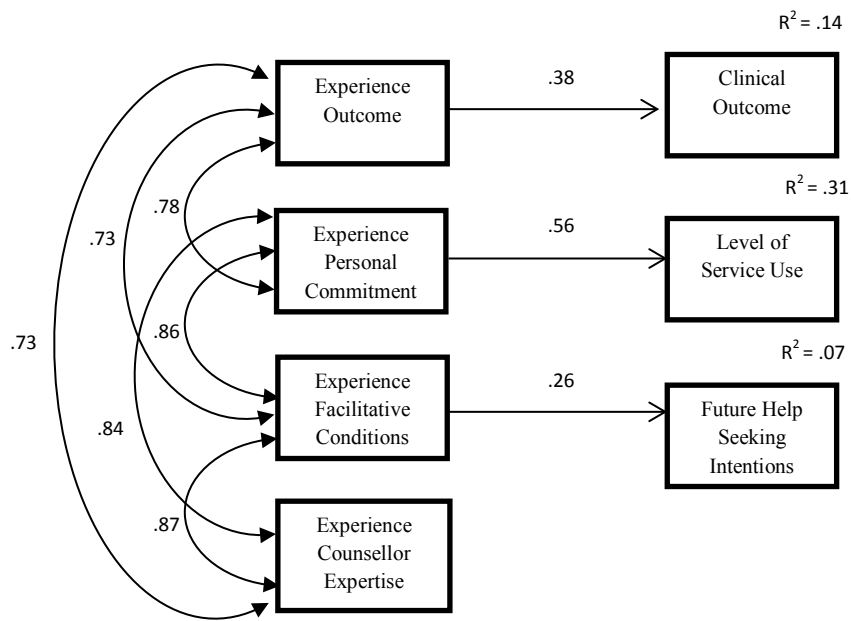


Figure 2. Final path model predicting clinical outcomes, level of service use, and future help-seeking intentions.

CHAPTER VIII

Disconfirmed Expectations of Therapy and Young People's Clinical Outcome, Help-Seeking Intentions, and Mental Health Service Use

Paper Five: Chapter Introduction

The final research paper is presented in chapter eight and is titled 'Disconfirmed Expectations of Therapy and Young People's Clinical Outcome, Help-Seeking Intentions, and Mental Health Service Use'. This research paper examined the effects of expectancy confirmation and disconfirmation on clinical outcome, engagement and help-seeking intentions. Paper five has been peer-reviewed and was accepted for publication in the journal *Advances in Mental Health* in September 2013 (Manuscript ID: AMH4278).

Disconfirmed expectations of therapy and young people's clinical outcome, help-seeking intentions, and mental health service use

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ABSTRACT: *Objective:* Disconfirmed client expectations of therapy have been linked with poorer clinical outcomes and higher premature termination of therapy for adult clients, however, research with young people has been lacking. The present study aimed to address this gap by examining the effects of disconfirmed expectations in relation to roles, outcomes, and processes of therapy on young people's clinical outcome, mental health service use, and future help-seeking intentions. Age and gender differences were also examined. *Method:* Participants included 102 young people aged 12–25 years who completed an initial questionnaire on contact with a youth mental health care service, which was targeted at mild to moderate early presentations of mental health problems, and a follow-up questionnaire 2 months later. *Results:* Findings showed that young people who experienced negatively disconfirmed expectations related to their role as a client or the processes of therapy had a poorer clinical outcome and attended fewer sessions. Furthermore, young people who had a negative experience of their role as a client or the therapist's role attended fewer sessions and those who had a negative experience of their outcome expectations had a poorer clinical outcome. No age or gender differences were found. *Conclusions:* The potentially detrimental effect of having a worse therapy experience than expected on outcomes and engagement for young people indicate a need for clinicians to help young consumers to have realistic expectations as well as a positive experience of therapy.

KEYWORDS: disconfirmed expectations, young people, clinical outcomes, psychotherapy, help-seeking

Clients' expectations of therapy have long been recognised as an influential factor affecting important outcome variables such as client engagement, drop-out rates, therapeutic alliance, and clinical outcomes. Four different domains of client expectation have been distinguished as relevant. Clients can hold expectations related to: (1) their role as a client (e.g., how personally motivated or involved they expect to be); (2) the therapist's role (e.g., how experienced and skilled they expect the therapist to be); (3) the processes of therapy (e.g., what techniques therapy will involve); and (4) the outcomes of therapy (e.g., expectations that therapy will help improve psychological distress) (Dew & Bickman, 2005; Glass, Arnkoff, & Shapiro, 2001; Thompson & Sunol, 1995). Prior research with adult population samples has established associations between optimistic outcome expectations and improved clinical outcomes (Dew & Bickman, 2005; Glass et al., 2001; Joyce, Ogradniczuk, Piper, & McCallum, 2003; Price, Anderson, Henrich, & Rothbaum, 2008) as well as a medium-sized effect for better client-rated therapeutic alliance (Joyce et al., 2003). Furthermore, clients' pre-treatment role and outcome expectations have

been found to be useful measures in identifying clients who may be at risk for early termination of treatment, and accounted for 11–14% of the variance in premature termination (Callahan, Aubuchon-Endsley, & Swift, 2009). Optimistic client role expectations are linked with greater client-rated therapeutic alliance (Al-Darmaki & Kivlighan, 1993; Patterson, Uhlin, & Anderson, 2008). Both client and therapist expectations for the number of sessions to be attended have been shown to predict the actual number of sessions attended, with client expectations being the stronger predictor (Mueller & Pekarik, 2000).

Research has not only been interested in exploring the effects of clients' initial expectations of therapy on clinical improvement and engagement, but has also examined how disconfirmed expectations influence outcome variables. Expectancy disconfirmation refers to discrepancies between clients' initial expectations of therapy compared to their actual experience of therapy (Duckro, Beal, & George, 1979). It has been suggested that a client's engagement in the processes of therapy and their trust in the therapist increases when there is a match between their expectations of therapy and the intervention provided

(Duncan, Sparks, & Miller, 2000). A review by Noble, Douglas, and Newman (2001) found that when clients' expectations of the process of care were incongruent with the service provided, therapy outcomes were poorer. A number of studies have linked disconfirmed client role expectations to poorer clinical outcomes of therapy (Westra, Aviram, Barnes, & Angus, 2010) as well as increased likelihood of premature termination of therapy (Nock & Kazdin, 2001; Reis & Brown, 1999; Walitzer, Dermen, & Conners, 1999). Other research has found clients' expectations for treatment recovery rates were significantly higher than actual recovery rates and raised the issue that a large number of clients are at risk of discontinuing treatment before they have actually recovered when expectations are not met (Swift & Callahan, 2008). A qualitative study of 18 adult clients found almost all of them rated their actual experience of cognitive behavioural therapy to be inconsistent with their initial expectations of therapy, with pleasant surprises more prevalent among clients who had favourable clinical outcomes, and disappointing experiences more common among clients with poorer outcomes (Westra et al., 2010). Research exploring adult clients' expectations of therapy found that the majority of clients initially held moderate, rather than very high or low expectations of therapy, and also found that differences in expectations and actual experience of therapy were mainly in the positive direction (Dimcovic, 2001). Discrepancies between clients' pre-treatment expectations for the typical therapy session and their actual experience of session usefulness and comfort have also been shown to predict therapeutic alliance (Joyce & Piper, 1998).

A major limitation in prior research examining disconfirmed expectations is that expectancy disconfirmation is often measured as any incongruence between initial expectations and actual experience of therapy, whereas there are actually four possible combinations of expectations and experience (Horenstein & Houston, 1976). A client can experience: (1) positive expectancy disconfirmation, where their experience of therapy is perceived to be more positive than their initial expectations; (2) negative expectancy disconfirmation, where experience is more negative

than initial expectations; (3) positive expectancy confirmation, where expectations and experience of therapy match and both are positive; or (4) negative expectancy confirmation, where expectations and experience of therapy match and both are negative. Prior research has failed to assess all four expectancy confirmation groups on important outcome variables, and rather has just focussed on any incongruence and often not included the valence of the incongruence, and therefore cannot ascertain the potentially distinct impact that each expectancy confirmation group may have. Furthermore, research to date has neglected to simultaneously assess all four expectation domains on outcome variables, again, making it difficult to compare the unique effects of each expectancy type.

Moreover, research exploring expectancy disconfirmation has predominantly focussed on adult client samples, with research exploring young people's expectations of therapy being extremely limited. In recent times, there has been a focus on the critical importance of early intervention for mental health problems (Bertolote & McGorry, 2005; Patel, Flisher, Hetrick, & McGorry, 2007), and young people aged 12–25 years are recognised as a vulnerable age group for the onset of mental illness and represent a critical age period for early intervention to take place (Kessler et al., 2007; Patel et al., 2007; Slade et al., 2009). One in four young people will experience a mental health problem in a 12-month period, and evidence suggests that young people often fail to seek help from professional services (Slade et al., 2009). Young people have been shown to hold not well defined expectations of therapy, and often have higher hopes for therapy compared with what they expect therapy to involve (Watsford & Rickwood, 2012; Watsford, Rickwood, & Vanags, 2012). Some age and gender differences have been found regarding young people's expectations for therapy, with females less likely to expect the therapist will like and accept them and to expect the therapist to self-disclose compared to males, and younger adolescents have been found to be more likely to expect the therapist to be directive compared with older adolescents and young adults (Watsford & Rickwood, 2012).

It is important that young people engage with appropriate mental health care services early in the developmental trajectory of mental disorder to improve their psychological functioning; it is also important that young people have a positive experience of therapy to promote optimistic future help-seeking intentions (Gulliver, Griffiths, & Christensen, 2010; Patel et al., 2007). Given the links established among adult populations between disconfirmed expectations and therapy outcomes, it is timely that this area be examined specifically for young people, as results from adult samples may not apply for younger clients. The transition from adolescence through young adulthood is a critical developmental period comprising major change in all developmental domains, but no prior research has examined the effects of disconfirmed expectations on engagement with therapeutic services and clinical outcomes for clients in these life stages. As most mental health problems and disorders emerge at this time, investigating the factors that engage and retain young people in mental health services and maximise their clinical outcomes is a vital area of investigation.

The present study addresses this gap in the research by examining the effects of disconfirmed expectations on young people's service engagement and clinical outcome. The study also builds on previous research by examining the effects of all four possible expectancy outcomes across the multiple domains of client, therapist, process and outcome expectations. It was hypothesised that disconfirmed expectations across all the domains, when there were positive initial expectations, would be associated with poorer clinical outcome, less service use and reduced help-seeking intentions. Such effects were expected to be stronger for young adults compared with adolescents, as expectations were anticipated to be more well-formed for the older clients.

METHOD

Participants

Participants comprised a total of 102 young people who were seeking help from an Australian youth mental health care service in the capital city of Canberra. The service is part of an innovation

in mental health service delivery that transcends the usual child and adolescent versus adult service dichotomy and caters for young people aged 12–25 years presenting with mild to moderate mental health concerns (McGorry, Purcell, Hickie, & Jorm, 2007). The aim is to intervene early in the development of mental health problems, and so, effective engagement is essential. Participants covered the whole age range of the service, with a mean age of 17.81 years ($SD = 3.16$). Of the total participants, 73 (71.6%) were female and 29 (28.4%) were male. Consistent with the early intervention focus of the service, most young people presented with emerging symptoms of high prevalence mood disorders, mainly anxiety and depression, and had sub-threshold symptoms or first diagnosis of a mood disorder. Treatment approaches varied, but generally entailed brief evidence-based interventions delivered over three to six sessions.

Procedure

Ethics approval was obtained from the University of Canberra Committee for Ethics in Human Research prior to the study commencing. The participants were invited to participate in the study while in the reception area of the mental health care service immediately prior to their initial intake session commencing. An information sheet with details of the study was provided to all participants and to their parents if present. Participants were informed that participation in the study was voluntary and that their responses would be treated with confidentiality and that the researcher was independent of the mental health service. Consent forms were signed by each young person and parental consent was also sought for those young people under the age of 16.

After consenting, the participants filled out a brief self-report questionnaire while waiting in the reception area. The initial questionnaire asked the participants a series of questions around their expectations for therapy, their age and gender, and assessed baseline psychological distress levels. Two months after completing the initial survey, the participants were emailed by the primary researcher and invited to complete an online follow-up questionnaire. This asked questions about

their actual experience of seeking help at the youth mental health care service and measured follow-up psychological distress levels and future help-seeking intentions. Actual service use was obtained from service records documenting how many sessions were attended during the intervening 2-month period.

Measures

Demographics

Participants were asked to identify their age, gender, and to provide contact details so that the researcher could contact them regarding participation in the follow-up survey.

Client expectations

To measure expectations of therapy, participants completed the Expectations About Counselling-Brief Form (EAC-B) immediately prior to their initial intake session commencing (Tinsley, Workman, & Kass, 1980). The EAC-B has been found to have good internal consistency, with coefficient alphas ranging from 0.69 to 0.82, test-retest reliabilities of 0.60 or higher (Tinsley, 1982), and support for construct validity (Tinsley, Holt, Hinson, & Tinsley, 1991; Tinsley & Westcot, 1990). The 66 self-report questionnaire items are measured on a seven-point scale ranging from (1) Not True, through to (7) Definitely True. Items are phrased as 'I expect to ...' and 'I expect my counsellor to ...'. The EAC-B measures four domains related to the participants' expectations of: (1) their role as a client, this factor is labelled *Personal Commitment* and assesses the client's expectation to assume personal responsibility for working hard and achieving progress in counselling; (2) the therapist's role, labelled *Counsellor Expertise* measures the client's expectation that the counsellor will be a skilled practitioner who will be capable of helping them; (3) the processes of therapy, labelled *Facilitative Conditions* addresses expectations that therapeutic conditions that have been identified as being theoretically necessary for progress in counselling will be present; and (4) clinical outcomes of therapy, labelled *Outcome Expectations* shows how much the client expects their mental health and wellbeing to improve. Domain scores are computed by averaging the

relevant item scores, and can range from one to seven, with higher scores indicating more positive or optimistic expectations about therapy within that domain. Expectation scores for each domain were then categorised into two groups: Negative expectations (scores <4) or positive expectations (scores ≥4).

Client experience

In the follow-up survey, the participants were invited to complete an adapted version of the EAC-B to determine their actual experience of seeking help from the mental health care service. The 66 items were now phrased to assess actual experience of therapy, such as 'In counselling I did ...' or 'The counsellor was ...'. Scores for each of the four domains of personal commitment, counsellor expertise, facilitative conditions, and outcomes were computed, corresponding to those for expectations. Higher scores indicate a more positive experience of therapy. As with the expectation scores, the experience scores for each domain were then categorised into two groups: Negative experience (scores <4) or positive experience (scores ≥4).

Expectancy confirmation

Based on their expectancy and experience scores, participants were categorised into one of four expectancy confirmation groups: (1) Positive disconfirmation – participants whose actual experience of therapy was more positive than their initial expectations of therapy; (2) Negative disconfirmation – participants whose actual experience of therapy was more negative than their initial expectations; (3) Positive confirmation – participants whose actual experience and initial expectations of therapy were congruent and both were positive; and (4) Negative confirmation – participants whose actual experience and initial expectations of therapy were congruent and both were negative. Table 1 shows the four expectancy confirmation groups.

Clinical outcome

The 10-item Kessler Psychological Distress Scale (K-10) (Kessler et al., 2003) was used as a clinical outcome measure. This scale yields a global measure of psychological distress based on questions

TABLE 1: NUMBER OF PARTICIPANTS IN EACH EXPECTATION, EXPERIENCE AND CHANGE CONDITION (EXPECTANCY CONFIRMATION GROUP) FOR EACH DOMAIN

| Domain | Low (negative) (<4) | High (positive) (≥4) |
|--------------------------------|----------------------------|-----------------------------|
| Personal commitment | | |
| Expectation | 20 (19.6%) | 82 (80.4%) |
| Experience | 22 (21.6%) | 80 (78.4%) |
| Change | Low to high: 12 (11.8%) | High to low: 14 (13.7%) |
| | Low to low: 8 (7.8%) | High to high: 68 (66.7%) |
| Counsellor expertise | | |
| Expectation | 46 (45.1%) | 56 (54.9%) |
| Experience | 37 (36.3%) | 65 (63.7%) |
| Change | Low to high: 27 (26.5%) | High to low: 18 (17.6%) |
| | Low to low: 19 (18.6%) | High to high: 38 (37.3%) |
| Facilitative conditions | | |
| Expectation | 18 (17.6%) | 84 (82.4%) |
| Experience | 16 (15.7%) | 86 (84.3%) |
| Change | Low to high: 14 (13.7%) | High to low: 12 (11.8%) |
| | Low to low: 4 (3.9%) | High to high: 72 (70.6%) |
| Outcome | | |
| Expectation | 15 (14.7%) | 87 (85.3%) |
| Experience | 33 (32.4%) | 69 (67.6%) |
| Change | Low to high: 7 (6.9%) | High to low: 25 (24.5%) |
| | Low to low: 8 (7.8%) | High to high: 62 (60.8%) |

Low to high, positive disconfirmation; Low to low, negative confirmation; High to low, negative disconfirmation; High to high, positive confirmation.

about anxiety and depressive symptoms that a person has experienced in the most recent 4-week period. K-10 scores can range from 10 to 50, with higher scores reflecting higher levels of psychological distress. Participants completed a K-10 both as part of the initial survey and the follow-up survey. To create a clinical outcome score, the initial K-10 score was subtracted from the follow-up score to create a difference score, so that higher positive scores reflected an improvement in psychological functioning and higher negative scores showed a decline.

Level of service use

To measure level of mental health care service use, the number of sessions attended by each participant over the 2-month research period was recorded by the clinicians at the youth mental health care service.

Future help-seeking intentions

As part of the follow-up survey, to measure the young people's likelihood of seeking help from professional sources in the future, participants were asked to rate on a seven-point scale ranging from (1) Extremely Unlikely, through to (7) Extremely Likely 'How likely is it that you would seek help from a mental health professional for a personal or emotional problem in the future?' This question was administered as part of the follow-up survey and the item was taken from the General Help-Seeking Questionnaire (Wilson, Deane, Ciarrochi, & Rickwood, 2005). Scores range from one to seven, with higher scores indicating greater likelihood of seeking professional help in the future.

RESULTS

Analyses were undertaken using SPSS 21 statistical package (IBM Corp, 2012). Data were screened and scale scores were first examined for reliability and other psychometric properties. Specific assumptions including normality, linearity, and homogeneity of variance were tested prior to conducting the analyses, and were not violated. Cells with less than seven participants were excluded from the analyses to maintain adequate power (Wilson VanVoorhis, & Morgan, 2007). A series of Pearson's Chi-square tests of contingencies was used to examine age group and gender differences for each expectancy confirmation group. One-way analyses of variance (ANOVA) were used to determine whether baseline psychological distress varied across the expectation confirmation groups. Further ANOVAs determined the effect of expectancy confirmation group for each of the four expectation domains on young people's clinical outcome, service use, and future help-seeking intentions.

Expectancy confirmation groups
Differences between expectations and experience

The number and percentage of young people in each of the expectancy confirmation groups across the four expectation domains are presented in Table 1. This shows that for personal commitment, the vast majority of the young people had both positive expectations and positive experience of their level of personal commitment for therapy. Two-thirds of the young people were in the positive confirmation group, very few young people were in the negative confirmation group, and just over 10% were in each of the positive disconfirmation and the negative disconfirmation groups.

For counsellor expertise, the proportions were more evenly spread when compared to the other expectation domains, although the majority still reported positive expectations and positive experience, in this case for the counsellor’s role. Around a third of the young people fell into the positive confirmation group; with 26.5% in the positive disconfirmation group, and close to 20% in each of the negative confirmation and the negative disconfirmation groups.

For facilitative conditions, the vast majority of the young people had both positive expectations and experience of the processes of therapy. Most young people were in the positive confirmation group, with just over 70% reporting both expectations and experience of the processes of therapy to be positive. Notably, very few young people were in the negative confirmation group.

Finally, for outcome, a large portion of the young people had positive initial expectations of their outcomes of therapy, and over two thirds reported a positive experience of this domain. Just over 60% of the young people were in the positive confirmation group, less than 10% in each of the negative confirmation and the positive disconfirmation groups. Notably, however, a quarter were in the negative disconfirmation group, having more positive expectations than actual experience.

Age and gender differences

To determine whether there were developmental or gender differences in membership of each of the expectancy confirmation groups, Chi-Square analyses were undertaken separately for age group and gender. Due to small proportions in

some of the expectation groups, age effects could only be examined comparing adolescents (12–17 years) with young adults (18–25 years). Results revealed that there were no significant age group or gender differences across the expectancy confirmation groups, although it is important to note that for many of these analyses the assumption of an expected cell frequency of >5 was violated. There was no age effect for personal commitment $\chi^2(9) = 4.66, p = 0.198$ (two cells had expected

TABLE 2: MEAN OUTCOME SCORES (SD) BY EXPECTANCY DIS/CONFIRMATION GROUP FOR EACH DOMAIN

| Domain | Positive disconfirmation | Negative disconfirmation | Positive confirmation | Negative confirmation |
|--------------------------------|--------------------------|--------------------------|-----------------------|-----------------------|
| Personal commitment | | | | |
| *Clinical outcome | 5.42 (10.17) | -1.79 (8.49) | 4.28 (8.47) | -1.00 (4.93) |
| *Service use | 5.08 (2.91) | 2.07 (1.59) | 4.93 (2.47) | 1.88 (1.54) |
| *Help-seeking Intentions | 5.08 (1.31) | 4.57 (2.03) | 5.60 (1.45) | 5.00 (2.33) |
| Counsellor expertise | | | | |
| Clinical outcome | 3.81 (7.15) | 1.89 (10.20) | 4.55 (9.14) | 0.68 (8.36) |
| *Service use | 5.52 (2.59) | 2.44 (1.82) | 4.79 (2.38) | 3.42 (2.78) |
| Help-seeking intentions | 5.95 (1.42) | 4.78 (1.96) | 5.39 (1.50) | 5.47 (1.78) |
| Facilitative conditions | | | | |
| Clinical outcome | 5.21 (10.09) | -1.17 (9.05) | 3.83 (8.35) | - |
| *Service use | 5.64 (2.68) | 2.17 (1.40) | 4.58 (2.57) | - |
| Help-Seeking Intentions | 5.21 (1.31) | 4.50 (2.02) | 5.53 (1.51) | - |
| Outcome | | | | |
| *Clinical outcome | 5.71 (10.67) | 0.64 (9.17) | 4.73 (8.04) | -3.25 (7.11) |
| Service use | 4.71 (2.63) | 4.12 (2.83) | 4.48 (2.51) | 3.25 (3.24) |
| Help-seeking intentions | 5.57 (0.98) | 5.20 (1.66) | 5.45 (1.60) | 4.88 (2.23) |

*Significant result. Cells with N < 7 were excluded from the analyses.

frequencies <5), counsellor expertise $\chi^2(9) = 6.61$, $p = 0.085$, facilitative conditions $\chi^2(6) = 3.13$, $p = 0.209$, and outcome $\chi^2(9) = 2.82$, $p = 0.420$. There were also no gender effects for personal commitment $\chi^2(3) = 1.27$, $p = 0.737$ (three cells had expected frequencies <5), counsellor expertise $\chi^2(3) = 4.67$, $p = 0.198$, facilitative conditions $\chi^2(2) = 1.29$, $p = 0.524$ (two cells had expected frequencies <5 and the negative confirmation group was excluded due to cell size less than $N = 7$), and outcome $\chi^2(3) = 5.52$, $p = 0.137$ (two cells had expected frequencies <5).

Baseline psychological distress

To determine whether initial levels of psychological distress varied by expectancy confirmation group, a series of ANOVAs were undertaken with expectancy confirmation group for each of the four domains as an independent variable and baseline K-10 scores as the dependent variable. This revealed that there was no significant difference in baseline psychological distress across the expectancy confirmation groups for: Personal commitment $F(3,98) = 2.24$, $p = 0.088$; counsellor expertise $F(3,98) = 0.73$, $p = 0.539$; facilitative conditions $F(2,95) = 2.32$, $p = 0.104$; or outcomes $F(3,98) = 2.25$, $p = 0.087$.

Effects of expectancy confirmation across domains

Personal commitment

As the cell count for each of the four expectancy groups was greater than $N = 7$ for the personal commitment domain, the ANOVAs were conducted including all four confirmation groups. There was a statistically significant large effect found for personal commitment expectancy confirmation group on level of service use $F(3,97) = 8.86$, $p < .001$, $\eta_p^2 = 0.213$, a significant small effect was found for clinical outcome $F(3,97) = 2.84$, $p = 0.042$, $\eta_p^2 = 0.081$, but a non-significant effect was found for help-seeking intentions $F(3,97) = 1.91$, $p = 0.133$. *Post hoc* tests showed that young people in the negatively disconfirmed and negatively confirmed expectations groups attended significantly fewer sessions compared to those whose expectations were either positively confirmed or positively

disconfirmed. For clinical outcome, however, *post hoc* tests revealed that those in the negatively disconfirmed expectation group had significantly poorer outcome than those with positively confirmed and positively disconfirmed expectations, but were not different from those in the negatively confirmed expectation group. Those in the negatively confirmed group were not, however, significantly different from those in any of the other groups.

Counsellor expertise

For the counsellor expertise domain, as the cell count for each of the expectancy groups was greater than $N = 7$, the ANOVAs were conducted including all four groups. There was a statistically significant large effect for counsellor expertise expectancy group on level of service use $F(2,94) = 7.09$, $p < 0.001$, $\eta_p^2 = 0.18$, however, non-significant effects were found for clinical outcome $F(2,94) = 1.48$, $p = 0.225$, and help-seeking intentions $F(2,94) = 1.00$, $p = 0.398$. *Post hoc* tests showed that young people in the negatively disconfirmed and negatively confirmed expectations groups attended significantly fewer sessions compared to those whose expectations were either positively confirmed or positively disconfirmed.

Facilitative conditions

For this domain, there was a very low cell count for the negative confirmation group ($N = 4$), consequently the ANOVAs were conducted excluding this group. There was a statistically significant large effect for facilitative conditions expectancy group on level of service use $F(2,94) = 6.83$, $p = 0.002$, $\eta_p^2 = 0.126$, however, non-significant effects were found for help-seeking intentions $F(2,94) = 2.32$, $p = 0.104$, and clinical outcome $F(2,94) = 2.05$, $p = 0.134$. *Post hoc* tests revealed that the negatively disconfirmed expectations group attended significantly fewer sessions compared to those whose expectations were either positively confirmed or positively disconfirmed.

Outcomes

For outcomes expectancies, the ANOVAs were conducted including all four confirmation groups as the cell count for each group was greater than

$N = 7$. There was a statistically significant large effect for outcome expectancy group on clinical outcome $F(3,97) = 4.17, p = 0.008, \eta_p^2 = 0.114$, however, non-significant effects were found for level of service use $F(3,97) = 0.608, p = 0.611$, and help-seeking intentions $F(3,97) = 0.418, p = 0.741$. *Post hoc* tests revealed that both the negatively disconfirmed and the negatively confirmed group had poorer clinical outcome compared with the positively confirmed group, but only the negatively confirmed group also had poorer outcome compared with the positively disconfirmed group.

DISCUSSION

This study examined the effects of all four possible expectancy confirmation combinations across four different therapy domains on important therapeutic outcomes for young people, namely their clinical outcome in terms of psychological distress, their level of actual service use, and future help-seeking intentions.

Firstly, it was shown that there was considerable variation in expectation confirmation or disconfirmation across the different therapy domains. Of special note, the highest level of negative disconfirmation was evident for outcome expectancies; for this domain a quarter of the participants had positive expectations of their therapeutic outcome that were not met. This is very concerning, as it shows that a considerable proportion of young people do not have an experience of therapy that shows them that it is effective. One of the main barriers to help-seeking is the belief that therapy is not effective (Rickwood, Deane, & Wilson, 2007), and although there was no effect in this study on future help-seeking intentions, the perception that they were not helped as they had initially expected may impact on young people's future service use. The next highest level of negatively disconfirmed expectations was for the counsellor's expertise, followed by commitment within the client role, and lastly expectations regarding the processes of therapy.

No age or gender differences were evident across any of the expectancy domains for the effect of expectancy confirmation group. It was hypothesised that the older youth might differ from adolescents because prior research has indicated that younger

adolescents do not have well defined expectations of therapy (Watsford & Rickwood, 2012; Watsford et al., 2012). This was not supported in the present study, although it should be highlighted that age could only be considered in terms of comparison between adolescents and young adults due to the small number of participants in some of the expectancy confirmation groups. Consequently, there may be more graduated age differences that could not be determined by this study. There may also be an interactive effect with gender, which also could not be ascertained here.

The expectancy domain that yielded the most effects was in relation to the level of personal commitment for therapy. The majority of young people had both positive expectations and experience of their personal commitment, and were in the positive confirmation group. There was a strong effect for personal commitment on mental health service use and a weaker effect on clinical outcome. For the effect on service use, it appears that the impact of negative experience is most relevant, as both negative disconfirmation and negative confirmation groups had equally lower service use. This seems to suggest that it is the negative experience of personal commitment, rather than expectation confirmation or disconfirmation *per se*, that is important. Although research with adults has demonstrated the significance of disconfirmed role expectations on clinical outcomes and engagement in therapy (Nock & Kazdin, 2001; Reis & Brown, 1999; Walitzer et al., 1999; Westra et al., 2010), these studies did not consider the valence of the expectation as they did not include a negative confirmation group for comparison. The findings of the present study confirm how important it is for young people to feel a strong sense of commitment and willingness to be an active participant throughout the therapy experience, as it is this that helps maintain their service engagement. This finding provides support for suggestions that clinicians should assist clients to maintain a high level of commitment by regularly monitoring commitment levels through motivational interviewing techniques (Rubak, Sandbaek, Lauritzen, & Christensen, 2005).

A weaker effect of personal commitment expectation was shown on the clinical outcome

of change in psychological distress. Again, both confirmation groups where there was a negative experience had less improvement in psychological distress, although the effect of negative disconfirmation was somewhat more evident. When a client's commitment to the therapy process decreases, he or she is less likely to experience clinical improvements as well as being at risk of prematurely terminating therapy.

For expectations around the counsellor's role, only about half of the young people had positive expectations and experience of the counsellor's level of expertise, and they were comparatively more evenly spread across the expectation conditions than for the other expectancy domains. Relatively more young people began with negative expectations in this domain, and for almost one in five, these low expectations were met. The only impact was on service use, where there was a strong effect whereby those with either negative disconfirmation or negative confirmation had lower levels of service use. Again, it seems to be the negative experience that is most relevant. This highlights how important it is for clinicians to establish a strong therapeutic relationship with younger consumers, and also demonstrate that they have relevant and appropriate expertise. Interestingly, young people have been shown to have a preference for therapists who are quite directive and who have a strong presence in the therapeutic interaction (Watsford & Rickwood, 2012). This may be particularly important for younger clients, who have less experience of therapy, and who need to be reassured that they are in safe hands and that they can trust the therapist, as this has been identified as a facilitator of help-seeking behaviours (Gulliver et al., 2010).

A similar effect was evident for expectations related to the processes of therapy, although for this expectation domain the category of negative confirmation could not be investigated because there were too few young people in this group. Consequently, it was young people in the negative disconfirmation group, who initially had a positive expectation of therapeutic processes that was not met, who had less service use than those who had positive experiences, regardless of their initial expectation. This demonstrates the potentially detrimental effect that negatively disconfirmed

expectations can have on young people's engagement in therapy, and is consistent with past research with adults (Nock & Kazdin, 2001; Reis & Brown, 1999; Walitzer et al., 1999). Specifically related to the processes of therapy, engagement is critical for young people to retain them in therapy by ensuring they have a positive experience of the therapeutic process. Furthermore, this shows the importance of implementing effective evidence-based interventions and that clinicians work towards incorporating the client's personal expectations and desires into the psychological intervention provided. Promoting client choice in therapy can lead to better engagement and outcomes, and it is beneficial for therapists to tailor psychological interventions to suit each client's individual expectations and strive for a collaborative approach (American Psychological Association, 2006).

Almost all the young people commenced therapy with high expectations for their outcome, but for a quarter these expectations were not met. These unmet expectations had a significant association with poorer outcomes, as did having both negative initial expectations and negative experience, although there were only eight young people in this latter group. This lends support for an argument that clinicians need to consider using brief therapeutic interventions for adolescents and young adults presenting with sub-threshold and early onset symptoms, because they hold high expectations for relief of their psychological distress that need to be met. Younger clients require early improvements to relieve some of their psychological distress and provide assurance early on that therapy can help them. The common perception held by young people that therapy will not alleviate their distress or be helpful needs to be debunked through delivery of effective therapies that young people perceive meet their expectations and needs.

Clinical implications

The present study highlights the importance that health professionals should place on assessing young people's expectations about therapy at the beginning of the therapy process, and provide opportunities to discuss and clarify what the young person can expect regarding their role, the therapist's role, outcomes, and what the processes of

therapy will involve. Clients tend to adjust their responses to therapy based on a number of factors, such as their motivation to attend, personal fit with the model of treatment, and perception of the therapist (Stiles, Barkham, Connell, & Mellor-Clark, 2008). It is crucial that clinicians assess and consider the significance of client expectations in the early phases of the therapeutic encounter, given the significance of expectancy confirmation group on engagement and clinical outcome. Including a focus on client expectations in the training of health professionals could be of value. Clinicians should dedicate time in the first session to discuss with the client what they can expect regarding the therapeutic encounter, identify the client's individual expectations and desires for therapy, address any major misconceptions, and work towards incorporating the young person's personal expectations and desires into the psychological intervention provided. Furthermore, in particular when working with young consumers, it would be beneficial for clinicians to view psychotherapy as a 'self-correcting' process whereby if a particular technique or approach is not working, another is applied (Seligman, 1995). Research based on both adult and child participant samples has shown that pre-treatment interventions aimed at educating clients about what to expect from the therapeutic encounter can promote more accurate, positive, and realistic expectations of therapy (Nock & Kazdin, 2001; Ogrodniczuk, Joyce, & Piper, 2005; Shuman & Shapiro, 2002). Clinicians should inform clients what they can expect from evidence-based psychological interventions, and explain that therapeutic change can take time, and that with the client's active input in therapy, positive outcomes can be achieved. Clients are not passive agents in the process of therapy in terms of selecting therapists or approaches and can make informed decisions about who, when, where and for how long they will engage in therapy, as they have their own perceptions about their own experience of recovery (Seligman, 1995; Stiles et al., 2008). It is important that therapists instil a sense of hope by informing young people that by engaging in and collaboratively participating in therapy, they are increasing their chances of experiencing improved mental health and wellbeing (Seligman, 1995).

Strengths and limitations

A major strength of this study is that it is the first prospective study using a clinical sample to examine the effect of young people's expectations of therapy on clinical outcome, engagement and help-seeking intentions, and addresses an important gap in the literature. The study is also the first to examine all four expectancy confirmation groups, and explore the four expectation domains on relevant outcome variables for youth. There are, however, several important limitations. Firstly, the participants were recruited from one youth mental health care service in Canberra, ACT, Australia, and thus it is unknown how well these results may generalise to young people more widely. Furthermore, the mental health care service is specifically set up to address the needs of young people within an early intervention approach and it is carefully promoted in this way. Young people accessing more traditional mental health services may have quite different expectations and experiences, especially those who have more established mental disorder. Future research comparing the expectations of young people accessing more traditional with innovations in mental health services is warranted. Another limitation of the current study was that the outcome measures assessed were limited and were mostly self-report. There has been a long debate about the use of difference scores to measure change (Rogosa & Willett, 1983), and change in self-reported psychological distress is only one small indicator of clinical outcome. Investigating clinician's ratings of clinical outcome would be of particular value.

The small numbers of young people in some of the expectation groups, particularly the facilitative conditions negative confirmation group, which needed to be excluded from most analyses, is a further restriction. Similarly, age and gender differences could not be fully explored because of the need for large sample sizes in some expectation confirmation conditions. While it is comforting that few young people engage in therapy with negative expectations, this poses a challenge for obtaining adequately sized samples for comparison.

CONCLUSION

The present study highlights the important role that negatively disconfirmed expectations and negative experience can have on service engagement and therapeutic outcomes for adolescents and young adults. The client's level of personal commitment and motivation to be an active participant in the therapeutic relationship was identified as an important factor that needs to be promoted and maintained. Clinicians need to work collaboratively with young clients, build a strong alliance, provide education on realistic expectations, and tailor psychological interventions to meet the clients' individual needs as this will promote engagement and better outcomes. Effectively engaging young people in appropriate mental health care when symptoms are emerging and ensuring they have as positive an experience as possible, is likely to facilitate better service use and outcomes in adulthood.

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CHAPTER IX

Discussion

The research reported in this thesis aimed to comprehensively examine young people's expectations, preferences and actual experience of therapy as well as to explore the effects of these factors on engagement, clinical outcome, and future help-seeking intentions. Prior research on client expectations and preferences had focused almost exclusively on adults, and this literature revealed that client expectations and preferences for mental health services have a significant influence on decisions to seek help, engagement in therapy, and clinical outcomes for adult clients (Dew & Bickman, 2005; Swift & Callahan, 2009). Very few studies had explored young people's expectations and preferences of therapy, and prior research had not examined if these factors affect young people's help-seeking experience; as such, this represented a major gap in the literature. Given the recent and current focus on youth mental health, it was timely that young people's expectations and preferences for therapy be thoroughly explored.

To address this significant gap in the literature, this research project firstly set out to explore young people's pre-treatment expectations of therapy, across the therapy domains of client and therapist roles, processes, and outcomes. Due to the limited prior research exploring client expectations with young consumers, a qualitative research approach was initially utilised to address this research aim. Participants in the qualitative study included 20 young people aged 12 to 25 years who participated in a brief interview immediately prior to their initial assessment at headspace, a youth mental health care service targeted at mild to moderate early presentations of mental health problems.

This research project then aimed to build on the qualitative research by quantitatively examining initial expectations and preferences, as well as subsequent actual experience of

therapy for youth, and to determine the effects of these factors on young people's engagement in therapy, clinical outcome, and future help-seeking intentions. Lastly, this research project aimed to examine the effects of disconfirmed expectations on young people's therapy outcomes, help-seeking intentions, and therapy engagement. To address these research aims, a quantitative method comprising both cross-sectional and prospective components was utilised. Participants involved in the quantitative study included a total of 228 young people aged 12 to 25 years who completed an initial questionnaire on contact with the youth mental health care service, headspace, and of these, 102 who completed an online follow-up questionnaire two months later.

Exploring Young People's Expectations

This research project firstly set out to qualitatively explore the pre-treatment expectations of 20 young people accessing help from a youth mental health care service. Overall, the most outstanding result of this initial qualitative study was that overwhelmingly the young people were unsure of what to expect from therapy and the professional help-seeking process. These poorly defined expectations were evident across the four therapy domains, with young people disclosing high levels of uncertainty regarding their role as a client, the therapist's role, the processes of therapy, and their expected outcomes.

This result suggests that young consumers may not enter therapy with clearly defined expectations regarding the therapeutic process. This finding was not overly surprising, given that many young people first make contact with mental health services because someone else, typically a parent or caregiver, has initiated and facilitated the professional help-seeking process (Gulliver et al., 2010; Medlow et al., 2010; Rickwood et al., 2007). Because of this, it may be that many young people find themselves in therapy despite not having considered

what the professional help-seeking process may entail, which maybe an explanation as to why young people have not developed well-defined therapy expectations.

Interestingly, another prominent finding of the qualitative research was related to the processes of therapy, with results showing that the majority of the young people expected that psychological interventions would involve simply talking to the therapist. Related to this, most of the young people did not expect that therapy would include activities during sessions or homework tasks, and even stated that this suggestion was unappealing and/or anxiety provoking.

Another notable theme that emerged from the data was related to the young people's level of readiness and personal motivation for therapy. Results revealed that although half of the participants felt they were motivated for therapy, a quarter of the young people reported that they did not feel ready or willing to participate in therapy at the present time, with several young people reporting that they felt pressured and/or bribed by their family members to attend the mental health care service.

These results indicate that young people may commence the help-seeking journey without an expectation that they will be an active participant in the therapeutic encounter, and rather, are more likely to expect that they will simply talk without actively engaging in therapeutic activities and they anticipate the therapist will take on the more directive role in therapy. Moreover, young people may struggle with their personal motivation to participate in the therapeutic process and, despite the fact that they may have actually turned up for their initial session, may face difficulties with how ready they feel they are to engage in therapy. Across the lifespan, young people represent the age group least likely to seek help from professional sources (Barney et al., 2005; Kessler et al., 2007) and it appears that even for

those young people who do make contact with mental health care services, motivation and readiness still represent a significant challenge for this age group.

Optimistically, however, the young people commenced the help-seeking journey with a high level of hopefulness, with the majority expecting to like their therapist and anticipating that therapy would help them to feel better. This suggests that despite results showing that young people commence the professional help-seeking journey with a level of uncertainty about engaging in therapy, they are hopeful that therapy will be a positive experience that will work for them. This result is consistent with findings from prior research based on adult studies, as well as from the limited studies with children and youth, which have shown that consumers tend to commence therapy with optimistic outcome expectations and hopefulness that therapy will be helpful (e.g., Bonner & Everett, 1982; Rapaport et al., 1996; Garland et al., 2007; Lax et al., 1992). These optimistic hopes and expectations reported by the young people in the present research are crucially important and need to be maintained, as past research has also demonstrated that optimistic expectations of therapy are associated with greater help-seeking intentions, improved therapy outcomes, and greater therapeutic alliance for adult clients (e.g., Joyce et al., 2003; Mussell et al., 2000; Vogel et al., 2005).

Expectations and Preferences

This research project then aimed to build on the qualitative findings by further examining young people's expectations as well as their preferences for therapy by using quantitative methods; specifically aiming to examine differences between young people's expectations and preferences for therapy and to explore developmental age and gender effects.

The results of the quantitative research, undertaken with 228 young people accessing a youth mental health service, confirmed the findings of the qualitative component, revealing

that the young people commenced therapy with high hopes and preferences for therapy. Interestingly, a notable finding was that these pre-treatment therapy preferences were significantly more optimistic than their initial expectations for therapy, showing that the young people hoped for a lot more than they expected they would actually get out of therapy. While no prior research had examined differences between young people's therapy expectations and preferences, in keeping with the adult literature these results were expected, as early past research with adults had revealed that client preferences are typically rated as more optimistic than initial expectations for therapy (Tracey & Dundon, 1988).

Another notable research finding showed that overall, across all of the therapy domains, the young people had the highest preference for the therapist to be genuine and they highly desired to work therapeutically with someone they could really trust. This result is consistent with literature based on youth, which has indicated that young people place high value on seeking help from trusted sources (Gulliver et al., 2010). This finding highlights just how crucial the role of developing a strong therapeutic bond is with younger consumers, as this was rated as an essential element of treatment for them, even rated higher than their desire for therapy to help them improve.

Interestingly, and consistent with the qualitative research findings, the young people did not rate their desires for their own motivation for therapy highly. Across all of the therapy domains, the young people identified that their lowest preference was related to their own role in therapy. The young people disclosed that they did not really want to be an active participant in therapy, rating their desire to be motivated and actively involved in the therapeutic encounter the lowest out of all the therapy domains. Again, these findings suggest that young people are not likely to commence therapy with high levels of motivation.

Notably, results revealed some important age differences. The younger adolescents had a stronger desire for a more directive style of therapy interaction, wanting to take on a more passive role than the young adults did. Furthermore, while motivation levels were found to be fairly low across this age group as a whole, this was especially true for the younger adolescents, who were far less motivated for therapy than the young adults were.

Recently, young people aged 12 to 25 years have been viewed as a particular target population group, with new models of care, such as headspace, developed to specifically address their needs (Hodges et al., 2007; Muir et al., 2009). The results of this research revealed several significant age effects, showing that while young people represent a distinct age group with a unique set of needs for mental health care when compared to adults, the wide developmental range between 12 and 25 years means that there is considerable variability in expectations and desires for therapy. In particular, it appears that younger adolescents may require a more directive therapy approach with a focus on motivation building when compared to older adolescents and young adults, given that the younger adolescents reported very low motivation. This is congruent with age-related human development over this period, which spans the time of substantial change from childhood to adulthood, with the commensurate major changes in all domains including cognitive and social, as well as physical development (Kessler et al., 2007; McGorry, 2007; Slade et al., 2009).

Gender differences were also evident, with results showing that females were less likely to enter therapy expecting that the therapist would like them or accept them and they also did not rate therapist self-disclosure very highly when compared to males. This result indicates that the development of the therapeutic relationship may be quite a different experience for female and male young consumers, with females more likely to initially be sensitive to the therapeutic bond and how they perceive the therapist feels about them. A

possible explanation of this finding is that females are typically more attuned to relational cues and are more sensitive in assessing the quality of the interpersonal match compared to males (Wallner-Samstag, Batchelder, Muran, Safran, & Winston, 1998).

Expectations, Preferences and Actual Therapy Experience

This research project then aimed to examine differences and relationships between young people's initial expectations, preferences and their subsequent actual experience of seeking help at a youth mental health care service. Age and gender differences were also examined. Follow-up data two months after initial contact with the service were available for about half the original sample. Importantly, however, analyses showed that the follow-up sample did not differ in major ways from the original participants.

The longitudinal data showed that young people's initial expectations and actual experiences were rated significantly lower than their preferences for therapy, indicating that young people desire a lot more out of therapy than they both expect and actually get. Interestingly, however, their initial expectations and actual experience of therapy were found to generally match, suggesting that young people commence therapy with relatively realistic expectations that tend to be met by the mental health care service. Of note, no prior research has directly compared therapy expectations, preferences and actual experience, particularly for youth. Results reveal that young people commence therapy with optimistic desires, yet feel their actual experience of therapy does not live up to these high hopes, although they typically have realistic expectations that tend to be met. Their preferences are for a better experience than they receive or expect.

Conversely, this was not the case for outcomes, where results revealed that the young people's initial expectations around their clinical outcomes were far more optimistic than their actual experience of their outcomes of therapy. This result indicates that young people

not only want, but also expect to receive, better therapeutic outcomes and possibly more quickly than they actually get out of the therapy experience. This result was not surprising, and is congruent with the prior research based on adult population samples, which has indicated that clients' outcome expectations for therapy are typically greater than the actual rate of improvement as demonstrated in the psychotherapy literature (Swift & Callahan, 2008; Mueller & Pekarik, 2000).

Again, age and gender effects were found, confirming previous results which showed that the younger adolescents had lower preferences for their own personal commitment to therapy when compared to the young adults. Results further showed that females and the young adults commenced therapy with more pessimistic expectations regarding the therapist's role in therapy when compared to males and the younger adolescents. These results again indicate that relevant age and gender differences are present among young consumers in terms of their expectations and desires for therapy, in particular related to motivation and the therapeutic alliance, and as such, this should be a consideration for clinicians working in youth mental health settings, and will be discussed further as a clinical implication.

Effects on Outcomes

Importantly, this research project then set out to examine the effects of young people's expectations, preferences, and actual experience of therapy on their clinical outcome, level of mental health care service use, and likelihood of seeking help from professional sources in the future. It was hypothesised that more positive expectations, preferences and actual experience would be associated with improved outcomes in terms of lower psychological distress, greater service engagement, and greater future help-seeking intentions.

Interestingly, and unexpectedly, the results revealed no significant relationship between young peoples' expectations of therapy and their clinical outcome, engagement in therapy or their help-seeking intentions. This result is contrary to prior research, which has established the influential role that client expectations can have on clinical outcomes and engagement in therapy for adults. Past research among adult samples has frequently found that more optimistic initial expectations across the domains of roles, processes and outcomes are linked with improved clinical outcomes, engagement in therapy, and help-seeking intentions and behaviours, with effect sizes ranging from weak to moderate (Dew & Bickman, 2005; Glass et al., 2001; Joyce & Piper, 1998; Thompson & Sunol, 1995).

This unexpected finding suggests that young people's initial expectations for therapy may not be as important in predicting therapy outcomes as they are for adult clients. It is possible that this may be due to the fact that young people do not appear to have as well-defined expectations of therapy as adults. Young people often rely on others, usually their parents or caregivers to initiate the professional help-seeking process, unlike adults, who are more likely to have independently sought professional help. For this reason, it is likely that adults may have dedicated more time to consider, research, and think through the help-seeking process when compared to young people. This additional deliberation over the help-seeking experience may lead to adults developing more considered and well-defined expectations than youth. As such, adult clients' expectations may have a greater impact on their therapy experience, and consequently, on their therapy outcomes, when compared to young people, who have less well-defined expectations.

Rather, the results revealed the significance of the young people's therapy experience, finding that their actual experience of therapy was predictive of therapy outcomes. Results showed that there were significant bivariate associations amongst most of the actual experience domains and the outcome variables. Specifically, results showed that: more

positive actual experiences of therapy outcomes was related to greater reduction in psychological distress and higher level of service use; more positive experience of the processes of therapy was also related to improved clinical outcome, more sessions attended and greater likelihood of future help-seeking; more positive experience of personal commitment was associated with greater session attendance and higher likelihood of seeking professional help in the future; and as actual experience of counsellor expertise was more positive, so were clinical outcomes and number of sessions attended. However, in the multivariate models the only direct predictor of clinical outcome was a moderately strong relationship with the young people's perceived experience of their outcomes. The only direct predictor of level of service use was a strong relationship with actual experience of personal commitment, and, future help-seeking intentions were only directly predicted by a weak relationship with actual experience of the processes of therapy.

These results were expected, given that past research with both adults and youth have demonstrated the importance of the actual therapy experience for help-seeking, improved outcomes, and better service engagement (e.g., Schedin, 2005; Westra et al., 2010). Prior research for youth has indicated that an important facilitator of help-seeking is positive past experiences with help-seeking, with those who have had favourable past experiences or who have previously been helped by a professional more likely to seek help again in the future (Gulliver et al., 2010). This result highlights how important the therapy experience is for youth, and indicates that it is not enough to simply get young people to make contact with mental health care services; they also need this help-seeking experience to be a positive one to facilitate improved outcomes and engagement and greater likelihood of future service use if needed.

Notably, results again confirmed the importance of the client's self-motivation, with results revealing that the young people's desires to be personally committed to therapy were

related to therapy outcomes. Specifically, results showed that as the young people's preferences to be personally motivated in therapy increased so too did improvement in clinical outcome in terms of reduction in psychological distress. This result is congruent with past research which has also shown that adult clients with a higher desire to be motivated and committed to therapy saw greater clinical outcomes than clients who were less likely to want to be personally committed to therapy (Schneider et al., 1999; Timmer et al., 2006). This finding further highlights the key role self-motivation appears to play in young people's help-seeking experience and mental health care, and evidently this is a factor that needs to be addressed in therapy with young consumers.

Disconfirmed Expectations

Finally, this research project aimed to specifically examine the effect of disconfirmed expectations by investigating the effects of all four possible expectancy confirmation combinations (positive confirmation, negative confirmation, positive disconfirmation, and negative disconfirmation) across the domains of roles, processes and outcome on important therapeutic outcomes for young people. In keeping with the adult-based disconfirmed expectations literature, it was hypothesised that young people who experienced negative disconfirmation—that is, who had a more negative therapy experience than initially expected—would have poorer clinical outcomes, attend fewer sessions, and have lower help-seeking intentions than those in the other confirmation groups.

Firstly, results revealed that generally most of the young people experienced positive expectancy confirmation, meaning that they had both positive expectations and a positive experience of therapy across the different domains comprising their own and the therapist's role, processes, and outcomes. This result is consistent with research by Joyce and Piper (1998) which showed that the actual experience of therapy was generally in line with or

exceeded adult clients' initial expectations for therapy. Again, this finding indicates that young people typically commence therapy with generally realistic expectations that tend to be met by what the mental health care service actually delivers.

However, this was less the case for outcomes, with a quarter of the young people in the negative disconfirmation group, having more positive expectations of their therapy outcomes than their actual experience of outcomes. In contrast, less than 12% and 14% were in the negative disconfirmation groups for therapy processes and their own role regarding personal commitment, respectively. For the therapist's role, less than 40% of the young people experienced positive confirmation, however, 67% and 70% were in the positive confirmation group for therapy processes and personal commitment, respectively. Thus, results suggest that in terms of comparing expected and actual therapeutic outcomes, young people anticipate they will get better and do so faster than their actual experience. Moreover, young people expect a more positive experience of the therapist's role in therapy when compared to their actual experience.

As predicted, results revealed that young people who experienced negative expectancy disconfirmation were more likely to have poorer clinical outcomes, attend fewer sessions, and have lower help-seeking intentions. However, a particular strength of this research design was that by assessing all four possible expectancy confirmation groups, it was able to determine whether the valance of the expectancy disconfirmation or confirmation played an important role in affecting therapy outcomes. Interestingly, results revealed that not only did those young people who experienced negative disconfirmation have poorer therapy outcomes, but so too did those who experienced negative confirmation. These results suggest that irrespective of whether young people commence therapy with positive or negative initial expectations of therapy, if their actual experience of therapy is a negative one, they will

experience poorer clinical outcome, attend fewer sessions, and have lower help-seeking intentions.

While this finding makes sense, it was somewhat unexpected given the substantial expectancy disconfirmation literature, which has demonstrated that the greater the discrepancy between a client's expectations of therapy and the reality of the therapy experience, particularly when initial positive expectations are disconfirmed, the less effective treatment will be and the more likely the client will be to disengage from therapy (e.g., Duckro et al., 1979; Elkin et al., 1999; Noble et al., 2001; Westra et al., 2010). As already noted, however, a major limitation of prior research on expectancy disconfirmation is that many studies fail to assess all four expectancy confirmation groups, and instead typically include as disconfirmation any incongruence between expectations and experience (regardless of valence) or only include a measure of negative disconfirmation. As such, it has not been possible to determine the unique effect of each expectancy confirmation outcome in previous research. Results from the current demonstrate how important it is that young consumers have a positive therapy experience, regardless of initial expectations, to promote improved engagement and outcomes.

Clinical Implications and Recommendations

The current research findings lead to several important clinical implications and recommendations. Firstly, young people require psycho-education on the help-seeking experience, specifically targeting client expectations across the domains of client and therapist roles, therapy processes, and outcomes, as this will support greater understanding and a sense of hopefulness for youth. Secondly, there is a need to promote a positive therapy experience for young consumers and, as such, clinicians should monitor and foster young consumers' motivation and commitment to therapy, build a strong therapeutic alliance, strive

to meet the client's individual needs by offering flexible psychological interventions, and aim to relieve psychological distress early. Lastly, while youth-focused models of care are imperative to address youth-specific needs for mental health care service delivery, these need to be able to address the wide developmental range and changing needs evident across this age group.

Greater Understanding

In consideration of the current research findings which showed that young people do not have well-defined expectations of therapy, the first major implication of this research is that young people require greater education on the processes of therapy and seeking professional help. While results revealed that young people tend to commence therapy with generally realistic expectations of therapy, results also indicated that young people do not have clear expectations of what the therapeutic encounter will likely entail. In particular, the young people disclosed high levels of uncertainty regarding what was expected of them as a client and what exactly psychological interventions would involve.

It is possible that being unsure of what therapy will be like and what they as a client may be required to do in therapy sessions may be anxiety provoking for young consumers and may even act as a barrier to seeking and engaging in professional help. Notably, prior research with youth has established that being unsure or misinformed about what therapy will involve represent important help-seeking barriers (Gulliver et al., 2010). Given that only one in four young people with a mental illness will seek professional help (Slade et al., 2009), these findings highlight the importance of increasing young people's knowledge on what to expect around seeking professional help, which if done effectively may reduce their anxiety levels and facilitate help-seeking amongst this age group.

As such, it is crucial that health professionals engage young people in therapy with an awareness that young consumers are not likely to commence therapy with a sound understanding of the processes of therapy, and it is therefore extremely important that clinicians working with this age group provide age appropriate education in the early phases of the therapy experience on what realistic expectations for therapy entail. This should be considered an essential therapeutic process that includes: assessing and determining each young person's individual set of expectations and preferences; providing information on therapy processes in an effort to reduce anxiety around not knowing what to expect; clarifying any major misconceptions; and promoting positive expectations and a sense of hopefulness.

During the initial stages of therapy, clinicians should dedicate time to openly discuss and determine each young consumer's unique set of expectations and explore how these expectations may have developed, for example, through past help-seeking experiences. It is also relevant for health professionals to assess young consumers' therapy preferences and for clinicians to be aware that these desires may differ from their expectations. This process will allow both clinician and consumer to develop a greater understanding of the client's therapy expectations and preferences and may identify any misconceptions warranting further clarification, and guide the development of treatment plans that can complement these unique needs and desires.

Following on from the process of assessing and exploring the young person's individual set of therapy expectations, clinicians should provide information on the processes of therapy in order to offer young consumers a greater understanding of what they can reasonably expect from this help-seeking experience. It is essential that during this process of psycho-education, clinicians cover the four therapy domains and clearly explain to young

consumers what they can reasonably expect from their role as a client, the therapist's role, the processes of therapy, and the likely outcomes of therapy.

Of particular note, current results indicated that young people often commence therapy initially expecting a fairly passive style of therapy interaction, with the majority of the young people expecting that therapy would involve simply talking and that the therapist would take on the more directive role. As such, clinicians should help young people to develop a greater understanding of what evidence-based psychological interventions entail by providing psycho-education that informs them that many therapeutic practices, including Cognitive Behavioural Therapy, Dialectical Behavioural Therapy, and Acceptance and Commitment Therapy entail more than simply talking and typically involve homework tasks, worksheets, as well as participating in therapeutic activities (Arch & Craske, 2008; Hayes, 2008; Kliem et al., 2010). Given that the young people commonly reported a level of apprehension regarding their readiness and motivation to actively participate in the therapeutic process, during the initial phases of therapy clinicians need to instil a sense of empowerment and confidence to be an active participant, as this is crucial to achieving desired outcomes.

Related to this, results further showed that young people commonly entered therapy with highly optimistic expectations regarding how quickly they anticipated therapy would help them to relieve their psychological distress. These findings further highlight the need for psycho-education to address therapy outcomes and for clinicians to openly discuss with young consumers that therapeutic change is a process to work towards and can take some time to attain. Of note, adult-based research has indicated that long-term therapeutic change can take over 20 sessions to achieve (Callahan & Hynan, 2005; Kadera, Lambert, & Andrews, 1996).

However, while it is crucial that young people are provided with opportunities to be better informed of what they can reasonably expect from therapy, clinicians should also be aware that such psycho-education may inhibit help-seeking, in particular if this informs them that what they hope will happen in therapy may not happen or may take considerable time and effort. Specifically for youth, there is a need to balance the psycho-education process with the promotion of positive expectations and a sense of hopefulness, as this will facilitate service engagement with this client population. This is particularly important when evidence shows that young people often commence therapy with high levels of psychological distress (Rickwood, Telford, Parker, Tanti, & McGorry, 2014).

Inspiring Hopefulness

This research has indicated that although young people commenced the professional help-seeking journey with a level of uncertainty and apprehension about their readiness and willingness to engage in therapy, they were also optimistic that therapy would be a positive experience, resulting in improvements in their mental health. The young people's positive preferences of therapy indicate that they feel a sense of hopefulness when commencing the help-seeking process and that they want to gain a lot out of therapy.

It is important that young people are optimistic about therapy, as pessimistic beliefs about therapy have been found to be an important barrier to help-seeking (Gulliver et al., 2010). Hopefulness has also been identified as an essential factor in facilitating recovery from mental health difficulties, with adult-based research indicating that hope is a crucial element in mental health recovery and in helping people to adjust to adversity and to inspire people to move forward (Clarke, 2003; Deegan, 1988; Landeen et al., 2000; Perry, Taylor, & Shaw, 2007). Moreover, youth-based research has indicated that higher levels of hopelessness are linked with lower intentions to seek help from a wide range of sources including family,

friends, teachers, GP, or mental health professionals for both thoughts of suicide and personal-emotional problems. These results suggest that clinicians should promote a sense of hopefulness with young consumers with respect to the help that can be provided from both informal sources and from professional mental health sources (Wilson, Deane, & Ciarrochi, 2005)

Several factors have been associated with maintaining a sense of hopefulness with consumers presenting with mental health difficulties. Firstly, prior research with adults diagnosed with first episode psychosis has highlighted the importance of friendships and belonging to social groups in terms of promoting feelings of hope (Perry et al., 2007). Furthermore, when consumers can find individual meaning for their mental health difficulties they were also more likely to sustain hopefulness (Perry et al., 2007). Additionally, perceived stigma has been associated with lower levels of hope, with consumers reporting that learning they were not alone in their experience of mental illness helped to inspire hope (Landeem et al., 2000). Finally, health professionals can promote hopefulness and recovery with consumers presenting with psychiatric difficulties by providing encouragement and expressing their own hopefulness during the course of treatment (Anthony, 1993).

In consideration of these findings, clinicians working with young consumers could help to facilitate a sense of hopefulness by encouraging young people to connect socially with their peers and to join support groups where young consumers can talk to others with similar difficulties. A sense of connectedness may facilitate reduced stigma and help them to feel as though they are not alone. Moreover, social connectedness is especially relevant for youth, as the influence of peers peaks during mid-adolescence and remains strong throughout these years (Monahan, Steinberg, & Cauffman, 2009). Clinicians can further promote hopefulness by guiding young consumers through collaborative and shared case formulation, as this process may help young consumers develop individual meaning for their mental health

presentation (Lincoln et al., 2012; Pain, Chadwick, & Abba, 2008). Clinicians should also provide reassurance and encouragement of the effectiveness of therapy and inform young people that it is expected that therapy will help them to improve, and that set-backs may be part of the process. Fostering and maintaining a sense of hopefulness that therapy will be helpful is crucially important in facilitating motivation and greater help-seeking and engagement in therapy for young people. Consequently, a fundamentally hopeful attitude must be genuinely and routinely portrayed by clinicians in youth mental health settings.

Promoting a Positive Therapy Experience

The results of the present study demonstrated the significance of the young people's actual experience of therapy on their clinical outcome, help-seeking intentions, and engagement in therapy. Interestingly, the results revealed that regardless of whether young people commenced therapy with positive or negative initial expectations of therapy, if their actual experience of therapy was a negative one, they experienced poorer clinical outcome, attended fewer sessions, and had lower help-seeking intentions compared to those who had a positive therapy experience. These results highlight that it is fundamental that young people's actual therapy experience is a positive one, as this will promote improved therapeutic outcomes, engagement in therapy, and future-seeking intentions.

Moreover, it is crucial that young consumers have a positive experience of therapy because if young people have a negative experience of therapy, they are at greater risk of not seeking help again in the future (Gulliver et al., 2010). It is particularly important given the recurring nature of most mental health problems that younger clients perceive therapy as something they would be prepared to engage in again should they need it, especially given that evidence is emerging that most young people do not engage for long periods of time with therapy and are likely to access mental health services only a few times (Rickwood, 2013).

Moreover, as it appears young people have less well-formed expectations, their first experiences of therapy are essential as they lay the foundation for future expectations, which as adults are more likely to have an effect on outcomes (Dew & Bickman, 2005).

As such, clinicians working with young people need to ensure that early help-seeking for mental health care is a positive experience. In consideration of the current findings, the following therapeutic factors are proposed to be essential in promoting positive therapy experiences for youth, and will subsequently be discussed in further detail: promoting therapy motivation and personal commitment; developing a strong therapeutic alliance; striving to meet the young person's individual needs with flexible psychological interventions; and aiming to reduce psychological distress early.

Importance of Self-Motivation

Results of the present study revealed the central role that personal commitment and self-motivation plays in young people's help-seeking experience and on their subsequent clinical outcomes of therapy, specifically showing that as young people's desires to be personally motivated and committed to therapy increased, so too did improvement in their psychological functioning. Evidently, self-motivation represents a factor that needs to be promoted and maintained in therapy with young consumers.

Interestingly, current findings showed that most of the young people initially faced difficulties with how ready and motivated they felt they were to engage in therapy on contact with a youth mental health care service. This is a particularly noteworthy finding, as prior research has shown that young people commonly face a number of barriers during the initial stages of the help-seeking process, where reluctance and lack of readiness for therapy can prevent young people from actually seeking help from professional sources (Gulliver et al., 2010; Rickwood et al., 2005). Yet, current results suggest that even for those young people

who do make contact with professional help-seeking sources, readiness and motivation appear to remain a challenge for this age group.

It seems that young people's motivation for therapy is fundamentally different to adult's therapy motivation. Prior research based on adult populations has shown that adult clients commonly self-refer for treatment and typically commence the voluntary help-seeking process with a level of insight into their presenting problem, a willingness to explore the possible advantages of change, and a commitment to implement actions to change (DiGiuseppe, Linscott, & Jilton, 1996). Further, many evidence-based psychological interventions have been developed targeting self-referred clients, and insight and willingness to engage in therapy are often assumed to be prerequisites of therapy (DiGiuseppe et al., 1996).

Conversely, youth do not typically self-initiate treatment, generally being encouraged by family to access services and, as a result, young people may be more likely to commence therapy with a lack of insight into their presenting problem and may be less willing to actively engage in therapy when compared to self-referred adult client populations (DiGiuseppe et al., 1996). Therefore, health professionals working therapeutically with young consumers should be aware that young people are not likely to initially commence therapy with high levels of motivation, and accordingly, pre-treatment readiness cannot be viewed as a requirement for therapy, but a key goal for therapy with youth. Consequently, it is crucial that young people's self-motivation for therapy is regularly assessed during the course of therapy and that psychological interventions for youth include a motivational building element.

Clinicians working with young consumers can use motivational interviewing techniques to assess, monitor, and promote commitment levels with young consumers

(Rubak, Sandbaek, Lauritzen, & Christensen, 2005). In terms of assessing motivation, it is important that clinicians determine which one of the four stages of change the young person is identifying with at the present time: the pre-contemplative stage, which reflects no desire to change; the contemplative stage, where people are willing to explore whether change is desirable; the action stage, where people take concrete steps to change; or the maintenance stage, where people attempt to consolidate the changes they have made (Prochaska & DiClemente, 1992). Clinicians should also be aware that motivation levels will likely fluctuate during the course of therapy, with past research highlighting that therapy motivation is subject to specific changes during the course of treatment, dependent upon interactions between the client and the therapist, the therapeutic process, as well as general conditions of therapy (Schneider et al., 1999). Thus, monitoring motivation levels with young consumers should become a regular part of the therapy experience rather than a one-off assessment.

To enhance and promote young people's commitment and motivation to therapy, particularly when the client is assessed as presenting as pre-contemplative, motivational interviewing strategies can also be utilised. For example, clinicians can facilitate young consumers' motivation for change by clarifying their therapy goals, as this is an important aspect of increasing client motivation (DiGiuseppe et al., 1996; Rubak et al., 2005). Exploring the client's individual values can be an effective way of helping the client to develop these treatment goals and, importantly, these goals should be the client's own, and should also be realistic and obtainable. Clinicians can then assist young consumers to develop self-motivational statements, which include: naming the presenting problem; identifying concerns related to the problem; stating their intention to reach their goals; and maintaining optimism about change (DiGiuseppe et al., 1996; Rubak et al., 2005).

Importantly, motivational interviewing has been identified as an attractive therapy model for young people, as the techniques are non-confrontational, do not impose specific

outcomes, and reduce treatment resistance (Lawendowski, 1998). Furthermore, research based on youth aged 16 to 20 years has shown the efficacy of single-session motivational interviewing in reducing drug use and drug-related risk and harm, indicating that these techniques are effective for youth even when delivered as a brief psychological intervention (McCambridge & Strang, 2004). Thus, it appears that motivational interviewing skills can be utilised in therapy with young consumers to effectively assess and promote young people's motivation for therapy which may, in turn, promote engagement in mental health service use and improved clinical outcomes.

Strong Therapeutic Alliance

The therapist and client relationship was also revealed as an important element of the therapy experience for youth, with young people disclosing strong desires for the therapist to be genuine and trustworthy and significant associations evident between more positive evaluations of the therapist's role in therapy and improved clinical outcomes and number of sessions attended. These findings highlight the crucial role of developing a strong therapeutic alliance in therapy to promote young consumers' engagement in treatment and improved clinical outcomes.

Therapeutic alliance is considered to be a well-established predictor of treatment outcome across a range of psychological interventions and clinical presentations (Kivlighan & Shaughnessy, 1995). Therefore, the development of an effective therapeutic alliance with adolescents and young adults should be considered a priority during the course of therapy. Techniques commonly utilised as part of Cognitive Behavioural Therapy to facilitate engagement and to help build therapeutic alliance include normalising the client's mental health presentation, as well as developing a shared understanding of the nature of the client's mental health presentation through collaborative discussion of triggers and social or

biological factors that might have contributed to the development of symptoms (Lincoln et al., 2012).

While most prior research exploring factors that facilitate therapeutic alliance have been based on adult population samples, a review by DiGiuseppe and colleagues (1996) presented evidence-based strategies specifically for building therapeutic alliance with child and adolescent clients. The utilisation of a collaborative therapy approach with supportive and reflective strategies was identified as assisting in building a strong therapeutic alliance with younger consumers. Furthermore, clinicians should provide encouragement and affirmation of the client's efforts, express empathy and understanding, and involve the client actively in decision making and problem solving (DiGiuseppe et al., 1996).

Clinicians can also build rapport by utilising creative techniques to engage young people in therapy, for example by using email, texting, or on-line resources and tools (Collin et al., 2011; Monshat, Vella-Brodrick, Burns, & Herrman, 2012; Roy & Gillett, 2008) or using creative therapeutic mediums such as art or music (Dingle, Gleadhill, & Baker, 2008). These modalities can be particularly effective at engaging younger clients. Establishing an effective therapeutic alliance with adolescents and young adults is particularly important in retaining young people in mental health care service use and consequently, in improving their psychological functioning.

Flexible Psychological Interventions

To further promote a positive therapy experience for youth, it is essential that young consumers are provided with access to psychological interventions that are delivered in a collaborative and flexible manner that also complement the young person's individual needs and desires. To achieve this, during the initial phases of therapy clinicians should determine the client's expectations and desires for therapy and then work with the young consumer to

develop an individualised treatment plan that is congruent with these wishes. It is essential that mental health professionals work collaboratively with adolescent and young adult clients to determine which therapeutic interventions best suit their personal preferences, as this will promote engagement by maximising client choice (APA, 2006).

However, actually determining what young people want out of therapy may be a challenging process for this age group, because typically, young people have not carefully considered what they want or expect from therapy and may also struggle with disclosing these desires. Consequently, this process should be embedded in the delivery of a collaborative and youth-friendly approach, as this therapeutic environment will foster client engagement and assist in the exploration of the young person's individual needs and desires. Importantly, a recent youth-focused review revealed that establishment of trust with the clinician was a vital prerequisite for adolescents to discuss sensitive issues in session (Ambresin, Bennett, Patton, Sancı, & Sawyer, 2013).

There is growing interest in shared decision making in health care settings, where clinician and client go through all phases of the decision making process together (Charles, Gafni, & Whelan, 1997; Hamann, Leucht, & Kissling, 2003). Shared decision-making refers to a process of health care delivery in which health practitioners and clients seeking help for problems or disorders share information about treatment options and work together to reach an agreement regarding the preferred treatment method. The benefits of utilising shared decision making with young consumers is that this model of service delivery fosters a collaborative therapeutic environment, helps the client to better understand and self-manage their disorder, and encourages the client to develop a sense of autonomy and control over treatment decisions that affect their well-being (Charles et al., 1997; Hamann et al., 2003).

Offering youth access to flexible psychological interventions that are tailored to specifically meet the individual needs and desires of each client is particularly relevant when considering age and gender differences amongst this client population. In particular, youth mental health care services catering for young people aged 12 to 25 years, such as headspace, should be aware that there will likely be considerable variability across this wide developmental age range in relation to young consumers' expectations and preferences for mental health care service delivery.

Specifically, current results revealed that younger adolescents typically commence therapy with particularly low levels of self-motivation and also have a strong desire for a more directive therapy interaction when compared to young adults. A youth-based systematic review revealed that young people wanted health practitioners to use a directive communication style and provide clear health-based information; yet, they did not want this information delivered in a lecturing tone of voice (Ambresin et al., 2013). As such, psychological interventions offered to younger adolescents may be most appropriately delivered with the clinician initially taking on the lead role in therapy, with a particular focus on motivation building to assist the client to develop confidence and readiness to take on a more active role during the course of therapy. However, clinicians also need to be careful how to balance this with changes in level of need for autonomy over the adolescent and early adult years. For instance, younger consumers in early adolescence need to be engaged in a more directive way, yet, as young people mature and enter late adolescence and early adulthood, clinicians need to accommodate their growing autonomy and independence (Ambresin et al., 2013).

In terms of gender differences, females were far more likely to expect a poorer quality therapeutic relationship than the males, with females disclosing higher expectations that the therapist would not like them or accept them and having less interest in the clinician

providing information about themselves in the therapeutic interaction. These gender differences may have emerged because females tend to be more attuned to social relationships, even with a therapist, with prior research indicating that females are more sensitive in assessing the quality of the therapeutic bond when compared to males (Wallner-Samstag et al., 1998). In the initial stages of therapy with young females it may be important to build trust and rapport by ensuring that the young woman feels accepted and valued and that her disclosures are prioritised.

Early Effectiveness

The present study revealed that young people commenced therapy with high levels of psychological distress, yet also initiated this help-seeking experience with high hopes that therapy would help them relieve this distress. However, results further showed that overall the young people's actual experience of their therapeutic outcome, in terms of reduction in distress levels, was far less effective than they both initially anticipated and also hoped.

It seems that clinicians working with young consumers need to focus on alleviating psychological distress earlier in therapy so that young people start to feel better sooner. Rather than initially emphasising assessment, which is often the primary focus of early therapy sessions (Bradford & Rickwood, 2012) young consumers require early improvements to relieve some of their psychological distress and provide assurance early on that therapy can help them. Given the high distress levels of youth presenting to mental health care services (Rickwood et al., 2014), it appears that initial sessions should focus on alleviating psychological distress, and as a result, traditional modes of assessment could be revisited for youth. For instance, there is growing interest in assessments for young people being self-administered or completed on-line (Collin et al., 2011; Bradford & Rickwood, 2012). Interestingly, a recent systematic review revealed that young people find the acceptability of

self-administered assessment tools to be more desired than assessments delivered through an interview format, indicating that young people prefer self-completed assessment modes over more traditional face-to-face methods (Bradford & Rickwood, 2012). If part of the assessment process can be delivered using on-line or self-administered forms, this would allow face-to-face sessions to focus on therapy comprising distress reduction, rapport and motivation building.

This further lends support for an argument that clinicians need to consider using brief therapeutic interventions for adolescents and young adults presenting with early onset symptoms, because they hold high expectations for relief of their psychological distress that need to be met through delivery of effective therapies. Prior research has demonstrated the efficacy of brief psychological interventions for adolescents and youth presenting with Post Traumatic Stress Disorder (Goenjian et al., 1997), Major Depressive Disorder (Birmaher et al., 2000), and substance misuse and addiction (Goti, Diaz, Serrano, & Gonzalez, 2010; McCambridge & Strang, 2004). Brief interventions typically involve the stages of assessment, feedback, information, advice, and providing self-help materials. Brief therapies commonly last for one to five sessions and are delivered in a flexible manner with a focus on building client motivation and reaching specific goals (SAMHSA, 1999). These short, problem-specific approaches can be valuable in the treatment of a range of mental health presentations; in particular, there is a large evidence base for the efficacy of brief interventions for substance use (Goti et al., 2010; McCambridge & Strang, 2004). Brief interventions are also particularly well suited to clients who may not be willing or able to commit to more intensive long-term interventions (SAMHSA, 1999). Because young people commonly experience low motivation and an unwillingness to engage in therapy, place high importance on a quick reduction in psychological distress, and typically only attend therapy for a few sessions, it appears that brief interventions may be more appropriate for many of

those in this age group than intensive long-term treatment options, although these are clearly necessary for those with more serious, complex and enduring mental disorders.

As young people commonly commence therapy with high levels of psychological distress, and also, have high expectations and desires for this distress to be reduced quickly, results highlight the central role of early intervention strategies for young people with emergent mental disorders (McGorry et al., 2007; Rickwood et al., 2014). There is a need for mental health care services to prioritise the implementation of early intervention strategies, as this will maintain best practice in services to people with mental illnesses (Herrman, 2001). Early intervention specifically aims to target youth during the early stages of illness onset, prevents progression of illness, and minimises the “collateral damage” to social, educational, and vocational functioning (Patel et al., 2007). As such, getting young people to engage in effective, youth-focused psychological services early, will promote improved outcomes for this vulnerable client population.

Youth-Focused Models of Care

Current findings have indicated that young people represent a unique age group with distinctive needs for mental health care, in particular, in terms of how mental health care services can appropriately address young people’s expectations, desires, and actual experience of therapy. Results suggest that psychological interventions for youth need to be delivered in a collaborative, flexible, and youth-friendly manner with a focus on improving understanding, inspiring hopefulness, building rapport, promoting motivation, and prioritising reducing psychological distress. As such, specialist youth-focused models of care are imperative so that young people can access early and effective youth-specific interventions.

The World Health Organisation (WHO) has emphasised the need to develop youth-friendly health services to improve the care provided to young people and to address the large

gap between the high prevalence of mental illness and low service use amongst this client population (WHO, 2002). There is growing evidence to support the efficacy of new youth-focused models of care that cater specifically to young people aged 12 to 25 years, with the aim of providing continuous and developmentally appropriate support to young people until they reach adulthood (McGorry, 2007). These youth-specific models of care strive to deliver high quality interventions targeting the needs of young people and, as a result, promote positive help-seeking experiences for youth as well as improved engagement and outcomes (McGorry, 2007; McGorry et al., 2007).

Youth-specific initiatives such as headspace, the National Youth Mental Health Foundation, Orygen Youth Health (OYH), and the Early Psychosis Prevention and Intervention Centre (EPPIC) were specifically developed to allow a more targeted response to the unique mental health needs of young people within a multi-disciplinary, client-centred, and early intervention approach (McGorry, 2007; McGorry et al., 2007). On-line youth-focused initiatives have also been developed to facilitate youth engagement, such as ReachOut.com and youth beyondblue. Recent research by Collin and colleagues (2011) revealed that ReachOut.com is successful in effectively engaging young people, especially those youth who are experiencing high levels of psychological distress, and also supports young people to become service ready. Moreover, youth beyondblue is an on-line support tool which provides young people and their families with links to teen-focused fact sheets, forums, and information on how to connect with youth-specific services (Jorm & Morgan, 2007). These youth-focused initiatives are fundamental in reducing the impact of mental ill-health on young people, their families and society, and to promoting positive health and improved social and economic outcomes (McGorry et al., 2007; McGorry, 2007).

Current results indicated that young people's expectations, preferences, and experiences of therapy are unique to those described in the adult-based literature, and should

be considered and addressed in youth-specific mental health care services. In particular, young people's evaluation of their actual therapy experience significantly influenced their engagement with the service, therapeutic outcomes, and help-seeking intentions, and consequently, there is a need for young consumers to be able to access high quality youth-friendly models of care.

With the aim of determining how well health services meet young people's expectations and needs, a recent systematic review explored domains and indicators of youth-friendly health care from young people's perspectives (Ambresin et al., 2013). The review identified eight core domains that were important to young people and represented key indicators of youth friendliness in service delivery and included: accessibility; staff attitude; medical competency; guideline driven care; communication; age appropriate environments; youth involvement; and health care outcomes.

The review revealed that service accessibility was an important youth-friendly indicator, and as such, service affordability as well as location, visibility and flexibility of youth-focused service sites must be carefully considered, striving to promote ease of service access for youth. Staff attitude was also influential in young people's evaluation of the friendliness of the service, with youth-friendly health care providers described by the young people as being respectful, trustworthy, honest, friendly and supportive (Ambresin et al., 2013). Interestingly, these clinician attributes were also rated as highly desirable by the young people in the present research project, and evidently, these represent essential characteristics of clinicians working with this client population.

The review further revealed that medical competency and guideline driven care were important to young people, showing that young people valued clinician skill, and desired respect of their confidentiality and autonomy, and assistance with the transition from youth

services to adult services. Communication was also rated as an indicator of youth-focused care, with young people wanting to be provided with clear information in a directive style of communication (Ambresin et al., 2013). The identification of clinician directiveness as a youth-focused therapeutic approach is congruent with the findings of this research project.

Importantly, the review showed that young people wanted access to age appropriate environments within the service; for instance, young people desired adolescent-friendly clinic rooms and/or reception areas with games, a television, and teen-oriented information sheets. Finally, young people highly valued being involved in their health care and greater youth involvement was associated with improved health outcomes (Ambresin et al., 2013). In line with the current results, these findings support the need for a collaborative, shared decision making approach for young consumers.

Strengths and Limitations

The results of this thesis support the need for specialist youth-focused models of care that promote service engagement and improved outcomes, allowing young people to access early and effective youth-specific interventions delivered in a youth-friendly manner and specifically address the unique mental health needs of this client population. A major strength of the research approach adopted is that it comprises the first mixed-method longitudinal study utilising a clinical sample to examine young people's expectations, preferences and actual experience of therapy and to explore the effects of these factors on clinical outcomes, and therefore addresses an important gap in the literature. This research initially utilised a qualitative research method, to allow a previously neglected area of research to be explored in further detail, and consequently, provided valuable insight into young people's pre-treatment expectations for therapy in relation to roles, processes, and outcomes. The quantitative research component aimed to build on the qualitative research by further

examining young people's expectations, preferences and subsequent actual experience of therapy and to examine the effects of these factors on clinical outcome, engagement and help-seeking intentions. By using this mixed-method approach, a thorough examination of young people's therapy experience was able to be explored.

This study further aimed to address a number of major limitations of prior research. Firstly, prior research had neglected to assess the four expectation domains of client role, therapist role, therapy processes and outcomes simultaneously, making comparisons between these domains a challenge. Thus, this study utilised a client expectations measure to assess all four of these expectancy domains, and further modified this measure to also assess the clients' preferences and actual experience of therapy across the four therapy domains to allow direct comparison between these factors. While this technique has been used in prior research to compare expectations and preferences (Tracey & Dundon, 1988), no prior research has included actual experience or all four therapy domains. This thesis is also the first study to examine all four expectancy confirmation groups (i.e. positive confirmation, negative confirmation, positive disconfirmation and negative disconfirmation), and explore the effects of disconfirmed expectations on relevant outcome variables for youth. Lastly, the thesis also addressed a number of measurement flaws in past research by exploring all four expectancy types simultaneously, using a reliable and validated measure of client expectations, measuring expectations prior to therapy commencing, comparing expectations and preferences to actual experience, and examining all four possible expectancy confirmation groups across the four expectancy domains on important outcome variables. The present study makes an original contribution to knowledge by offering insight into an area previously not explored and by comprehensively examining young people's expectations, preferences and actual experience of therapy.

There are, however, several important limitations to this research that should be noted. Firstly, the participants were recruited from one youth mental health care service in Canberra, Australia, and thus it is unknown how well these results may generalise to young people more widely. It would improve generalisability to recruit participants from multiple headspace sites across the country; in particular, it would be valuable to include young people accessing regional, remote, and metropolitan headspace sites to increase the representativeness of the results to Australian young people more broadly.

Furthermore, headspace, is specifically set up to address the needs of young people within an early intervention approach and it is carefully promoted in this way. It is possible that young people accessing more traditional mental health services, such as public mental health care services, inpatient treatment programs, or private psychological services, especially those young people who have a more established mental disorder, may have quite different expectations, preferences, and experiences of therapy. Future research exploring these factors with a cohort of young people accessing a variety of mental health services is warranted, and again would improve the representativeness and generalisability of the results.

Furthermore, just under half of the original participant sample agreed to participate in the follow-up survey, and while results found no significant differences between these groups on the variables measured, it is likely that the participants who dropped out of the study differed to those who did not in other meaningful ways, for instance, in their actual experience of therapy. In addition, an overall response rate of just over one-quarter from those initially approached to participate shows that caution should be taken with the representativeness of the sample and highlights the difficulties with recruiting young people to participate in research.

Further, the small numbers of young people in some of the expectation confirmation groups, particularly the facilitative conditions negative confirmation group, which needed to be excluded from most analyses, is a further restriction. While it is comforting that few young people engage in therapy with negative expectations, this poses a challenge for obtaining adequately sized samples for comparison. Similarly, age and gender differences could not be fully examined in all the analyses because of the need for large sample sizes in some groups. Future research could build on the findings of this thesis by recruiting a significantly larger sample size until adequate numbers across age, gender and expectation groups were obtained to allow all analyses to be conducted with sufficient power. It is also noted that of the participants, in both the qualitative and the quantitative components, the majority of the young people had some prior contact with therapy or health professionals. Thus, it is likely these prior help-seeking experiences may have influenced the participants' expectations and preferences for therapy and these influences were not specifically explored or controlled for in the present study.

Another limitation of the current study was that the outcome measures assessed were limited and were mostly self-report, and it would improve validity to corroborate clinical outcomes with clinician measures. For example, investigating clinician's ratings of clinical outcome would be of particular value. Further, there has been a long debate about the use of difference scores to measure change (Rogosa & Willett, 1983), and change in self-reported psychological distress is only one small indicator of clinical outcome. In particular, using change in K-10 scores provides only a rudimentary indication of improvement in clinical outcomes. Other indicators may be more relevant to the young people themselves. While service use information was gathered by the service providers, this did not include service use from other service providers, nor show whether future help-seeking intentions were matched by future service use behaviour.

Furthermore, for the purpose of this study, the EAC-B client expectations measure was adapted to measure preferences and actual experience to allow direct comparisons to be made between these factors. However, the focus of this study was not to go on and formally assess the psychometric properties of these modifications, and as such, further analyses to determine the reliability and validity of these modifications would be warranted. In particular, possible order effects as a result of measuring both expectations and preferences at the same time were not controlled for.

Future Research

In consideration of the current findings which revealed the importance of young people's motivation for therapy, one of the main directions for future research is to gain a greater understanding of young people's motivation for therapy and explore what factors affect their self-motivation and readiness for therapy. Moreover, future research could determine whether young people's motivators for therapy are different to adults, and if differences do exist, there is a need to examine effective ways of measuring and monitoring young people's motivation. Youth-specific motivational building techniques could be developed and used during the course of therapy by both the therapist and client to promote service engagement for youth. This is particularly important for younger clients, who may have been brought by a parent or may not want to engage in therapy. If services want to effectively intervene early with younger consumers, there is a need to know what will engage and retain the younger groups in therapy.

In relation to clinical outcomes, it would also be of value to determine how specifically young people perceive meaningful change and what precisely matters to them in regards to clinical improvements and how services may monitor these changes. Finally, many evidence-based psychological interventions and traditional assessment modes have been

developed with adult populations, and these models tend to be relatively rigid in delivery and the language used is not attuned to youth. Consequently, an important direction for future research would be to check the perceived acceptability of these approaches for youth and determine whether more youth-focused interventions are better suited to this client population.

Summary and Conclusions

The current research project has addressed a major gap in prior research by comprehensively examining young people's expectations, preferences and actual experience of therapy as well as exploring the effects of these factors on engagement, clinical outcome, and help-seeking intentions. The project has made an original contribution to knowledge by revealing that: young people do not have well-defined expectations of therapy; young people have higher hopes for therapy than they both expect and actually experience from therapy; younger adolescents desire a more directive therapy approach than young adults; females are more sensitive about the formation of the therapeutic alliance compared to males; initial expectations for therapy are not related to therapy outcomes for youth; positive actual experiences of therapy are related to and predict greater engagement, clinical improvement, and higher help-seeking intentions; and lastly, self-motivation for therapy is typically low, and desire to be motivated is related to greater improvements in psychological functioning for youth.

These results have important implications for clinical practice and youth-focused models of care. Effectively engaging young people in youth-friendly mental health care services is of the utmost importance, where evidence-based psychological interventions are delivered to youth in a collaborative, inspiring, and flexible manner. Clinicians working therapeutically with youth must strike a careful balance between: promoting realistic

expectations by educating young consumers of the processes of therapy, while also fostering hopefulness; initially taking on a more directive role in therapy, while also working towards building the young person's self-motivation to be an active participant in this process; and offering interventions that are congruent with individual needs and desires, while acknowledging that this process will be challenging due to young people often commencing therapy with high levels of uncertainty. Importantly, these findings inform the development of youth mental health care services and highlight that it is fundamentally important that young people have positive early experiences of seeking professional help, as this will help in retaining young people in therapy and will promote improved clinical outcomes and higher help-seeking intentions.

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APPENDIX A

Qualitative Research - Participant Information Sheet

Project Title

Exploring Young People's Expectations of a Youth Mental Health Care Service.

Researcher

Miss Clare Watsford

Psychology, Faculty of Health, University of Canberra ACT 2601

Ph: 62012653

Email: u3004017@uni.canberra.edu.au

Supervisor

Professor Debra Rickwood

Psychology, Faculty of Health, University of Canberra ACT 2601

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Project Aim

The aim of this study is to explore what young people expect will happen when coming to headspace ACT and when going to therapy with a psychologist.

Benefits of the Project

This information will be used to help us to understand more about young people's expectations and to provide better services to young people.

General Outline of the Project

This study is being done by Clare Watsford, a student at the University of Canberra. I am interested in what types of things you expect will take place when you come to headspace.

Participant Involvement

If you agree to participate in this study, you will be asked to:

- 1) Be asked a few questions by me, before you start your first session. We will do this in the chill out room together, or go into one of the clinic rooms. I will record the conversation with an audio tape, or write down your answers if you prefer. Your name and personal details will not be recorded.

Participation in this study is completely up to you, and you can choose to say “No” at any time without saying why. If you do want to participate in the study, you can choose to participate in some or all of the questionnaires. Whether or not you choose to participate in this study will not affect your time at headspace in anyway.

Confidentiality and Anonymity

Only I will have access to your individual answers, as your privacy and confidentiality is very important and will be assured at all times.

Data Storage

The information I get from you today will be stored securely at the University of Canberra until it is later destroyed.

Ethics Committee Clearance

The project has been approved by the Committee for Ethics in Human Research of the University.

Queries and Concerns

If you have any questions about this study you are very welcome to contact me (Clare Watsford). My contact details are at the top of this form.

APPENDIX B

Qualitative Research - Family/Carers Information Sheet

Project Title

Exploring Young People's Expectations of a Youth Mental Health Care Service.

Researcher

Miss Clare Watsford

Psychology, Faculty of Health, University of Canberra ACT 2601

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Supervisor

Professor Debra Rickwood

Psychology, Faculty of Health, University of Canberra ACT 2601

Ph: 6201 2701

Email: Debra.Rickwood@canberra.edu.au

Project Aim

The aim of this research is to investigate what expectancies young people hold regarding seeking help from headspace ACT and attending therapy with a psychologist.

Benefits of the Project

The information gained from the research will be used to inform the field of clinical psychology and the wider community regarding the importance of young people's expectations of mental health service delivery.

General Outline of the Project

This research project will be run by Clare Watsford, an intern psychologist, studying Clinical Psychology at the University of Canberra. The project will investigate what expectancies young people (aged 12-25) accessing help from headspace ACT hold regarding a) their role as a client, b) the therapists role, c) their expected outcomes from attending headspace, and d) what psychological procedures they expect will take place.

Participant Involvement

Parents who agree to allow their child to participate in the research will be asked to:

- 1) Allow their child be involved in a brief interview with the researcher. Your child's personal details will not be recorded.

Participation in the research is completely voluntary and your child may, without any penalty, decline to take part or withdraw at any time without providing an explanation, or refuse to answer a question. Participants may choose to participate in some or all of the interview questions. While the researcher values and encourages participation, she will respect the right of the clients to choose not to participate in research.

Confidentiality and Anonymity

Only the researcher will have access to the individual information provided by clients. Privacy and confidentiality will be assured at all times. The research outcomes will be provided in a research article or thesis and may be presented at conferences and written up for publication. However, in all these reports, the privacy and confidentiality of individuals will be protected.

Data Storage

The information collected will be stored securely on a password protected computer throughout the project and then stored at the University of Canberra for the required five year period after which it will be destroyed according to university protocols.

Ethics Committee Clearance

The project has been approved by the Committee for Ethics in Human Research of the University.

Queries and Concerns

Queries or concerns regarding the research can be directed to the researcher, Clare Watsford, whose contact details are at the top of this form. She welcomes answering any queries.

APPENDIX C

Qualitative Research - Participant Consent Form

Project Title

Exploring Young People’s Expectations of a Youth Mental Health Care Service.

Consent Statement

I have read and understood the information about the research. I am not aware of any condition that would prevent my participation, and I agree to participate in this project. I have had the opportunity to ask questions about my participation in the research. All questions I have asked have been answered to my satisfaction.

Please indicate whether you agree to participate in the following parts of the research:

- Participate in a brief interview with the researcher.
- Let the researcher audio record our time together.

Name.....

Signature.....

Date

A summary of the research report can be forwarded to you when published. If you would like to receive a copy of the report, please include your mailing (or email) address below.

Name.....

Address.....

APPENDIX D

Qualitative Research - Family/Carers Consent Form

Project Title

Exploring Young People’s Expectations of a Youth Mental Health Care Service.

Consent Statement

I have read and understood the information about the research. I am not aware of any condition that would prevent my child’s participation, and I agree to consent to their participation in this project. I have had the opportunity to ask questions about my child’s participation in the research. All questions I have asked have been answered to my satisfaction.

Name.....

Signature.....

Date

A summary of the research report can be forwarded to you when published. If you would like to receive a copy of the report, please include your mailing (or email) address below.

Name.....

Address.....

APPENDIX E

Quantitative Research - Participant Information Sheet

Project Title

Examining the Effects of Young People's Initial Expectancies around Therapy on Mental Health Outcomes at a New Youth Mental Health Service.

Researcher

Miss Clare Watsford

Psychology, Faculty of Health, University of Canberra ACT 2601

Ph: 62012653

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Supervisor

Professor Debra Rickwood

Psychology, Faculty of Health, University of Canberra ACT 2601

Ph: 6201 2701

Email: Debra.Rickwood@canberra.edu.au

Project Aim

The aim of this study is to explore what young people expect will happen when coming to headspace ACT and when going to therapy with a psychologist.

Benefits of the Project

This information will be used to help us to understand more about young people's expectations and to provide better services to young people.

General Outline of the Project

This study is being done by Clare Watsford, a student at the University of Canberra. I am interested in what types of things you expect will take place when you come to headspace and if what you expect will happen, does happen.

Participant Involvement

If you agree to participate in this study, you will be asked to:

- 2) Complete two questionnaires, one now (before your first intake appointment) and the second one in two months time at headspace. If you don't end up coming to headspace for two months, that's fine, I will then ask if I can call you instead, to ask you if we can do the second questionnaire on the phone. To thank you, you will go in the draw to win a prize.

Participation in this study is completely up to you, and you can choose to say "No" at any time without saying why. If you do want to participate in the study, you can choose to participate in some or all of the questionnaires. Whether or not you choose to participate in this study will not affect your time at headspace in anyway.

Confidentiality and Anonymity

Only I will have access to your individual answers, as your privacy and confidentiality is very important and will be assured at all times.

Data Storage

The information I get from you today will be stored securely at the University of Canberra until it is later destroyed.

Ethics Committee Clearance

The project has been approved by the Committee for Ethics in Human Research of the University.

Queries and Concerns

If you have any questions about this study you are very welcome to contact me (Clare Watsford). My contact details are at the top of this form.

APPENDIX F

Quantitative Research - Family/Carers Information Sheet

Project Title

Examining the Effects of Young People's Initial Expectancies around Therapy on Mental Health Outcomes at a New Youth Mental Health Service.

Researcher

Miss Clare Watsford

Psychology, Faculty of Health, University of Canberra ACT 2601

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Supervisor

Professor Debra Rickwood

Psychology, Faculty of Health, University of Canberra ACT 2601

Ph: 6201 2701

Email: Debra.Rickwood@canberra.edu.au

Project Aim

The aim of this research is to investigate what expectancies young people hold regarding seeking help from headspace ACT and attending therapy with a psychologist.

Benefits of the Project

The information gained from the research will be used to inform the field of clinical psychology and the wider community regarding the importance of young people's expectations of mental health service delivery.

General Outline of the Project

This research project will be run by Clare Watsford, an intern psychologist, studying Clinical Psychology at the University of Canberra. The project will investigate what expectancies young people (aged 12-25) accessing help from headspace ACT hold regarding a) their role as a client, b) the therapists role, c) their expected outcomes from attending headspace, and d) what psychological procedures they expect will take place. It will also assess if young people perceive their initial expectations to be consistent with what the service provided.

Participant Involvement

Parents who agree to allow their child to participate in the research will be asked to:

- 2) Allow their child be involved in two brief questionnaires, one immediately prior to their initial intake appointment, and in two months time at headspace. If your child is no longer attending sessions at headspace in two months time, allow the researcher to call my child to invite them to do the second questionnaire over the phone.

Participation in the research is completely voluntary and your child may, without any penalty, decline to take part or withdraw at any time without providing an explanation, or refuse to answer a question. Participants may choose to participate in some or all of the interview questions. While the researcher values and encourages participation, she will respect the right of the clients to choose not to participate in research.

Confidentiality and Anonymity

Only the researcher will have access to the individual information provided by clients. Privacy and confidentiality will be assured at all times. The research outcomes will be provided in a research article or thesis and may be presented at conferences and written up for publication. However, in all these reports, the privacy and confidentiality of individuals will be protected.

Data Storage

The information collected will be stored securely on a password protected computer throughout the project and then stored at the University of Canberra for the required five year period after which it will be destroyed according to university protocols.

Ethics Committee Clearance

The project has been approved by the Committee for Ethics in Human Research of the University.

Queries and Concerns

Queries or concerns regarding the research can be directed to the researcher, Clare Watsford, whose contact details are at the top of this form. She welcomes answering any queries.

APPENDIX G

Quantitative Research - Consent Form

Project Title

Examining the Effects of Young People’s Initial Expectancies around Therapy on Mental Health Outcomes at a New Youth Mental Health Service.

Consent Statement

I have read and understood the information about the research. I am not aware of any condition that would prevent my participation, and I agree to participate in this project. I have had the opportunity to ask questions about my participation in the research. All questions I have asked have been answered to my satisfaction.

Please sign if you agree to participate in the following parts of the research:

- Participate in two questionnaires, one now and one in two months time. I give permission to be called on the phone to invite participation in the second questionnaire if I am no longer attending sessions at headspace in two months time.
- To allow the researcher to obtain demographic information and how many sessions I have attended, which is stored at headspace.

Name.....

Signature.....

Parents Signature (if you are under the age of 16).....

Date

A summary of the research report can be forwarded to you when published. If you would like to receive a copy of the report, please include your mailing (or email) address below.

Email.....

APPENDIX H

Semi-Structured Interview Questions

Participant's Age:

Participant's Gender:

Is this your first time getting help from a service like headspace? Is this the first time you have seen a psychologist/counsellor?

Have you looked on the headspace website? (i.e. at what to expect when coming to headspace?)

- 1) Could you tell me about what you think **you** will do, or what you will be like when you come to an appointment at headspace? (Examples of prompts if required: will you do most of the talking? Will you do activities, play games, who will decide what you talk about? What will you say, what will you do? How involved will you be? Where will you sit?)
- 2) Could you please tell me about what you think **your therapist** or psychologist will do or be like when you come in to an appointment at headspace? (Examples of prompts if required: who do you think you'll be seeing? Different roles of counsellor, psychologist, psychiatrist, youth worker? What will they say, what will they do? Will they be male or female? How involved will they be? Will they tell you what to do?)
- 3) Could you tell me about what you think **will happen** during your appointments at headspace – that is what sort of things you will do, what therapy will be like? (Examples of prompts if required: who will decide what happens? Will it be all talk based or will there be paper-based type work? What activities or tasks do you expect

you will do? Will there be out of session activities? Do you know the names of any therapies? Will your parents come in? How often will you come? How long will sessions go for? For how long will you be coming for?)

- 4) Could you tell me about what you **expect will happen** for you after coming to headspace for a while – what do you think will change or be different for you? (Examples of prompts if required: do you think it will help? Do you think you will feel better, or worse? Will life be better or worse for you?)

APPENDIX I

First Questionnaire

Today's Date: _____

Name: _____

How old are you? _____

Phone Number: _____

Email Address: _____

Gender: **Male/Female** (*circle one*)

Is this the first time you have gone to headspace? **Yes/No** (*circle one*)

Have you ever been in therapy or counselling before (even if for only one session)? **Yes/No** (*circle one*)

Please circle which health professionals you have seen before:

| | | | |
|--------------|---------------|-------------------|-------|
| Psychologist | Counsellor | School Counsellor | None |
| Youth Worker | Social Worker | Psychiatrist | Other |

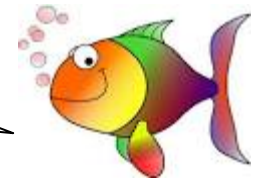
Have you looked on the headspace website on "What to expect when coming to headspace"? **Yes/No** (*circle one*)

Who referred you to headspace? (e.g. Parent, GP/Doctor, You, Friend)



The next few questions are looking at what you think counselling at headspace will be like. On the following pages you will see some statements about counselling. For each question we want to know what you expect or think counselling will be like **AND** also what you would actually like counselling to be like. Remember... just because you **THINK** something will happen doesn't always mean you actually **WANT** it to happen... The rating scale we would like you to use is printed at the top of each page. Just circle the number that you think is most true for you.

For each question circle what you think counselling will be like AND also what you would actually like counselling to be like...



1 Not True 2 Slightly True 3 Somewhat True 4 Fairly True 5 Quite True 6 Very True 7 Definitely True

| | I expect/think I will... | I would like to... |
|---|---------------------------------|---------------------------|
| 1. Take psychological tests | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 2. Like the counsellor | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 3. See a counsellor in training | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 4. Gain some experience in new ways of solving problems within the counselling process. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 5. Openly express my emotions regarding myself and my problems. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 6. Understand the purpose of what happens in the session. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 7. Do assignments outside the counselling sessions. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 8. Take responsibility for making my own decisions. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| | I expect/think I will... | I would like to... |
| 9. Talk about my present concerns. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 10. Get practice in relating openly and honestly to another person within the counselling relationship. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 11. Enjoy my sessions with the counsellor. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 12. Practice some of the things I need to learn in the counselling relationship. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 13. Get a better understanding of myself and others. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 14. Stay in counselling for at least a few weeks, even if at first I am not sure it will help. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 15. See the counsellor for more than three sessions. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |

1 2 3 4 5 6 7
 Not Slightly Somewhat Fairly Quite Very Definitely
 True True True True True True True

| | I expect/think I will ... | I would like to... |
|---|----------------------------------|---------------------------|
| 16. Never need counselling again. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 17. Enjoy being with the counsellor. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 18. Stay in counselling even though it may be painful or unpleasant at times. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 19. Contribute as much as I can in terms of expressing my feelings and discussing them. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 20. See the counsellor for only one session. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 21. Go to counselling only if I have a very serious problem. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 22. Find that the counselling relationship will help me and the counsellor identify problems on which I need to work. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 23. Become better able to help myself in the future. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| | I expect/think I will... | I would like to... |
| 24. Find that my problem will be solved once and for all in counselling. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 25. Feel safe enough with the counsellor to really say how I feel. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 26. See an experienced counsellor. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 27. Find that all I need to do is to answer the counsellor's questions. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 28. Improve my relationships with others. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 29. Ask the counsellor to explain what he or she means whenever I do not understand something that is said. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 30. Work on my concerns outside the counselling sessions. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 31. Find that sessions are not the place to bring up personal problems. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |

For these next questions, I want you to imagine what your counsellor might be like. Then, circle what you THINK your counsellor will be like, and also what you WOULD LIKE them to be like...



1 2 3 4 5 6 7
 Not Slightly Somewhat Fairly Quite Very Definitely
 True True True True True True True

| | I expect/think the counsellor will... | I would like the counsellor to... |
|---|--|--|
| 1. Explain what's wrong. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 2. Help me identify and label my feelings so I can better understand them. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 3. Tell me what to do. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 4. Know how I feel even when I cannot say quite what I mean. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 5. Know how to help me. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 6. Help me identify particular situations where I have problems. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 7. Give encouragement and reassurance. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 8. Help me to know how I am feeling by putting my feelings into words for me. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| | I expect/think the counsellor will... | I would like the counsellor to... |
| 9. Be a "real" person, not just a person doing a job. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 10. Help me discover what aspects of my behaviour are important to my problems. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 11. Inspire confidence and trust. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 12. Frequently offer me advice. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 13. Be honest with me. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 14. Be someone who can be counted on. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 15. Be friendly and warm towards me. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |

1 2 3 4 5 6 7
 Not Slightly Somewhat Fairly Quite Very Definitely
 True True True True True True True

| | I expect/think the counsellor will... | I would like the counsellor to... |
|--|--|--|
| 16. Help me solve my problems. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 17. Discuss his or her own attitudes and relate them to my problem. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 18. Give me support. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 19. Decide what treatment plan is best. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 20. Know how I feel at times, without my having to speak. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 21. Do most of the talking. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 22. Respect me as a person. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 23. Discuss his or her experiences and relate them to my problems. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 24. Praise me when I show improvement. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 25. Make me face up to the differences between what I say and how I behave. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 26. Talk freely about himself or herself. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 27. Have no trouble getting along with people. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| | I expect/think the counsellor will... | I would like the counsellor to... |
| 28. Like me. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 29. Be someone I can really trust. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 30. Like me in spite of the bad things that he or she knows about me. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 31. Make me face up to the differences between how I see myself and how I am seen by others. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 32. Be someone who is calm and easygoing. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 33. Point out to me the differences between what I am and what I want to be. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 34. Just give me information. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 35. Get along well in the world. | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |

YOU'RE ALL DONE NOW, THANK YOU!!!

APPENDIX J

Follow-up Questionnaire

Name: _____

These questions are asking you about what your experience at headspace has been like. The rating scale we would like you to use is printed at the top of each page. Circle the number on each question that is most true for you. For example, if you definitely liked your counsellor, you would circle 7, but if you really didn't like your counsellor, you would circle 1.

| | | | | | | |
|-------------|------------------|------------------|----------------|---------------|--------------|--------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Not True | Slightly True | Somewhat True | Fairly True | Quite True | Very True | Definitely True |

| | In counselling I did... | | | | | | |
|---|--------------------------------|---|---|---|---|---|---|
| 1. I took psychological tests | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. I liked the counsellor | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3. I saw a counsellor in training | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. I gained some experience in new ways of solving problems within the counselling process. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5. I openly expressed my emotions regarding myself and my problems. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6. I understood the purpose of what happened in the sessions. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7. I did homework tasks outside the counselling sessions. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8. I took responsibility for making my own decisions. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9. I talked about my present concerns. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 10. I got practice in relating openly and honestly to another person within the counselling relationship. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 11. I enjoyed my sessions with the counsellor. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 12. I practiced some of the things I needed to learn in the counselling relationship. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 13. I got a better understanding of myself and others. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 14. I stayed in counselling for at least a few weeks, even if at first I was not sure it would help. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 15. I saw the counsellor for more than three sessions. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

1 2 3 4 5 6 7
 Not Slightly Somewhat Fairly Quite Very Definitely
 True True True True True True True

| | In counselling I did... | | | | | | |
|--|--------------------------------|---|---|---|---|---|---|
| 16. I now never need counselling again. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 17. I enjoyed being with the counsellor. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 18. I stayed in counselling even though it may have been painful or unpleasant at times. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 19. I contributed as much as I could in terms of expressing my feelings and discussing them. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 20. I saw the counsellor for only one interview | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 21. I feel like I should only go to counselling if I have a very serious problem. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 22. I found that the counselling relationship has helped me and the counsellor identify problems on which I need to work on. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 23. I have become better able to help myself in the future. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 24. I found that my problem was solved once and for all in counselling. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 25. I feel safe enough with the counsellor to really say how I feel. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 26. I saw an experienced counsellor. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 27. I found that all I needed to do was to answer the counsellor's questions. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 28. I have improved my relationships with others. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 29. I asked the counsellor to explain what he or she meant whenever I did not understand something that was said. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 30. I worked on my concerns outside the counselling sessions. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 31. I found that sessions were not the place to bring up personal problems. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

For these next questions, circle what you think your counsellor or psychologist is actually like now that you have seen them a few times.

1 2 3 4 5 6 7
 Not Slightly Somewhat Fairly Quite Very Definitely
 True True True True True True True

| | The counsellor was... | | | | | | |
|--|-----------------------|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 32. The counsellor explained to me what was wrong. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 33. The counsellor helped me to identify and label my feelings so I could better understand them. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 34. The counsellor told me what to do. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 35. The counsellor knew how I felt even when I couldn't say quite what I meant. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 36. The counsellor knew how to help me. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 37. The counsellor helped me identify particular situations where I have problems. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 38. The counsellor gave me encouragement and reassurance. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 39. The counsellor helped me to know how I am feeling by putting my feelings into words for me. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 40. The counsellor was a "real" person, not just a person doing a job. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 41. The counsellor helped me discover what particular aspects of my behaviour are relevant to my problems. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 42. The counsellor inspired confidence and trust. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 43. The counsellor frequently offered me advice. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 44. The counsellor was honest with me. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 45. The counsellor was someone who can be counted on. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 46. The counsellor was friendly and warm towards me. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 47. The counsellor helped me solve my problems. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 48. The counsellor discussed his or her own attitudes and related them to my problem. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 49. The counsellor gave me support. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 50. The counsellor decided what treatment plan was best. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

1 2 3 4 5 6 7
 Not Slightly Somewhat Fairly Quite Very Definitely
 True True True True True True True

| | The counsellor was... | | | | | | |
|---|------------------------------|---|---|---|---|---|---|
| 51. The counsellor knew how I felt at times, without my having to speak. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 52. The counsellor did most of the talking. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 53. The counsellor respected me as a person. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 54. The counsellor discussed his or her experiences and related them to my problems. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 55. The counsellor praised me when I showed improvement. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 56. The counsellor made me face up to the differences between what I say and how I behave. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 57. The counsellor talked freely about himself or herself. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 58. The counsellor has no trouble getting along with people. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 59. The counsellor liked me. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 60. The counsellor was someone I can really trust. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 61. The counsellor liked me in spite of the bad things that he or she may know about me. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 62. The counsellor made me face up to the differences between how I see myself and how I am seen by others. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 63. The counsellor was someone who is calm and easy-going. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 64. The counsellor pointed out to me the differences between what I am and what I want to be. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 65. The counsellor just gave me information. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 66. The counsellor gets along well in the world. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

1=Extremely Unlikely to 7= Extremely Likely

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. How likely is it that you would seek help from a mental health professional (e.g., school counsellor, psychologist, psychiatrist) for a personal or emotional problem in the future? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|---|

K10

For all questions, please fill in the appropriate response circle.

In the past 4 weeks:

None of
the time

A little of
the time

Some of
the time

Most of
the time

All of
the time

1. About how often did you feel tired out for no good reason?

— — — —

2. About how often did you feel nervous?

— — — —

3. About how often did you feel so nervous that nothing could calm you down?

— — — —

4. About how often did you feel hopeless?

— — — —

5. About how often did you feel restless or fidgety?

— — — —

6. About how often did you feel so restless you could not sit still?

— — — —

7. About how often did you feel depressed?

— — — —

8. About how often did you feel that everything is an effort?

— — — —

9. About how often did you feel so sad that nothing could cheer you up?

— — — —

10. About how often did you feel worthless?

— — — —