

Outcome Measure	Change Assessment Questionnaire (CAQ)
Sensitivity to Change	No
Population	Adult
Domain	Measures of Self
Type of Measure	Self-report
ICF-Code/s	b1, e4?
Description	<p>The CAQ, adapted from McConaughy, Prochaska, and Velicer's (1983) Stages of Change Scale. The scale is based on the notion that behavioral change is a process with 4 distinct measurable stages as follows:</p> <ol style="list-style-type: none"> 1. Pre-Contemplation: The person is entering into a treatment situation but does not think s/he has a problem, or does not want to change. He or she may feel pressured or coerced by others to participate in treatment. 2. Contemplation: The person is beginning to be aware that a problem exists. He or she is struggling to understand the problem (e.g., cause, solution) and is seeking more information, but has not made a commitment to change. 3. Action: The person has actively started to change the behavior. 4. Maintenance: The person has already changed and seeks treatment to consolidate previous gains and to prevent relapse from occurring <p>The scale has a 5-point Likert format in which a score of 5 indicates strong agreement and 1 shows strong disagreement.</p>
Properties	<p>Cronbach's alphas from a previous study (Lam et al., 1988) were .85, .91, and .92, respectively. The following Cronbach coefficient alphas were obtained for the three scales in Lam et al. (1991): Pre-Contemplation, .86; Contemplation, .89; and Action, .91.</p> <p>In a factor analysis, a three-factor solution, which accounted for 59.3% of the variance, was determined to yield the most meaningful results (Lam et al., 1991). In spite of the converse loadings of some items on the Contemplation and Action scales, the results of the principal component analysis indicated a clear structure yielding three distinct stages-Pre-Contemplation, Contemplation, and Action, supporting the factorial validity of the CAQ.</p> <p>Also see Fleming et al. (1998) – used CAQ Action scale (8 items) and a revised version of the Pre-contemplation scale (6 items). ICCS of .60 and .66 for 1-week test-retest (n = 20). Cluster analysis yielded meaningful differences in motivation, with high self-awareness group reporting greater motivation than the low self-awareness group. However, these groups didn't differ in functional status or community integration.</p>
Advantages	Theory-guided tool

Disadvantages	<p>Needs to be administered in the context of rehabilitation for the items to make sense.</p> <p>I administered the CAQ for my post-doc, but didn't use the data because the internal consistency was poor in my sample (possibly because people were at different stages of rehab).</p>
Other details	<p>There are few tools to compare and contrast the CAQ with – e.g., Readiness to Change Index of the SRSI (single item only), CARROT (Card Arranging Reward Responsivity Objective Test) - comparison of response speed on a simple psychomotor task with and without small financial rewards, and the PPI (Percent Participation Index)- a structured therapist observations of effort within treatment sessions</p> <p>The Motivation for Traumatic Brain Injury Rehabilitation Questionnaire (MOT-Q; Chervinsky et al., 1998) is a Likert scale questionnaire specifically developed to assess motivation for post-acute rehabilitation. The scale does not assess apathy or lowered motivation in other situations. Hence this is best for use in an in-patient or day-patient setting.</p> <p>Measure by Mike Oddy et al. (2008) BIRT Motivation Questionnaire (BMQ) – 34 items. Motivational deficits following acquired brain injury have been found to be both prevalent and particularly disabling. Despite this, relatively little attention has been given to such deficits. The development of self and informant versions of a new questionnaire measure of the changes in motivation that may occur following acquired brain injury is described. The measure demonstrates excellent psychometric properties including high test-retest ($r = .90$) and split-half reliability (.94), high internal consistency (Cronbach's alpha = .94), and good concurrent validity. The study also demonstrates that the questionnaire is measuring a different domain to cognitive tests and tests of affect, but one that is predictive of brain injury outcome. There was moderate overlap between self-report and relative versions of the questionnaire ($r = .41$) but results suggest that the relative version has the stronger predictive value. The potential uses of the measure in relation to theory and practice are discussed.</p>
Reviewers	Tamara Ownsworth

References

Lam, C.S., McMahon, B.T., Priddy, D.A., & Gehred-Schultz, M.A. (1988). Deficit awareness and treatment performance among traumatic head injury adults. *Brain Injury*, 2, 235–242.