



The Adolescent Substance Abuse Goal Commitment (ASAGC) Questionnaire: An Examination of Clinical Utility and Psychometric Properties[☆]



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ABSTRACT

Commitment to change is an innovative potential mediator or mechanism of behavior change that has not been examined in adolescents with substance use disorders (SUD). The Adolescent Substance Abuse Goal Commitment (ASAGC) questionnaire is a 16-item measure developed to assess an individual's commitment to his/her stated treatment goal. The objectives of this study are to explore the research and clinical utility of the commitment construct as measured by the ASAGC. During sessions 3 and 9 of a 10-week SUD treatment, therapists completed the ASAGC for 170 13–18 year-old adolescents. An exploratory factor analysis was conducted on the ATAGC items. Concurrent validity with related constructs, self-efficacy and motivation for change, was examined as well. At both sessions, the factor analysis resulted in two scales – Commitment to Recovery and Commitment to Harm Reduction. The ASAGC scales were found to demonstrate a high level of internal consistency (alpha coefficients ranged from .92 to .96 over time). In contrast to the Commitment to Harm Reduction scale, the Commitment to Recovery scale consistently correlated with scales from the Situational Confidence Questionnaire assessing self-efficacy, evidencing concurrent validity. Similarly, the Commitment to Recovery scale was related to the Problem Recognition Questionnaire, providing further evidence of the validity of the ASAGC. The ASAGC is a reliable and valid clinical research instrument for the assessment of adolescents' commitment to their substance abuse treatment goal. Clinical researchers may take advantage of the clinical utility of the ASAGC including its ability to differentiate between commitment to abstinence versus commitment to harm reduction.

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1. Introduction

Significant progress has been made over the past 20 years in the development of evidence-based-practice treatment protocols for youth with substance use disorders (SUD) (Dennis & Kaminer, 2006). Most interventions have been provided in outpatient settings where more than 80% of youth are treated (Office of Applied Studies, 2005). The focus of outpatient treatment for youth has been on several therapeutic approaches and modalities including family/community therapies, cognitive behavioral therapy, motivational interviewing, and 12-step/fellowship meetings as reviewed in recent meta-analyses (Becker & Curry, 2008; Waldron & Turner, 2008), as well as integrated interventions reported in the benchmark cannabis Youth Treatment (CYT) study (Dennis et al., 2004).

Despite prominent differences in theory, and design and methodology, studies employing various treatment modalities in youth with SUD have reported remarkably similar outcomes (Waldron & Turner, 2008). Rates of adolescent relapse of substance involvement are comparable to those of adults during the first year post treatment completion (Chung & Maisto, 2006; Kaminer, Burleson, & Goldberger, 2002). Research has shown that about 60% of adolescents continue to vacillate in and out of recovery after discharge from 3-month treatment programs (Dennis et al., 2004; Williams & Chang, 2000). At this point, relatively little is known about mechanisms of behavior change (MBC) in adolescents receiving these interventions, which highlights the need to study the underlying processes involved (Black & Chung, 2014; Waldron & Kaminer, 2004). Most evidence-based treatments are “theory-driven,” at least to some degree. However, meta-analyses examining the hypothesized mechanisms of action on which the interventions are based have not yielded clear results (Magill, 2009; Morgenstern & McKay, 2007) on how adults engaged in Alcoholic-Anonymous (Kelly, Magill, & Stout, 2009), cognitive behavioral therapy (Morgenstern & Longabaugh, 2000) (CBT), and motivational interviewing (Apodaca &

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Longabaugh, 2009) (MI) actually change by regularly scheduled treatment sessions over a prolonged period of time (Baskin, Tierney, Minami, & Wampold, 2003; Wampold, 2001). Changes in self-efficacy (Burlinson & Kaminer, 2005; Moss, Kirisci, & Mezzich, 1994), coping skills (Waldron & Kaminer, 2004), and motivation or readiness to change (O'Leary & Monti, 2004), appear to account for some portion of treatment effects in the adolescent research literature.

It has been proposed that a higher order construct of motivation to change may reflect commitment to change by adhering to identified treatment goals (Kelly & Greene, 2013). Kelly and Greene recently developed a five-item commitment to sobriety scale for emerging adults 18–25 years of age (Kelly & Greene, 2013). They argued that “in contrast to being motivated to change, being committed to change implies the presence of a stronger desire that is more compelling and forceful, and that may be less susceptible to the undulating future circumstances and contingencies that so often weaken resolve and make motivation fluctuating.” Hall and colleagues developed a single-item commitment to abstinence questionnaire for adults, which uses six response categories to differentiate the participant's goals surrounding abstinence (Hall, Havassy, & Wasserman, 1991). This measure was validated by subsequent research (Mensingher, Lynch, TenHave, & McKay, 2007; Morgenstern, Frey, McCrady, Labouvie, & Neighbors, 1996).

At this time, we are not aware of an instrument measuring commitment to change tailored to specific treatment objectives in adolescents with SUD. We have developed a 16-item questionnaire, the Adolescent Substance Abuse Goal Commitment (ASAGC) questionnaire, to assess the adolescent's commitment to his/her stated goal of substance abuse treatment (see appendix for the ASAGC). Although the ultimate goal of treatment is recovery (i.e., abstinence/relapse prevention), some youth might choose a harm reduction goal (i.e., decrease only in frequency and/or severity of use), or might drift between the two goals at different points in the continuity of care (Kaminer & Godley, 2010) from assessment and through treatment, aftercare or follow-up. Therefore, the instrument was designed to assess commitment to both of these two goals. The items included in the instrument were the result of a selective review process of multiple relevant items from the abstinence and harm reduction oriented literature generated by the authors before the onset of the study. The objectives of this study are to 1) introduce the construct of and the rationale for measuring commitment to treatment goals; and 2) examine the clinical utility and initial psychometric properties of the ASAGC.

2. Methodology

2.1. Participants and procedures

A total of 294 adolescents were screened for the study. Of those screened, 235 met the eligibility criteria for participation. Of those eligible, 179 completed intake and signed consent forms. This study included individuals from intake who had complete data.

Specifically, the sample included 170 13–18 year-old adolescents (67% male). Most of the adolescents were Caucasian (79%); 13% were Latino, 4% were African American, and 4% were biracial/other. The mean age of the adolescents was 15.90 (SD = 1.20). All of the adolescents were receiving treatment for a current DSM-IV diagnosis of an alcohol use disorder (29% met the criteria for alcohol abuse and 26% met the criteria for alcohol dependence) or consistent with eligibility criteria, had reported at least 3 days of drinking within the last 90 days. In addition, 77% of the adolescents met the criteria for cannabis use disorder (25% met the criteria for cannabis abuse and 52% met the criteria for cannabis dependence). Additional inclusion criteria included the ability to read and comprehend English at a fifth-grade level, not planning to move out of state for the next 12 months, and willingness to accept aftercare. Exclusion criteria included meeting substance dependence criteria for any substance other than alcohol, nicotine, or marijuana, a lifetime diagnosis of schizophrenia, suicidal ideation with a

plan, suicidal behavior or self-injurious behavior in the past 30 days, or any current medical condition that would compromise their ability to participate in the study.

This study was a prospective, intent to treat study. The treatment phase consisted of ten weekly cognitive behavioral therapy sessions. For additional information relating to the design and outcomes, please refer to Kaminer, Burlinson, and Burke (2008). The protocol and informed assent and consent procedures from subjects and their guardians respectively were approved by the University of Connecticut Health Center's Institutional Review Board.

2.2. Measures

2.2.1. Adolescent Substance Abuse Goal Commitment (ASAGC)

Therapists completed the ASAGC questionnaire for the participants during sessions 3 and 9 of treatment. The ASAGC assesses an individual's commitment to his/her stated treatment goal. The ASAGC includes 16 items that are completed on a response scale ranging from 0 = *definitely not* to 4 = *definitely committed*. A representative item is “Does the adolescent express commitment to recovery (abstinence/relapse prevention) as a goal?”

2.2.2. Situational Confidence Questionnaire (SCQ)

The adolescents also completed the revised 39-item Situational Confidence Questionnaire (Annis, 1987) at session 8. The SCQ was designed to assess perceived confidence to resist alcohol or substance use in high-risk situations. A sample SCQ item is “I would be able to resist the urge to use heavily if I had an argument with a friend.” The response scale ranges from 0 to 10, with higher scores reflecting more confidence in resisting substance use. The SCQ includes the following subscales: Unpleasant Emotions/Frustrations, Physical Discomfort, Social Problems at Work, Social Tension, Pleasant Emotions, Positive Social Situations, Urges and Temptations, and Testing Personal Control. The SCQ has been shown to be a valid and reliable instrument for use with adolescents (Burlinson & Kaminer, 2005; Moss et al., 1994).

2.2.3. Problem Recognition Questionnaire (PRQ)

The adolescents completed the 25-item Problem Recognition Questionnaire (Cady, Winters, Jordan, Solberg, & Stinchfield, 1996) at session 5. The PRQ assesses both adolescent problem recognition and willingness to change drug use and seek treatment. A representative PRQ item is “Using alcohol or drugs is a real problem in my life.” The response scale is a 4-point Likert-type scale ranging from 1 = *strongly disagree* to 4 = *strongly agree*. The PRQ has been shown to be both a reliable and valid measure to assess motivation and readiness for treatment (Cady et al., 1996). PRQ scores are trichotomized as follows: low recognition for treatment (PRQ score = 21–39), moderate recognition for treatment (PRQ score = 40–59), and high recognition for treatment (PRQ score = 60 or greater).

2.3. Data analysis

An exploratory factor analysis was conducted on the ASAGC assessed during session 3 and session 9 of treatment. For the factor analysis, an oblique promax rotation was specified to allow for factors to be correlated. Conceptually, the decision was made to extract and compare 2, 3, and 4 factor solutions at each time of assessment. Cronbach's alpha coefficients were calculated to measure homogeneity and to assess the internal consistency of the ASAGC factors. Concurrent validity was examined by correlating the ASAGC factors with scales from the SCQ. Analysis of variance (ANOVA) models also were conducted to examine the relationship between the ASAGC factors and the PRQ.

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