



## Effectiveness of the Treatment Readiness and Induction Program for increasing adolescent motivation for change



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### ARTICLE INFO

#### Article history:

Received 21 April 2014

Received in revised form 20 September 2014

Accepted 6 October 2014

#### Keywords:

Adolescents

Substance use

Motivation

Intervention effectiveness

### ABSTRACT

Success in substance abuse treatment is improved by problem recognition, desire to seek help, and readiness to engage in treatment, all of which are important aspects of motivation. Interventions that facilitate these at treatment induction for adolescents are especially needed. The purpose of this study is to assess the effectiveness of TRIP (Treatment Readiness and Induction Program) in promoting treatment motivation. Data represent 519 adolescents from 6 residential programs who completed assessments at treatment intake (time 1) and 35 days after admission (time 2). The design consisted of a comparison sample ( $n = 281$ ) that had enrolled in treatment prior to implementation of TRIP (standard operating practice) and a sample of clients that had entered treatment after TRIP began and received standard operating practice enhanced by TRIP ( $n = 238$ ). Repeated measures ANCOVAs were conducted using each time 2 motivation scale as a dependent measure. Motivation scales were conceptualized as representing sequential stages of change. LISREL was used to test a structural model involving TRIP participation, gender, drug use severity, juvenile justice involvement, age, race–ethnicity, prior treatment, and urgency as predictors of the stages of treatment motivation. Compared to standard practice, adolescents receiving TRIP demonstrated greater gains in problem recognition, even after controlling for the other variables in the model. The model fit was adequate, with TRIP directly affecting problem recognition and indirectly affecting later stages of change (desire for help and treatment readiness). Future studies should examine which specific components of TRIP affect change in motivation.

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### 1. Introduction

Substance use is a significant problem among youth in the United States (Aarons, Brown, Hough, Garland, & Wood, 2001; Gilvarry, 2000; Johnston, O'Malley, Bachman, & Schulenberg, 2008). Youth completing specialized treatment for their substance use show better follow-up outcomes (Williams, Chang, & Addiction Centre Adolescent Research Group, 2000; Winters, Latimer, & Stinchfield, 1999) in the areas of drug use, criminal activity, psychological adjustment, and school performance (Hser et al., 2001; Joe, Knight, Becan, & Flynn, 2014). While effective treatments exist, numerous studies have found that sizable individual differences in client responsiveness to treatment manifest even when administered with attention to protocol adherence (Dennis et al., 2004; Waldron, Slesnick, Brody, Turner, & Peterson, 2001). While these differences can be attributed to numerous individual and programmatic factors, client motivation to change (Titus & Dennis, 2006) and sufficient treatment tenure (Etheridge, Smith, Rounds-Bryant, & Hubbard, 2001; Pompei & Resnick, 1987; Williams et al., 2000) are considered to be pivotal.

Not surprisingly, adolescent clients often state that their substance use is not a problem. Furthermore, they show a lack of interest in taking personal responsibility for change, and often have insufficient internal motivation to respond favorably to treatment (Titus & Dennis, 2006). Because adolescents generally tend to pay more attention to the positive social effects of drinking and substance use, and less attention to the negative consequences that their use can have on family, school, physical, and psychological well-being (National Institute on Alcohol Abuse & Alcoholism (NIAAA), 2005), interventions are needed that focus on improving judgment and decision making, factors that have been hypothesized as crucial to internal motivation. It is anticipated that interventions aimed at improving general thinking skills—self-awareness, goal-directed thinking, and exploring negative consequences—might promote higher motivation to change. There is growing support that these interventions use stimulating and meaningful activities to increase motivation and preparedness for change immediately upon entry into treatment (DiClemente, Garay, & Gemmell, 2008).

The purpose of this study is to test the effectiveness of a new intervention for improving motivation for change, called the Treatment Readiness and Induction Program (TRIP). This is done by testing whether adolescents who received TRIP in addition to standard operating procedure (SOP) improved significantly more on motivation for change compared to those receiving only SOP. For the purpose of this study,

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motivation for change is defined by the treatment process model (Simpson, 2004) and includes three elements—recognition of a substance use problem, desire for help with substance use, and readiness for treatment. This study extends research conducted by Knight, Dansereau, Becan, Rowan, and Flynn (2014) on the effectiveness of TRIP for improving decision making to include an examination of the extent to which TRIP promotes greater gains in motivation for change beyond that experienced with SOP alone.

### 1.1. Motivation for change models

Global models of change and the treatment process [e.g., the transtheoretical model (TTM; Prochaska, DiClemente, & Norcross, 1992), integrative recovery model (De Leon, 1996), and the treatment process model (Simpson, 2004)] recognize treatment readiness and client responsiveness as key components of the change process. The progression of change, as conceptualized by the TTM, typically starts with pre-contemplation (unawareness of behavior), then progresses to contemplation (become aware, decide if action is desired), which leads to preparation (intent to change) and action (steps have been taken, receive reinforcement), and eventually maintenance (continuation of change). Stages represented by the treatment process model correspond with the TTM starting with recognition of a substance use problem (i.e., contemplation), desire to seek help with substance use (i.e., preparedness), and readiness and commitment to treatment (i.e., action).

Significant relationships between stages of change and treatment outcomes have been documented. Adolescents who do not acknowledge that negative consequences result from their substance use (i.e., in the lower pre-action stages of change) are more likely to drop out of treatment prematurely than youth in more advanced, action-oriented stages of change (Callaghan et al., 2005). Conversely, youth in the action stages who show a desire for help with their substance use and a high level of readiness and commitment to the therapeutic process are more likely to engage in meaningful interactions with the clinical staff and other youth receiving treatment (Joe et al., 2014). Further, the later stages of change interrelate to promote positive treatment outcomes. Treatment readiness serves as a mediator of the relationship between desire for help in treatment and eventual treatment completion (Fickenscher, Novins, & Beals, 2006).

Behavioral change, as represented by these global models, is now more commonly understood as a cyclical or dynamic recovery process, rather than a linear progression across stages (White & Kelly, 2011). Adolescents with substance use problems can move forward, backward, and recycle through the stages of change (DiClemente, 2005), with many youth requiring multiple treatment episodes due to their severity of use (Dennis et al., 2004; Godley, Godley, & Funk, 2005). The revised transtheoretical model, referenced as intentional behavioral change (DiClemente, 2005), suggests that there is a ‘constellation of tasks’ that promote advancement between early and later stages of change. Cognitive/experiential activities (e.g., planning, organizing, and problem solving) can serve as ‘engines’ to facilitate mastery of stage specific tasks, which often necessitate a recycling through the stages (DiClemente et al., 2008). While there are engines that promote advancement through the stages of change, there are also cognitive/experiential factors that could serve as potential inhibitors to intentional behavioral change. For example, youth tend to place more value on the social rewards that accompany risky behavior, like substance use, rather than the potential negative consequences associated with use. Studies show that the tendency for youth to respond rashly when experiencing positive emotions (termed positive urgency) is connected with greater risky decision making (Zapolski, Cyders, & Smith, 2009) and behaviors such as substance use. Moreover, impulsive tendencies may also interfere with progress in treatment, especially motivation for change. Kazemi, Wagenfeld, Van Horn, Levine, and Dmochowski (2011) found that impulsivity served as a barrier for college binge

drinkers' intent to change, especially for those in the pre-contemplation stage. Furthermore, adolescents with high levels of impulsivity at treatment intake remain abstinent fewer weeks during treatment than clients with lower baseline levels of impulsivity (Stranger et al., 2011).

### 1.2. Adolescent treatment practices

Several highly innovative and effective practices and therapies for adolescents have emerged, including multi-dimensional family therapy (MDFT; Liddle, Rodriguez, Dakof, Kanzki, & Marvel, 2005; Rowe & Liddle, 2006), adolescent contingent reinforcement approach (A-CRA; Dennis et al., 2004; Godley et al., 2001), cognitive-behavioral therapy (CBT; Kaminer, Blitz, Bursleson, & Sussman, 1998; Kaminer, Bursleson, & Goldberger, 2002; Waldron et al., 2001), and multisystemic therapy (MST; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). These are often stand-alone, manualized interventions and are designed to be transportable with adequate training (Schoenwald & Hoagwood, 2001). They are effective for improving client outcomes (Bender, Springer, & Kim, 2006), are embraced by therapists (Godley & White, 2001), and provide excellent models for targeted interventions for adolescents. While these practices are often highly inventive, such multi-faceted interventions are often resource-intensive (i.e., staff time for training, funding for new staff) and may be difficult to incorporate into existing protocols. Therefore, the need exists for additional, empirically tested interventions for youth that easily interface with existing treatment programs and fit within available resources (McWhirter, 2008). For intervention adoption and implementation to occur, demands on programs have to be realistic and within the scope of existing facility and staffing resources (Flynn & Brown, 2011).

Tools to enhance motivation for change, including readiness training that help prepare individuals to take advantage of treatment (Aharonovich, Nunes, & Hassin, 2003; Wexler, Melnick, Lowe, & Peters, 1999), are becoming an integral part of the therapeutic process (DiClemente et al., 2008). There are a few evidence-based practices specifically developed for youth as induction tools to be administered during the initial phase of treatment. These include motivational interviewing (MI), motivational enhancement therapy (MET; Henggeler et al., 1991; Liddle et al., 2001), and brief motivational interventions (BMI; Dennis et al., 2004). In most applications, counselors are trained to work one-on-one with clients to increase motivation for change. While shown to be effective (Miller & Rollnick, 2002; Monti, Barnett, O'Leary, & Colby, 2001; Walker et al., 2006), group-based interventions are more prevalent in community-based treatment (Kaminer, 2005; Macgowan & Wagner, 2005; Stinchfield, Owen, & Winters, 1994). For these settings, group-facilitated readiness interventions that incorporate cognitive behavioral techniques and that can be integrated easily into standard practice are warranted.

### 1.3. The Treatment Readiness and Induction Program

The Treatment Readiness and Induction Program (TRIP; Bartholomew, Dansereau, Knight, Becan, & Flynn, 2012) is a package of effective tools and materials that is intended as a group-based treatment with a focus on increasing motivation for treatment by encouraging youth to think more clearly and systematically about their drug use and personal problems. Although the components of TRIP were originally developed with adult treatment samples, it has been adapted for use with adolescent clients (see Dansereau, Knight, & Flynn, 2013; Knight, Dansereau, Becan, Rowan, & Flynn, 2014). Three primary strategies are used to achieve TRIP objectives—mapping-enhanced counseling (MEC), experiential games and activities, and peer facilitation. MEC (Dansereau & Simpson, 2009) forms the core of TRIP and takes advantage of spatial thinking to improve cognition and commitment to change. Activities include guide maps which are “fill in the blank” templates that “guide” thinking around a particular topic. Mapping focuses

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