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Social pressure, coercion, and client engagement at treatment entry: A self-determination theory perspective

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Abstract

Research on coercion in addiction treatment typically investigates objective sources of social pressure among legally mandated clients. Little research has examined the impact of clients' *perceptions* of social pressures in generalist addiction services. Clients seeking substance abuse treatment ($N=300$; 221 males and 79 females; M age = 36.6 years) rated the extent to which treatment was being sought because of coercive social pressures (*external motivation*; $\alpha=.89$), guilt about continued substance abuse (*introjected motivation*; $\alpha=.84$), or a personal choice and commitment to the goals of the program (*identified motivation*; $\alpha=.85$). External treatment motivation was positively correlated with legal referral, social network pressures to enter treatment, and was inversely related to problem severity. In contrast, identified treatment motivation was positively correlated with self-referral and problem severity, and was inversely related to perceived coercion ($ps<.05$). Hierarchical multiple regression analyses showed that referral source (i.e., mandated treatment status), legal history, and social network pressures did not predict any of 6 measures of client engagement at the time treatment was sought. However, treatment motivation variables accounted for unique variance in these outcomes when added to each model (ΔR^2s = .06–.23, $ps<.05$). Specifically, identified treatment motivation predicted perceived benefits of reducing substance use, attempts to reduce drinking and drug use, as well as self (and therapist) ratings of interest in the upcoming treatment episode (βs = .18–.31, $ps<.05$). Results suggest that the presence of

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legal referral and/or social network pressures to quit, cut down, and/or enter treatment does not affect client engagement at treatment entry.

Keywords: Treatment; Coercion; Motivation; Self-determination theory

1. Introduction

Entry into alcohol and other drug treatment programs often occurs in conjunction with *legal* mandates from the criminal justice system, *formal* mandates from employers and social assistance agencies, and *informal* mandates (e.g., threats, ultimatums, interventions) issued by family and friends (Gerdner & Holmberg, 2000; Gregoire & Burke, 2004; Joe, Simpson, & Broome, 1999; Polcin & Weisner, 1999; Rush & Wild, 2003; Weisner, 1990). Clinicians, researchers, and policy-makers alike increasingly recognize that these social control tactics are an integral part of the process of seeking treatment for alcohol and other drug problems.

A review of 170 English language articles on this topic revealed several trends and limitations in recent research (Wild, Roberts, & Cooper, 2002). First, there is a relatively weak empirical base to inform decision-makers about the use of social control tactics, since over half of published articles merely provide legal, ethical, and/or clinical arguments for or against the use of social pressure to facilitate treatment without reporting empirical data. Second, informal mandates occur more frequently than formal and legal social pressures (Polcin & Weisner, 1999) and may be more influential in facilitating treatment entry (Marlowe et al., 1996). But existing research overemphasizes legal mandates (e.g., court-ordered treatment, diversion to treatment from criminal justice systems). Third, few studies have used longitudinal and comparative designs to understand relationships between social pressures and treatment outcomes. Finally, research has rarely examined relationships between social pressures, client motivation for seeking help, and engagement in the treatment process. For example, Farabee, Prendergast, and Anglin (1998) reviewed 11 studies of coerced addiction treatment and found that none of them assessed motivational correlates of social pressure.

1.1. Assessing coercion in addiction treatment

Fully 78% of 71 empirical studies reviewed by Wild et al. (2002) used referral source (e.g., court referral versus self-referral) to operationally define whether treatment was "coerced" or not. When coercion is assessed independently of referral source, measurement strategies typically emphasize objective features of social pressure. For example, several studies used an ordinal measure assessing low, medium, and high levels of coercion with reference to legal status along with the presence or absence of legal referral and urine testing requirements at the time treatment was sought (Hser, Maglione, Polinsky, & Anglin, 1998; Joe, Simpson, & Broome, 1999; Joe, Simpson, Greener, & Rowan-Szal, 1999; Maglione, Chao, & Anglin, 2000). Marlowe et al. (1996), Marlowe, Merikle, Dirby, Festinger, and McLellean (2001) developed a behaviourist measure of coercion in which clients' reasons for seeking addiction treatment were coded in relation to reinforcement schedule, social mediation, and psychosocial domain. Finally, Polcin and Weisner (1999) developed a coercion index by asking clients to indicate