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BRIEF REPORT

MOTIVATION IN THE TREATMENT OF ALCOHOLISM

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INTRODUCTION

One of the first studies in which motivation in the treatment of alcoholism was analysed was published by Lemere, O'Hollaren, and Maxwell (1958) about three decades ago. Content analysis of interview data from 1,038 alcoholics participating in an inpatient treatment program not only show the spectrum of motives alcoholics have for treatment, but also some interesting relationships between the reasons for accepting treatment, as well as initial insight into goals and need for treatment, and the results of treatment. Lemere et al. (1958) devoted care to the fact that some external pressure, such as threatened loss of job or spouse, is favorable for treatment outcome. This is not true for patients who have already lost a job or spouse; for them the prognosis is less favorable. However, Lemere et al. (1958) present their data purely descriptively and somewhat cursorily and neglect any statistical evaluation. Not only are methodological standards higher today, but also the literature on treatment motivation and help-seeking behavior has expanded in general. Static as well as dynamic aspects of treatment motivation such as outcome expectancies, causal attributions, suffering, reasons for treatment, insight into goals of and need for treatment, and treatment readiness have been differentiated by authors such as Krause (1966) and Kadushin (1969), who also emphasize the plasticity of these motivational variables before and during treatment.

The present study is an extended replication of the work of Lemere et al. (1958) including a broadened list of reasons for accepting treatment and statistical methods of evaluation. The research questions focus on (a) the reasons for accepting inpatient treatment for alcoholism and (b) the relation of these reasons to two different indicators of treatment outcome.

METHOD

Two studies were carried out in which two unselected samples of alcoholics just starting inpatient treatment participated. In the first study 191 alcoholics beginning a six-week inpatient treatment answered a questionnaire in which agreement with 14 reasons for accepting treatment was assessed on 7-point rating scales (ranging from "absolutely wrong" to "very true"). The list of reasons used is given in Table 1. The sample consisted of 51 women and 140 men (mean age: 41.9 years, $SD = 10.67$; mean duration of alcoholism: 11.6 years, $SD = 7.96$). One-year follow-up data of 89 former patients (follow-up data from patients validated by verbal data of their family doctors) indicate that 69 of them are still living abstinently. As a conservative estimation

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Table 1. Reasons for accepting treatment for alcoholism and their relation to results of treatment in several samples

Reason for Accepting Treatment	Study of Lemere et al. (1958)+		Sample 1 (N = 191)					Sample 2 (N = 72)		
					Means and Mean Comparison					
	Yes (%)	Rank	Yes (%)	Rank	Not Abstinent	Abstinent	$t(189)$	Yes (%)	Rank	r_{DMOT}
1. Physical health being ruined by drinking	82	1	98	1	4.7	4.8	0.82	90	1	.13
2. Mental capacity failing because of drinking	74	2	92	3	4.1	4.3	0.51	87	2	.01
3. Work threatened by drinking	69+	3	65	5	2.7	3.6	2.42*	83	4	.35*
4. Lost job because of drinking	13−	9	24	13	3.0	1.2	−3.02*	51	12	−.29*
5. Marriage threatened by drinking	55+	4	58	8	2.4	3.6	3.11*	72	7.5	.31*
6. Spouse left because of drinking	20−	8	21	14	2.5	1.3	−2.81*	41	14	−.30*
7. Arrest(s) for drinking	50	5	25	11.5	1.1	1.6	0.98	49	13	.05
8. Drinking harming family (others than spouse)	42#	6	72	4	3.7	3.2	0.77	79	5.5	.13
9. Lost friends because of drinking			58	8	2.8	2.8	0.02	69	9	.09
10. Economic security threatened by drinking	36	7	58	8	2.6	2.5	−0.17	72	7.5	−.02
11. Well-being disturbed by drinking	−/−	−/−	96	2	4.0	5.3	3.14*	85	3	.32*
12. Driver's license threatened by drinking	−/−	−/−	60	6	2.4	3.1	3.05*	62	10	.25*
13. Driver's license lost because of drinking	−/−	−/−	28	10	2.8	1.5	−2.91*	54	11	−.27*
14. External pressure to start inpatient treatment	−/−	−/−	25	11.5	1.3	1.5	0.90	79	5.5	.17

*$p < .05$.

+ = favorable prognosis, − = less favorable prognosis, # = considered together, −/− = not considered by Lemere et al.

it is assumed in the following that all patients, of which no follow-up data were available, were not living abstinently.

In the second study the same list of reasons for accepting treatment for alcoholism was used in a sample of 72 alcoholics who participated in a short inpatient detoxification program (duration: two weeks). Furthermore these patients answered a scale measuring general motivation and readiness for a long-term inpatient treatment (12 items, $r(tt) = .85$), which was constructed with reference to the work of Lemere et al. (1958) and of Adamson, Fostakowsky, and Chebib (1974). Besides a pretest administered at the beginning of detoxification treatment, a posttest (including both measures) was given to all patients at the end of the short-term inpatient detoxification program. The sample of study 2 consisted of 20 women and 52 men (mean age: 40.1 years, $SD = 8.27$; mean duration of alcoholism: 7.6 years, $SD = 5.52$).

RESULTS

In Table 1 the quotas of agreement to the 14 reasons for accepting treatment for alcoholism in the two samples are presented. Additionally the results of the study from Lemere et al. (1958) are given in the first two columns. Comparisons of the rank orders of the reasons between the three samples indicate a high level of agreement. Taking into consideration only the nine specified reasons from Lemere et al. (1958), the rank correlation (Spearman) with the data from sample 1 is $r(s) = .83$ ($p < .01$), that with the data from sample 2 is $r(s) = .81$ ($p < .01$). The comparison of the rank orders from our samples 1 and 2, including all 14 reasons, leads to a rank correlation coefficient of $r(s) = .70$ ($p < .01$). Apparently the rank order of reasons for accepting treatment for alcoholism is relatively independent from historical and cultural differences between samples. The test–retest reliabilities of the 14 reasons for accepting treatment in sample 2 (interval: 10 days) are very high ($.89 \leq r(tt) \leq .96$; mean $r(tt) = .92$), indicating a high temporal stability of the reasons for accepting treatment within subjects as well.

As with the results (not inference-statistically assured) of Lemere et al. (1958) a positive relationship between threatened loss of job, spouse, and driver's license and a good prognosis are found in both samples (see Table 1). Additionally, high agreement with the reason "well-being disturbed by drinking" at the beginning of treatment is positively related to treatment outcome. Less favorable prognoses are observed in those patients who already had lost a job, spouse, or driver's license. Again this is in accordance with the results of Lemere et al. (1958). It is worth noting that these results were found to be congruous in the independent samples 1 and 2 using two different criteria for treatment outcome. Follow-up data on drinking behavior one year after treatment were used in sample 1 as criteria of treatment outcome; positive changes in general motivation and readiness for a long-term inpatient treatment (DMOT in Table 1) were used in sample 2 as criteria. All results are in agreement. This is also true for the fact that all other reasons for accepting treatment are not significantly related to treatment outcome criteria (see Table 1).

DISCUSSION

About three decades after the work of Lemere et al. (1958) very similar results concerning the degree of agreement with and the rank order of reasons for accepting treatment in alcoholics just beginning inpatient treatment were found in two samples. The same is true for the relationships between the reasons for accepting treatment and the results of the treatment. Threatened loss of job, spouse, or driver's license as

well as the subjective disturbance of well-being are positively related to treatment outcome which confirms the statement of Lemere et al. (1958; p. 430) that in clinical samples of alcoholics "few if any alcoholics decide to stop drinking until some pressure is put on them." But it is worthwhile to note that the prognosis is less favorable in those patients who have already experienced a loss in one of those areas. This may be an indicator of social decline, deficient social support and/or social isolation, through which the necessary external motivational pressure is minimized. Thus, data on motivational variables make it possible to identify more impaired alcoholics, who need special treatment preceding long-term inpatient programs. John (1985) differentiates in his biographical analysis of alcoholics not motivated to participate in treatment two groups, from which the second (alcoholics with a high degree career) is in very good agreement with our patients having a bad prognosis.

With regard to theories of treatment motivation (see Kadushin, 1969; Krause, 1966) the presented results point at the necessity of analysing the motivation accepting treatment and other motivational variables like insight into the need for treatment and general treatment readiness (see also Miller, 1985). Differential operationalizations are possible and useful for predictive purposes. This is especially relevant for treatment motivation programs which should be administered before or at the beginning of inpatient treatment of alcoholism. Results with corresponding treatment motivation programs which are founded on group dynamics, behavior analysis, and cognitive-behavioral modification verify the dynamic character and plasticity of insight into the need for treatment and general treatment readiness (Krampen & Petry, 1987; Miller, 1985).

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