4-29-2011

Effect of Distress, Referral Source, and Pressure to Attend Therapy on Motivation to Change

Lyn E. Moore
University of Connecticut, lynmoore@gmail.com

Effect of Distress, Referral Source, and Pressure to Attend Therapy on Motivation to Change

Lyn Erin Moore

B.A., Franklin & Marshall College, 2009

A Thesis

Submitted in Partial Fulfillment of the

Requirements for the Degree of

Master of Arts

at the

University of Connecticut

2011

APPROVAL PAGE

Master of Arts Thesis

Effect of Distress, Referral Source, and Pressure to Attend Therapy on Motivation to Change

Presented by

Lyn E. Moore, B.A.

Major Advisor _____

Rachel B. Tambling, PhD

Associate Advisor _____

Stephen Anderson, PhD

Associate Advisor _____

Shayne Anderson, PhD

University of Connecticut

2011

Acknowledgements

First and foremost I want to thank my advisor, Dr. Rachel Tambling, for her guidance, support, and attention to detail. Without her this project and past year would have been insurmountable. Her ability to edit my countless drafts with expediency and precision demonstrated her care and concern for my work and personal wellbeing. Thank you, Dr. Tambling, for always keeping me motivated. I also want to sincerely thank and appreciate the other members of my committee, Dr. Stephen Anderson and Dr. Shayne Anderson for their assistance and mentorship throughout my research and time in the program. I am indebted to the clinic for the data collection and resources, as well as the opportunity to perform this study. I am thankful for the support of my colleagues, friends, and family during the past two years as they motivated my clinical, personal, and academic development. Thank you to everyone that supported, guided, asked about my work, or helped with last minute edits! Your care and concern did not go unrecognized and made a difference to my stress and anxiety. Last but not least, I owe my education and supervision to the Marriage & Family Therapy faculty, the Human Development and Family Studies Department, and the Graduate School of the University of Connecticut. Thank you!

Abstract

Psychotherapy is an effective form of treatment, yet difficulties with engagement and dropout continue to plague the field. Poor outcomes are more likely to be achieved by poorly motivated clients and those who are mandated to attend therapy (Prochaska, DiClemente, & Norcross, 1992). This study examined links between motivation to change, initial levels of distress, referral source, and pressure to attend therapy in a sample of 587 individuals who attended therapy at a university-based counseling center in the Northeast. Results indicated a relationship between distress and motivation to change as well as a link between the perceived pressure felt by a client and motivation to change.

Keywords: motivation to change, stages of change, pressure, therapy, treatment factors

CHAPTER 1: INTRODUCTION

Effect of Distress, Referral Source, and Pressure to Attend Therapy on Motivation to Change

Psychotherapy researchers have devoted significant attention to determining the efficacy of therapy. Individual reports and meta-analyses indicate that psychotherapy can be a highly effective form of treatment that creates the desired change for clients (Piper, Ogrodniczuk, Joyce, & Weideman, 2011; Matusiewicz, Hopwood, Banducci, Lejuez, 2010). Despite the efficacy of psychotherapy, researchers and clinicians report difficulties in client engagement (Repel & Destefano, 2009), high incidences of early termination from therapy (Pekarik, 1992), and frequent relapses after brief improvement (Shadish & Baldwin, 2003; Sprenkle, 2002). Of additional concern are findings that suggest that poor outcomes are more likely to be achieved by those clients who are poorly motivated to change (O'Hare, 1996; Sue, Zane, & Young, 1994) and those clients who are mandated to attend treatment (Prochaska, DiClemente, & Norcross, 1992). One possible explanation for poor outcomes in psychotherapy populations is the lack of understanding of factors associated with motivation to change among such clients.

It is apparent that motivation to change shapes a client's engagement in treatment and the process of therapy. Initial research on motivation studied mandated clients in addiction treatment (Prochaska & DiClementi, 1982; Prochaska & DiClementi, 1983). Studies expanded to include perpetrators of serious crimes such as pedophiles and those convicted of incest or child abuse (Taft et al., 2001; Azar, 1984). Much of the research suggests that mandated clients appear resistant, are poorly motivated or difficult to motivate, and difficult to engage in therapy (Begun et al., 2003; O'Hare, 1996). With respect to motivation, mandated and voluntary clients appear to experience different factors that affect their experience and tenure in therapy. Research is

necessary to determine the role of the therapist or referring agency in aiding in the engagement of clients in therapy.

Factors such as distress levels, perceived pressure to attend, and the effect of the referring agency may influence a client's motivation in therapy, yet these connections need further examination. This research will contribute to a greater understanding of potential factors that contribute to a client's motivation to change. To understand the role of distress, pressure, and referral source on a client's motivation to change, it is necessary to examine client's initial distress levels, perceived pressure to attend therapy, and the referring agency in relation to motivation to change.

Distressed clients are more difficult to engage in therapy and often experience higher rates of premature termination from therapy (Knerr et al, 2009). Mandated clients appear to experience high levels of distress when entering therapy (Knerr et al, 2009) and this distress appears to impact their tenure in therapy (Knerr et al, 2009). Additional research is necessary to examine the relationship between referral source, the pressure exerted by that referral source, and client distress.

Minimal research is known to this author on the effect of pressure and the effect of the referral source on clients in therapy. No research is known to this author on a potential relationship between these two factors. Agencies making a referral expect changes in client behavior. For example, they may expect greater use of coping skills for anxiety or a reduction in anger or abusive behavior. Referring agencies exert varying amounts of pressure on clients depending on their perception of the client's need to change. Mandated clients experience high levels of pressure and they also experience lower levels of engagement and higher rates of drop out (Begun et al, 2003; Chamberlain et al, 1984). It is possible that the pressure experienced by

clients influences engagement in therapy. High levels of pressure to attend therapy can result in a client feeling as though they have lost their free will (Anker, Duncan, & Sparks, 2009). Clients who have reported a loss of their autonomy report feeling judged by their therapist, which leads to poor engagement (Ackerman, Colapinto, Scharf, Weinshel, & Winwaer, 1991). Factors such as distress, the referring agency, and the pressure they experience from that agency appear to interact with motivation and engagement in treatment. Distress, referral source, and pressure to attend therapy may affect clinical motivation to change but these relationships have yet to be examined.

The second chapter of this manuscript will describe the current theories and research on mandated and non-mandated clients. This chapter will also identify clinical profiles that are defined and examined. The second chapter will also highlight research related to the effects of initial levels of distress, the referring agencies, and the pressure to attend therapy while emphasizing the importance of motivation within different populations. In the third chapter the methodology used in the study will be identified. The fourth chapter will discuss the results. A discussion of the results and a summary of the present study and suggestions for future research will be presented in the fifth chapter.

CHAPTER 2: LITERATURE REVIEW

Although therapy is effective for a variety of clients (Piper, Ogrodniczuk, Joyce, & Weideman, 2011; Matusiewicz, Hopwood, Banducci, Lejuez, 2010), it is necessary to develop the dialogue related to factors that influence motivation and engagement in psychotherapy. To provide the most effective treatment to clients, additional research is needed to better understand potential links between distress, referral source, pressure to attend, and motivation to change among psychotherapy clients.

This study will explore three key areas related to motivation to change. First, clients who are highly distressed when entering treatment experience higher levels of dropout and lower levels of engagement in the therapeutic process (Knerr, Bartle-Haring, McDowell, Adkins, Delaney, Gargamma, Glebova, Grafsky, Meyer, 2009) than voluntary clients. This study will examine the relationship between a client's initial level of distress, as measured by depression and anxiety scales, and his or her motivation to change. Second, the potential relationship between the client's referral source and his or her motivation will also be assessed to determine the role that various referring agencies play in the development of client motivation to change and perceived pressure to attend therapy. Third, it is clear that mandated clients often struggle to engage in therapy and have high rates of dropout (Begun et al., 2003; O'Hare, 1996). It is necessary to determine if pressure applied by the referral source to attend therapy influences motivation to change. This study will explore potential links between the pressure perceived by a client and motivation to change. Taken together, a better understanding of the relationships among distress, referral source, perceived pressure to attend therapy, and motivation to change will provide a more insightful depiction of the development of motivation to change in psychotherapy.

Motivation to Change

Developing a framework for motivation. Many individuals, couples, and families choose to enter psychotherapy and other forms of mental health treatment voluntarily. However, some individuals are referred or mandated to attend therapy for a variety of reasons, such as alcohol or drug dependency (Haley, 1992; Harris & Watkins, 1987; Rooney, 1992). Clinicians and researchers working with alcohol and drug dependent clients have identified varying levels of motivation among these clients. Based on the idea that individuals appear to be experiencing varying levels of motivation, research explored models to assess and understand motivation to change. This research is grounded in a belief that some form of intrinsic motivation is necessary to change one's behavior, particularly one's maladaptive behavior. Among the most popular models, the Transtheoretical Model of Change (Prochaska & DiClemente, 1982) stands out. The Transtheoretical Model is perhaps the most widely accepted and well-researched model of motivation to change. This model is a stage-based model developed by Prochaska, DiClemente, and colleagues within the framework of alcohol and other drug treatment. In its present conceptualization, the model has five stages (Prochaska & DiClemente, 1982, 1992), precontemplation, contemplation, preparation, action, and maintenance. Within each stage, information is provided which addresses addiction severity (McLellan, Luborsky, Woody, & O'Brien, 1980), patterns of addiction and family characteristics (Wanberg & Horn, 1983), or common factors among substance users.

Transtheoretical Model of motivation to change. Developed in the field of addictions treatment, the Transtheoretical Model of Change (Prochaska & DiClemente, 1982) describes motivation to change as occurring in a series of mutually exclusive stages. The model originally

included six stages, but was later modified (Prochaska & DiClemente, 1986, 1992) to include five stages of change: precontemplation, contemplation, preparation, action, and maintenance.

Individuals in the first stage of motivation to change, precontemplation, do not foresee making changes in near future, which is defined at the next six months (Prochaska, Johnson, & Lee, 2009). Unaware of the impact of their behavior or demoralized by prior attempts to change, these clients present to therapy as resistant or poorly motivated (Prochaska, Johnson, & Lee, 2009). Many agencies and clinicians may not be prepared to handle the needs of mandated clients in the precontemplation stage, which could lead to frustration on the part of the therapist resulting in poor alliances and unproductive treatment (O'Hare, 1996).

Individuals considering making a change within the next six months but who have not yet begun to undertake any changes are in the contemplation, the second stage of motivation to change. Individuals in this stage are not yet committed to the idea of changing problematic behavior. They are weighing the pros and cons of changing, which can result in extended ambivalence. Therapists may refer to this behavior as "behavioral procrastination" or "chronic contemplation" (Prochaska, Johnson, & Lee, 2009, p. 61). The contemplation stage of change may be an extended stage for some clients in which they are beginning to ponder the possibility of change but do not know how to make change, do not know what change would look like, and may never move towards the next stage of change. Clients in this stage may appear similar to those in the precontemplation stage, but they anticipate that there might be something worth changing.

Individuals in the preparation stage are planning to undertake action in the near future, commonly defined as within the next month. They have likely tried to make changes in the past, which have not been successful, but they are now ready to make changes with support.

Individuals in the preparation stage are seeking information and tools for change. In regard to treatment, these individuals are ready for action-focused interventions (Procahska, Johnson, & Lee, 2009). People in the preparation stage may continue gathering information for a period of time before making active changes.

Individuals in the action stage have begun actively making changes to their lives. They have made observable changes that are concrete in nature and related to the identified problem (Prochaska, Johnson, & Lee, 2009). Within the context of therapy, they may be seeking ideas, techniques, guidance, or support in regard to making permanent their new temporary changes. Clients in the action stage appear motivated to make and maintain changes, open themselves to the assistance of others, and actively engage with their therapist.

In the maintenance stage, individuals are working to prevent relapse and maintain the changes that they have made in regard to their behavior. The further into the maintenance stage the individual is, the less likely and the less tempted he or she will be to relapse. Over time confidence builds within these clients. This stage can become permanent (Prochaska, Johnson, & Lee, 2009).

Movement through the stages is not always linear. Many clients may progress and regress through the stages as doubts increase, initial attempts at change fail, or their commitment and motivation strengthens. Individuals may simultaneously be in different stages for different problems. Further, individuals may pass through various stages of change relative to a problem throughout a day or a week, as motivation fluctuates. These issues make it difficult to clearly identify one stage of motivation for each individual.

Stage-matched interventions. Interventions are most appropriate when matched with a client's stage of motivation, according to the Transtheoretical Model of Change (Prochaska &

DiClemente, 2005; 2009; DiClemente et al., 1991; Edens & Willioghby, 2000). For this reason it is important that clinicians assess client motivation. Certain stages of change have been linked with lower alliance scores and premature termination (DiClemente et al., 1991; Edens & Willoghby, 2000). For example, those in the precontemplation and contemplation stage are often less motivated to change and less engaged in treatment (DiClemente et al., 1991). It is suspected that mandated clients enter treatment in these pre-action stages of change and have yet to accept that they need assistance or would benefit from making the change suggested by a referring agent.

Therapeutic interventions are most appropriate and applicable when matched to a client's level of motivation (McConnaughy Prochaska, & Velicer, 1983). In order to match interventions to a client's stage of change, therapists need to assess a client's level of motivation. The application of behavior interventions with pre-action or poorly motivated clients will strain the therapeutic relationship, as the client is not read for this advancement (DiClemente & Hughes, 1990). Therapists who do not assess for motivation are more likely to mismatch interventions. The stages of change may provide guidance for the therapeutic process and aid the therapist's understanding of the experience of his or her client. Assessing for motivation is an essential component of therapy (McConnaughy Prochaska, & Velicer, 1983; DiClemente & Hughes, 1990).

Assessment of Motivation. One of the most popular formal assessments of motivation to change is the University of Rhode Island Change Assessment, a 32-item self-report measure (URICA; McConnaughy Prochaska, & Velicer, 1983; DiClemente & Hughes, 1990). It includes four subscales that measure the five stages of change: precontemplation, contemplation, preparation, action, and maintenance (McConnaughy et al., 1983; DiClemente & Hughes, 1990).

The majority of research on the URICA has been done with smoking cessation and addiction populations; the generalizability is assumed, but unknown. Until 2006 all of the research on the TTM had been done with homogeneous addiction treatment populations, but noting the gap in the research Hoffman and colleagues (2006) conducted a study on smoking cessation in an ethnic minority population. In Hoffman et al., 2006, individuals seeking treatment were from a variety of backgrounds. Additional research, which examines the utility of the URICA with ethnic minority clients, is necessary to determine its applicability. Other formal (Readiness to Change Questionnaire, Rollnick et al, 1992; SOCRATES, Miller and Tonigan, 1996) and informal (body language, verbal response, tone, acceptance of the therapist, attitude, and willingness to engage) assessments exist to assess motivation and should be incorporated into the therapeutic process and assessment. Clinicians who assess for motivation have greater awareness of their client's needs, can appropriately address resistance, and apply interventions fittingly.

Assessing resistance versus poor motivation. Without proper assessment, poorly motivated clients are often misinterpreted as resistant and are treated as hostile and uncooperative within the context of therapy. With a greater understanding of resistance and assessment of motivation to change in psychotherapy, clinicians could better evaluate whether clients are resistant or simply in need of motivational enhancement (McConnaughy Prochaska, & Velicer, 1983; DiClemente & Hughes, 1990). This transition from resistant to poorly motivated would promote the use of stage-matched interventions with these poorly motivated clients, enhancing the outcome of therapy (McConnaughy Prochaska, & Velicer, 1983; DiClemente & Hughes, 1990). Current research does not examine whether different applications of theories, models, and techniques with voluntary, mandated, and soft mandated clients is necessary (Begun et al., 2003; Orlinsky & Howard, 1986).

Factors Influencing Treatment in Outpatient Psychotherapy

A variety of factors appear to affect a client's level of motivation. This review examines the effect of distress on motivation to change, the effect of the referral source on motivation to change, and the effect of pressure on motivation to change. High levels of distress are associated with low levels of engagement, poor alliance, and higher rates of dropout (Knerr et al., 2009; Tambling & Johnson, 2008). Initial research on mandated substance abusing populations indicates a relationship between distress and motivation (Velasquez, Crouch, von Sternberg, & Grosdanis, 2000). The referral source is the link between the client and the clinician and therefore appears to hold considerable power. An examination of the effect of the referral source is important to improve the referral process and prepare clients to enter into therapy. Clients who have a difficult, hostile, or antagonistic relationship with the referral source may bring those feelings into therapy and experience high levels of distress and resistance. Both the client's level of distress and referral source may be affected by and affect client's experience of pressure. Pressure has been linked with a client's display of resistance towards the therapist (Satterfield, Buelow, Lyddon, & Johnson, 1995).

Distress

Client's experience of distress prior to and throughout therapy likely influences engagement in psychotherapy. Distress levels have been linked to low levels of engagement and trouble forming a strong therapeutic alliance (Knerr et al., 2009) both of which likely influence the high rates of dropout in distressed populations (Tambling & Johnson, 2008). Foundational to the field of motivation, research on substance abusing populations also indicates that client's distress affects client motivation (Velasquez, Crouch, von Sternberg, & Grosdanis, 2000). This research goes on to posit that motivational enhancement is a key role of the therapist due to the

many factors affecting a client's motivation when they enter treatment (Velasquez, Crouch, von Sternberg, & Grosdanis, 2000). Research examining the link between distress and substance abusers' motivation to change indicates that severe alcohol problems cause high levels of distress, which may be enough to motivate these clients to attend treatment (DiClemente, Bellino, & Neavins, 1999). The origins of the clients' distress are unknown, but one potential cause is the pressure placed on traditionally mandated clients from their referral source. A link between clients' distress levels and pressure to attend therapy has yet to be identified and future research should explore this relationship.

The pressure applied by the referral source, the agency or person who requests that the client obtain therapy, has the power to influence the client's approach to and engagement in therapy. Referring agencies may be seen as oppressive and authoritarian towards clients, which limits the client's autonomy and role in the process (Ackerman, Colapinto, Scharf, Weinshel, & Winwaer, 1991), leading clients to feel coerced. Due to links between distress and motivation the manner in which a referral is made has the ability to impact the course of therapy (Knerr, Bartle-Haring, McDowell, Adkins, Delaney, Gargamma, Glebova, Grafsky, Meyer, 2009).

Mandated clients likely experience significant amounts of pressure from their referring agency, particularly if that agency has the potential to effect negative outcomes for failure to cooperate. Such is the case for powerful referees, such as the court system or a state social service agency like the Department of Children and Families. Clients referred by such powerful sources may present to therapy with high levels of distress exhibited through anxiety. Throughout the legal process or state proceedings mandated clients are labeled as problematic, resistant, or highly reactive (Anker, Duncan, & Sparks, 2009). Resistance appears normative when placed in the context of a coercive referral process and potentially invasive therapeutic

treatment. The lack of free will experienced by traditionally mandated clients may escalate their levels of distress (Anker, Duncan, & Sparks, 2009).

Highly distress client demonstrate high levels of engagement and high rates of drop out from therapy (Knerr et al., 2009; Tambling & Johnson, 2008). Client experiencing high levels of distress may feel violated by the invasive therapeutic process. It is important that the origins of their distress be explored as well as the relationship between clients' distress and motivation. Other factors such as the referral source and the pressure experienced may also be affecting a client's distress levels. Relationships between these factors are important to examine, as therapists and referring agencies may be able to address them.

Effect of distress on client engagement. Initial levels of a client's motivation may play a key role in his or her willingness to engage in treatment. It is clear that a client's engagement in the therapeutic process is essential to the change process and effectiveness of therapy (Connors et al., 1998). Current research highlights a link between a client's therapeutic alliance and his or her level of motivation to change (Conners et al., 1998). Understanding a client's level of motivation may allow a clinician to understand strains in the client's level of engagement and then to assist the client in making the adjustment to therapy.

Research on engagement is most commonly explored in terms of the therapeutic alliance. An integrative model of alliance defines the alliance as having three parts: the collaborative relationship, the bond between patient and therapist, and their ability to collaborate on goals and tasks (Bordin, 1987). The therapeutic alliance is essential no matter the unit of therapy, individual, couple, or family, and has been linked with success rates (Martin, Garske, & Davis, 2008). A client's alliance may be a direct consequence of his or her motivation. Clients experiencing high levels of distress generally have low levels of engagement (Knerr et al., 2009)

Clinicians must be cognizant of the effect of motivation on the client's engagement in the therapy and the client's alliance with the therapist (Orlinsky & Howard, 1986; Schottenfeld, 1989; O'Hare, 1996; Prochaska, Johnson, & Lee, 2009). For a client to be receptive to a therapist's interventions, an alliance must be present, especially in behavioral interventions or in stretching of the client for those in the later stages of motivation (Bordin, 1979, as cited in Connors et al., 1998; Greenson, 1967, as cited in Martin, Garske, & Davis, 2008). Clients who believe that their therapist is attuned to their therapeutic needs, and who engaged with the client, are more likely to disclose personal information and follow through with therapeutic interventions, both of which demonstrate alliance and motivation.

Pressure to Attend Therapy

The pressure applied by the referral source, the agency or person who requests that the client obtain therapy, has the power to influence the client's approach to and motivation in therapy. Clients may see referring agencies as oppressive and authoritarian, which limits their autonomy and role in the process (Ackerman, Colapinto, Scharf, Weinshel, & Winwaer, 1991). Pressure from the referral source has the potential to increase clients' perceptions of stigma related to therapy attendance or the view that therapy is a form of punishment. Clinical resistance may be increased by the client's negative opinion of the referring agency, which is then transferred to the clinician (Larke, 1985).

Pressure to attend therapy may be especially significant among mandated clients. Mandated individuals may experience pressure, and therefore distress, from the court system or other agencies such as the Department of Children and Families. Throughout the legal process or state proceedings mandated clients are labeled as problematic, resistant, or highly reactive. Anker, Duncan, and Sparks (2009) found that the lack of free will experienced by traditionally

mandated clients escalated their levels of distress. Mandated clients typically enter therapy with a presenting problem that has been identified by someone else and which they are likely to disagree with because of its origin an external system (O'Hare, 1996). The distress experienced by traditionally mandated clients is likely high, as they are facing a variety of threats from the court system or state agencies, such as incarceration, loss of children, financial burdens, or social isolation from the community.

Different client profiles experience different effects and levels of pressure. A population experience the most apparent level of pressure are mandated clients. Mandated clients experience low levels of motivation and have low alliances (Begun et al., 2003). Poorly motivated clients are likely to display resistance in therapy (Chamberlain, Patterson, Reid, Kavanaugh, & Forgatch, 1984; Haley, 1992; Lhmer, 1986; Miller & Rollnick, 1991; Rooney, 1992). Resistance, which influences the overall therapeutic process (O'Hare, 1996) and decreases the chance of a successful outcome (Smith, Subich, & Kalodner, 1995), has been linked to higher rates of dropout (Satterfield, Buelow, Lyddon, & Johnson, 1995). Motivation is likely instrumental in clients' initial engagement or termination of treatment, but individuals, couples, and families may have different experiences of both motivation and termination. Without intrinsic motivation clients may likely be resistant to treatment, be more susceptible to the effect of pressure, have minimal desire to engage with the clinician, and have higher rates of dropout (Phillips, 1985; Howard et al., 1989; Garfield, 1994).

The pressure to attend, along with messages of stigmatization, oppression, therapy as punishment, and the distress associated with a lack of free will has the potential to affect client's motivation to change in therapy. Pressure to attend therapy has the potential to affect clients'

motivation to change and the entire course of therapy (Knerr, Bartle-Haring, McDowell, Adkins, Delaney, Gargamma, Glebova, Grafsky, Meyer, 2009).

Pressure and resistance. Research on resistance indicates that resistant clients have experienced a loss of free will, likely due to feelings of pressure. Resistance and pressure have also been linked with early termination (Satterfield, Buelow, Lyddon, & Johnson, 1995). It is this loss of free will and other factors, which affect their display of resistant in treatment. Clinical resistance limits the effectiveness of therapy and increases the rate of dropout from therapy (Begun et al, 2003; Miller & Rollnick, 1991). Resistant clients may have experienced high levels of pressure from their referring agency. Their experience of pressure may have reduced their engagement in therapy and their lack of patience with the therapeutic process.

Two large national studies have found that individual dropout rates in outpatient therapy are quite high and that dropout is very common (Garfield, 1994). In a study by NIMH (1981), 69 percent of over 350,000 children and adolescents attended no more than five sessions. In another survey "44% of adults seen by psychologists and psychiatrists came to fewer than four sessions" (Howard et al., 1989). On average between 40 percent and 55 percent of clients discontinue treatment after the first session (Phillips, 1985). Research indicates that many clients drop out of treatment early on in the process (Phillips, 1985; Howard et al., 1989; Garfield, 1994). Not all clients in treatment are engaging in the process or entering into an alliance with their therapist. These clients may not receive any benefits from therapy, frustrate both the therapist and themselves, become more entrenched in their current behaviors, and become resistant to future assistance. Poor motivation not only impedes the client experience in therapy but also affects the therapists who are working with resistant clients, as the therapist may become discouraged (O'Hare, 1996). Clients who prematurely terminate therapy are unnecessarily

wasting clinicians' and referring agencies' time and mental health resources. Therefore, it is imperative to study the possible reasons for premature termination in order to provide the most effective treatment and the best use of clinical resources (Garfield, 1994; Weisz, Weiss, & Langmeyer, 1987, as cited in Masi, Miller, & Olson, 2003).

Studies focusing on traditionally mandated clients include research on the motivation, resistance, and attendance of those accused of or convicted of crimes for child abuse or incest. These populations likely experience the highest levels of pressure to attend treatment, as they are given little to no option to attend. These individuals are commonly in denial about their actions and resistant to help (Azar, 1984). Although these individual are resistant, research indicated they have an increased attendance rating of five times the voluntary clients (Wolfe, Aragona, Kaufman, & Sandler, 1980; Irueste-Montes & Montes, 1988). This is likely due to the high level of pressure place on the client and a greater understanding of the ramifications they will face should they fail to attend therapy. In these cases, the severe consequences and high levels of pressure faced by the parents appear to motivate them to complete treatment. The client's motivation appears to be one of the most important determinants of the therapeutic outcome (Horton, Johnson, Roundy, & Williams, 1990). Those convicted of accused of crimes against children are facing very different consequences then voluntary or soft mandated client. This again supports the identification of a third category of soft mandated clients who face less severe consequences should they fail to attend therapy.

Referral Source

The referral source has the potential to increase the stigma of therapy attendance. Therapy may feel or be associated with punishment due to the referring agency. The client's relationship with their referral source may impinge on their view of therapy and may be a factor

affecting the client's engagement with the therapist. Clinical resistance may be increased by the client's negative opinion of the referring agency, which is then transferred to the clinician (Larke, 1985).

Experience of voluntary clients in outpatient psychotherapy. Voluntary clients are often highly motivated (Orlinsky & Howard, 1986; Schottenfeld, 1989; O'Hare, 1996; Prochaska, Johnson, & Lee, 2009) due to their intrinsic desire or need for treatment. Research indicates that psychotherapy is effective with these populations (Matusiewicz, Hopwood, Banducci, Lejuez, 2010). Highly motivated clients will likely engage in treatment and collaborate with the therapist on creating change. Motivated clients are more likely to engage with their therapist promoting the formation of the therapeutic alliance, which is necessary for treatment persistence (Connors, DiClemente, Dermen, Kadden, Carroll, & Frone, 1998). Voluntary clients are considered the therapeutic norm for treatment. It is unknown whether mandated clients have a similar experience in therapy and whether or not theories apply to mandated clients and voluntary clients in similar ways.

Voluntary clients collaborate with their therapist to identify a presenting problem and path for therapy. These clients may feel more motivation to work on something they had an active role in identifying and engage more fully in the overall process because it is collaborative (Orlinsky & Howard, 1986; Schottenfeld, 1989; O'Hare, 1996).

Experience of mandated clients in outpatient psychotherapy. Twenty-five percent of clients in therapy are mandated to attend treatment (Phillips, 1985; Howard et al., 1989; Garfield, 1994). A limitation of the current understanding of mandated clients is that much of the research has focused on those referred due to substance use. Yet many other individuals, couples, and even families are mandated to attend treatment. Traditionally mandated clients are referred to therapy

by legal systems or state agencies to work towards goals developed by the court or other referring agency (Storch & Lane, 1989). The court uses mandated therapy as a form of treatment to change negative behaviors and avoid incarceration. Court systems and state agencies utilize varying degrees of pressure when making a referral to therapy, as some clients are required to attend whereas others are provided an option. Only 20 percent of those referred under duress to psychotherapy end up attending treatment (Mohr, Hart, Howard, Julian, Vella, Catledge, & Feldman, 2006). It is unknown whether these 20 percent believe that therapy could help them or they see no other option then to attend. Therapists need to assess client's resistance and motivation in order to provide the best care.

Research suggests that mandated clients are resistant and less motivated than those who enter therapy voluntarily (Begun et al, 2003; Chamberlain et al, 1984; Lehmer, 1986; Miller & Rollnick, 1991; Rooney, 1992; Taft, Murphy, Elliot, & Morrel, 200l, as cited in Snyder & Anderson 2009). Most therapists presume that if a client enters therapy voluntarily, the client is motivated to change (Cingolani, 1984; Haley, 1992; Harris & Watkins, 1987; Rooney, 1992), but this says little for those who enter under duress.

For mandated clients, their experience of the referral and the relationship with the referral source appears to not only influence their attendance in therapy but more importantly their perception of the therapist and attitude towards engagement. The client's involvement with the legal system may have tainted their perception of the therapist prior to the start of treatment. The therapist is likely viewed as an outsider who, in association with the legal system and oppressive society, will judge their family (Ackerman, Colapinto, Scharf, Weinshel, & Winwaer, 1991). Even greater barriers exist in the treatment of minority and oppressed groups, who are disproportionately represented in mandated client populations (Pinderhughes, 1989). These

clients may be resistant towards the therapist who they perceive as part of the oppressive society and legal system that has disadvantaged them.

Court ordered clients are mandated to treatment to address a specific problem and prevent incarceration. These individuals many enter therapy with a lack of acceptance of the problem or motivation to change, which manifests itself through resistance (Chamberlain et al., 1984). Research by Miller and Sovereign (1989), indicates the more resistant the client, the less likely the client is to experience change through therapeutic intervention and even less likely that traditionally mandated clients will remain in therapy (Chamberlain et al., 1984).

Research indicates that mandated clients experience low levels of motivation and are poorly engaged in therapy (Begun et al., 2003). Traditionally mandated clients may attend therapy, agitated, frustrated, and resistant towards the therapist and process. Other factors leading to resistance include the embarrassment of disclosing information to a therapist, an outsider, especially if they are in treatment for something uncomfortable or socially unacceptable (O'Hare, 1996). Resistance on the part of a traditionally mandated client appears valid when explored by the therapist.

Resistant clients, deemed untreatable in the past, may be individuals who are either unsure about their ability to make a change or have been forced to confront a prescribed problem they do not yet understand. Resistant clients may appear quiet, sullen, rude and argumentative, or have frequent attendance failures (Chamberlain et al, 1984; Miller & Sovereign, 1989). Unfortunately, these clients have high dropout rates (Miller & Sovereign, 1989).

Mandated clients are commonly sent to therapy with an identified problem, whether the problem has been identified by the court system, the state agency, or the client (Lhmer, 1986; Miller & Rollnick, 1991; Rooney, 1992). Mandated clients have lost their freedom to identify a

collaborative problem. Therapists can assist a client in feeling engaged in the therapeutic process if they collaborate with the client and explore the presenting problem with the client, whether the client is voluntary or mandated (Connors, DiClemente, Dermen, Kadden, Carroll, & Frone, 1998). It is important for clinicians to assess the client's motivation, take it into consideration when working on alliance, and to work with the client on collaborative goals and tasks for therapy.

The current research on mandated clients is limited and focuses predominately on individuals and couples who have committed crimes, engaged in antisocial behavior, or are presently abusing alcohol or other drugs. Much of the research examined clients who were given no alternative but to complete treatment, or face incarceration. Current research with traditionally mandated client's highlights the confusion in regard to the client's motivation. Some studies find both similarities and differences between the experience of motivation for traditionally mandated and soft mandated client (Begun et al., 2003; De Leon, Melnick, & Tims, 2001; Irueste-Montes & Montes, 1988; Azar, 1984). Soft mandated clients are not mandated to attend therapy and face mild consequences such as family or social pressure rather then incarceration. The experience of soft mandated clients in therapy is expanded later in this manuscript. In some cases, research indicates that mandated referrals appear to negatively impinge on the client's motivation, while other research suggests that it may increase a client's extrinsic motivation (Larke, 1985). This contradiction in the research may be due, in part, because clients who might be more accurately categorized as soft mandated are considered mandated in some studies and voluntary in other studies. The variation within the literature is an indication that more research on the topic is necessary.

Some studies have explored possible benefits of mandating psychotherapy. One hypothesis posits that hard mandated clients will experience high levels of motivation due to the severe consequences they are facing (De Leon, Melnick, & Tims, 2001). Some studies indicate that clients who are actively involved with the Department of Children and Families in a custody case when entering treatment are much more likely to be actively involved and complete treatment (De Leon, Melnick, & Tims, 2001). These clients are likely motivated by the potential loss of custody, which also signifies the potential importance of motivation for mandated clients (De Leon, Melnick, & Tims, 2001).

Experience of soft mandated clients in outpatient psychotherapy. Currently, the research makes a distinction between voluntary and mandated clients (Synder & Anderson, 2009; O'Hare, 1996; Storch & Lane, 1989). While the two distinct groups have been studied broadly, not all clients fit well into one of these two categories. Clients who enter into therapy under pressure to do so have diverse experiences and further differentiation is necessary.

This author proposes the use of a third category, "soft mandated," to better capture unique differences among clients of varying motivational categories. Voluntary clients experience internal motivation that drives them to seek treatment. Mandated clients are typically referred by the court system or a state social service agency and face severe consequences, such as the removal of children from the home, incarceration, or high fines if they do not attend treatment. Not all clients who are referred to therapy will encounter such severe consequences, thereby creating another distinct population in treatment: soft mandated clients. Soft mandated clients will face milder consequences such as family or social pressure, negative effects in court, or extra court-regulated educational classes from their referral source if they fail to attend therapy. For example, clients who are encouraged to attend therapy by the court to aid in their

case, parents who bring their children to therapy for the sake of the family, and couples who are encouraged by social services to seek counseling all fit into this category. Soft mandated clients are neither required to attend therapy nor severely punished for not attending therapy. In the case of soft mandated clients, the power, influence, and pressure applied by the referral source often generates the motivation to attend therapy.

Engagement levels for soft mandated clients are unknown, as this has yet to be researched. Potential differences between the engagement levels of soft mandated, hard mandated, and voluntary clients are unknown. The pressure that the client feels from the referring agency may impact their engagement in the process of therapy; however, little is known about the pressure experienced by soft mandated clients.

Soft mandated clients experience very different consequences than mandated clients, yet they, unlike voluntary clients, lack the internal motivation to seek therapy on their own. Soft mandated clients may or may not experience the same barriers to treatment and it is possible that they have their own unique barriers. Soft mandated clients may be ambivalent towards change but may welcome the referral to assistance. Despite valuable research that suggests stage matching as a useful strategy in psychotherapy (Prochaska & DiClemente, 1986, 1992), little is known about the interventions suitable for soft mandated clients. While it is possible that soft mandated clients may benefit from strategies that are part of many stage-matched interventions to increase motivation, it is unknown if this is true. Presently it is unclear how motivation will impact this population, but future research should try to discern the barriers affecting this population to gain a better understanding of which types of stage-matched interventions may work with this population.

Summary of factors affecting clients' motivation. Research on factors affecting motivation indicates that a client's level of motivation may have a clinically significant impact on the possible outcomes of psychotherapy. Clients with low levels of motivation appear to have lower rates of engagement (Begun et al., 2003), lower therapeutic alliances (Connors et al., 1998), and higher rates of premature dropout (Phillips, 1985; Howard et al., 1989; Garfield, 1994). Without addressing these barriers to treatment with mandated clients, a therapist may unknowingly contribute to the problem or label the client as unworkable. It is necessary that research expand the clinical understanding of differences between varying client profiles with concentration on other potential client profiles such as soft mandated clients. This research has the potential to provide a means of preventing or reducing dropouts and resistance, which appear to occur more with poorly motivated and highly pressured clients. Currently poorly motivated clients contribute to the misuse of mental health resources. It is important to have further research and development on the effect of referral source on drop out rates potentially through the medium of motivation.

Conclusion

Current research on motivation to change has been focused in the context of the client profiles created by referral sources. Clients experience varying levels of distress, which appears to affect their engagement and tenure in therapy. The referral course creates different client profiles depending on the level of pressure placed on the client. Both the referral source and pressure may be linked with the client's level of motivation to change through the context of therapy. Two client profiles previously examined include voluntary and mandated clients. Voluntary clients enter treatment willing to engage with the therapist, form an alliance, and are motivated to make and maintain changes. Mandated clients, who are pressured to attend therapy,

experience higher rates of dropout (Miller & Sovereign, 1989), lower levels of engagement (Conners et al, 1998; Rempel & Destefano, 2001), are resistant toward forming an alliance, and experience high levels of distress. Clients interact with a spectrum of factors and barriers to treatment.

This research will expand knowledge about the relationship between pressure and distress on client motivation to change. Further, distress among soft mandated and voluntary clients will be explored as distress has been linked to differences in motivation. The research also hopes to draw attention to a third client profile, soft mandated clients. The formation of this new category will facilitate the examination of different levels of motivation for a variety of mandated clients.

Current research has left many gaps in the information available that links initial distress levels, effects of referral source, and the perceived pressure the client feels to attend therapy or motivation to change. This research addresses the impact of initial distress, referral source, and pressure to attend therapy on motivation to change by answering the following research questions:

1. Does a client's level of distress, as measured by depression and anxiety scales, predict membership in the stages of motivation to change?
2. Does the degree of pressure to attend therapy predict membership in a particular motivation to change stage?
3. Among high versus low motivated clients, is there a difference in regard to their referral source?

CHAPTER 3: METHODOLOGY

Sample

Data was obtained from individuals, couples, and families who participated in at least one therapy session at the Humphrey Clinic for Individual, Couple, and Family Therapy (hereafter referred to as "Humphrey Clinic"). No new participants were recruited or enrolled in the study as the study utilized archival data from the Humphrey Clinic database. No specific population was targeted as the data was obtained exclusively from the existing archival data set. The existing archival data represent a period from 2008 - December 2010. Participants for this study were from a university-based counseling center in the Northeast United States. Participants were 587 individuals seen at the clinic between 2008 and December 2010. Two hundred and thirty-eight individuals identified as male and 348 identified as female. Participants were predominantly Caucasian (n=437; 74%). The other ethnicities represented included Hispanic (n=29; .5%), Black/African American (n=26; .4%), and Asian (n=15; .3%). Two hundred and twenty three participants made less than $49,000 annually (40%) and 156 participants made more than $50,000 (28%) annually, the 32% did not state their income level. Three hundred and seventy one participants had previously attended some type of therapy and 178 had not been in therapy before. Clients were between 12 and 76 years of age (M = 31.7; SD = 12.5).

Procedure

This study was a retrospective analysis of existing clinic data from clients who sought treatment at a COAMFTE – accredited marriage and family therapy training program in the Northeastern United States. The Humphrey Clinic is the on-site training clinic for graduate students enrolled in the Department of Human Development and Family Studies programs in marriage and family therapy. Individuals, couples, and families seek treatment for a variety of

presenting problems, including anxiety, depression, relational conflicts, behavior problems, domestic violence issues, general life skills, parenting skills, and coping skills. The therapists are masters or doctoral students in marriage and family therapy. To ensure proper care and increase training opportunities, professors in the marriage and family therapy program, supervise all therapists.

Clients contacted the clinic seeking treatment via phone or walk-in. Clients went through a phone triage and were then matched with a therapist. Clients were normally seen on weekly or biweekly basis and paid a sliding fee based on their income or student status. As part of routine treatment at that clinic, various clinical data were collected from clients via clinical questionnaires. Those data were then stored in an archive. Clients who consented to treatment filled out a demographic and assessment questionnaire at the start of therapy, weekly feedback forms, and assessment packets periodically throughout the course of treatment. Data for this study were obtained from the archive of data entered from clinical questionnaires.

Measures

Clients who consented to treatment were asked to fill out an intake questionnaire that included general demographic questions and a variety of measures of personal, relational, and familial functioning. This questionnaire included a set of questions regarding the client's motivation to change, questions identifying their referral source, the pressure they felt to attend therapy, the locus of the problem, past experience in therapy, and other services they were receiving. These data were the focus of this study.

Motivation to change questions. The client's perceived readiness to change was measured with a set of several questions based on the theoretical constructs underlying the Transtheoretical Model of motivation to change. Clients were asked to rate their willingness to

change in regard to the problem or problems for which they were seeking treatment. There were five response categories. Participants responded to the following question: "Starting with the most important, please list the issues that brought you to therapy. Following each issue indicate which sentence below best describes how you feel about it. 1. I don't intend to make any changes related to the issue. 2. It might be worthwhile to work on this issue, but I haven't made any decisions yet. 3. I know this is a difficulty and I'm getting ready to make some specific changes. 4. I've already started working on this issue, 5. I'm here to maintain the changes I've made and to prevent the difficulty from returning." Participants then wrote a list of the problems on which they intended to focus in therapy and checked the number of the corresponding motivational statement that best captured their thinking about that problem. Category 1 is representative of the precontemplation stage of change. Category 2 is representative of the contemplation stage of change. Category 3 is representative of the preparation stage of change. Category 4 is representative of the action stage of change. Category 5 is representative of the maintenance stage of change. This study only examined their answer for their first presenting problem as many client's only stated one problem and they were asked to rank their problems in order of importance.

Referral source. Participants reported their referral source by responding to the question: "Who referred you to the clinic?" Responses were provided by indicating that one was referred by one of the following: self, partner, friend, former or current client, physician, minister/clergy, school, DCF/Court, Other (please specify).

Pressure to attend. The pressure that the client felt to attend therapy was assessed by asking "How much did someone else pressure you to come for therapy?" Participants responded

by checking one of the following: not at all pressured, a little pressured, somewhat pressured, very pressured.

Depression & anxiety scales. Depression was assessed with the Major Depression Inventory (MDI; Bech, Rasmussen, Olsen, Noerholm, & Abildgaard, 2001); anxiety was assessed with the Generalized Anxiety Disorder 7-item scale (GAD-7; Spitzer, Kroenke, Williams, Lowe, 2006).

Major depression inventory. The Major Depression Inventory (Bech, Rasmussen, Olsen, Noerholm, & Abildgaard, 2001) is a 10-item scale that assesses clients' level of clinical depression. There are three different cut off scores provided: mild depression (20-24), moderate depression (25-29), and severe depression (30 or more). The highest possibly score on the MDI is 50. The MDI was developed to cover all of the symptoms from the DSM-III/DSM-IV and the ICD-10 (Olsen, Jensen, Noerholm, Martiny, & Bech, 2003). The MDI has been assessed for internal and external validity (Olsen et al., 2003). The MDI has adequate internal validity for a unidimensional scale (Olsen et al., 2003) and the external validity of the MDI and the MDI total score is significantly correlated with the HAM-D. (Hamilton, 1960, Beck, Steer, & Garbin, 1988). Multiple tests indicated that the MDI has concurrent validity with the Hamilton Depression Scale (Hamilton, 1960; Beck, Steer, & Garbin, 1988).

***Generalized anxiety disorder*.** The GAD-7 (Spitzer, Kroenke, Williams, Lowe, 2006) is a 7-item scale that has been tested for reliability. Increased scores on the scale are associated with increased levels of anxiety. Spitzer et al, (2006) found that the scale has good "criterion, construct, factorial, and procedural validity" (p. 1092), and they found that there is "good agreement between self-report and interviewer- administered versions of the scale (p.1092)." The internal consistency is excellent according to Spitzer et al, (2006), and the test-retest

reliability was also good in the sample. The scale was also related to the Health-Related Quality of Life Scale (Spitzer et al., 2006).

CHAPTER 4: RESULTS

The purpose of this study was to examine the association between a variety of factors known to influence motivation to change in outpatient psychotherapy. Using data obtained from counseling intake questionnaires, the effects of distress, referral source, and pressure to attend therapy were examined to explore a potential relationship with motivation to change and a reciprocal association.

Descriptive statistics

Frequency statistics for each variable are presented in Table 1. The most frequently reported referral source was Department of Children and Families/court referrals (n=163; 27.9%). The second most frequently reported referral source was referrals reported as "other" by respondents (n=114; 19.5%). Self-referrals were the third most frequently reported source (n=89; 15.2%). Most (n=321; 54.7%) clients felt no pressure to attend therapy. The second most reported answer were clients who felt a little pressure to attend (n=114; 19.5%). The mean score on the MDI (MDI; Bech, Rasmussen, Olsen, Noerholm, & Abildgaard, 2001) was 57.29 (SD = 12.13). The mean score on the GAD-7 (GAD-7; Spitzer, Kroenke, Williams, Lowe, 2006) was 13.91 (SD = 5.88). The MDI has a range of 0 to 63, with higher scores indicating high levels of depression. The GAD has a range of 0 to 21, with higher scores being indicative of high levels of anxiety. Depression and anxiety are significantly negatively correlated ($r = -.690$, $p < .01$).

Table 1
Frequency Statistics

Questions	n	%
Referral Source	538	92
Self (1)	89	15.2
Partner (2)	34	5.8
Friend (3)	38	6.5
Former or Current Client (4)	11	1.9
Physician (5)	38	6.5
Minister/clergy Person (6)	4	.7

School (7)	47	8
DCF/Court (8)	163	27.9
Other (9)	114	19.5
Pressure to Attend	561	1
Not at all Pressured (1)	321	54.7
A Little Pressured (2)	114	19.4
Somewhat Pressured (3)	70	11.9
Very Pressured (4)	56	9.5

Table 2
Descriptive Statistics: Means and Standard Deviations

	N	Minimum	Maximum	M	SD
Depression	504	18	72	56.07	12.47
Anxiety	533	7	28	14.58	5.98

Table 3
Correlations: Depression and Anxiety

	Pearson Correlation	
	Depression	Anxiety
Depression	-	-.692**
Anxiety	-.692**	-

Note: ** p < .01 (2-tailed)

Association between distress, as measured by depression, and referral source. In order to determine the relationship between scores on the Major Depressive Inventory and referral source, a one-way analysis of variance was conducted. The independent variable, the referral source, included nine variables: self referral, partner referral, friend referral, former or current client referral, physician referral, minster/clergy person referral, school referral, Department of Children and Families/court referral, or other referral. The between groups ANOVA was significant, $F(8) = 11.17$, $p = .00$. To determine the source of the variation in depression scores, Tukey post hoc testing was conducted. A Bonferroni adjustment was used to modify the expected level of significance. As eight tests were conducted, the p value required to assume significance is .00625 (p=.05/8). Each referral source was analyzed to determine

differences in depression scores across referral sources. Those not reported were not significant. The results indicated that self-referral is significantly different from a Department of Children and Families or court referral (p=.000). A referral by a friend is significantly different than a Department of Children and Families or court referral (p=.000). A physician referral is significantly different than a Department of Children and Families or court referral (p=.000). A school referral is significantly different than a Department of Children and Families or court referral (p=.000). Last, any referring agencies not provided as options are also significantly different than a court referral (p=.000). Two other noteworthy comparisons, although they were not statistically significant, were the comparison between self and a partner referral (p=.041) and a former or current client referral from a Department of Children and Families or court referral (p=.037).

Results of this test suggest that depression scores differ by referral source. Clients who are referred by the Department of Children and Families/ court system or by their partner have lower scores on the MDI, indicative of lower levels of depression than those who are self referred and seeking therapy of their own accord. Those referred by the courts or by the Department of Children and Families have higher scores on the MDI than those referred by their friends, other clients, physicians, their school, or any other referral source.

Association between distress, as measured by anxiety, and referral source. To determine if a relationship exits between scores on the Generalized Anxiety Disorder – 7 items (GAD-7; Spitzer, Kroenke, Williams, Lowe, 2006) and referral source, a one-way analysis of variance was conducted. The independent variable, referral source, included nine conditions: self referral, partner referral, friend referral, former or current client referral, physician referral, minster/clergy person referral, school referral, Department of Children and Families /court

referral, or other referral. The between groups ANOVA was significant, F(8)=5.73, p=.00. To determine the source of the variation in anxiety scores, Tukey post hoc testing was conducted. A Bonferroni adjustment was used to modify the expected level of significance. As eight comparisons were made, the p value required to assume significance is .00625 (p=.05/8). Self-referral is significantly different from a Department of Children and Families or court referral (p=.000). A physician referral is significantly different than a Department of Children and Families or court referral (p=.005). A DCF or court referral is significantly different than a friend referral (p=.000). Last, any referring agencies not provided as options, are also significantly different than a court referral (p=.000). Two other noteworthy comparisons, although they were not statistically significant, were the comparison between a friend referral and a Department of Children and Families or court referral (p=.027) and a DCF or court referral and other referral (p=.000). Results indicate that scores on the GAD-7 differ by referral source. Clients referred by the Department of Children and Families or by the court system have higher scores on the GAD-7, indicative of higher levels of anxiety, compared to clients referred from friends, other clients, physicians, their school, or any other referral source.

Effect of referral source on client's motivation. To determine whether there were differences in level of motivation between clients who received a soft mandated referral, one that comes from the court or Department of Children and Families, and a voluntary referral, one that comes from other more casual sources, a one-sample Chi-squared test was conducted. For this analysis, the categorical variable of referral source was collapsed into a dichotomous variable to highlight the contrast of interest. Clients who stated that their primary source of referral was an agent of the court or the Department of Children and Families were distinguished from those who were referred by all other options, such as school, friends, religious leaders, and others. This

study examined the referral source with the most power, which was determined to be the legal system or Department of Children and Families, as compared to the less powerful referring agencies. The results of the test were not significant, $\chi^2(1, N=155) = 2.39$, $p > .05$. These results indicated that there was no significant difference in level of motivation between clients referred by the court or Department of Children and Families and those referred by all other options.

Distress and motivation. To determine whether scores on the Major Depression Inventory (MDI; Bech, Rasmussen, Olsen, Noerholm, & Abildgaard, 2001) varied based on client's self reported level of motivation, an independent-samples t-test was conducted. The test was not significant, $t(180) = .856$, $p = .999$. The results indicated that there are no differences in MDI scores across all groups. To determine whether a client's motivation differed by their level of anxiety on the GAD-7, an independent-samples t-test was conducted. The test was not significant, $t(180) = .999$, $p = .856$. There is no significant difference between scores on the GAD-7 and the client's reported level of motivation. These results indicate that motivation does not vary in relation to depression and anxiety scores.

Effect of pressure to attend on client's motivation. To determine the association between pressure to attend therapy and level of motivation to change, a one-sample Chi-squared test was conducted. Clients stated their perception of the level of pressure they had to attend therapy on by selecting one of the following options: "not at all pressured," "a little pressured," "somewhat pressured," and "very pressured." To highlight the differences between those clients who felt very pressured and clients who felt less pressured, the scale was condensed. Data from those clients who felt very pressured was compared with data from all other clients. The data were collapsed due to the researcher's belief that there is a distinct difference between very pressured and all other clients and that the differences between not at all and a little pressure are

not of significance. Overall the researcher is most interested in learning about clients reporting the highest level of pressure. The results of the test were significant, $\chi^2(3, N=197) = 11.19$, $p < .011$. Twenty four percent of people who felt very pressured were in the pre-contemplation stage of change. In contrast, seventy six percent of those who reported feeling not al all, a little or somewhat pressured were in the action stage of change ($p = .011$). These results suggest that pressure to attend therapy is associated with motivation to change in the expected fashion. Those clients who feel more motivation to change are more likely to attend therapy under less pressure. Those clients who felt most pressured were also those most likely to be in pre-action stages of change.

CHAPTER 5: DISCUSSION

This study provides some initial evidence that distress levels are associated with a client's motivation to change and that there experience of pressure affects their motivation to change. Results of the quantitative analysis include several interesting findings. First, depression scores significantly differ by referral source. Those clients referred to therapy by the court system or the Department of Children and Families experienced higher levels of depression than those who were self-referred or referred by friends, other clients, physicians, their school, or any other referring agency. Also participants referred by their partner had higher levels of depression than those who were self-referred. In addition, participants' anxiety scores and their referral source were significantly associated. Results indicated that anxiety differs by referral source. Clients who were referred by the courts or the Department of Children and Families were more likely to have high scores on the anxiety measure when compared to clients referred by friends, other clients, physicians, their school, or any other referral source.

Results indicated that there is an effect of perceived pressure on a client's motivation. These results suggest that pressure to attend therapy is associated with motivation to change in the expected fashion. Those clients who attend therapy under less pressure are more likely to feel more motivation to change. Clients who are more pressured to attend therapy are less motivated to change in therapy. Clients who felt the most pressure were most likely to be in the pre-action stages of change, meaning that they have the lowest motivation or interest in changing. These clients also commonly believe that they do not have a problem and there is nothing that they could use therapy to work on.

Results examining the effect of the referral source were not significant indicating that the referral source is not as impactful as the perceived pressure from that referral source. The

pressure place on a client is very important and yet the specific referral source appears to have less of an impact according to this research. This indicates that referral sources could have great influence in regard to the experience of the client by engaging with the client and monitoring the perceived pressure.

Factor's Effecting Mandated and Voluntary Clients

Psychotherapy has been shown to be efficacious with a variety of voluntary and motivated clients and assisted them in creating desired change. Yet many clients are mandated to attend therapy by legal systems, state agencies, and other referral sources. Mandated clients have a different experience in therapy because they may be resistant to attending therapy. Mandated clients who are coerced into attending therapy may feel resistant or may feel that their sense of autonomy has been challenged. Soft mandated clients experience less pressure then traditionally mandated clients and face less severe consequences. Soft mandated clients may have similar feelings with respect to loosing their autonomy but they are not facing the severe and potentially life-changing consequences that mandated clients may encounter.

This study found that the perceived pressure a client experiences is more important than the source of the referral. High levels of pressure may be hindering the client's therapeutic engagement and follow through with the course of therapy. The experience of the client both prior to and in therapy is important as it is affecting the outcome of the therapeutic process. This research identified that soft mandated clients, clients referred by the court or DCF, may also experience high levels of pressure and low levels of motivation, similar to the experience of a mandated client. Soft mandated clients differ from traditionally mandated clients because they may not feel as compelled to follow through with therapy as they are not facing as severe consequences as hard mandated clients. There appear to be both similarities and differences

between voluntary, soft mandated, and hard mandated clients in therapy, which require further examination. Factors that distinguish among traditionally mandated, soft mandated, and voluntary clients appear to include the client's level of distress and the pressure felt by their referral source.

The present study contributes to the already collected research on voluntary and hard mandated clients while also contributing to the knowledge of important factors that the therapist should address in the therapeutic process, distress and pressure. This research highlighted the different between pressure and referral source, which is an important distinction and factor to assess with hard and soft mandated clients.

Implications

The results of this study are valuable for agencies, clinicians, and researchers in family therapy due to a variety of reasons. First, the pressure to attend therapy perceived by the client predicts membership in a particular motivation to change stage. Clients who reported feeling high levels of pressure to attend were most likely to also report being in the pre-action stages of change, indicating that they have the lowest levels of motivation. This signifies that the more pressure a client is feeling from their referral source, the less engaged they might be and the more resistant they may be to the typical tasks of therapy. Clinicians should question their clients, not only about their motivation, but also about the pressure that they feel to attend therapy. Agencies need also be aware of the pressure they are placing on clients to attend therapy and the ways in which the referral is being portrayed to the client.

Second, the results of this study indicate that distress is related to motivation. Clients who are experiencing high levels of depression are more likely to refer themselves to therapy, perhaps because others have noticed their depression and commented or because they find it to be getting

in the way of living a normal life. Clients who are experiencing high levels of anxiety are more like to be referred by the Department of Children and Families or the court system, indicating that those referred by these powerful agencies are experiencing high levels of anxiety, which may be interfering with their treatment. The clinician should monitor high levels of anxiety.

Finally, motivation does not seem to be directly connected to referral source. Instead, the pressure put on the client appears to have the greatest effect on the client rather then the specific referring agency. The same referral source can cause different levels of pressure for a client and this is something of which the agency needs to be aware. An individual could be told by the courts that they must attend counseling but the delivery, time frame, and expectations could all be used as ways to indicate the importance and severity while maintaining the client's autonomy as much as possible. Clients who feel forced and pressured into attending are likely to have lower levels of motivation to change. This may explain why prior studies on mandated clients had varying results in regards to client motivation. If pressure is the most important factor then the presence of a third profile of clients, soft mandated, many affect the results.

Strengths and Limitations

As with any research, this study had strengths and limitations. Some limitations of the study included the data set, population, and the assessment measure used. The archival data set did not provide as diverse a sample as would have been preferred. Using archival data meant that no one sample was selected for and limited the possibility of researcher's selection bias. The sample size was adequate but many of the clients were voluntary due to the type of clinic and its location, therefore the sample of more pressured and lower motivated clients weakened the power of the tests. Other limitations included the accuracy of the assessment use of motivation to determine concrete differences between the stages of motivation for a client.

The measure used to assess motivation was a variation of the University of Rhode Island Change Assessment, which assesses for the five stages of change indicated by the Transtheroretical Model of Change (Prochaska & DiClemente, 1986, 1992). The measurement of motivation used in this research, as well as the URICA, both have room for improvement. The method used in this study was a variation of the URICA in which clients ranked their presenting problems and then answered a scaling question that identified the 5 stages of change. This study only examined their answer for their first presenting problem, which many have limited the variability of answers. Another limitation was the possibility that clients disproportionally wrote something that they were very motivated to change for their first option. The scale did not assess for overall motivation to change through the process of therapy rather it was in regard to their presenting problem. With respect to the URICA assessment, the precontemplation and action stages of change appear to have validity, but the distinctions between the other stages appear to be less clearly differentiated. It appears hard to differentiate between each of the pre-action stages, which is why this study analyzed pre-action versus action.

The strengths of the current research includes the sample size, the assessments used to measure clients distress, pressure, and referral source, and the identification of a third category for examination. The research questions were appropriately addressed by the assessments used and the previously collected data. Another strength includes the use of deidentified data to assess an accurate clinical population.

Future Research

This study is only a starting point for future research into the factors influencing mandated and voluntary clients. Future research is necessary to examine diverse samples of voluntary, soft mandated, and hard mandated clients and the factors that shape their treatment.

Continued research is necessary for the development of techniques and models that may be vital to assist in the treatment of differently motivated clients.

Additionally, future research should not only expand to include differently motivated clients but to also include different formulations of clients such as couples and families as the field of family therapy research needs to expand measures to assess motivation for couples and families. It is unknown whether the properties of the URICA make it appropriate for use with couples and families.

Overall the validity of the URICA as a measurement for distinctive stages of motivation needs to be assessed and reexamined. It may provide the path to greater understanding and assessment of motivation especially if it can be generalized across treatment modalities and populations. The current research using the URICA with substance abusing individuals and perpetrators of serious crimes may not be generalizable to other populations. Indeed, some studies (Blanchard, Morganstern, Morgan, Labouvie, & Bux, 2003; Dozios et al., 2000; Greenstein, Franklin, & McGuffin, 1999) suggest that the URICA may not have adequate predictive and discriminant validity to suggest that it is an adequate measure of stage of change. The use of the URICA should be examined by future research and new measurements or modifications could be developed to expand motivational assessment measures.

Conclusion

Despite some weaknesses, the present study contributes to the literature in the area of motivation to change and factors affecting clients in treatment. It is the first study to identify and then examine soft mandated clients as a population. The assessment of the data in this study provided information about distress levels, perceived pressure, and referral source in regard to

motivation in voluntary and soft mandated clients. This study has advanced the dialogue on motivation and provided suggestions for necessary research in the future.

References

Ackerman, F., Colapinto, J. A., Scharf, C. N., Weinshel, M., & Winawer, H. (1991). The involuntary client: Avoiding pretend therapy. *Family Systems Medicine*, 9, 261–266.

Anderson, S., & Johnson, L. (2010). A Dyadic Analysis of the Between- and Within-System Alliances on Distress. *Family Process*, 49(2), 220-235.

Anker, M.G. Duncan, B.L. & Sparks, J.A. (2009). Using client feedback to improve couple therapy outcomes: A randomized clinical trial in a naturalistic setting. *Journal of Counseling and Clinical Psychology*, 77(4), 693-704.

Azar, S. T. (1984). Methodological considerations in treatment outcome research in child maltreatment. Presented at the National Conference of Family Violence Researchers, Durham, N.H.

Babcock, J. C., & Steiner, R. (1999). The relationship between treatment, incarceration, and recidivism of battering: A program evaluation of Seattle's coordinated community response to domestic violence. *Journal of Family Psychology*, 13(1), 46–59.

Bastien, R. T., & Adelman, H. S. (1984). Noncompulsory versus legally mandated placement, perceived choice, and response to treatment among adolescents. *Journal of Consulting and Clinical Psychology*, 52, 171–179.

Bech, P., Rasmussen, N.A, Olsen, L.R., Noerholm, V., Abildgaard, W. (2001). The sensitivity and specificity of the Major Depression Inventory, using the Present State Examination as the index of diagnostic validity. *Journal of Affect Discord*, 66, 159-164

Begun, A. L., Murphy, C. M., Bolt, D., Weinstein, B., Strodthoff, T., Short, L., et al. (2003). Characteristics of the Safe at Home instrument for assessing readiness to change intimate partner violence. *Research on Social Work Practice*, 13, 80–107.

Blanchard, K. A., Morgenstern, J., Morgan, T. J., Labouvie, E., & Bux, D. A. (2003). Motivational subtypes and continuous measures of readiness for change: Concurrent and predictive validity. *Journal of Addictive Behaviors, 17*(1), 56 – 65.

Bordin, E. S. (1979). The generalizability of the psychoanalyticconcept of the working alliance. *Psychotherapy: Theory, Research and Practice*, 16, 252-260.

Boyd-Franklin, N. (1989*). Black families in therapy: A multisystem approach*. New York: Guilford Press.

Boyd-Franklin, N., & Garcia-Preto, N. (1994). *Family therapy: The case of African American and Hispanic women*. In L. Comaz-Diaz & B. Greene (Eds.), Women of color: Integrating ethnic and gender identities in psychotherapy. New York: Guilford Press.

Brocato, J., & Wagner, E. (2008). Predictors of retention in an alternative-to-prison substance abuse treatment program. *Criminal Justice and Behavior*, 35(1), 99-119.

Busby, D. M., Crane, D. R., & Larson, J. H. (1995). A revision of the Dyadic Adjustment Scale for use with distressed and nondistressed couples: Construct hierarchy and multidimensional scales. *Journal of Marital & Family Therapy*, 21(3), 289–308.

Chamberlain, P., Patterson, G., Reid, J., Kavanaugh, K., & Forgatch, M. (1984). Observation of client resistance. *Behavior Therapy*, 15, 144–155.

Cingolani, J. (1984). Social conflict perspective on work with involuntary clients. *Social Work*, 29, 442–446.

Crane, D. R., Busby, D. M., & Larson, J. H. (1991). A factor analysis of the Dyadic Adjustment Scale with distressed and nondistressed couples. *American Journal of Family Therapy*, 19(1), 60–66.

Crane, D. R., Middleton, K. C., & Bean, R. A. (2000). Establishing criterion scores for the

Kansas Marital Satisfaction Scale and the Revised Dyadic Adjustment Scale. *The American Journal of Family Therapy*, 28, 53–60.

DiClemente, C, Prochaska, J. 0., Fairhuret, S. K., Velicer, W. F., Velasquez, M. M., & Rossi, J. S. (1991). The process of smoking cessation: An analysis of precontemplation, contemplation, and preparation stages of change. *Journal of Counseling and Clinical Psychology,* 59,295-304.

Connors, G. J., DiClemente, C. C., Dermen, K. H., Kadden, R., Carroll, K. M., & Frone, M. R. (2000). Predicting the therapeutic alliance in alcoholism treatment. *Journal of Studies on Alcohol*, 61, 139–149.

De Leon, G., Melnick, G., & Tims, F. M. (2001). *The role of motivation and readiness for change in treatment and recovery*. In F. M. Tims, C. G. Leukefeld, & J. J. Hart (Eds.), Relapse and recovery in addictions (pp. 143–171). New Haven, CT: Yale University Press.

DiClemente, C. C., & Hughes, S. L. (1990). Stages of change profiles in alcoholism treatment. *Journal of Substance Abuse*, 2, 217–235.

DiClemente, C., & Prochaska, J. (1998). *Toward a comprehensive, transtheoretical model of change: Stages of change and addictive behaviors*. In Treating addictive behaviors (2nd ed.) (pp. 3-24). New York, NY US: Plenum Press.

Doss, B.D., Atkins, D.C., & Christense, A. (2003). Who's dragging their feet? Husbands and wives seeking marital therapy. *Journal of Marital and Family Therapy*, 29(2), 165-177.

Dozois, D. J. A., Westra, H. A., Collins, K. A., Fung, T. S., & Garry, J. K. F. (2004). Stages of change in anxiety: Psychometric properties of the University of Rhode Island Change Assessment (URICA) scale. *Behaviour Research and Therapy, 42*(6), 711-729.

Edens, J. F., & Willoghby, F. W. (2000). Motivational patterns of alcohol dependent patients: A replication. *Psychology of Addictive Behaviors*, 14, 397–400.

Farabee, D., Nelson, R., & Spence, R. (1993). Psychosocial profiles of criminal justice- and non-criminal justice- referred substance abusers in treatment. *Criminal Justice and Behavior*, 20, 336–346.

Farabee, D., Prendergast, M., & Anglin, M. D. (1998). The effectiveness of coerced treatment for drug abusing offenders. *Federal Probation*, 62(1), 3–10.

Garfield, S. L. (1994). *Research on client variables in psychotherapy*. In S.L. Garfield & A.E. Bergin (Eds.), Handbook of psychotherapy and behavior change (4th ed.), 72-113. New York: John Wiley & Sons.

Garland, R. J., & Dougher, M. J. (1991). *Motivational intervention in the treatment of sex offenders*. In W. T. Miller & S. Rollnick (Eds.), Motivational interviewing: Preparing people to change addictive behavior (pp. 303–313). New York: Guilford Press.

Gelles, R.J. (1995). Domestic Violence Factoids. University of Rhode Island Family Violence Research Program. http://www.mincava.umn.edu/documents/factoid/factoid.html

Golberstein, E., Eisenberg, D., & Gollust, S. (2009). Perceived stigma and help-seeking behavior: Longitudinal evidence from the Healthy Minds Study. *Psychiatric Services*, 60(9), 1254-1256.

Goldstein, H. (1986). A cognitive –humanistic approach to the hard-to-reach client. *Social Casework*, 67, 27-36.

Greenstein, D. K., Franklin, M. E., & McGuffin, P. (1999). Measuring motivation to change: An examination of the University of Rhode Island Change Assessment Questionnaire

(URICA) in an adolescent sample. *Psychotherapy: Theory, Research, Practice, Training, 36*(1), 47-55.

Haley, J. (1992). Compulsory therapy for both client and therapist. Topics in Family Psychological Counseling,1(2), 1–7.

Hamilton, M. (1960). A rating scale for depression. *Journal Neurological Neurosurgery Psychiatry*, 23, 56–62

Harris, G. A., & Watkins, D. (1987). Counseling the involuntary client. College Park, MD: Amercian Correctional Association.

Hoffman, B.R., Monge, P.R., Chou, C., & Valente, T.W. (2006). Perceived peer influence and peer selection on adolescent smoking. *Addictive Behaviors*, 32(8), 1546-1554.

Horton, A. L. (1992). The transition from punishment to compulsory treatment for incest perpetrators: An emerging holistic model for family treatment. In J. Carlson (Ed.), Topics in family psychology and counseling 1(2), *Compulsory Family Therapy* (pp. 23–29). Frederick, MD: Aspen.

Horton, A. L., Johnson, B. L., Roundy, L. M., & Williams, D. (1990). *The incest perpetrator: A family member no one wants to treat*. London: Sage.

Irueste-Montes, A. M., & Montes, F. (1988). Court ordered vs. voluntary treatment of abusive and neglectful parents. *Child Abuse and Neglect,* 12(1), 33–39.

Knerr, M., Bartle-Haring, S., McDowell, T., Adkins, K., Delaney, R.O., Gangamma, R., Glebova, T., Grafsky, E., & Meyer, K., (2009). The impact of initial factors of therapeutic alliance in individuals and couples therapy. *Journal of Marital and Family Therapy*, 1-18.

Knopp, F. H. (1984). *Retraining adult sex offenders: Methods and models*. Syracuse, NY: Safer Society Press.

Lambert, M. J., Shapiro, D. A., & Bergin, A. E. (1986). *The effectiveness of psychotherapy*. In S. L. Garfield & A. E. Bergin (Eds.), Handbook of psychotherapy and behavior change (3rd ed.). New York: Wiley.

Larke, J. (1985). Compulsory treatment: Some practical methods of treating the mandated client. *Psychotherapy*, 22(2): 262-268

Lehmer, M. (1986). Court-ordered therapy: Making it work. *American Journal of Forensic Psychology*, 4(2), 16–24.

Masi, M., Miller, R., & Olson, M. (2003). Differences in dropout rates among individual, couple, and family therapy clients. *Contemporary Family Therapy: An International Journal*, 25(1), 63-75.

Matusiewicz, A., Hopwood, C., Banducci, A., & Lejuez, C. (2010). The effectiveness of cognitive behavioral therapy for personality disorders. *Psychiatric Clinics of North America*, 33(3), 657-685.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables. *Journal of Consulting and Clinical Psychology*, 68, 438–450.

McConnaughy, E. A., Prochaska, J. Q, & Velicer, W. F. (1983). Stages of change in psychotherapy: Measurement and sample profiles. *Psychotherapy*, 20, 368-375.

Mclellan, A., Luborsky, L., Woody, G., & O'Brien, C. (1980). An improved diagnostic evaluation instrument for substance abuse patients: The addiction severity index. *Journal of Nervous and Mental Diseases*, 168, 26-33.

Miller, W. R., & Rollnick, S. (1991). *Dealing with resistance*. In W. R. Miller & S. Rollnick (Eds.), Motivational interviewing: Preparing people for change (pp. 100–112). New York: Guilford Press.

Miller, W. R., & Tonigan, J. S. (1996). Assessing drinkers' motivation for change: The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES). *Psychology of Addictive Behaviors*, 10(2), 81-89.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change.* New York: Guilford Press.

Mohr, D.C., Hart, S.L., Howard, I., Julian, L., Vella, L., Catledge, C., & Feldman, M.D. (2006). Psychotherapy among depressed and nondepressed primary care patients. *Annals of Behavioral Medicine*, 32(3), 254–258.

O'Hare, T. (1996). Court-ordered versus voluntary clients: Problem differences and readiness for change. *Social Work*, 41, 417–422.

Orlinsky, D. E., & Howard, K. I. (1986). Process and outcome in psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), Handbook of psychotherapy and behavior change (3rd ed., pp. 311–381). New York: Wiley.

Pekarik, G. (1992). Relationship of clients' reasons for dropping out of treatment to outcome and satisfaction. *Journal of Clinical Psychology*, 48(1), 91.

Pepin, R., Segal, D., & Coolidge, F. (2009). Intrinsic and extrinsic barriers to mental health care among community-dwelling younger and older adults. *Aging & Mental Health*, 13(5), 769-777.

Phillips, L. E. (1985). *Psychotherapy revised: New frontiers in research and practice*. Mahwah, NJ: Lawrence Erlbaum Associates.

Pinderhughes, J.O. & DiClemente, C.C. (1984). *The transtheoretical approach: Crossing traditional boundaries of therapy.* Homewood, IL: Dow Jones Irwin.

Piper, W., Ogrodniczuk, J., Joyce, A., & Weideman, R. (2011). *Effectiveness of individual and group therapies.* In Short-term group therapies for complicated grief: Two research-based models (pp. 21-49). Washington, DC US: American Psychological Association.

Prochaska, J., & DiClemente, C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice*, 19, 276-288.

Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, 51, 390-395.

Prochaska, J. Q, & DiClemente, C. C. (1986). *Toward a comprehensive model of change*. In W. R. Miller & N. Heather (Eds.), Treating addictive behaviors: Processes of change (pp. 3-27). New York: Plenum Press.

Prochaska, J. Q, & DiClemente, C. C. (1992). *Stages of change in the modification of problem behaviors*. In M. Hersen, R. M. Eisler, & P. M. Miller (Eds.), Progress in behavior modification (pp. 184-214). Sycamore, IL: Sycamore Press.

Prochaska, J., & DiClemente, C. (2005). *The Transtheoretical Approach*. In Handbook of psychotherapy integration (2nd ed., pp. 147-171). New York, NY US: Oxford University Press.

Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*, 47(9): 1102-1114.

Prochaska, J.O., Johnson, S.S., & Lee, P. (1998). *The Transtheoretical Model of behavior change.* In E. Schron, J. Ockene, S. Schumaker, & Exum, W.M. (Eds.), The handbook of behavioral change, second edition. New York: Springer.

Prochaska, J.O., Johnson, S.S., & Lee, P. (2009). The transtheoretical model of behavior change. *The handbook of health and behavior change*, 59-83.

Olsen, L.R., Jensen, D.V., Noerholm, V., Martiny, K., Bech, P. (2003). The internal and external validity of the Major Depression Inventory in measuring severity of depressive states. *Psychological Medicine*, 33, 351-356.

Orlinsky, D. E., & Howard, K. I. (1986). *Process and outcome in psychotherapy*. In S. L. Garfield & A. E. Bergin (Eds.), Handbook of psychotherapy and behavior change (3rd ed., pp. 311–381). New York: Wiley.

Rempel, M. & Destefano, C.D., (2009). Predictors of engagement in court-mandated treatment. *Journal of Offender Rehabilitation*, 33(4),87-124.

Rollnick, S., Heather, N., Gold, R., & Hall, W. (1992). Development of a short 'readiness to change' questionnaire for use in brief, opportunistic interventions among excessive drinkers. *British Journal of A*, 87, 743—754.

Rollnick S., & Miller, W.R. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherap*y, 23, 325-334.

Rooney, R. H. (1992). *Strategies for working with involuntary clients*. New York: Columbia University Press.

Rooney, J., & Hanson, R. K. (2001). Predicting attrition from treatment programs for abusive men. *Journal of Family Violence,* 16, 131□149.

Rosenfeld, B. D. (1992). Court-ordered treatment of spouse abuse. *Clinical Psychology Review*, 12, 205–226.

Rounsaville, B. J., & Kleber, H. D. (1985). Untreated opiate addicts: How do they differ from those seeking treatment? *Archives of General Psychiatry*, 42, 1072–1077.

Satel, S. L. (2000). Drug treatment: The case for coercion. *National Drug Court Review*, 3(1), 1–43.

Satterfield, W. A., Buelow, S. A., Lyddon, W. J., & Johnson, J. T. (1995). Client stages of change and expectations about counseling. *Journal of Counseling Psychology*, 42, 476–478.

Shadish, W. R., & Baldwin, S. A. (2003). Meta-analysis of MFT interventions. *Journal of Marital & Family Therapy*, 29(4), 547 – 570.

Shapiro, R.J. & Budman, S.H. (2004). Defection, termination, and continuation in family and individual therapy. *Family Process*, 12(1), 55-67

Smith, K. J., Subich, L. M., & Kalodner, C. (1995). The transtheoretical model's stages and processes of change and relation to premature termination. *Journal of Counseling Psychology*, 42, 34–39.

Snell-Johns, J., Mendez, J.L., & Smither, B.H. (2004). Evidence-based solutions for overcoming access barriers, decreasing attrition, and promoting change with underserved families. *American Psychological Association*. 18(1), 19-35.

Snyder, C.M.J & Anderson, S.A. (2009). An examination of mandated versus voluntary referral as a determinant of clinical outcome. *Journal of Marital and Family Therapy*, 35(3) 278-292.

Spanier, G. (1976). Measuring dyadic adjustment: new scales for assessing the quality of marriage and similar dyads. *Journal of Marriage & the Family*,38(1), 15-28.

Spitzer, R.L., Kroenke, K., Williams, J.B.W., Lowe, B. (2006). A brief measure for assessing generalized anxiety disorder. *Archives of Internal Medicine*, 166, 1092-1097.

Sprenkle, D. H. (2003). Effectiveness research in marriage and family therapy: Introduction. *Journal of Marital & Family Therapy*, 29(1), 85-96.

Stark, M. J. (1992). Dropping out of substance abuse treatment: A clinically oriented review. *Clinical Psychology Review*, 12, 93-116.

Stroch, R.S. & Lane, R.C. (1989). Resistance in mandated psychotherapy: Function and Management. *Journal of Contemporary Psychotherapy*. 19(1), 25-38.

Sue, S., Zane, N., & Young, K. (1994). *Research on psychotherapy with culturally diverse populations*. In A. E. Bergin & D. E. Garfield (Eds.), Handbook of psychotherapy and behavior change (5th ed., pp. 783-820). New York: John Wiley & Sons.

Taft, C. T., Murphy, C. M., Elliott, J. D., & Morrel, T. M. (2001). Attendance-enhancing procedures in group counseling for domestic abusers. *Journal of Counseling Psychology*, 48, 51–60.

Tambling, R., & Johnson, L.N. (2008). The relationship between stages of change and outcome in couple therapy. *The American Journal of Family Therapy*, 36, 229-241.

Velasquez, M., Crouch, C., von Sternberg, K., & Grosdanis, I. (2000). Motivation for change and psychological distress in homeless substance abusers. *Journal of Substance Abuse Treatment*, 19(4), 395-401.

Vogel, P., Hansen, B., Stiles, T., & Götestam, K. (2006). Treatment motivation, treatment expectancy, and helping alliance as predictors of outcome in cognitive behavioral

treatment of OCD. *Journal of Behavior Therapy and Experimental Psychiatry*, 37(3), 247-255.

Waldman, F. (1999). Violence or discipline? Working with multicultural court-ordered clients. *Journal of Marital and Family Therapy*, 25, 503–515.

Wanberg, K., & Horn, J. (1983). Assessment of alcohol use with multidimensional concepts and measures. American Psychologist, 38, 1055-1069.

Wolfe, D., Aragona, J., Kaufman, J., & Sandler, J. (1980). The importance of adjudication in the treatment of child abusers: Some preliminary findings. *Child Abuse and Neglect*, 4, 127–135.

Zane, N., Nagayama-Hall, G. C., Sue, S., Young, K., & Nunez, J. (2004). *Research on psychotherapy with culturally diverse populations*. In A. E. Bergin & D. E. Garfield (Eds.), Handbook of psychotherapy and behavior change (5th ed., pp. 767–804). New York: John Wiley & Sons.