Congruence of Perceptions of Motivation Between Adolescent Clients, Their Therapist, and Parent

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CONGRUENCE OF PERCEPTIONS OF MOTIVATION BETWEEN ADOLESCENT CLIENTS, THEIR THERAPIST, AND PARENT

by

Amberly R. Johnson

A thesis submitted in partial fulfillment of the requirements for the degree of

MASTER OF SCIENCE

in

Family, Consumer, and Human Development
ABSTRACT

Congruence of Perceptions of Motivation Between Adolescent Clients, Their Therapist, and Parent

by

Amberly R. Johnson, Master of Science
Utah State University, 2007

Major Professor: D. Kim Openshaw, Ph.D.
Department: Family, Consumer, and Human Development

The purpose of this study was to explore perceptions of adolescent’s motivation to change in therapy, specifically while residing in a residential treatment center (RTC) and participating in family therapy. Motivation for change was examined in three contexts. The first context for examining the adolescent’s motivation for change was in relation to their stage of therapy. The second and third contexts for examining the adolescent’s motivation for change was in relation to perceptions the adolescent’s therapist and parent had of their motivation to change. In addition, the study explored whether there was a relationship between the congruence of perceptions of motivation to change between adolescent and therapist, and adolescent and his or her parent with the adolescent’s progress in therapy. A sample of 10 adolescent clients in a RTC completed the University of Rhode Island Change Assessment (URICA). The sample also included the adolescents’ 10 parents and four therapists. Parents and therapists completed revised versions of the URICA developed to obtain therapists’ and parents’ perceptions of
adolescents’ motivation to change. The findings indicated that most adolescents reported scores suggesting that their level of motivation would be classified as in the preparation stage of change. Data from the study also suggested that therapists and parents perceived adolescents as higher on the precontemplation subscale of URICA than the adolescents perceived themselves. No support was found for the theoretical relationship between congruence in perceptions of motivation and progress in therapy, but future research needs to determine if a relationship exists given the inability to examine this relationship statistically due to limitations of the study. Considerations for future research are given along with implications for marriage and family therapy.
ACKNOWLEDGMENTS

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Amberly R. Johnson
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CHAPTER I

INTRODUCTION

Increasingly researchers have focused on what works in therapy (Hubble, Duncan, & Miller, 1999). The body of literature these researchers have published provide us with many critical factors that contribute to successful therapy outcomes. One of these factors is motivation (Tallman & Bohart, 1999). Motivation is a complex idea consisting of several aspects. Miller and Rollnick (2002) have developed a three-factor definition of motivation including readiness to change, willingness to make changes, and one’s sense of ability to make a change.

Other researchers (e.g., Deci & Ryan, 1985; Harter, 1981) have characterized motivation as either intrinsic or extrinsic. Intrinsic motivation is a sense of urgency one feels for change, and an internal desire to make a change. Research has supported the necessity of intrinsic motivation in order for therapy to be effective (Duhig & Phares, 2003). Extrinsic motivation is pressure from outside sources. With adolescents in therapy, many times there is substantial extrinsic motivation for change. This comes from parents, teachers, or even legal systems. With so much pressure from outside sources, parents and therapist may assume that the adolescent client is motivated to change. However, the client may or may not be ready to change, and what he is motivated to change may or may not be what others feel he needs to change (Duhig & Phares).

Researchers have found that when therapists are not sensitive to their client’s motivation level, therapy is less effective, particularly if the clients have low initial levels of motivation (Miller & Rollnick, 1991). In a face-to-face outpatient setting, the
motivational level is important to understand and address across the therapeutic time frame. When the context of the face-to-face outpatient setting moves into a residential treatment center (RTC), then the issue of congruence in perception of motivation seems to be of particular importance considering the variety of interventions being employed, as well as the number of staff involved (Phares & Danforth, 1994). In this situation, it seems logical that the primary therapist would be the individual to assess for motivation and communicate the level of motivation to those who perform critical, but adjunctive, roles in the therapy process (recreational therapist, music therapist, line staff, and other professionals involved in the system).

This research examines motivation in a residential treatment center with a focus on the understanding of the client’s motivation through the eyes of the therapist. Two research questions the researchers seek to address are; first, “Where do adolescents’ URICA scores place them along the continuum of change, as proposed by Prochaska and DiClemente (1984)?” and second, “When grouped according to their length of time in treatment (Phase 1 or Phase 2), where do adolescents’ URICA scores place them along the continuum of change?”

The next two research questions of this study attempt to examine the congruence between the therapist and client’s perceptions and the relative impact it might have on therapy. The third question the researchers of this study ask is, “Is there a difference between the adolescent’s motivation scores on the URICA, when compared with that of his or her therapist motivation score derived from the T-PCMI?” The fourth question also deals with the level of congruence between adolescent client’s perception and the therapist’s perception. It has two parts: first, “Is the congruence between the adolescent’s
and therapist’s motivation scores, as measured by the URICA and the T-PCMI, related to the adolescent’s reported progress in therapy?” and second, “Is the congruence between the adolescent’s and therapist’s motivation scores, as measured by the URICA and the T-PCMI, related to the therapist’s reported level of the adolescent’s progress in therapy?”

Family Therapy

Family Therapy is an intervention increasingly looked toward for the treatment of mental health concerns across the context spectrum from the individual to the family (Nichols & Schwartz, 2004). Family systems theory would recommend that adolescent problems be treated within a family context, or at least family therapy be a part of the overall therapeutic regimen. Although an adolescent is involved in a residential treatment center, family therapy has been demonstrated to be of significance to the short and long-term outcome for therapy. When applying systems theory to family therapy in a RTC setting, there are several concepts of particular importance, namely, wholeness and blame (Guttman, 1991).

The rationale for including the concept of wholeness when examining change in adolescents, specifically those who are being provided therapy in a RTC, lies in the nature of the interaction of the subsystems. Family subsystems are unique in that their initial focus is morphostasis. When change is initiated, for example the adolescent is provided therapy and then returned home. The tendency is towards wholeness and stability. Family therapy allows for all subsystems to accommodate and assimilate changes during and prior to the adolescents return, thus allowing the family to remain “whole.”
One advantage of using a family therapy approach, beyond the likelihood that it provides better adjustment when the adolescent returns to the home, is that the basic philosophy is one that avoids blaming any one member or subsystem (Guttman, 1991). For instance, parents are not blamed for a child’s oppositional behavior, but rather looked to as part of the long-term solution. The more involved the entire system is, the greater the chance for second-order change and less likelihood of relapse (Guttman).

In family therapy, parents are part of the therapeutic system and may experience dissonance and accompanying frustration similar to the therapist’s if they are not sensitive to their adolescent’s level of motivation to address the problem in therapy. Duhig and Phares (2003) found that parents were often more distressed about their adolescent’s presenting problem than the adolescent was, leading to the parents to have higher levels of motivation to change the adolescent’s behavior than the adolescent themselves had. In that it is posited, that when adolescent and parental perceptions of motivation are not congruent, both parties experience frustration in the therapeutic process, the question arises, “Is there a difference between the adolescent’s motivation score, as measured by the URICA, when compared with that of his or her parent motivation score derived from the P-PCMI?” In addition, the researchers want to know if there is a difference between the adolescent’s perceptions of his or her level of motivation to change when compared to that of his or her parent, is it related to their progress in therapy. The sixth and final research question the researchers of this study will explore is has two parts. The first states, “Is the congruence between the adolescent’s and parent’s motivation scores, as measured by the URICA and P-PCMI, related to the adolescent’s reported progress in therapy?” The second states, “Is the congruence between the
adolescent’s and parent’s motivation scores, as measured by the URICA and P-PCMI, related to the parent’s reported level of the adolescent’s progress in therapy?” These research questions appear to be important to understand both at the beginning of therapy, as well as during the course thereof.

Purpose of the Study

The purpose of this study was to explore perceptions of adolescent’s motivation to change in therapy, specifically while residing in a RTC and participating in family therapy. Motivation for change was examined in three contexts. The first context for examining the adolescent’s motivation for change was in relation to their stage of therapy. The second and third contexts for examining the adolescent’s motivation for change was in relation to perceptions the adolescent’s therapist and parent had of their motivation to change. In the following review of the literature the researchers support the hypothesis that this congruence between the adolescent’s motivation to change in therapy and the perceptions their parents and therapist’s have of the adolescent’s motivation to change appears to be an influential factor for successful therapeutic outcome. To further examine this hypothesis, this study began to explore whether there is a relationship between the congruence of perceptions of motivation to change between adolescent and therapist, and adolescent and his or her parent with the adolescent’s progress in therapy.
CHAPTER II

REVIEW OF THE LITERATURE

Many factors make the difference between successful therapy that helps facilitate change and therapy that does not (Hubble et al., 1999). One of the factors that influence therapeutic success appears to be motivation (Tallman & Bohart, 1999). Motivation entails an individual’s readiness for change, willingness to experience the change, and the individual’s perceived ability to feel she is capable of change (Miller & Rollnick, 2002). Researchers have found motivation to be a critical factor, particularly when the therapist and client are not approaching the problem from the same level of motivation (Miller & Rollnick, 1991, 2002). In family therapy, parents may experience problems similar to the therapist when there is not a congruence of perception in regards to the client’s level of motivation. In this study, systems theory is used as the lens from which to view how a lack of perceptual congruence leads to struggle or dissonance that interferes with the therapeutic process (Butler & Bird, 2000; Miller & Rollnick, 2002).

Systems Theory

A variety of concepts underlie the theoretical makeup of systems theory. Several are pertinent to this study, including subsystems, boundaries, rules, interdependence, feedback, wholeness, blame, and change. A system is made up of subsystems (Bronfenbrenner, 1989), the most basic level being the individual system, which is composed of a person’s biological and psychological attributes. Beyond the individual system, Bronfenbrenner noted that there is the micro-, macro-, meso-, and exosystem
that are chronologically organized. Subsystems are hierarchical, differ in their presentation of power (French & Raven, 1962), and are uniquely coordinated in their interaction by the mechanisms of boundaries, which are rule defined (Guttman, 1991). Rules and/or meta rules clarify, though not necessarily at a conscious level, the nature and extent of, or lack of, interaction one can anticipate (Guttman).

Change is a dynamic systems concept suggesting ongoing systemic alteration that is regulated by feedback systems (Guttman, 1991). There are two basic feedback “loops” that regulate systemic organization, namely, positive feedback (positive feedback forces a family into a new way of behaving by making old behavior patterns untenable or morphogenesis) and negative feedback (negative feedback attempts to correct the system in trouble and to re-establish its previous state of equilibrium, homeostasis; Sauber, L’Abate, & Weeks, 1985). These feedback loops involve everyone in the system, thus one person or part of the system is not to “blame” for when things change or do not change. The entire system is involved because as part of the system changes the entire system must change to incorporate that change if it is to remain whole. This is the concept of wholeness (Guttman).

Family systems theory describes how interconnectedness influences change, suggesting theoretically, that when change does occur, a change in one member of the system will result in a concomitant response in one or more other members of that system. Guttman (1991) described how the individual member of the system that changes is the source of new information, which the family responds to with either positive or negative feedback. Positive feedback supports the change and results in an accommodating change in the rest of the system. This change is called morphogenesis.
Negative feedback supports morphostasis, or a lack of change. Through negative feedback, the source of new information is told to forgo the changes they have made and fit back into the system. Some members of a system can more easily foster change than others due to their position and power, which is often determined by age (Guttman).

When considering the adolescent in the context of the family, it is logical to assume that the parents will have a greater power differential than will the adolescent. If the parents impose change [e.g., through coercive power (French & Raven, 1962)], while change may occur, it may do so in a way that results in a negative outcome. For example, the parents may hope that an adolescent will be obedient through their forcing of rules, yet the outcome may be the adolescent rebelling through oppositional behavior.

When the adolescent is in therapy it is important to understand the rules governing parent and adolescent interaction. It is suggested that these rules will affect the possibility of change as therapy progresses. Most importantly, if the family rules are not facilitative of ongoing change or stabilization once the adolescent returns to the home, it is likely that the changes brought about by therapy may be undone. On the other hand, because of the influence of the family rules system, if the family is involved in the therapy, so that underlying rules and meta-rules become congruent with changes the adolescent adopts, it is highly likely that when the adolescent returns home he will accommodate and assimilate in such a manner that therapeutic change is supported.
Families Presenting to Therapy

There are many factors to be considered when attempting to understand the dynamics of change, not only individually, but systemically as well. Increasingly clients (i.e., referring to individuals, couples or families) are presenting to therapy for a variety of reasons, most commonly associated with subjective distress, or in other words, distress that they experience emotionally (American Psychological Association, 2000). These individuals tend to be good at verbalizing the nature of their emotional discomfort, yet do not seem to be able to identify the source of these emotionally, distressful cognitions or behaviors. Interestingly, however, while there seems, at first glance, a desire to alter their emotional, cognitive or interactive states to resolve and reconcile the distress, many, once in therapy, show little therapeutic progress towards goals set out and identified in the treatment plan. It is suggested that one reason for this is that the client’s motivation to maintain the predictability of their current situation may be higher than their motivation to alter their situation (Miller & Rollnick, 1991).

Motivation

Motivation to change assumes that one desires change to occur—or that through the therapeutic process, desire to change will be enhanced so that change can occur. Motivation has commonly been viewed as an “all or nothing” phenomena in therapy, perpetuating the belief that clients are willing to work and bring about change, or they are not (van Bilsen, 1995). From the perspective of therapists and theorists, a lack of motivation could be attributed to such factors as a client’s unwillingness to (a) accept the
therapist's diagnosis, (b) agree with the therapist's recommendations, (c) accept her role in the problem (denial), (d) engage therapeutic interventions and homework (resistant), or (e) to put forth the effort necessary to bring about change (resistant; Miller & Rollnick, 1991, 2002). Miller and Rollnick (1991), however, disputed these suggestions, indicating that that resistance is a normal stage in the process of change, especially if the client does not feel they have the ability to make the necessary changes. Miller and Rollnick further stated that an emphasis on what the client does or is willing to do is the more critical determinant of therapeutic outcome.

A review of the literature suggests that there are a variety of factors correlated with the process of change and successful therapeutic outcome. Three such factors relevant to this study are motivation (Tallman & Bohart, 1999), strength of the therapeutic relationship (Bachelor & Horvath, 1999), and encouraging hope or expectancy (Snyder, Micheal, & Cheavens, 1999). While many factors are relevant, the intent of this study is to focus specifically on motivation (Tallman & Bohart) as defined by Miller and Rollnick (1991). Although the focus on motivation may suggest to the reader a linear effect on change, it must be realized that motivation is only one variable, and most likely has a direct, indirect and interactive effect.

The Many Faces of Motivation: Towards a Definition

Motivation has been touted as one of the critical factors associated with change, regardless of whether we are examining a clinical population, adolescents in an academic setting, or employment advancement. In other words, it does not appear to matter what the person is engaging in, if that person desires to do something different, or have a
different outcome than what is being experienced, the person must have an internal sense of "urgency" to move beyond one's original position (Hanna, 2002). While "urgency" may be considered an internal or intrapsychic phenomenon, the researchers of this study conceptualize it in the context of three dimensions of change, namely, (a) readiness to change, (b) willingness to do something different, and (c) recognition and acceptance of one's abilities and capabilities for change (Miller & Rollnick, 2002).

*Readiness to make a change to a new life position.* Miller and Rollnick (1991) conceptualized motivation as "a state of readiness or eagerness to change" (p. 14). Conceptualizing motivation as "a state of readiness" allows for the therapist to influence the client's motivation. For example, if a client presents to therapy and wavers with regards to whether or not to make change, the therapist can recognize and acknowledge the level of readiness as an issue and orient initial therapeutic efforts towards this ambivalence. In so doing, therapy could prepare the client for change and increase the likelihood of a successful outcome. On the other hand, if the client's level of readiness suggests motivation of a sufficient degree to move the therapeutic process forward, then interventions are designed collaboratively and commensurate to the client's level of readiness.

It is not meant to oversimplify the nature of readiness. Readiness must take into consideration a variety of factors including, though not limited to, presenting complaint, context in which the complaint is grounded, resources available, methods previously employed to bring about change and their relative degree of success, and so forth (Miller & Rollnick, 1991).
Willingness to do what it takes to make a difference. Hanna (2002) and Hanna and Hunt (1999) suggested that while “urgency” is a necessary condition for change, it is not sufficient to engage the motivational level required for it to occur. They suggested that another component of motivation is the client’s “willingness” to change or to adopt life strategies that are translated into new or revised systemic rules and/or meta-rules. The extent to which a person is willing to change represents the perceived relative importance of change and is often a function of the degree of discrepancy between the client’s status (e.g., degree of oppositionality) and the desired or sought after goal (e.g., social compliance; Miller & Rollnick, 2002).

Recognition and implementation of one’s abilities to change. Ability is conceptualized at the general sense of self-efficacy or confidence for change, and is the third characteristic of motivation (Miller & Rollnick, 2002). If a client feels they do not have the ability or efficacy to change, they may use defense mechanisms such as denial, rationalization, or displacement to ease the perceived discrepancy between his current state and desired goal (Miller & Rollnick). For instance, using the example above, if a client is currently oppositional, and the desired goal is social compliance, although the client feels that he is so different from the rest of society that he is not capable of social compliance, he may use denial and resist the therapist’s suggestions towards social compliance.

These three characteristics of change are not mutually exclusive, but rather interrelated. If the client is not ready to change, because she feels an inability to change, then increasing her perceived ability to change may likely lead to increases in her willingness to change. Likewise, if the client is unwilling to change because she does not
like the therapist she is working with, or the means of change presented to her, this may decrease her readiness to change from previous levels. When referring to motivation in this study, the researchers are referring to these three interactive factors as critical attributes of the concept.

**Intrinsic compared to extrinsic motivation.** Some theorists (Deci & Ryan, 1985; Harter, 1981; Lepper, Iyengar, & Corpus, 2005; Otis, Grouzet, & Pelletier, 2005) have conceptualized motivation based on the source, including intrinsic and extrinsic motivation. Intrinsic motivation is motivation that comes from within oneself, which has been used as an operational definition of motivation in this manuscript. Extrinsic motivation is pressure from external sources such as parents or the law, which attempt to force change. Although, these external regulations are helpful sources in that they bring the client to opportunities for help, research has supported the hypothesis that intrinsic motivation is associated with more effective therapy (Joe, Simpson, & Broome, 1998; Pelletier, Tuson, & Haddad, 1997). In fact, external factors of motivation have only been related to positive treatment outcome when internal factors are also present (Ryan, Plant, & O’Malley, 1995).

Based on these findings, motivation is best conceptualized as intrinsic motivation, which is further clarified by the interaction of the three interconnected factors described previously, namely readiness, willingness, and one’s sense of ability to make a change. 

**Theories of Change and Motivation**

Although therapists have unique theories of change, only a handful of models have been developed to explain how change occurs in therapy and received empirical
support. Prochaska and DiClemente’s (1984) Stages of Change model and Hanna’s (2002) precursors to change model are two empirically supported models that specifically address motivation.

**Stages of change.** Prochaska and DiClemente’s (1984) transtheoretical model, often referred to as the “stages of change model” has been popular with clinicians and researchers for some time (Sutton, 2001). The transtheoretical model resulted from over 12 years of studying how people change addictive behaviors (Prochaska, DiClemente, & Norcross, 1992). This model has since been applied to other presenting problems including anxiety (Dozios, Westra, Collins, Fung, & Garry, 2003), nutrition (Hoy et al., 2005), and adolescents with diverse mental health issues (Cohen, Glaser, Calhoun, Bradshaw, & Petrocelli, 2005; Rochlen, Rude, & Barón, 2005). The transtheoretical model is a major component of Miller and Rollnick’s (1991) Motivational Interviewing model.

The transtheoretical model focuses on the process of change using a stage of change framework. The process of change refers to the underlying mechanisms used by an individual or system in bringing about alteration in its governing rules and meta-rules. If change is merely a momentary alteration in the rules without overall impact on the functioning of the system, it is perceived as first order change. On the other hand, when change occurs in such a way so that the governing rules and meta rules elicit consistent and long-term variation in cognition, affect, and behavior, such change is referred to as second order change. The latter is most critical to therapeutic intervention and outcome. The desire of therapy is to bring about sufficient change in the person or system to
encourage increased personal and systemic well-being while decreasing subjective distress or conflict.

It is the presumption of the transtheoretical model that change occurs within the context of given stages, beginning with the precontemplative stage and continuing on through to the stage known as maintenance. According to Prochaska and DiClemente (1984), the stages of change include precontemplation, contemplation, preparation, action, and maintenance. Although these stages of change proceed one from another, in reality they represent a description of the client’s readiness to change. A short description of each of these stages follows (Prochaska et al., 1992).

The stage of precontemplation is characterized by a lack of awareness that a problem exists. Family members or other people in the individual’s life may see that a problem is evident, but there is no personal awareness. When the individual begins to gain awareness of the problem he enters the contemplation stage. At this stage the individual considers change and often goes back and forth between desiring change and being ready to commit to the process of changing. Once he commits to change the individual begins making preparations for change. The preparation stage was at one time eliminated from the model because it appeared that there was not empirical support for this stage. However, distinct groups were found with high levels of both contemplation and action scores. This describes the stage of preparation. These individuals have decided to take action, but have not yet engaged in the change process. This stage was originally labeled Decision-Making (Prochaska et al., 1992).

The action stage begins when change and behavior modification begin to be evident. The individual is taking active steps to change her problem and become the
person they want to be. Individuals are only classified as being in the action stage if they have successfully made change for somewhere in between one day to six months. After six months they move to the maintenance stage. At the stage of maintenance the individual has successfully changed her behavior and her problem is no longer evident. However, the work is not done in that the client is still working to maintain the progress that has been made and the occurrence of a relapse is still a concern. The individual is working to stabilize the behavior change (Prochaska et al., 1992).

In sum, the stages of change model is not a linear model, but rather a spiral model of change (Prochaska et al., 1992). People will often go through the stages several times before finally exiting the spiral, but each time getting closer to the goal.

**Hanna’s model.** Hanna (2002) describes seven precursors to change. At first glance they appear similar to Prochaska and DiClemente’s (1984) stages of change, but Hanna explained that these seven precursors come even before the second of Prochaska and DiClemente’s stages of change and are especially helpful when the client is in the first stage, precontemplation. He describes how these seven precursors are how one overcomes the precontemplation stage. The seven precursors are: (a) a sense of urgency, (b) a willingness or readiness to experience anxiety or difficulty, (c) awareness, (d) confronting the problem, (e) effort or will toward change, (f) hope for change, and (g) social support for change. Hanna described how therapists can also use these seven precursors in making the change to overcome therapist interference.

Prochaska and DiClemente’s (1984) transtheoretical model is used in this study for two reasons. First, it is more extensive than Hanna’s model in that it addresses clients who might be labeled as having low motivation (precontemplation and contemplation
stages) as well as clients with sufficient motivation to change (preparation and action stages). The second reason for choosing this theoretical framework is the extensive empirical support for the model. The model was developed based on empirical findings and revised as new information was presented (Prochaska et al., 1992). The empirical interest in this model has contributed to the development of several instruments [e.g., URICA (McCohhaughy, Prochaska, & Velicer, 1983) and SOCRATES (Miller & Tonigan, 1996)] designed to assess a client’s stage of change (Miller & Rollnick, 1991).

Summary of Theoretical Framework

To this point, basic concepts of systems theory have been presented so as to provide a foundation for understanding the critical dimension of subsystems working (e.g., client and therapist) together in the process of change. The traditional concept of resistance has been reframed from being viewed as unwillingness to put forth effort or engage in the therapeutic process, to that of a state of low motivation. Motivation, for purposes of this study, is conceptualized around three concepts: willingness to engage in the change process, readiness to change, and self-efficacy or sense of ability to make the change. Finally, the stages of change, as presented by Prochaska et al. (1994), have been articulated.

The next focus of this thesis will be on why the client’s level of motivation is a necessary condition for the therapist to understand if therapeutic endeavors are going to result in change.
Motivation has been shown to be an important factor in the outcome of therapy in many age groups and areas of therapy. In treating substance abuse and other addictive behaviors the importance of motivation has been especially emphasized. One example is the findings of Joe et al. (1998), which demonstrated that low levels of motivation are associated with high therapy dropout rates. In contrast, high motivation levels were associated with increased session attendance and strong therapeutic alliances. DeLeon, Melnick, and Kressel (1997) found that dynamic characteristics, notably motivation, of clients presenting to treatment for drug abuse appear to be more relevant to retention than “fixed” characteristics such as demography or the client’s preferred drug. DeLeon et al. also emphasized the extent to which the relationship between retention and treatment effectiveness has been consistently documented.

As introduced previously, it is especially important to look at the influence of motivation on therapy because motivation is not a constant characteristic of a client. It can move from one degree to another throughout the therapy process (Miller & Rollnick, 1991). In order to overcome the barrier to treatment low levels of motivation create, therapists can take different approaches, depending on the client’s readiness to change his level of motivation (Davidson, Rollnick, & Mac Ewan, 1991). Rapp, Li, Siegal, and DeLiberty (2003) emphasized the importance of starting where the client is in regard to motivation. They found that initial motivation levels were unrelated to the outcome of therapy, arguing that initial low levels of motivation do not necessarily mean treatment will fail as many therapists assume.
If the findings of Rapp et al. (2003) are valid, then why have so many other studies (e.g., DeLeon et al., 1997; Joe et al., 1998) identified low motivation as a predictor of poor treatment outcome? Research conducted by Rapp et al. and Davidson et al. (1991) illuminates this paradox. These researchers articulated the importance of the therapist’s acknowledgment of the client’s current state, and using an approach unique to the client’s level of motivation, in order to facilitate a successful treatment outcome. However, this answer leads us, as researchers, to another question. If motivation is amendable to change, why do so many clinicians apparently fail to increase the client’s level of motivation? What Miller and Rollnick (2002) have labeled as dissonance appears to be a primary reason why many clients do not move through the stages of change toward the action stage, which is the stage that appears to lead to the most favorable outcomes when using traditional therapeutic approaches.

**Dissonance**

Miller and Rollnick (2002) described dissonance and consonance as the degree to which the counselor’s strategies match the client’s readiness level. Dissonance occurs when there is a mismatch of strategies to the client’s readiness level. An example of a mismatch of strategies is if a therapist works with a client to make behavioral changes toward gaining prosocial friends when the client is still only considering whether or not she wants to change her situation. Miller and Rollnick (1991, 2002) illustrated how this leads to frustration and can even heighten clients’ resistance. When there is dissonance, the therapist and client are working on different tasks resulting in frustration that is often misinterpreted as client’s unwillingness to work. While the client is often viewed as
unwilling to work, the therapist is likely to be blamed for using inadequate techniques or having poor relational skills (Prochaska et al., 1992).

Another way dissonance between client and therapist has been conceptualized is by the term “struggle.” Butler and Bird (2000) defined struggle as the systemic process that occurs when a therapist and client are not working on the same tasks. They also emphasize that neither the therapist nor the client is to blame, because both are working on the goal they feel is going to be most beneficial; however, clinicians can become aware of struggle and employ efforts to match their goals to that of the client. Struggle or dissonance is often hard to observe, yet leads to significant negative outcomes in therapy such as treatment dropout (Butler & Bird).

A compounding factor to dissonance is that when clients present to treatment, motivation is often assumed by the therapist (van Bilsen, 1995). Professionals can unintentionally lower client’s motivation by working from an assumed perspective of client motivation (Wagner & McMahon, 2004). Assuming a client is motivated to change can lead to the therapist taking upon himself too much of the responsibility for change (Butler & Bird, 2000; van Bilsen, 1995). As the therapist takes on the responsibility for change he focuses more and more on the client’s resistance and get further out of touch with where the client is at. Hanna (2002) referred to this as therapist interference.

The frustration that results from dissonance may on the one hand contribute to therapist interference and decrease a client’s level of motivation, yet on the other hand, it may affect the overall therapeutic process, particularly joining and treatment planning.
One of the most critical aspects of therapy, as it relates to motivation and as such, therapeutic outcome, is the relationship developed between the client and therapist (Broome, Knight, Knight, Hiller, & Simpson, 1997). The underlying process involved in fostering an effective therapeutic alliance is joining. Minuchin, Nichols, and Lee (2007) suggested that joining is a prerequisite to making [a client] feel sufficiently understood to trust a therapist who asks [him or her] to re-examine [his or her] interactions.... Before [a] person is willing to attempt some therapeutic exercise, he or she needs to feel secure that the [therapist] understands ... the limitations it imposes. Likewise, [clients] need to know that a therapist understands that they’re doing what they’re doing for a reason, and they may be hesitant to try something different for fear that it might make things worse. (p. 108)

It appears, therefore, that a pre-condition of change, which might be noted by the transition from precontemplation to contemplation, would be the establishment of a positive therapeutic relationship through the therapeutic modality known as joining.

In support of the power of the therapeutic relationship, Rochlen et al. (2005) noted that, according to therapist ratings, the therapist’s perception of the working alliance was the only factor in the study that was not significantly different between clients in the precontemplation stage and clients at other stages. The researchers interpreted this finding as evidence that the therapists in the study were not aware of the impact the client’s stage of change or level of motivation was having on the working alliance. It was further suggested by Rochlen et al. that the therapeutic relationship, if constant across the course of therapy, will continue to facilitate movement from one stage of change to the next. Unfortunately, it was also noted that not only do therapists pay
only modest attention to the process and stages of change per se, they oft times neglect—or do not know how—to assess for it.

_Treatment Planning and Motivation_

Once a therapeutic alliance has been established, treatment planning becomes the next essential step in the process of engaging therapy. While this is the case, it is not uncommon for the client and therapist to come together, initially, with mismatched goals and objectives, or desired outcomes. This mismatch is an example of ‘dissonance’ as described by (Miller & Rollnick, 2002). In that joining is a continuous process within and across therapy, frustration caused by dissonance may not only affect the therapeutic alliance, but may also ripple out into the therapeutic process in general, and more specifically treatment planning.

Although therapists understand the importance of formulating a treatment plan to guide their interventive strategies, some therapists assume this role without establishing the level of readiness of the client in making change. The astute therapist will, however, realize that the client rarely, if ever in the beginning of therapy, makes her agenda explicit. This recognition speaks to the issue of initial motivation as it relates to treatment planning, and specifically brings attention for why therapists need to be aware of the client’s level of readiness as they move towards fostering a collaborative treatment planning process. When there is consonance, or a match between the therapist’s strategies and the client’s readiness level, effective treatment planning is facilitated and the treatment goals are more likely to be met (Miller & Rollnick, 2002). When consonance is
present, the therapist will not expect the client to begin changing behaviors she is not yet motivated to change, but rather will work toward increasing the client's motivation.

Adolescents

Adolescence is recognized as that stage of development beginning at about the age of 10 or 11 (onset of puberty) and continues, at least according to current research, up through the end of the development of formal operative thought (age 25; Santrock, 2007). Although Hall (1904) identified adolescence as a period of “storm and stress,” other researchers (Mead, 1928; Offer, Ostrov, Howard, & Atkinson, 1988) have suggested that it is not as traumatic as Hall has proposed. Although most adolescents make the transition into adulthood without significant difficulty, there are those who do present with psychological, behavioral and/or social problems (e.g., affective or anxiety disorder, conduct disorder, oppositionally defiant disorder; Hanna & Hunt, 1999). While some of the research will tie these difficulties to biological predispositions, most now adopt a biopsychosocial perspective, which suggests that while there may be biological predispositions, such predispositions are in interaction with the adolescents psychological functioning and social environment (Santrock). One of the critical social contexts influencing adolescent development is that of the family (Berman & Napier, 2000).

Adolescents and the Process of Change

Change is an ongoing process experienced by all human beings, adolescents being no exception. There are, when one investigates the process of change as it relates to adolescents, identifiable factors that are supportive of this process; for example, two most
specific to this study include, the system or systems in which the adolescent is involved (e.g., family and therapeutic) and the adolescents' motivation to change.

Motivation to change has been noted as one key area of working with adolescents (Adelman, Kaser-Boyd, & Taylor, 1984; Long & Adams, 2001). The first research question of this study simply asks “Where do adolescents’ URICA scores place them along the continuum of change, as proposed by Prochaska and DiClemente (1984)?” The second research question is similar to, but builds on the first. The second research question originally stated, “When grouped according to their stage of therapy (beginning, middle, or end), where do adolescents perceive themselves along the continuum of change?” The wording of this question was modified based on the demographics of the sample to more accurately ask the question intended to be asked. The second research question now reads, “When grouped according to their length of time in treatment (Phase 1 or Phase 2), where do adolescents’ URICA scores place them along the continuum of change?” Phase 1 included those who had been at the RTC less than five months, while Phase 2 included those adolescents who had been at the RTC longer than five months.

Adolescents are often brought to therapy by outside sources due to DSM-IV-TR diagnoses such as Conduct Disorder, Oppositional Defiant Disorder (Hanna & Hunt, 1999), and disorders related to substance abuse (Greenstein, Franklin, & McGuffin, 1999). These outside sources may include the law, teachers, or the parents of adolescents who, they themselves, may be experiencing distress due to the adolescent’s behavior (Duhig & Phares, 2003).

Outside pressure to participate in therapy may make the issue of motivation and dissonance more pronounced (Phares & Danforth, 1994). These outside pressures are
sources of what some consider external motivation and may increase a client’s readiness to address the problem then, but only if intrinsic motivation is also present (Duhig & Phares, 2003). As in the therapeutic process of treatment planning, consensus is often assumed when there is external motivation applied. Contrary to this assumption Adelman et al. (1984) found only 31% of adolescents were motivationally ready to begin treatment, while 60% indicated strong interest in starting treatment. When a client is court-ordered to attend therapy or brought in by his parents and it is said that he is required to make specific changes, the changes are incorporated into some form of treatment plan. It is often assumed that this explicit treatment plan is the same agenda the client has in mind, while the treatment plan may or may not be what the client is motivationally ready to work on. It is interesting to note that Duhig and Phares found that adolescents from a clinical sample wanted to change internalizing behaviors more than the externalizing behaviors for which they were more often referred to treatment.

When working with adolescents, it is just as important to avoid assuming that an adolescent client is unmotivated, as it is to avoid the automatic assumption that she is motivated (Bowling, Kearney, Lumadue, & St. Germain, 2002). Adolescents are often given a bad reputation, and it is assumed they are resistant to change and resistant to accepting help (Hanna & Hunt, 1999). Rapp et al. (2003) found that motivation was not significantly related to coercion or self-referral, and it is possible for clients who were brought to therapy through external sources to also have high levels of intrinsic motivation. The findings of Rapp et al. and Bowling et al. (2002) emphasized the importance of assessing motivation rather than assuming the adolescent client’s motivation. Their research also raised the question of how well clinicians judge the
motivational level of their adolescent clients. In other words, what is the degree of congruence between the perceptions of the therapist, as it relates to the motivational level of the client with that perception of the client relative to their perceived state of motivation for change? Focusing on this, the third question of this study is, “Is there a difference between the adolescent’s motivation scores on the URICA, when compared with that of his or her therapist motivation score derived from the T-PCMI?” In addition, the fourth research question asks, “Is the congruence between the adolescent’s and therapist’s motivation scores, as measured by the URICA and the T-PCMI, related to the adolescent’s reported progress in therapy?” and, “Is the congruence between the adolescent’s and therapist’s motivation scores, as measured by the URICA and the T-PCMI, related to the therapist’s reported level of the adolescent’s progress in therapy?”

The Role of the Family in the Treatment of an Adolescent in a Residential Treatment Center

The family is the primary context in which an adolescent has learned about change. Research suggests that when therapy is done outside of the family, when the adolescent returns to the family, that it is likely that the underlying rules and meta-rules of the family will operate in such a manner so as to undue lasting therapeutic progress and restore the family to a level of homeostasis (Guttmann, 1991). The logic of this statement is found in the basic concepts of systems theory wherein the adolescent is seen as a subset of the overall system. Changes in one part of the system necessitate that the overall system decide how to adapt to these changes (morphogenesis). This adaptive process may be noted in accommodation or assimilative actions that allow for new rules and/or meta rules to accept the change and be integrated. On the other hand, the stability
and tenacity of the system may be such that it will reject the change (morphostasis) and, using old rules and meta-rules act to defeat the altered subsystem (Guttmann).

Family therapy, and even specifically parents' participation in therapy with the adolescent, has gained increasing support in recent years (Nichols & Schwartz, 2004). Increased support for family therapy has led to more frequent use of family therapy as an intervention (Dugih & Phares, 2003). The foundation of family therapy is systems theory, and highlights the systems concept that changing the entire family system changes the lives of each family member. Family therapy differs from other forms of therapy in that the therapist is the source of new information that is presented to the whole family system who works together to change the rules and meta rules in order to facilitate change (Guttmann, 1991). In most other forms of therapy, an individual presents to therapy and makes changes, which may or may not result in a change in the larger system. For example, consider an oppositional adolescent who works to gain autonomy through socially acceptable means such as earning more freedoms through a system devised in treatment. If the family is not involved in this treatment, the adolescent may attempt to apply these methods at home, but find they do not result in more freedom so she will return to the oppositional behavior that did allow her more freedom. However, if the family is involved in treatment and begins implementing a similar method of earning freedom at home, the adolescent will find that her need for autonomy can be met without oppositional behavior.

The need for family involvement in treatment may be amplified in the RTC setting where there is a greater period of time between treatment and implementing the changes at home. A RTC is an in-patient treatment approach that strives to make every
aspect of daily life a therapeutic process. The client resides at the RTC, away from their family. An adolescent client in an outpatient setting may practice what was discussed in therapy during the week and then report the outcome to the therapist the following week. If it is not being accepted by the family system, the therapist may try something new. In the RTC, a therapist may not know how the family system will respond to the adolescent client’s change until the end of therapy. Therefore, it is especially important that the family system is involved throughout the treatment process to assure lasting changes (Guttman, 1991).

As noted previously, with adolescents, parents often present their children to treatment, and are part of the client system as well as major figures in the client’s family system. If therapists assume motivation or a lack of motivation at the onset of therapy, might parents of adolescents also have a perception of their child’s readiness to change that may or may not be congruent with the adolescent’s perception of his own readiness to change? Phares and Danforth (1994) found that mothers and teachers were more motivated to change adolescents’ problem behaviors than were the adolescents themselves. Duhig and Phares (2003) supported this finding when they found fathers and mothers were found to both have similar levels of distress regarding adolescent’s internalizing behaviors. In addition to the finding that one’s own distress is most important to change, rather than the distress of others, Duhig and Phares’s study showed a strong association between distress and motivation to change behavior for, fathers, mothers, and adolescents.

Duhig and Phares (2003) also noted the importance of considering the perceptions of both parents in that there may be differences between the two. Their
research showed that mothers were bothered and therefore motivated to change, both internalizing and externalizing behaviors, while fathers where only sufficiently motivated to change externalizing behaviors. Just as dissonance in the therapeutic relationship leads to frustration and decreased effectiveness, different perceptions of readiness to change on the parent’s part will likely lead to similar results. The parent’s may begin implementing new strategies at home and be frustrated when the adolescent does not change her behavior accordingly. It appears just as important to know whether parents’ perceptions of their adolescent’s level of motivation are in line with the adolescent’s self-perception of their motivational level and if this is related to therapeutic progress. The fifth research question of this study is designed to assess this and states, “Is there a difference between the adolescent’s motivation score, as measured by the URICA, when compared with that of his or her parent motivation score derived from the P-PCMI?” and the sixth question states, (a) “Is the congruence between the adolescent’s and parent’s motivation scores, as measured by the URICA and P-PCMI, related to the adolescent’s reported progress in therapy?” and, (b) “Is the congruence between the adolescent’s and parent’s motivation scores, as measured by the URICA and P-PCMI, related to the parent’s reported level of the adolescent’s progress in therapy?”

Summary of Literature

Several researchers, including Prochaska et al. (1992) and Hanna (2000), have recognized motivation as an important factor to consider when a client is approaching change. Miller and Rollnick (1991, 2002) have added that when a therapist fails to consider the client’s level of motivation, therapy is much less effective due to a
phenomenon they identify as “dissonance.” Butler and Bird (2000) have identified the process that this lack of consideration leads to (struggle) as a systemic process that frustrates both the client and therapist, preventing effective movement toward the treatment goals.

For adolescents, family therapy is often a major component of their treatment, and a necessary one for lasting change (Guttman, 1991). Because family therapy expands the therapeutic system from the therapist and client to the therapist, client, and their parent(s) the impact of motivation may become even more pronounced. Parents are often a source of extrinsic motivation, which typically does not result in change, unless the adolescent has within him/herself a sufficient level of intrinsic motivation that they are ready, willing, and able to change. If the parent’s perceives the adolescent’s motivation at a different level than the adolescent client views his/her own level of motivation, this might produce a level of dissonance sufficient to interfere with effective therapy.

This study seeks to explore perceptions of motivation from three sources, namely (a) where adolescent clients perceive their own level of motivation to be, (b) the level of congruence between the adolescent client’s self report and their therapist’s perception of the adolescent client’s level of motivation, and (c) whether parents, involved in family therapy with their adolescent clients in a RTC, perceive their son or daughter’s level of motivation to be at the same level their son or daughter perceives their own level of motivation. In addition, the study seek to examine whether congruence between perceptions are related to the adolescent’s progress in therapy.
Research Questions

1. Where do adolescents' URICA scores place them along the continuum of change, as proposed by DiClemente and Prochaska (1984)?

2. When grouped according to their length of time in treatment (Phase 1 or Phase 2), where do adolescents' URICA scores place them along the continuum of change?

3. Is there a difference between the adolescent's motivation scores on the URICA, when compared with that of his or her therapist motivation score derived from the T-PCMI?

4. (a) Is the congruence between the adolescent's and therapist's motivation scores, as measured by the URICA and the T-PCMI, related to the adolescent's reported progress in therapy?

   (b) Is the congruence between the adolescent's and therapist's motivation scores, as measured by the URICA and the T-PCMI, related to the therapist's reported level of the adolescent's progress in therapy?

5. Is there a difference between the adolescent's motivation score, as measured by the URICA, when compared with that of his or her parent motivation score derived from the P-PCMI?

6. (a) Is the congruence between the adolescent's and parent's motivation scores, as measured by the URICA and P-PCMI, related to the adolescent's reported progress in therapy?
(b) Is the congruence between the adolescent’s and parent’s motivation scores, as measured by the URICA and P-PCMI, related to the parent’s reported level of the adolescent’s progress in therapy?
CHAPTER III

METHODS

Introduction

This study examined adolescent’s level of motivation to change. It also examined the congruence between adolescents’ perception of their motivation to change with that of their therapists and parents, and whether this congruence may be related to progress in therapy. Ten adolescents residing in an RTC and participating in weekly family therapy, their therapist, and one of their parents completed a packet containing several instruments. Adolescents completed a sociodemographic instrument, the University of Rhode Island Change Assessment (URICA), and a validity instrument composed of defensiveness and social desirability scales derived from the Minnesota Multiphasic Personality Inventory – A (MMPI-A; adolescent version). Parents and therapists completed a sociodemographic instrument, a revised version of the University of Rhode Island Change Assessment (URICA), and a validity instrument derived from the Minnesota Multiphasic Personality Inventory – 2 (MMPI-2; adult version). The data were primarily analyzed using descriptive statistics and Mann-Whitney $U$ Tests.

Procedures

Sample

A convenience sample of adolescents residing in a residential treatment center (RTC), the adolescents’ therapists, and the adolescents’ parents were invited to participate in the study. Adolescents included in the study were from different
geographical regions of the United States. Their ages ranged from 14 to 17, with a mean age of 15.70 (SD = 1.06), and their grades in school ranged from eight to 12. All of the students described themselves as either Caucasian (n = 7) or marked the “other” category (n = 3). In this sample an equal number of males (n = 5) and females (n = 5) were represented.

In order to address each research question, it was necessary that the therapist of the adolescent and the adolescent’s parent(s) be willing to participate. Thus, the sample consisted of 10 adolescents, 4 therapists, and 10 parents. If one party chose not to participate, the remaining parties’ data were excluded if their data no longer assisted in answering the research questions. Participants were excluded if: (a) a therapist was unwilling to participate, then the therapist’s adolescent clients and clients’ parents were excluded from the study, (b) an adolescent choose not to participate, the adolescent’s therapist was still involved in the study only if the therapist had other clients who were participating in the study, and (c) an adolescent chose not to participate, the adolescent client’s parent was excluded.

Sample Selection

Involvement of the agency administration and therapists. Cooperation for involvement of the adolescents and therapists in this study was sought from administrators of the RTC. A presentation to the administrators provided an understanding of the study and how the adolescents, therapists, and parents would be involved. The presentation addressed: (a) how perceived motivation towards change is a critical factor in the therapeutic process and overall outcome, (b) the critical nature of
congruence of perceptions, (c) instruments that adolescents, therapists and parents would complete that would allow for assessing for perceptions of motivation to change, (d) role of the agency and therapists in facilitating the study, and (e) how information gleaned from the study would be brought back to the agency for their review.

After receiving approval for the study from the Utah State University Institutional Review Board (USU IRB) and the RTC administrators, the researchers contacted therapists at the RTC. A meeting was held in which the researchers (a) sought therapists’ participation and answered questions about the study, (b) discussed with therapists their role in the study and how to protect the confidentiality of the participants, (c) provided therapists with, and discussed, the Letter of Informed Consent for them to personally sign, (d) provided therapists with Letters of Informed Consent (parents) and Assent (adolescents), and discussed with the therapists strategies to facilitate acquiring parental consent and assent from the adolescents for participation, and protocol for follow-up if necessary for those who did not immediately respond, (e) encouraged therapists to acquire signed Letters of Informed Consent from the parents and Assent from the adolescents, (f) provided therapists with the packet of instruments for the parents and adolescents to complete, and (g) discussed with the therapists the administration of the instruments.

**Therapist selection.** All therapists currently involved at the RTC where the study was conducted were invited to participate. Eight out of nine therapists consented to participate in the study; however, the number of therapists actually involved in the study was reduced to four after excluding those with no participating clients. All of the participating therapists were Masters level therapists, with licensure either in social work
(n = 2) or marriage and family therapy (n = 2). There were an equal number of males (n = 2) and females (n = 2). All therapists described themselves as Caucasian with ages ranging between 31 and 40.

Adolescent selection. All adolescents residing in the RTC had the study explained to them by the researcher and were invited to be involved. Adolescents were given a Letter of Informed Assent to read along with as the researcher explained the study. Adolescents then had the opportunity to ask questions, and sign the Letter of Informed Assent. Thirty-four students returned signed Letters of Informed Assent. The researchers kept one copy of the Letters of Informed Assent and the adolescents kept one copy for themselves. Parents of adolescents desiring to be involved in the study were sent a Letter of Informed Consent. Only adolescents whose parents returned a signed Letter of Informed Consent were included in the study. Thirteen parents returned signed Letters of Informed Consent. Three adolescents dropped out of the study resulting in a final adolescent sample size of ten (N = 10).

Parental selection. Parents of adolescents who desired to be involved in the study were sent a Letter of Informed Consent by mail along with an explanation of the study from the researcher. They had an opportunity to ask questions and were invited to sign and return the Letter of Informed Consent in the self-addressed stamped envelope provided. Thirteen parents consented to participate in the research and allow their son or daughter to participate. All of these participants returned completed research instruments; however, three were excluded due to their son or daughter dropping out of the study (N = 10). Their ages ranged from 31 to 60 with the modal age category being 41 to 50. All of the participating parents described themselves as Caucasian, nine were female and one
was male. All of the participating parents had completed some post-high school education, ranging from trade school to doctorate degree.

**Administration of Research Instruments**

Research instruments were administered to therapists, adolescents, and the parent(s) of the adolescents. The following describes how this administration proceeded.

*Administration of the research instruments to the therapists.* Therapists received a Letter of Informed Consent from the researchers. After the therapist signed and returned the Letter of Informed Consent, the researchers provided them with a packet of four research instruments. The therapist completed two of the four instruments one time for him or herself, while the second two instruments were completed in reference to each adolescent client the therapist had participating in the study. The first two instruments included the Therapist Sociodemographic Data Sheet (T-SDS) and the Therapist and Parent Validity Scale (TP-VS). The T-SDS (see Appendix A) takes approximately five minutes to complete and the TP-VS (see Appendix B) takes 10 minutes to complete. The remaining two instruments, given for each adolescent client, included the Therapist’s Perception of the Client’s Motivation Instrument (T-PCMI), and the therapist portion of the Adolescent Sociodemographic Data Sheet (A-SDS). The T-PCMI (see Appendix C) takes 10 to 15 minutes to complete, and the therapist portion of the A-SDS takes five minutes or less. Therapists sent their completed instruments in a postage-paid envelope to the researchers. Each instrument was individually coded to match the therapist’s responses to those of their clients and clients’ parents.
Administration of the research instruments to the parents. Once the researchers had received the Letter of Informed Consent from a parent, the therapist mailed the research packet to them. The packet consisted of three instruments, the Parental Sociodemographic Data Sheet (P-SDS; see Appendix D), the Validity Scale (TP-VS; see Appendix B), and the Parental Perception of the Client's Motivation Instrument (P-PCMI; see Appendix E). The instruments could be completed in less than 45 minutes. Therapists encouraged the parents to complete and submit the instruments to the researchers within three working days. Each of the parents' instruments was individually coded to match their responses to those of their adolescents, and no identifying information was attached to the completed instruments. The return envelope was addressed directly to the researchers.

Administration of the research instruments to the adolescents. When the researcher received both the Letter of Informed Consent from the parent and the signed Letter of Informed Assent from the adolescent, the therapist provided the adolescents with the research packet. The adolescent packet consisted of a sociodemographic data sheet (A-SDS; see Appendix F), the Adolescent Validity Scale (A-VS, see Appendix G), and the University of Rhode Island Change Assessment (URICA, see Appendix H). These instruments could be completed in less than 45 minutes. A stamped and coded envelope addressed to the researchers was provided to the youth. Adolescents were asked to send their completed instruments directly to the researchers in order to assure confidentiality. Each of the adolescents' instruments was individually coded to match the adolescent's responses to those of his or her therapist's and parent's, and no identifying
information was attached to the completed information. All completed instruments were mailed directly to the researchers for analysis.

The researchers communicated with the therapists which instruments had been returned. Parents who had not returned the instruments within the given time frame were first contacted by the therapist through an email written by the researchers. If a response to the email had not been received within 14 days, the therapist then called the parent to ascertain if he or she was still willing to participate and if so, when the instruments would be returned.

Institutional Review Board

This study was submitted to the Utah State University Institutional Review Board for approval. Modifications suggested by the IRB were incorporated so that the standards required for human subject research were met. The researchers of the study completed IRB certification, that certification expires January of 2008.

Measures

Sociodemographic Instrument for Adolescents, Parents and Therapists.

A sociodemographic instrument was designed for therapists, adolescents, and parent(s). The “Adolescent Sociodemographic Sheet (A-SDS)” is an 11 item instrument designed to collect data in three areas: personal characteristics (age, gender, grade in school, and ethnicity), service receipt (length of time at LRA, previous places and length of treatment, and presenting problem), and diagnostic information [primary diagnosis, treatment focus, Global Assessment of Functioning (GAF) score, and Global Assessment
of Relational Functioning (GARF) score]. The third area of the A-SDS, the diagnostic
information portion, was completed by the therapist. The therapist’s instrument is a nine-
item instrument referred to as the “Therapist Sociodemographic Sheet (T-SDS),” and
collected data in three areas, including personal characteristics (gender, age, and
ethnicity), education (degree acquired), and professional experience (licensure, years
experience, model of therapy, time at LRA, and past experience). The parental instrument
was titled, “Parent Sociodemographic Sheet (P-SDS)” and collected data in two areas,
including personal characteristics (gender, age, ethnicity, marital status, and state of
residence), and basic SES data (level of income, educational level, and occupation). The
P-SDS is an eight item instrument.

Validity Scale Instruments

Therapist and Parent Validity Scale. An instrument designed to assess validity,
composed of items comprising the Lie (L, 15 items) and Defensiveness (K, 30 items)
scales from the Minnesota Multiphasic Inventory – 2 (MMPI-2) was included in the
study. In the MMPI-2, the L scale is designed to detect individuals attempting to place
themselves in a favorable light. The standardized mean score for males on the L scale is
3.53 with a standard deviation of 2.28, and the standardized mean score for women is
3.56 with a standard deviation of 2.08 (Butcher, Dahlstrom, Graham, Tellegen, &
Kaemmer, 1989). The K scale is a 30-item scale designed to detect individuals who
respond defensively to questions. The mean score for the K scale is 15.30 for males and
15.03 for females with a standard deviation of 4.76 and 4.58, respectively (Butcher et al.).
One item from the K scale was included in the L scale so the total number of items for
this measure was 44. This instrument was named the Therapist and Parent Validity Scale (TP-VS).

Therapists’ and parents’ L scale and K scale mean scores, with standard deviations, are shown in Table 1. Non-clinical norms for males and females are included (Butcher et al., 1989); t scores were derived based on mean scores using the MMPI-2 manual and MMPI-2 scoring sheet and are also shown in Table 1 (Butcher et al.). The clinical “cutoff” score is that score that has a t score of 65 or greater.

One of the parents completed the TP-VS in reference to another person and was therefore excluded from this analysis although included in the rest of the analysis, making the number of parents for this measure nine. Due to the small sample size and only having one male parent, it was not possible to analyze the scores by gender. The mean score for therapists on the L scale was 2.75 (SD = .96). This is lower than the national averages of 3.53 (SD = 2.28) and 3.56 (SD = 2.08) for males and females respectively, but is within one standard deviation of the norm. This likely indicates that the therapists are not trying to portray themselves in a more favorable light, but most likely answered the items honestly. The standard deviation is small, indicating that although there is a small number being described, their scores did not vary much around the mean.

The therapists’ mean score on the K scale (M = 16.50, SD = 6.24) was close to the national averages for males (M = 15.30, SD = 4.76) and females (M = 15.03, SD = 4.58). Therapists scored higher than the national norms, but again are within one standard deviation of the mean on the defensiveness scale. Their t score of 52 indicates that they did not likely respond to the measure in a defensive manner and are their scores were within the modal range (Butcher et al., 1989).
Table 1

*Therapist and Parent Validity Scores*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Therapist</th>
<th>Parent</th>
<th>National Norms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n = 4$</td>
<td>$n = 9$</td>
<td>Males</td>
</tr>
<tr>
<td>L scale t score</td>
<td>47.00</td>
<td>62.00</td>
<td>50.00</td>
</tr>
<tr>
<td>$M$</td>
<td>2.75</td>
<td>6.33</td>
<td>3.53</td>
</tr>
<tr>
<td>$SD$</td>
<td>.96</td>
<td>2.00</td>
<td>2.28</td>
</tr>
<tr>
<td>K scale t score</td>
<td>52.00</td>
<td>52.00</td>
<td>50.00</td>
</tr>
<tr>
<td>$M$</td>
<td>16.50</td>
<td>18.44</td>
<td>15.30</td>
</tr>
<tr>
<td>$SD$</td>
<td>6.24</td>
<td>4.42</td>
<td>4.76</td>
</tr>
</tbody>
</table>

The parent’s mean score ($M = 6.33, SD = 2.00$) for the L scale was higher than the national averages for males ($M = 3.53, SD = 2.28$) and females ($M = 3.56, SD = 2.08$). They are higher than the national norms by more than one standard deviation, indicating that the parents may be trying to portray themselves in a more favorable light, either consciously or unconsciously. Based on the parent’s average $t$ score of 62, the MMPI-2 suggests that their answers are probably still valid, but they may be somewhat defensive. This $t$ score may also suggest that these parents were overly conventional or conforming (Butcher et al., 1989).

The parent’s scores on the K scale ($M = 18.44, SD = 4.42$) were also above the national averages for both males ($M = 15.30, SD = 4.76$) and females ($M = 15.03, SD = 4.58$), although they are within one standard deviation of the mean. This indicates a possibility that the parents answered the items in a somewhat defensive manner, though not likely significantly more defensive than the national norm. Parents’ average $t$ score of 52 suggested that these parents were within the modal range and have answered without undue defensiveness (Butcher et al., 1989).
Adolescent Validity Scale. The instrument designed to assess validity for the adolescents in this study was comprised of items from the Lie (L, 14 items) and Defensiveness (K, 30 items) scales taken from the Minnesota Multiphasic Inventory – Adolescent (MMPI-A) (Butcher, Graham, Williams, & Kaemmer, 1992). As in the MMPI-2, the purpose of the L scale in the MMPI-A was to detect individuals attempting to place themselves in a favorable light. Archer, White, and Orvin (1979) found that elevated L scores were correlated with longer hospitalizations for adolescents. A moderately elevated L score has been shown to indicate desirable responding or random responding (Brophy, 2003). When determining national norms, the national mean L score for males was 2.94 with a standard deviation of 2.34, and the national mean L score for females was 2.26 with a standard deviation of 1.92 (Butcher et al.).

The K scale was designed to detect individuals who respond defensively to questions. The mean K score for males was 12.70 with a standard deviation of 4.73. The mean L score for females was 11.54 with a standard deviation of 4.39 (Butcher et al., 1992). Most of the items in this instrument were identical to the items in the TP-VS; however, one item was dropped from the MMPI-2 Lie scale when the MMPI-A was developed because it was inappropriate for this age group. In addition, the wording of several questions was changed to make the instrument more age appropriate. As in the TP-VS, one item was included in both scales, which resulted in 43 the total items for this instrument 43. This instrument has been named the Adolescent Validity Scale (A-VS).

Table 2 below shows the t scores, mean score, and standard deviation for the adolescents in this study as well as the national norms (Butcher et al., 1992). The
Table 2

*Adolescent Validity Scores*

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Males</th>
<th>Females</th>
<th>National Norms</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Males</td>
</tr>
<tr>
<td>L scale</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>t</em> score</td>
<td>44.00</td>
<td>43.00</td>
<td>44.00</td>
<td>50.00</td>
</tr>
<tr>
<td><em>M</em></td>
<td>1.40</td>
<td>1.20</td>
<td>1.60</td>
<td>2.94</td>
</tr>
<tr>
<td><em>SD</em></td>
<td>3.44</td>
<td>.84</td>
<td>1.52</td>
<td>2.34</td>
</tr>
<tr>
<td>K scale</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>t</em> score</td>
<td>47.00</td>
<td>50.00</td>
<td>45.00</td>
<td>50.00</td>
</tr>
<tr>
<td><em>M</em></td>
<td>11.30</td>
<td>12.40</td>
<td>10.20</td>
<td>12.70</td>
</tr>
<tr>
<td><em>SD</em></td>
<td>3.09</td>
<td>3.44</td>
<td>2.59</td>
<td>4.73</td>
</tr>
</tbody>
</table>

adolescents as a group had a mean score of 1.40 (*SD* = 3.44) on the L scale. This was lower than the national norms, indicating that the adolescents were not likely attempting to portray themselves in a more favorable light. Adolescent males (*M* = 1.20, *SD* = .84) scored lower than adolescent females (*M* = 1.60, *SD* = 1.52), however, both were within one standard deviation of their national comparisons. Based on the *t* score of 43 and 44, for males and females respectively, the MMPI-A manual indicated that both groups might have over-emphasized their pathology or possibly even faked bad (Butcher et al., 1992)

Adolescents had a group mean score of 11.30 (*SD* = 3.09) on the K scale, with a *t* score of 47. Adolescents males (*M* = 12.40, *SD* = 3.44) and females (*M* = 10.20, *SD* = 2.59) scored within the modal range for this instrument (Butcher et al., 1992). This *t* score indicates that the adolescent sample appeared to respond to the A-VS openly and in a nondefensive manner.
Perception of Change Instruments

Adolescent perception of change readiness. The University of Rhode Island Change Assessment (URICA) is a 32-item self-administered questionnaire addressing readiness to change (McConnaughey et al., 1983). Greenstein et al. (1999) as well as Dozois et al. (2004) provided psychometric properties scores on the instrument for adolescents. A coefficient alpha of .79 for the total URICA was found by Dozois et al. (2004) and Greenstein et al. reported Cronbach’s alpha of .77 for precontemplation, .80 for contemplation, .84 for action, and .82 for maintenance. Predictive validity was reported by Dozois et al. They found that those who scored in the action stage on the URICA were more likely to complete cognitive behavioral therapy (CBT) for anxiety management than those in other stages using univariate F-tests, $F(1,79) = 9.02, p < 0.05$.

The URICA provided an understanding of the adolescent’s personal perception of their level of change. Adolescents answered each item on the instrument (e.g., “As far as I’m concerned, I don’t have any problems that need changing”) by responding on a 5-point Likert scale ranging from 1 = Strongly Disagree to 5 = Strongly Agree.

The 32 items of the URICA were divided into four subscales, with eight questions in each subscale. The scores for these eight items were totaled to give each subscale’s score. The subscale with the highest score was associated with the participant’s current stage of change, except in the case of the preparation stage. When the participant’s scores on both the contemplation and action subscales were the highest of all four scores, Prochaska et al. (1992) indicated that they were to be placed in the preparation stage.

Adolescent perception of progress. Two additional items were added by the researchers at the end of the URICA to help answer the fourth and sixth research
questions. The first of these items stated, "I am making progress toward my treatment goals." And the second item stated, "I would recommend this program to a friend my age that was going through the same kind of problems as I am." Both items were answered on a 5-point Likert, ranging from 1 to 5, where 1 meant "I strongly disagree" and 5 meant "I strongly agree." These final two items were examined separately where the first provided a perception of progress in therapy, and the second assessed their perception of satisfaction with therapy at the RTC. The second question was determined to be unhelpful in answering any of the research questions and dropped from the analyses.

**Therapist perception of the client's readiness to change.** Retaining the same 32 items in the URICA, the researchers revised the URICA so as to assess the therapist’s perception of the client’s readiness for change. It was the intent in the revision to maintain the same content and questions with only modest revision so that the question reflected the perception of the therapist. For example the statement, "It might be worthwhile to work on my problem" was revised to read, "In my opinion, the client perceives it might be worthwhile to work on his/her problem." When the revision was completed, the instrument was renamed, the "Therapists Perception of the Client’s Motivation Instrument" (T-PCMI). To assure that the content of each of the items had been retained (i.e., face validity), the original URICA along with the T-PCMI was provided to several professionals in the area of education, therapy, and adolescence for review. Based on their feedback, the items of the T-PCMI did retain the original meaning. The T-PCMI format provided an understanding of the therapist’s perception of the client’s readiness for change. Therapists answered each item (e.g., "In my opinion, the client does not perceive him/herself as having any problems that need changing") by
responding on a 5-point Likert scale ranging from 1 = Strongly Disagree to 5 = Strongly Agree.

The 32 items of the T-PCMI were divided into four subscales for scoring, just like the URICA, with eight questions in each subscale. The scores for these eight items were totaled to get a subscale score. The subscale with the highest score was associated with the therapist’s view of the client’s current stage of change. If the precontemplation and action subscale score were both the two highest score, the participant was considered to be in the preparation stage (Prochaska et al., 1992).

Therapist perception of progress. Similar to the adolescent instrument, an item was added to assess the therapists’ perceptions of progress in therapy. This item that was added to help answer the fourth and sixth research questions stated; “In my opinion, this client is making progress toward his/her treatment goals” and was answered on a 5-point Likert, ranging from 1 to 5, where 1 meant “I strongly disagree” and 5 meant “I strongly agree.” This final item was examined separately.

Parental perception of the adolescent’s readiness to change. As with the T-PCMI, the researchers revised the URICA so as to assess the parent’s perception of the client’s readiness for change. It was the intent in the revision to maintain the same content and questions with only modest revision. For example, the statement, “It might be worthwhile to work on my problem.” was revised to read, “In my opinion, my son/daughter perceives it might be worthwhile to work on his/her problem.” Parents answered each item (e.g., “In my opinion, my son/daughter does not perceive him/herself as having any problems that need changing”) by responding on a 5-point Likert scale ranging from 1 = Strongly Disagree to 5 = Strongly Agree.
When the revision was completed, the instrument was renamed, the "Parental Perception of the Client's Motivation Instrument" (P-PCMI). To assure that the content of each of the items had been retained (i.e., face validity), the original URICA along with the P-PCMI was provided to several professionals in the area of education, therapy, and adolescence for review. Based on their feedback, the P-PCMI did retain the original content.

The P-PCMI format provided the researchers with an understanding of the parent's perception of their son/daughter's readiness for change. The 32 items of the P-PCMI were divided into four subscales for scoring, again just like the URICA, with eight questions in each subscale. The scores for these eight items were totaled for a subscale's score. The subscale with the highest score was determined to be the parent's view of the client's current stage of change. If the precontemplation and action subscale score were both the two highest score, the participant was considered to be in the preparation stage (Prochaska et al., 1992).

*Parent perception of progress.* Two additional items were added by the researchers at the end of the P-PCMI to help answer the fourth and sixth research questions. The first of these items stated, "In my opinion, my son/daughter is making progress toward his/her treatment goals." And the second item stated, "I would recommend this program to a friend who had a son/daughter that was in the same situation as my son/daughter." Both items were answered on a 5-point Likert, ranging from 1 to 5, where 1 meant "I strongly disagree" and 5 meant "I strongly agree." These final two items were examined separately where the first provided a perception of progress in therapy, and the second assessed their perception of satisfaction with therapy.
at the RTC. The second question was determined to be unhelpful in answering any of the research questions and dropped from the analyses.

Analysis

Research Design

Descriptive analyses. In order to answer each research question, the data collected in this study were primarily analyzed using descriptive statistics. The first question of interest was, “Where do adolescents’ URICA scores place them along the continuum of change, as proposed by Prochaska and DiClemente (1984)?” In examining this question, the URICA was scored as described above, giving the researchers a clarification of the level of motivation for each adolescent. Once motivation scores were calculated individually, mean scores and standard deviations were calculated for each stage of each URICA. The descriptive statistics were calculated, first for the group as a whole, and secondly by gender.

The second research question of interest stated, “When grouped according to their length of time in treatment (Phase 1 or Phase 2), where do adolescents’ URICA scores place them along the continuum of change?” Phase 1 included those who have been at the RTC less than five months, while Phase 2 included those adolescents who have been at the RTC longer than five months. The average stay at this RTC is 10 months, so those who have been there five months or less were likely in a transition phase where they were assimilating and accommodating to the RTC. On the other hand, those that have been at the RTC longer than 5 months were further into their treatment and possibly moving toward finishing treatment. The length of stay at the RTC for those in Phase 1 (n = 4,
40%) ranged from 2 to 5 months ($M = 3.75, SD = 1.5$) while the length of stay for those in Phase 2 ($n = 6, 60\%)$ ranges from 8 to 31 months ($M = 15.00, SD = 9.76$). 

As with the first research question, mean scores and standard deviations were calculated for each stage of therapy group as a whole and by gender. A Mann-Whitney $U$ Test was conducted to test for any statistically significant differences between the two groups (Phase 1 and Phase 2) at each stage. This non-parametric test was chosen because of its ability to compare small sample sizes such as those of this study ($n = 4$ and $n = 6$ for Phases 1 and 2, respectively).

Comparing of derived scores. The third and fifth research questions, “Is there a difference between the adolescent’s motivation scores on the URICA, when compared with that of his or her therapist motivation score derived from the T-PCMI?” and “Is there a difference between the adolescent’s motivation score, as measured by the URICA, when compared with that of his or her parent motivation score derived from the P-PCMI?” were answered using the scores calculated for the adolescents’ URICA, therapists’ T-PCMI and parents’ P-PCMI. The adolescents’ scores, which represented their perceived level of motivation, were compared with those of their therapists for each subscale of the URICA and T-PCMI. The adolescents’ scores were then compared with those of their parents for each subscale of the URICA and P-PCMI. Mean scores and standard deviations were examined for trends.

An examination for significant difference in scores. Considering the small “$n$”, the non-parametric Mann-Whitney $U$ Test was the selected statistical procedure for comparing adolescent’s URICA scores with those of their therapist and parent. The purpose of the Mann-Whitney $U$ Test was to compare two independent random samples.
This study used a convenience sample, which is a limitation. Using any inferential statistics without random, independent sampling jeopardizes the reliability of the findings; however, this test was selected, acknowledging the limitation of a convenience sample. In contrast to parametric tests, non-parametric tests, such as the Mann-Whitney U Test, are designed to assess for differences between samples that do not have homogeneity (Howell, 2002). Homogeneity cannot be assumed in small sample sizes, so using the Mann-Whitney U Test allows tests for clinical significance despite this limitation.

Two Mann-Whitney U Tests were conducted with the independent variables being therapists’ or parents’ perceptions of motivation. Other factors, such as adolescent gender and phase of therapy, were not included in this analysis because they would result in such small group sizes. Table 3 illustrates the comparisons used to answer the third and fifth research questions.

Progress in therapy. Two of the research questions were developed to examine, in a cursory manner, progress in therapy from the perceptions of the adolescents, therapists, and parents. The desire was to examine if there might be a relationship between progress in therapy and congruence of perceptions of motivation to change.

Table 3

Perception of Level of Motivation for Change Comparisons

<table>
<thead>
<tr>
<th>Level of Motivation to Change</th>
<th>Therapists’ Perception</th>
<th>Parental Perception</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescents’ Perception</td>
<td>Pr C A M</td>
<td>Pr C A M</td>
</tr>
</tbody>
</table>

*Note.* “P”, “C”, “A”, and “M” refer to the instrument subscales of precontemplation, contemplation, action and maintenance.
The fourth research question asked, (a) "Is the congruence between the adolescent’s and therapist’s motivation scores, as measured by the URICA and the T-PCMI, related to the adolescent’s reported progress in therapy?" and, (b) "Is the congruence between the adolescent’s and therapist’s motivation scores, as measured by the URICA and the T-PCMI, related to the therapist’s reported level of the adolescent’s progress in therapy?"

The final research question asked, (a) "Is the congruence between the adolescent’s and parent’s motivation scores, as measured by the URICA and P-PCMI, related to the adolescent’s reported progress in therapy?" and (b) "Is the congruence between the adolescent’s and parent’s motivation scores, as measured by the URICA and P-PCMI, related to the parent’s reported level of the adolescent’s progress in therapy?"

These questions were examined using a frequency table were each case was examined to formulate a theoretical connection between URICA, T-PCMI, and P-PCMI subscale scores and Item 33. Item 33 was added onto the URICA, T-PCMI, and P-PCMI, and was a measure of perception of progress in therapy that was answered on a 5-point Likert, ranging from 1 to 5, where 1 meant "I strongly disagree" and 5 meant "I strongly agree." The frequency table was examined for trends by looking at the scores of each case.
CHAPTER IV
RESULTS AND DISCUSSION

The purpose of this chapter was to present the results of the study and discuss their relevance to treatment of adolescents. Research question one and question two were answered using descriptive statistics to determine how motivated adolescents perceive themselves to be. Two Mann-Whitney U Tests were used with adolescent gender and phase of therapy as the independent variables to help answer these two research questions. Descriptive and inferential statistics were used to answer research questions three and five. A Mann-Whitney U Test was conducted for each of these research questions which addressed the level of congruence between perceptions of motivation between adolescents and therapists, and adolescents and parents. Descriptive statistics were used to answer research questions four and six. These two questions examined the level of congruence between perceptions of motivation as they relate to progress and satisfaction in therapy.

Research Question One

Where do adolescents’ URICA scores place them along the continuum of change, as proposed by Prochaska and DiClemente (1984)? Table 4 illustrates the adolescents’ mean scores on each subscale of the URICA along with standard deviations. Mean scores based on gender are also shown.
For the adolescent group as a whole, the contemplation stage \((M = 29.6, SD = 5.30)\), closely followed by the action stage \((M = 29.2, SD = 6.25)\), had the highest mean scores. When scoring the URICA, an equal score between the contemplation and action stages places the test-taker in, what Prochaska et al. (1992) refer to as the preparation stage.

Adolescent males reported scores that placed them in the contemplation stage of change \((M = 26.60, SD = 5.94)\), though their mean score on the action subscale \((M = 25.60, SD = 4.98)\) was very close to that of contemplation. Adolescent females, on the other hand, scored slightly higher on the action stage \((M = 32.80, SD = 5.51)\) than on the contemplation stage \((M = 32.60, SD = 2.30)\). An examination of the means illustrate, that it could be concluded that the female adolescents are likely in the preparation stage of change, while the male adolescents are likely in the contemplation stage of change. In general, however, in that group means were so closely related, it was concluded that most adolescents in the study perceived themselves to be in the preparation stage of change. Interpretatively, at this stage it is necessary for parents and therapists to encourage steps
toward action, and recognize that the adolescent client may not be sufficiently self-motivated to actually engage in a change of action without their support.

A Mann Whitney U Test was conducted with adolescent gender as the independent variable. Table 5 shows the results of this test. The Mann-Whitney U showed no significant rank difference at any stage between males and females for adolescent motivation, however, the rank difference at the action stage was very close to reaching statistical significance ($p = .056$). Future research, using a larger, random sample, should assess whether adolescent females may be more engaged in the action stage of change than are adolescent males.

Research Question Two

When grouped according to their length of time in treatment (Phase 1 or Phase 2), where do adolescents’ URICA scores place them along the continuum of change? In Table 6 the mean scores for adolescents’ perceived level of motivation according to their phase of therapy is depicted.

Table 5

*Mann Whitney Test for Difference of Motivation by Adolescent Gender*

<table>
<thead>
<tr>
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<tr>
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<td>Precontemplation</td>
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<tr>
<td>Contemplation</td>
<td>10</td>
</tr>
<tr>
<td>Action</td>
<td>10</td>
</tr>
<tr>
<td>Maintenance</td>
<td>10</td>
</tr>
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*$p < .05$.*
Table 6

Adolescent URICA Scores by Phase

<table>
<thead>
<tr>
<th></th>
<th>Precontemplation</th>
<th>Contemplation</th>
<th>Action</th>
<th>Maintenance</th>
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<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Group</td>
<td>n=10</td>
<td>16.90</td>
<td>3.93</td>
<td>29.60</td>
</tr>
<tr>
<td>Phase 1</td>
<td>4</td>
<td>15.75</td>
<td>2.99</td>
<td>29.75</td>
</tr>
<tr>
<td>Phase 2</td>
<td>6</td>
<td>17.67</td>
<td>4.55</td>
<td>29.50</td>
</tr>
</tbody>
</table>

Contemplation ($M = 29.75, SD = 3.40$) was the highest subscale on average for those adolescents in Phase 1, followed by action ($M = 28.00, SD = 6.06$). These data suggest that those in Phase 1 were likely in the contemplation stage of change, though moving into the preparation and action stages. The standard deviation for the contemplation stage was lower than the other stages, indicating there was less variation around the mean at this subscale, or in other words, there was less variation in this sample, one subject from the other. It is suggested from these findings that adolescents in Phase 1 are likely in the contemplation stage of change.

For those in Phase 2, action was the highest score ($M = 30.00, SD = 6.81$), closely followed by contemplation ($M = 29.50, SD = 5.09$). These data suggest that adolescents in Phase 2 were in the preparation stage of change, in that their scores for action and contemplation were only separated by $.50$. Adolescents in Phase 1 and Phase 2 appear to differ the most at the maintenance stage with mean scores of 21.00 ($SD = 7.07$) and 26.50 respectively ($SD = 9.09$) though whether this difference is clinically significant would need to be studied further. These data reflect a modest trend when one examines the movement from Phase 1 to Phase 2. The trend suggested is an increase in motivation for
change with the correlated assumption of greater responsibility for making change (self-efficacy) and, perhaps, that change being sufficiently internalized to be regarded as second order change. In other words, adolescents who were at the RTC more than 5 months may have been moving further from contemplation towards action, and may have perceived themselves as taking more steps toward maintenance than did those adolescents who were at the RTC less than 5 months.

A Mann-Whitney U Test was conducted to look at differences between the groups based on phase of therapy. Table 7 shows the results of this test.

When these data were examined in the context of the results presented in Table 6, a suggestive trend was noted. It appears from the data that there was progress towards increased motivation and an assumption of responsibility. While this trend may be observed from the data, there was no statically significant difference between the two phases at any stage, as illustrated in Table 7. Future research should study whether the trends noted in these data do indeed exist in other clinical populations. If, as found here, there is no significant difference in adolescents' motivation as they move from Phase 1 to Phase 2, future research should explore why adolescents are not less precontemplative and more action oriented as they prepare to exit treatment. One reason for the lack of

Table 7

<table>
<thead>
<tr>
<th>Mann Whitney Test for Difference of Motivation by Phase of Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>Precontemplation</td>
</tr>
<tr>
<td>Contemplation</td>
</tr>
<tr>
<td>Action</td>
</tr>
<tr>
<td>Maintenance</td>
</tr>
</tbody>
</table>
statistical difference between the adolescents in Phase 1 and those in Phase 2 in this sample may be due to the dichotomous nature of the groups. There were a couple of adolescents in Phase 2 who were at the RTC much longer than the average 10 months stay. Unique cases such as these may need to be analyzed as a separate group. Because there was no statistically significant difference shown between the adolescents in Phase 1 and those in Phase 2 for this sample, further analyses did not included phase of therapy as a variable.

Research Question Three

Is there a difference between the adolescent’s motivation scores on the URICA, when compared with that of his or her therapist motivation score derived from the T-PCMI? Table 8 includes the mean scores for therapists and adolescents on the T-PCMI and URICA at each stage and examined by adolescent gender. Therapists had a higher mean score for precontemplation ($M = 24.30, SD = 4.99$) and for maintenance ($M = 26.60, SD = 6.78$) than did adolescents whose mean scores for precontemplation and maintenance were $16.90 (SD = 3.39)$ and $24.30 (SD = 8.41)$, respectively. Adolescents scored themselves higher on the contemplation ($M = 29.60, SD = 5.30$) and action stages ($M = 29.20, SD = 6.26$) than did their therapists ($M = 26.40, SD = 6.11$ and $M = 26.70, SD = 4.83$ respectively). Assuming therapists have a better awareness of the level of motivation exhibited by the adolescents than they may have of themselves, their data might be interpreted to mean that the therapists saw two distinct groups, those who were still in the precontemplation stage, wondering if they needed or
Table 8

Comparison of Adolescent URICA and Therapist T-PCMI Scores

<table>
<thead>
<tr>
<th>Continuum of Change</th>
<th>Adolescent Group</th>
<th></th>
<th>Therapist Group</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>M</td>
<td>SD</td>
<td>n</td>
</tr>
<tr>
<td>Contemplation</td>
<td>5</td>
<td>18.40</td>
<td>3.98</td>
<td>5</td>
</tr>
<tr>
<td>Action</td>
<td>5</td>
<td>15.40</td>
<td>3.65</td>
<td>5</td>
</tr>
<tr>
<td>Maintenance</td>
<td>5</td>
<td>29.60</td>
<td>5.30</td>
<td>5</td>
</tr>
</tbody>
</table>

wanted to change, and those in the maintenance stage, or those who were taking action to maintain changes in attitude and behavior.

Mann-Whitney U Tests were conducted to determine if there was a significant difference between ranks for the adolescent’s perception of motivation and their therapist’s perception of motivation. Table 9 shows these results.

At the precontemplation stage a significant difference was found between adolescents as a group (Mean rank = 6.50) and therapists (Mean rank = 14.50) with

Table 9

Mann Whitney Test for Difference of Motivation Between Adolescent and Therapist

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Mann-Whitney U</th>
<th>Z</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplation</td>
<td>20</td>
<td>10.00</td>
<td>-3.03</td>
<td>.002**</td>
</tr>
<tr>
<td>Contemplation</td>
<td>20</td>
<td>38.00</td>
<td>- .91</td>
<td>.363</td>
</tr>
<tr>
<td>Action</td>
<td>20</td>
<td>36.00</td>
<td>-1.06</td>
<td>.289</td>
</tr>
<tr>
<td>Maintenance</td>
<td>20</td>
<td>41.50</td>
<td>-.64</td>
<td>.520</td>
</tr>
</tbody>
</table>

**p < .01.
adolescents perceiving themselves lower at this stage than therapists did, \((Z = -3.032, p = 0.002)\). There were no significant differences between adolescents’ and therapists’ perceptions found at any other stages.

Therapists may have rated adolescents significantly higher on the precontemplation subscale than the adolescents did for a couple of reasons. One possibility may be that therapists may have thought that the adolescents had not acquired adequate therapeutic insight into the problem(s) they brought with them to the RTC. This lack of psychological mindedness could interfere with their ability to recognize that they had a problem and thus, making the decision to do something different more difficult. If this were the case, and the adolescent did not feel it necessary to work on their attitude, emotion or behavior, manifest in the “problem” as perceived by the therapist, it would seem logical that the scores would be different. In this situation, it would seem appropriate for therapists to organize interventions in such a way that adolescents could recognize not only the problem(s) they faced, but also to enhance their motivation for change.

Another possibility might be that the adolescent was focused on a problem that they felt was significant, and of therapeutic importance, but not on that which the therapist viewed as a primary problem. In this case, the adolescents might not have rated themselves as high on the precontemplation subscale as their therapists would have. In this situation, a focused congruence on the problem would seem appropriate. To increase congruence, it would be important for therapists to either adjust their perception, focusing on that which the adolescent felt as critical to change, or work collaboratively with the adolescent to come to an agreement as to what was the therapeutic issue of relevance.
A third possible explanation for therapists scoring adolescents higher on the precontemplation subscale might be that the therapists did not recognize the adolescents’ acknowledgement of the problem, but did note that they were ineffectively progressing in therapy. If this were the situation, it is possible that the therapist may come to the conclusion that the adolescent did not recognize the problem or, even if he or she did, the adolescent was not adequately motivated to do anything about it.

Research Question Four

Research Question Four Part A

The fourth research question included two parts. The first part of question four stated, “Is the congruence between the adolescent’s and therapist’s motivation scores, as measured by the URICA and the T-PCMI, related to the adolescent’s reported progress in therapy?” Table 10 shows the adolescents’ and their therapists’ scores for each subscale on the URICA, and T-PCMI along with their reported perceptions of progress in therapy.

Each subscale score of the URICA and T-PCMI was the sum of eight items, each measured on a Likert scale with a possible range of 1 through 5. This made the possible range on each subscale a score from 8 through 40. The adolescents’ and therapists’ perceptions of progress in therapy were based on a Likert scale with a possible range of 1 through 5.

The adolescents’ perception of progress in therapy scores ranged from 2 through 5, with a 5 indicating greater progress in therapy. The modal rating of progress in therapy from the adolescents’ perspective was “4” (n = 4, 40%). The URICA and T-PCMI scores differed the most at the precontemplation stage, but there does not appear to be a trend
Table 10

Comparison of Adolescents’ and Therapists’ Perceptions of Adolescent Motivation

<table>
<thead>
<tr>
<th>Case</th>
<th>Adolescent</th>
<th>Therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>P</td>
<td>C</td>
</tr>
<tr>
<td>1</td>
<td>19</td>
<td>21</td>
</tr>
<tr>
<td>2</td>
<td>17</td>
<td>29</td>
</tr>
<tr>
<td>3</td>
<td>16</td>
<td>23</td>
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<tr>
<td>4</td>
<td>17</td>
<td>23</td>
</tr>
<tr>
<td>5</td>
<td>13</td>
<td>33</td>
</tr>
<tr>
<td>6</td>
<td>25</td>
<td>32</td>
</tr>
<tr>
<td>7</td>
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<td>32</td>
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<tr>
<td>8</td>
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<td>34</td>
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<td>9</td>
<td>14</td>
<td>34</td>
</tr>
<tr>
<td>10</td>
<td>12</td>
<td>35</td>
</tr>
</tbody>
</table>

*Note.* P, C, A, and M represent the four subscales or the URICA, and T-PCMI, namely precontemplation, contemplation, action, and maintenance. PP represents the perception of progress in therapy as measured by item 33 on the URICA and T-PCMI.

*Lowest Subscale Score*  
*Highest Subscale Score*

indicating that adolescents with a greater difference between URICA and T-PCMI scores report themselves as progressing more or less in therapy than adolescents with a lesser difference. The adolescent in case 1 rated his or her progress as a “2,” and had a lesser difference between his or her perception of motivation and the perception of his or her parent. However, the adolescent in case 9 had relatively large differences between his or her perception of motivation scores and that of his or her parent, yet rated his or her progress in as a “5.”

There do not appear to be any noticeable trends in the scores that would indicate that a relationship existed between the congruence of perception on any of the subscales and the adolescents’ perception of progress in therapy. The small sample size of this study made using any inferential statistics to answer this question unsound with groups so small, including one group where $n = 1$. Future research is needed to determine whether
or not a relationship would be found using a larger sample. Exploring the impact of congruence of perceptions of motivation on the progress of therapy is an area that needs further research. In order to do this, it would be important for future research to devise a more effective way of testing for progress in therapy, than the one used here, in addition to increasing the sample size. Perceptions of both the therapist and client should be considered, and perhaps some objective measure of progress could be included.

Research Question Four Part B

The second part of this research question states, "Is the congruence between the adolescent’s and therapist’s motivation scores, as measured by the URICA and the T-PCMI, related to the therapist’s reported level of the adolescent’s progress in therapy?"

The therapists’ perceptions of progress in therapy had an obtained range of 2 through 5, with a 5 indicating they perceived their adolescent client as having greater progress in therapy. The modal rating of progress in therapy from the therapists’ perspective was “4” ($n = 5$, 50%).

The therapist in case 4 rated his or clients’ progress as a “2” and also scored the highest for the precontemplation subscale leading to the greatest about of difference between adolescent and therapist precontemplation subscale scores. In other words, the therapist that perceived their client as making the least amount of progress in therapy also has the highest level of discrepancy between perceptions of motivation for the precontemplation subscale. The therapist in case 2 rated his or her client’s progress as a “5” and their scores only differed by one point on the precontemplation subscale. This appears to tentatively support the existence of a relationship between congruence
between adolescent’s and therapist’s motivation scores and progress in therapy, however, not all of the cases follow this trend. For example, the therapist in case 5 also rated his or her client’s progress as a “5,” but did not appear to have a high level of congruence between perceptions of motivation, and even had the greatest difference at the maintenance subscale.

Overall, there were no significant, statistical or clinical trends in the data that would lead to a conclusion about whether a relationship existed between the congruence of the adolescents’ and therapists’ perceptions of the adolescent’s motivation to change and the therapist’s perception of the adolescent’s progress in therapy. Further research is needed to determine this.

Research Question Five

Is there a difference between the adolescent’s motivation score, as measured by the URICA, when compared with that of his or her parent motivation score derived from the P-PCMI? The parent’s descriptive statistics for the P-PCMI are shown in Table II along with the adolescent’s descriptive statistics as a group and by gender.

Parents’ mean P-PCMI subscale scores were lower than adolescents’ mean URICA subscale scores for every stage except precontemplation, in which parents’ scores ($M = 25.10, SD = 7.81$) were higher than adolescents’ ($M = 16.90, SD = 3.39$). This may indicate that, overall, adolescents appeared to perceive themselves as more motivated than parents perceived them.
Table II

Comparison of Adolescent URICA and Parent P-PCMI scores

<table>
<thead>
<tr>
<th></th>
<th>Precontemplation</th>
<th>Continuum of Change</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Adolescent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>10</td>
<td>16.90</td>
<td>3.93</td>
<td>29.60</td>
<td>5.30</td>
<td>29.20</td>
</tr>
<tr>
<td>Males</td>
<td>5</td>
<td>18.40</td>
<td>3.98</td>
<td>26.60</td>
<td>5.94</td>
<td>25.60</td>
</tr>
<tr>
<td>Females</td>
<td>5</td>
<td>15.40</td>
<td>3.65</td>
<td>32.60</td>
<td>2.30</td>
<td>32.80</td>
</tr>
<tr>
<td>Parent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>10</td>
<td>25.10</td>
<td>7.81</td>
<td>26.20</td>
<td>6.20</td>
<td>28.70</td>
</tr>
<tr>
<td>Males</td>
<td>5</td>
<td>27.60</td>
<td>7.30</td>
<td>22.20</td>
<td>6.34</td>
<td>25.00</td>
</tr>
<tr>
<td>Females</td>
<td>5</td>
<td>22.60</td>
<td>8.26</td>
<td>30.20</td>
<td>2.49</td>
<td>32.40</td>
</tr>
</tbody>
</table>

The highest subscale score for parents was action (M = 28.70, SD = 5.54) suggesting that overall, parents considered their adolescents to be in the action stage of change. This finding suggests that parents perceived adolescents to be in a higher motivational stage than adolescents perceived themselves. This may indicate that parents felt adolescents were actively making more changes than the adolescents felt they were making or expect that they should be making changes since they are involved in such extensive treatment.

A Mann-Whitney U Test was conducted to compare adolescent scores and parent scores over adolescent motivation. Table 12 shows that a Mann-Whitney U Test resulted in a significant difference between adolescents as a group (Mean rank = 6.95) and parents (Mean rank = 14.05) at the precontemplation stage, with adolescents perceiving themselves lower at this stage than parents did, (Z = -2.690, p = .005). There were no significant differences between adolescents’ and therapists’ perceptions found at any other stages.
Table 12

*Mann Whitney Test for Difference of Motivation between Adolescent and Parent*

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Mann-Whitney U</th>
<th>Z</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplation</td>
<td>20</td>
<td>14.50</td>
<td>-2.69</td>
<td>.005*</td>
</tr>
<tr>
<td>Contemplation</td>
<td>20</td>
<td>31.00</td>
<td>-1.45</td>
<td>.165</td>
</tr>
<tr>
<td>Action</td>
<td>20</td>
<td>47.50</td>
<td>-.19</td>
<td>.853</td>
</tr>
<tr>
<td>Maintenance</td>
<td>20</td>
<td>43.50</td>
<td>-.49</td>
<td>.631</td>
</tr>
</tbody>
</table>

**p < .01.

These findings indicate that parents of adolescents in this sample perceived their adolescents as more precontemplative than the adolescents perceive themselves to be. Similar to the reasons why therapists might make the same conclusion, parents may feel their adolescents are not gaining adequate insight into all of their treatment issues, while actively addressing others. Another reason for this finding may be that parents do not recognize the adolescents’ insight and are not adequately assessing their son or daughters’ motivation to change.

Research Question Six

*Research Question Six Part A*

Is the congruence between the adolescent’s and parent’s motivation scores, as measured by the URICA and P-PCMI, related to the adolescent’s reported progress in therapy? Table 13 represents the adolescents’ and their parents’ scores for each subscale on the URICA, and P-PCMI along with their reported perceptions of progress in therapy. Each subscale score of the URICA and P-PCMI was the sum of eight items, each measured on a Likert scale with a possible range of 1 through 5. This made the
Table 13

Comparison of Adolescents’ and Parents’ Perceptions of Adolescent Motivation

<table>
<thead>
<tr>
<th>Case</th>
<th>Adolescent</th>
<th>Parent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>P</td>
<td>C</td>
</tr>
<tr>
<td>1</td>
<td>19</td>
<td>21&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>2</td>
<td>17</td>
<td>29</td>
</tr>
<tr>
<td>3</td>
<td>16</td>
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<td>17</td>
<td>23</td>
</tr>
<tr>
<td>5</td>
<td>13</td>
<td>33</td>
</tr>
<tr>
<td>6</td>
<td>25&lt;sup&gt;b&lt;/sup&gt;</td>
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<tr>
<td>7</td>
<td>21</td>
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<td>15</td>
<td>34</td>
</tr>
<tr>
<td>9</td>
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<tr>
<td>10</td>
<td>12&lt;sup&gt;a&lt;/sup&gt;</td>
<td>35&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Note. P, C, A, and M represent the four subscales or the URICA, and P-PCMI, namely, precontemplation, contemplation, action, and maintenance. PP represents the perception of progress in therapy as measured by item 33 on the URICA, and P-PCMI.

<sup>a</sup> Lowest Subscale Score  
<sup>b</sup> Highest Subscale Score

possible range on each subscale a score from 8 through 40. The adolescents’ and parents’ perceptions of progress in therapy were based on a Likert scale with a possible range of 1 through 5.

The adolescents’ perception of progress in therapy scores ranged from 2 through 5, with a 5 indicating greater progress in therapy. The modal rating of progress in therapy from the adolescents’ perspective was “4” ($n = 4, 40\%$).

These adolescents’ and parents’ scores did not appear to differ more or less as a relation of the adolescents’ progress in therapy rating. For example, perceptions of motivation between adolescents and parents appeared to differ as much for adolescents who rated their progress a “5” as for those who rated their progress a “2. The adolescent in case 1 rated his or her progress as a “2” yet appeared to close to the least amount of
discrepancy between his or her perception of motivation and the perception of his or her parent. Future research is needed to determine whether or not adolescents’ perceptions of progress in therapy, or adolescents’ progress in therapy as measured objectively, is related to congruence of perceptions of motivation between parents and adolescents.

*Research Question Six Part B*

Is the congruence between the adolescent’s and parent’s motivation scores, as measured by the URICA and P-PCMI, related to the parent’s reported level of the adolescent’s progress in therapy? The parents’ perception of their adolescents’ progress in therapy ranged from 1 through 5, with a 5 indicating greater progress in therapy. The modal rating of progress in therapy from the parents’ perspective was “3” \( (n = 4, 40\%) \).

The parent in case 2 rated his or her adolescent’s progress in therapy as a “5” and had the least amount of difference between perceptions of motivation for the precontemplation subscale. However, the difference between perceptions of motivation on the other subscales does not appear to be related to the perception of progress in therapy rating. The parent in case 5, who also rated his or her adolescent’s progress as a “5”, actually had the highest amount of discrepancy on the maintenance subscale. These findings did not appear to overtly support the existence of a relationship between the congruence of the adolescent and parent perceptions of adolescents’ motivation to change and the parents’ perceived progress in therapy, though no strong conclusions can be drawn due to the descriptive nature of the statistical procedures used.
This research represents a preliminary investigation of the congruence between adolescents' perceptions of their motivation and that of their therapists and parents. Motivation has been touted as one of the foundational requirements of change. While most research addressing motivation has examined it solely from the perspective of the client, the unique nature of this research does so by looking at congruence between the adolescent's perception and that of his or her therapist and parent. The assumption upon which this research is grounded is, if there is a lack of congruence between the adolescent's reported level of motivation and that of the clinician, there will most likely be incongruence between what is therapeutically needed and strategies of the therapist. This incongruence may not only hinder therapeutic progress, it may interfere with the therapeutic alliance, another critical dimension of change. In regards to parents, because they become a key factor in family therapy, and when the adolescent returns home, it is assumed that incongruence in perceptions of motivation may interfere with parents' expectations of progress in therapy and maintenance of therapeutic change during home visits and after the adolescents leave the residential center. Blame for a lack of maintenance is not placed on either the parent or adolescent. It is simply that if there is not a congruence of perception, and the whole system is not working to incorporate the same changes, then they are not likely to be maintained.

While these assumptions underlie the study, the overall purpose of the study was to examine the relative level of congruence of perceptions. Other purposes of the study
included making recommendations for future research as well as discussing the findings as they relate to the practice of marriage and family therapy, as it pertains to the treatment of adolescents residing in residential facilities and participating in family therapy.

Summary of Findings

The results of this study showed that, overall, adolescents considered themselves to be in the preparation stage of change. A Mann-Whitney U Test suggested no statistically significant gender differences on any of the subscales of the URICA. Modest trends were observed between adolescents in Phase 1 and those in Phase 2 of therapy, however, no statistically significant differences were found between adolescents in Phase 1 and Phase 2 using a Mann-Whitney U Test. Different from how the adolescents perceived themselves, parents and therapists perceived adolescents to be significantly higher on precontemplation. In other words, parents and clinicians both perceived adolescents as less motivated to work on aspects of their therapeutic problem than did adolescents. There were no significant differences found between adolescents’ perceptions of motivation and therapists’ or parents’ perceptions of the adolescents’ motivation on any other subscales.

No conclusive evidence was found to support the theoretical assumption that congruence between perceptions of motivation between adolescents and therapists, or adolescents and parents, was related to progress in therapy from the adolescents’ perspective. Due to sample size a statistical relationship between progress in therapy from the adolescents’, therapists’, or parents’ perspective, and congruence in perceptions of motivation, could not be tested for.
Recommendations and Implications

Research Recommendations and Implications

Sampling. This area of research, congruence between perceptions, does appear to have theoretical relevance and as such, suggestions are provided to enhance the likelihood of examining the research questions posed in this study. The suggestions for future research, based on the experience acquired through this study are associated with the research design, and specifically sampling.

The most obvious recommendation has to do with increasing the reliability of the findings by increasing sample size and using a randomized sampling procedure. The implication of implementing this suggestion is that there would be a sufficient number of participants to better examine for statistical significance. Further, if the sample were to be randomized, the generalizability of the findings to other RTC populations of a similar nature would be increased.

Next, research needs to extend to a variety of agencies where adolescents are in treatment. First attention would focus on residential treatment centers with homogenous populations (e.g., conduct disordered and oppositionally defiant youth, or eating disordered youth). To further enhance the credibility of the findings, it is recommended data be collected from residential treatment centers in various parts of the nation so that regional representation could be acquired. If the findings demonstrated clinical relevance in various settings, then this may form a basis for establishing a best practice resolution.

Finally, adding diversity into the equation would be a significant step in understanding the nature of motivation and the relevance of perception based on such
factors as gender, ethnicity and race, SES, sexual orientation, religiosity, etc. Thus, it is recommended that future research seek to obtain samples that are at least representative of the national population.

*Therapists' participation.* While the above suggestions are important to the research method, the following are critical underlying antecedents of accomplishing the above. In order to acquire an adequate sample it is imperative that the RTC, and most specifically, the therapists be actively involved in data collection. While there may be a variety of reasons for why the clinicians were reluctant to be actively involved, such as busy work schedules, it is possible that clinicians perceived themselves as being confident in their ability to assess motivation, and therefore felt this line of research did not apply to them. Regardless of the rationale for modest participation, it is essential that researchers use a variety of methods to encourage participation. One suggested method would be to help clinicians understand how their involvement helps not only the profession but also themselves in providing more effective, and evidence based treatment. A second approach may be to appeal to the clinicians' sense of ethics. While the AAMFT Code of Ethics does not make non-participation an "ethical violation," it does recommend that clinicians be actively involved in facilitating knowledge in the field. This recommendation is also noted in the NASW and APA Code of Ethics. Overall, helping clinicians see the need to continue improving their therapeutic skills and learning what will help them improve may encourage more active participation.

*Adolescent and parent participation.* The adolescent and his or her family system was the focus of the research in this study. In order to accomplish the goal of an adequate sample size, it is imperative to increase the participation of both adolescents and their
parents. While increasing the therapists’ participation may be helpful in increasing the involvement of adolescents and their parents, the following are some recommendations future research might use to increase participation on the part of both adolescents and parents. In this research, personal contact between the researchers, and the parents and adolescents, was avoided as much as possible in order to preserve confidentiality. If all other reasonable precautions were taken to preserve confidentiality, the risks of increasing personal contact between the researchers and participants may likely be minimal in comparison to the benefits of increasing the sample size. It is recommended that the future researchers supervise the overall process from initial contact through data collection. If the researchers were to be more involved, it is suggested that greater and more focused energy is likely to be expended in recruiting and data collection. It is suggested that this level of involvement by the researchers may reduce the liability created when organizations, though interested, may not be as committed to the research project.

Because the sample we were studying included adolescents, it was necessary for their parents to sign letters of informed consent in order for the adolescent to participate. To increase adolescent participation, it is imperative that parental participation be increased. For most RTCs, parents live in another state, and sometimes even another country, which makes contact between the parents and researchers difficult, but not impossible. Contacting parents of adolescents involves sensitivity to confidentiality. An RTC cannot simply give researchers phone or address lists, which necessitates considerable cooperation from the therapists and RTC administrators if an adequate sample is to be acquired. In that many RTCs host a parents’ day on the campus,
organizing a parent day at the RTC where a short presentation by the researchers on the subject under investigation was given may be one way to increase personal contact and participation. Those in attendance would have an opportunity to discuss the study with the researchers, and those desiring to be involved could read and sign a letter of informed consent. Further it would be possible to administer and collect the instruments in a single day or weekend. The implications of increasing personal contact may help the participants feel greater ownership in the research and increase convenience of collecting data.

*Parents' motivation.* While this research has increased our understanding of the therapy process with adolescents and their families, the importance of having a congruent perception of motivation is likely important to the entire therapeutic system. It is recommended that future research assess the motivation of parents involved in family therapy to change their own behaviors, as well as, the congruence between perceptions of motivation between parents and their family therapists, and parents and their adolescent. Studying perceptions of parents’ motivation to change may result in greater understanding of the therapeutic system, at least the rules associated with the system. It is suggested that if parents expect their adolescent son or daughter to change, but are unwilling to change any behaviors themselves, then system’s theory suggests that when the son or daughter’s returns to the family system, the changes these adolescents made in while at the RTC may not be maintained.

*Length of time in treatment.* Although modest differences in URICA mean scores were found between adolescents in Phase 1 compared to Phase 2 of therapy, they were not statistically significant. Future research is needed to determine whether motivation to
change is different for those in early stages of therapy, compared to those in later stages of therapy. It is likely that those in later stages of therapy would have lower levels of precontemplation and higher levels of action and maintenance. This remains a hypothesis for future research to assess. Understanding motivation at various stages would definitely help clinicians devise and select appropriate, thus increasing adolescent participation in therapy and desire to change.

While investigating adolescent change, according to phase of therapy, congruence of perception of change between therapist and adolescent needs further consideration. Although the findings of this study did not demonstrate significance between level of motivation and progress in therapy, this question remains relevant. It is suggested that the limitations of the study may have interfered with the findings.

Further, it is recommended that research question whether therapists base their perception on the length of time an adolescent client is in treatment or on an objective view of the adolescent’s actual level of motivation. The implication of this particular focus of study would be to determine the level of objectivity clinicians’ use when determining motivation to change and selection of interventions. It is suggested that a more objective perspective of their client is more beneficial and is more likely to drive evidence-based treatment. This seems logical when one considers that time may interfere with judgment of motivation as the clinician becomes fatigued with the client, or they “strike up” a friendship.

*Impact of congruence of perceptions on treatment.* In this study, we began to explore the relationship between congruence of perceptions and progress of adolescents involved in family therapy. The results did not support prior findings that suggest low
congruence would lead to decreased effectiveness in therapy (Butler & Bird, 2000; van Bilsen, 1995; Wagner & McMahon, 2004). It is likely that sample size may have been related to the lack of findings, as well as the measures used. There did, however, appear to be some supportive evidence that therapists’ and parents’ perceptions of progress in therapy increases in relation to congruence of perception of motivation, but not enough to draw any strong conclusions.

Future research into the relationship between congruence of perceptions and effectiveness of family therapy is needed using a critical sample size and a more refined measure of effectiveness or progress in therapy. This would allow for clinical and statistical significance to be established and would clarify the reliability of previous findings. The implications of such a study would be greater knowledge pertaining to the role of motivation, especially congruence of perceptions about motivations, and therapeutic progress. Greater understanding of how therapists, parents, and adolescents each perceive motivation and in turn affect the therapeutic outcome would encourage greater focus in the development of effective and efficient interventions.

**Recommendations and Implications for Marriage and Family Therapy**

While on the surface one may wonder, “How can findings relating to perceptions of an adolescent’s motivation, and congruence between their perception and that of their therapist and parents be useful to marriage and family therapy, especially if the adolescent is being treated in a residential treatment center away from their family?” The credibility of such research, as it pertains to marriage and family therapy will be discussed.
Role of the family therapist. Family therapists have been shown to be especially effective in working with adolescents (Carver, 2005). In addition, a number of family therapists are currently working primarily with adolescents and their families, especially in residential treatment settings. Family therapy research cannot overlook the importance of better understanding the dynamics of therapy with adolescents and their parents. Although residential treatment centers introduce dynamics that initially may appear as barriers to family therapy, primarily the out-of-home placement of the adolescent, systems theory and the basic tenets of family therapy are still very much applicable and effective in this setting as shown by Carver. It is proposed that one cannot provide therapy to an adolescent outside of a systems context, even if the adolescent is removed from the family. It is suggested that the residential treatment center become an extension of the family system during the duration of the treatment in the form of what Bronfenbrenner (1989) refers to as the “macro-system.” If RTC’s were to adopt a systems philosophy there would be a theoretical and clinical shift that might encourage systemic analysis and intervention.

The therapist is involved for a short period with adolescents; however, they may be considered the most critical person in the macro-system relative to change. It is suggested that therapists need to understand and apply systems concepts if they are going to understand their position in the macro-system and effectively interact with parents (also part of the macro-system) to effect change in the adolescent while in the residential treatment center, during home visits, and post-treatment change maintenance. Unfortunately, not all therapists in residential treatment centers are family therapists, and
not all residential treatment centers apply systems concepts, even though they may provide family therapy.

**Role of the parent.** Prior research has not established a strong theoretical framework for the importance of congruence between parent and adolescent perceptions of motivation as it has in the case of therapists. However, parents are, and will continue to be, in the adolescent’s “macro-system” (Bronfenbrenner, 1989). It appears that parents may not understand their importance to treatment while the adolescent is in the residential treatment center, and to change maintenance when the adolescent arrives back home. It is important that parents be an integral part of their adolescent’s treatment, regardless of whether one considers individual, group, or family therapy. Theoretically, the matter of congruent perceptions of motivation becomes of particular importance. If parents’ perception of their adolescent’s motivation to change is not congruent to the adolescent’s perception of their own motivation to change, parents will likely be frustrated with the lack of progress or seemingly unnecessary continuation of treatment.

Though the findings of this study were not able to support or refute the relationship between congruence of perceptions of motivation between adolescents and their parents and increased progress in therapy, this does not mean that the questions are not valid. Future research is critical, using an appropriate sample size to appropriately address these questions. Theoretically, it does appear that the congruence of perceptions may be most influential for relapse prevention. If an adolescent is released from a RTC and returns home, he or she needs to continue working toward a stage of maintenance in their customary system. If parents perceive their adolescents as more or less motivated to continue with the changes the adolescents began making in the RTC than the adolescents...
perceive themselves to be, parents will likely be less effective in helping maintain changes at home. It is suggested that parents continue to assess the motivation of their adolescent following treatment in order to more effectively help their son or daughter maintain changes initiated in treatment. Because of the potential benefit of understanding congruence of perception and relapse, this assumption requires further study.

The precontemplation stage. Significant differences between perceptions of motivation were found when examining the precontemplation stage for adolescents and therapists, and adolescents and parents. These data suggest that therapists and parents perceived adolescents to have higher levels of precontemplation than adolescents perceived themselves as having. If this were the case, then as it pertains to therapists, they may be working with interventions not reflective of the adolescents perceived level of motivation. If their interventions were more grounded in precontemplation than preparation, adolescents may have lost interest therapy. Relative to parents, this incongruence could undermine the adolescents’ perception of their parents support and result in the adolescents adopting a more foreclosed position in treatment, especially when they returned home. If these assumptions are true, it is recommended that therapists and parents be aware of this possibility and more accurately assess adolescents’ motivation for change so that they can be effective in their efforts to encourage and support change. Ignorance of these assumptions may result in the adolescent being mislabeled as “resistant” (Hanna & Hunt, 1999). On the other hand, increased awareness and active assessment may lead to a stronger therapeutic relationship, both between the therapist and adolescent and the adolescent and his parents. A greater therapeutic relationship means greater likelihood of sustained change.
Limitations

To put the findings in perspective, it is important to note the following limitations so that the reader does not make invalid assumptions or over generalize from the findings. The most poignant limitation involved the low return rate which resulted in a limited sample from which the findings were derived. The sample size was limited by the willingness of parents to give consent and the adolescents to complete measures once consent was obtained. Acquisition of consent was hindered in two ways. First, in that follow up efforts of the clinicians was voluntary, not all were as rigorous in their follow up as needed to get both parents and adolescents involved in the study. Second, some parents did not respond, so regardless if an adolescent was willing to participate, they could not be included in the study. A second limitation of the sample was that the sample of adolescents, therapists, and parents was a convenience sample limited to one cooperating residential treatment center. A final limitation of the study’s sample had to do with the number of males and females in the study. In that there was such a small sample size, analyses by gender could not be completed for parents and therapists.

The limitations regarding the sample of this study impacted the statistical procedures used to analyze the data as well as the conclusions that could be drawn from the results. Some conclusions are tentatively made based on the findings of both descriptive and inferential statistics used to answer the research questions, but they are done so tentatively, acknowledging the limitations of the sample.

A methodological limitation of this study includes the measure of progress in therapy used to answer research questions four and six. Progress in therapy was determined using
one question adolescent, therapists and parents each answered on a Likert scale ranging from 1 to 5, with 5 meaning “strongly agree.” The primary focus of this study was to examine perceptions of motivation, as determined by the URICA, T-PCMI, and P-PCMI, and how adolescents’ perceptions of their motivation compared to those of their therapists and parents. The relationship between congruence of perceptions of motivation and progress in therapy was examined in a cursory manner through questions four and six, but future research is needed to examine these or similar questions more fully to determine if a relationship between congruence of perceptions of motivation and progress in therapy exists, and what type of relationship it is. Besides devising a more effective way of measuring progress, future research would also need a sample size sufficient to lend itself to inferential statistical analysis.
REFERENCES


APPENDICES
Appendix A

Therapist Demographic Questionnaire
Therapist Demographic Instrument

**Instructions:** For each question please check the box by the answer that best describes you or write in the answer on the line.

1. Gender: □ Male □ Female

2. Which best describes you age?
   - □ 18-25
   - □ 26-30
   - □ 31-40
   - □ 41-50
   - □ 31-40
   - □ 41-50
   - □ 70+

3. Which best describes your Ethnicity/Race?
   - □ Caucasian/white
   - □ African-American/black
   - □ Asian
   - □ Hispanic
   - □ Native American
   - □ Other. Please Specify __________________________

4. What is the highest level of education you have obtained?
   - □ Masters degree
   - □ Doctorate degree
   - □ Other

5. What is your professional licensure? (check all that apply)
   - □ LMFT
   - □ LCSW
   - □ LPC
   - □ Psychologist
   - □ Psychiatrist
   - □ Intern (Specify field) ______
   - □ Other ______

6. How many years post-licensure experience do you have? ______

7. What is your predominant model of therapy? __________________________

8. How long have you been employed as a therapist at LRA? ______

9. What other positions have you held in the past 5 years?
   __________________________________________________________
   __________________________________________________________
Appendix B

Therapist and Parent Validity Scale
Therapist and Parent Validity Scale

Please answer each question according to whether or not it describes you. If the answer is true, or mostly true, mark TRUE. If the answer is false or mostly false, mark FALSE. Only mark one answer for each question. Put your first response to each question; work quickly, but don’t be careless.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Once in a while I think about things too bad to talk about.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>2.</td>
<td>At times I feel like swearing.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>3.</td>
<td>At times I feel like smashing things.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>4.</td>
<td>I do not always tell the truth.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>5.</td>
<td>I do not read every editorial in the newspaper every day.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>6.</td>
<td>I think a great many people exaggerate their misfortunes in order to gain the sympathy and help of others.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>7.</td>
<td>It takes a lot of argument to convince most people of the truth.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>8.</td>
<td>Once in a while I put off until tomorrow what I ought to do today.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>9.</td>
<td>I have very few quarrels with members of my family.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>10.</td>
<td>Sometimes when I am not feeling well I am irritable.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>11.</td>
<td>I get angry sometimes.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>12.</td>
<td>My table manners are not quite as good at home as when I am out in company.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>13.</td>
<td>Most people will use somewhat unfair means to gain profit or an advantage rather than lose it.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>14.</td>
<td>Often I can’t understand why I have been so irritable and grouchy.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>15.</td>
<td>At times my thoughts have raced ahead faster than I could speak them.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>16.</td>
<td>If I could get into a movie without paying and be sure I was not seen, I would probably do it.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>17.</td>
<td>Criticism or scolding hurts me terribly.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>18.</td>
<td>I certainly feel useless at times.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>19.</td>
<td>It makes me impatient to have people ask my advice or otherwise interrupt me when I am working on something important.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>20.</td>
<td>I would rather win than lose a game.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>21.</td>
<td>I have never felt better in my life than I do now.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>22.</td>
<td>I like to know some important people because it makes me feel important.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>23.</td>
<td>What others think of me does not bother me.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>24.</td>
<td>It makes me uncomfortable to put on a stunt at a party even when others are doing the same sort of thing.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>25.</td>
<td>I find it hard to make talk when I meet new people.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>26.</td>
<td>I am against giving money to beggars.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>27.</td>
<td>I do not like everyone I know.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>28.</td>
<td>I frequently find myself worrying about something.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>29.</td>
<td>I gossip a little at times.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>30.</td>
<td>I get mad easily and then get over it soon.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>31.</td>
<td>Sometimes in elections I vote for people about whom I know very little.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>32.</td>
<td>When in a group of people I have trouble thinking of the right things to talk about.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>33.</td>
<td>Once in a while I laugh at a dirty joke.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>34.</td>
<td>I have periods in which I feel unusually cheerful without any special reason.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>35.</td>
<td>I think nearly anyone would tell a lie to keep out of trouble.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>36.</td>
<td>I worry over money and business.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>37.</td>
<td>At times I am full of energy.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>38.</td>
<td>People often disappoint me.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>39.</td>
<td>I have sometimes felt that difficulties were piling up so high that I could not</td>
<td>T</td>
<td>F</td>
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<tr>
<td><strong>overcome them.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40. At periods my mind seems to work more slowly than usual.</td>
<td>T</td>
<td>F</td>
<td></td>
</tr>
<tr>
<td>41. I have often met people who were supposed to be experts who were no better than I.</td>
<td>T</td>
<td>F</td>
<td></td>
</tr>
<tr>
<td>42. I often think, “I wish I were a child again.”</td>
<td>T</td>
<td>F</td>
<td></td>
</tr>
<tr>
<td>43. I find it hard to set aside a task that I have undertaken, even for a short time.</td>
<td>T</td>
<td>F</td>
<td></td>
</tr>
<tr>
<td>44. I like to let people know where I stand on things.</td>
<td>T</td>
<td>F</td>
<td></td>
</tr>
</tbody>
</table>
Appendix C

URICA Revised for Clinicians (T-PCMI)
Each statement in this questionnaire describes how a clinician might perceive a person feels when starting therapy or approaching problems in their lives. Please indicate the extent to which you tend to agree or disagree with each statement. In each case, make your choice in terms of how you perceive the client right now, not what you have felt in the past or would like to feel. For all the statements that refer to your client’s "problem", answer in terms of what you write on the "PROBLEM" line below. And "here" refers to the place of treatment or the program.

In one or two words please indicate the problem your client is being seen for.

There are FIVE possible responses to each of the items in the questionnaire:

1 = Strongly Disagree   2 = Disagree
3 = Undecided   4 = Agree
5 = Strongly Agree

<table>
<thead>
<tr>
<th>In my opinion, this client:</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. does not perceive him/herself as having any problems that need changing.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. thinks s/he might be ready for some self-improvement.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. perceives s/he is doing something about the problem that had been bothering her/him.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. perceives it might be worthwhile to work on his/her problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. perceives s/he is not the problem one. I think that my child does not feel it makes sense for him/her to be there.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. is worried that s/he might slip back on a problem they feel they have already changed.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. perceives s/he is finally doing some work on his/her problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. has been thinking that s/he might want to change something about him/herself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. perceives s/he has been successful in working on his/her problem, but is not sure s/he can keep up the effort on his/her own.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. perceives his/her problem is difficult at times, but feels s/he is working on it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. perceives that being there is pretty</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>12.</td>
<td>is hoping this place will help him/her to better understand him/herself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13.</td>
<td>perceives s/he has some faults, but feels there is nothing that s/he needs to change.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14.</td>
<td>perceives s/he is really working hard to change.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15.</td>
<td>perceives s/he has a problem and really thinks s/he should work at it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16.</td>
<td>does not perceive that s/he has followed through with what s/he had already changed as well as s/he had hoped, and therefore is at this center to prevent a relapse of the problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17.</td>
<td>perceives that although s/he is not always successful in changing, s/he is at least working on his/her problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18.</td>
<td>thought once s/he had resolved his/her problem s/he would be rid of it, but sometimes still finds him/herself struggling with it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19.</td>
<td>wishes s/he had more ideas on how to solve the problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20.</td>
<td>perceives s/he has started working on the problem, but would like help.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>21.</td>
<td>perceives may be this place will be able to help him/her.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>22.</td>
<td>perceives s/he may need a boost right now to help him/her.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>23.</td>
<td>perceives s/he may be part of the problem, but doesn't really think s/he is.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>24.</td>
<td>hopes that someone there will have some good advice for him/her.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>25.</td>
<td>perceives anyone can talk about changing; but perceives s/he is actually doing something about it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>26.</td>
<td>perceives all this talk about psychology is boring, and wonders why can't people just forget about their problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>27.</td>
<td>perceives s/he is there to prevent him/herself from having a relapse of his/her problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>28.</td>
<td>perceives him/herself as being frustrated and believes that s/he might be having a recurrence of a problem s/he thought s/he had resolved.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>29.</td>
<td>has worries, but thinks so does the next guy. S/he wonders why spend time thinking about them.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>30.</td>
<td>perceives s/he is actively working on</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
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<td></td>
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</tr>
<tr>
<td></td>
<td>his/her problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>31.</td>
<td>would rather cope with his/her faults than try to change them.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32.</td>
<td>that after all s/he has done to try to change her/his problem, every now and again it comes back to haunt her/him.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>33.</td>
<td>is making progress toward his/her treatment goals.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Appendix D

Parent Demographic Questionnaire
Parent Demographic Instrument

Instructions: For each question please check the box by the answer that best describes you or write in the answer on the line.

1. Gender: □ Male □ Female

2. Which best describes you age?
   □ 18-25 □ 26-30 □ 31-40 □ 41-50
   □ 31-40 □ 41-50 □ 70+

3. Which best describes your Ethnicity/Race?
   □ Caucasian/white □ African-American/black
   □ Asian □ Hispanic
   □ Native American □ Other. Please Specify __________________________

4. What is your marital status?
   □ Married, first marriage □ Remarried □ Single, never married
   □ Divorced □ Widowed □ Cohabiting □ Other

5. What is your state of residence? ________

6. Which best describes your annual household income?
   □ Less than 100,000 □ 100,000 - 150,000 □ 150,000 - 200,000 □ More than 200,000

7. What is the highest level of education you have obtained?
   □ Some high school □ High school graduate □ Trade school
   □ Some college □ College graduate □ Some postgraduate
   □ Masters degree □ Doctorate degree

8. What is your occupation? ________________
Appendix E

URICA Revised for Parents (P-PCMI)
Revised URICA (Long Form)

(University of Rhode Island Change Assessment)

Perception of Perception
Revised for Parents

Each statement in this questionnaire describes how a parent might perceive how their son or daughter feels when starting therapy or approaching problems in their lives. Please indicate the extent to which you tend to agree or disagree with each statement. In each case, make your choice in terms of how you perceive your son or daughter right now, not what you have felt in the past or would like to feel. For all the statements that refer to your son or daughter's "problem", answer in terms of what you write on the "PROBLEM" line below. And "here" refers to Logan River Academy.

In one or two words please indicate the problem your son/daughter is being seen for.

<table>
<thead>
<tr>
<th>In my opinion, my son/daughter:</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. does not perceive him/herself as having any problems that need changing.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. thinks s/he might be ready for some self-improvement.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. perceives s/he is doing something about the problem that had been bothering her/him.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. perceives it might be worthwhile to work on his/her problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. perceives s/he is not the problem one. I think that my child does not feel it makes sense for him/her to be there.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. is worried that s/he might slip back on a problem they feel they have already changed.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. perceives s/he is finally doing some work on his/her problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. has been thinking that s/he might want to change something about him/herself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. perceives s/he has been successful in working on his/her problem, but is not sure s/he can keep up the effort on his/her own.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>10.</td>
<td>perceives his/her problem is difficult at times, but feels s/he is working on it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>perceives that being there is pretty much a waste of time for him/her because the problem doesn’t have to do with him/her.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>is hoping this place will help him/her to better understand him/herself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>perceives s/he has some faults, but feels there is nothing that s/he needs to change.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>perceives s/he is really working hard to change.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>perceives s/he has a problem and really thinks s/he should work at it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>does not perceive that s/he has followed through with what s/he had already changed as well as s/he had hoped, and therefore is at this center to prevent a relapse of the problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>perceives that although s/he is not always successful in changing, s/he is at least working on his/her problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>thought once s/he had resolved his/her problem s/he would be rid of it, but sometimes still finds him/herself struggling with it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>wishes s/he had more ideas on how to solve the problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>perceives s/he has started working on the problem, but would like help.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>perceives maybe this place will be able to help him/her.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>perceives s/he may need a boost right now to help him/her.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>perceives s/he may be part of the problem, but doesn’t really think s/he is.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>hopes that someone there will have some good advice for him/her.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>perceives anyone can talk about changing; but perceives s/he is actually doing something about it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>perceives all this talk about psychology is boring, and wonders why can’t people just forget about their problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>perceives s/he is there to prevent him/herself from having a relapse of his/her problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>perceives him/herself as being frustrated and believes that s/he might be having a recurrence of a problem s/he thought s/he had resolved.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
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<tr>
<td></td>
<td>Description</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>29.</td>
<td>has worries, but thinks so does the next guy. S/he wonders why spend time thinking about them.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>perceives s/he is actively working on his/her problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>31.</td>
<td>would rather cope with his/her faults than try to change them.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>32.</td>
<td>that after all s/he has done to try to change her/his problem, every now and again it comes back to haunt her/him.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>33.</td>
<td>is making progress toward his/her treatment goals.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>34.</td>
<td>I would recommend this program to a friend who had a son/daughter that was in the same situation as my son/daughter.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Appendix F

Adolescent Demographic Questionnaire
Adolescent Demographic Instrument

Instructions: For each question please check the box by the answer that best describes you or write in the answer on the line.

1. Gender: □ Male □ Female

2. What is your age? __________

3. Which grade are you in?
   □ 7th □ 8th □ 9th □ 10th
   □ 11th □ 12th □ Other __________

4. Which best describes your Ethnicity/Race?
   □ Caucasian/white □ African-American/black
   □ Asian □ Hispanic
   □ Native American
   □ Other. Please Specify __________

5. How many months have you been at LRA? ________ months.

6. Have you ever been in any other residential facilities? □ Yes □ No
   a. If yes, list the facility and how long you were there.

<table>
<thead>
<tr>
<th>Facility</th>
<th>Length of Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. What is the reason you came to LRA? __________________________________________________________________________

   Therapist Portion of Adolescent Demographic Instrument

   1. Diagnostically, what was this adolescent referred for? __________________________

   2. What is the diagnostic emphasis of therapy at this time (if different from referral)?
      ____________________________________________

   3. What is your estimate of the adolescents GAF score at this time? __________

   4. What is your estimate of the family’s GARF score at this time? __________
Appendix G

Adolescent Validity Scale
Please answer each question according to whether or not it describes you. If the answer is true, or mostly true, mark TRUE. If the answer is false or mostly false, mark FALSE. Only mark one answer for each question. Put your first response to each question; work quickly, but don’t be careless.

<table>
<thead>
<tr>
<th></th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Once in a while I think about things too bad to talk about.</td>
<td>T</td>
</tr>
<tr>
<td>2.</td>
<td>At times I feel like swearing.</td>
<td>T</td>
</tr>
<tr>
<td>3.</td>
<td>At times I feel like smashing things.</td>
<td>T</td>
</tr>
<tr>
<td>4.</td>
<td>I do not always tell the truth.</td>
<td>T</td>
</tr>
<tr>
<td>5.</td>
<td>I do not read every editorial in the newspaper every day.</td>
<td>T</td>
</tr>
<tr>
<td>6.</td>
<td>I think a great many people exaggerate their misfortunes in order to gain the sympathy and help of others.</td>
<td>T</td>
</tr>
<tr>
<td>7.</td>
<td>It takes a lot of argument to convince most people of the truth.</td>
<td>T</td>
</tr>
<tr>
<td>8.</td>
<td>Once in a while I put off until tomorrow what I ought to do today.</td>
<td>T</td>
</tr>
<tr>
<td>9.</td>
<td>I have been suspended from school one or more times for bad behavior.</td>
<td>T</td>
</tr>
<tr>
<td>10.</td>
<td>Sometimes when I am not feeling well I am irritable.</td>
<td>T</td>
</tr>
<tr>
<td>11.</td>
<td>I get angry sometimes.</td>
<td>T</td>
</tr>
<tr>
<td>12.</td>
<td>My table manners are not quite as good at home as when I am out in company.</td>
<td>T</td>
</tr>
<tr>
<td>13.</td>
<td>Most people will use somewhat unfair means to get what they want.</td>
<td>T</td>
</tr>
<tr>
<td>14.</td>
<td>Often I can’t understand why I have been so irritable and grouchy.</td>
<td>T</td>
</tr>
<tr>
<td>15.</td>
<td>At times my thoughts have raced ahead faster than I could speak them.</td>
<td>T</td>
</tr>
<tr>
<td>16.</td>
<td>If I could get into a movie without paying and be sure I was not seen, I would probably do it.</td>
<td>T</td>
</tr>
<tr>
<td>17.</td>
<td>Criticism or scolding hurts me terribly.</td>
<td>T</td>
</tr>
<tr>
<td>18.</td>
<td>I certainly feel useless at times.</td>
<td>T</td>
</tr>
<tr>
<td>19.</td>
<td>It makes me impatient to have people ask my advice or otherwise interrupt me when I am working on something important.</td>
<td>T</td>
</tr>
<tr>
<td>20.</td>
<td>I would rather win than lose a game.</td>
<td>T</td>
</tr>
<tr>
<td>21.</td>
<td>I have never felt better in my life than I do right now.</td>
<td>T</td>
</tr>
<tr>
<td>22.</td>
<td>I like to know some important people because it makes me feel important.</td>
<td>T</td>
</tr>
<tr>
<td>23.</td>
<td>What others think of me does not bother me.</td>
<td>T</td>
</tr>
<tr>
<td>24.</td>
<td>It makes me uncomfortable to put on a stunt at a party even when others are doing the same sort of thing.</td>
<td>T</td>
</tr>
<tr>
<td>25.</td>
<td>I find it hard to make talk when I meet new people.</td>
<td>T</td>
</tr>
<tr>
<td>26.</td>
<td>I am against giving money to beggars.</td>
<td>T</td>
</tr>
<tr>
<td>27.</td>
<td>I do not like everyone I know.</td>
<td>T</td>
</tr>
<tr>
<td>28.</td>
<td>I frequently find myself worrying about something.</td>
<td>T</td>
</tr>
<tr>
<td>29.</td>
<td>I gossip a little at times.</td>
<td>T</td>
</tr>
<tr>
<td>30.</td>
<td>I get mad easily and then get over it soon.</td>
<td>T</td>
</tr>
<tr>
<td>31.</td>
<td>When in a group of people I have trouble thinking of the right things to talk about.</td>
<td>T</td>
</tr>
<tr>
<td>32.</td>
<td>Once in a while I laugh at a dirty joke.</td>
<td>T</td>
</tr>
<tr>
<td>33.</td>
<td>I think nearly anyone would tell a lie to keep out of trouble.</td>
<td>T</td>
</tr>
<tr>
<td>34.</td>
<td>I worry about money.</td>
<td>T</td>
</tr>
<tr>
<td>35.</td>
<td>At times I am full of energy.</td>
<td>T</td>
</tr>
<tr>
<td>36.</td>
<td>I have periods in which I feel unusually cheerful without any special reason.</td>
<td>T</td>
</tr>
<tr>
<td>37.</td>
<td>People often disappoint me.</td>
<td>T</td>
</tr>
<tr>
<td>38.</td>
<td>I have sometimes felt that difficulties were piling up so high that I could not overcome them.</td>
<td>T</td>
</tr>
<tr>
<td>39.</td>
<td>At periods my mind seems to work more slowly than usual.</td>
<td>T</td>
</tr>
<tr>
<td></td>
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<tr>
<td>---</td>
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<td>---</td>
</tr>
<tr>
<td>40.</td>
<td>I have often met people who were supposed to be experts who were no better than I.</td>
<td>T</td>
</tr>
<tr>
<td>41.</td>
<td>I often think, “I wish I were a child again.”</td>
<td>T</td>
</tr>
<tr>
<td>42.</td>
<td>I find it hard to set aside a task that I have undertaken, even for a short time.</td>
<td>T</td>
</tr>
<tr>
<td>43.</td>
<td>I like to let people know where I stand on things.</td>
<td>T</td>
</tr>
</tbody>
</table>
Appendix H

University of Rhode Island Change Assessment (URICA)
Each statement of this questionnaire describes how a person might feel when starting therapy or approaching problems in their lives. Please indicate the extent to which you tend to agree or disagree with each statement. In each case, make your choice in terms of how you feel right now, not what you have felt in the past or would like to feel. For all the statements that refer to your "problem", answer in terms of what you write on the "PROBLEM" line below. And "here" refers to the place of treatment or the program.

In one or two words please indicate the problem you are in therapy for.

There are FIVE possible responses to each of the items in the questionnaire:

1 = Strongly Disagree  2 = Disagree  
3 = Undecided  4 = Agree  
5 = Strongly Agree

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>As far as I'm concerned, I don't have any problems that need changing.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>I think I might be ready for some self-improvement.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>I am doing something about the problems that had been bothering me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>It might be worthwhile to work on my problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>I'm not the problem one. It doesn't make much sense for me to be here.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>It worries me that I might slip back on a problem I have already changed, so I am here to seek help.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7</td>
<td>I am finally doing some work on my problem.</td>
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<td>8</td>
<td>I've been thinking that I might want to change something about myself.</td>
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<td>9</td>
<td>I have been successful in working on my problem but I'm not sure I can keep up the effort on my own.</td>
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<td>10</td>
<td>At times my problem is difficult, but I'm working on it.</td>
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<td>11</td>
<td>Being here is pretty much a waste of time for me because the problem doesn't have to do with me.</td>
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<td>12</td>
<td>I'm hoping this place will help me to better understand myself.</td>
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<td>13</td>
<td>I guess I have faults, but there's nothing that I really need to change.</td>
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<tr>
<td>Question</td>
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<td>14. I am really working hard to change.</td>
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<td>15. I have a problem and I really think I should work at it.</td>
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<td>16. I'm not following through with what I had already changed as well as I had hoped, and I'm here to prevent a relapse of the problem.</td>
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<td>17. Even though I'm not always successful in changing, I am at least working on my problem.</td>
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<td>18. I thought once I had resolved my problem I would be free of it, but sometimes I still find myself struggling with it.</td>
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<td>19. I wish I had more ideas on how to solve the problem.</td>
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<td>20. I have started working on my problems but I would like help.</td>
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<td>21. Maybe this place will be able to help me.</td>
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<td>22. I may need a boost right now to help me maintain the changes I've already made.</td>
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<td>23. I may be part of the problem, but I don't really think I am.</td>
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<td>24. I hope that someone here will have some good advice for me.</td>
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<td>25. Anyone can talk about changing; I'm actually doing something about it.</td>
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<td>26. All this talk about psychology is boring. Why can't people just forget about their problems?</td>
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<td>27. I'm here to prevent myself from having a relapse of my problem.</td>
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<td>28. It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved.</td>
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<td>29. I have worries but so does the next guy. Why spend time thinking about them?</td>
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<td>30. I am actively working on my problem.</td>
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<td>31. I would rather cope with my faults than try to change them.</td>
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<td>32. After all I had done to try to change my problem, every now and again it comes back to haunt me.</td>
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<td>33. I believe I am making progress toward my treatment goals.</td>
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<td>34. I would recommend this program to a friend my age that was going through the same kind of problems as I am.</td>
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