CHAPTER 2
LITERATURE REVIEW

2.1   Introduction

For the purpose of this study, this chapter will discuss three major sections that present a review of literature that is related to the study. The literature covers relevant theory and concepts as well as previous research. Sections that will be discussed are the following:

(1)   Transtheoretical Model of Behavioural Change

(2)   Group Therapy and Behavioural Change

(3)   Theoretical and Conceptual Framework of the Study

2.2   Transtheoretical Model of Behavioural Change (TTM)

2.2.1   Overview of Transtheoretical Model

According to DiClemente (2006), the TTM, which emerged from his seminal research series with James Prochaska, examines how smokers are able to free themselves from their nicotine addiction and the Model has been primarily applied for recovery from addiction. Many studies have demonstrated that elements of TTM are important for all three types of behaviour change: (1) creating patterns of behaviour; (2) modifying habitual behaviour patterns; and (3) stopping problematic patterns (Connors et al., 2001; DiClemente, 2006).

The TTM brings together all divergent perspectives to understand addiction by focusing on how individuals change their behaviour and by identifying key change dimensions involved in this process (DiClemente & Prochaska, 1998; Prochaska & &

DiClemente, 1984). With regard to the drug addiction problem, addiction is seen as a personal pathway that is not limited to person or environment, but it is best seen as an integration of understanding the multiple influences involved in the acquisition and cessation of addiction (DiClemente, 2006).

The TTM uses four dimensions of change which are able to describe a similar path that leads an individual into and out of the habitual patterns of behaviour, called addiction. These dimensions of change and their interactions can be simplified as Table 2.1 shown below:

Table 2.1

The Four Dimensions of the TTM

Stages of change	
Pre-contemplation – Contemplation – Preparation – Action – Maintenance	
Processes of change	
<u>Cognitive/experiential</u>	<u>Behavioural</u>
Consciousness-raising	Self-liberation
Self-evaluation	Conditioning/counter-conditioning
Environmental reevaluation	Stimulus generalization/control
Emotional arousal/dramatic relief	Reinforcement management
Social liberation	Helping relationship
Markers of change	
Decisional balance	Self-efficacy/temptation
Context of change	
Areas of functioning that complement or complicate change	
1. Current life situation	
2. Beliefs and attitudes	
3. Interpersonal relationships	
4. Social systems	
5. Enduring personal characteristics	

Source: DiClemente (2006). Addiction and change, p. 24.

DiClemente (2006) explains this model of four dimensions:

(a)   The stages of change divide the process of change into distinct segments, and each stage is defined by specific tasks that need to be

accomplished to a greater or lesser degree if movement forward to the next stage is to happen. The stages depict a person's movement through the process of change in terms of the motivational and temporal aspects needed to create a successfully sustained pattern of behaviour.

(b)   The processes of change represent the internal and external experiences and activities that enable a person to move from one stage to the next. Engaging in these processes provides the means for the individuals to accomplish the stage "tasks".

(c)   The markers of change are signposts that identify where a person stands in two key change-related areas, namely, decision-making about the change (decisional balance), and the strength of one's perceived ability to manage the behavioural change (self-efficacy/temptation).

(d)   The context of change surrounds the change process and often interacts with it. It represent both the internal workings of the individual and the important interactions with the environmental influences. Issues, problems, resources, and liabilities within these areas can help or hinder movement through the process of change.
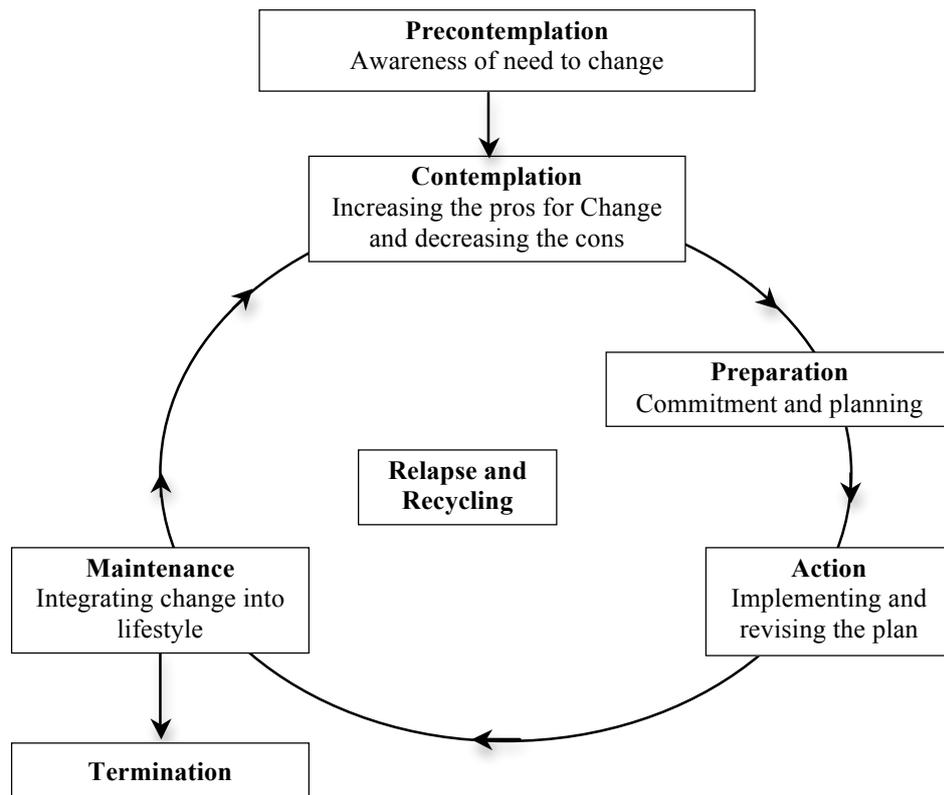
In guiding rehabilitation researchers and professionals who use TMM in research and practice, Prochaska, Johnson and Lee (2008) listed seven main critical assumptions of this theory:

(a)   No single theory can account for all the complexities of behaviour change. Therefore, a more comprehensive model will likely emerge from an integration across major theories;

(b)   Behaviour change is a process that unfolds over time through a sequence of stages;

(c)   Stages are both stable and open to change, just as chronic behavioural risk factors are both stable and open to change;

(d)   Without planned interventions, most populations will remain stuck in the early stages. There is no inherent motivation to progress through the stages of intentional change as there seems to be in the stages of physical and psychological development;

(e)   The majority of at-risk populations are not prepared for action and will not be served by traditional action-oriented prevention programs. Health promotion can have much greater impact if it shifts from an action paradigm to a stage paradigm;

(f)   Specific processes and principles of change need to be applied at specific stages if progress through the stages is to occur. In the stages of change, paradigm intervention programs must be matched to each individual's stage of change; and

(g)   Chronic behaviour patterns are usually under some combination of biological, social, and self-control. Stage-matched interventions have been designed primarily to enhance self-controls.

2.2.1.1   The Stages of Change

According to Prochaska and DiClemente (1984), Connors et al. (2001), and DiClemente (2006), an individual's change takes place over time in five distinct stages of change: pre-contemplation, contemplation, preparation, action, and maintenance. The movement through the stages of change is more cyclical and circuitous, as shown in Figure 2.1.

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           ┌─────────────────────────────┐
           │     Precontemplation        │
           │   Awareness of need to change│
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Precontemplation
Awareness of need to change

Contemplation
Increasing the pros for Change
and decreasing the cons

Preparation
Commitment and planning

**Relapse and
Recycling**

Maintenance
Integrating change into
lifestyle

Action
Implementing and
revising the plan

Termination

(Source: Diclemente (2006). Addiction and change, p.30)

Figure 2.1: A cyclical representation of movement through the stages of change

The pathway that leads an individual to change an addictive behaviour begins in the Pre-contemplation stage, where he/she has no current interest in change, and lacks awareness of the need for change, sustaining a belief that change is unlikely. The individual then moves through the Contemplation stage, where he/she becomes aware of a serious need for change and is considering modifying his/her behaviour but has not translated those thoughts into actions. The hallmark of the contemplation stage is ambivalence about change. The third movement stage is Preparation. The individual who in this stage has made some small attempts at change but has not embraced everything necessary to make change occur. This individual's plan is to take action in the very near future. After some change has been initiated and then actively engaged

in to modify his/her behaviour, the individual will progress to the Action stage. The fifth stage, Maintenance, is characterized by energy and effort devoted to relapse prevention, and maintains the change that has been made. Gains made during the action stage are consolidated during this stage, and it is plausible that the individual will remain in this stage indefinitely as he/she continues to minimize his/her risk factors and manage his/her vulnerabilities (Connors et al., 2001; DiClemente, 2006; Reid, 2007). As mentioned before, the movement is more cyclical and circuitous, so the tendency of an individual to recycling reverse stage (move back to the previous stages) and relapse can occur.

2.2.1.2   The Processes of Change

Prochaska and DiClemente (1984), Connors et al. (2001), Velasquez et al. (2001), and DiClemente (2006) describe the processes of change as the engines that create and sustain the transitions through the stages and facilitate successful completion of the stage tasks. The processes are also the province and responsibility of the individual making the change and initiating, modifying, or stopping the behaviour.

Ten processes of change have been identified which can enable people to move from one stage to the next. These processes fall in two groups: cognitive/experiential process, and behavioural process. The ten processes and their accompanying descriptions are shown in Table 2.2. According to DiClemente (2006), the cognitive/experiential processes of change are critical ingredients for creating movement through the stages of change, and more importantly, in negotiating passage through the earlier stages of change, namely, Pre-contemplation and Contemplation, while the behavioural processes of change are more important in the Preparation,

Action, and Maintenance stages. All these processes operate in similar ways but in different directions for initiating, modification and cessation of the behaviour (DiClemente, 2006).

The first set of processes, the cognitive/experiential processes of change, which are the main processes of change in the early stages of change (which is the focus of this study), are used to identify the ways of thinking and feeling that create change. The most important and fundamental process is consciousness-raising. Consciousness-raising is defined as "increasing awareness of the causes, consequences, and responses to a particular problem" (Prochaska, 2003). This process will increase awareness of the current and the new behaviour or of the need to change or not. It is a prime target for most prevention and treatment programs (DiClemente, 2006), where the clients will be provided with more information and knowledge to gain his or her awareness about himself or herself and the nature of the behaviour. Increasing information about the self and the problem behaviour is brought to the attention of the individual with the problem behaviour (Prochaska, DiClemente & Norcross, 1992). For instance, in the pre-contemplation stage, the client does not see a problem. He/she must first become aware of the problem in order to address it, and the process will help to shift the client toward considering change (Velasquez et al., 2001). The emotional arousal process involves the emotional experiences or reaction of the new or old behaviour. The activities targeted by this process aim to either enhance the value of the current or new behaviour or to decrease the value or need for the behaviour (DiClemente, 2006).

Table 2.2

Ten processes of change

<div style="text-align: center;">Cognitive/experiential</div>

1. *Consciousness rising:* Gaining information that increases awareness of the current behaviour pattern or the potential new behaviour

2. *Emotional arousal:* Experiencing emotional reactions to the status quo and/or the new behaviour

3. *Self-reevaluation:* Seeing and evaluating how the status quo or the new behaviour fits in or conflicts with personal values

4. *Environmental reevaluation:* Recognizing the positive and negative effects that the status quo or new behaviour has upon others and the environment

5. *Social liberation:* Noticing and increasing social alternatives and norms that help support the status quo and/or change and initiating of the new behaviour

<div style="text-align: center;">Behavioural</div>

1. *Self-liberation:* Making choices, taking responsibility for, and making commitments to engage in a new behaviour or a behaviour change

2. *Stimulus generalization/control:* Creating, altering, or avoiding cues/stimuli that trigger or encourage a particular behaviour

3. *Conditioning/counter-conditioning:* Making new connections between cues and a behaviour or substituting new, competing behaviours and activities in response to cues for the "old" behaviours

4. *Reinforcement management:* Identifying and manipulating the positive and negative reinforcers for current or new behaviours. Creating rewards for new behaviours while extinguishing (eliminating reinforcements) current behaviour

5. *Helping relationship:* Seeking and receiving support from others (family, friends, peers) for current or new behaviour

Source: DiClemente (2006). Addiction and change, p. 34.

Other processes of change in this group include self-reevaluation, a reassessment process whereby one re-evaluates the current or new behaviour. Through this process, the individual will make re-evaluations of his or her behaviour and then make clarification of how the behaviour fits with current or aspirational values, beliefs, and goals. The process of environmental re-evaluation will help the client to reevaluate the effects of his/her current or new behaviour that could be experienced by others and the environment. Lastly, the process of social liberation is that which will make the individuals notice and increase their social alternatives and norms that help

support the current and new behaviour. According to DiClemente (2006), this process promotes the realization and acceptance of social norms and societal sanctions, and helps the individual to view change as possible as well as to experience viable alternatives.

2.2.1.3 The Markers of Change

In their TTM, Prochaska and DiClemente (1984) proposed that decisional balance, as noted in the work of Janis and Mann (1977), and self-efficacy, as derived from Bandura's social-cognitive theory (Bandura, 1997), were the primary factors that predicted an individual's ability to transition through various stages of change. DiClemente (2006) insisted that although there are many potential markers and mechanisms that can interact with the process of human intentional behaviour change, TTM view decision-making and self-efficacy as equally important markers of movement through various stages in the process of change for addiction.

Decisional balance refers to the process of cognitively appraising the benefits and costs associated with behaviour modification (DiClemente, 2006). Decisional balance also refers to the perception of the benefits and costs of the targeted behaviour, which are believed to influence decisions and behaviour (Buckworth & Wallace, 2002). It identifies the relationship between the pros and cons for change, and becomes an important marker of movement through the stages of change in the early stages of change (Pre-contemplation and Contemplation) (DiClemente, 2006). For an individual in the stage of Pre-contemplation for recovery, his/her reasons for being against abstinence and in favor of continuing addictive behaviour are greater than the pros of stopping and the cons of continuing the behaviour. His/her decisional balance is in favor of the status quo. In Contemplating, the decisional balance favors

the pros for change and has greater balance between the positives and negatives. If the individual is to continue to move forward, the pros for change and the cons for the status quo must increase (DiClemente, 2006).

Janis and Mann (1977) believe that four factors underlie an individual's decision process, the process of the anticipated gains (benefits) and losses (costs). The first two factors address how the decision will affect the decision maker, namely, the utilitarian gains and losses for self, and the utilitarian gains and losses for significant others. The two additional factors address how the decision will affect the decision maker's moral standards and self-image (self-approval or disapproval) and the approval or disapproval of others who may be evaluating the decision maker (approval or disapproval of others). Janis and Mann (1977) are of the opinion that it is essential to consider these four factors or the decision maker will be vulnerable to retracting his/her decision. Nevertheless, studies conducted by Prochaska, Velicer, Rossi, Goldstein, Marcus, Rakowski, Fiore, Harlow, Redding, Rosenbloom and Rossi (1994) to investigate the relationship between stages of change and decisional balance constructs in 12 types of problematic behaviours (inclusive of quitting cocaine) discovered that only two main categories of decisional balance, pros and cons were found to clearly represent decisional categories for making behaviour change across the stages of change.

The second marker is self-efficacy, which refers to an individual's self-perceived confidence in his or her ability to make change occur, a degree of measure to which individuals believe they can be successful in achieving or resisting a behaviour, and how confident the individual is in performing a specific behaviour (Bandura, 1997). According to Bandura's concept of self-efficacy, what people know, the skills they possess, or what they had previously accomplished are not always good

predictors of subsequent attainments because the beliefs they hold about their capabilities powerfully influence the ways in which they will behave (Pajares, 1997). The sources of self-efficacy beliefs are derived from four aspects and these are: mastery experience (the interpreted result of one's purposive performance), vicarious experience (felt or experienced indirectly), verbal persuasions (exposure to the verbal judgments that others provide), and physiological states (such as anxiety, stress, arousal, fatigue, and mood states) (Pajares, 1997).

Efficacy evaluations can represent an individual's self-reported confidence to abstain from a problematic behaviour as well as to perform a desired one (DiClemente, 2006). DiClemente and Hughes (1990) found that individuals who have little confidence in their ability to perform a behaviour might become stuck in the Pre-contemplation stage, feeling hopeless about the possibility of change. It also has been a strong, effective predictor and important marker of the transition through the stages of change, and does seem to play a role in earlier stages as well. For individuals in the early stages of change, higher levels of efficacy are related to increasing use of experiential and behavioural change processes (DiClemente, 2006).

2.2.1.4   The Context of Change

TTM represents five areas of functioning to describe the context of change, where any pattern of behaviour change occurs in these areas of an individual's life. These areas are current life situation, beliefs and attitudes, interpersonal relationships, social systems, and enduring personal characteristics (DiClemente & Prochaska, 1998; Prochaska & DiClemente, 1984). Any related issues, problems, resources, or liabilities in each of these five areas can facilitate or hinder successful change of any specific pattern of behaviour (DiClemente, 2006).

The current life situation includes the current internal and external environments in which the change is to take place, the emotional and mental status of the individual, and the current living situation. Addiction is typically viewed as a problem symptom in the current life situation. DiClemente (2006) states that in general, an individual who has more resources and fewer problems in the current life situation has a better prognosis for a successful transition through the stages. An assessment of the individual's current life situation will identify the strengths and/or problems in the life situation that can interact with movement through the stages of change.

The beliefs and attitudes of an individual interact with the process of change in many ways. They provide the cognitive framework in which the change is to take place, how change should happen, what is needed for successful change, and what the general beliefs are about self and world, religion and family, for the change process. Assessing how the beliefs and attitudes are involved in changing the specific behaviour pattern in question can assist in understanding why one individual may get stuck in contemplation, rush into action, or fail in maintaining the behaviour change (Prochaska & DiClemente, 1984; DiClemente, 2006).

The interpersonal relationships in an individual's life involves dyadic interactions, and these include interactions with significant others such as spouses, special friends, and lovers. The relationships also can foster or hinder movement through the process of change in many ways. Interpersonal relationships and their influence are often considered important elements in decision-making since individuals contemplate changing a particular behaviour, such as evaluation and approval of others, in the process of weighing the pros and cons for change (DiClemente, 2006). In addition, DiClemente, Dolan-Mullen and Windsor (2000)

state that interpersonal problems can play a decisive role in the decision to make a change and often influence whether that change is sustained over time.

The fourth area of functioning is the social system. Various social systems of which the individual is part of, such as the individual's family system, social network, societal and work systems, can influence the process of change (DiClemente, 2006). Social systems influence the individual by way of persuasion, modeling, social norms and social reference (Bandura, 1986), incentives or barriers for change (Prochaska, Norcross & DiClemente, 1992; DiClemente & Prochaska, 1998), and may offer support for or interfere with the change. The fifth and last area of functioning is the enduring personal characteristics. This encompasses basic personality characteristics and conflicts that influence the change process. They can hinder or promote decision-making, influence planning, and affect the implementation of the plan and action to be taken. Some characteristics, including personal identity, self-esteem, conscientiousness, extraversion, agreeableness, and neuroticism, could play a role in contemplating or complicating change (DiClemente, 1994).

According to DiClemente (1994, 2006), besides the influence of these five areas of functioning on the process of behaviour change, the context of change also helps us to identify factors that complement or complicate the process of change. For instance, practitioners have to assess whether these five areas of functioning influence transitions through the stages of change for the specific targeted behaviour. If the issues in one or more of these areas of functioning are complementing or complicating the process of change, they may have to be addressed, augmented, neutralized, or modified in order to facilitate movement. However, as individuals initiate, modify, or stop a behaviour (addictive behaviour), changes in other areas of functioning almost certainly will occur (DiClemente, 2006).

2.2.2   How the change takes place

TTM states that the processes of change are the engines that create and sustain the transitions through the stages and facilitate successful completion of the stage tasks. These processes are also the province and responsibility of the individual making the change and initiating, modifying, or stopping the behaviour (Prochaska & DiClemente, 1984; Connors et al., 2001; Velasquez et al., 2001; and DiClemente, 2006). The framework of the TTM also outlines the important steps, tasks, activities, experiences, and contextual influences that can help practitioners to understand the differences between success and failure in the movement through the process of intentional behaviour change (DiClemente, 2006). The transtheoretical model also posits that individuals will utilize differential *processes* of change depending on their particular stage of change (Prochaska, Velicer, DiClemente, & Fava, 1988). The more the clients are actively committed to changing a particular behaviour, the more likely they are to use more effective behaviour change processes, thus leading to more positive treatment outcomes (Eckhardt, Babcock & Homack, 2004).

Prochaska, Johnson and Lee (2008) suggest various intervention techniques that can be implemented to drive the cognitive/experiential processes of change, as illustrated in Table 2.3. These techniques that the TTM provides are matched to treatment interventions based on the client's current stages of readiness to change. Treatments or interventions which are mismatched to the client's stage of change are likely to be unhelpful and may even be harmful. However, knowing what stage the client is in provides important clues to what will work and what will not (Washton & Zweben, 2006).

Table 2.3

Processes of change and appropriate intervention

Processes of change	Intervention techniques
1. Consciousness-raising	Feedback, education, confrontation, interpretation, bibliotherapy, and media campaign
2. Emotional arousal (dramatic relief)	Psychodrama, role playing, grieving, personal testimonies, and media campaign
3. Self-reevaluation	Value clarification, healthy role models, and imagery
4. Environmental reevaluation	Empathy training, documentaries, and family intervention
5. Social liberation	Advocacy, empowerment procedures, and appropriate policies implementation

According to Prochaska and DiClemente (1986), the stages-of-change model not only describes the characteristics of the client in each stage, it also shows the types of interventions that are most likely to be effective within each stage and to promote movement onto the next stage. In addition, as mentioned by DiClemente (2006), the secret to successful human intentional behaviour change appears to be doing the right thing (specific process activities) at the right time (specific stages) in the process. To begin with all the strategies and interventions to move the client to change, we have to state how to achieve the treatment tasks in each stage should be stated. For the current study, as DiClemente (2006) stated, the treatment task for the pre-contemplator is to increase concern and hope for change, while the treatment task for the contemplator is to tip the decisional balance.

To describe how the change takes place as a process in the context of the TTM model, it is necessary to understand the characteristics of the individuals, the stages they are in (especially pre-contemplation and contemplation stages as focused upon in

this study), the processes of change they experience in each stage, the decisional balance, and self-efficacy as markers of change.

2.2.2.1 Precontemplating for recovery

In the context of the recovery process, pre-contemplation is the first stage of change, which is experienced by an addict. Addicts who are at this stage are considered to be unaware or ignorant of their drug usage problem. Even if they are aware of the problem, addicts usually do not seriously think of making any changes to the problem (Connors, Donovan & DiClemente, 2001). They are often at this stage because they are uninformed or under-informed about the consequences of their behaviour. Moreover, if they had been involved in change previously, they would be those who had felt demoralized and been unable to have the courage to change (Prochaska & Velicer, 1992). Eventually, these addicts avoid talking or thinking about it, become noncompliant, resistant, unmotivated or unready to participate in any therapy or intervention (Prochaska, Johnson & Lee, 2008).

The general characteristics of individuals who are at the stage of pre-contemplation (Prochaska & DiClemente, 1984; DiClemente & Hughes, 1990; Carney & Kivlahan, 1995; Connors, Donovan & DiClemente, 2001; DiClemente, 2006) are listed in Table 2.4. DiClemente (1991, 2006), and DiClemente and Velasquez (2002) specifically explained that an individual who is at this stage naturally prefers the status quo, is satisfied with his current behaviour and is not ready to disturb it. This individual perceives change as something that is irrelevant, unwanted, unneeded, or impossible to achieve. As long as this behaviour is considered to be functional to the individual, or no compelling reason arises to disrupt this behavioural pattern, this individual will remain a pre-contemplator.

Table 2.4

Common characteristics of individuals in pre-contemplation stage

1.	Defensive
2.	Resistant to suggestion of problems associated with their drug use
3.	Uncommitted to or passive in treatment
4.	Consciously or unconsciously avoids steps to change their behaviour
5.	Lacks awareness of the problem
6.	Often pressured by others to seek treatment
7.	Feeling coerced and "put upon" by significant others

DiClemente (2006), and DiClemente and Velasquez (2002) characterized an individual at the pre-contemplation stage as an individual who often uses various excuses or strategies to neutralize any momentum that can cause him to evaluate any kind of change in his behaviour. CSAT (2005) noticed that five excuses or strategies are reflective of a real pre-contemplator:

(a)   Reveling

A reveling pre-contemplator refers to any addict who claims that being in addiction is a wonderful moment, is having too good a time and that it is a condition which does not require any change. Such a situation occurs because the addict has not accepted or experienced the negative effects of drug abuse. If he has experienced any negative effects, they have usually been mild or replaced by benefits. Moreover, a reveling pre-contemplator also feels that he is able to control or change his addictive behaviour if he wants to.

(b)   Reluctant

Reluctant pre-contemplators are individuals who are simply unwilling to consider change. They do not resist change, but these addicts are often not ready to change because of their own indecision or hesitancy about the prospect of changes that they will, or have promised to, go through. Situations like these are attributed to the addictive behaviour that they are experiencing: it provides more benefits to them than disadvantages or problems. To reluctant pre-contemplators, change is disruptive to the comfortable way of life to which they are accustomed.

(c)   Rebellion

Rebellious pre-contemplators are individuals who are prone to seeing themselves as fully in control of shaping their way of life, as well as determining their own decisions. They are often passionately invested in their ability to make their own choices and decisions, and they resent anyone telling them what to do. In addition, rebellious pre-contemplators are hostile and resistant towards any notion that they have changed. Their perception about their right to decide on their own way of life and to make decisions is usually the reason they loathe admitting their physical or psychological dependency on their addictive behaviour.

(d)   Resignation

Resigned pre-contemplators are individuals who feel helpless and unable to change. They resign themselves to being dependent on the addictive behaviour, because they feel that change is unattainable as a result of the addiction problems which have overwhelmed them. This could also be due to the fact that they had previously tried to change but found it completely unachievable. Having resigned to

their fate, these contemplators believe that change is not an option in their lives because they have been struggling with addiction and are now fully dependent on drugs physically and psychologically. These reasons cause them to continue with their addictive habits even if they have to experience pain and discomfort.

(e)   Rationalizing

Rationalizing pre-contemplators are individuals who often provide rationales for to their addictive behaviour. For instance, the common rationales given by them are, "I am not an alcoholic since I only drink beer"; "I am still young and will stop later"; and "I am addicted to marijuana and not heroin", among others. They are always armed with answers which make them believe that drugs or addictive behaviour do not affect them, and they also believe that they are capable of escaping the negative effects of addiction.

These strategies are commonly used by pre-contemplators to enable them to avoid seriously thinking of modifying, or contemplating the need to modify, their addictive behaviour in the short term, which according to DiClemente (2006), can last for as long as six months. They consider themselves "not ready to change", adamantly oppose any changes, and take a long time to begin seriously contemplating whether or not they should significantly modify or change their behaviour. "Why change?" becomes the central question for them to challenge an intervenor (DiClemente, 2006).

Pre-contemplators are also characterized by DiClemente (2006) as individuals who are still at the stage of well-maintained addiction. They perceive and believe that any problem that disrupts their various areas of functioning can be solved by carrying out any activity, which is supportive of addictive behaviour. Their belief system, relationships, social system, and personality traits are shaped to fit their addictive

behaviour and to minimize any problems that they face. Pre-contemplators are those addicted individuals who manage the consequences and concerns that arise in their lives, so that they can maintain a positive decisional balance that supports continued engagement in their addiction. According to O'Brien and Abel (2011), such a condition causes them to perceive their addictive behaviour as positive, and also shapes their denial attitude by minimizing, rationalizing, and/or being resistant to change.

2.2.2.2 Moving the pre-contemplator

In order to move an individual who is at the pre-contemplation stage, the specific tasks of this stage must be completed (achieved by the intervenor) and the objective achieved. DiClemente (2006) listed the specific tasks and goals to be achieved at the pre-contemplation stage, as illustrated in Table 2.5.

Table 2.5

Tasks and goal for pre-contemplators

Pre-contemplation
The state in which there is little or no consideration of change of the current pattern of behaviour in the foreseeable future.
Tasks: Increase awareness of need for change; increase concern about the current pattern of behaviour; envision possibility of change.
Goal: Serious consideration of change for this behaviour.
(Source: Adapted from DiClemente (2006), Addiction and Change, p.27)

According to DiClemente (2006), the major basis for moving from pre-contemplation to a higher stage, at least to contemplation, is that the individual (pre-contemplator) must become involved in the process. Movement from pre-contemplation must occur from within the individual in order to begin the process of intentional behaviour change. In order to initiate change from within an individual,

Simpson and Joe (1993) proposed four focused interventions which must be given to the pre-contemplator, which are: (1) see the problem; (2) perceive the risks; (3) experience and digest the consequences; and (4) see the potential for change. CSAT (2005), DiClemente (2006), Connors, Donovan and DiClemente (2001), and Velasquez et al. (2001) perceived that change processes can be a significant intervention to drive individual change at the pre-contemplation stage. According to these authors, the recovery task at this stage is to discover any consequences and concerns from the problematic pattern of addictive behaviours that will arouse a consideration of change. Table 2.6 summarizes the change processes which can be used and the intervention focus.

Table 2.6

The processes of change for intervention

<u>Change processes at work</u>

The cognitive/experiential processes used to promote awareness of and concern about addictive behaviour, in order to spur movement out of pre-contemplation, are:

1. *Consciousness-raising*: Focus is on finding reasons and experiences which challenge views that addictive behaviour does not cause problems.

2. *Emotional arousal*: Experiences that counter reveling in the benefits of addiction, and which highlight negative reactions and consequences associated with addiction.

3. *Self-reevaluation*: Shifting discussions away from issues of independence and alternative causes of consequences (rationalizing), and onto values and considerations that create dissonance; moving from rebellion to personal realizations.

4. *Environmental reevaluation*: The person sees the environment as challenging engagement in the addiction; reevaluates environmental concerns and impact of the addiction.

5. *Social liberation*: The person begins to realize shifting societal norms and how policies and laws attempt to control behaviour or provide alternatives.

(Source: Adapted from DiClemente (2006), Addiction and Change, p.132)

According to Velasquez et al. (2001) however, to enable pre-contemplators to move forward in the cycle of change, they have to admit that their behaviour is problematic and become more aware of its negative effects. For these people, the key processes of change include consciousness-raising, dramatic relief, self-reevaluation, environmental reevaluation, and tipping the decisional balance. Similar suggestions were presented by Connors, Donovan dan DiClemente (2001), who stated that activities in the process of change involve all cognitive/experiential change processes as they are most relevant in moving pre-contemplators to the next stage, directed by achieved stage tasks such as raising awareness of the problem, realization of the consequences and the impact of behaviour on others, and the contrast of current life versus goals.

All these processes of change are considered to be "engines" that assist an individual to complete the task at this stage (DiClemente, Nidecker & Bellack, 2008). They are needed to create the conditions necessary to meet the task goals of the stage, to move through the entire process of change, and ultimately to achieve behaviour change outcomes (DiClemente, 2006; DiClemente, 2003; Prochaska, DiClemente & Norcross, 1992). DiClemente (2006) added that the processes of change which are applied in this intervention are those of consciousness-raising in order to enhance the awareness of problem recognition and self-reevaluation which involve individuals who make costs-benefits behaviour analysis. Any activities which aim to increase knowledge and information of behaviour are the critical mechanisms to propel pre-contemplators to change.

In order to handle different categories of pre-contemplators (reveling, reluctance, rebellion, resignation, and rationalizing), processes of change which are used as intervention input (processes of change activities) are able to assist pre-

contemplators to picture or to admit the problems they are facing, and the potential change that they can explore (DiClemente, 2006; CSAT, 2005; Connors, Donovan & DiClemente, 2001).

For reveling pre-contemplators, addiction has become a part of them. They are happy and elated as they enjoy that addiction. The intervention challenge is to increase their concern and to assist them to see that their problem contributes to many negative effects, and that change will benefit them. Forcing and punishing them might cause them to retaliate. A suitable intervention is to provide objective normative feedback about their behaviour and information about negative physical effects, highlighting real and potential negative consequences (DiClemente, 2006). This is able to provide information to enhance the pre-contemplator's awareness and assist them in re-evaluating the negative aspects of their behaviour.

In the case of reluctant pre-contemplators, the intervention challenge is to break through the inertia (living without energy) and develop negative perceptions towards addictive behaviour, while strengthening the benefits of change. Consciousness-raising and self-reevaluation processes can be the focus of intervention to assist the pre-contemplator to re-evaluate any previous change, any possibility of successful change, and increased ability to overcome any hurdles that may be in their way. These processes can assist to reassure them that they can still function normally without the use of drugs, and that they are able to manage the urge or need to be involved in drugs again. If these processes are conducted in groups, the support given by the other individuals who are going through the same stage or process of change will help the relationship process most effectively (DiClemente, 2006; Velasquez et al., 2001).

Rebellious pre-contemplators can limit or obstruct any change process they experience if they feel that it is imposed externally. Therefore, any self-liberation change process activities that are used must focus on the change as the pre-contemplator's responsibility and choice, which means that they must be in charge of the change. Social liberation change process activities are required to assist pre-contemplators to recognize and understand the social barriers practiced in the community and the choices that are available. (DiClemente, 2006).

The main challenge in intervention to spur the change for resigned pre-contemplators is to offer hope and a vision of the changes that they need, since they often have a high temptation for drugs and a low ability to change. In the intervention, self-reevaluation process activities must focus on the pre-contemplator's addiction history, such as questioning them on when and why they used drugs. This is to ensure that they are able to clearly view the scenario of their addictive behaviour in a wider perspective. Using their peers as helpers in activities, such as sharing experiences, successful and unsuccessful attempts, and environmental reevaluation can offer hope and lessons to the pre-contemplators to begin intentional behaviour change (DiClemente, 2006).

The challenge in convincing rationalized pre-contemplators to change is that they have all the answers for their behaviour. Change process activities such as consciousness-raising, self-reevaluation or emotional arousal need not focus on convincing them that their behaviour is wrong and non-beneficial to others. They themselves are the first persons that they have to convince. Change process activities must promote an interactive stance which respects the individual engaging in the addictive behaviour, and attempt to begin with the perspective of the addicted individual. These activities promote consciousness-raising, environmental-

reevaluation and self-reevaluation by listening, summarizing back to the individual to ensure that he understood what he heard, looking for any ambivalence and discrepancies between the individual's behaviour and his values, beliefs and experiences (DiClemente, 2006). Another way is to provide accurate feedback and objectives based on assessments done on the individuals and their behaviour (DiClemente, Marinilli, Singh & Bellino, 2001).

Meta-analysis studies by Hall and Rossi (2008) on 48 types of behaviour found that change process activities conducted with pre-contemplators must focus on increasing the pros and cons for change, with perhaps twice as much emphasis placed on raising the benefits (pros for changing) as on reducing the costs or barriers (cons for changing). The basis of this finding was based on the results of analysis which found that pre-contemplators have higher cons for change as compared to pros. However, according to CSAT (1999), nine intervention strategies can be used to drive change among procontemplators. These are to:

i.   establish rapport and trust;

ii.   explore and 'decontaminate' the referral process;

iii.   affirm the client's willingness to attend and talk;

iv.   explore the meaning of events that brought the client to treatment;

v.   elicit the client's perceptions of their behaviours in the larger situation;

vi.   offer factual information about the risks of substance use;

vii.   provide personalized feedback about assessment findings;

viii. explore the good things and less good things about substance use; and

ix.   express concern and 'keep the door open'.

All these intervention strategies can assist the counselor to achieve his goal of helping clients to be involved in paying attention to the patterns and effects of taking substances that can leave effects on them.

2.2.2.3   Contemplating for recovery

In general, an individual who is at the contemplator stage has successfully completed the pre-contemplation phase, which is a "serious consideration of change for addictive behaviour". According to Connors, Donovan and DiClemente (2001), contemplators start to seriously think of making changes to their behaviour but are not involved in making the move, or they have not decided to act. They are seriously considering resolving the problem (Prochaska, DiClemente & Norcross, 1992). Prochaska and DiClemente (1982) on the other hand, characterized contemplators as individuals who are beginning to admit the existence of problems and are striving to understand or make sense of them, and who are feeling pressured and uncomfortable with their problems. Prochaska and DiClemente (1992), Connors, Donovan and DiClemente (2001) and Velasquez et al. (2001) listed in detail the general characteristics of individuals who are at the contemplation stage, as illustrated in Table 2.7 below.

Table 2.7

Common characteristics of individuals in contemplation stage

1.	Seeking to evaluate and understand their behaviour
2.	Distressed
3.	Desirous of exerting control or mastery
4.	Thinking about making a change
5.	Have not begun taking action and are not yet prepared to do so
6.	Frequently have made attempts to change in the past
7.	Evaluating pros and cons of their behaviour, and of making changes to it

According to Velasquez et al. (2001), contemplators might be far from making any commitment to taking any action to change. This is because at this stage, they will accept and absorb all information related to their problems in the rehabilitation program, but are not able to do anything. They know where they are (the level of their addiction), their problems and desires. In fact, they may even know how to get the solutions, but they are still not ready to make any commitment. CSAT (2005) categorized contemplators as individuals who are in the state of ambivalence, which means they simultaneously see reasons to change and reasons not to change. They will gather as much information as possible and make comparisons between the negative and positive aspects of both current and new behaviours. DiClemente (2006), in describing this situation, explained that a consideration of change entails struggling with ambivalence about leaving one behaviour pattern and moving to another, and as a result the addict enters into a period of instability.

Prochaska, Johnson and Lee (2008) explained that contemplators will remain in this stage for a long period of time if the pros and cons of changing are balanced, which causes them to be ambivalent. These are the chronic contemplators or behavioural procrastination contemplators, and they will fight against or will not be ready for any traditional action-oriented intervention programs. DiClemente (2006) stated that the group of individuals who are identified as contemplators are incapable of making the change simply because they are not convinced of the need for change despite the clear and present danger of the addiction.

2.2.2.4   Moving the contemplator

The contemplator's aim in the context of change is to make a firm decision to change through the implementation of tasks of change, such as:

(a)   gathering decisional considerations (positive and negative considerations);

(b)   examining them (evaluating the considerations); and

(c)   engaging in the comparative process that would resolve decisional conflict to make a firm decision (DiClemente, 2006).

DiClemente (2006), in addition, suggested implementing change process activities to assist the contemplator to move to a high stage of change, that is the preparation stage. These processes enable the contemplator to gain as many considerations as possible (of the advantages and disadvantages of current and new behaviours), in order to assist them to make the decision to change (decisional considerations). The contemplators' ability to balance the negative considerations against the positives could be the determiner of success in producing concrete decisions. Balancing these negative and positive considerations becomes more challenging at this stage, since the negative considerations (the pros for an activity or behaviour, or the cons for change) are higher at contemplation stage. This could temporarily prevent change while the positive considerations (the cons of the addictive behaviour or the pros for change) are low (DiClemente, 2006).

The processes of change that could be utilized and focused upon for the intervention are summarised in Table 2.8. Other than the change process activities which assist the contemplator to get the information (decisional considerations), Miller and Rollnick (1991, 2002), posited that considerations of the gains and losses of the anticipated change also influence the contemplator. There are many strong positive reasons for continuing an addictive behaviour, including the consideration of potential losses and problems associated with stopping the addictive behaviour. Considerations involving issues of approval and disapproval from self and significant

others are also taken into account, and these can influence the decision made (Janis & Mann, 1977).

Table 2.8

The processes of change for intervention

Change processes at work
Cognitive/experiential processes which promote decision-making and movement into Preparation (particularly those promoting awareness and reevaluation of negative consequences and positives for change)

1. *Consciousness-raising*: Discovering negatives of the addictive behaviour and positive reasons and expectancies for change.
2. *Emotional arousal*: Getting in touch with some core values that would promote change, realizing the negative reactions created by the addiction.
3. *Self-reevaluation*: views and valuing of the addictive behaviour to emphasize consequences and of the potential benefits of the change.
4. *Environmental reevaluation*: The person begins to realize the impact of his addiction on others and the risks of continuing his addiction in contrast to the benefits of change.
5. *Social liberation*: The person begins to see how others in society support and encourage the behaviour.

In order to assist the contemplator in making a decision to change based on considerations gained from change process activities, rehabilitation activities (especially those in groups) can emphasize balanced ledger activities, such as that proposed by DiClemente (2006), named Decisional Balance Worksheet (DBW). Through this activity, the contemplator will be asked to list down all considerations on a piece of paper provided. These considerations will be categorized according to themes as described in Table 2.9. Through this activity, the importance and current significance of all of these considerations feed into the decisional balance about changing the contemplator's behaviour.

Having gone through the first stage, contemplators have to be assisted in making an evaluation of their considerations and must be engaged in the comparative process to make a firm decision. This evaluation is called tipping of the decisional

balance and decision making. An accurate evaluation of what role behaviour plays in the life of the individual's addiction appears to be an important element in fostering serious consideration of change. Evaluation focus must be given due attention, particularly on the aspects of both negative and positive behaviours, in order to avoid or overcome the problem of ambivalence. DiClemente (2006) indicated that contemplators who fail to gather enough data about both benefits and negative consequences do not have a complete picture of the pros and cons of their addictive behaviour (process of evaluation of considerations), and will later fail to make the right decisions.

Table 2.9

Decisional balance worksheet

No change (considerations against change)	Change (considerations for change)
Pros (Drugging)	Cons (Drugging)
Lists of the positives of the behaviour	Lists of the negatives of the behaviour
Cons (Change)	Pros (Change)
Lists of the negatives of the change	Lists of the positives of the change

 (Source: Adapted from DiClemente (2006) and Connors, Donovan & DiClemente (2001)

CSAT (1999) proposed four strategies which can be used to help clients tip the decisional balance:

(a) eliciting and weighing the pros and cons of continuing substance use, versus discontinuing or changing use patterns;

(b) examining the client's personal values in relation to change;

(c) imagining the future; and

(d) emphasizing the client's free choice, responsibility, and self-efficacy for change.

As a result, the client will be able to view changes in a wider context (bigger picture), learn about the differences between their current behaviour and their future goals, and consider making changes to parts of their lives.

Janis and Mann (1977, in Yahne & Miller, 1999) explained that there are four main questions which must be focused upon when assisting contemplators to produce concrete decisions to change, in order to make them (contemplators) feel safer after that. These questions are:

(a)   What are the potential gains and losses for me in this choice?

(b)   What are the gains and losses for others in this choice?

(c)   What are aspects of my self-approval or self-disapproval in this choice?

(d)   What are aspects of approval and disapproval by others in this choice (including criticism or exclusion from a group as well as being praised or obtaining prestige, admiration, and respect)?

DiClemente (2006), Velasquez et al. (2001), and Connors, Donovan & DiClemente (2001) listed at least four strategies which can be used by therapists to assist contemplators to make decisions:

(a)   provide feedback when there is time, and in an atmosphere that promotes openness and listening;

(b)   demonstrate as much objectivity as possible, be direct and concrete in discussions;

(c)   provide feedback in the context of concern. Genuine expressions of concern for the well-being of addicted individuals enhance and encourage an exploration of their own concerns; and

(d)   find effective and doable consequences that reinforce your expressions of concern.

2.3   Group Therapy and Behavioural Change

2.3.1   Overview of group therapy

Group therapy, a shortened or colloquial version of group psychotherapy (Gazda, 1982), is a popular form of treatment across many clinical disciplines, and across a wide range of clinical problems. It is a most common form and is popular because of (1) the provision of social support to clients, and (2) the ability to treat multiple clients concurrently and at a lower cost than individual therapy (Sobell & Sobell, 2011).

The use of groups as therapy in any kind of treatment, including drug treatment and rehabilitation, is not new. It is human nature to live in groups and to be influenced by the group. Group members can help during difficult or hard times, but groups can also lead members into deviant and unhealthy behaviour. It all depends on the aims and objectives held by the group. A group built on principle and therapeutic goals may provide its members with literacy-intelligence and guidance, assist members who are in distress, provide positive peer reinforcement and a forum for self-expression, and teach a variety of new social skills. In short, group therapy is able to provide therapeutic services more extensively than individual therapy, even most common form of treatment for substance users (Stinchfield, Owen & Winters, 1994).

In fact, according to Scheidlinger (2000), in some cases, therapy in groups is more useful than individual therapy, while Kaufman (1994) said it is thought to be an essential component of an integrated, individualized approach to the treatment of substance use disorders. This was supported by Washton and Zweben (2006), who were convinced that the healing power of the group experience can be especially powerful for people with alcohol and drug problems, considering the pervasive social

stigma and the intense feelings of shame, guilt, and self-recrimination often associated with these problems. Knowing that all members "have been there" helps to instil optimism and hope that a successful recovery is attainable.

The studies by Project MATCH (1997) and the Center for Substance Abuse Treatment (CSAT, 2005) revealed that group therapy and addiction treatment have natural connections and relationships (natural allies). One reason is that individuals who engage in substance abuse are more likely to remain abstinent and committed to recovery when the treatment provided is in the form of groups, because there are elements of reward and therapeutic energy such as affiliation, confrontation, support, gratification and identification. Furthermore, Yalom and Flores (in Connors, Donovan & DiClemente, 2001) stated that the group delivery format capitalizes on the operation of a number of "curative factors" associated with groups as a form of treatment. These curative factors include the following:

(a)   Many of the problems or skill deficits associated with substance abuse are interpersonal in nature, and the context of a group provides a realistic yet "safe" setting for practice in the acquisition or refinement of new social skills.

(b)   Important aspects of social skills training treatment, particularly modeling, rehearsal and feedback, occurs more powerfully in a group setting.

(c)   A number of features of group approaches, including the instillation of hope, the imparting of information, the realization that others share similar problems, helping others with their problems, the development of socializing techniques, the modelling of appropriate behaviours, and the development and enhancement of interpersonal learning and trust,

appear to produce cognitive, affective, and behavioural changes.

(d)   Peer feedback in the context of a therapy group provides an opportunity to observe and confront others' and one's own "denial system" either directly or indirectly through identification and modelling.

(e)   A client model whose skill level is only somewhat greater than that of the observer is likely to have more impact on behaviour than a therapist serving as a model. Rehearsal with and feedback from peers is likely to be more realistic than in individual treatment and may also serve to produce generalizability of the behaviour change.

(f)   Groups provide clients the opportunity to change their social networks, resulting in the development of a meaningful support system that will further enhance the recovery process.

(g)   The group supports and directs an individual towards a commitment to recovery. This commitment is a fundamental ingredient in the process of behaviour change, and in the process of achieving and maintaining an alcohol- and drug-free lifestyle.

Sobell and Sobell (2011) drew the following conclusions about the role and utility of group therapy:

1)   group processes play an important role through the efficacy of groups;

2)   because of their inherent structure, group therapy offers important advantages that do not exist in an individual therapy setting;

3)   groups that incorporate group processes have reported comparable outcomes to individual therapy; and

4)   multiple patients can be treated in groups at one time, thereby reducing

the financial burden on the payer.

In addition, according to Connors, Donovan and DiClemente (2001), over the course of the group therapy, clients or members of the group found that they were not alone in dealing with their problems, but that other group members had similar experiences. They were able to talk openly about their addiction in a safe and supportive environment without experiencing feelings of shame and loneliness. The closeness and camaraderie (friendship and mutual trust) that developed among the clients were particularly important for them. In terms of therapeutic change, Yalom (1985) insisted that group therapy provides a context in which individuals can experience consensual validation, hear others report familiar struggles, recognize similarities, and reframe elements of their personal dilemma as part of human dilemma. Group therapy is also an empowering experience, where group members serve as change agents and individuals give to one another, offering support, encouragement, reassurance, and insight through feedback and interpretations, which facilitates growth for all of them (Norcross & Goldfried, 2005).

2.3.2   Types of group therapy

In the field of substance abuse treatment, a variety of group treatment approaches are employed by professionals to meet the needs of clients in recovery. According to CSAT (2005), there are five models of group therapy currently used in substance abuse treatment, namely psychoeducational groups, skills development groups, cognitive-behavioural groups, support groups, and interpersonal process group or interpersonal process therapy.

Psychoeducation is one of the motivational techniques or approaches of the that implemented didactically to give and provide information to the client (Velásquez

et al., 2001) related to a problem, especially in relation to substance abuse. While the psychoeducational group is designed to educate clients about the problem, in the context of substance abuse treatment and rehabilitation, it is to educate clients about substance abuse and its related behaviour and consequences. This group provides the necessary information for the client to inculcate self-awareness, suggests options to grow and change, identifies community resources that can help recovering clients, develops an understanding of the process of recovery, and prompts a desire to take immediate action to overcome the client's addiction problems on their behalf (CSAT, 2005). A detailed explanation about psychoeducational groups as used in this study will be provided in the next section.

Skills development groups typically emerge from a cognitive-behavioural theoretical approach which assumes that people with substance disorders lack the needed life skills, a coping skills (CSAT, 2005). Because a deficit in skills to cope with the consequences of drinking/drug use is considered to be a major contributor to the development and maintenance of addictive behaviour (Miller & Hester, 1989), this group attempts to cultivate the skills an individual needs to achieve and maintain abstinence (CSAT, 2005). According to Kadden (2002), skills training can be used to teach coping behaviours not currently in a client's repertoire, to refresh or enhance deficient behaviours, and to identify and reduce inhibiting factors. In all cases, adequate practice of skills is essential, both during sessions and as homework, so that clients become 'fluent' in the skills and are able to apply them fairly easily when the appropriate circumstances arise, without having to do a lot of thinking about the various steps involved or figuring out how to apply them.

In general, group therapy with a cognitive-behavioural approach (cognitive-behavioural groups) perceives that drug dependence is a learned behaviour that is

acquired through repeated actions on the same occasion in order to gain the desired results. Consistent with this view, drug addicts' coping skills are important to enable them to cope with high-risk situations. Even though the behaviours and coping skills of drug addicts are emphasized within the treatment, their cognitions, thoughts, and emotions are taken into account to precipitate and maintain their abstinent behaviour, whereby constructive behaviours are utilized to modify cognitive and emotions of drug addicts as a consequence of the behaviour change. Hence, cognitive behaviour group therapy (CBGT) is more frequently used in drug treatment settings and has been claimed to be a cost-efficient method (Courbasson & Nishikawa, 2010).

Support groups are used in post-treatment and include both family and peers. Previous studies have revealed that peer support groups play an important role in determining treatment outcomes. Peers in recovery often have similar experiences that enable them to assist each other to refrain from relapse and risky behaviour (Ramirez, Hinman, Sterling, Weisner, & Campbell, 2012; Passetti, Godley, & White, 2008; Maxwell, 2002). Participation in 12-step programs and other types of support groups can potentially enable peers to form recovery networks, which are an important source of support for abstinence (Chi, Kaskutas, Sterling, Campbell & Wiesner, 2009).

Group interpersonal psychotherapy, or interpersonal process groups, serves as a phasic process that focuses on interpersonal precipitant in relapse. The groups use psychodynamics, or knowledge of the way people function psychologically, to promote change and healing. There are three variations of how such groups are handled: individual-, interpersonal-, and group-as-a-whole-focused groups. The principles of these groups is delve into major developmental issues, searching for patterns that contribute to addiction or interfere with recovery (CSAT, 2005).

On the other hand, the Association of Specialists in Group Work (ASGW) has

categorized four types of groups which play a significant role in substance abuse treatment, including drugs (Fisher & Roget, 2009). They are:

(a)   Psychoeducational group is a group that provides information and training using new knowledge. It is often short-termed and created as an educational group at the early stage of the addicts' treatment;

(b)   Counseling group is a group that concentrates on normal problems and is less focused on education compared to the interactive process between the members and group resolution of problems. This group is also usually short-termed;

(c)   Psychotherapy group is a group that focuses entirely on the members' issues with the aim of changing them, and it is often conducted over a long time and in a consistent manner; and

(d)   Task or work group refers to a group that is non-therapeutic and focuses on specific aims, such as completing an assigned task or work. The group will be dispersed right after the goals of the tasks or work are achieved.

2.3.3   Psychoeducation and psychoeducational groups

'Psychoeducation' is a term which was first introduced by Anderson, Gerard, Hogarty, and Reiss (1980) in order to explain the behavioural therapeutic concept to the patients. This concept consists of four elements, namely, (1) briefing on the disease, (2) training in problem solving, (3) communication training, and (4) self-assertive training. These processes involve the patient's family members (Bauml, Frobose, Kraemer, Rentrop & Pitschel-Walz, 2006). However, psychoeducation is believed to have been first introduced and used since the era of Freud, Adler, Erikson,

Aichorn and Lewin, and was later popularized by Fritz Redl who is also known as the father of modern education (White-McMahon, 2009). Psychoeducation is also termed as re-education, educational approach, psychological education and psychologically informed education (Richards, 2012).

In addition, according to Bhattacharjee, Rai, Singh, Kumar, Munda and Das (2011), this approach was pioneered in the 18th century and early 19th century by Johann Heinrich Pestalozzi and Samuel Gridley Howe who applied the educative method in psychiatric services to the people who were suffering from physical and psychological problems. However, the method was not performed in a structured and arranged manner. The psychoeducation field began to be widely accepted in psychiatry after an article by John E. Donley entitled "Psychotherapy and re-education" was produced in 1911. Psychoeducation continued to be established when Brian E. Tomlinson published his book "The psychoeducation clinic" in 1941. The popularity and development of the term 'psychoeducation' in present day is the result of relentless efforts by a researcher, CM Anderson who founded psychoeducation intervention in 1980 as an effective supporting treatment for schizophrenia.

A psychoeducational group's primary or main focus is to educate on psychological concepts and topics. Gladding (1995) emphasized skill training and Brown (2011) focused more on the significance of educational goals and prevention, such as teaching any individual how to face a potential threat or to cope with a development life event, as well as teaching a person to have the will to act when he or she faces an immediate life crisis (ASGW, 1991). It contains main educational components as an addition to psychological components that include support and therapy-related groups (Brown, 2011).

Compared to other therapy groups, these psychoeducational groups possess special characteristics, including group counseling, based on several main factors. First, they focus on educational content and on member learning related to the content (Brown, 1997) because content is the pulse or the most important (*sine quo non*) aspect in psychoeducational groups (Champe & Rubel, 2012). Second, group process concentrates more on helping group members to acquire knowledge, learn new skills, and engage in activities (DeLucia-Waack, 2006), or to teach clients about attitudes and personal as well as interpersonal skills that can be used to solve psychological problems today and in the future (Guerney, Stollak & Guerney, 1971). Third, these groups are less dependent on relationships between members and the elements of group process since members have clearly understood the aim and objective of the psychoeducational group (Sheim & Niemann, 2006). Fourth, the content and process of psychoeducational groups are usually presented in a structure and a manual is used (Champe & Rubel, 2012; Brown, 2011). The fifth factor is that they perceive individuals who join the groups as participants, and teachers who teach are perceived as therapists (Anderson, Boris & Kleckham, 2000; Buwalda, Bouman & van Duijn, 2006).

2.3.3.1 Psychoeducation model

The implementation of the psychoeducation model either as an approach or as an intervention strategy, specifically in the treatment field, is based on several psychological theories or models. One of them, psychoeducation is part of a crucial component of Dialetical Behavioural Therapy (DBT; Brown, 2011; Linehan, Armstrong, Suarez, Allmon & Heard, 1991), as the core component of cognitive therapy (Beck & Coffey, 2007; O'Neil et al., 2005), as a significant component of

Cognitive-Behavioural Therapy (CBT; Brown, 2011; Lang, 2004), and as a separate model which embraces various clinical practice theories and models such as the ecological system theory, cognitive-behavioural theory, learning theory, group practice models, stress and coping models, social support models, and narrative approaches (Lukens & McFarlane, 2004; McFarlane, Dixon, Lukens & Lucksted, 2003).

DBT was created by Marsha M. Linehan in 1993 as a therapy method to treat borderline personality disorders which combines several approaches, such as humanistic, cognitive-behavioural techniques and Buddhist mindfulness meditation (Brown, 2011). This therapy applies individual and group treatment methods which are inclusive of individual therapy sessions, psychoeducational group, homework and professional consultant groups that are divided into two main components, namely, individual and group. Psychoeducation is the therapy's significant approach and it aims to teach new skills to the clients such as interpersonal, emotional regulation and distress tolerance skills (Brown, 2011; Linehan, 1993; Linehan et al., 1991). It is also perceived as part of the core components of a cognitive model which is used to teach clients about new patterns of thinking and behaving. The main goal of this approach is to solve interpersonal and intrapersonal problems faced by the clients and prevent them from happening again in future (Beck & Coffey, 2007; O'Neil et al., 2005).

Brown (2011) also believed that psychoeducation is part of the CBT approach component which combines cognitive and behavorial technique approaches. Some of the methods in the treatment approach which use the psychoeducational method in CBT are systematic problem technique, assertion training, relaxation training, behavioural rehearsal, social skills training, and stress management training. Lang (2004), on the other hand, perceived psychoeducation as a leading component of the

CBT therapy process which is able to function therapeutically to improve the client's treatment success through reassurance, destigmatization, motivational enhancement and treatment adherence. The same opinion was shared by March and Mulle (1998) who stated that psychoeducation is part of the CBT component which is used as the first step in the therapy process.

Luken and McFarlane (2004) claimed that psychoeducation is one of the evidence-based treatment models that are effectively and widely applied by professionals in the treatment of mental health, health care and social services across system levels and various contexts. This model is an integration and synergy between psychotherapeutic and educational intervention, based on clinical models such as:

(a)   Ecological system theory – provides the framework to psychoeducational practices for assessing and helping people to understand their illness or experience in relation to other systems in their lives.

(b)   Cognitive-behavioural theory – CBT techniques such as problem solving and role-play are used in the model to increase delivery of didactic materials. These techniques enable the clients to rehearse and review any information and skills taught in a safe setting.

(c)   Group practice models – applies dialogue methods in group, social learning, support and cooperation development, group affirmation for positive changes and network building. All these methods can reduce isolation and act as a forum for recognizing and normalizing experience and response patterns among group members.

(d)   Narrative models – applies the recount method, which is to encourage the group members to tell in detail their stories about circumstances

that they face in order to enable them to identify their strengths and sources as well as move any capability available for an action.

For the purpose of this study, the psychoeducational approach used refers to an integrated approach, or an approach that is open to various integrations of psychotherapy theories and techniques, in order to enhance efficiency and applicability (Norcross & Beutler, 2008) in a supportive relationship. The notion of this integrated approach is "the outcome will be richer than either theory alone" (Corey, 2009). Through this type of approach, Norcross and Beutler (2008) added that a therapy service should be flexibly tailored to the unique needs and contexts of the individual client, not universally applied as "one-size-fits all". The process of therapy is improved if the counselor is able to tailor the theory and technique to match the client's unique needs as compared to forcing the client to match up to the theory's requirement (Corey, 2009). Integration approach in psychoeducational group will be further explained in detail in the next section, theoretical and conceptual framework of the study.

2.3.3.2   Definitions and concept

Richards (2012) stated that the term 'psychoeducation' has a wide variety of definitions and it can sometimes be confusing since it is dependent on the researcher's own orientation and discipline. In general, the definition of psychoeducation depends on the purpose of its use: it is used either as a model or approach in counseling and psychotherapy, or as a strategy or tool by the counselor in handling a session. In terms of concept, Wood, Brendtro, Fecser and Nichols (1999) defined psychoeducation as any term which is coined from the combination of two basic previously used terms: 'psychology' and 'education'. To them, the word 'psycho' refers to the variation of

psychological theories which are the anchor for approaches, issues, program goals, contents and psychoeducational practices. As for 'education', the word is directed at the theories and pedagogy which determine the teaching and learning characteristics applied.

Psychoeducation as an approach is used in many settings. For instance, in medicine and psychiatry, Rummel-Kluge, Pitschel-Walz, Bauml and Kissling (2006) defined psychoeducation as a systematic and structured didactic approach which is used to provide information on diseases and their treatments with the aim of enhancing the coping mechanism in the patients and their families towards the disease. Psychoeducation is also defined as a purely educational modality with the objective of offering information to the patient on psychiatric conditions. Its goal is to educate the patients on the stage of their illness as well as enhancing their capability to produce written decisions about suitable treatment (Miklowitz, 2008; O'Neil, Cather, Fishel & Kafka, 2005; Howard & Goelitz, 2004). On the other hand, Brendtro and Long (2005) referred to psychoeducation as an approach that combines various strategies: it is "a well-planned blending of methods designed for meeting growth needs of children and youth".

For some professionals and researchers, psychoeducation is a tool or strategy that is used in the intervention of counseling and psychotherapy. For example, Srinivasan, Cohen and Parikh (2003) classified psychoeducation as a nontreatment tool which serves as a starter or the foundation to provide patients and practitioners with the same process, either in psychotherapy intervention or in psychopharmacotherapy. Psychoeducation is defined as a reflective training with a pre-treatment structure to provide information, skill training and support, and the main objective is to assist the patients in identifying their problems and choosing the one

which will be discussed in the therapy (Banerjee, Duggan, Huband & Watson, 2006). An almost similar definition is presented by Fallot and Harris (2002) who stated that psychoeducation is a main component in many treatment approaches that provides the patients or clients with information on symptoms and managing the disease; the effects of drug and alcohol abuse; possible existing relationships between trauma and psychological and emotional symptoms; and other main topics. It is often used as a way to explain to the patients about their illness and increase their motivation to comply with the treatment processes (Han, Chen, Hwang & Wei, 2006; Colom & Lam, 2005). In the psychotherapy framework, psychoeducation refers to a treatment component that emphasizes activities such as information communication, sharing of information among the parties involved, and disease treatment (Bauml et al., 2006).

Although there are various definitions available from different perspectives, as well as the practitioner's or researcher's orientations as discussed above, for the purpose of this research, the author is concurs with Velasquez et al. (2001) who defined psychoeducation as an approach and strategy that is used to educate and disseminate information to the clients about their problems and to help them learn to overcome them (skill development). It is also in line with Aguilar, DiNitto, Franklin and Lopez-Pilkinton's (1991) study which stressed that psychoeducation is a therapeutic process that is didactic and experiential which aims to increase clients' awareness and understanding of the illness' symptoms through didactic presentations, group discussions, role-plays, structured trainings and tasks. Similarly, this definition supports Authier's (1977) which emphasized psychoeducation as a therapeutic approach that requires the therapists to play the role of a "teacher" who teach "students" about ambition, goal-setting, skill-teaching, and satisfaction or goal achievement. Moreover, the researcher also agrees with the opinion of Guerney,

Stollak and Guerney (1971) that psychoeducation is a practice conducted by psychologists who believe in the educational model as not only being able to 'cure' neurosis, eliminate symptoms (or complaints) and develop the patient's intellectual directly or indirectly, it could also teach them skills and personal and interpersonal attitude. This is to enable the individuals to use them to solve their psychological problems now and in future so that they can increase their enjoyment of life.

2.3.3.3 Characteristics and types of psychoeducational groups

As there are various definitions for psychoeducation, the characteristics of a psychoeducational group also depend on the researchers' and practitioners' orientation aside from the purpose of its application. In general, Brown (2011) listed 12 basic characteristics of psychoeducational groups and they are:

(a)   Emphasis on didactic and instructions;

(b)   Use of planned, structured activities;

(c)   Goals usually defined by leader;

(d)   Leader operates as facilitator, teacher;

(e)   Focus on prevention;

(f)   No screening of members;

(g)   Cannot set limits on number in group;

(h)   Group can be very large (e.g., 50);

(i)   Self-disclosure accepted but not mandated;

(j)   Privacy and confidentiality not primary concerns or emphasis;

(k)   Sessions may be limited to one; and

(l)   Task functions emphasized.

However, according to Brown (2011) these characteristics can be adapted or changed based on purposes, structure and categories of the psychoeducational group. In terms of the psychoeducational group's purposes, Brown (2011) presented three types, namely:

(a)   Education groups: These are groups which focus on learning of new things via cognitive mode through the use of methods such as lectures, discussions, and observation/participation. Dissemination of materials like ideas, concepts and new facts are given priority in this group. It is often carried out almost entirely by the facilitators or group leaders.

(b)   Skills training groups: These are groups which emphasize learning and practice of new or required skills. These groups have a strong experiential component. Facilitators or group leaders play an important role in teaching required skills and structure experiences to assist the members in carrying them out. Feedback in groups is the main priority for each training taught and practiced.

(c)   Self-understanding/self-knowledge groups: The main purpose of these groups is to enhance knowledge and understanding of the focused topics in the group. Both knowledge and understanding enable the members to feel reassured, obtain feedback from others on the impact of their behaviour on others, and develop self-confidence. The focus of the group has many similarities with counseling/therapy groups, but it is different in terms of the knowledge acquisition stage and there is more superficial understanding since there is unnecessary self-exposure, any resistance is not identified or worked through, and past relationships are not explored.

From the perspective of group structures, there are several types of psychoeducational groups that have different group structures. Brown (2011) indicated that five common group structures for this group are:

(a) Size: All psychoeducational groups have group sizes of between five and 50 people, whereas psychoeducational groups in the form of workshops or seminars can afford to have group sizes that exceed 50 people. Groups that are based on counselling and therapy have five to ten members as well as eight to 12 people (Velasquez et al., 2001). Groups with les than five members will face difficulties in developing cohesion.

(b) Management of content: All psychoeducational groups have their own contents based on each group's objective. Management of content refers to the mode of presentation, initiator and processing. In terms of mode, it can be presented via a lecture, role-play and demonstration. Initiators of topics, concepts, skills, or process can be done by the facilitator. In fact, facilitators or group leaders are usually responsible for preplanning, and obtaining information/input to determine goals and structuring activities. Processing and reflection are the depth and extent to which emerged material is talked about in the group.

(c) Group length and duration: Psychoeducational groups can be carried out from one to several series, long-term or continuous. However, they can usually be done in short sessions over a brief time period (one to two hours). Educational groups normally have more sessions compared to skills training or self-help groups.

(d)   Group leader responsibilities; A group leader or facilitator plays a major role in determining the group's aim and objective, form the groups, choose the activities, and monitor the group's function. Depending on the type of group, facilitators or group leaders may get external experts to assist in outlining the aim and choice of activities. These experts can offer their opinions or identify the requirements of the group members. Ivey (1974) stresses that the facilitators' role cannot be separated from the role of the therapists, and in psychoeducational groups, therapists are known as educators or teachers. The same views are shared by Lightburn and Black (2001) who proposed that clinicians must act as teachers to clients who are considered as students to enable them to adapt to life transitions when faced with challenges and difficult times.

(e)   Severity of the problem: Psychoeducational groups focus on problems (such as anger management, relapse prevention) which determine the topic and focus of the session, as well as the severity of the problem (impact on relationships and functioning).

(f)   Competency of the group leader: Psychoeducational group leaders require the same basic knowledge and a huge part of the skills required by the counseling group leader or group therapy. The difference is that a psychoeducational group leader requires knowledge and skills to help him to understand the members and their needs. Among the requisite knowledge and skills about group dynamics are basic counseling; group leadership communication and skills; knowledge of human development and related issues; specific knowledge and skills such as

substance abuse and career development (according to group focus); training; and experience in field work.

In terms of psychoeducational group, Brown (2011) stated that it can be categorized into several methods, which are: structural versus unstructured; personal versus abstract; developmental versus remedial; and open versus closed. A structured psychoeducational group's purpose is normally to ease the group's sessions and to achieve the goals. The group will be fully managed by a leader/facilitator who is in charge of the group for choice of activities, determining the objectives of each activity and facilitating group discussion, such as using the paper-pencil-task method. The members are often not involved or contribute very little to determining the objective and activity. Non-structured groups, on the other hand, minimize the role of the leader/facilitator to starting the group and informing them about the objectives that they have to achieve. After that, the members decide the flow of the group.

A personal group is more focused on self-awareness, personal issues or any issue that concerns the members. Personal involvement among the members is emphasized and leaders/facilitators have to be prepared to deal with personal issues. In addition, abstract groups focus on topics that may hold personal interest for participants, but they do not ask for the same level of self-disclosure or self-involvement. The topics can be talked about with only mild emotional involvement or with none.

The third category, the developmental group, focuses on developing members' strength, while the remedial group centers on ways to overcome weaknesses or deficits. A developmental group is more preventive in nature whereby it capitalizes on existing strengths since that is easier compared to fixing or improving weaknesses and shortcomings. A remedial group is more difficult to handle since the leader/facilitator

must face members who join involuntarily, who are in denial of their weaknesses and who resent having to attend the group.

The open category in the psychoeducational group usually involves members who keep on changing, that is, some members leave and new ones are received. The duration of time taken for the group's sessions is quite long and it depends on the members' presence. As for the closed group, it is limited to only specific members and when there is a member who leaves or drops out from the group. No replacement is usually required. The time spent with this group is also quite short.

Center for Substance Abuse Treatment (CSAT, 2005) and Velasquez et al. (2001) view a psychoeducational group as a group which is formed to prepare and provide information to the client, and educate clients on their problems. It also has 13 specific characteristics, as listed below:

(a)   it is a highly structured group;

(b)   it contains an optimum of between eight to 12 members in each group;

(c)   group members can have homogeneous or heterogeneous characteristics, depending on the needs or aims of the lessons;

(d)   group membership and purpose can determine the type of psychoeducational group formed, such as relapse prevention, early recovery, and education in substance abuse;

(e)   the time for each group session depends on the members' (clients') learning requirement; however, it is often conducted between 60 to 90 minutes;

(f)   the ideal frequency of sessions is between once to twice per week, depending on the members' needs and it is not burdensome to them;

(g)   implementation of activities in groups is based on the provided content but other activities or pre-planned curriculum is also welcomed;

(h)   activities and the content are often more specific and related to/focused on group-specific content requirement;

(i)   group activity is not limited to lectures alone, as there are many instances where the lecture is combined with activities in skill development. In certain circumstances, groups can be used to assist members to reflect on their behaviours, learn the methods or new ways to face their problems and increase their self-esteem;

(j)   each group member must be actively involved in each discussion held in the group and bring himself to relate whatever that is learned to the problems faced;

(k)   instructor (facilitator or group leader) usually plays a very active role in the ongoing discussions within the group;

(l)   group format differs from one to another. For instance, group format for sitting arrangements must take into consideration the aim of the group as a learning group; and

(m)   a quiet and private place must be taken into account to maximize the learning achievement or group's objective.

Explanations and discussions on characteristics and types of psychoeducational groups presented above have guided the researcher to form the structure and the concept of psychoeducational group therapy for the purpose of this study. In short, the characteristics of a psychoeducational group, for the purpose of this research, are as follows:

(a)   Time-limited group with fixed membership, which is a small group with fixed and stable membership (the same members, and not more than 12 individuals), and a pre-determined number of sessions (15 sessions);

(b)   Group members are represented by the same target group:

      (i)   Early stage of change (pre-contemplator and contemplator);

      (ii)   Early stage of rehabilitation (within a period of 14 days to 6 months); and

      (iii)   Rehabilitation experience: inexperienced and experienced (enrolled in rehabilitation centers once or more than once)

(c)   All selected group members will go through intake screening and assessment using a prepared evaluation test tool before the formation of the group is achieved. For the purpose of this research, several tests will be done simultaneously with the initial tests to collect the data required;

(d)   All group activities will be guided by the manual available;

(e)   Group sitting and space arrangement will be based on learning classroom method which is centered on the facilitator (in a circle or horseshoe shape) and they sit with their backs facing each other;

(f)   In order to avoid group drop-out, the facilitator will take the following steps:

      (i)   Use the first slot of the first session to explain to the group members on the significance of group therapy, establish the sessions/groups' aim which is agreed upon together as well as being achievable, explain expected behaviours from the

members, and determine the norms and group rules that are collectively concurred and adhered to;

(ii) Choose clients who are really interested to join this group therapy. They have to sign an agreement to participate in the group sessions until completion and adhere to all the established norms and regulations;

(iii) Facilitators use a variety of methods in handling the sessions and interesting activities such as games and role-play, so that they are not limited to lectures and discussions alone;

(iv) Use of appointment card to monitor the group members' attendance for each session; and

(v) Provide rewards such as presents and incentives to attract the members' interest to stay and contribute in the group.

(g) Each client who has gone through initial screening and evaluation will be assigned to one of the four groups:

(i) Group 1 is the group named Psychoeducational Group Therapy for Naive Clients (PGTN) which contains members who are at the pre-contemplation and contemplation stages of change, and they have no previous experience in treatment;

(ii) Group 2 is a group named Psychoeducational Group Therapy for Experienced Clients (PGTE) which has members who are at the stage of pre-contemplation and contemplation, and they have gone through treatment before (once or more times);

(iii) Group 3 is a control group which is named Group for Naive Clients (CGN) that contains members who are at the pre-

contemplation and contemplation stages of change, and they

have not been treated before; and

(iv) Group 4 is a control group which is called Control Group for

Experience Clients (CGE) which comprise members who are

at the pre-contemplation and contemplation stages of change,

and they have experienced treatment before (once or more

times).

(h) The duration of time taken for the psychoeducational group sessions

for the purpose of this research is set at 8 weeks (two sessions per

week), and the total number of sessions for the PGTN and PGTE

groups is 30 sessions, that is, as many as 15 sessions for each group.

Each session will take about 60 to 90 minutes. There is no

psychoeducational session conducted for CGN and CGE during the

study; and

(i) Progress and achievement level of the rehabilitation objective for all

group members will be evaluated at the end of the 15th session by

using test tools which have been developed, and a follow-up evaluation

will be carried out three months after the group session ends.

2.3.3.4 Psychoeducational group in the treatment of addiction

A psychoeducational group in the context of treatment and rehabilitation for

addiction is not an entirely new approach. In fact, it is considered as an approach used

to enhance the effectiveness of treatment for addiction (La Salivia, 1993), and it is

proven as one of the most effective types of treatments that exists in clinical treatment

and a community setting, since it is a treatment modality which is handled by

professionals who are integrated and synergized with psychotherapeutic and educational interventions (Lukens & McFarlane, 2004). This treatment is also a more holistic, competence-based approach, and gives more emphasis on health, collaboration, coping and empowerment (Lukens & McFarlane, 2004; Dixon, 1999; Marsh, 1992).

La Salivia (1993) asserted that clients with addiction problems generally suffer from deficit issues in self-care, which is proven by their inability to face or solve day-to-day problems. With psychoeducation group that makes education as one of the process in shaping and developing individual's ability and source as one of the therapy's objective, it is able to provide members with information, encourage and nurture behaviour change, erase misunderstanding, identify and improve clients' cognitive disorder about their behaviour, put the symptoms (addiction) into perspective, reduce the feeling of being demoralized, and expose clients to therapeutic situations or functions in the group.

A pyschoeducational group can, among others, act as "a synthesis of the problem-solving skills training" (Liberman, King, DeRisi & McCann, 1975); conduct goal setting and gain achievement via skill teaching (Authier, 1977); re-establish a sense of control over self and daily life (Shiffman & Wills, 1985); promote cognitive mastery (Hayes & Gantt, 1992); promote awareness and understanding of conditions and symptomatology of addiction (Aguilar et al, 1991); coping and empowerment (Lukens & McFarlane, 2004); and gain or regain greater control over the members' well-being (Phoenix, 2007). These are the things needed by a drug addict to achieve the recovery aim, or at least to begin the process of addictive behaviour change. This situation, according to La Salivia (1993), makes the psychoeducational group an accurate medium to empower addicts to solve their problems by using intervention

strategies which are taught to them, and to assist them to adopt new behaviours and systematically leaving the old ones.

Using the psychoeducational approach as an intervention in increasing the effectiveness of a treatment program has not gained a lot of response in empirical research, especially for drug addicts who are going through residential treatment and rehabilitation programs. Nevertheless, this is not indicative of the ineffectiveness of the psychoeducational approach as an intervention in a target group. Spas, Ramsey, Paiva and Stein (2012) in their research review analysis concluded that (1) the psychoeducational approach can and does work within correctional settings, (2) psychoeducation in residential treatment can reduce substance use in adulthood, and (3) psychoeducation appears to be especially helpful in residential treatment settings and correctional facilities.

Several previous researchers have focused on an interesting dimension of this approach as an intervention method in the treatment of addiction, such as the effects of intervention on the effectiveness of addiction treatment (Knight, Simpson & Dansereau, 1994; Kelley, 2010; Khodayarifard, 2010; Battjes, Gordon, O'Grady, Kinlock, Katz & Sears, 2004; Bartholomew, Hiller, Knight, Nucatola & Simpson, 2000), effects of prediction on the follow-up treatment (Katz, Brown, Schwartz, O'Grady, King & Gandhi, 2011; Houghton & Saxon, 2007), predicting the retention rate in treatment programs (Martin, Giannandrea, Rogers & Johnson, 1996; Reimer, Schmidt, Schulte, Gansefort, Golz, Gerken, Scherbaum, Verthein & Backmund, 2013), and co-dependency (Nilsen, Frich, Friis & Rosberg, 2014; Platter, 2009).

Knight, Simpson and Dansereau (1994) in their study introduced the mapping knowledge as a psychoeducational tool to examine the effectiveness of relapse prevention training (RPT), a part of an outpatient-drug education program, on

preventing relapse among probationers. This study involved 83 drug addicted probationers. They found that the patients who successfully completed RPT sessions had lower rates of drug use after RPT and higher test scores on lesson material. It also found that program participation by probationers improved during the use of RPT, as indicated by higher completion rates compared to a usual program curriculum used the previous year.

Kelley (2010) conducted an experimental research on 54 respondents who were actively participating in inpatient treatment for drugs and alcohol, in order to test the effectiveness of two psychoeducational intervention methods in enhancing the treatment's efficiency. Treatment efficiency was measured by three variables, which were the rate of repeated addiction, emotional regulation, and compliance to treatment. Two methods of psychoeducational intervention introduced by the researcher were: (1) interactive journal, which is a method that involves reading informative journals about addiction and rehabilitation, and later writing the information again in the context of personal experience and relating it to the experimental group's process of addiction and rehabilitation; and (2) read only, a method of reading informative journals about addiction and rehabilitation or rewriting the content (the control group). Measurement was carried out during the onset of treatment (baseline), at the end of the treatment (30 days after onset), and 60 days after treatment (three months after onset). The results of the study showed that both groups did not show any significant changes statistically, nor also in terms of change of relapse in addiction rate and emotional regulation. Comparisons between the groups on the effectiveness of the psychoeducational approach in this research was not empirically conclusive due to the fact that both interventions used were psychoeducational.

On the other hand, researches conducted by Khodayarifard (2010), Battjes et al. (2004), and Bartholomew et al. (2000) conclusively showed that a psychoeducational intervention strategy was effective in treating drug addicts. Khodayarifard's (2010) study conducted 57 therapy sessions (once a week) using the abstinence-oriented cognitive-behavioural therapy approach on a couple, husband and wife drug addicts who also suffered from drug-related disorders such as anxiety, depression, and sexual malfunction. This approach in therapy applied cognitive-behavioural techniques such as psychoeducation (providing information about drugs and its effects), teaching and exercising of coping skills, problem-solving methods, communication skills, relaxation, positive thinking, self-monitoring, self-management, and contingencies control and cognitive construction. Results obtained after the therapy showed that the treatment method used was effective in treating the respondents for their dependency on drugs, where the respondents reported that they had stopped using drugs (drug use was decreased to zero), were more satisfied with their marriage and social relationships, and no longer faced problems related to drug use such as anxiety, depression or aggression. In a follow-up interview which was conducted a year after the therapy, the respondents reported that they were still successful at avoiding drinking and drug abuse, and were also satisfied with their relationship and social functions.

Battjes et al. (2004) studied the effects of group-based treatment methods on 194 teenagers who were involved in alcohol and marijuana abuse as well as crimes, by using a manual-guided module named Group-based Treatment for Adolescent Substance Abuse (GBT). The GBT module comprised 20 main program sessions (conducted in the course of 20 weeks) and seven supporting sessions. The 20 main program sessions involved one introduction session, four drug education sessions, and

15 sessions for skills training and prevention of relapse in addiction. In addition, the supporting treatment sessions involved three individual counselling sessions (to assist the respondent in providing a rehabilitation plan), and four family therapy sessions (drug education and improving the respondent's relationship with parents). The results of this research showed that the therapy method which used the GBT module was effective in assisting teenagers to reduce the use of marijuana after six months of treatment (reducing by half the mean days of use), and the reduction was maintained after 12 months. Furthermore, for the use of alcohol and involvement in criminal activities, the GBT treatment did not show any significant decline or difference after it was completed.

Bartholomew et al. (2000), however, were more specific in studying the effects of the psychoeducational approach by focusing on a group of male addicts who were going through a substance abuse treatment program. A total of 122 individuals who were involved in alcohol and drug abuse were the main research respondents. They were divided into two groups: 64 respondents in an experimental group (who received treatment in groups using the TOFMEN, or Time Out! For Men module), and 58 respondents in a control group (no treatment, but TOFMEN was offered after the study). Respondents who were in the experimental group received eight TOFMEN sessions (two hours each session) in groups that were divided into two main sections: communication skills (listening, assertive, express feeling, and conflict resolution), and relationship skills (sexual reproductive health, gender roles, and socialization). Additional psychoeducational treatment involved homework assignments that required each respondent to discuss with their spouses or significant others any issues which surfaced after each group session that they attended. Results from the study showed that the experimental group which experienced the TOFMEN module was

successful in significantly increasing their knowledge level on communicative and relationship skills. They reported that they had benefitted a lot from the materials provided, increased in psychosocial functioning (specifically in social conformity), showed stronger endorsement of social norms (eg., honesty), and endorsed more egalitarian attitudes about gender roles and sexual beliefs, than the control group. The research results provided support for the utilization of male-targeted programming in substance abuse treatment.

The psychoeducational group approach in addiction treatment also serves as a method of determining the viability of a treatment service to addicts, especially in terms of providing them with the next treatment service currently and in the future. Katz et al. (2011) found that addicts who participated in psychoeducational therapy in detoxification programs adhered to the detoxification treatment regime (treatment protocol), succeeded in completing the program, and maintained their status in the treatment system by participating in follow-up programs (long-term treatment programs) after the completion of the detoxification program, compared to addicts who did not participate in any psychoeducational therapy. This finding was obtained from an experimental research conducted by them to study the effect of the psychoeducational method in increasing the transition rate of opioid addicts who participated in a detoxification program by using buprenorphine in long-term treatment. A total of 240 respondents were involved in this research. They were randomly divided into three groups: experimental group 1 (intensive role induction, IRI), experimental group 2 (IRI and case management, IRI+CM), and a control group (standard treatment, ST). All respondents received five individual treatment sessions (one hour/five weeks of sessions) in the course of 30 days of the detoxification

program, and experiment group 2 received one additional session about case management.

In this study, the IRI treatment conducted was based on a manual-guided treatment which consisted of five individual treatment sessions. In general, IRI focuses on psychoeducation in relation to detoxification, addressing misperceptions about detoxification and treatment, addressing concerns and barriers to continued involvement in treatment, and emphasizing the value of continuing in treatment beyond detoxification to fortify treatment gains. CM, on the other hand, is a treatment session that focuses on helping respondents to obtain outside resources, in order to aid their rehabilitation in terms of referral and active advocation by the counselor. As for standard treatment, it is a treatment method that uses individual counseling regarding addiction models and problem-solving issues, as well as treatment problems which are brought out by respondents during the sessions. The findings of the research showed that the IRI group respondents enjoyed the most positive outcomes from the treatment compared to the control groups. They showed higher levels of attendance for counseling sessions during detoxification, completed the program with flying colors, rated counselors more favorably, and remained in treatment for a longer period following detoxification. Comparing IRI+CM, the results from the research showed that for this group, there was a significant effect on their attendance in counseling sessions during detoxification when compared to the control group.

Houghton and Saxon (2007) in their research tried to evaluate the acceptability of brief psychoeducational intervention to clients and the clinical effectiveness of the psychoeducational intervention within the service. It was delivered to help clients to step up to higher intensity treatments, such as to individual treatments provided by specialists. By applying the brief CBT psychoeducational course approach, patients

were given large group treatment (24 patients in each group) for two months by participating in psychoeducational sessions for 90 minutes each week. Results showed that the majority of the patients reported that psychoeducational intervention treatment was very helpful, acceptable by the majority of the patients, and effective in treating their psychological distress symptoms. Upon completion of the treatment, 92 patients (48.2%) applied to enrol in higher intensity treatment, 97 patients (50.8%) were discharged from treatment, and another two continued with the treatment. From the 97 patients who completed the treatment, 23 patients (23.7%) reported that they had recovered, and 68 patients (70.1%) did not show any interest in getting any further treatment (no further contact with the service).

Psychoeducational therapy group can also be used as an adjunct treatment to reduce the negative outcomes of a certain disease (Chan, 2005) in order to increase retention in the main treatment program. This was proven by Martin et al. (1996), whose studied two treatment interventions, which is the psychoeducational and recovery oriented, for patients in the pre-recovery stages of addiction. The "pre-recovery" means the patients is actively drinking or using drugs, does not recognize a problem, and has no intention of changing. The found that the patients in psychoeducational groups, compared to the recovery-oriented group, demonstrated greater duration in treatment and agreement with the first three steps of the Twelve Steps.

Reimer et al. (2013) in a study aimed at testing the effects of psychoeducational group sessions on retention rate in hepatitis C virus (HCV) therapy sessions among opiate addicts who used needles (people who inject drugs, PWID) and who were diagnosed with hepatitis C. Respondents were divided into four research groups, which were experimental group 1 (48 weeks antiviral treatment +

psychoeducational group session), experiment group 2 (24 weeks antiviral treatment + psychoeducational group session), control group 1 (48 weeks antiviral treatment only), and control group 2 (24 weeks antiviral treatment only). The psychoeducational group session treatment comprised three educational modules (examples of topics are HCV infection, symptoms, episodes, interactions and risk factors), HCV treatment, coping skills, sources of support including self-help and health care, as well as the role of a healthy lifestyle and nutrition. Respondents who were in experiment groups attended at least nine psychoeducational group sessions. The results obtained showed that psychoeducational group treatment (PE) had a significant impact and increased the retention rate in treatment (patients had significantly higher treatment completion rates when receiving PE), and revealed a strong effect for patients who attended five or more PE sessions.

In the context of treatment for co-dependents (individuals or significant others who are affected from the addiction of addicted people), psychoeducational intervention was found to play an important role in assisting co-dependents to achieve recovery, and also indirectly helped the drug addicts' rehabilitation because of support from co-dependents. Platter (2009) in his research attempted to study the change in coping skills strategies and enabling behaviours among the addicts' family members who participated in the psychoeducational group and adjunct groups in the community (The Friends and Family Program). With six treatment sessions (per week), this program applied a psychoeducational approach which aimed to educate family members about addiction, enabling behaviours and ways to cope. Results of the study showed that this program appeared to be helpful in reducing behavioural enabling among co-dependents (participants reported significantly less enabling behaviour),

and improving three adaptive coping strategies (positive reframing, instrumental support, and behavioural disengagement).

In another study, Nilsen et al. (2014) tried to explore patients' and family members' experiences of different elements of psychoeducational family intervention, found most of the patients and family members felt that the intervention gave them elements of alliance, support, and knowledge and learning. The patients and family members also reported that meeting with others in the same situation like them was reduced the feeling of shame and increased hope for the future.

2.3.4 The TTM and psychoeducational group therapy

TTM proven has general implications, through many studies, for all aspects of intervention development and implementation across a broad range of problem behaviours as well as a wide variety populations with such behaviours (Prochaska, Velicer, Rossi, Goldstein, Marcus & Rakowski, 1994), including drug abuse (DiClemente, 2006; Velasquez et al, 2001; Connors, Donovan & DiClemente, 2001). As noted by DiClemente (2006), the TTM proven used as predictors to explain three types of behaviour change, such as creating patterns of behaviour, modifying habitual behaviour patterns and stopping problematic patterns.

Meta-analysis study by Noar, Benac and Harris (2007) on a broad range of behaviours found that the TTM construct was mainly used in researches to identify the suitability of this theoretical construct to prepare tailored intervention that matched the client, and this involved 35 out of 57 studies. Their analysis showed that the preparation of interventions based on the TTM construct (stages of change, pros and cons of changing, self-efficacy, and processes of change) showed significant results in the effects of treatment measured (that is, in terms of effectiveness, significantly

greater effects were produced when tailored inteventions included each of the TTM constructs). In contrast, interventions that have no TTM construct's perceived susceptibility had significantly worse outcomes, and tailoring on non-TTM constructs like social norms and behavioural intentions produced no significant differences.

In the context of using psychoeducational intervention in the TTM theoretical framework, specifically when it involved stage-matched intervention, psychoeducational intervention approach in groups attracted the attention of several researchers. However, none had focused on the effects of psychoeducational intervention in improving the addict's stage of change. Lovejoy, Rosenblum, Magura, Foote, Handelsman and Stimmel (1995), in an ethnographic interview research to obtain an overview of change processes experienced by 17 cocaine addicts who participated in treatment using Relapse Prevention Treatment Model, found that 64.7% of the respondents reported that the educational materials prepared for the session (such as video viewing and notes) were highly effective in increasing their awareness of the effects and results of cocaine use. In addition, one or two skills which were taught (thought-stopping, money management, avoidance skills, and positive/alternative activities) were effective in reducing the addicts' drug usage. Results showed that this model succeeded in reducing cocaine use for at least 50% at the end of the treatment among 88% of the respondents. It also increased participants' motivation to take part in treatment (also 88%) compared to 64.7% previously who reported that they were resistant or highly ambivalent.

Martin et al. (1996) attempted to observe the effects of psychoeducation through different contexts in the treatment of drug and alcohol addicts who were at varying pre-recovery stages (or pre-treatment). They also had similar characteristics with addicts who were at the stages of pre-contemplation, contemplation and

preparation (TTM), which meant that they were actively involved in alcohol and drugs, did not see these as problems, and had no intention to change. Psychoeducational intervention with passive role and recovery-oriented intervention through active roles were compared in terms of effects on severity index, drug attitude and treatment evaluation. These two groups possessed the elements of the psychoeducational approach (education and didactic) that provided eight sessions of treatment for four weeks and the duration for each session was two hours. Results obtained from this research showed that both methods of intervention (passive and active roles) indicated the same effects. There was a decrease in the severity of illness, decrease in urine drug screen results, and an increase in their disapproval of drug use (drug attitude). As for the differences in treatment effects, the recovery-oriented (RG) group showed an increased in duration of treatment and positive self-report evaluation of treatment, and was less threatening compared to the passive-role psychoeducational group (PG). On the other hand, PG was effective in reducing the drop-out rate among respondents in treatment, which was 51% compared to 65% (RG) at the end of the treatment session, and 67% (PG) compared to 100% (RG) three months after the treatment.

Guajardo (2008) also used respondents who were at the pre-treatment stage. However, he wanted to study the effects of pre-treatment preparation (prepatory or educational intervention) that applied the psychoeducational approach on client's expectations and fears about psychotherapy, working alliance, and therapeutic outcomes (client's engagement in psychotherapy) among new clients (pre-treatment or first-time clients). Clients who were in the experiment group watched a multimedia program (interactive CD-ROM) for 15 to 30 minutes for six times (once a week) before they participated in individual or group counseling sessions. This multimedia

program provided information interactively (that is, clients were given notes according to the syllabus in the multimedia program) about therapy or counseling and what happens in the therapy sessions or counseling. Results from this research showed that the multimedia program had little effect on reducing fears and expectations associated with therapy, and did not account for any improvement in symptoms or increase in the therapeutic alliance. Findings pointed out that this program was ineffective and it was caused by new clients in treatment (less prior treatment experience) who had high expectations of their involvement. As for the experienced clients (more prior treatment experience), they were expecting higher levels of efficient therapeutic environment.

James, Preston, Koh, Spencer, Kisely and Castle's (2004) study aimed to see the effects of psychoeducational intervention in groups to assist dual-diagnosis patients to reduce their drug use. This research was carried out using the experimental method where respondents were divided into two groups, namely, the experiment group (n = 29, each group consisted of not more than 6 respondents) and the control group (n = 29). The experiment group was exposed to six psychoeducational group sessions based on the prepared manual that was tailored to each participant's stage of change and motivations for drug use, as well as to standard community mental health service. The researchers did not state in detail the status of the respondents' stages of change and grouping according to their stages, although it was stated that the treatment module was developed based on the respondents' stage of change and motivation. The control group went through its treatment as usual. Results of the study showed that psychoeducational intervention in groups provided significant effects to greater improvement in psychopatholgy, reduction in drug use (cannabis, poly substance and alcohol), and reduction in severity of dependence, when compared to

the control group. This research showed that psychoeducational intervention can be employed in group-based interventions which are conducted within routine clinical service settings.

Burleson and Kaminer (2005), on the other hand, sought to find out the change in the self-efficacy stage of addicts who participated in an outpatient substance abuse treatment program based on two intervention methods, which were CBT group therapy and psychoeducation. In this research, all respondents received treatment in either CBT groups or psychoeducational groups for eight sessions in a week (75 to 90 minutes for each session) according to the manual provided. Results showed that the self-efficacy stage became the significant predictor of the decrease in drug use during treatment, but not of the after-treatment effects. The results also showed that both groups (CBT and psychoeducation) did not reveal significant differences in effects of treatment on the increase in self-efficacy. The researchers concluded that both treatment methods used were able to enhance the self-efficacy stage which could contribute to positive results in treatment.

Research reviews done by Kadden and Litt (2011) regarding the role of self-efficacy in the effectiveness of substance abuse treatment found that self-efficacy served as an important predictor of treatment results and psychoeducational intervention could enhance the self-efficacy stage. They referred to the study by Dolan, Martin and Rohsenow (2008) which found that high self-efficacy was able to maintain the addicts in the abstinent state or reduced drug intake within three to six months after the treatment. As for the aspect of intervention, studies by Ilgen, McKellar and Moos (2007) indicated that a client with greater participation in skill-building activities (such as coping skills and stress management) during treatment was

associated with greater self-efficacy, and that self-efficacy was closely related to treatment outcome.

2.4   Theoretical and conceptual framework of the study

Before it becomes permanent, any type of behaviour will go through a process or stages, which TTM names the stages of change. According to DiClemente (2006), these stages provide an overview of the huge motivational stage and the dynamics of stages of change according to the time. In order to establish the path to behaviour change in an individual, the process must begin with the pre-contemplation stage, a situation where an individual does not have any interest or intention to change. Later, it would move to the situation (of thinking) to make the change (contemplation), making preparation to change, taking the action to change, and maintaining change.
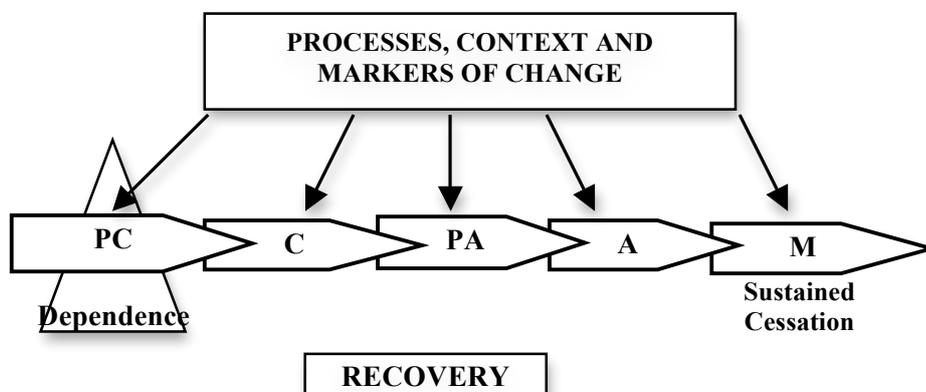
(Source: Adapted from DiClemente (2006), Addiction and Change)

Figure 2.2: The research theoretical framework

Based on the Figure 2.2, the process of recovery begins from the pre-contemplation stage and progresses to the maintenance stage, and this is characterized by change processes, change context and several markers of change according to the

stage of change experienced. In this study, the movement of the two stages of change (the pre-contemplation (PC) and contemplation (C) stages) to a higher stage was given the focus. In order to achieve it, TTM proposed the use of specific change processes (POC) and when they occurred at both stages of change, they could move the clients' change process to a higher level, as suggested by DiClemente (2006), Connors, Donovan and DiClemente (2001), and Prochaska, Norcross and DiClemente (1994) who believed that "the matching of stage and process is a key to change".

According to DiClemente (2006), Miller and Rollnick (2002), and Velasquez et al. (2001), at the early process of change (pre-contemplation and contemplation) an individual strives to change his behaviour, and the change processes that happened could be used to ease the process of facilitating change. Facilitating change is the processes of changing which involve cognitive/experiential awareness, which are consciousness-raising, dramatic relief, self-reevaluation, environmental reevaluation, and social liberation. The main indication of the processes of change that took place was the existence of decisional balance and self-efficacy. A very brief overview of the most relevant stages and the processes of change is illustrated in Table 2.10.

Table 2.10

The stages dan processes of change

Stages of change	PC → C	C → PR
The most relevant processes of change	Consciousness-raising	Self-reevaluation
	Dramatic relief	Environmental reevaluation
	Self-reevaluation	Decisional balance
	Environmental reevaluation	Self-efficacy
	Decisional balance	Social liberation

(Source: Adapted from Velasquez et al. 2001, p.10)

The rehabilitation demands and needs of addicts at this stage of change are the awareness about the danger and effects of drug use as well as having the motivation to

spur the change (DiClemente, 2006; Connors, Donovan & DiClemente, 2001); information on addiction and recovery; and support and reinforcement of the changes which were initiated through feedback on motivation and ambivalence (Miller & Rollnick, 1991). This also involved skills in decision-making as a result of the problem of ambivalence (ambivalent about the pros and cons of change) and barriers to utilization of sources of rehabilitation (DiClemente, 2006; Connors, Donovan & DiClemente, 2001). Hence, the best approach to attain the addicts' needs and demands for rehabilitation at this stage is psychoeducation (Velasquez et al., 2001) that functions, among all, as an approach that focuses on education and learning (Brown, 1997; Brown, 2011), skills training (Brown, 2011; Banerjee et al., 2006; Velasquez et al., 2001), helping clients to make decisions (Milkowitz, 2008; O'Neil et al., 2005; Howard & Goelitz, 2004), and it is more holistic, efficiency-driven, as well as able to emphasize on health, collaboration, coping and empowerment (Lukens & McFarlane, 2004).

For the purpose of this study, an integrated model based on the TTM theoretical framework and psychoeducation are used and formed as the conceptual framework. The model uses the psychoeducational approach as an intervention strategy and tool to drive the change in addicts who are at the early stage of recovery and it is tailored to meet their rehabilitation needs and demands. It is a planned intervention with the use of specific processes and principles of change, and is matched to each individual's stages of change (stage-matched intervention for early stages). The model's main assumption is that addicts who receive treatment that matches their rehabilitation needs and demands at the early stages of change will move towards the later stages of change, as characterized by better markers of change such as improvement in self-efficacy, and decisional balance.

The research conceptual framework is briefly illustrated in Figure 2.3. Based on the model (Figure 2.3), the psychoeducational model which was developed (manualised-intervention) by applying five processes of change will be used to build a PGT intervention as strategies to move addicts through from one stage to another according to the present stages of pre-contemplation and contemplation. It will move the drug addict's stages of change from (1) Pre-contemplation stage to the next stage, at least at Contemplation stage, and from (2) Contemplation stage to the next stage, at least at Preparation stage. To evaluate the change (behaviour change to a stage higher) to determine whether it occurred, two variables will be used, i.e. self-efficacy and decisional balance (markers of change). The psychoeducational module will be described in detail in the next chapter.
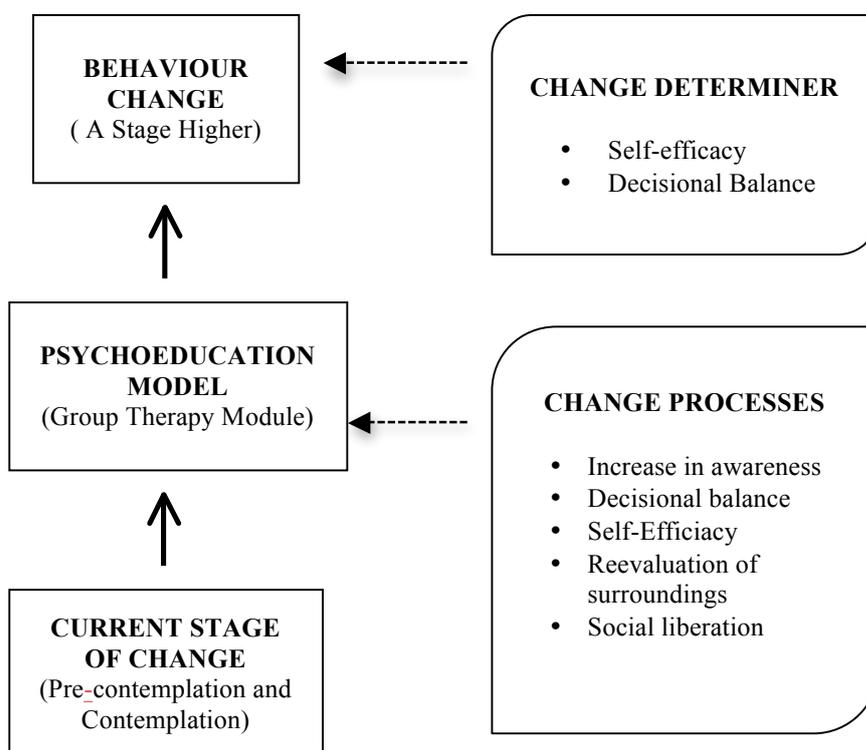

Figure 2.3: The conceptual framework of the study

2.5   Chapter summary

This chapter discussed the behavioural change process based on the perspective of TTM theory (DiClemente, 2006) which categorizes the change process into four main dimensions. Three main dimensions – the stages of change, the change processes, and the markers of change which are considered to be dominant in the theory – were the focus of the literature review. Two stages of change, precontemplation and contemplation which are processes of change that took place at these stages, as well as the markers of change for self-efficacy and decisional balance which are variables in this research, were thoroughly explained in this chapter.

In addition, this chapter also presented the description of perspectives in intervention strategies based on group, specifically the most effective group therapy in the drug addiction treatment and rehabilitation program, as suggested by CSAT (2005) and ASGW (Fisher & Roget, 2009). Group therapy with the psychoeducational approach as an intervention method was explained in detail in the context of drug addiction treatment and rehabilitation. Lastly, one theoretical and conceptual research framework was created on the basis of TTM theory and psychoeducation, with its main ground established through the development of the psychoeducational treatment model in group therapy (based on experiential/cognitive change process activities) as variables which influence behavioural (stages of change) and markers of change.