PSIHOLOGIJA, 2007, Vol. 40 (2), 245-262 UDC 159.947.5.072:616.89-052

RELATION BETWEEN STAGES OF CHANGE AND MOTIVATION IN THE TREATMENT OF PSYCHIATRIC PATIENTS[1]

Vesna Gavrilov-Jerković[2]
Department of Psychology, University of Novi Sad

Main aim of this research was to investigate the relation between psychiatric patients' motivation for their participation in treatment and a stage of change they were in. Hypothesis on relation quality of examined variables have been defined from the perspective of transtheoretical model created by Prochaska and associates. Decision balance, specific and general self-efficacy and inclination to relapse have been examined as indicators of motivation. One hundred and twenty-nine psychiatric patients with diagnosis of neurosis or personality disorders have been examined in this research.

Results have shown that stages of changes are significantly related to inspected motivational variables. Patients in higher stages of readiness express specific motivational profile characterized by the proactive optimism, which means that they rely on their own resources and expect positive outcome of the treatment. Patients in lower stages of readiness express motivational profile characterized by passive resignation receptiveness, by inclination towards demoralization and low trust in their own strength. Results of this research are in conformity with the basic hypothesis of transtheoretical model of change.

Key words: *motivation for change, stages of change, transtheoretical model of change*

[1] The paper is the result of the project 'Psychological characteristics of society in the process of transition' supported by the Ministry of Science and Environmental Protection of Republic of Serbia (Contract No. 149008).
[2] Author's address: Jerkovso@eunet.yu

THEORETICAL PERSPECTIVE OF RESEARCH

Although the studying of the nature of human motivation has been of high importance for outlining psychotherapy models, the way in which the academic psychology deals with this subject has been left isolated from the psychotherapeutic scene for a long time. This does not mean that psychotherapy models remain undefined on this subject. We might even say that in case of psychoanalysis, the psychotherapeutic model was the generator of leading theoretical hypothesis on motivation nature (Mackay, 1989). In most of the theoretical concepts, the relation between theoretically defined answer to the question of motivators of human behavior and psychotherapeutic interventions remains insufficiently explicit.

Explication of mechanisms about the influence of motivational factors on the process of therapeutic change has recently become provocative for researchers in a domain of clinical psychology and psychotherapy. Primarily, we might attribute this to changes in the domain of social and clinical psychology (Rotter, 1954; Forsterling, 1988; Brewin, 1988; Snyder & Forsyth, 1990) which closeness of these two disciplines resulted in the the occurrence of influential social learning theories and attribution theories. These theories have introduced mental concepts such as expectation, level of aspiration, decision balance, beliefs, consistency, cognitive dissonance etc. They represent hypothetical processes designed for explanation of behavior, firstly, motivational aspects of behavior. Human motivation to implement and keep the specific behavior is, in the most of the cases, seen as the product of two basic factors: the value of the aim that should be achieved and expectations that the chosen behavior would lead to that aim. To the greatest extent, modern theories of motivation rely on and elaborate this two-factor reference framework.

Considering motivation for change from the transtheoretical model perspective

Authors of the transtheoretical model (Prochaska et al. 1994) are the authors who are not explicitly dealing with the question of motivation of human behavior, but whose work, we might say, represents a strong contribution to the question of motivation in psychotherapy. Their attitude coincides with the results of numerous researches (Bergin & Garfield, 1994) which showed that motivation plays a very important role in treatment through the stimulation of patients to ask for treatment, to complete it, to accept it and to make successful short-term and long-term changes. However, they change the approach to the question of motivation. Authors of transtheoretical model made specific contribution by paying attention to the fact that it is wrong to consider motivation as something that exists or does not exist, or consider

it as something that 'appears' in a moment enabling the psychotherapists to work with their clients. Outlining the series of stages of changes and describing the processes, which occur when a person makes some personal or behavioral change, offers a new perspective of the motivation research.

The special challenge for the research of the client's motivation for change, which should be carried out through some treatment, is the evaluation of that motivation (DeLeon et al., 1997; Treasure et al, 2003). Authors of transtheoretical model support the attitude that evaluation of client's motivation requires the evaluation of their specific attitudes and intentions, beliefs in possibility for change and benefits from it, capability to make decisions and commitment to the certain behavior (DiClemente & Prochaska 1998). In his researches, DiClemente (DiClemente et al., 1999) showed that many clients start the treatment with very vague idea of change. Although they may be involved in the therapy, they might be actually unprepared for the concrete action. Participation in treatment represents the more adequate measure of motivation, but there is a problem of its evaluation though.

Trying to find ways to conceptualize client's readiness for change, so that it could positively answer to the previously mentioned dilemmas appearing in domain of research and the evaluation of motivation, especially the motivation for psychotherapy, the authors of transtheoretical model have offered the perspective of stages for change and the coordination of change processes with the client's stage of readiness to carry out the change (Gavrilov-Jerkovic, 2004). Since they had determined, in numerous researches, that every stage of change brings with it a specific number of tasks which client should accomplish in order to move to the next stage and change their attitude toward the problem-solution and their capability to reach that solution, the authors have begun to wonder if it is possible to predict the patient's 'transfer' from one stage to another during the treatment (Prochaska et al., 1982; Velicer et al., 1985). Therefore, they have expanded their model with two motivational constructs – a decision balance and a self-efficacy, which are originally developed within the other psychological models.

The decision balance has been thoroughly discussed within the alternative model of a change. That is the conflict model on decision-making process, by Janis and Mann (1977). According to this model, the decision-making includes continuous and careful weighing of potential advantages and disadvantages of new behavior, as well as the importance of individual reasons for change or non-change.

After series of studies, Velicer and associates (1985) have concluded that the concept of decision balance is compatible with the transtheoretical model and that it functions as a good framework for further researches on structure of cognitive and motivational changes through the stages of change. Clients' decision on whether or not to undertake some behavioral steps that will lead them to the healthier functioning is based on the relative weight, which is given to pros and cons for adopting this new, more adaptive behavior. Pros are related to positive aspects of behavior change or changed behavior and they represent the reasons why client might decide to make

a change. Cons are negative aspects of changed behavior or the process that one should go through in order to change behavior, and they represent the reasons why clients might not want to make a change. These two dimensions might be observed independently or in combination. Prochaska and associates (1994) have shown their power of prediction in research of 12 different problem situations related to the health improvement behavior, such as: giving up smoking, body weight regulation, safe sex etc. The main result of the mentioned research is that ratio change of pros and cons scales appears to be a good predictor of client's transfer from one stage to another, and that it makes sense to include this concept in the transtheoretical model in order to research the structure of cognitive and motivational changes during the treatment. As it is expected, anticipated advantages of abandoning the unhealthy behavior or adoption of healthy behavior are low in the first stages of change, and if it comes to the increase of these advantages then we might see client's movement to the next stage. The situation is quite opposite in the case of disadvantages. While they are expressed in the initial stages, decreased values can be recorded in the later stages.

It is assumed that through a decision balance we become familiar with client's internal representation of actual consequences of change and with the fact that these representations are in correlation with client's stage of change.

The self-efficacy and the resistance to the temptation represent two concepts used for further research of patients' improvement through the stages of changes. The self-efficacy is the concept taken from Bandura (1982) and it is used in scope of this model as a measurement of a person's specific belief that they can cope with highly risky situation without going back to old, unhealthy forms of behavior, while the temptation represents measurement of urgency or an impuls to repeat the old behavior which has been worked on. Very early, DiClemente (1981) started to deal with the relation of the self-efficacy and the success of some treatment procedures, as well as with the relation of the self-efficacy and the success of persons who have tried to solve some problem independently. He has been consistently founding significant correlation. In scope of transtheoretical model, researchers examined the relation between the self-efficacy and some key constructs. Thus, in one of his early researchers, Prochaska and associates (1982) investigated a difference between smokers who have successfully managed to stop smoking by working independently and not having a treatment and those who have relapsed. Stages of changes, processes of changes and the self-efficacy were among examined variables. One of their results was that the successful ones differ from the unsuccessful by the processes of change they have been using in a specific stage. While the successful ones more relied on internal aspects of the process, that is on changing their experience and reaction with the consciousness raising, self-liberation, development of new forms of self-reinforcement, relapsers have generally shown less relying on the processes and in the case when they used them, they relied on their environmental aspects, showing dependence on the environmental factors. As the environmental stimuli had de-

creased by the time they reached the abstinence level, they relapsed very soon afterwards. Taking into consideration that these two groups mostly differed in the degree of self-efficacy, the authors concluded that the low self-efficacy was correlated with generally low activation, as well as with the preference to more rely on environmental stimuli and less on the change of internal resources. The authors concluded that the self-efficacy represented an important concept, which could be correlated with the application of adequate or inadequate processes of change.

In another research, DiClemente, Prochaska and Gibertini (1985) found that the self-efficacy increases during the stages of changes. The correlation between high self-efficacy and greater relying on processes of change has been repeated, but not for the patients in maintenance stage, in which the high self-efficacy was correlated with the decrease in the application of the change processes. In this case, higher temptation correlates with greater application of processes, but only in maintenance stage. In other stages, the higher result on temptation is correlated with the feeling of helplessness for taking action and less relying on processes of change, especially the behavioral ones. Results of this research have shown that the evaluation of efficacy and resistance to temptation, although correlated, still represent separated aspects of self-evaluation, thus it was justified to include both measures.

Although the authors of transtheoretical model have not emphasized it explicitly, the influence of social learning theories on the solution of the question of motivational factors can be recognized easily. The choice of concepts like a decision balance, self-efficacy and resistance to temptation completely fits into the motivation theories, which consider behavior as a result of mutual and intertwined influence of expectation and anticipated reinforcement value. This concept of anticipated reinforcement value was firstly promoted by the authors like Lewin, Atkinson and Rotter, and later by the authors of attribution theories like Seligman and Weiner, as well as Bandura. All of the mentioned authors have recognized the importance of these factors for the outcome of one's decision and for starting and maintaining certain behavior.

In light of these theories, the probability that some behavior will be performed is reflected through the person's assessment to have or control the means or the ways for reaching some aim or the relation of positive and negative goal valence. Concerning these issues, the important contribution of the authors of the transtheoretical model is in simple operationalisation of mentioned motivational variables, as well as in connection of these ideas with the therapeutic procedure, that is with the processes and stages of change. These contributions have been gaining importance, especially because almost every serious research on efficacy of psychological treatment includes the question of client's motivation and influence of that motivation to the therapy flow and the outcome of the therapy (Evans, 1992; Frayn, 1992). However, the survey of the available literature shows that this concept is approached mostly in a global way. Only a few researches (Barth et al., 1988; Freyer et al., 2004) have been engaged in factor analysis of motivation, who found out that, beside the motivation for therapy, it is possible to extract a factor of a need for change.

However, besides pointing out to these factors and their empirical connection to the outcome, they are not dealing with the nature of this connection. Observing the therapeutic change through the concepts of transtheoretical models can give important answers to these questions.

RESEARCH

Numerous researches carried out by the authors of the transtheoretical model mostly in the domain of the health behavior change, convinced them in the key role of motivational factors. It means that in order to change a stage it is necessary to make a change in a decision balance, then it is necessary for a person to increase his/her trust in their own ability to control the outcome of the action and to decrease the temptation strength in relation to stimuli related to the problematic behavior. According to these results, we have become interested in what happens with the motivational development among patients who have been receiving psychiatric treatment and whether the insight into a development of their motivation can give us relevant directives of the treatment course organization. The question we wanted to examine was whether and how the psychiatric patients differed in the expressed self-efficacy, decision balance and inclination to relapse, depending on the stage of change they were in.

Method

The research was carried out on 129 psychiatric patients on both in-patient and outpatient treatments. The sample included patients with diagnoses of neurosis or personality disorders. Psychologists, employed in the same psychiatric institution where the patients were treated, carried out the research.

The Questionnaire of stages of change was used for examination of stages – a categorical form, represented through the series of five items, in which each item represented an expression of a particular stage of change. Subjects were asked to decide on the item that represented the best their current state in relation to the problem and possible solution of that problem, according to their opinion.

The following stages were included with the items:

1. Precontemplation – a client's evaluation that currently offered treatments as well as the treatment with the psychological resources are not the treatments of choice for their problems.
2. Contemplation – a patient's assessment to want and need to solve their problem still without a clear idea of how to do that;
3. Preparation – a patient's assessment of conviction that he knows what he needs to do in order to get better;

4. Action – a patient's assessment of the relevant personal involvement into the problem-resolution;
5. Maintenance – a patient's belief that his current task is to maintain accomplished changes and prevent the recurrence of symptoms.

Such examination of the stages of change has been developed for different areas of health behavior and it has been applied in numerous studies of the examination of the transtheoretical model's concepts (Maurischat, 2001). According to the available questionnaires, we selected and adapted the content of the questionnaire form in our research.

For assessment of decision balance, we used the Decision Balance Questionnaire (O'Connell and Velicer, 1988). We used 24 items version, in which the items were expressed by five point Likert scale. Patients had to answer about how often they thought about or felt in a certain way over the last week. Twelve items represented positive aspects of taken psychiatric treatment, and the other twelve items represented negative aspects of the treatment. The result for every patient was expressed as a summed score for the scale of pros and as a summed score for the scale of cons. The component analysis extracted two independent factors that include items belonging to these two scales. Calculated reliability of this questionnaire is on a satisfactory level, with the alpha coefficient of 0.90 for scale of advantages and 0.94 for scale of disadvantages (Bellis, 1993).

General self-efficacy was assessed by the Scale of general self-efficacy (Scholz et al., 2002). It is a ten items scale, using the ratings by Likert's five-point scale. Items in this scale were formulated in the way to target person's wide and stabile sense of personal competence for the efficient solution of different types of stress and new situations. Different studies provided similar results on internal consistency of this scale (Schwarzer & Born, 1997; Scholz et al., 2002), which typically ranges from 0.75 to 0.91.

The Scale of specific self-efficacy and the scale of inclination to relapse are the instruments constructed for the needs of this research, since we have not found adequate scales in the available literature.

The Scale of specific self-efficacy consists of nine items, which express patients' belief to have strength and ability to improve their functioning through participation in the treatment. Patients were expected to answer to each item by expressing their degree of agreement through the five-point scale. Reliability of this instrument calculated by Cronbach alpha method is 0.86 and by Split half method is 0.85. Factor analysis presents this instrument as one-dimensional.

In this research, resistance to the temptation is represented through the inclination to relapse. Inclination to relapse scale consists only of four items relating to the measurement of patients' tendency to get demoralized and to suspect possibility to improve their functioning through the current treatment. Reliability of this instrument calculated by Cronbach alpha method is 0.79 and by Split half method is 0.78. The factor analysis extracted one factor.

RESULTS AND DISCUSSION

Before we start to analyze a correlation of examined variables, we would like to show the subjects' results for each variable independently.

Table 1 represents a distribution of subjects through the stages of changes.

Table 1. Distribution of patients through the stages of changes

Stage of change	Frequency	Percentage	Cumulative percent-age
Precontemplation	25	19.4	19.4
Contemplation	42	32.6	51.9
Preparation	35	27.1	79.1
Action	22	17.1	96.1
Maintenance	5	3.9	100.0
Total	129	100.0	

It can be noticed that in the moment of the examination most of the patients were in the contemplation stage. It means that most of the patients recognized that they have a problem, which needed to be treated, but at the same time, they did not know the ways to help themselves. There is a relatively high percentage of patients who have started to recognize the possible ways of solving their problem, although they have not taken any concrete actions in that sense. Only one fifth of the patients reported to be currently working on the problem solution, and the least number of patients considered being in the stage of the treatment where the problem was already solved and they only needed help concerning the prevention of the symptoms reappearance. Even one fourth of the patients considered they should not have been on the current treatment.

In Table 2 it is possible to see the patients' answers to the questions on included motivational variables.

Table 2. Values of motivational variables

Motivational variable	N	Minimum	Maximum	Mean	Standard deviation
Inclination to relapse	129	.00	15.00	6.95	4.08
Cons of the treatment	129	.00	37.00	12.05	9.16
Pros of the treatment	129	.00	46.00	31.19	9.09
Specific self-efficacy	129	9.00	36.00	25.83	5.58
General self-efficacy	129	.00	30.00	16.99	6.71

What is interesting in this table of results is the average value of the answers on the scale of the treatment's pros almost three times higher than the average value on the scale of treatment's cons. It means that patients were more ready to talk about treatment's pros than on its cons. However, it remains unclear whether it is the consequence of different social bias of these two scales or of the fact that the patients really do perceive pros more than cons of the treatment. Anyway, this is the same situation, as the one existed in the original study (O'Connell & Velicer, 1988) in contrast to results obtained by questioning the smokers using the questionnaire of decision balance (Velicer et al., 1985).

Correlation of motivational variables with stages of changes

In order to test whether the patients differ in a quality of their motivation depending on the stage of change, we used multivariate analysis of variance. The grouping variable was stages of change. Table 3 represents the results of multivariate analysis.

Table 3. Results of multivariate analysis of variance

Wilks λ	Approximately F	Significance of F
.50	4.57	.000

Table 4 represents the results of univariate analysis, which provide us more detailed insight into the nature of correlation between stages of readiness and dynamic variables.

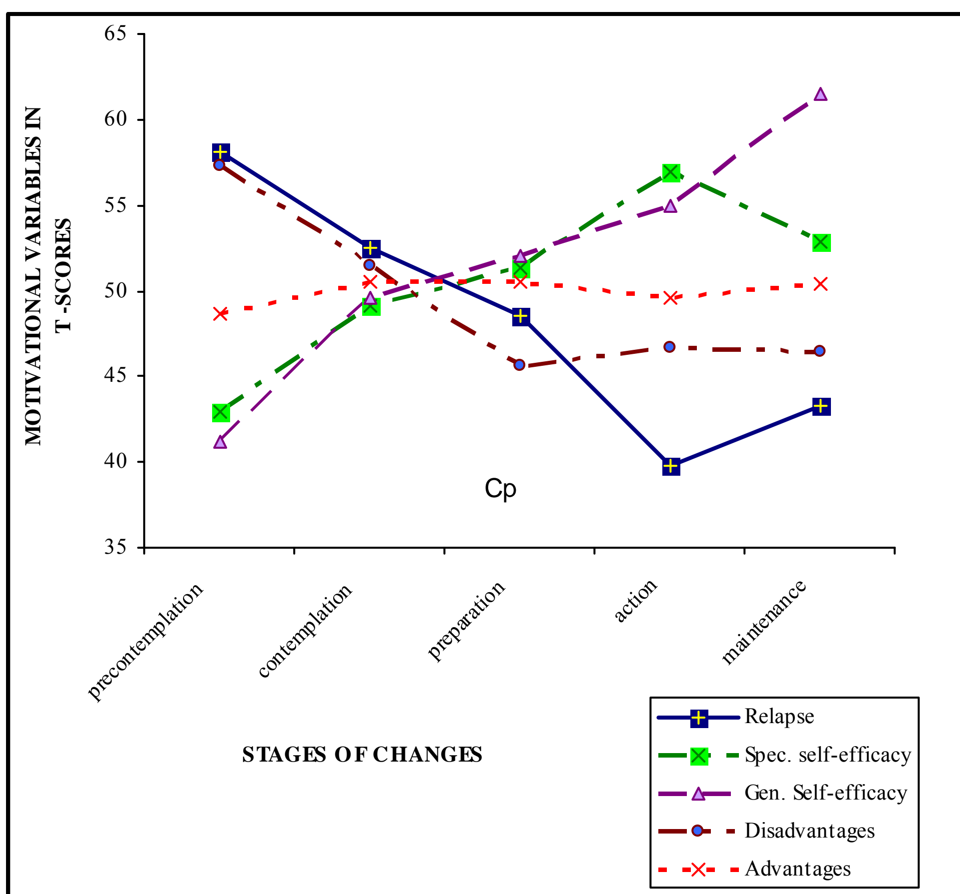
Table 4. Results of univariate analysis of variance – motivational variables differences in dependence on the stages of change

Motivational variable	Value of F	Significance of F
Relapse	16.75	.000
General self-efficacy	10.74	.000
Specific self-efficacy	7.40	.000
Cons	7.20	.000
Pros	.17	.953

When the motivational variables are observed as a group, there is significant difference depending on the stage of readiness in which the patient is. We can see that all the univariate analysis except one gives their contribution to this significance. Subjects do not differ only in relation to how often they think of treatment's advantages. This is opposite to our expectations. We have expected advantages to increase suddenly in the stage of preparation, and the explanation of high socially biased scale is the most probable.

We were especially interested in how our patients differed in demonstration of each motivational variable depending on the stage of change they were in. In order to make mutual comparison of the results, we transformed raw data into T-scores with M=50 and SD=10. We presented results with the graphic in order to make it more understandable.

Graphic 1: Relation of motivational variables and stages of change



In this way, we get a very illustrative picture how motivational variables change depending on the stage of change the patient is in.

Firstly, as we look at the patients in precontemplation, action and maintenance stage, we can see an obvious symmetry between stimulating and restricting aspect of variables, as they are clearly separated and placed to the positive and negative pole. While patients in precontemplation stage expressed negative poles of these variables above the average and positive poles below the average, patients in action and maintenance stage expressed this quite opposite – positive poles of motivational variables were expressed above the average and the negative ones were below the average. Hence, both of these groups are clearly determined. Patients in precontemplation stage express more cons of treatment without hesitation. They also express a high degree of inclination to relapse, which means that they doubt to find solution to their

problem and, at the same time, their general and specific self-efficacy is on the low level. The situation with patients in action and maintenance stage is quite opposite. Relatively speaking, they are more oriented toward positive then negative aspects of the treatment, their degree of general and specific self-efficacy is on the high level and they have significantly less tendency to get demoralized easily. Although both of these groups have the same relation to the pros of the treatment when we look at the absolute values, relative position of this variable in relation to the other variables is very informative., For the patients in precontemplation stage, this position points out to an existence of non-differentiate belief in the treatment along with the emphasis on the treatment's cons and the feeling of the absence of their own ability to find the problem solution through the personal action. On the other hand, patients in action and maintenance stage recognize the same positive aspects of the treatment, but they rarely consider treatment's cons; they rely more on their own abilities and this is the point where the absolute belief in the treatment ceases to be so important.

The interesting detail is, for example, the relation between some variables with the action and maintenance stage. While a specific self-efficacy, as an indicator of commitment and attention direction toward activity necessary for problem solving, is more expressed in the action stage, a general self-efficacy is more expressed in the maintenance stage. In the maintenance stage, the specific self-efficacy slightly decreases as well as the inclination to relapse slightly increases. It seems like the patients in this stage develop an experience of globally increased belief in their own strength, but at the same time they feel like they have reached a limit in their treatment and they have started to doubt the possibility of the actual and final problem solution. This result points to the need to work with these clients in a very specific manner directed toward relapse exceeding.

Another thing to be noticed is the knot placed on the intersection of variables, more precisely between the contemplation and preparation stage and this is very informative for understanding the situation of patients who have recognized themselves to be in one of these two stages. We can see that patients in contemplation stage feel ambivalence about all variables, and this is what the model has expected. At the same time and with the equal frequency they think of treatment's pros and cons, and they are with equal intensity assured in their own ability to cope with the difficulties, in the same way, as they doubt in this possibility getting easily demoralized in this way. We believe that the constellation of motivational variables defined in this way significantly explains why these patients show only contemplative readiness, or maybe a wish, to get better, but without actual commitment to some concrete actions.

On the other hand, patients in the preparation stage are the ones who start to reconsider these questions in order to make concrete decision. In this way, we can recognize the separation of observed variables and mild preponderance of stimulating aspects in relation to limiting aspects, but this is still not so obvious and intensive as it will be in the next stage. Namely, although we might notice certain mild

increase of general and specific self-efficacy and preponderance of the treatment's pros, the inclination to relapse still represents a challenge for more active commitment to a change, which will occur only in the action stage.

Concerning the scale of cons, we can notice that exactly in the preparation stage, as the transtheoretical model has assumed, the appearance of the crucial decrease of consideration of treatment's negative aspects, and it remains on that level through the following stages. However, this does not happen with other motivational variables, which continue to develop in the expected way. On these bases, we might conclude that it is desirable to change the evaluation of the very treatment so the patients could move to stages, which imply higher commitment to change and transfer from thinking of change to its actual realization. It means that it is necessary to work with patients during the treatment, especially with those who are in precontemplation and contemplation stage, on their reconsideration of the treatment's negative consequences, their fears regarding being in psychiatric institution, what it could mean to them, what their fears are, how the psychiatric treatment could jeopardize their self-respect, and their social image, with the aim to to decrease these fears. Our results point to the beneficial influence of the fear reduction on the change of type of readiness for a change, what indirectly provides possibility for a positive outcome of the treatment.

On the other hand, reduction of a negative attitude toward treatment is not that important for moving from the preparation stage to the action stage, as it is important to be directed to personal capacity for the problem-solution, both for the concrete problem and for a wide range of problems in life as well. It is also very important to parallel work on weakening of the temptation for demoralization, as these are the basic characteristics of the motivational profile of the patients who have improved further from the preparation stage.

These results have confirmed Schwarzer's hypothesis on unequal role of different types of expectations in the first or the second phase of the treatment. This author (Schwarzer, 1999) as well finds that the expectation of the treatment's outcome, expressed through the evaluation of pros and cons of changed behavior, is more important in the phase of starting the initiative, while the self-efficacy is more important in the voluntary phase, i.e. in the phase of transfer from intentions to the level of a concrete action.

When we sum up the achieved results, we could see that the examined motivational variables are of high importance during the entire treatment, but while issues related to decision-balance appeared to be more important at the beginning of the treatment, the issues related to self-efficacy and relapse appeared to be important at the beginning and in the middle of the treatment, and even at the end of it. Specific self-efficacy appeared to be slightly more important at the beginning and in the middle of the treatment, while general self-efficacy gets a specific importance at the end of the treatment. Inclination to relapse appeared to be a significant factor from the beginning to the end of the treatment. This goes in favor of Frank's hypothesis

(1985 according to Kanfer & Schefft, 1988) on patients seeking for psychiatric or psychotherapeutic help not only because of the symptoms, but because of the symptoms associated with demoralization. The implementation of the therapeutic aim is impossible without restoration of the clients' belief in their own strength and possibility for a positive outcome. This implies that it is wrong in the therapeutic process, to limit work on client's motivation to initial and very often low stages of treatment, and this is exactly what can be recognized in programs for education of future therapists as a formal recommendation. More precisely, our results show that it is possible to differentiate more motivational profiles. What we find to be the most important result is the fact that it is not the same which aspect of motivation in what therapeutic stage is more emphasized, which means that it is necessary for therapeutic work to be differentiate and oriented toward the aim.

CONCLUSION

When we organized this research, our first hypothesis we started from was that the motivation of psychiatric patients to participate in the treatment and solve their problem was a complex phenomenon, which must be traced through more indicators. The second hypothesis was that there was a specific correlation between motivational variables and stages of changes patients were in. Theoretical framework for defining and examining the motivation and stages of change was the transtheoretical model by Prochaska and associates. The results we have obtained confirm both our hypothesis. More concretely, decision balance variables appeared to be more significant in lower stages of change. It means that is necessary to come to the perception preponderance of positive consequences of the treatment over the negative ones, so that the patients could start to solve their problem more actively. For the inclusion of action processes and for the patients' transfer to the action stage, variables related to self-efficacy appeared to be of the most importance. More precisely, the specific self-efficacy is more important in the action stage and general self-efficacy is specifically important in the maintenance stage. Inclination to relapse appears to be constantly significant predictor for patients' improvement through stages. These results confirm hypothesis about the development of motivation for behavioral change, originally developed within the framework of the social learning theories.

The practical value of the results rests on the possibility to define basic directives for organization of therapeutic programs on their basis, independently on the theory perspectives.

REFERENCES

Bandura, A. (1982). Self-efficacy mechanism in human agency. *American Psychologist*, *37*, 122-147.

Barth, K., Havik, O. E., Nielsen, G., Haver, B., Molstad, E., Rogge, H., Skatun, M., Heiberg N. A. & Ursin, H. (1988). Factor Analysis of the Evaluation Form for Selecting Patients for Short-Term Anxiety-Provoking Psychotherapy. *Psychother Psychosom*, *49*, 47-52.

Bellis, J. M. (1993). *The transtheoretical model of change applied to psychotherapy: A psychometric assessment of related instruments (stages of change).* Dissertation, University of Rhode Island.

Bergin, A. E. & Garfield, S. L. (Eds.) (1994). *Handbook of Psychotherapy and Behavior Change*. 4th edition. New York, John Wiley & Sons Inc.

Brewin, C. (1988). *Cognitive Foundations of Clinical Psychology*. London & Hove, Lawrence Erlbaum

DeLeon, G., Melnick, G. & Kressel, D. (1997). Motivation and readiness for therapeutic community treatment among cocaine and other drug abusers. *American Journal of Grug & Alcohol Abuse*, *23*, 169-189.

DiClemente, C. C. (1981). Self-efficacy and smoking cessation maintenance. *Cognitive Therapy and Research, 5*, 175-187.

DiClemente, C. C., Bellino, L. E. & Neavins, T. M. (1999). Motivation for Change and Alcoholism Treatment. *Alcohol Research & Health*, *23*, 86-92.

DiClemente, C. C. & Prochaska, J. O. (1998). Toward a comprehensive, transtheoretical model of change: Stages of change and addictive behavior. In Miller, W. R., Heather, N. (Eds.) *Treating Addictive Behaviors*, 2nd edition. New York, Plenum Press.

DiClemente, C. C., Prochaska, J. O. & Gibertini, M. (1985). Self-efficacy and the stages of self-change of smoking. *Cognitive Therapy and Research*, *9*, 181-200.

Evans, C. (1992). Could "objective, experimental" analysis of human motivation really improve psychotherapy? *British Journal of Medical Psychology*, *65*, 245-254.

Forsterling, F. (1988). *Attribution Theory in Clinical Psychology*. New York, John Wiley & Sons.

Frayn, D. H. (1992). Assessment Factors Associated with Premature Psychotherapy Termination. *American Journal of Psychotherapy*, *46*, 250-261.

Freyer, J., Hapke, U., John, U., Keller, S., Rumph, H. J. & Tonigan, J. S. (2004). Readiness to Change versus Readiness to Seek Help for Alcohol Problems: The Development of the Treatment Readiness Tool. *Journal of Studies on Alcohol. 65*. Retrieved May 20, 2006. from: http://www.questia.com.

Gavrilov-Jerkovic, V. (2004). The Profile of Client's Readiness for Change and Preference to Typical Processes of Change. *Psychology*, *37*, 89-108.

Janis, I. L. & Mann, L. (1977). *Decision Making: A psychological analysis of con-*

flict, choice, and commitment. London, Cassel & Collier Macmillan.

Kanfer, F. H. & Schefft, B. K. (1988). *Guiding the Process of Therapeutic Change*. Champaign, Illinois, Research Press.

Mackay, N. (1989). *Motivation and explanation. An essay on Freud's philosophy of science.* Psychological Issues, Monograph 56. Madison, Connecticut, International Universities Press, Inc.

Maurischat, C. (2001). Erfassung der Stages of Change im Transtheoretischen Modell Prochaskas - eine Bestandsaufnahme. Retrieved October 17, 2002. from: http://www.psychologie.uni-freiburg.de/pi-zentral/fobe-files/154.pdf.

O'Connell, D. & Velicer, W. F. (1988). A decisional balance measure and the Stages of Change Model for weight loss. *The International Journal of the Addictions*, *23*, 729-750.

Prochaska, J. O. Crimi, P., Lapsanski, D., Martel, L. & Reid, P. (1982). Self-change processes, self-efficacy and self-concept in relapse and maintenance of cessation of smoking. *Psychological Reports*, *51*, 983-990.

Prochaska, J. O. & Norcrosss, J. C. (1994). *Systems of Psychotherapy: A Transtheoretical Analysis,* 3rd edition. California, Brooks/Cole Publishing Company.

Prochaska, J. O., Velicer, W. F., Rossi, J. S., Goldstein, M. G., Marcus, B. H., Rakowski, W., Fiore, C., Harlow, L. L., Redding, C. A., Rosenbloom, D. & Rossi, S. R. (1994). Stages of Change and Decisional Balance for 12 Problem Behaviors. *Health Psychology*, *13*, 39-46.

Rotter, J. R. (1954). *Social Learning and Clinical Psychology*. New York, Prentice-Hall, Inc.

Scholz, U., Guitierres-Donna, B, Sud, S. & Schwarzer, R. (2002). Is General Self-Efficacy a Universal Construct? Psychometric findings from 25 countries. *European Journal of Psychological Assessment*, *18*, 242-251.

Schwarzer, R. (1999). Self-regulatory processes in the adoption and maintenance of health behaviors. The role of optimism, goals, and threats. *Journal of Health Psychology*, *4*, 115-127.

Schwarzer, R. & Born, A. (1997). Optimistic self-beliefs: Assessment of general perceived self-efficacy in thirteen cultures. *World Psychology, 3*, 177-190.

Snyder, C. R. & Forsyth, D. R. (Eds.) (1990). *Handbook of social and clinical psychology. The Health Perspective.* New York, Pergamon Press.

Treasure, J., House, T. G. & Bocconi, L. (2003). Assessment and Motivation. In E. Van Furth, U. Schmidt & J. Treasure (Eds.). *Handbook of Eating Disorders*. Hoboken (NJ), John Wiley & Sons.

Velicer, W. F., DiClemente, C. C., Prochaska, J. O. & Brandenburg, N. (1985). Decisional Balance Measure for Assessing and Predicting Smoking Status. *Journal of Personality and Social Psychology*, *48*, 1279-1289.

REZIME

POVEZANOST STADIJUMA PROMENE I MOTIVACIJE U TRETMANU PSIHIJATRIJSKIH PACIJENATA

Vesna Gavrilov-Jerković
Odsek za psihologiju, Filozofski fakultet, Novi Sad

Ekspliciranje mehanizma delovanja motivacionih faktora na proces psihoterapijske promene je tek od nedavno postalo tema provokativna za istraživače. Prvenstveno, to možemo pripisati promenama u oblasti socijalne psihologije i kliničke psihologije čije približavanje je dovelo do pojave uticajnih socijalnih teorija učenja i atribucionih teorija. Ove teorije su uvele mentalne koncepte kao što su očekivanje, nivo aspiracije, balans odluke, verovanja, konzistentnost, kognitivna disonanca i sl. Ljudska motivacija da sprovede i održi određeno ponašanje je najčešće viđena kao proizvod dva osnovna faktora: vrednosti cilja koji treba biti dostignut i očekivanja da će izabrano ponašanje dovesti do tog cilja.

Autori koji se ne bave eksplicitno pitanjem motivacije ljudskog ponašanja, ali za čiji rad možemo da kažemo da predstavlja snažan doprinos pitanju motivacije u psihoterapiji, su autori transteorijskog modela. U okviru ovog modela ističe se da je na motivaciju da se promeni neko ponašanje pogrešno gledati kao na nešto čega ima ili nema i kao na nešto što se u jednom momentu "pojavi" omogućavajući terapeutu rad sa klijentom. Koncipiranje serije stadijuma promene i opisivanje procesa koje osoba upražnjava kad pravi neku personalnu ili bihevioralnu promenu, nudi novu perspektivu istraživanja motivacije.

Poseban izazov u istraživanju motivacije klijenta da se promeni uz pomoć nekog tretmana je procena te motivacije. Po transteorijskom modelu, procena klijentove motivacije zahteva procenu njegovih specifičnih stavova i namera, verovanja o mogućnosti i korisnosti promene, sposobnosti donošenja odluka i posvećenosti određenom ponašanju.

Brojna istraživanja koja su sproveli autori modela, i to uglavnom u oblasti promene zdravstvenog ponašanja, uverila su ih u ključnu ulogu motivacionih faktora, u smislu da je za napredovanje kroz stadijume promene potrebno da dođe do promene u balansu odluke, zatim da osoba poveća uverenost u svoju sposobnost da kontroliše ishod akcije i da smanji snagu iskušenja u odnosu na stimuluse koji su povezani sa problematičnim ponašanjem.

U skladu sa ovim nalazima, mi smo se zainteresovali šta se dešava sa razvojem motivacije kod osoba koje su na psihijatrijskom tretmanu i da li nam uvid u razvoj

njihove motivacije može dati relevantne smernice za organizovanje toka tretmana. Istraživačko pitanje koje smo sebi postavili je da li se i kako razlikuju psihijatrijski pacijenti u izraženosti samoefikasnosti, balansa odluke i sklonosti da recidiviraju, u zavisnosti od toga u kojem stadijumu promene se nalaze.

Istraživanje je sprovedeno na 129 psihijatrijskih pacijenata na hospitalnom i ambulantnom tretmanu. U uzorak su ušli pacijenti sa dijagnozom neuroza ili poremećaj ličnosti. Teorijski okvir za definisanje i ispitivanje motivacije i stadijuma promene kao istraživačkih varijabli je bio transteorijski model Prochaske i saradnika.

Dobijeni su rezultati koji ukazuju da su stadijumi promene značajno povezani sa ispitanim motivacionim varijablama. Pacijenti u nižim stadijumima spremnosti (prekontemplaciji i kontemplaciji), pokazuju motivacioni profil koji se odlikuje pasivno-rezigniranom receptivnošću, sklonošću ka lakoj demoralizaciji i niskim poverenjem u sopstvene snage. Pacijenti u višem stadijumu spremnosti (akcija i održavanje promene), pokazuju specifičan motivacioni profil koji se odlikuje proaktivnim optimizmom, odnosno, očekivanjem pozitivnih ishoda tretmana, padom sklonosti ka demoralizaciji i oslanjanjem na sopstvene resurse.

Varijable balansa odluke (prednosti i nedostaci promene ponašanja) se pokazuju kao značajnije u nižim stadijumima spremnosti. To znači da je za razvoj klijentove pripreme da počne aktivno da rešava svoj problem važno da dođe do prevage percipiranja pozitivnih nad negativnim konsekvencama tretmana. Dotle se za uključivanje akcionih procesa i za prelazak u stadijum akcije kao važnije pokazuju varijable self-efikasnosti i to prvo specifična self-efikasnost, a u stadijumu održavanja na posebnom značaju dobija generalna self-efikasnost. Sklonost ka recidivu se pokazuje konstantno kao značajan prediktor napredovanja kroz stadijume.

Rezultati istraživanja su u skladu sa osnovnim pretpostavkama transteorijskog modela promene. Praktična vrednost rezultata se ogleda u mogućnosti da se na osnovu njih definišu osnovne smernice za organizovanje terapijskog programa.

Ključne reči: *Motivacija za promenu, stadijumi promene, transteorijski model promene*

RAD PRIMLJEN: 2.02.2007.