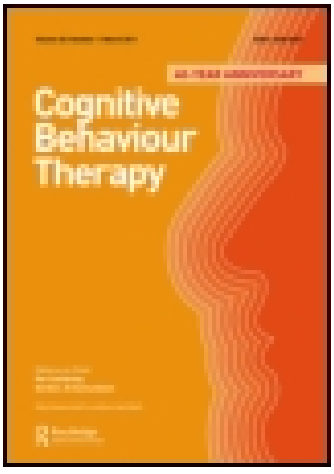

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Reasons for Entering Treatment Reported by Initially Treatment-Resistant Patients with Substance Use Disorders

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Abstract. Many individuals with substance use disorders are resistant to entering formal treatment, despite the negative consequences that plague their own lives and the lives of concerned significant others (CSOs). Community Reinforcement and Family Training (CRAFT) has been developed as an effective strategy for helping family members who are concerned about the alcohol/drug use of a loved one who refuses to seek treatment. The present study explored reasons and feelings that played a part in these resistant individuals' (identified patients [IPs]) decision to begin treatment. Written statements and feelings of 36 initially treatment-refusing IPs, who were engaged into treatment via their CRAFT-trained CSOs, were examined upon entering treatment. Self-report forms assessed three complementary domains about entering treatment: (1) feelings about coming for treatment, (2) important reasons for entering treatment, and (3) reasons for entering treatment narratives. It was shown that the occurrences of self-reported positive emotions and statements that expressed a positive wish for change outweighed negative feelings and statements. Although conceivably these CRAFT-exposed IPs may have provided different responses than other treatment-seeking populations, the current study's strong IP reports of positive feelings, reasons, and narrative statements regarding treatment entry nonetheless address potential concerns that treatment-refusing IPs might only enter treatment if felt coerced by family members and while experiencing salient negative feelings overall. *Key words: treatment-resistant; community reinforcement and family training; CRAFT; family; addiction; substance use disorder; recovery; evidence-based.*

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Introduction

Most individuals with alcohol or drug use disorders have never been in formal treatment, as recent studies indicate that lifetime treatment- or help-seeking behavior can be characterized as "uncommon" (Compton, Thomas, Stinson, & Grant, 2007; Hasin, Stinson, Ogburn, & Grant, 2007; Institute of Medicine, 1990; Stinson et al., 2005). The typical elusiveness and reluctance to seek help have adverse consequences for individuals with substance use disorders, as well as having a profound impact on the lives of close family members and friends (Collins, Leonard, & Searles, 1990). It has been estimated that half of American adults have a close family member who has suffered from alcoholism (Dawson & Grant, 1998; U.S. Department of Health and Human Services, 1995). Furthermore, it has been indicated that for every chemically dependent individual, approximately four to five individuals bear its consequences directly (Daley & Raskin, 1991; Hussaarts, Roozen, Meyers, van de Wetering, & McCrady, 2012; Paolino & McCrady, 1977). The myriad of negative repercussions on the family members often affects their health and personal lives. For example,

women with partners who had alcohol problems were more likely to experience victimization, injury, mood or anxiety disorders, and an impaired health status than women whose partners did not have alcohol problems (Dawson, Grant, Chou, & Stinson, 2007). Similarly, family members of individuals who abuse *illicit* drugs also report multiple problems across life areas, including economic, psychological, and familial problems, and relationship dissatisfaction (Fals-Stewart, Birchler, & O'Farrell, 1999; Hussaarts et al., 2012; Kahler, McCrady, & Epstein, 2003; Kirby, Dugosh, Benishek, & Harrington, 2005; Winters, Fals-Stewart, O'Farrell, Birchler, & Kelley, 2002).

For those substance-abusing individuals who do eventually seek treatment, records show that this occurs 6–10 years after the initiation of drug use (Joe, Simpson, & Broome, 1999). This is particularly disconcerting, because research indicates that individuals who are engaged in treatment at earlier stages of drug dependence generally experience more favorable outcomes (e.g., McLellan, Luborsky, Woody, O'Brien, & Druley, 1983; Scott, Dennis, & Foss, 2005). What factors might influence those individuals with substance abuse problems to seek and engage in treatment, even while they are fully immersed in an alcohol or drug-using lifestyle? Many clinicians believe that help-seeking behavior is associated with individuals' addiction severity, and that these individuals must hit "rock bottom" before they are motivated to enter formal treatment. In contrast to this assumption, research has clearly substantiated that having more severe drug-related problems is inversely associated with treatment admission (Hser, Maglione, Polinsky, & Anglin, 1998).

It has been systematically shown that the "old school" confrontational approach of "breaking down" defense mechanisms consistently fails to be successful in the treatment of substance use disorders (see Miller & Wilbourne, 2002). Furthermore, confrontation may even be responsible for diametrical effects, as detrimental consequences have been reported (Miller & White, 2007). Congruently, there is a growing body of literature which establishes that an empathic, benign, respectful, and collaborative therapy approach is effective in encouraging individuals with substance abuse problems to sample healthy new behaviors (e.g., Azrin, 1976; Hunt & Azrin, 1973; Meyers & Smith, 1995; Miller & Rollnick, 1991; Vasilaki, Hosier, & Cox, 2006).

A comprehensive behavioral treatment, called Community Reinforcement and Family Training (CRAFT), works through the family members of unmotivated substance-using individuals to influence them to enter treatment. In addition, CRAFT focuses on improving family relationships, and enhancing the self-efficacy of the nonusing family member (Meyers & Wolfe, 2004; Smith & Meyers, 2004). The CRAFT intervention focuses on behavioral strategies and skills training, wherein the concerned family member learns to reinforce alternative non-substance-related behavior and gently enforce contingencies with the aim of increasing the likelihood of the substance-using individual initiating treatment.

A recent review revealed that CRAFT is superior to traditional approaches (Johnson, 1986; Nowinski, Baker, & Carroll, 1992) in terms of engaging treatment-refusing individuals into substance abuse treatment (Roozen, de Waart, & van der Kroft, 2010). It should be noted that engagement via CRAFT occurred rapidly in most cases, with an average of only four to six CRAFT sessions attended by the family members. Importantly, the efficacy of CRAFT has been demonstrated across a wide range of substances (i.e., alcohol, various illicit drugs), within multiple ethnic populations (e.g., Native-American, African-American, Hispanic, Anglo), and in a broad set of types of relationships with respect to the substance-abusing individual (spouse, partner, sibling, parent, grandparent, etc.).

The objective of the present study was to explore (qualitatively and quantitatively) the feelings upon entering treatment and the reasons given for doing so by initially treatment-refusing substance-using individuals who entered treatment through CRAFT-trained family members.

Method

Overview

Since the present study was planned as a secondary part of the Meyers, Miller, Smith, and Tonigan (2002) study, a supplemental dataset was used from this controlled clinical

trial of 90 family members who were aimed at getting treatment-resistant illicit drug users into treatment (Meyers et al., 2002). The family members (concerned significant others [CSOs]) were randomly assigned to one of three intervention conditions: (1) CRAFT ($n = 29$), (2) CRAFT + aftercare (i.e., optional additional CRAFT group sessions) ($n = 30$), or (3) Al-Anon/Nar-Anon facilitation therapy (Al-Nar/FT) ($n = 31$). There were no CSO pretreatment group differences on any measures. The two CRAFT conditions were collapsed ($n = 59$), because both groups were statistically equivalent in terms of treatment engagement rates (average engagement = 68%). Engagement was defined as completing baseline assessment, signing the written informed consent, and attending at least one treatment session (Miller, Meyers, & Tonigan, 1999).

The study was approved by the Institutional Review Board of the University of New Mexico. All assessments were conducted by CASAA's (Center on Alcoholism, Substance Abuse, and Addictions) Program Evaluation Services. Research assistants of this service were separate from this study. All potential study IPs were informed of other available treatment options at the time they presented for the CRAFT study, in the event that they were not interested in a clinical treatment that was part of a research project.

Study sample

The participants for this study were 36 of the 40 CRAFT IPs who entered treatment. The remaining four IPs were either ineligible to participate in this study because their substance use problem had subsided ($n = 1$), or they were unwilling to complete the questionnaires ($n = 3$). A total of 86.1% of the CRAFT IPs were male. The mean age of the IPs was 30.72 (SD = 8.99) years. Their ethnicity was predominately Anglo (52.8%) and Hispanic (38.9%). A majority of the individuals lived with their parent(s) in their house or apartment (38.9%), with their spouse or family (30.6%), or shared a house or apartment with a friend or friends (13.9%). Roughly two-thirds of the clients were single or divorced and 44.4% were unemployed.

The substance use section of the Structured Clinical Interview for DSM–IV (SCID; First, Spitzer, Gibbon, & Williams, 1996) was conducted to ensure that IPs met either substance abuse or dependence criteria for an illicit drug, and to identify their drug of choice. The breakdown of substances by category included: crack/cocaine (27.8%), marijuana (16.7%), heroin (13.9%), amphetamines/stimulants (14.0%), and multiple substance use (25.2%). Severity of substance use was assessed with the Form 90-DI (Westerberg, Tonigan, & Miller, 1998). On average, IPs used across six illicit drug categories for more than 3 years (lifetime), with an estimate of 60 days of any drug use in the past 90 days. Furthermore, IPs used alcohol for more than 10 years (lifetime), and reported a mean of 35 days of any alcohol use in the past 90 days.

Instruments

Structured Clinical Interview for DSM-IV. (SCID; First, Spitzer, Gibbon, & Williams, 1996). The SCID is a gold standard structured diagnostic interview for psychiatric disorders. Versions of the SCID have shown good psychometric properties (Segal, Hersen, & Van Hasselt, 1994).

Form-90-DI. (Westerberg et al., 1998). The original Form-90 (Miller, 1996) was developed as part of Project MATCH to assess alcohol use. The adapted drug version has good psychometric properties (Westerberg et al., 1998). This structured interview uses a modified calendar timeline follow-back procedure to obtain information about drug and alcohol use patterns and quantity for the last 90 days.

Given the lack of relevant questionnaires devoted to the treatment entry research questions at the time of the study, the researchers constructed self-report forms drawn from items from the Drinker Inventory of Consequences (DrInC; Miller, Tonigan, & Longabaugh, 1995) investigating three complementary domains about the IP entering treatment: (1) feelings about coming for treatment, (2) important reasons for entering treatment, and (3) reasons for entering treatment narrative:

Feelings about coming for treatment. The first questionnaire focused on *feelings* the IPs may have had about entering treatment. On a seven-point Likert scale ranging from "not at all" (1) to "very much" (7), the IPs filled in a

Table 1. *Likert-scale outcomes of feelings about coming for treatment*

$n = 36$	Percentage							Descriptor		
Item	1	2	3	4	5	6	7	Median	Mean	SD
1. Relieved	2.8	8.3	16.7	25.0	11.1	13.9	22.2	4.00	4.64	1.76
2. Angry	61.1	13.9	8.3	2.8	5.6	0	8.3	1.00	2.11	1.86
3. Guilty	50.0	8.3	8.3	8.3	11.1	5.6	8.3	1.50	2.72	2.12
4. Scared	52.8	13.9	5.6	8.3	5.6	5.6	8.3	1.00	2.50	2.06
5. Relaxed	13.9	8.3	16.7	16.7	16.7	19.4	8.3	4.00	4.06	1.88
6. Resentful	58.3	16.7	13.9	0	5.6	0	5.6	1.00	2.00	1.64
7. Hopeful	8.3	8.3	8.3	8.3	19.4	16.7	30.6	5.00	4.94	2.00
8. Confused	41.7	11.1	19.4	16.7	2.8	0	8.3	2.00	2.61	1.83
9. Happy/glad	11.1	0	19.4	19.4	13.9	16.7	19.4	4.50	4.53	1.89
10. Worried	44.4	11.1	2.8	13.9	13.9	5.6	8.3	2.00	2.92	2.13
11. Anxious	33.3	8.3	16.7	13.9	8.3	16.7	2.8	3.00	3.17	1.98
12. Ashamed	58.3	2.8	11.1	8.3	8.3	5.6	5.6	1.00	2.44	1.99

Note. *Seven-point Likert-scale outcomes of 12 feelings.*

score on the following dimensions: relieved, angry, guilty, scared, relaxed, resentful, hopeful, confused, happy/glad, worried, anxious/fearful, and ashamed (see Table 1).

Important reasons for entering treatment. The second questionnaire dealt with the *importance* of 20 predefined reasons to start treatment (see Table 2). The same seven-point Likert scale was used.

Reasons for entering treatment narrative. Finally, given that the instruments for this study were newly developed and exclusively involved forced-choice items, an opportunity to reply in an unconstrained manner to

Table 2. *Likert-scale outcomes of reasons to come for treatment*

$n = 36$	Percentage						
Item	1	2	3	4	5	6	7
1. I was forced to come	77.8	8.3	5.6	0	5.6	0	2.8
2. I want to be a good example	22.2	2.8	11.1	8.3	13.9	11.1	30.6
3. I want to find out if I have a problem	33.3	5.6	8.3	8.3	19.4	8.3	16.7
4. I want help	5.6	0	0	13.9	16.7	16.7	47.2
5. I want to feel good about myself	0	2.8	2.8	2.8	16.7	22.2	52.8
6. I had no choice	75.0	11.1	0	0	2.8	0	11.1
7. My family wants me to do this	5.6	5.6	8.3	5.6	13.9	19.4	41.7
8. I want to please someone	33.3	8.3	5.6	11.1	16.7	11.1	13.9
9. I know other people who have been helped	36.1	8.3	13.9	11.1	13.9	5.6	11.1
10. I have legal problems	66.7	5.6	0	5.6	8.3	0	13.9
11. God wants me to do this	38.9	2.8	8.3	5.6	5.6	8.3	30.6
12. I want to stop using drugs	8.3	5.6	8.3	5.6	2.8	8.3	61.1
13. The treatment is free	13.9	8.3	13.9	19.4	5.6	11.1	27.8
14. This came along at just the right time	16.7	8.3	0	11.1	16.7	16.7	30.6
15. I want to cut down my use of drugs	8.3	2.8	2.8	5.6	11.1	16.7	52.8
16. I am tired of living the way I have been	0	2.8	2.8	0	13.9	19.4	61.1
17. I am worried about my health	13.9	11.1	5.6	8.3	13.9	5.6	41.7
18. Getting into treatment was easy	11.1	13.9	8.3	8.3	22.2	2.8	33.3
19. I want to know that I've tried every option to change	11.1	5.6	5.6	11.1	5.6	13.9	47.2
20. I could not afford to keep using	47.2	5.6	5.6	5.6	0	8.3	27.8

Note. *Seven-point Likert-scale outcomes of 20 predefined reasons to come for treatment.*

treatment entry questions was desired. So each IP was asked to respond to two open-ended questions about entering treatment. The questions were:

(1) "People decide to enter treatment for many different reasons. Most people seem to have several reasons for coming in. Tell me what are the main reasons you came in."
(2) "Why are you coming for treatment now? What were the events that led up to your deciding to come in?"

Their responses were later divided into two groups: intra- and interpersonal reasons (see Results section for details regarding how the content was categorized). The DrInC intra- or interpersonal consequences subscales served as a template for dividing the written reasons into both groups (Miller et al., 1995). Both DrInC subscales were factor analytically derived on a clinical sample ($n = 1389$) from Project MATCH (Matching Alcoholism Treatments to Client Heterogeneity), which is one of the largest clinical treatment trials conducted with individuals with alcohol use disorders (Project MATCH Research Group, 1997). Based on the MATCH-derived DrInC subscales, each statement was assigned a score according to whether its content was: 1 = intrapersonal, 2 = interpersonal, or 3 = both.

Statistical analysis

First, for the two Likert-scale questionnaires ("Feelings about Coming for Treatment" and "Important Reasons for Entering Treatment"), each individual item was appraised by its percentage of responses with respect to lowest and highest score: "not at all" (1) or "very much" (7). This analysis gave insight into the items that were most often rated the highest or lowest. In addition, mean scores (SDs) were calculated regarding each individual item for the "Feelings about Coming for Treatment" questionnaire. Cohen's kappa statistic was performed to analyze the inter-rater agreement on the written content of the narrative statements.

The internal structure of the first questionnaire "Feelings about Coming for Treatment" was examined by two complementary techniques: exploratory factor analysis (EFA) and reliability analysis. The factorability was inspected by means of Kaiser–Meyer–Oklin value and Barlett's test of sphericity. The EFA analysis, by means of principal component analysis (PCA), was conducted on the reported scores. In the PCA analysis, only factors with eigenvalues >1.0 and with a factor loading criterion >0.50 were used. This procedure was followed by visual inspection of the Scree plot and a computerized parallel analysis (Patil, Singh, Mishra, & Donavan, 2007). After determining the number of factors, an orthogonal Varimax rotation was carried out. The internal consistency was examined by computing Cronbach's α for the subscales with 95% confidence intervals (CI) (Dunn, Baguley, & Brunsden, 2013). In addition, mean factor scores were calculated, which were compared by means of a paired-samples t-test to investigate differences between the types of reported feelings. All p-values were two-sided and considered significant at $p < 0.05$.Computations were performed with the Statistical Package for Social Sciences (SPSS version 15.0, 2004, SPSS Inc., Chicago, Illinois) and MBESS, an Open source *R* package (Kelley, 2007).

Results

Feelings about coming for treatment

Among the items about *feelings* that were assigned the highest percentages on "very much" (7) and thus considered most important were: hopeful, relieved, and happy/glad. The feelings with the highest percentage "not at all" (1) and therefore considered least important were: angry, ashamed, scared, resentful, and guilty.

The highest mean scores of the most important feelings about entering treatment were: hopeful, relieved, happy/glad, and relaxed. Among the lowest means scores were: resentful, angry, ashamed, and scared (see Table 1).

We applied an EFA to assess the underlying dimensionality of the included items. Performing an EFA was valid as both the Kaiser–Meyer–Olkin measure of sampling was 0.79 (>0.70) and Bartlett's test of sphericity showed statistical significance ($p < 0.001$). By means of an inspection of the Scree plot and parallel analysis, it was decided to retain two components, which comprised two distinctive factors, together explaining 66.74% of

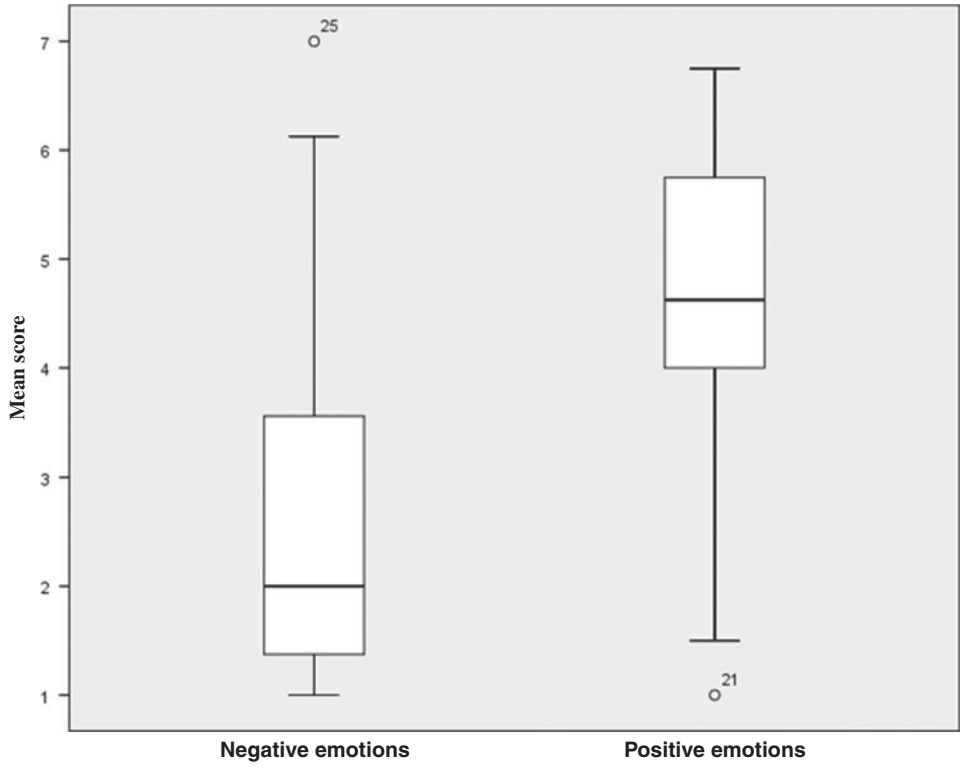

Figure 1. Box plot representing positive and negative emotions ($n = 36$). Note. On the right side the box plot represents the factor with positive emotions and on the left side the negative emotions. Outliers and extremes are not suppressed. Cases 21 and 25 gave the impression that they systematically responded to questionnaire items with other motives than the item content. The black line in the box represents the median value. Horizontal lines under and above the box (whiskers) indicate the range of values. Length of the box indicates the interquartile range (IQR), which covers the range between the 25th and 75th quartile. The IQR is an estimate of the spread of the data.

the variance. One factor with a Cronbach's α of 0.82 (95% CI: 0.72–0.92) contained all the positive items (happy/glad, hopeful, relieved, and relaxed), whereas the other factor with a Cronbach's α of 0.92 (95% CI: 0.88–0.96) contained the remaining (negative) items. There was a statistically significant ($t(35) = -4.97$, $p < 0.001$) difference between the scores on the positive ($M = 4.54$; SD = 1.52) and negative ($M = 2.56$; SD = 1.56) factors (Figure 1).

Important reasons for entering treatment

The *importance* of the 20 predefined statements was identified by examining those reasons that were assigned the highest percentage on "very much" (7), such as "I am tired of living the way I have been," "I want to stop using drugs," "I want to cut down my use of drugs," "I want to feel good about myself," and "I want help." The feelings with the highest percentage on "not at all" (1) and therefore considered least important were: "I was forced to come," "I had no choice," "I have legal problems," "I could not afford to keep using," and "I know other people who have been helped" (see Table 2).

Reasons for entering treatment narrative

Finally, upon treatment engagement, IPs supplied written reasons for entering treatment. A total of 70 unique narratives derived from the IPs were collected and appraised. These reasons were divided into two groups: intra- and interpersonal reasons. Each statement was assigned a score according

to whether its content was mainly: 1 = intrapersonal, 2 = interpersonal, or 3 = both. Two authors (BEE and HGR) independently assessed the content, resulting in a percentage of agreement of 84.3% ($\kappa = 0.72$, $p < 0.001$). After reaching consensus regarding the final scores, it was shown that 54.3% of the statements were evaluated as intrapersonal, 34.3% were characterized as interpersonal, and 11.4% were considered as both. All written statements that had more than one reason (e.g., "It is a good reason for *me* and *my mother* to walk through this program") were reappraised, and subsequently, cut down, and separately added to the categories intra- and interpersonal reasons ($n = 12$). All 82 statements were appraised and subdivided by three authors (BEE, HGR, and RJM) measuring the frequency of "positive" and "negative" statements for each category. The positive statements highlighted an active step toward positive change (what *will* be done), whereas the negative statements were associated with things that the IP hopes to *avoid* in the future. In Table 3, the percentages and examples of statements are provided.

Discussion

The primary objective of this project was to examine the factors that were associated with treatment entry (Booth, Kwiatkowski, Iguchi, Pinto, & John, 1998; Miller & Rollnick, 1991; Miller & Heather, 1998; van der Pol et al., 2013) for individuals who initially were treatment-refusers, but who sought treatment after their CSOs received CRAFT. Whereas only a small number of individuals with substance use disorders enter treatment, more insight into crucial factors that potentially influence treatment entry is needed (Tsogia, Copello, & Orford, 2001).

Pertaining to the reported feelings while engaging in treatment, clients' highest ranked scores were: hopeful, relieved, and happy/glad. Conversely, the least important were: angry, ashamed, scared, resentful, and guilty. Also regarding the EFA, it was shown that self-reported positive emotions about coming into treatment prevailed over the negative ones. In general, the clients reported higher scores on statements that expressed a wish for change. These statements included items such as, "I am tired of living the way I have been," whereas the lowest scores were assigned to reasons reflecting an external motivation including: "I was forced to come." Hence, irrespective of how the data were presented (i.e., percentages, mean scores), the current findings highlight that positively labeled emotions and statements expressing a wish for change were reported more often than

Table 3. *Written statements examples*

Intrapersonal	Negative ($n = 22$)	26.8%	I lost my car, my home and my job in one day
			I was losing control of my life
			I am tired of being put in risky situations
			I lost everything I had
	Positive ($n = 28$)	34.1%	I felt I needed help
			I need to get help because my life has become unmanageable
			I want to get clean and sober
			I want to change my life around
Interpersonal	Negative ($n = 20$)	24.4%	I am having a difficult time in my relationship
			My mom brought me here
			My wife and I are having trouble communicating and fighting
			My mother seems to be suffering a great deal
	Positive ($n = 12$)	14.6%	I want to have a more successful relationship
			I am seeing changes in my wife's behavior and attitude
			My wife cared about me so much that she entered a program to help me
			Things at home helped me to realize that I need help

Note. *Selection of examples of a total of 82 written statements about reasons to enter treatment provided by 36 IPs. The percentages reflect the type of statements that were categorized in each of the four categories. Positive statements indicate an active step toward positive change (what will be done), whereas negative statements reflect what he or she hopes to avoid in the future.*

negative feelings and coercion-related reasons for engaging in treatment. This is particularly noteworthy, given that these individuals were all treatment-refusers initially.

It has been reported that negative attitudes and perceptions are considered counterproductive in getting substance-using individuals into treatment (Miller & White, 2007). On the other hand, it is well known that intimate partners, family members, and close friends can alter their own behavior and thereby encourage persons with addiction problems to enter treatment (Copello & Orford, 2002; McCrady, 2004). Also, the finding that positive feelings about family relationships were associated with entering treatment is important in this perspective (Brown, Bennett, Li, & Bellack, 2011). Interestingly, almost 40% of the narrative statements in the current study were considered interpersonal (both positive and negative), which conveys an interaction with family members and demonstrates the inherent power of close relationships to improve life (Copello & Orford, 2002; Hingson, Mangione, Meyers, & Scotch, 1982; Kirby, Marlowe, Festinger, Garvey, & La Monaca, 1999; McCrady, 2004; Miller & Meyers, 2001; Miller et al., 1999; Sisson & Azrin, 1986). Moreover, the current study's findings that among the top *least* important reasons for entering treatment were being "forced" to come or legal problems are in line with the results of Marlowe et al. (1996) that family interactions are superior to coercion and legal pressure in terms of fostering treatment admission. Recent research confirms that individuals with positive feelings about their family are more likely to enter treatment, and that recently arrested individuals are less likely to engage in treatment (Brown et al., 2011). Overall, a glimpse at the change process in the current study was illustrated through several measures, and although not definitive, the outcome was consistently in line with the CRAFT training offered to the CSOs.

The studied sample consisted of only those clients whose family member utilized the CRAFT intervention to get the IP into treatment (Meyers et al., 2002). CRAFT is designed to help CSOs function better by teaching them how to take better care of their own needs, to stay safe, and to interact with a substance-using individual in a way that promotes nonuse and avoids judgment of his/her using behaviors. When these types of interactions are coupled with a gentle invitation to attend treatment, the clients' treatment perception is likely more open and positive, which is an important factor in the decision to seek help when weighing the likelihood and value of the consequences of continuing substance abuse against the anticipated positive consequences of seeking treatment (Varney et al., 1995). Given that CRAFT teaches the CSO how to be positive, upbeat, and motivational (Meyers & Wolfe, 2004; Smith & Meyers, 2004), one might speculate that these IPs entered treatment at least in part due to the overall improved communication through the CRAFT intervention. Nonetheless, more in-depth research on the family interaction characteristics is needed to determine the precise mechanism of change for CRAFT.

Interestingly, information about the initially treatment-resistant clients' motivation is clarified somewhat when their treatment attendance is compared with that of individuals from the Albuquerque Project MATCH sample, who voluntarily entered treatment (Project MATCH Research Group, 1997). In this latter project, clients attended only 60% of the 12 scheduled sessions (CBT and 12-step), whereas the initially resistant alcohol-using individuals who attended treatment in the CRAFT program (Miller et al., 1999) attended 73% of the scheduled treatment sessions. This is of particular interest, given that these IPs in the CRAFT alcohol study started treatment with lower motivation than the typical CASAA voluntary client (Meyers, 2001). The present study focused on illicit drug-using individuals, so a direct comparison is not possible. The percentages, however, indicate that the IPs in the current CRAFT study did not produce a reduced level of treatment attendance compared to Project MATCH. The focus on treatment entry is important, since it has been found that the factors that facilitate an individual to seek help are sometimes the same ones that keep the individual in treatment (Pelissier, 2004).

Limitations

The present study has several limitations. First, the sample was characterized by only

drug-using individuals and the sample size was particularly small, which tends to overestimate effects. Thus, it would be useful to replicate this type of research with a larger sample size in other diagnostic populations, and by targeting clients with other cultural backgrounds (e.g., European). Second, the research sample encompassed a broad set of different types of relationships with respect to the substance abuser (spouse, partner, sibling, parent, grandparent). Future studies may focus on the treatment admission of one specific type of relationship (e.g., romantic partners) to avoid possible heterogeneity regarding admission rates and concomitant reasons to enter treatment. A third limitation is that the study used only CSOs who received the CRAFT intervention. The sample size of the IPs was too small to compare the treatment entry reasons with those individuals who were allocated to the Al-Anon/Nar-Anon condition. A fourth limitation was the use of constructed self-report forms. Although the obtained psychometric characteristics indicated that the measures were reasonably sound, more research is needed to confirm the psychometric properties of these instruments. A fifth limitation was that this study did not investigate causal effects, and instead only reported on factors associated with getting in treatment. Finally, other studies have demonstrated that most clients report multiple pressures/reasons for seeking treatment, and oftentimes the factors are a combination of positive and negative reasons (Marlowe, Merikle, Kirby, Festinger, & McLellan, 2001). Future studies with treatment-refusing IPs should be sure to investigate such multiple domains using better-established instruments.

Conclusion

The occurrence of self-reported positive emotions and statements that expressed a positive wish for change was reported more frequently than negative feelings and statements by CRAFT IPs who entered treatment (despite being treatment-refusers initially). Thus, it appears that the high prevalence of positive feelings, reasons, and narrative statements regarding treatment entry address potential concerns that IPs might only enter treatment if felt coerced by family members and with salient negative feelings overall.

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