CHAPTER 2

LITERATURE REVIEW

This chapter begins with discussion of definitions, concepts that related to the drug treatment and rehabilitation. In particular, this chapter discusses about motivation, treatment readiness and self-efficacy. The chapter ended with conclusion

2.1 Concept of Motivation

The origin of the word motivation is the Latin word "movere," which means "to move." Motivation is the process that initiates, directs, and sustains goal-directed behaviour. Motivation is what drives us to act, whether it's drinking water to quench our thirst or perusing a book to increase our knowledge. It is comprised of the biological, affective, social, and cognitive forces that motivate behaviour. Motivation is frequently used in everyday language to express why a person does something. Motives are the "whys" of behaviour; they are the necessities or desires that motivate and explain our actions. Motive is the interior state that animates, motivates, and directs behaviour towards objectives.

Motivation encompasses a constellation of interconnected beliefs, perceptions, values, interests, and actions. Consequently, different approaches to motivation may emphasise cognitive behaviours (such as monitoring and strategy use), noncognitive aspects (such as perceptions, beliefs, and attitudes), or both. Motivation is mental in nature. Motivation is what prompts a person to act in a particular manner or, at the very least, develops a propensity for particular behaviour. This inclination to act can be triggered by an external stimulus or generated by an individual's physiological and

cognitive processes. Motivation is the act of stimulating another person or oneself to act in a desired manner. Motivation is the force that propels us to achieve our objectives.

Motivation can be divide into two types: 1) Intrinsic Motivation and 2) Extrinsic motivation. Intrinsic motivation resides within the individual and is motivated by internal rewards, as opposed to external pressures or extrinsic rewards. It requires a genuine interest or delight in the process itself (Ryan & Deci, 2000). Activities with intrinsic rewards provide motivation independent of external rewards. When one is intrinsically motivated to complete a certain objective, it is simpler and more enjoyable to pursue challenges and goals; for instance, because the individual is more interested in learning than in achieving the goal.It has been suggested that intrinsic motivation is associated with increased subjective well-being and is crucial for cognitive, social, and physical development (Tak et al., 2017). It can also be observed in animal behavior, such as when organisms indulge in playful or curious behaviors in the absence of a reward. According to studies, intrinsically motivated individuals have greater interest, enthusiasm, and self-confidence, which leads to enhanced performance, persistence, and creativity.

According to some theories, self-determination or autonomy and competence are required for intrinsic motivation (Ryan & Deci, 2000). According to this view, the cause of the behavior must be internal, and the person engaging in the behavior must perceive that the task enhances their competence. Social-contextual events, such as feedback and reinforcement, can contribute to sentiments of competence and, consequently, to intrinsic motivation. However, a lack of autonomy prevents feelings of competence from enhancing intrinsic motivation. People are more intrinsically

motivated when faced with options, emotions, and opportunities because they have a higher sense of autonomy. Some studies suggest that there is a negative correlation between external rewards and intrinsic motivation (Deci, 1972), meaning that when high external rewards are provided for an activity, the intrinsic motivation to engage in it tends to decrease.

Intrinsic motivation is typically more durable, self-sustaining, and gratifying than extrinsic motivation (Ryan & Deci, 2000). As a result, numerous initiatives in education seek to modify intrinsic motivation in order to improve student learning performance and creativity. However, numerous studies indicate that intrinsic motivation is difficult to modify or stimulate. Attempts to recruit existing intrinsic motivators necessitate an individualized strategy, which entails identifying and making pertinent the various motivators required to motivate various students. This typically necessitates the instructor to possess additional skills (Yarborough & Fedesco, 2020). (Donald et al., 2020) have discovered that mindfulness is an intraindividual factor that supports autonomous motivation and thus contributes to intrinsic motivation.

Extrinsic inspiration is external motivation.These might be rewarding or punishing (Ryan & Deci, 2000). Intrinsic and extrinsic drive differ in motivation. Intrinsically driven people accomplish things because they enjoy them. Extrinsic motivation means the agent's aim isn't the activity. Agents may act for internal and external motives, but one is generally stronger (Yarborough & Fedesco, 2020). Extrinsic incentive is playing tennis for a prize, while intrinsic motivation is enjoying it.

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Some research demonstrate that extrinsic rewards can make people overjustify their conduct, decreasing motivation (Schroeder T, 2020). In one study, youngsters who expected ribbons and gold stars for drawing images received them. After that, they spent less time drawing than children who received a surprise prize. This illustrates that people care less about the activity if they obtain something from it. However, external rewards can improve intrinsic drive. This suggests that prize type may affect extrinsic motivation on intrinsic motivation.

According to the article "Self-Determination Theory and the Facilitation of Intrinsic Motivation, Social Development and Well-Being," a lot of what we do after childhood is not inspired by intrinsic motivation because we must comply with social pressures to do things that are not intrinsically motivating (Donald et al.).

Extrinsic motivation can readily motivate others to achieve goals (Deci, 1997). Since the agent may not be motivated, work quality may need to be monitored. After rewards are taken away, extrinsic drive fades. Extrinsic motivators may lose their effectiveness with time, making it harder to encourage the same person.

Johnmarshall Reeve classifies extrinsic motivation as external, introjected, identifiable, or integrated. Extrinsic motivation is least autonomous when regulated externally. The agent solely cares about the result. Students are driven to study for good grades. The agent's expectations determine injected regulation (Reeve & Johnmarshall, 2018). A student knows they "should" study and doesn't want to feel guilty, so they do.Personal values determine regulation. The student may realize that studying is crucial to their success and pursue their academics. When extrinsic incentive comes from personal identity, integrated regulation is the most autonomous. This extrinsic

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motivation is almost innate. This is because the person is motivated by how well an activity represents their values rather than by sheer curiosity and enjoyment. This student studies because it expresses their ideals and self-image. Intrinsically driven students study just because they enjoy it.

2.2 Concept of Self Efficacy

According to Bandura (1977, 1986, and 1997), self-efficacy can be defined as an individual's belief in his or her own competence to carry out the behaviours necessary to create certain performance attainments. A person's level of self-efficacy indicates the degree to which they believe they are able to exert control over their own motivation, behaviour, and the social situation in which they find themselves. These cognitive self-evaluations have an effect on every aspect of human experience, including the objectives that people work towards, the amount of effort that they put forth towards accomplishing those objectives, and the chance that they will achieve specific levels of behavioural performance. Self-efficacy beliefs, on the other hand, are different from standard psychological conceptions in that it is hypothesised that they change based on the domain of functioning as well as the conditions surrounding the occurrence of behaviour.

The self-efficacy model makes a number of assumptions, but one of the most important ones is that psychological procedures, in whatever shape they take, can be used as a way to create or increase expectations of personal efficacy. However, direct performance accomplishments are thought to provide by far the most convincing evidence that an individual possesses the necessary abilities. Self-efficacy can be affected by verbal persuasion, vicarious experience (seeing another person cope with

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the task), imaginal enactment (imagining oneself doing it), or emotional arousal; however, direct performance accomplishments are believed to be the most important factor (Schunk & DiBenedetto, 2021). Therefore, the self-efficacy model postulates that change is effected primarily through behaviour, despite the fact that it is built on a cognitive mechanism that underpins its foundation.

Self-efficacy is situated within the context of Bandura's (1986, 1997) social cognitive theory. According to this theory, human functioning is determined by three sets of interacting factors (Fig. 1): personal (e.g., cognitions, emotions); social/environmental (e.g., classroom; teacher commendation); and behavioural (e.g., school attendance, homework completion; Bandura, 1986). Each set of factors influences and is influenced by the others. People's thoughts can influence their actions, and their actions can alter their environments. In turn, social and environmental variables can influence the beliefs of individuals. Students who feel competent about performing well in school (high self-efficacy—a personal variable) may persist and exert effort to learn (behavioural variables) to exemplify these reciprocal relationships. If a teacher were to comment on how well they are learning (social/environmental variable), this may corroborate their perception of learning progress (personal variable) and encourage them to persist. An underpinning premise of social cognitive theory is that individuals desire a sense of agency, or the belief that they can exert a great deal of control over significant life events. This sense of agency is exercised in numerous ways, such as by setting goals and implementing strategies to achieve them. They monitor their progress towards their objectives and modify their strategies accordingly. Individuals' perception of self-efficacy, which results from self-reflection that is both evaluative and goal-oriented, is central to this agentic perspective.

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People utilise information sources to assess their self-efficacy, as self-efficacy does not spontaneously appear. These sources consist of performance achievements, vicarious experiences, social persuasion techniques, and physiological/emotional indices (Schunk, 2012).Performance achievements are the most reliable evidence because they demonstrate what an individual is capable of achieving. However, individuals also evaluate their self-efficacy based on the observations of others. Observing a successful performance can increase the self-efficacy of observers, whereas observing a failure can decrease it.Persuasion from others (e.g., "You can doit!") can also influence self-efficacy. Although vicarious and persuasive sources can increase self-efficacy, for the increase to be sustained, the individual must demonstrate success.Physiological indexes are a source as well. People who experience less anxiety in a given situation may believe that they are more capable of achieving success.

The addition of motivational elements to social cognitive theory. Personal elements include objectives, self-evaluations of development, social comparisons, values, outcome expectations, and attributions (Schunk & DiBenedetto, 2020).Social cognition is motivated by goals (Bandura, 1986, 1997). Goals inspire achievement. Self-evaluations are crucial.Progress towards goals enhances self-efficacy and motivation. (2012) (Schunk, 2012). Students may persevere if the objective and perceived progress diverge.However, goals do not motivate.The importance of goal specificity, proximity, and difficulty (Locke & Latham, 2002, 2015). "Do your best" is less motivating than "Perform to the best of your ability" (Schunk & DiBenedetto, 2016). Short-term, nearby objectives are more motivating than distant ones. (2016) Wigfield, Tonks, and Klauder. (2016) Wigfield et al.Beliefs about the outcomes of acts. They inspire others because

they are confident in the success of their actions. People may be motivated to continue their actions by their anticipation of the outcomes of their actions. This is necessary for long-term motivation (e.g., career choice).(2010). (Weiner, 2010).Why? Attributions. Schunk and DiBenedetto (2017). Controllable elements (e.g., effort, strategy application) are more motivating than uncontrollable elements (e.g., chance, task difficulty). Attributes influence self-efficacy.

2.3 Concept of Relapse

A relapse occurs when an individual abandons their efforts to reduce or abstain from alcohol or other substance use and reverts to their previous levels of use. This is distinct from a lapse, which is a temporary deviation from a person's alcohol and other substance goals followed by a return to those goals. For instance, a person whose aim is to abstain from alcohol may consume a glass of wine at a party, only to return to abstinence the following day. A lapse differs from a relapse in that it consists of a brief period of substance use followed by an evident return to the individual's recovery objectives. Relapse is the process of sobriety becoming dysfunctional due to sobriety-based symptoms that lead to renewed drug or alcohol use, physical or emotional collapse, or suicide. The relapse process is marked by identifiable and predictable warning indicators that begin well before alcohol or drug use or relapse (Gorski, 1990). Relapse prevention therapy teaches patients to recognise and respond to these warning signs, allowing them to interrupt the relapse progression early and resume positive recovery progress.

According to Melemis (2015), one of the most important components of effective relapse prevention is an awareness of the fact that it is a process that develops

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over the course of time. It might begin several weeks or even months before a person takes their very first sip or dose of a chemical. Therapy is intended to assist individuals in detecting the early warning indications of relapse and in developing coping skills to prevent recurrence during the early phases of the recovery process, when the possibility of success is at its highest. The objective of therapy is to assist individuals in recognizing the early warning signals of relapse and in establishing coping skills during this time. It has been established that doing so makes a significant difference in reducing the likelihood of a recurrence of the condition. Relapse can be broken down into three stages that can be categorized as follows: the emotional stage, the mental stage, and the physical stage.

During emotional relapse, individuals do not consider substance use. They recall their previous relapse and do not wish to repeat it. However, their emotions and behaviors are preparing them for future relapse. Denial is a major component of emotional relapse because clients do not consciously consider using during this stage. Poor self-care is the common denominator of emotional relapse, where self-care is broadly defined to encompass emotional, psychological, and somatic care. The transition between emotional and mental relapse is not arbitrarily determined, but rather the natural result of protracted, substandard self-care. When individuals practice inadequate self-care and remain in emotional relapse for an extended period of time, they eventually begin to feel uncomfortable in their own skin. They become agitated, irritable, and dissatisfied. As their tension increases, they begin to consider using to escape.

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During mental relapse, individuals' minds are at conflict with themselves. Part of them desires to use, while the other part does not. As individuals progress further into mental relapse, their cognitive resistance to relapse decreases and their desire to flee increases. These are a few indicators of a mental relapse Gorski (1990), 1) craving for drugs or alcohol; 2) thinking about people, locations, and things associated with past use; and 3) downplaying or romanticizing the consequences of past use. Clinical experience has demonstrated that therapy must normalize occasional drug impulses. They do not indicate that the individual will relapse or is performing poorly in recovery. Once a person has experienced addiction, the memory cannot be erased. With effective coping skills, a person can learn to swiftly dismiss thoughts of substance use. By observing a client's behavior longitudinally, clinicians can differentiate between mental relapse and occasional notions of using. When thoughts of substance abuse change in nature and become more insistent or frequent, this is a red flag.

A physical relapse occurs when an individual resumes substance abuse. Some researchers classify physical relapse as a "lapse" (the initial use of alcohol or drugs) and a "relapse" (a return to uncontrolled use) (Larimer et.al, 2009). When clients focus excessively on how much they drank during a relapse, they do not completely comprehend the consequences of one drink, according to clinical experience. Once a person has consumed a single alcoholic beverage or used a single substance, they are at risk for relapsing into uncontrolled use. But more importantly, it usually results in obsessive or unrestrained thoughts about using, which can eventually lead to physical relapse. The majority of physical relapses are due to opportunity. They occur when the individual believes they have a window in which they will not be discovered. In order to prevent relapse, it is necessary to practice these situations and develop healthy exit

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strategies. People who do not comprehend relapse prevention believe that it entails stating no right before they are about to use. However, this is the concluding and most challenging phase to stop, which is why people relapse. Clinical experience has shown that if a person remains in mental relapse for an extended period of time without the necessary coping skills, they are more likely to turn to drugs or alcohol to escape their misery.

2.4 Drug treatment and Rehabilitation

At first, drug rehabilitation was based on the beliefs of its founders and how they saw the causes of alcoholism and drug abuse. A quick look back at the differences that were made in the past will help primary care clinicians understand which precursors may still be used or rule in programmes, even though most programmes now use the following three approaches. Different treatment models are still based on three past points of view: There are three types of models: medical, psychological, and social (SAMHSA, 1997). A medical model that focuses on the biological, genetic, or physiological reasons of addiction, such as disulfiram, methadone, and medical withdrawal management, in order to treat symptoms or change behaviour. A psychological model that says that the main cause of drug abuse is bad learning about drive or emotional problems. A mental health professional leads psychotherapy or behavioural therapy as part of this method. Sociocultural model that focuses on problems in the social and cultural environment or socialisation process that can be fixed by changing the physical and social environment, especially by getting involved in self-help groups, spiritual activities, and social networks that help each other. People in recovery are often given the power to make decisions about care, because their knowledge comes from their own experience.

Most contemporary rehabilitation have recently integrated these three models into a biopsychosocial framework. The Minnesota model of residential chemical dependency treatment, Drug-free outpatient treatment, Methadone maintenance -- or opioid substitution, and Therapeutic community residential treatment are the four primary treatment approaches currently prevalent in public and private programmes.

A biopsychosocial illness concept of addiction underpins Minnesota's residential chemical dependency therapy. Treatment aims for abstinence, and the AA 12-Step process helps heal and prevent recurrence. Willmar State Hospital, Hazelden Foundation, and Johnson Institute pioneered this strategy. It requires 28–30 days of inpatient treatment and much of community-based followup. Newer approaches replace inpatient stays with intensive outpatient treatment and less intensive continuous care. 12-Step principles and medical practises are now combined. Public and private programmes use it often. Skilled chemical dependency counsellors, who are typically persons in recovery and mental health and social work professionals, use a variety of behavioural and reality-based strategies. Psychological and psychosocial assessments are done. If a problem is detected, medical and mental care is given, and the inpatient plan is based on therapeutic groups. Despite the disease model of aetiology, the patient must adjust their conduct. Detox may require pharmaceutical therapies. Lectures, reading, and writing regarding chemical dependency abound. The family plans treatment and aftercare and emphasises individual and group therapy (Institute of Medicine, 1990; Gerstein and Harwood, 1990; Landry, 1996).

Drug-free outpatient treatment addresses the requirements of those transitioning from active substance misuse to abstinence through counselling, skills training, and

educational supports. This treatment strategy has the most variation in intensity, length, and staffing. Most programmes see patients once or twice a week and employ counselling, social work, and 12-Step or self-help meetings. Some programmes prescribe medications to alleviate prolonged withdrawal symptoms, while others emphasise case management and referral to community resources for medical, mental health, or family treatment; educational, vocational, or financial counselling; and legal or social services. Combining onsite and referral services provides the best direct and supported services. Drug-free outpatient programmes have high attrition rates, thus legal, familial, or employment pressure may be utilised to keep patients in treatment (Landry, 1996; American Psychiatric Association, 1995; Gerstein and Harwood, 1990).

Chronic heroin or opioid users who haven't responded to other treatments are treated with methadone maintenance. Replace licit or illicit morphine derivatives with longer-acting, medically safe, stabilising oral alternatives of recognised potency and purity. In adequate quantities, methadone or another long-acting opioid lessens drug need, prevents euphoric effects from heroin or other illegal opioids, and removes the rapid mood swings associated with short-acting and commonly injected heroin. The strategy, which helps people function normally, prioritises rehabilitation and a productive lifestyle above abstinence. Recent efforts have focused on reducing HIV transmission rates among patients who stay in treatment and cease injecting. Most programmes offer individual and group counselling, medication, urine testing, and psychological and medical treatments, but the best ones also offer family therapy, vocational training, and social work help. Methadone maintenance treatment, the most controversial and extensively studied treatment method, reduces illicit opioid use,

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criminal activity, and health, social functioning, and employment (Gerstein and Harwood, 1990; Landry, 1996; National Institute on Drug Abuse, 1996).

Therapeutic community residential treatment is ideal for people with substance dependency and substantial psychosocial adjustment issues who need organised resocialization. Reality-oriented individual and group therapy, extensive peer encounters, and participation in a therapeutic atmosphere with hierarchical positions, privileges, and duties can modify negative thinking and behaviour. Rewards and punishments encourage self-control and societal responsibility by reinforcing strict behavioural norms. Tutorials, remedial and formal education, and daily communal or conventional employment are frequently required for residents in the last phases before graduation. Enrollment requires 3–9 months of residential living and progressive reintegration into the community. While patients who stay in therapeutic communities for at least a third to half the planned course of treatment usually have markedly improved functioning in terms of reduced criminal activity and drug consumption and improved rates of employment or schooling (and graduates do even better), the biggest drawback is that 75 percent or more of enrollees never complete treatment (Gerstein and Harwood, 1990; Landry, 1996).

The drug addiction problem that was widespread in the 1960s gave rise to the development of three forms of treatment or modalities of drug treatment and rehabilitation in Malaysia. These are Residential Therapeutic Community (TC) rehabilitation, Methadone Maintenance (MM), and Outpatient Drug Free-(ODF). TC was the At the present time, there are normally two ways that are utilised in the process of treating and rehabilitating drug abusers. These two approaches are known as behaviour therapy and medical therapy or pharmacology. Because of the high cost and

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extended amount of time required for the pharmacology therapy strategy to take effect, it is rarely used in this country. One of the most frequent and well-known approaches to behaviour change is called cognitive behavioural therapy, or CBT. CBT is a type of counselling that focuses on recognising and avoiding drug urges, as well as finding healthy ways to cope with them.

In addition to that, there are now increasingly common methods of treatment that entail involvement in religious or traditional practises, as well as spiritual practises. Some researchers have come to the conclusion that persons who have a strong believe that we are involved in drugs and that if this group is involved in it, then spiritual rehabilitation is acceptable should be considered. Both Pusat Inabah and PERKID Malaysia are examples of treatment facilities that take a religious perspective.

2.5 The Therapeutic Community

A therapeutic community is a treatment facility in which the community itself, through self-help and mutual support, is the primary means of fostering personal transformation. In a therapeutic community, residents and staff contribute to the management and operation of the community, creating a psychologically and physically secure learning environment conducive to transformation. In a therapeutic community, the social, psychological, and behavioural dimensions of substance use are prioritised, and the community is used to rehabilitate individuals emotionally and to promote the development of healthy lifestyle behaviours, attitudes, and values.

When entering a TC, there are no indications of a school, clinic, hospital, or treatment plan. On the other hand, portions of a home, a school, and a business are

visible, and a number of domestic, educational, professional, and community-based activities are occurring. From an anthropological perspective, the TC is more akin to a bustling village than a service-providing organisation or location (De Leon, 2000:119). The therapeutic community (TC) is a treatment method grounded in family and community. It is, at its core, a method of self-help that seeks to preserve the essential elements of a positive and social family environment. Additionally included is the transmission of wholesome values.

The TC is intended to improve the types of life experiences that help people learn about themselves, create self-esteem, cultivate self-respect, learn about other people, and promote mutuality and respect for others. This teaches them about responsibility, authority, and essential rules of behaviour. Clients are expected to adhere to the group's core values and behavioural guidelines. The therapeutic community's (TC) 24-hour house environment milieu (surroundings) provides a novel method of receiving therapy. Formal, structured group and individual therapy sessions are essential, but so are therapies that are more grounded in reality, such as working, playing, relaxing, making choices, solving problems, empathising, extending oneself, assisting, and teaching. All activities are a part of rehabilitation and are intended to help the individual acquire new skills, gain a better understanding of who they are, and manage their own recovery. Even the most mundane tasks, such as doing laundry, cooking, making repairs, or working in an office, can be therapeutic and help individuals develop vital life skills. Work is one of the factors that distinguishes the therapeutic community plan (TC).

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2.6 Theories and Models related to the study

2.6.1 The Stages of Change (SoC) Model / Transtheoritical Model (TTM)

The stages of change (SoC) are conceptualised as a series of changes that people go through as they start and maintain behavioural change (Miller, 1996). One of the key ideas in the trans-theoretical model (Prochaska, 1986). This model describes the method by which people experience change, with or without the help of professionals. According to the model, recovery is generally not a linear process, but involves going through different stages over and over again. The way a person views their problem and the extent to which their behavior changes are the factors that divide the stages. Previous studies have found that altered patient stage can predict future drug use (Prochaska et al., 1994), alcohol use (Heather, Rollnick, & Bell, 1993)) and dropped out of treatment (Simpson and Joe, 1993). However, motivation to engage in treatment is not the same as motivation to change problematic behaviours. Many prisoners only participate in treatment because it is required of them; they do not give it their full commitment. They might still not be prepared to change, which could lead to a relapse.

The Transtheoretical model posits five stages of change. Individuals in the precomtemplation stage, the initial stage of change, do not intend to modify their behavior, and in fact may not acknowledge they have a problem. When persons in this stage find their way into substance abuse treatment, coercion usually plays a role. As long as they remain in this stage, they are unlikely to benefit from the experience. Persons identified as contemplators are probably aware that a problem exists and may be thinking about addressing the problem. However, contemplators have yet to make a commitment to action. Many persons become stuck in this stage for long periods. These individuals are described as ‘‘. . .not quite ready yet’’ (Prochaska et al., 1994, p. 1103).

The preparation stage reflects an intention to take some form of change action during the next 30 days. It also refers to those persons who have made an unsuccessful attempt to change within the past 12 months. In the action stage persons have initiated new behavior. Placement in this stage requires that an individual must have modified behaviour for at least one day. In the case of substance use, this means a person has modified their use of alcohol or other drugs. The final stage is maintenance. During this stage, beginning at 6 months after behavior change, persons take steps to avoid relapse and consolidate gains.

The transtheoretical model of change (Prochaska et al. 1992) describes people at different stages of changing addictive behaviours: before thinking about it, thinking about it, getting ready, doing it, and keeping it up. Even though they aren't called that at first, the stages are usually seen as motivation and, more specifically, "readiness to change" (Tierney and McCabe 2002). Motivation starts when a person realises the problems caused by drug use, and it grows as they think about the possibility of changing. People think that the change process is more like a cycle than a straight line. So, people can go through the change cycle more than once before they reach a state of maintenance and long-term change. Also, each stage is said to be marked by a certain balance between the pros and cons of the behaviour, self-change strategies, and beliefs about the person's ability to change the behaviour (Prochaska 1994).

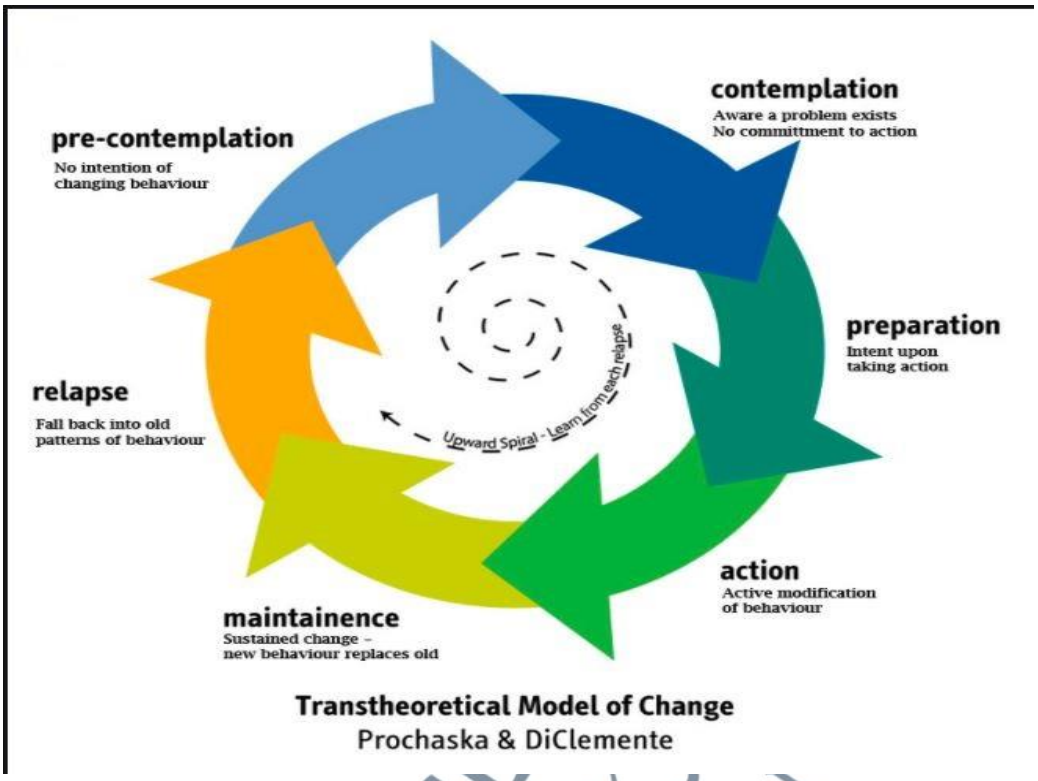

Figure 1 : Transtheoretical Model of Change by Prochanska & DiClemente (1970)

2.6.2 Self-efficacy theory

The degree to which an individual believes they are capable of overcoming challenges is a critical factor in determining whether or not they will be successful in overcoming any psychological issues (Bandura, 1977). Because of this, the self-efficacy theory was able to demonstrate how changes in behaviour brought about by various therapeutic approaches stem from a common cognitive mechanism known as "efficacy expectancy" (El,Sheikh & Bashir, 2004). Self-efficacy is inextricably related to the assumption that one can handle ever-increasingly perilous situations. There are two components to an individual's expectation: I the cognitive (informational) components, which are associated with what the individual "knows" or anticipates will occur as a result of engaging in significant behaviour, and (ii) the motivational (incentive)

components, which are associated with the interest (or "reinforcement values") of the specific outcomes or effects. When one builds confidence in one's ability to successfully handle potentially harmful situations, one's sense of self-efficacy increases.

The concept of self-efficacy, on the other hand, is intrinsically tied to the faith that an individual will be able to manage a succession of high-risk occurrences. A person's self-efficacy can be defined as the confidence they have in their own skills to achieve their goals and realise their aspirations. Both a person's confidence and their behaviour are influenced by their level of self-efficacy. Self-efficacy can be defined as a person's belief in his or her own ability to perform at a high enough level to produce a significant accomplishment or event in his or her life. Self-efficacy is a trait that can be developed and strengthened through time (Bandura, 1994).

According to Bandura (1997), self-efficacy is dependent on an individual's trust in his or her own talents, which induces an immediate behavioural change toward the objective. Bandura went on to argue that an individual's level of self-efficacy influences how they react to adversity as well as how successfully they execute challenging activities. People who have faith in their own skills to find solutions to issues and satisfy their own desires will always be successful in doing so. They are more likely to apply a disciplined work ethic to whatever they do because they set high objectives for themselves, which increases their chances of being successful (Jackson, 2001). According to Maddux (2002), self-efficacy has nothing to do with a person's innate talent; rather, it is the confidence that comes from knowing that one can achieve in a certain environment. There is a connection between this and having faith in our capacity to organise and direct the skills that we already have. The capacity of an individual to

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adapt easily in the face of adversity and change is an additional component of self-efficacy.

A person's self-efficacy can be broken down into its component parts, which include belief in one's own capabilities and the assurance to put those capabilities to action (Maddux, 2002 ,: Snyder & Lopez, 2007). According to Creer (2007), one of the meanings of the phrase "self-efficacy" is the ability to exert influence over one's surrounding environment. The term "self-efficacy" refers to an individual's confidence in their own capacity to evaluate a given situation and formulate an acceptable response to it. In addition to this, it is helpful in the management of pain associated with chronic illness.

2.7 Theoretical Framework of the study

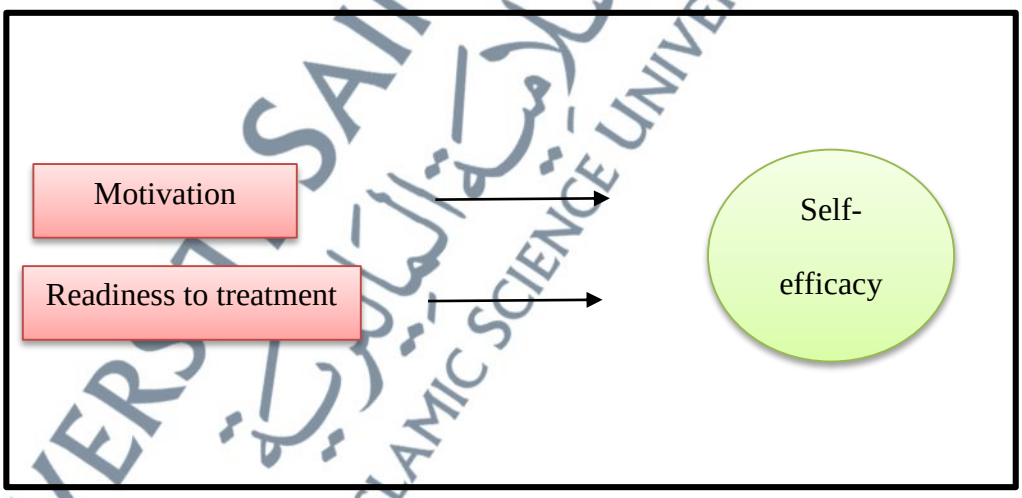

Figure 2: Theoretical Framework of the study

2.8 Review of related study

2.8.1 Motivational and Readiness to treatment

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Circumstances (external factors that affect a decision to change a behaviour), motivation (recognising the need to change a behaviour from the inside), and readiness (being able to and wanting to change a behaviour) have been found to be important predictors of how long someone stays in drug treatment (Ali et.al, 2017). These ideas fit with the Stages of Change model, which says that behaviour changes happen in a series of steps: pre-contemplation, reflection, preparation for change, action, and maintenance (Ali et.al, 2017).). Conceptually, the circumstances and motivation subscales correspond to the pre-contemplation, contemplation, and preparation stages of the Stages of Change model, while the readiness subscale corresponds to the action and maintenance stages of the Stages of Change model.

Situation, motivation, and readiness are all strongly linked, and Soyez et al., (2006) found that they can be used together to predict how likely someone is to stay in treatment. In line with previous research, the current study looked at how circumstances, motivation, and readiness affect the whole (hereinafter referred to as CMR). Research (Ali et.al, 2017) has shown over and over again that a higher CMR makes it much more likely that someone will enter and stay in treatment for drug abuse. CMR is a good predictor, but it doesn't fully explain why people stay in treatment for drug abuse. The conditional effect of distress tolerance on the relationship between CMR and substance abuse treatment retention is supported by both theoretical and empirical evidence. This helps to explain treatment retention even more.

In research from De Leon et al (2000), about 75% of the highest possible score on the CMR total scale is represented by the average scores for each of the three groups. These elevated levels are not surprising given that the entire study sample was made up

of drug users who self-reported their use and volunteered for a highly sought-after treatment, like the prison TC. However, the prisoners' motivation was lower than that of those who were admitted to a TC with a community focus. Therefore, the causes of the lower motivation in the prison sample are still unknown. It is possible that inmates' intrinsic motivations and various non-recovery factors may affect their willingness to volunteer for prison treatment.

2.8.2. Self-efficacy in drugs' rehabilitation

According to the findings that Ibrahim et al. (2011), self-efficacy has a substantial inverse link with relapse into addictive behaviours. This was proven to be the case. People who have a poor perception of themselves are more likely to continue using drugs in the long term. Researchers came to the conclusion that an individual's degree of self-efficacy is connected, albeit in a roundabout way, to their degree of drug dependence (Torrecillas, 2015). According to Abdollahi et al. (2014) showed that an individual's level of confidence in their capacity to abstain from using substances was connected to both the chance of relapsing and the age at which substance use was first began .

Individuals who have a high opinion of themselves in terms of their capacity to achieve a goal have a greater possibility of not abusing substances and are less likely to be resistant to changing their behaviour when given the option to do so (Dolan et al., 2008). A further limitation is that self-efficacy can only be used to make predictions for returning to drug use three months after treatment has been completed. In addition, Moos & Moos (2006) found that those who have a high self-efficacy are more likely to

abstain from drinking alcohol over the course of a three-year period. On the other hand, individuals who have a low impression of their own skills have a greater chance of successfully completing alcohol withdrawal. Several researchers, including (McKay et al., 2004 : Ramo et al., 2005)have established an inverse relationship between self-efficacy and relapsing to drug use following a period of abstinence. They also came to the conclusion that people who have a high self-efficacy score have a higher level of confidence in themselves and are more likely to abstain from abusing substances for an extended period of time.

According to the findings of McKay and colleagues (McKay et al., 2004), people who abstain from drugs and have faith in their abilities are more likely to be successful in safeguarding themselves and quitting their habit. As a result, recovering addicts will find it easier to give up drugs if they have faith in their own abilities to be successful. If an addict believes that they will not be able to resist from inappropriate behaviour or that they will not receive the outcomes that they desire by refraining from drugs, then they will lose the incentive to do so. However, addicts who have a high level of confidence in their own capabilities have a tendency to be more focused and systematic in their decision-making, which ultimately leads to higher success in a variety of disciplines, including the fight against drug dependency.

A study conducted by Nikmanesh et al. (2016) found that individuals who did not relapse had higher levels of self-efficacy beliefs and better social support than those who did relapse. The eta square also demonstrated that social support factors (with a value of 0.22) are a better predictor of abstinence relapse than self-efficacy (with a value of 0.17) when it comes to substance abuse. The concept that self-efficacy has a

protective effect in regards to drug abuse has been supported by the observation that those with higher levels of self-efficacy are more likely to abstain from drug use.

According to El,Sheikh and Bashir (2004), a study that involved 180 sample males who were admitted to Al-Amal Hospital in Jeddah, Saudi Arabia, for treatment from substance abuse found that there was a negative correlation between situational confidence questionnaire (SCQ) subscale scores and negative emotion (NE). The primary objective of the current research was to evaluate the differences between alcoholics and heroin addicts on a number of characteristics pertaining to relapse as well as self-efficacy.

2.8.3 Motivation and Abstinence Self-Efficacy

Due to conflicting findings from prior research, the nature of the relationship between abstinence self-efficacy and motivation cannot be determined with certainty. For instance, motivation and abstinence self-efficacy were both found to predict favourable abstinence outcomes at three months in a sample of young adults with substance use disorders (J. Kelly et al., 2012). This finding suggests that there is a connection between these two resources. On the other hand, the findings of other research are contradictory. Brief motivational interventions were not found to increase abstinence self-efficacy among people with alcohol use disorders (Castro et al., 2014). On the one hand, motivation was found to be positively related to abstinence self-efficacy among people trying to quit smoking (Castro et al., 2014). On the other hand, brief motivational interventions were found to be effective among people trying to quit smoking (Romo et al., 2009).

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To get a better understanding of the intrapersonal dynamics that are involved in recovery-related transformation, there is a pressing need to investigate the connections that exist between the many recovery options available to people who struggle with substance use disorders. Extending our knowledge of change among those who are recovering from substance use disorders would be facilitated by conducting research on the relationship between abstinence self-efficacy and motivation as well as treatment readiness.

Majer et al. (2015) looked at the relationships between motivation, treatment readiness, and abstinence self-efficacy among 270 ex-offenders with substance use disorders who were leaving inpatient treatment in northern Illinois, USA. From this research, a few things were learned. Contrary to what we thought, the significant negative relationship between abstinence self-efficacy and motivation suggests that the need for abstinence self-efficacy among people with substance use disorders is linked to their desire to change. The fact that the relationship between these intrapersonal resources is backwards, for example, suggests that people who finish treatment for substance use disorders are motivated in part to improve their abstinence self-efficacy, which is a key resource for staying sober. This data may also show that people with high levels of abstinence self-efficacy at the end of treatment are less likely to want to change because they already know enough about how to control their thoughts and actions and how to avoid relapse.

In the present study, there was a negative relationship between these intrapersonal resources and abstinence self-efficacy. This is in line with research that

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looked at alcohol-specific populations and found that brief motivational interventions had no effect on abstinence self-efficacy (Romo et al., 2009) and that DUI offenders who said they were in higher stages of change on two measures of motivation had significantly lower levels of abstinence self-efficacy for alcohol (Nochajski & Stasiewicz, 2005).

2.9 Chapter conclusion

The level of motivation an individual possesses is one of the primary factors that plays a part in determining whether or not they will complete outpatient treatment for substance misuse (Hiller et al., 2002). Upward trends are being seen in methadone maintenance, drug-free outpatient therapy, and extended stays in inpatient rehabilitation facilities all at the same time. Inspiring others to change themselves is one of the most critical parts of successfully transforming other people. One way to define motivation is as the collection of mental states that serve as the basis for the impulse to take some kind of action. The desired result is for the individual to give up their drug use and return to leading a regular, law-abiding lifestyle. The addict's level of drive to change their behaviour is a critical factor in determining how successful their recovery from addiction will be.

It's possible that mental representations of future consequences, which are formed as a result of events in the outside world, could give rise to a motivation. Self-efficacy is the single most important protective factor in reducing drug use, and it has a direct correlation to one's level of motivation. A person must go through the precontemplation, contemplation, preparation, action, and maintenance stages before

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they can effectively break an addiction. These stages are precontemplation, contemplation, action, and maintenance.

The fact that people understand the significance of the problem and have faith in their own potential for improvement drives their readiness to make changes. The tasks that are included in the phases of change have been used to describe the level of motivational readiness for change. This, in turn, has been used to offer different intervention strategies and evaluate the level of motivation to refrain from engaging in addictive behaviour. Therefore, the following research questions were addressed

1. What was the level of circumstances, motivation and readiness according to CMR scales among inmates in prison?
2. What was the level of self-efficacy according to DASESS scales among inmates in prison?
3. What was the relationship between CMR (motivation) and DASES (self-efficacy) among inmates in prison?
4. What was the relationship between CMR subscales and the DASES scale among inmates at the prison?

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