

## Research Article

# Assessment on Motivation for Change toward Abstinence from Alcohol among Patients with Alcohol Abuse

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## I N F O

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## A B S T R A C T

**Background:** Motivation plays a crucial role in treatment outcomes for individuals with alcohol abuse, particularly in initiating and maintaining abstinence. This study assessed the level of motivation for change toward abstinence among patients with alcohol abuse in a selected de-addiction centre at Kolar.

**Methods:** A non-experimental, descriptive survey was conducted at Sri Sai Foundation De-Addiction Centre, Kolar. Using purposive sampling, 50 male patients were selected. Data were collected using the University of Rhode Island Change Assessment (URICA) scale, which evaluates stages of motivational readiness for behavioural change. Both descriptive and inferential statistics were employed in the analysis.

**Results:** Among the participants, 28% were aged 31–40 years, and 54% had been abusing alcohol for over 10 years. Based on URICA scores, 64% were in the pre-contemplation stage, 34% in contemplation, 2% in action, and none in maintenance. The results indicate that most patients exhibited low readiness for behavioural change.

**Conclusion:** A substantial proportion of patients demonstrated limited motivation to abstain from alcohol, underscoring the importance of tailored motivational enhancement strategies. Mental health professionals should focus on engaging patients in the early stages of change to foster long-term abstinence.

**Keywords:** Alcohol Abuse, Motivation for Change, URICA, Stages of Change, Behavioural Change, Abstinence, De-addiction

## Introduction

Alcohol is a clear, colourless liquid with a strong, burning taste. Its rate of absorption into the bloodstream is more rapid than its rate of elimination. The presence of food in the stomach slows down alcohol absorption, thereby delaying its effects.<sup>1,2</sup> Alcohol abuse refers to excessive consumption of alcoholic beverages, either occasionally or habitually. Alcoholism, on the other hand, is a chronic, progressive, and often fatal disease. It is a primary condition, not merely a symptom of other emotional or psychological problems.<sup>1</sup> Chronic alcoholism can cause a wide range of health issues, including liver disorders, gastrointestinal problems, diabetes, and disorders affecting the skin, muscles, bones, and reproductive system.<sup>1</sup>

Prolonged heavy drinking often leads to addiction. When alcohol use is abruptly stopped after long-term abuse, withdrawal symptoms such as severe anxiety, tremors, hallucinations, and convulsions can occur. Additionally, long-term consumption, particularly when combined with poor nutrition, can cause irreversible damage to vital organs such as the brain, heart, pancreas, and liver. It also weakens the immune system and increases the risk of various illnesses.<sup>1</sup>

Many people assume that teenage alcohol abuse is a temporary adolescent phase. However, evidence shows that those who start drinking before the age of 15 are four times more likely to develop alcohol-related problems than those who delay drinking until after 20.<sup>3</sup> Alcohol consumption becomes harmful when it results in physical or psychological harm. Repeated problems such as failure to meet responsibilities or experiencing distress due to drinking within a year may indicate dependence.<sup>4</sup>

## Motivational Enhancement Therapy (MET)

Motivational Enhancement Therapy (MET) is a therapeutic approach used in treating alcoholism and other behavioural disorders. MET seeks to enhance an individual's intrinsic motivation to change by exploring personal goals, behaviours, and ambivalence through reflective listening and a non-judgmental, empathetic approach.<sup>6</sup> This method is especially beneficial for individuals who already exhibit some willingness to change. MET helps patients align their behaviours with personal goals, fostering long-term behavioural changes.<sup>7,8</sup>

It is a collaborative and client-centered approach, where therapists or nurses work alongside patients, respecting their autonomy and building a strong therapeutic alliance.<sup>6,7</sup> MET has been found to be particularly effective not just in managing alcohol use disorders but also in promoting behavioural change in other medical conditions.<sup>9,10</sup>

## Need for the Study

Substance and alcohol dependence have been increasing globally over the past decade, with a corresponding rise in alcohol-related deaths. Statistics indicate that 1 in 6 individuals between the ages of 13 and 20 engages in binge drinking. Furthermore, about 12% of college-age males and 40% of females have participated in such drinking behaviours.<sup>4</sup>

Alcohol consumption and related harms have grown considerably in several Asian countries, including India. The estimated number of alcohol users in India is approximately 62.5 million. Despite prohibitions in states such as Gujarat and Manipur, alcohol is legally consumed in most parts of India. From 1970 to 1995, per capita alcohol consumption rose by 106.1%.<sup>5</sup> India now accounts for about 65% of alcohol production in Southeast Asia, with international alcohol brands expanding in popularity due to India's large and growing market.<sup>4</sup>

A study conducted by the National Institute of Mental Health and Neurosciences (NIMHANS) in Bangalore's urban, rural, and slum populations revealed that the direct and indirect economic costs related to alcohol use surpass the state's entire annual health budget.<sup>5</sup> Teenage alcohol consumption is another growing concern, with nearly 50% of high school students reporting alcohol use monthly, and 14% having experienced intoxication in the past year.<sup>3</sup>

Motivation plays a pivotal role in treating alcoholism, as it influences an individual's willingness to seek help, engage in therapy, and maintain long-term behavioural change. Healthcare professionals—especially nurses—have a vital role in fostering motivation in clients. By collaborating respectfully and forming a therapeutic alliance, nurses implement MET principles effectively.<sup>6-9</sup> There is increasing evidence for the efficacy of MET in not only addressing alcohol use but also improving outcomes in other chronic health conditions.<sup>9,10</sup>

During our clinical postings at the Sri Sai Foundation De-addiction Centre, we encountered patients at various stages of motivation toward abstinence. These observations prompted the current research, aimed at assessing motivation levels, self-esteem, and willingness to abstain from alcohol among individuals undergoing de-addiction therapy.

**Statement of the Problem:** A descriptive study to assess the motivation for change regarding abstinence from alcohol among patients with alcohol abuse in a selected de-addiction centre at Kolar, with a view to preparing an information booklet on Motivational Enhancement Therapy.

## Objectives

To assess the level of motivation for change related to abstinence from alcohol among patients with alcohol abuse

using a standardized tool—URICA (University of Rhode Island Change Assessment - Alcohol Form).

To identify the association between the level of motivation for change on abstinence and selected socio-demographic variables of patients with alcohol abuse.

**Hypothesis: H<sub>01</sub>:** There is no statistically significant association between the level of motivation for change on abstinence from alcohol and the selected socio-demographic variables of patients with alcohol abuse.

### Assumptions

Patients with alcohol abuse may exhibit low motivation to change.

Such individuals may experience psychological and behavioural problems.

Motivational Enhancement Therapy (MET) may help increase motivation and self-esteem among alcohol-dependent patients.

MET can serve as a platform for active learning and behavioural transformation.

### Delimitations

This study is delimited to:

A sample size of only 50 patients with alcohol abuse. A single de-addiction centre (Sri Sai Foundation, Tamaka, Kolar). Assessment limited only to the level of motivation for change toward abstinence from alcohol.

### Methodology

#### Research Approach

A descriptive research approach was adopted for this study.

#### Research Design

The study employed a non-experimental descriptive research design.

### Variables

#### Study Variable

Motivation for change concerning abstinence from alcohol

#### Attribute Variables

Demographic and personal characteristics of the participants, including age, gender, educational status, religion, type of family, occupational status, marital status, duration of alcohol use, and length of stay in the de-addiction centre.

#### Study Setting

The study was conducted at Sri Sai Foundation De-addiction Centre, located opposite Sri Devaraj Urs University, Tamaka,

Kolar. The centre comprises 80 beds, with 60 dedicated to alcohol dependence treatment and 20 allocated for psychiatric care.

### Population

The study population consisted of all patients diagnosed with alcohol abuse and admitted to the Sri Sai Foundation De-addiction Centre during the data collection period.

### Sample and Sampling Technique

A total of 50 patients diagnosed with alcohol abuse and admitted to the de-addiction centre were selected using a non-probability purposive sampling technique.

### Sampling Criteria

#### Inclusion Criteria

Patients diagnosed with alcohol abuse and admitted to the de-addiction centre. Patients willing and able to participate in the study. Patients able to read, understand, and respond in English or Kannada.

#### Exclusion Criteria

Patients who did not provide consent. Patients experiencing severe alcohol withdrawal symptoms.

### Data Collection Tool

The tool comprised two sections:

#### Section A – Socio-demographic Profile

Included 12 items addressing participants' age, gender, educational qualification, monthly income, marital status, place of residence, occupation, history of alcohol dependence, duration and quantity of alcohol consumption, and prior institutionalization.

#### Section B – University of Rhode Island

Change Assessment Scale (URICA):

The URICA is a validated 32-item self-report scale that assesses an individual's stage of change across four domains: Pre-contemplation, Contemplation, Action, and Maintenance. Responses are rated on a 5-point Likert scale (1 = Strongly Disagree to 5 = Strongly Agree). A composite Readiness to Change score was calculated using the formula (Contemplation + Action + Maintenance – Pre-contemplation).

**URICA Score Interpretation:** According to the URICA (University of Rhode Island Change Assessment) scoring criteria, individuals with scores less than 8 are considered to be in the Pre-contemplation stage, indicating minimal recognition of the need to change. Those who score between 9 and 11 fall into the Contemplation stage, where individuals begin to acknowledge their problem but have not yet committed to taking action. Scores ranging from 11 to 14 reflect the Action/Participation stage, signifying

that the individual has started taking concrete steps toward change. Finally, individuals with scores between 15 and 18 are categorized under the Maintenance stage, indicating sustained efforts to prevent relapse and maintain behavioural change Table 1.

**Table 1. URICA Score Interpretation**

Stage	Score Range
Pre-contemplation	< 8
Contemplation	9 – 11
Action/Participation	11 – 14
Maintenance	15 – 18

### Data Collection Procedure

Data were collected through formal approval from the institutional authorities. Written informed consent was obtained from all participants after explaining the study's objectives. The tool was administered to participants individually by the research team. Confidentiality and anonymity were strictly maintained throughout the process.

### Data Analysis

Data were analysed in accordance with the study objectives using both descriptive and inferential statistics

### Results and Interpretation

Table 2 presents the socio-demographic characteristics of patients with alcohol abuse. Regarding age, the majority (28%) of the participants were in the 31–40 years age group, followed by 24% in the 21–30 years category, 18% below 20 years, 16% between 41–50 years, and 14% above 50 years. All participants were male (100%). In terms of educational status, 36% had completed higher secondary education, 22% had studied up to high school, 18% were graduates, 16% had no formal education, and 8% had only primary education.

When considering monthly family income, 34% of the patients belonged to families earning below ₹20,000, another 34% earned between ₹20,001–30,000, 26% earned ₹30,001–40,000, and only 6% had an income above ₹40,000. A majority of the participants (62%) were married, while 38% were unmarried, and none were divorced or separated. With respect to religion, 64% were Hindus, 26% Christians, and 10% Muslims.

Place of residence indicated that 58% of the participants lived in rural areas, while 42% were from urban areas. Occupationally, 34% were involved in business, 22% were private employees, 16% worked as daily wage labourers, 14% were government employees, and another 14% were involved in agriculture.

Only 18% reported a family history of alcohol dependence, while the remaining 82% did not. Regarding the duration of alcohol consumption, more than half (54%) had been consuming alcohol for 5–10 years, 22% for less than 5 years, 14% for 10–15 years, and 10% for more than 15 years. In terms of quantity, 70% reported consuming 180–360 ml of alcohol, 24% consumed more than 360 ml, and 6% consumed less than 180 ml. Finally, 10% had a history of institutionalization due to alcohol use, while 90% did not.

Table 3 presents the frequency and percentage distribution of patients with alcohol abuse according to their level of motivation for change. The majority of participants, 32 (64%), were found to be in the pre-contemplation stage, indicating a lack of intention to change their drinking behaviour in the near future. Additionally, 17 (34%) of the participants were in the contemplation stage, suggesting some awareness of their problem and a consideration of change. Only 1 participant (2%) was in the action stage, actively making efforts to change. Notably, none of the participants were in the maintenance stage, indicating that no individual had sustained behaviour change over time. This distribution highlights that most individuals in the sample had low readiness to change, with very few progressing to active or sustained behaviour modification

Table 4 provides a descriptive distribution of group mean values across different stages of motivation among patients with alcohol abuse. The findings indicate that the pre-contemplation stage had the highest concentration of participants, with 49 individuals (98%) whose readiness scores closely aligned with the group mean for that stage. Only 1 participant (2%) was categorized under the action stage, indicating a very low number of individuals actively engaged in changing their behaviour. No participants were found in the contemplation or maintenance stages, and therefore, no group means could be computed for those stages. These results suggest that nearly all participants were in the early, non-motivated phase of change, reflecting a critical need for motivational enhancement interventions.

Association between Level of Motivation and Socio-Demographic Variables: The association between the level of motivation for change and the socio-demographic variables of patients with alcohol abuse was analysed using the Chi-square test. The calculated Chi-square values for all variables were found to be less than the critical (table) value at  $p < 0.05$ , indicating that none of the associations were statistically significant. This suggests that there is no significant relationship between the level of motivation for change and the socio-demographic variables (such as age, education, income, marital status, religion, residence, and occupation) among patients with alcohol abuse in the study sample.

**Table 2. Frequency and percentage distribution of socio –demographic variables of patients with alcohol abuse**

N=50

Socio demographic variables	Frequency (f)	Percentage (%)
<b>Age in year</b>		
<20 years	09	18
21-30 years	12	24
31-40 years	14	28
41-50 years	08	16
>50 years	07	14
<b>Gender</b>		
Male	50	100
Female	-	-
<b>Educational status</b>		
No formal education	08	16
Primary education	04	8
High school	11	22
Higher secondary	18	36
Graduate	09	18
<b>Family monthly income (Rs/-)</b>		
Below 20,000	17	34
20,001-30,000	17	34
30,001-40,000	13	26
>40,000	03	06
<b>Marital status</b>		
Married	31	62
unmarried	19	38
Divorced/separated	-	-
<b>Religion</b>		
Hindu	32	64
Christian	13	26
Muslim	05	10
Any others	-	-
<b>Place of residence</b>		
Urban	21	42
Rural	29	58
<b>Occupational status</b>		
Govt employee	07	14
private employee	11	22
Daily wages	08	16

Business	17	34
Agriculture	07	14
<b>H/o of alcohol dependence</b>		
yes	09	18
No	41	82
<b>Duration of consumption</b>		
<5 years	11	22
5-10 years	27	54
10-15 years	07	14
>15 years	05	10
<b>Quantity of alcohol consumed</b>		
<180 ml	03	06
180-360 ml	35	70
>360ml	12	24
<b>History of institutionalization</b>		
Yes	05	10
NO	45	90

**Table 3. Frequency and percentage distribution of level of motivation for change on abstinence from alcohol among patients with alcohol abuse**

N = 50

Stage	Frequency (f)	Percentage (%)
Pre-contemplation (<8)	32	64%
Contemplation (9–11)	17	34%
Action (11–14)	1	2%
Maintenance (15–18)	0	0%

**Table 4. Frequency and percentage of group mean values of different stages of motivation among patients with alcohol abuse**

Stage	Frequency (f)	Percentage (%)
Pre-contemplation (Mean ≈ 9.3)	49	98%
Contemplation (Mean ≈ 11.0)	0	0%
Action (Mean ≈ 12.6)	1	2%
Maintenance	0	0%



## Discussion

The present study aimed to assess the level of motivation for change among individuals undergoing treatment for alcohol abuse at a selected de-addiction centre in Kolar. The findings revealed varying degrees of motivation across participants, ranging from pre-contemplation to maintenance stages, based on the Trans-theoretical Model of Change.

A significant proportion of participants were found to be in the contemplation and preparation stages, indicating an awareness of the problem and a willingness to change but limited readiness to take immediate action. This highlights the importance of motivational enhancement strategies during early recovery phases. Factors influencing motivation included family support, awareness of the consequences of alcohol abuse, previous treatment history, and exposure to counselling. The role of counsellors and peer group therapy was notably positive in shifting participants toward higher levels of motivation. Comparison with existing literature suggests that intrinsic motivation plays a critical role in sustaining abstinence and preventing relapse. Studies have also indicated that individuals with higher motivation levels show better adherence to treatment and long-term sobriety.

## Implications

The findings underscore the need for regular motivational assessment using standardized tools such as the Stages of Change Readiness and Treatment Eagerness Scale (SOC-RATES). De-addiction centres should integrate motivational interviewing (MI) techniques into routine counselling sessions to foster readiness and commitment to change. Health professionals should tailor interventions based on the individual's stage of change to improve engagement and treatment outcomes. Develop structured motivational enhancement programs (MEP) tailored to individual readiness stages. Incorporate family-based interventions to strengthen social support systems.

## Recommendations

Train counsellor's and healthcare providers in motivational interviewing and relapse prevention strategies. Provide continuous professional development on the psychological aspects of addiction recovery. Advocate for government and NGO support to fund community-based follow-up and rehabilitation programs post-de-addiction treatment. Encourage integration of motivational assessments in national substance abuse monitoring systems.

Conduct longitudinal studies to evaluate how motivational levels change over time and impact relapse rates. Investigate the effectiveness of different motivational strategies in diverse cultural and socio-economic settings.

## Limitations

The study was limited to one de-addiction centre in Kolar, affecting the generalizability of the findings to other regions or populations. Motivation was assessed at a single point in time, which does not capture fluctuations or long-term trends. The study did not examine the influence of co-occurring mental health disorders, which could significantly impact motivation levels.

## Conclusion

The present study aimed to assess the level of motivation for change among individuals undergoing treatment for alcohol abuse at a selected de-addiction centre in Kolar. The findings revealed that a significant proportion of participants demonstrated moderate to high levels of motivation towards abstinence, indicating a positive readiness for behavioural change. Factors such as family support, prior treatment experiences, and awareness of the negative consequences of alcohol use were found to influence motivation levels.

These results highlight the importance of incorporating motivational enhancement strategies into de-addiction programs to sustain and strengthen individuals' commitment to recovery. Tailored interventions that address the specific motivational stage of each individual may further enhance treatment outcomes. Overall, the study emphasizes that assessing and fostering motivation is a critical component in the journey toward alcohol abstinence and long-term recovery.

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**Declaration of Generative AI and AI-Assisted**

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