

**Final Report**

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**ASIAN TRANSPORTATION RESEARCH SOCIETY**

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# **Influencing change in unsafe driving by road safety education**

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## **Final Report**

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# CHAPTER 1 Introduction

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## 1.1 Introduction

Road accidents are one of the major causes of young mortality worldwide. In OECD countries they account for 35-40% of injury-related among teenagers and young adults (OECD-ECMT, 2008). In Thailand, approximately 10-15% of road fatalities are 15-24 year olds (Road Traffic Death Data Integration (RTDDI), Bureau of Non Communicable Disease, Thailand).

In OECD countries (OECD-ECMT, 2008), they found that young driver crashes differ from those of more experienced drivers. Their crashes primarily because of immaturity, lack of experience, risk taking, impairment, distraction by passengers and lifestyles associated with their age and gender.

Human factors appear to be one of the main causes for almost of the crashes. It was found that three distinct patterns of behaviour have a powerful influence on driver safety: (1) lapses or absentminded behaviour, (2) errors caused by misjudgement of danger or failures of observation, and (3) violations or deliberate neglect of safe driving (Blockey and Hartley 1995; Parker et al. 1995). Many studies on driver behaviour have focused on individual differences as contributors to unsafe driving behaviour (Moeckli and Lee, 2007). They suggest that safety culture is an important influence on driving behaviour, and plays a critical role in driving safety (Lee, 2006).

It is very likely that improving driving behaviour can decrease accident rate significantly. In Thailand many activities, such as raising public awareness on driving safely through public events and media, improving road geometries, and law enforcement, have been deployed to manage change in driving behaviour, in order to reduce number of accidents. However, numbers of road fatality in Thailand has still not shown any sign of reduction.

To manage change in driving behaviour, an ATRANS previous research (Jaensirisak et al, 2018) found that students (mainly motorcyclists) are less likely to perceive road accident as "my serious problem". So they value the cost of accident less than the convenience of unsafe driving behaviours e.g. not wearing helmet, speeding, and drunk driving. Driving behaviour change is the first and most important thing that has to be changed, in order to create safe society. However, typical campaigns and activities (TV, roadside messages, etc.) are unlikely to influence behaviour (only intention). The study suggests that enforcement is the most

effective strategy to influence the change, particularly in a short term. However, safe driving behaviours cannot be achieved by law enforcement alone. For a long term, road safety education would increase individuals' perception of road accident. The study found that education measures that could affect the behaviour change include campaigns promoting to save lives of families and friends, direct campaigns for each road user group and each behaviour, and campaigns to change perception of "no accident for short distance traveling".

Although, enforcement is generally judged as more efficient and able to bring quicker benefits than education in changing unsafe driving behaviour; we need education approaches to have a balanced and comprehensive traffic safety policy, as well as, gain social acceptability of other strategies (Assailly, 2017).

Thus, the main aims of this research are to manage unsafe driving behaviour by road safety education, and to evaluate the behaviour change.

## **1.2 Objectives**

Road safety education for changing driver behaviour must be a structured process, particularly for young drivers, and design to match type of person and behaviour. Therefore, objectives of this research are:

- (1) to design and organise road safety education campaigns for managing change in unsafe driving behaviour; and
- (2) to evaluate effectiveness of the road safety education campaigns in changing unsafe driving behaviour.

## **1.3 Outputs of the projects**

Outputs of the projects include:

- Understanding unsafe driving behaviour of young motorcyclists
- Road safety education campaigns for managing change in unsafe driving behaviour
- Effectiveness of road safety education

# CHAPTER 2 Road Safety Education

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## 2.1 Introduction of Road Safety Education

While traditional driver education programs tended to focus primarily on increasing overall knowledge, today's effective programs attempt to promote safe driving through increases in knowledge, attitudes, and skills (Ferguson, 2003; King et al., 2008).

The objective of road safety education is defined as achieving an optimal use of the transportation system with optimal safety for all road users (OECD, 1986). Road safety education covers all measures that aim at positively influencing traffic behaviour patterns, with three main targets (ROSE 25 project, 2005): (1) Promotion of knowledge and understanding of traffic rules and situations, (2) Improvement of skills through training and experience, and (3) Strengthening and/or changing attitudes toward risk awareness, personal safety and the safety of other road users.

Road safety education is a lifelong learning process. It is very important to link safety education to specific problems and to a target group (Assailly, 2017; GIZ, 2017). When planning a road safety education, attitudes of teenagers or young adults, such as avoidance of risk taking, resistance to peer group pressure, no overestimation of one's own skills, etc. should be considered (Arnett, 2002), including:

- Adolescents are strongly influenced by their peers and friends. When together, adolescent friends often generate a state of elation.
- Adolescents try to escape from the control of parents and other adults, and to experiment with what is explicitly forbidden by parents and other authorities;
- Adolescents underestimate the likelihood of negative events such as getting involved in a crash.
- Adolescents overestimate their own skills and competencies.
- Adolescents have strong mood swings;
- Male adolescents have a tendency to aggressiveness and sensation seeking.

Assailly (2017) reviews many road safety education programs and identify characteristics of good practices, as follows.

- The most effective teaching methods are those that encourage active student participation (role playing, simulations, etc.) and interaction with adults (discussion).

- The best results are achieved by interventions that improve the psycho-social skills of students such as self-esteem, assertiveness and resistance to peer pressure.
- It is necessary to adapt the program to the level of maturity and experience of the students.
- Interventions on “at risk groups” are usually more efficient, but school contexts are not well suited to this type of approach for reasons of ethics and confidentiality.
- “Multifocal” interventions that combine multiple targets seem to be more effective (youth, interventions with parents, teachers, action on the environment of the school, etc...), especially those which actively involve parents throughout the program.
- The consistency of messages is a key success factor, consistency in the speech of stakeholders, consistency between rhetoric and action.
- The quality of the implementation of the program is as important as the program itself (involvement of teachers).
- The training and supervision of stakeholders is essential for the success of the action, such as training teachers to group dynamics in order to ensure their relationships with students.
- The quality of the school environment plays a role beyond teacher training on the program: provision of new school activities, tutoring for students, development of the relationship between parents and teachers, involving health services, representation of parents.
- The main causes of failure are related to interventions in crisis situations or moralistic approaches based on fear, or programs too dependent on the outside (that is, not having enough involved the school staff and parents), or did not, or insufficiently developed teacher training.

## **2.2 Good Practices of Road Safety Education for Young Adults**

Many interventions for road safety education have been used in many countries. Good Practices of road safety education for young adults can be categorised into eight groups, including:

- Road safety messages
- Social norms media marketing
- E-learning
- Workshop
- Traffic clubs
- Peer-to-peer road safety intervention

- Parental involvement
- Comprehensive strategies

### **2.2.1 Road safety messages**

Lewis et al. (2008) examine message-relevant affect and, in particular, the relative effectiveness of negative and positive emotional appeals in the road safety advertising context.

The results revealed, as predicted, interactions of the key variables and evidence of the greater persuasiveness of negative appeals immediately after exposure whilst greater improvement of positive appeals over time. The findings highlight the importance of continuing the exploration of positive appeals as a persuasive alternative to negative appeals.

For instance, given that appeals to positive emotions are seldom used in the road safety context they may be considered relatively less effective than fear-based approaches simply because the latter approach is utilised more frequently (see Lewis, Watson, White, & Tay, 2007).

Despite the frequent use of fear-based health messages, a substantial body of literature attests to the contradictory findings between the level of fear evoked and the extent of subsequent persuasion achieved (for review of the use of fear in road safety campaigns, see Elliott, 2003; Lewis, Watson, Tay, & White, 2007).

### **2.2.2 Social norms media marketing**

Social norms media marketing can be effective at changing behaviours by correcting normative misperceptions. Perkins et al. (2010) evaluated the efficacy of a high-intensity social norms media marketing campaign. The results demonstrate the campaign reduced normative misperceptions, increased use of designated drivers, and decreased drinking and driving among those young adults. Social norms media marketing can be effective at changing drinking-related behaviours. This research provides a model for utilizing social norms media marketing to address other behaviours related to public health.

Social norms marketing consists of disseminating accurate norms such as with drinking usually in the form of newspaper ads, flyers, posters, electronic media, etc. The social norms media campaign was comprised of television, radio, print, and theatre ads, in addition to posters and promotional gifts, college newspaper advertisements, theatre slides, billboards, various print

and promotional items (i.e., t-shirts, key chains, pens, and windshield scrapers), and indoor advertisements.

The approach has a theoretical foundation that can be expressed by four tenets (Perkins, 2003). First, perceived norms are consistently and positively associated with drinking. Second, people tend to overestimate the drinking of their peers (i.e., normative misperception). Third, overestimation of peer drinking is associated with heavier subsequent drinking. Fourth, and finally, successful correction of normative misperception should reduce drinking.

### **2.2.3 E-learning**

Wahlberg (2011) study that new ways of educating offending drivers are being introduced, notably e-learning. The results seem to indicate a positive effect of the e-learning course for young driving offenders. An e-learning course for offending young drivers was therefore evaluated as to its effects upon offence. Significant reductions in number of offences and penalty points were found for an e-learning group, while this was not the case for drivers who had been fined only, or had taken a more traditional solely class-room based educational scheme. On-line driver education has a number of features that are different from standard educational approaches. It is highly visual and interactive, and not requires any travel or pacing, apart from a deadline for completion. Moreover, the lack of possible embarrassment for the drivers may be a very positive attribute of e-learning.

### **2.2.4 Workshop**

Road safety education has been used to influence driving attitudes and behaviours. An example of effective road safety workshop for young adults (Rosenbloom, et al., 2009) is used in the Loewenstein Hospital Rehabilitation Center (Israel). It is a 4–5h workshop (groups of 50–100 students). Activities include: (1) watching a video documenting the lives of young people like themselves leading up to a road accident and the ensuing recovery process, (2) meeting with a young person who has survived an accident, hearing this person's story, participating ask questions and hold a discussion, and (3) taking part in a "simulation" in which they learn about living with a disability – for example, by controlling a wheelchair or by attempting routine activities with one limb tied to their body. However, the workshop should be tailored to the need of the participants.

Fylan and Stradling (2014) evaluated interventions and to identify the effective mechanisms by which behaviour can be changed. They reviewed 26 behavioural change techniques (BCTs)

(that reports in Abraham and Michie (2008) as having been used in changing health-related behaviours, with an emphasis on smoking) and then mapped with six interventions to change young people's road user behaviour. An effective intervention was 1-day workshop. The workshop could provide (1) giving information ("*Information about risk*" - information about the increased risk associated with risk behaviour and "*Information about consequences*" - information about what might happen to themselves and/or others if they are involved in a collision, get demerit points, lose their licence, etc.), (2) teaching ("*Instruction*" - telling people how they can achieve the target behaviour), (3) planning ("*Identifying and overcoming barriers*" - anticipating what might prevent people from carrying out the new behaviour and identifying how they can overcome any potential difficulties) and (4) implementing ("*General encouragement*" - giving the person praise and encouragement while they try to change, independent of the success they actually have in changing).

### **2.2.5 Traffic clubs**

Traffic clubs represent a form of the road safety education. Dragutinovic and Twisk (2006) review implementation and effectiveness of Traffic clubs. They found that traffic clubs were first established in the 1960s in Norway, and later were introduced in other Scandinavian countries, Great Britain, Germany and Luxemburg. The main idea of a traffic club (focusing on children from 3-7 years old) is to involve parents in teaching their children road safety. Books on road safety are sent to children (members) on regular basis (most cases is free of charge). However, study on the effectiveness of the traffic club cannot reach a conclusion.

### **2.2.6 Peer-to-peer road safety intervention**

It is widely accepted that peer passengers is one of the key factors implicated in the risky driving behaviour and increased collision rate of young drivers (e.g. Preusser et al., 1998; Rice, Peek-Asa, and Kraus, 2003; Shope and Bingham, 2008; Williams and Tefft, 2014).

Weston and Hellier (2018) explored the relationship between susceptibility to peer influence and young drivers' engagement in risky driving - specifically how different types of active and passive peer influence predicted self-reported engagement in risky driving. They also used this insight to facilitate and evaluate a novel peer-to-peer education intervention.

The data suggest

- that high susceptibility to peer influence is related to more self-reported risky driving behaviours and

- that attaining social prestige (passive influence) and peers intervening in decisions (active influence) were the specific aspects of peer influence that predict violations.

High susceptibility to peer influence is found to be related to more self-reported risky driving behaviours. Young drivers perceive the input of their peer passengers to be collaborative, rather than coercive; and they appear to be using their passengers to help them decide their driving behaviour (be it safe or dangerous).

Road safety interventions (RSIs) may be able to utilise the susceptibility of young people to peer influence – by using that influence for positive effect. RSIs might seek to provide young drivers with strategies to identify and resist peer influence.

- Peer education might need multiple ‘doses of intervention’ to produce long-term changes in behaviour. Participants had many opportunities during the intervention to have the safe driving message reinforced, through multiple events and email reminders.
- In this way if a young driver’s social group no longer considers risky driving to be acceptable, then they will have nothing to gain by engaging in it, and this should lead to safer driving. Siegel’s (2014) research supports this strategy, he suggested that removing the ‘rewarding’ aspects of risky driving would make young drivers less likely to want to engage in it (Siegel, 2014).
- The intervention presented here moved away from the fear appeal model (focussing on the negative and shocking consequences of collisions). Previous evaluations have found that fear appeals have limited efficacy, despite their substantial cost and continued use (e.g. McKenna, 2010).

### **2.2.7 Parental involvement**

Simons-Morton et al. (2008) describes the contexts of and opportunities for parental involvement in teenage driving and the effectiveness of interventions to increase and improve parental management of young drivers. Parents can be involved in their teenagers’ driving. Parents can and should be involved in novice teenage driving, and their appropriate involvement might partially alleviate the teenage driving problem. The evidence indicates that the most important actions would be to delay licensure and then, for some months after licensure, to maintain strict limits on high-risk driving conditions while novices gain experience and develop complex driving skills.

### **2.2.8 Comprehensive strategies**

Comprehensiveness and synergy between various techniques are needed. Theory and practice, knowledge and skills are complementary. King and Vidourek (2008) evaluated the short-and long-term efficacy of the You Hold the Key (YHTK) Teen Driving Countermeasure.

YHTK was associated with significant immediate and long-term improvements in teen seatbelt use, safe driving, and perceived confidence in preventing drunk driving. Compared to pretests, students at immediate and long-term posttest more frequently wore seatbelts when driving or riding, required passengers to wear seatbelts, and limited the number of passengers to the number of seatbelts in the vehicle. Students were more likely at both posttests to avoid drinking and driving and to say no to riding with a friend who had been drinking. In summary, YHTK was associated with increases in safe teen driving and passenger behaviors. Future programs should consider comprehensive strategies when attempting to modify teen behaviors.

Recent research indicates that reducing young drivers' risk-taking decisions and behaviors may result in decreased crashes, crash-related injuries and crash-related fatalities (Beirness & Simpson, 1997; McKnight, 1999).

The You Hold the Key (YHTK) Teen Driving Countermeasure was developed by the Hamilton County General Health District in Cincinnati, Ohio to increase safe driving and passenger behaviors among teens 15–19 years of age in Hamilton County, Ohio.

YHTK is a 10 week comprehensive school-based program consisting of safety promotion education, cooperative learning, student-oriented discussion, interactive lessons, student-led role-plays, prevention videos, and presentations from safety experts.

Students in YHTK receive information on the consequences of motor-vehicle collisions, importance of safe and healthy decision-making, potential consequences to risky driving behaviors, problem-solving skills related to driving, and the legal ramifications of risky driving behaviors.

The YHTK teen driving program produced significant increases in student likelihood to wear seatbelts, to require passengers to wear seatbelts, to avoid drinking and driving, and to reduce distractions while driving.

YHTK concentrates on a variety of teen driving behaviors including distractions, passengers, seatbelt use, drinking and driving, resistance skills, and strategies to reduce crashes. Unique features of YHTK include: (a) a trauma slide presentation graphically depicting car crashes and their devastating consequences to human life; (b) presentations from law enforcement officials regarding the laws related to driving safety, driver responsibility, drinking and driving, and field sobriety tests; (c) presentations from judicial prosecutors regarding the county court system, charges and mandatory penalties for driving under the influence, operating a motor-vehicle while intoxicated and 1st, 2nd, and 3rd moving violations; (d) panel discussions of community young adults discussing how their lives were drastically affected by risky driving behaviors and/or drinking and driving; (e) crash victims' experiences of being victimized by risky and unsafe drivers; (f) youth videos addressing drinking and driving, seat belt and air bag usage, how to avoid collisions, and ways to reduce risky behaviors; and (g) educational prevention videos including the Making the Right Choice video.

All of the activities and presentations provided by YHTK are focused on increasing safe driving knowledge, attitudes, and behaviors among young drivers.

This program also includes activities that **require students to work in small cooperative learning groups to develop effective strategies to prevent high-risk driving behaviors and situations.**

Based on the findings of this study several recommendations are offered.

- First, schools should offer a comprehensive prevention program as a means to increase safe driving attitudes and behaviors.
- Second, a three-year program cycle is recommended to ensure program consistency and cost-effectiveness. In the first year, schools would receive the program, be extensively trained on the program, and would be supplied with a program coordinator to lead program implementation. In the second year, schools would take on more responsibilities with some technical assistance from the program coordinator. In the third year, schools would implement the program completely on their own. Data would be collected in all three years and subsequently analyzed.
- Third, annual evaluations of school-based countermeasures should be conducted. Ideally, these evaluations should be conducted at the same point in time each year and seek to measure students' knowledge, attitudes, and behaviors regarding safe driving.

## 2.3 Summary

Key findings from the review can be summarised as shown in Table 2.1. There are many interventions can be applied to influence driving attitudes. However, from the previous studies it was found that in order to produce long-term behaviour change, RSE needs multiple interventions, events and reminders.

Table 2.1 Key findings from the review of road safety interventions

<b>Interventions</b>	<b>Key findings</b>	<b>Sources</b>
<b>Road safety messages</b>	Positive and negative (fear-based) appeals	Lewis et al. (2008) Elliott (2003)
<b>Social norms media marketing</b>	Changing behaviors by correcting normative misperceptions	Perkins et al. (2010)
<b>E-learning</b>	Re-education of young driving offenders (better than fine and class-room based education)	Wahlberg (2011)
<b>Workshop</b>	Influence driving attitudes and behaviours (e.g. watching video documenting, meeting accident survivors, simulation, playing games, ...)	Rosenbloom, et al. (2009); Fylan and Stradling (2014)
<b>Traffic clubs</b>	Messages and booklets on road safety are sent to members on regular basis.	Dragutinovic and Twisk (2006)
<b>Peer-to-peer road safety intervention</b>	Relationship between susceptibility to peer influence and young drivers' engagement in risky driving	Preusser et al. (1998) Rice, et al. (2003) Shope and Bingham (2008) Williams and Tefft (2014) Weston and Hellier (2018)
<b>Parental involvement</b>	Appropriate involvement of parents could alleviate the teenage driving problem.	Simons-Morton (2008)
<b>Comprehensive strategies</b>	A 10 week comprehensive school-based program. Comprehensiveness and synergy between various techniques require students to work in small cooperative learning groups.	King and Vidourek (2008)

## CHAPTER 3 Methodology and Case Study

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The project is divided two tasks: (1) designing and organising road safety education campaigns, and (2) evaluating behaviour change.

### 3.1 Designing and organising road safety education campaigns

In this study, road safety education campaigns for managing change in driving behaviour were designed according to the experiences, reviewed in Chapter 2. Then the campaigns through workshops were organised in Thaluang Cementhaianusorn Technical College (see Section 3.3).

Various road safety education campaigns include:

- Establishing a safety club at Thaluang Cementhaianusorn Technical College
- A 2 hours-workshop (30 participants ) at the college on 27 June 18 (with Pre- and post-tests)
- Data collection (165 samples – not attending workshop) on perception and behaviour
- Helmet wearing campaign during June – November 2018
- One day training (44 participants ) at TPRO Training Center on 26 October 2018 (with Pre- and post-tests)
- The 1<sup>st</sup> Road Safety on Campus (about 1000 participants ) on 22 November 2018
- The 2<sup>nd</sup> Road Safety on Campus (about 2000 participants ) on 20 December 2018

### 3.2 Evaluating behaviour change

During running the campaigns for encouraging change of unsafe driving behaviour, the project has been evaluated the behaviour change based a questionnaire survey (pre- and post-tests). This collected data on students' perceptions and behaviours based on the Transtheoretical Model (TTM) which aimed to explain a change in a risky behaviour (see Appendix A).

TTM identifies four transtheoretical dimensions of change (Prochaska & DiClemente, 1984; Prochaska et al.,1992; Prochaska & DiClemente, 2005; Prochaska et al., 2008) including:

1. Stages of Change: people make attitudinal, intentional, motivational, and behavioural changes as they move through the precontemplative, contemplative, preparation, action, and maintenance stages of readiness for change.

- Precontemplation stage – being unaware of the problem behavior
- Contemplation stage – starting to think about the problem and ambivalence
- Preparation stage – being motivated to take action in the immediate future
- Action stage – investing time and energy in taking the necessary steps toward an actual behavioral change
- Maintenance stage – working steadily to sustain the achieved change

2. Processes of Change: These are the overt and covert activities that various therapy systems use to initiate change.

3. Pros and Cons of Changing: The relative pros and cons of changing undergo a shift as clients move through the stages. Cons outweigh pros in the precontemplative stage, become equivalent by the contemplative stage, and lose relevance by the action stage. Pros gain strength and motivation increases as clients move through the stages.

4. Levels of Change: More intensive intervention is required depending on whether problems are conscious or unconscious. Some problems are symptomatic responses to a difficult situation, but more complex problems may have nested levels: e.g., symptoms may be supported by maladaptive cognitions, which create interpersonal conflicts that repeat childhood family conflicts, which were internalized in the form of intrapersonal conflicts.

According to TTM, stages of change for wearing helmet behaviour are divided into five stages, and can be seen as three broad groups as: unaware, having intention, and being behaviour, as shown in Table 3.1. The data from the pre- and post-tests were analysed which factors affected these stages of behaviour change (presented in Chapter 4).

Table 3.1 Stages of change for wearing helmet behaviour

Stages of change		Wearing helmet	
Precontemplation stage	being unaware of the problem behaviour	Wearing helmet is not an important behaviour	Unaware
Contemplation stage	starting to think about the problem and ambivalence	Wearing helmet is an important behaviour	Having intention
Preparation stage	being motivated to take action in the immediate future	Wearing helmet is a behaviour that I should do	
Action stage	investing time and energy in taking the necessary steps toward an actual behavioural change	I usually wear helmet	Being behaviour
Maintenance stage	working steadily to sustain the achieved change	I have been wearing helmet more than a year	

### 3.3 Case study

This project is in collaboration with the Siam Cement Group (SCG) to trial road safety education at the Thaluang Cementthaianusorn Technical College. This college is a vocational school, established more than 70 years ago by SCG. It is in Thaluang, Saraburi province (about 100 kilometers North of Bangkok).

Currently, there are about 2,600 students, aged between 15 and 20 years. Most students go to school by motorcycles either as drivers or passengers. SCG considers that road accident is one of the main problems for students. Therefore, this study is set up in cooperation between the SCG and ATRANS to trial road safety education for young motorcyclists.

## CHAPTER 4 Results

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The purposes are to help students to evaluate road accident problem in their communities, to understand road safety concept, to be able to find out causes of road accidents, and to encourage communities to drive safely on roads. The main target is motorcyclists which are the main travel mode for students. Campaigns focus on three main behaviours including helmet wearing, speeding, and drink and drive.

- Workshop
- One day training
- Event on safety on campus
- Evaluation of behaviour change at Khon Kaen University (KKU) and Prince of Songkla University (PSU)

### 4.1 Workshop

This project organised a workshop at the Thaluang Cementhaianusorn Technical College (Figure 1). The workshop was to establish a safety club in the college. There were 30 student members. It was also intended to provide information (about road accident and about what might happen to themselves and/or others if they involved in a collision). Moreover, the members discussed on the most frequent unsafe driving behaviours they found, including no helmet wearing, speeding, and traffic law offending.



Figure 4.1 The workshop at the Thaluang Cementhaianusorn Technical College

Before and after the workshop, the members were asked to fill in pre- and post-tests. These tests were to understand students' attitudes and behaviours, and their intentions to take risk behaviour after the workshop (Table 4.1). This was to initially evaluate effect of the workshop on behaviour change.

Table 4.1 Pre- and post-tests for workshop

Pre-tests	Post-tests
Demographics and background	
Travel modes to school and alternative modes	
Risk taking behaviour	Intention to take risk behaviour
Crash involvement	
Reasons to wear and not to wear helmet	
Influences of helmet wearing	

Characteristics of workshop participants are presented in Table 4.2. Students age between 15-19 years old. The main transport mode for students is motorcycle. Most of them do not have driving license.

Table 4.2 Characteristics of workshop participants

Number of samples	30
Age	15 – 19
Gender male female	9 21
Travelling to school by MC	87%
MC by own MC with parent MC with friend	47% 30% 10%
Involving road accident	43%
No driving license (MC users)	79%

Most students wear helmet because they think helmet can reduce accident injury, and when there is police enforcement (as presented in Table 4.3). They tend to not wear helmet when travelling for a short distance or on small roads (as presented in Table 4.4).

Table 4.3 Reasons of wearing helmet (workshop participants)

Wearing, because	%
Reducing accident injury	<b>70</b>
Police enforcement	<b>53</b>
Families or close friends suggest to wear	<b>27</b>
Families or close friends force to wear	<b>13</b>
Others wear	<b>7</b>

Table 4.4 Reasons of not wearing helmet (workshop participants)

Not wearing, because	%
Short distance travelling	57
Travelling on small roads	46
No police	13
In a hurry	10
Loss of hair style	10
Difficulty in carrying	3
Uncomfortable	7
No helmet	3
Confidence in riding without accident	0
Others not wearing	0

Police is the most effective in influencing on helmet wearing (as presented in Figure 4.2).

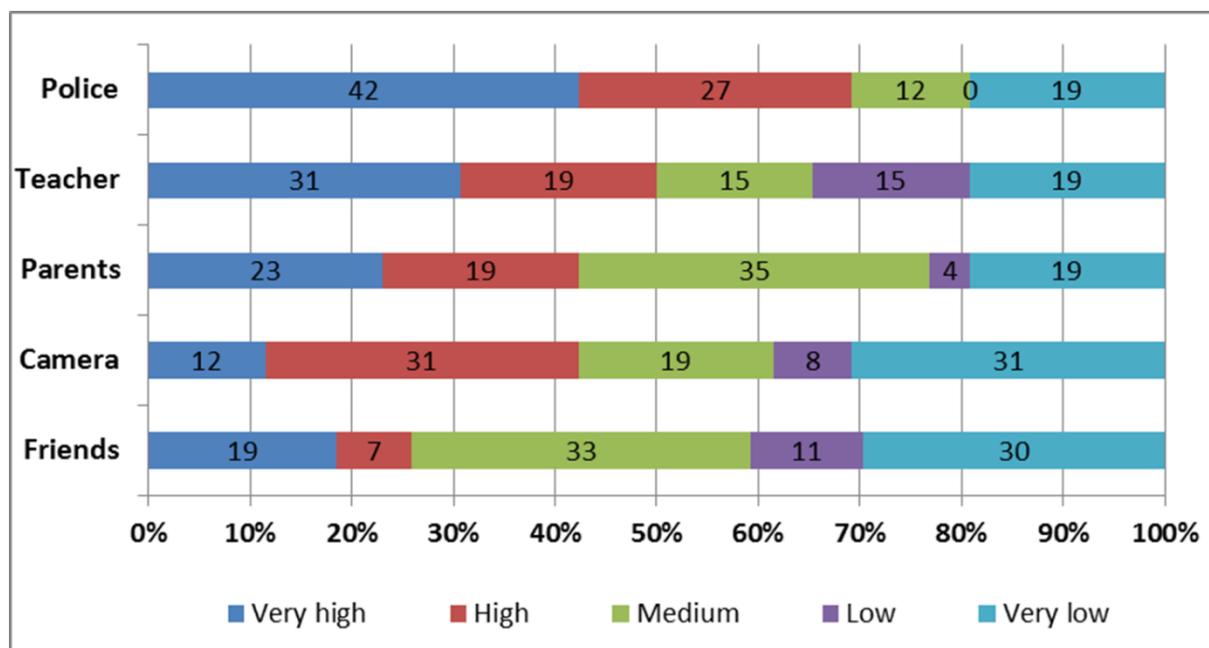


Figure 4.2 Influence on helmet wearing (workshop participants)

Students were asked how often they involved in risk driving behaviour before attending the workshop and their intentions to take risk behaviour after the workshop. The results present in Figures 4.3 and 4.4. Speeding and no helmet wearing are the most frequent risk driving behaviour. Most of them are sometime taking these behaviours. After the workshop, students significantly reduce intention to take the behaviours (as presented in Figure 4.5).

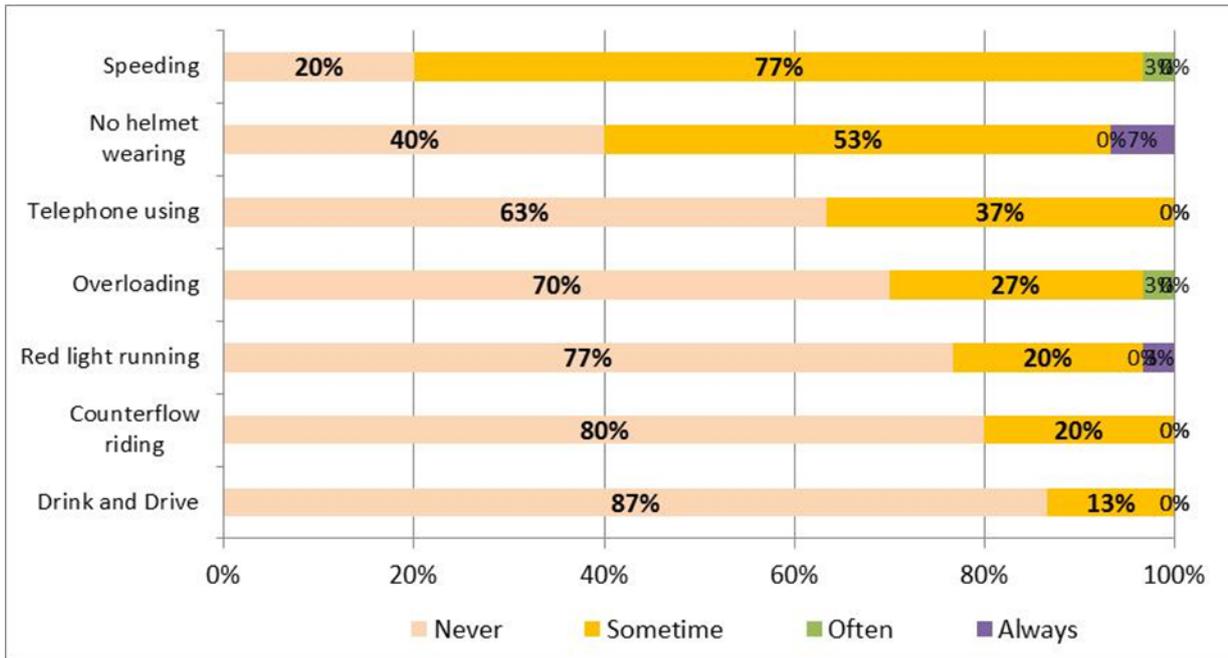


Figure 4.3 Risk driving behaviour before attending the workshop

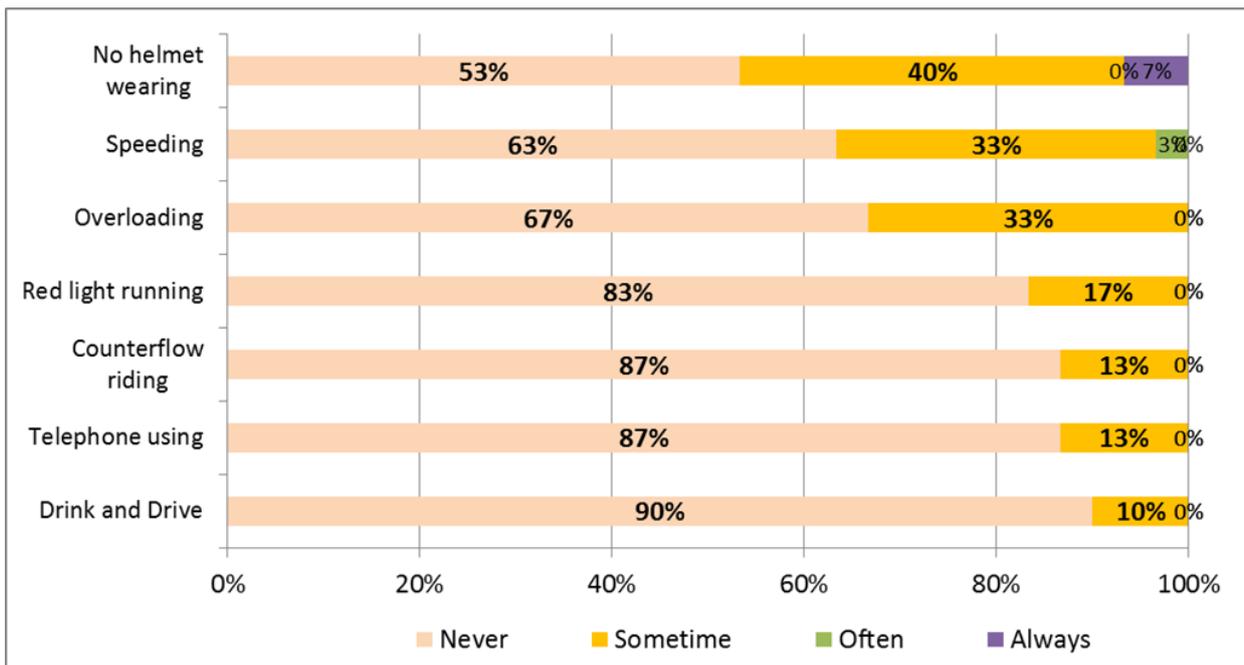


Figure 4.4 Intention to take risk driving behaviour after attending the workshop

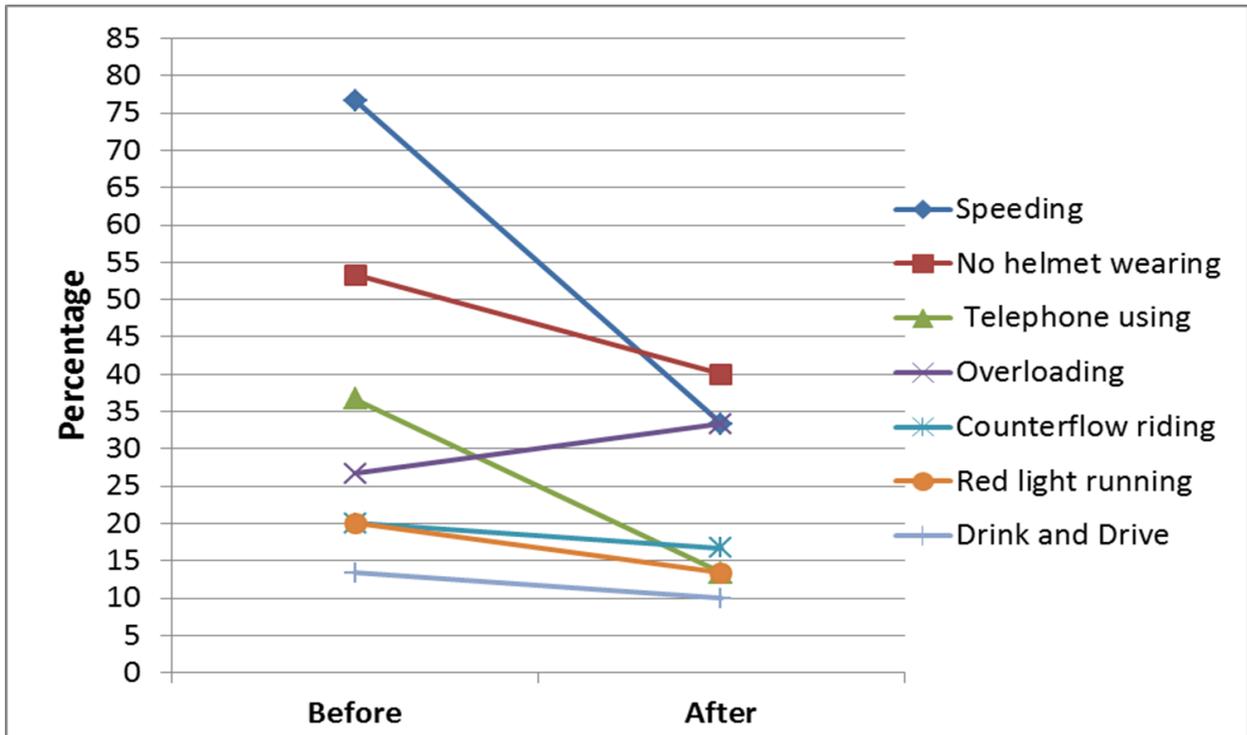


Figure 4.5 Percentages of those who are sometime taking risk driving taking behaviour – before and after attending the workshop

## 4.2 One day training

This project organised one-day training for 44 students. The activities included training on traffic laws by a police officer and four driving demonstrations on factors affecting on driving safety. The demonstrations were breaking distance on wet surface, responding time, blind spots, and seat belt wearing.

Characteristics of training participants (44 students) are presented in Table 4.5. Students age between 16-21 years old. The main transport mode for students is motorcycle. Most of them do not have driving license.

Before and after the training, the participants were asked to fill in pre- and post-tests. They were asked how often they involved in risk driving behaviour before attending the training and their intentions to take risk behaviour after the training. The results present in Figures 4.6 and 4.7. Speeding and no helmet wearing are the most frequent risk driving behaviour. Most of them are sometime taking these behaviours. After the training, students significantly reduce intention to take the behaviours, particularly speeding behaviour (as presented in Figure 4.8).

Table 4.5 Characteristics of training participants

Samples	44
Age	16 – 21
Gender male female	19 25
Travelling to school by MC	88%
MC by own MC with parent MC with friend	84% 2% 2%
Involving road accident	70%
No driving license (MC users)	91%

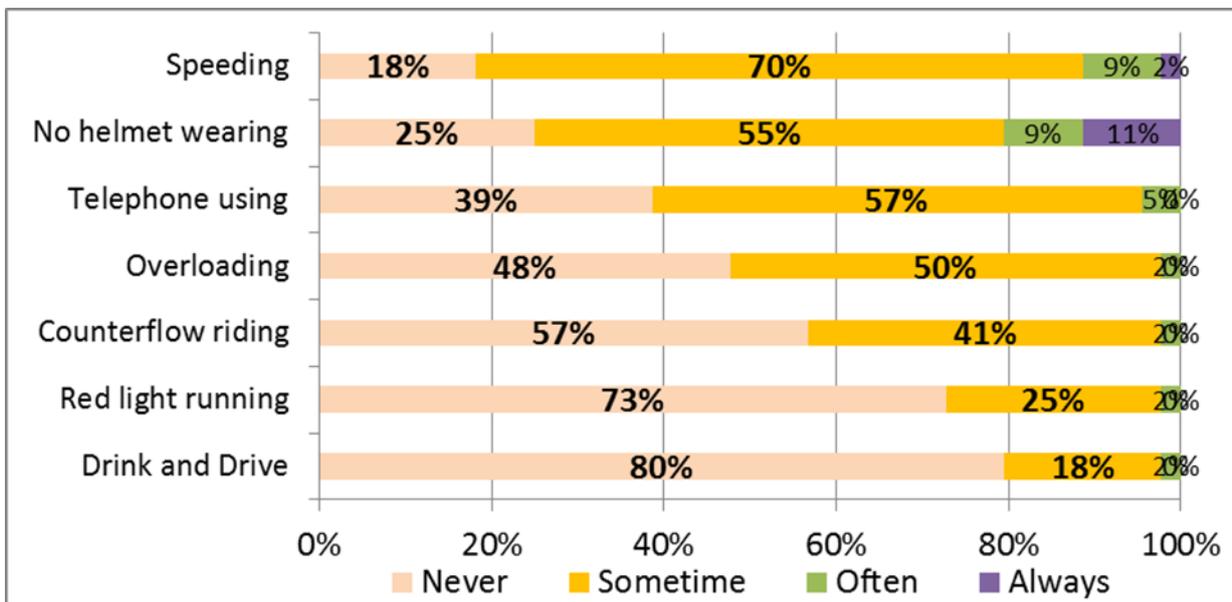


Figure 4.6 Risk driving behaviour before attending the training

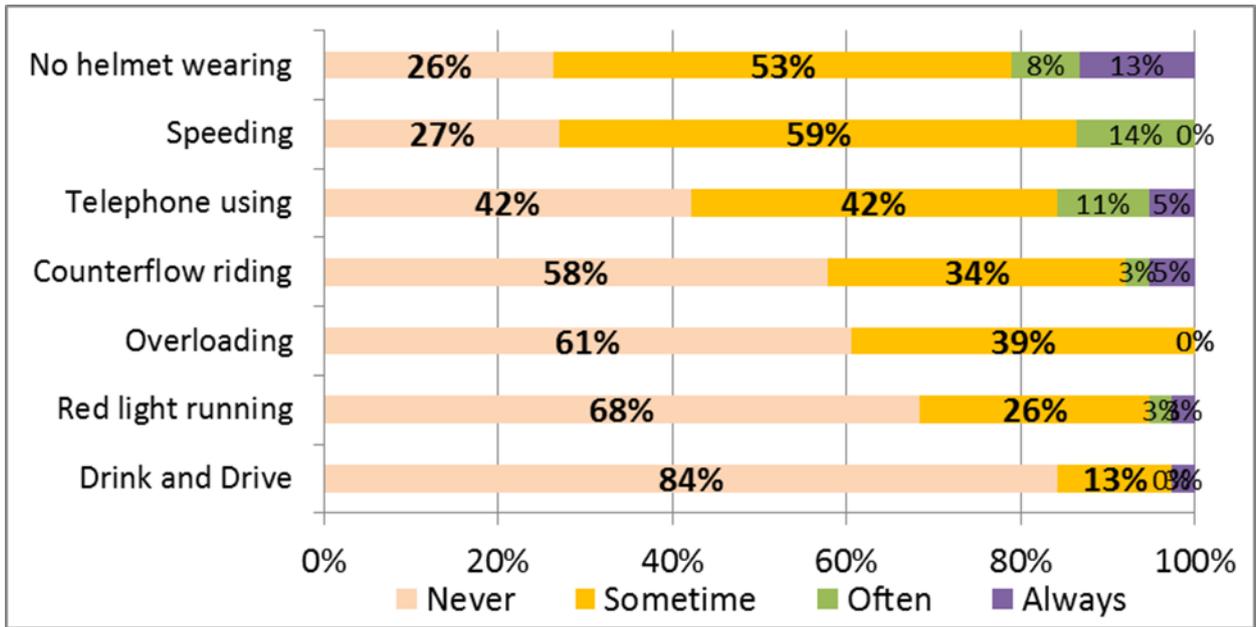


Figure 4.6 Intention to take risk driving behaviour after attending the training

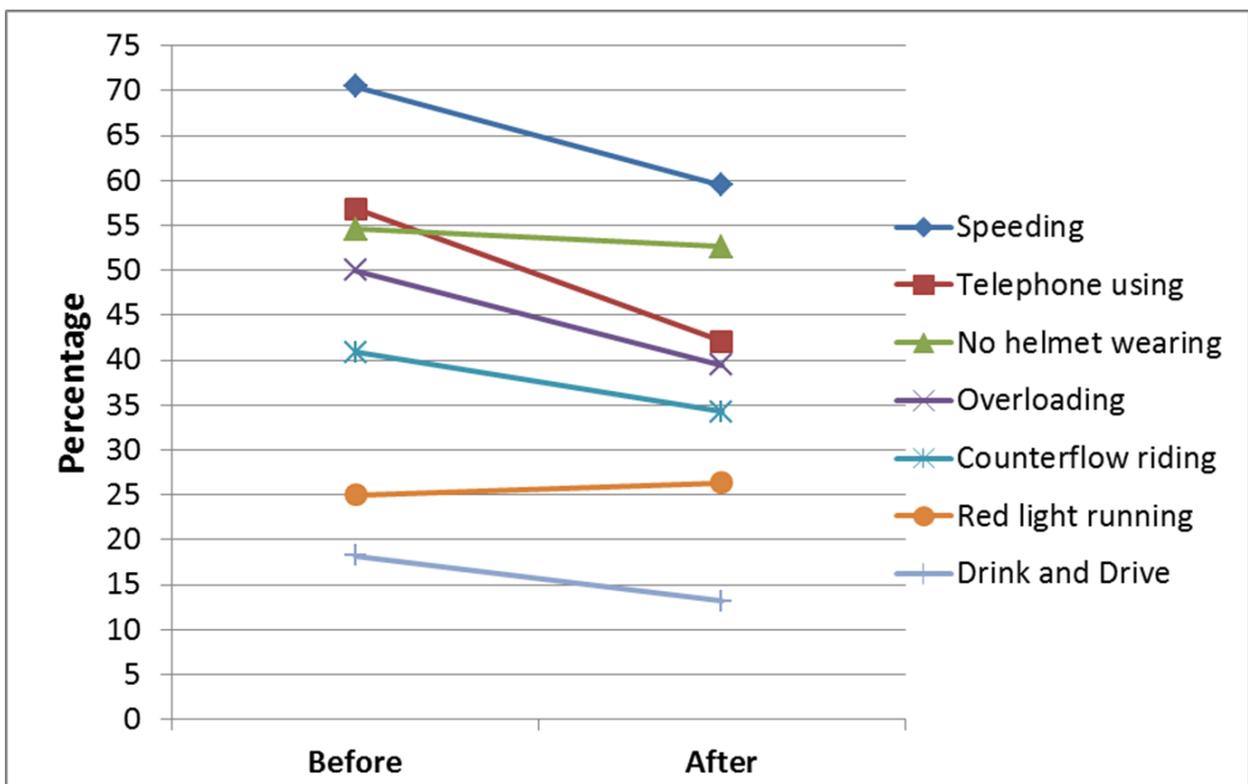


Figure 4.7 Percentages of those who are sometime taking risk driving taking behaviour – before and after attending the training

### 4.3 Event on safety on campus

An event on safety on campus was organised on 22 November 2018. There were more than a thousand students attending. In order to understand students' attitude and behaviour change, two surveys were done before and after the event. The first one was before starting the project in June 2018 and the second was after the event in November 2018.

Characteristics of samples are presented in Table 4.6. Students age between 15-22 years old. The main transport mode for students is motorcycle. Most of them do not have driving license, and ever have experience in road accidents.

Table 4.6 Characteristics of participants in the event on safety on campus

	Before 27 June 18	After 22 Nov 18
Samples	165	160
Age	15-22	15-20
Gender male female	41% 59%	75% 25%
Travelling to school by MC	65%	75%
MC by own MC with parent MC with friend	37% 17% 12%	65% 5% 5%
Involving road accident	62%	68%
No driving license (MC users)	78%	59%

Most students wear helmet because they think helmet can reduce accident injury, and when there is police enforcement (as presented in Table 4.7). They tend to not wear helmet when travelling for a short distance or on small roads (as presented in Table 4.8). These attitudes are similar results between before and after the event.

Table 4.7 Reasons of wearing helmet (participants in the event on safety on campus)

Wearing, because	Before (%)	After (%)
Reducing accident injury	81	84
Police enforcement	72	68
Families or close friends force to wear	36	33
Families or close friends suggest to wear	39	34
Others wear	29	16

Table 4.8 Reasons of not wearing helmet (participants in event on safety on campus)

Not wearing, because	Before (%)	After (%)
Short distance travelling	56	54
Travelling on small roads	53	51
No police	16	10
In a hurry	25	16
Difficulty in carrying	14	9
Loss of hair style	11	16
Uncomfortable	12	13
No helmet	7	16
Confidence in riding without accident	4	3
Others not wearing	2	2

Most students perceive that police is the most effective to influence them to wear helmet. The results are similar for both cases before and after the event on safety on campus (as presented in Figures 4.8 and 4.9).

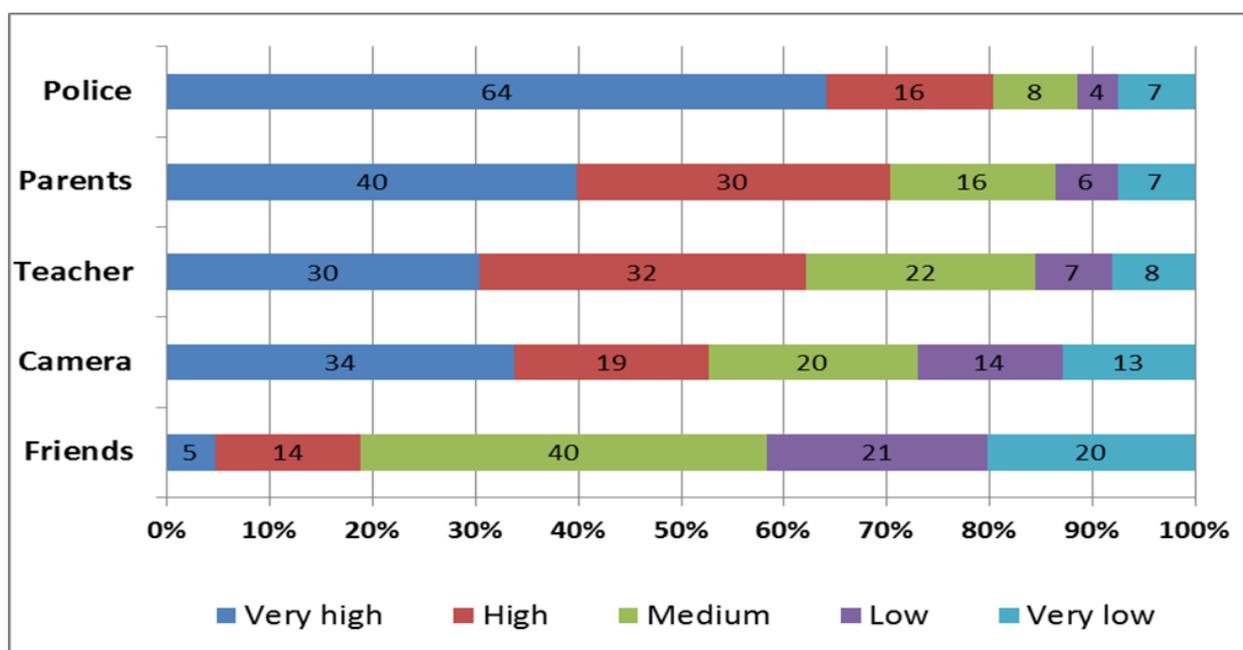


Figure 4.8 Influence on helmet wearing (before the event on safety on campus)

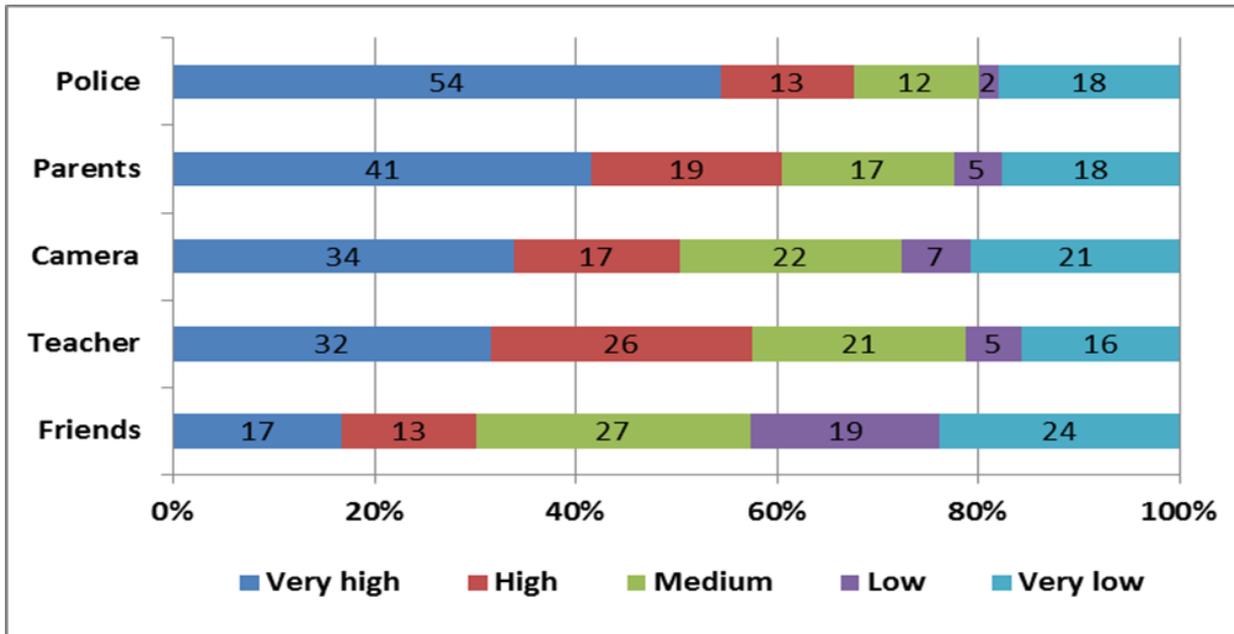


Figure 4.9 Influence on helmet wearing (after the event on safety on campus)

Students also were asked how often they involved in risk driving behaviour before attending the events and their intentions to take risk behaviour after the event. The results present in Figures 4.10 and 4.11. Speeding and no helmet wearing are the most frequent risk driving behaviour. Most of them are sometime taking these behaviours. After the event, students significantly reduce intention to take the behaviours.

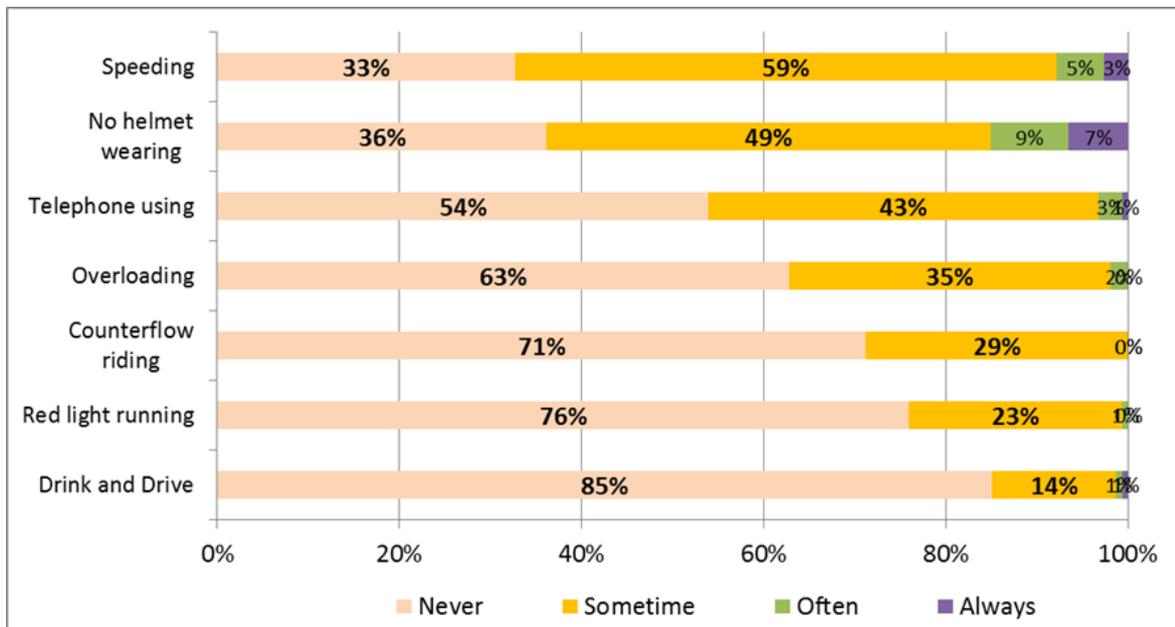


Figure 4.10 Risk driving behaviour before attending the training

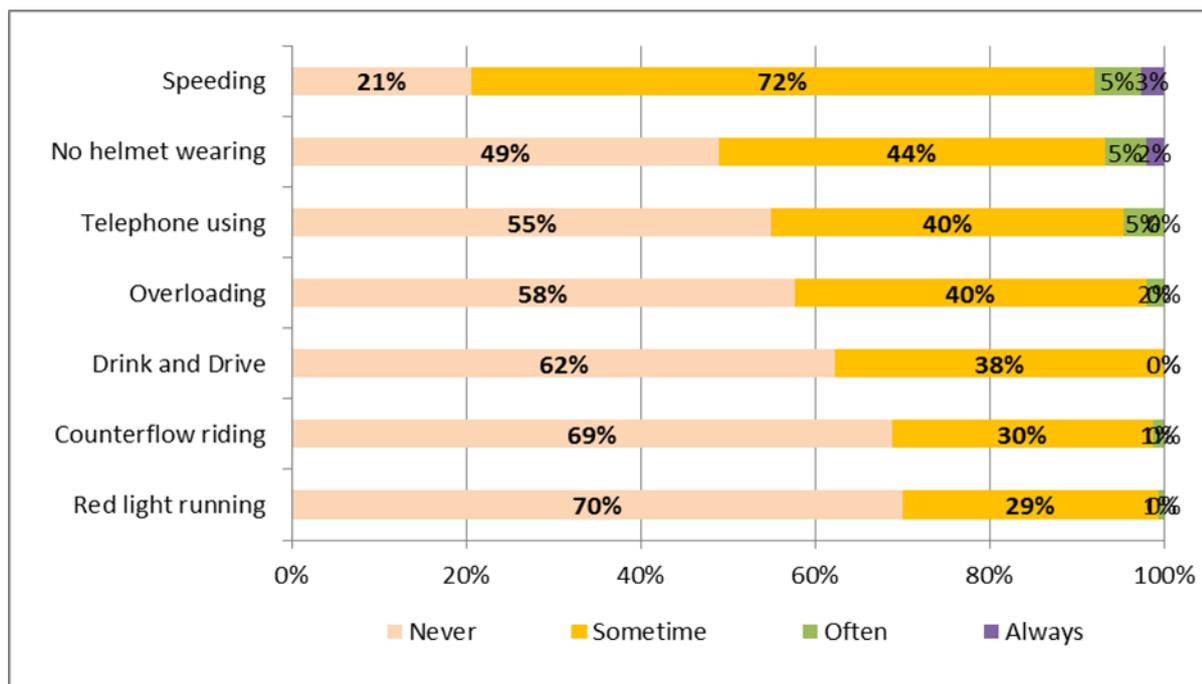


Figure 4.11 Intention to take risk driving behaviour after attending the training

According to TTM, stages of change for wearing helmet behaviour are divided into five stages (as presented in Chapter 3). The questionnaire asked students to indicate which stages they were previously (before attending the training) and currently (after attending the training). The results found that proportion of those who often and always wore helmet (considering helmet wearing as behaviour) increases from 18% to 29% (as presented in Table 4.9).

Table 4.9 Stages of change before and after attending the training

Stages of change	Before	After
Wearing helmet is not an important behaviour	1%	2%
Wearing helmet is an important behaviour	42%	40%
Wearing helmet is an behaviour that I should do	39%	28%
I often wear helmet	8%	18%
I always wear helmet	10%	11%

Based on the Transtheoretical Model (TTM)

#### 4.4 Evaluation of behaviour change at Khon Kaen University (KKU) and Prince of Songkla University (PSU)

Survey at KKU and PSU is to collect data on behaviour change at Khon Kaen University (KKU) and Prince of Songkla University (PSU). This is to evaluate the safety campaigns during 2017 and 2018.

For PSU, there were helmet wearing campaigns in the campus, mainly poster presentation on road sides. Data collection was based on a questionnaire survey asking students to indicate which stages they were previously (before the campaigns) and currently (after the campaigns). The results (as presented in Table 4.10) found that proportion of those who often and always wore helmet (considering helmet wearing as behaviour) reduces from 25% to 20%, and who feel that wearing helmet is not an important behaviour (unaware) reduces from 12% to 2%, while proportions of those who feel that wearing helmet is an important behaviour or they should do (considering helmet wearing as intention) increases from 63% to 78%. These reflect that the poster campaign is effective in increasing intention to wear helmet, not behaviour. Without enforcement, some students may reduce their helmet wearing behaviour.

For KKU, there were three interventions of helmet wearing in the campus, including: poster presentation on road sides, enforcement by check points, and enforcement by CCTV. Data collections were based on questionnaire surveys (after implementation of each intervention) asking students to indicate which stages they were before the campaigns and after the campaigns. The results (as presented in Table 4.11) found that enforcement by check points and CCTV are very effective in influencing helmet wearing behaviour (the proportions of those who often and always wore helmet increases from 16% to 30% for check points and to 44% for CCTV). The poster campaign is only effective in increasing intention to wear helmet.

Table 4.10 Stages of change at PSU

Stages of change	2017 Before	2018 After
Wearing helmet is not an important behaviour	12	2
Wearing helmet is an important behaviour	27	32
Wearing helmet is an behaviour that I should do	36	46
I often wear helmet	9	10
I always wear helmet	16	10

Table 4.11 Stages of change at KKU

Stages of change	2017	2017	2018	2018
	Before	Campaign	Campaign + Check point	Campaign + CCTV
Wearing helmet is not an important behaviour	19	4%	1%	1%
Wearing helmet is an important behaviour	30	31%	16%	11%
Wearing helmet is an behaviour that I should do	35	50%	54%	45%
I often wear helmet	9	8%	19%	27%
I always wear helmet	7	8%	11%	17%

## CHAPTER 5 Conclusions

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The main aims of this research are to manage unsafe driving behaviour by road safety education, and to evaluate the behaviour change. Road safety education campaigns for managing change in driving behaviour were designed according to the previous experiences (reviewed in Chapter 2). Then selected interventions were organised in Thaluang Cementaianusorn Technical College, as a case study. Behaviour change was evaluated based on the Transtheoretical Model (TTM), using questionnaire surveys (pre- and post-tests).

This project focused on helmet wearing behaviour. Various road safety education campaigns were organised, including workshop, training, and road safety events on campus. Moreover, the project also evaluated education and enforcement campaigns on the behaviour change at Khon Kaen University (KKU) and Prince of Songkla University (PSU).

In conclusions, safety education is effective in increasing intention to wear helmet (not behaviour), while enforcement is effective (particularly for a short term) in influencing helmet wearing behaviour. However, safety education and enforcement should be integrated to influence both intention and behaviour. Moreover, in order to induce more behaviour change by safety education, safety campaigns may need to be designed with specific purposes, for each target group, and with multiple interventions and events. Further trails and evaluations is needed to draw guidelines for designing road safety education campaigns.

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## Appendix A: Transtheoretical Model

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The Transtheoretical Model (or TTM, Prochaska & DiClemente, 1984; Prochaska, DiClemente, & Norcross, 1992; Prochaska, Redding, & Evers, 2008) is aimed at explaining a change in an unhealthy or risky behavior. This appendix provides a summary of TTM, which is from Prochaska et al. (2008), as follows.

The TTM uses stages of change to integrate processes and principles of change across major theories of intervention. The TTM emerged from a comparative analysis of leading theories of psychotherapy and behavior change in an effort to integrate a field that had fragmented into more than 300 theories of psychotherapy (Prochaska, 1984).

From initial studies of smoking, the stage model rapidly was expanded to include investigations and applications to a broad range of health and mental health behaviors, including alcohol and substance abuse, anxiety and panic disorders, bullying, delinquency, depression, eating disorders and obesity, high-fat diets, HIV/AIDS prevention, mammography and other cancer screening, medication compliance, unplanned pregnancy prevention, pregnancy and smoking, radon testing, sedentary lifestyles, sun exposure, and physicians practicing preventive medicine.

The core constructs of the TTM includes (as briefly describes in Table A1):

- Stages of Change
- Processes of Change
- Decisional Balance
- Self-Efficacy

Table A1 Transtheoretical Model Constructs

Constructs		Description
Stages of Change	Precontemplation	No intention to take action within the next 6 months
	Contemplation	Intends to take action within the next 6 months
	Preparation	Intends to take action within the next 30 days and has taken some behavioral steps in this direction
	Action	Changed overt behavior for less than 6 months
	Maintenance	Changed overt behavior for more than 6 months
Processes of Change	Consciousness raising	Finding and learning new facts, ideas, and tips that support the healthy behavior change
	Dramatic relief	Experiencing the negative emotions (fear, anxiety, worry) that go along with unhealthy behavioral risks
	Self-reevaluation	Realizing that the behavior change is an important part of one's identity as a person
	Environmental reevaluation	Realizing the negative impact of the unhealthy behaviour or the positive impact of the healthy behavior on one's proximal social and/or physical environment
	Self-liberation	Making a firm commitment to change
	Helping relationships	Seeking and using social support for the healthy behaviour change
	Counterconditioning	Substitution of healthier alternative behaviors and cognitions for the unhealthy behavior
	Reinforcement management	Increasing the rewards for the positive behavior change and decreasing the rewards of the unhealthy behavior
	Stimulus control	Removing reminders or cues to engage in the unhealthy behavior and adding cues or reminders to engage in the healthy behavior
	Social liberation	Realizing that the social norms are changing in the direction of supporting the healthy behavior change
Decisional Balance	Pros	Benefits of changing
	Cons	Costs of changing
Self-Efficacy	Confidence	Confidence that one can engage in the healthy behavior across different challenging situations
	Temptation	Temptation to engage in the unhealthy behavior across different challenging situations

## **Stages of Change**

The stage construct is important, in part, because it represents a temporal dimension. In the past, behavior change often was construed as a discrete event, such as quitting smoking, drinking, or overeating. The TTM posits change as a process that unfolds over time, with progress through a series of five stages, although frequently not in a linear manner.

Precontemplation is the stage in which people do not intend to take action in the near term, usually measured as the next six months. The outcome interval may vary, depending on the behavior. People may be in this stage because they are uninformed or under-informed about the consequences of their behavior. Or they may have tried to change a number of times and become demoralized about their abilities to change. Both groups tend to avoid reading, talking, or thinking about their high-risk behaviors.

In contemplation, people intend to change their behaviors in the next six months. They are more aware than precontemplators of the pros of changing but are also acutely aware of the cons. This balance between the costs and benefits of changing can produce profound ambivalence and keeps people stuck in contemplation for long periods of time. This phenomenon is often characterized as chronic contemplation or behavioural procrastination. These folks also are not ready for traditional action-oriented programs that expect participants to take action immediately.

In preparation, people intend to take action soon, usually measured as the next month. Typically, they already have taken some significant step toward the behaviour in the past year. They have a plan of action, such as joining a health education class, consulting a counselor, talking to their physician, buying a self-help book, or relying on a self-change approach. These are the people who should be recruited for action-oriented programs.

People in the action stage have made specific, overt modifications in their lifestyles within the past six months. Because action is observable, behavior change often has been equated with action. Typically, not all modifications of behavior count as action in this model. In most applications, people have to attain a criterion that scientists and professionals agree is sufficient to reduce risks for disease.

Maintenance is the stage in which people have made specific, overt modifications in their lifestyles and are working to prevent relapse, but they do not apply change processes as frequently as people in action. They are less tempted to relapse and are increasingly more

confident that they can continue their changes. Based on temptation and self-efficacy data, it was estimated that maintenance lasts from six months to about five years.

## **Processes of Change**

Processes of change are the covert and overt activities people use to progress through stages. Processes of change provide important guides for intervention programs, as processes are like independent variables that people need to apply to move from stage to stage. Ten processes have received the most empirical support in research to date.

1. Consciousness raising involves increased awareness about the causes, consequences, and cures for a particular problem behavior. Interventions that can increase awareness include feedback, confrontations, interpretations, bibliotherapy, and media campaigns.

2. Dramatic relief initially produces increased emotional experiences, followed by reduced affect or anticipated relief if appropriate action is taken. Role-playing, grieving, personal testimonies, health risk feedback, and media campaigns are examples of techniques that can move people emotionally.

3. Self-reevaluation combines both cognitive and affective assessments of one's self-image with and without an unhealthy behavior, such as one's image as a couch potato and an active person. Values clarification, healthy role models, and imagery are techniques that can move people evaluatively.

4. Environmental reevaluation combines both affective and cognitive assessments of how the presence or absence of a personal behavior affects one's social environment, such as the impact of one's smoking on others. It can also include awareness that one can serve as a positive or negative role model for others. Empathy training, documentaries, testimonials, and family interventions can lead to such reassessments.

5. Self-liberation is both the belief that one can change and the commitment and recommitment to act on that belief. New Year's resolutions, public testimonies, and multiple rather than single choices can enhance what the public calls willpower.

6. Social liberation requires an increase in social opportunities or alternatives, especially for people who are relatively deprived or oppressed. Advocacy, empowerment procedures, and appropriate policies can produce increased opportunities for minority health promotion, gay health promotion, and health promotion for impoverished people. These same procedures can

be used to help all people change, as is the case with smoke-free zones, salad bars in school lunchrooms, and easy access to condoms and other contraceptives.

7. Counterconditioning requires learning healthier behaviors that can substitute for problem behaviors. Relaxation, assertion, desensitization, nicotine replacement, and positive self-statements are strategies for safer substitutes.

8. Stimulus control removes cues for unhealthy habits and adds prompts for healthier alternatives. Avoidance, environmental re-engineering, and self-help groups can provide stimuli that support change and reduce risks for relapse.

9. Contingency management provides consequences for taking steps in a particular direction. Although contingency management can include the use of punishment, we found that self-changers rely on reward much more than punishment. Reinforcements are emphasized, since a philosophy of the stage model is to work in harmony with how people change naturally. Contingency contracts, overt and covert reinforcements, incentives, and group recognition are procedures for increasing reinforcement and the probability that healthier responses will be repeated.

10. Helping relationships combine caring, trust, openness, and acceptance, as well as support for healthy behavior change. Rapport building, therapeutic alliances, counselor calls, and buddy systems can be sources of social support.

### **Decisional Balance**

Decisional balance reflects an individual's relative weighing of the pros and cons of changing. Originally, TTM relied on Janis and Mann's (1977) model of decision making that included four categories of pros (instrumental gains for self and others and approval from self and others) and four categories of cons (instrumental costs to self and others and disapproval from self and others). Over many studies attempting to produce this structure of eight factors, a much simpler two-factor structure was almost always found—pros and cons of changing.

### **Self-Efficacy**

Self-efficacy is the situation-specific confidence that people can cope with high-risk situations without relapsing to their former behaviors.

Temptation reflects the converse of self-efficacy—the intensity of urges to engage in a specific behavior when in difficult situations. Typically, three factors reflect most common types of temptations: negative affect or emotional distress, positive social situations, and craving.

**Relationships Between Stages and Processes of Change.**

One of the earliest empirical integrations was the discovery of systematic relationships between people’s stages and the processes they were applying. Table A2 presents the empirical integration (Prochaska, DiClemente, and Norcross, 1992). This integration suggests that, in early stages, people apply cognitive, affective, and evaluative processes to progress through stages. In later stages, people rely more on commitments, conditioning, contingencies, environmental controls, and support for progressing toward maintenance or termination.

Table A2 Processes of Change That Mediate Progression Between the Stages of Change

	Precontemplation	Contemplation	Preparation	Action	Maintenance
<b>Processes</b>	Consciousness raising Dramatic relief Environmental reevaluation				
	Self-reevaluation				
			Self-liberation		
					Counterconditioning Helping relationships Reinforcement management Stimulus control

*Note: Social liberation was omitted due to its unclear relationship to the stages.*

Table A2 has important practical implications. To help people progress from precontemplation to contemplation, such processes as consciousness raising and dramatic relief should be applied. Applying processes like contingency management, counterconditioning, and stimulus control to people in precontemplation would represent a theoretical, empirical, and practical mistake. But for people in action, such strategies would represent optimal matching.

As with the structure of processes, relationships between the processes and stages have not been as consistent as relationships between stages and pros and cons of changing. Although part of the problem may be due to the greater complexity of integrating ten processes across five stages, processes of change need more basic research and may be more specific to each problem behavior.

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# Final Report

Research Grant 2018

ATRANS