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Standardization of the Persian Version of the Treatment Entry Questionnaire for Students with Internet Addiction

Fatemeh Alavi asil[1], Khadijeh Abolmaali Alhosseini[*2], Simin Bashardoust[2]

Abstract

Objective: One of the basic human needs that plays a vital role in sustainable development is mental health. In the digital age, Internet addiction is a threat to mental health. So this study aimed at validating the treatment entry questionnaire for Tehran University students in 2019.

Method: Participants were 324 undergraduate and postgraduate students of public universities in Tehran, who were selected through one-step cluster random sampling. All participants completed the Urbanoski and Wild's (2012) Treatment Entry Questionnaire, the Miler and Tonigan (1996) Change Readiness and Treatment Eagerness Scale, and the Young Internet Addiction Questionnaire.

Results: Data were analyzed using the confirmatory factor analysis model. Confirmatory factor analysis of the data showed that the three-factor structure of the identified, intrinsic, and extrinsic treatment motivation has a good fit, and the validity of the scale was confirmed by face and content validity. Convergent validity evidence confirmed the positive relationship between identified, intrinsic, and extrinsic treatment motivation with subscales of recognition, taking the step, and ambivalence of the Readiness for Change and Treatment Motivation scale. Cronbach's alpha test was used to assess the reliability of the whole scale (0.95) and each subscale of identified motivation (0.94), intrinsic motivation (0.89), and extrinsic motivation (0.86).

Conclusion: The results showed that the Persian version of the treatment entry scale for the student population has acceptable psychometric properties and can be used as a valid tool in psychological research.

Keywords: Mental Health, Internet Addiction, Confirmatory Factor Analysis, Validation, Therapy, Treatment Entry Questionnaire.

Introduction

Mental health is a common issue in many cultures, and, over the past few decades, has been recognized as a human right and a social goal in the world (Safarinia, 2014). Among the factors that affect the mental health of the society is the technology and everyday communication through it (Mosavi Moghaddam, Nouri, Khodadadi, Ahmadi, & Ghiasi, 2017). With the increasing access of people to the Internet, the world witnesses a new type of addiction called Internet addiction, which is a growing obstacle in the information age and like other types of addictions, is associated with symptoms such as depression, bad temple, anxiety, distress, the disintegration of social relationships, and academic failure (Hajizadeh Meymandi, Vakili Qasem Abad, & Mirmangareh, 2016). The term Internet addiction disorder was used for the first time by Amichai Hamburger (2003) to describe and identify the characteristics of people who have problems using the Internet. He was the first person to form a group of people to help Internet addicts (Moghnizadeh,

1. PhD Student, Department of Psychology, Islamic Azad University, Roodehen Branch, Roodehen, Iran.
2. Associate Professor, Department of Psychology, Faculty of Psychology, Islamic Azad University, Roodehen, Iran
*Corresponding Author: Khadijeh Abolmaali Alhosseini, Email: abolmaali@riau.ac.ir

Sanagoye Moharer, Talebi, & Asoudi, 2016). Young believes that Internet addiction includes constant mental engagement with the Internet, recurring thoughts about it, feeling disabled against its temptation, persistent engagement despite problems in various aspects of life, and a strong temptation to use it (Young, 1998). Among the factors that affect students' mental health and academic performance are technology and daily communication (Ganji, Tavakoli, Bani Asadi Shahrbabak, & Asadi, 2016). In this regard, it has been stated that educational environments such as high schools and universities are good places for Internet addiction (Hosseini, Hemmat Fard, Isfahani, & Moradpour, 2018).

According to research conducted in Iran and other countries, Internet addiction is increasing among students (Khatib Zanjani & Agah Harris, 2014). Nastizadeh in a study on the relationship between public health and Internet addiction of students of Sistan and Baluchestan University concluded that the general health of Internet-addicted users was more at risk than normal users, but Internet addicts and normal users were in the same situation globally, and there was no significant difference in social dysfunction in the group (Farhadinia, Malekshahi, Jellilund, Foroughi, & Rezaei, 2015). Research results indicate that there is a negative and significant relationship between Internet addiction and academic desire (emotional, behavioral, cognitive) (Ganji et al., 2016). The study of Komleh et al. revealed that there is a negative and significant relationship between Internet addiction and academic motivation, in that Internet addiction has been effective in reducing students' academic motivation (Arian, Oghazian, Amini, Khosravi Pour, & Abbaszadeh, 2018).

Although the treatment of any type of addiction is considered in different societies, the rate of entry into treatment and successful continuation of treatment is low, and clients need services that are not fully available in such treatments (Simpson, Joe, Knight, Rowan-Szal, & Gray, 2012). Preparation for treatment clearly indicates the motivation for treatment and shows the client's decision to enter therapy (Hallgren & Moyers, 2011).

Motivation plays an important role in the treatment of any disease, especially for patients with addiction (Sudraba et al., 2015). Motivation is a process in which goal-oriented activity is evoked and maintained, in other words, motivation is a process and not a product (Hokmabadi, 2013). Motivation is a concept derived from self-determined theory(SDT) and is defined as why people decide to participate in a program, how much effort they dedicate for participation, and how much perseverance they put into an activity (Hunter, 2008). The self-determined theory believes that this internal process is crucial to sustaining improvement and mental health (Urbanoski & Wild, 2012).

Motivation is a hypothetical construct used to describe internal or external pressures or forces that affect the initiation, direction, intensity, and endurance of a particular behavior. Motivation is defined as a set of forces that determine entry, commitment, persistence, and perseverance for treatment (Jamshidi, 2017). In fact, the efforts for therapy are not complete without considering the motivational argument. Asghari, Ebrahimi, Chehre Barghi and Molaei (2012) showed that the motivation to quit addiction plays an important role in the recurrence of addiction (Khosravi Nia, 2014). Motivation to change by treatment, which is described as the client's responsibility and conscientiousness, is a major prerequisite for treatment and without it, the therapist can not succeed in treatment (Beckman, 1980). The self-determined theory has been proposed as a comprehensive theoretical framework for understanding the effects of promoting motivational therapy (Markland, Ryan, Tobin, & Rollnick, 2005; Vansteenkiste & Sheldon, 2006). In this theory, extrinsic motivation refers to the clients' beliefs

about external events or factors (e.g., the legal system, employers, friends, and family) that have forced them to pursue their therapy, and intrinsic motivation refers to the internal conflicts (e.g., guilt and anxiety) associated with treatment decisions (Yurbansky & Wilde, 2012). Assessing the self-determined motivation at the time of admission and during the treatment period can provide further empirical findings of recovery processes in addiction and provide a way to follow-up for psychologists to find out how much the clients have internalized their decision to receive treatment. Therefore, a better understanding of motivation may lead to more effectiveness of strategies in treatment (Mazlum & Mohammad Khani, 2019). Motivation is effective as a key therapy and is also a dynamic state that can be modified (Abu Hamza & Mustafa, 2020).

Since health plays an important role in ensuring the dynamism and efficiency of any society, the goal of all societies is to provide conditions to maintain and promote the health of their members (Safiri & Mansoorian, 2014). Considering that students have a special role and position as the basic element of the educational system in achieving the goals of the educational system, and the health of this group is of special importance, the present study was designed to assess the validity and reliability of the Treatment Entry Questionnaire for Internet addiction therapy in students with Internet addiction.

Method

The current study is descriptive-correlational and the statistical population was students of state universities in Tehran in 2019. The sampling method was multi-stage random sampling that in the first stage, four universities were selected from state universities, and in the second stage, the classes were selected as random clusters to conduct the research. Bentler (1993) suggested that the ratio of the sample size to the number of parameters estimated in a model must be at least 5 to 1 (5:1), and preferably 10 to 1 (10:1), or 50 to 1 (50:1) to make statistically significant correct results (cited in Mueller, 1996). In the measurement model of this research, there was a total of 30 parameters, including 12 parameters in the Landa matrix (the matrix of structural coefficients of the observed exogenous variables to latent variables), 12 parameters in the Theta matrix (matrix of error coefficients of observed exogenous variables), and 6 parameters in Phi matrix (matrix of covariance/variance of latent exogenous variables). Considering 10 subjects for each parameter, the minimum sample size is estimated to be 300. In this study, about 10 people were considered for each parameter and a sample of 324 students was selected through multi-stage random sampling. There was no compulsion for participating in the study. The questionnaires were anonymous and the results were completely kept confidential, and in this regard, the ethical criteria of the research were observed.

Ethical Statement

The present study is derived from a doctoral dissertation with the ethic code of IR. IAU. TMU. REC. 1398. 151, approved on 2019/04/13. Data collection in this study was done after collecting informed consent letters from the participants and the collected data were kept confidential. It is worth noting that the participants had the right to withdraw from the study whenever they wanted to. We would like to thank all the students who participated in the research, as well as the counseling centers of the state universities in Tehran and the Ministry of Science, Research, and Technology.

Research instruments

Treatment Entry Questionnaire (TEQ): This questionnaire was developed by Urbanoski and Wild (2012) to measure the motivation for entrance to and continuation of treatment in adults with an average age of 32 years. In the primary version, there were 12

items and three subscales of identified motivation, intrinsic motivation, and extrinsic motivation. Confirmatory factor analysis showed that the three-factor structure with 12 items was fit, and in the final model, the subscales were identified motivation (5 items), intrinsic motivation (3 items), and extrinsic motivation (4 items). Urbanoski and Wild (2012) reported the reliability of the questionnaire in the dimensions of identified motivation 0.89, intrinsic motivation 0.60, and extrinsic motivation 0.82. In this questionnaire, the items are scored based on the Likert scale, from strongly agreed to strongly disagree. In this study, the 12-item questionnaire developed by Urbanoski and Wild (2012) was used.

Change Readiness and Treatment Eagerness Scale: This scale is an experimental tool designed by Miller and Tonigan in 1996 to assess the readiness for change and treatment of drug abusers. The instrument has 19 items and measures the treatment motivation in three subscales of recognition (7 items), taking a step (8 items), and ambivalence (4 items). Cronbach's alpha coefficient was calculated for the recognition subscale in the range of 0.85 to 0.95, for ambivalence in the range of 0.60 to 0.88, and for taking steps in the range of 0.83 to 0.96. Simultaneous validity of this tool with the 39-items questionnaire showed that there was a high correlation between the two subscales in three components of recognition (r = 0.96), taking a step (r = 0.94), and ambivalence (r = 0.88) (Miller & Tonigan, 1996). For the Iranian version, the coefficient for recognition was 0.76, for ambivalence was 0.71, and for taking a step was 0.85 (Basharpour & Ahmadi, 2019). In the present study, Cronbach's alpha was 0.70 for recognition, 0.64 for taking steps, and 0.75 for ambivalence.

Internet Addiction Test (IAT): This test was developed by Kimberly Young in 1998 to measure Internet addiction among adults and student samples and has acceptable validity and reliability compared to other questionnaires in this field. In this questionnaire, which has 20 items, the subject must answer each question on a 5-point Likert scale. The test scores range from 0 to 100, with a higher score indicating greater dependence on the Internet and more severe problems resulting from overuse of the Internet. Vidianto and McMuran (2004) reported the high face validity for this questionnaire. Also, through factor analysis, they obtained six factors of prominence, overuse, neglect of job duties, lack of control, social problems, and impact on performance, indicating the validity of the questionnaire (Shahbazi Rad & Mirdrikund, 2014). Using Cronbach's alpha, Poe et al. reported the reliability of this questionnaire higher than 90% (Kim, Han, Lee, & Renshaw, 2012). Lee and Chou also obtained the reliability of this scale 0.95 through the test-retest method after two weeks' interval (Dargahi & Razavi, 2007). In the present study, using Cronbach's alpha, the reliability coefficient was obtained at 0.81.

Procedure and participants

In order to conduct the research, first, the scale was translated into Persian by two experts, then it was back-translated, and in a pilot study, the translated version was given to a sample of 30 students. After collecting the questionnaires, words that were not understandable to the students were rewritten. The average time for completing the questionnaires was 30 minutes. Data were analyzed with spss22 and LISREL8.80 software.

Participants were 324 students [171 males (52.80%), 153 females (47.20%)] in undergraduate and postgraduate studies [220 undergraduates (67.90%), 104 postgraduates (32.10%)] from public universities in Tehran, including the University of Tehran, Allameh Tabatabai University, Sharif University of Technology, Kharazmi University, and Amirkabir University. The age range of the participants was 18 to 30 years [age group 18-21, 40 people (12.30%), age group 22-25, 131 people (40.40%), and age group 26-30, 135 people (14.20%)].

Results

Face and content validity: In order to evaluate the face validity of the Treatment Entry Questionnaire, the scale was provided to 30 students of the statistical population in order to examine its attractiveness, fluency, conciseness, and comprehensiveness, and whether the wording was acceptable for respondents from the point of view of the target group.

The relative coefficient of content validity of the scale was evaluated based on the opinions of 10 specialists in the field of treatment and 5 faculty members in psychology, and their comments were applied in the questionnaire. There was no need to delete any of the items. By designing a questionnaire for each item, the opinions of these 15 people were collected in the Likert scale of "item is necessary", "item is useful but not necessary" and "item is not necessary", and the result of Content Validity Ratio (CVR) for all questions was higher than 0.49, which was acceptable.

Waltz-Basel's (1981) method was used for Content Validity Index (CVI). In this method, experts define items' relevance, clarity, and simplicity based on four-point Likert scales for each. They rate the relevance of each item as 1 for "not relevant", 2 for "relatively relevant", 3 for "relevant", and 4 for "completely relevant". The simplicity of the item is also determined by the scores 1 for "not simple", 2 for "relatively simple", 3 for "simple", and 4 for "simple relevant". And finally, the clarity of the item is determined from 1 for "not clear", 2 for "relatively clear", 3 for "clear", to 4 for "clear relevant" (Table 1).

The CVI index for each item was higher than 0.79, which is a measurable value.

Confirmatory factor analysis

Theoretically, the internal relationships of the items were tested in a three-factor model. For the experimental test of the model, the fitness indices of Root Mean Square Error of Approximation, Standardized Root Mean Square Residual, Comparative Fix Index, Goodness of Fit Index, and Adjusted Goodness of Fit Index were used. For fitness indicators, numerous values have been proposed by experts. For example, a value equal to or less than (0.05) for Root Mean Square Error of Approximation, a value equal to or higher than (0.96) for the Comparative Fix Index, and a value equal to or less than (0.07) for Standardized Root Mean Square Residual, indicate the adequate fitness of the model (Jurskag, 2003, cited by Akbari Balootbangan & Tale Pasand, 2016). On the other hand, it has been suggested that if the Comparative Fix Indices, Goodness of Fit, and Adjusted Goodness of Fit indices are greater than (0.90), and Root Mean Square Error of Approximation and Standardized Root Mean Square Residual indices are less than (0.05), the fitness is very desirable, and the value less than (0.1) indicates the desired fitness.

Table 1. Determining content validity

	Relevance				Simplicity				Clarity			
Title	not relevant	relatively relevant	relevant	completely relevant	not simple	relatively simple	simple	simple relevant	not clear	relatively clear	clear	clear relevan
ITEM 1												
ITEM 2												
ITEM 3												

$$CVI = \frac{\text{Number of specialists who gave the item a score of 3 and 4}}{\text{Total number of specialists}}$$

The CVI index for each item was higher than 0.79, which is a measurable value.

The fit indices of the initial model were examined. Fitness indices showed that the initial three-factor model with 12 items did not have good fitness. Examining the Standardized Root Mean Square Residual matrix showed that items 1 and 4, 4 and 8, 9 and 12 have covariance. Since these items are related to a subscale, it was reasonable to assume that there was a covariance between the variance of their error. Finally, the revised model was tested with three factors and 12 items (Table 2). The majority of fitness indicators show that the final model with three factors and 12 items has good fitness.

Examining the factor loads shows that for the first factor, i.e. identified motivation, items 1, 4, 8, 10, and 2 had appropriate factor load, and question 8 with a factor load of 0.92 is the most effective indicator of this subscale. For the second factor, i.e. the intrinsic motivation, items 5, 7, and 11 had appropriate factor load and the highest factor load in this subscale belonged to item 5 with a factor load of 0.90, which

Table 2. Fit Indicators of the three-factor model of Treatment Entry Questionnaire (TEQ), (n = 324)

Model	*X2	CFI	IFI	NFI	RMSEA	RMSEA CI 90%	RMR	GFI	AGFI
Initial	323/36	0/68	0/67	0/66	0/41	0/4;0/40	0/60	0/40	0/10
Final	223/89	0/96	0/96	0/95	0/13	0/15;0/12	0/17	0/85	0/76

* Chi-square through maximization method

Table 3. Factor loads of Treatment Entry Questionnaire's items

Item	Content	Idzentified motivation	Intrinsic motivation	Extrinsic motivation
1	I decided to enter a treatment program because I was interested in getting help.	0/83		
4	I decided to get into a treatment program because I really want to make a reform in my life.	0/85		
8	I decided to enter a treatment program because my personal feelings to deal with the problem of Internet addiction are important.	0/92		
10	I plan to go with a treatment plan because not using the Internet is the choice I really want to make.	0/87		
2	I decided to stay in a treatment program because I do not like myself very much if my Internet use is not controlled.	0/83		
5	I intend to continue treatment otherwise I will be embarrassed.		0/90	
7	I stay in treatment probably because if I can not stay, I will feel like a failure.		0/79	
11	I'm going to deal with a treatment plan because not using the Internet is a choice I really want to stick to.		0/86	
3	I stay in treatment probably because if I can not stay, others will be angry with me.			0/84
6	The reason I am in treatment is because other people are pressuring me.			0/80
9	I agreed to follow a treatment plan because if I did not follow up, I would have problems with all my friends and family.			0/67
12	I agreed to pursue a treatment plan because I was under pressure to come.			0/79

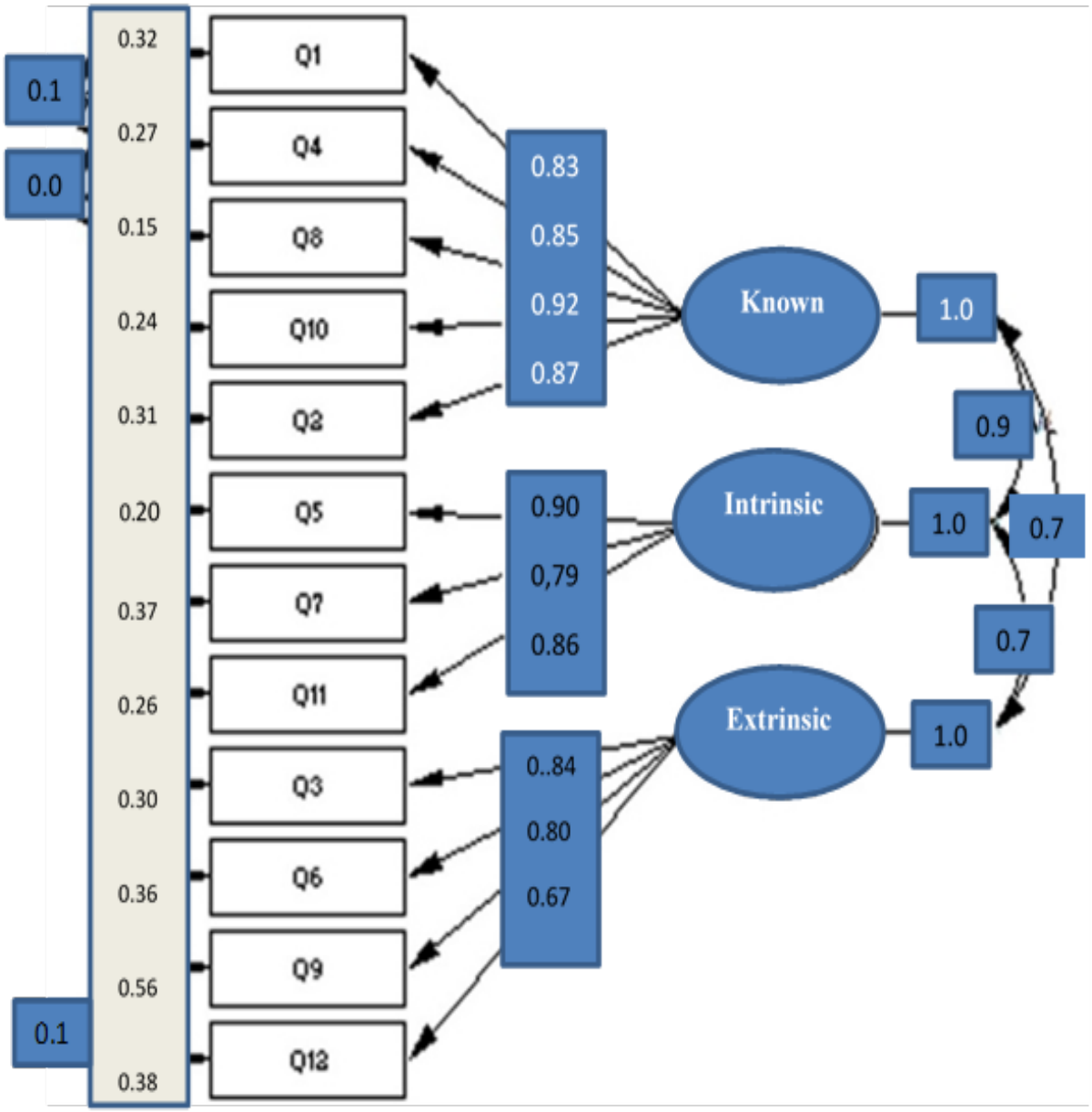

Figure 1: Final tested model

was the most effective indicator of this subscale. For the third factor, i.e. external motivation, items 3, 6, 9, and 12 had appropriate factor load and item 3 with factor load 0.84 was the most effective indicator of this subscale (Table 3).

Estimation of parameters

Since the fit indices showed that the final model with three factors and 12 items has a good fit, the standard coefficients, determination coefficient, and error variance (R2) are reported (Table 4). For the first factor, i.e. the identified motivation, the highest coefficient is for item 8 (R2 = 0.88) and the lowest coefficient is for item 2 (R2 = 0.68), and thus the highest standard coefficient is for item 8 (λ71(stand)= 0.92) and the lowest for item 2 (λ81(stand)= 0.83). For the second factor, i.e. intrinsic motivation, the highest coefficient of determination is for item 5 (R2 = 0.80) and the lowest coefficient is for item 7 (R2 = 0.64), and thus the highest standard coefficient is for item 2 (λ12(stand = 0.90) and the lowest belongs

to item 6 (λ22(stand)= 0.80). For the third factor, i.e. extrinsic motivation, the highest coefficient is for item 3 (R2= 0.67) and the lowest coefficient is for item 9 (R2= 0.50), and thus the highest standard coefficient belonged to item 3 (λ13(stand)= 0.84) and the lowest to item 9 (λ23(stand)=0.76) (Table 4).

Table 4. Estimation of standard parameters of Treatment Entry Questionnaire (n = 324)

Factors	Item	Standard coefficient	Error variance	Determination coefficient
Identified motivation	1	0/83	0/32	0/69
	4	0/85	0/27	0/76
	8	0/92	0/15	0/88
	10	0/87	0/24	0/75
Intrinsic motivation	2	0/83	0/31	0/68
	5	0/90	0/20	0/80
	7	0/79	0/37	0/63
	11	0/86	0/26	0/74
Extrinsic motivation	3	0/84	0/30	0/67
	6	0/80	0/36	0/62
	9	0/67	0/56	0/50
	12	0/79	0/38	0/66

Convergent and divergent validity

To calculate the convergent, divergent, and criterion validity of the treatment entry questionnaire, Miller and Tunigan's Change Readiness and Treatment Eagerness Scale, and Young's Internet Addiction questionnaires were used. The mentioned scales were performed simultaneously for 324 students and the obtained data was analyzed using the Pearson correlation coefficient. The results are shown in (Table 5).

The results showed that there was a positive and significant relationship between the subscales of identified motivation of the treatment entry questionnaire and the subscales of recognition (0.93), taking a step (0.71), and ambivalence (0.97) of the Change Readiness and Treatment Eagerness Scale, in a predetermined theoretical direction. And also a negative and significant correlation (-0.39)

Table 5. Correlation between the Treatment Entry Questionnaire with Achievement Emotions Questionnaire and Internet Addiction Questionnaire

	Variable	1	2	3	4	5	6	7
1	Identified motivation	0/94						
2	Intrinsic motivation	0/96**	0/89					
3	Extrinsic motivation	0/82**	0/86**	0/86				
4	Recognition	0/93**	0/90**	0/69**	0/70			
5	Taking step	0/71**	0/62*	0/71**	0/65**	0/64		
6	Ambivalence	0/97**	0/96**	0/73**	0/94**	0/62**	0/75	
7	Internet addiction	-0/39**	-0/38**	-0/39**	-0/30**	-0/13**	-0/38**	0/81
	Mean	18/39	10/89	12/34	21/67	24/48	13/05	60/97
	staandard deviaation	8/23	4/92	5/45	6/71	8/72	3/66	9/71

The alpha coefficients are on the sub-diameter * P≤ 0.05 ** P≤0. 01

was observed between the identified motivation and the Young Internet addiction questionnaire.

It was also shown that there was a positive and significant relationship between the internal motivation subscale of the treatment entry questionnaire and the recognition, taking a step, and ambivalence subscales of Change Readiness and Treatment Eagerness Scale in the predetermined theoretical direction, which were (0.90), (0.62), and (0.96), respectively. In addition, a negative and significant relationship (-0.38) was observed between the external motivation subscale and the Young Internet addiction questionnaire.

Reliability of Treatment Entry Questionnaire dimensions was calculated using the internal consistency method through Cronbach's alpha coefficient. The results showed that the reliability coefficient obtained for the whole scale was (0.95) and for each of the subscales, i.e. identified motivation, intrinsic motivation, and extrinsic motivation were (0.94), (0.89), and (0.86), respectively.

Discussion and Conclusion

The aim of this study was to determine the characteristics of Urbanoski & Wild's (2012) Treatment Entry Questionnaire. Confirmatory factor analysis was performed on items and subscales of this tool and the convergent and divergent validity of the scale was evaluated by its simultaneous implementation with the Miller and Tonigan Change Readiness and Treatment Eagerness Scale and Young Internet addiction scale. Confirmatory factor analysis confirmed the suitability of data with a three-factor structure. High standard coefficients and determination coefficients were obtained for three factors (i.e. identified motivation, intrinsic motivation, extrinsic motivation). These findings are consistent with previous findings presented by Urbanoski and Wild (2012) for initial evidence of validation of the questionnaire structure. They also presented a three-factor structure, including identified motivation, intrinsic motivation, and extrinsic motivation with 12 items.

Evidence of convergent and divergent validity showed that there was a positive and significant relationship between the subscales of identified motivation and the subscales of Change Readiness and Treatment Eagerness Scale, including recognition, taking a step, and ambivalence. This finding was consistent with the findings of Ryan et al. (1995) and Wild et al. (2006). The results of their research showed that there was a positive relationship between identified motivation and the variables of treatment entry questionnaire (taking step) in people who have made a personal choice without the presence of social controls and pressures, who were more successful in treatment. The results of the current study also showed that there was a positive and significant relationship between the subscale of internal motivation of treatment entry questionnaire and the subscales of Change Readiness and Treatment Eagerness Scale including recognition, taking a step, and ambivalence. Consistent with this finding, the findings of many studies have shown the importance and relevance of intrinsic motivation to enter treatment and consistent change of addiction and dependence (Curry, Grothaus, & McBride, 1997; Williams, Gagne, Ryan, & Deci, 2002; Williams, Grow, Freedman, Ryan, & Deci, 1996).

There was a positive and significant relationship between the subscale of external motivation of the treatment entry questionnaire and the subscales of the Change Readiness and Treatment Eagerness Scale, i.e. recognition, taking a step, and ambivalence. Ekendahl (2007) showed that realizing the psychological and social bed effects and the pressure of others lead to treatment and regular continuation of the treatment program, while this factor alone is not enough to successfully quit the addiction. In explaining these findings, it can be pointed out that it

is likely that external pressures by friends and family upon entrance to the treatment program may affect the person's sense of autonomy to make decisions. Therefore, external motivations have less effect than internal and identified motivations on entering and continuing Internet addiction treatment.

Examining the divergent validity, the results showed that there was a negative relationship between the identified motivation of treatment and Internet addiction. There was a negative and significant relationship between subscale of external motivation and Internet addiction and a negative relationship was found between identified treatment motivation and Internet addiction. In explaining this finding, it should be noted that in classifying the types of addicts, we can put them into three categories: 1. addicted candidates, 2. a group that is satisfied with their addiction, and 3. addicts who want to quit, whose motivation for treatment is different, and Internet addiction in many of these people leads to pleasure, reduced anxiety and depression (Heydari Mokarrar, 2006), so there is less motivation to enter treatment despite the addiction to the Internet. This finding is consistent with the findings of the current study in that there is a negative relationship between Internet addiction and various motivations for treatment.

Evidence related to instrument reliability showed that Cronbach's alpha coefficient was appropriate for the whole scale and each subscale, i.e. identified motivation, intrinsic motivation, and extrinsic motivation. Urbanoski and Wild's (2012) reported similar Cronbach's alpha coefficients for identified motivation, intrinsic motivation, and extrinsic motivation. Thus, reliability evidence is consistent with the research background. Based on the evidence of validity and reliability, it can be concluded that this scale is a good tool to measure the motivation to enter and continue treatment in patients with Internet addiction and researchers can use it in research related to addiction and treatment.

The limitations of this study (like other self-assessment tools) may have resulted in the bias of participants' responses. It is worth mentioning that the small number of items and the possibility of easy implementation of this questionnaire individually and in groups (in the non-clinical community) and its desirable psychometric properties are the advantages that make it easy to use in research and diagnostic activities. Also, since the questionnaire measures only a sample of behavior and can not be used in clinical practice as a single tool for diagnosis, it is recommended that clinical interview and observation be used along with this questionnaire. In addition, it is suggested that other researchers, in order to determine the cut-off point, implement this questionnaire in addition to the clinical community to the non-clinical community as well, and based on it, determine the psychological profile of individuals. Due to the satisfactory reliability and validity of this questionnaire, its use by psychologists and counselors to determine the motivation of the clients to enter the treatment and use it in research activities is recommended.

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