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Motivational Interviewing with Individuals In Recovery: Effects On Hope, Meaning, Empowerment and Service Participation

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MOTIVATIONAL INTERVIEWING WITH INDIVIDUALS IN RECOVERY: EFFECTS ON HOPE, MEANING, EMPOWERMENT AND SERVICE PARTICIPATION

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Dissertation Approval

This is to certify that the thesis presented to us by Scott Glassman

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Abstract

Service engagement continues to challenge providers working with individuals with serious mental illness and substance abuse disorders. Motivational Interviewing (MI), an intervention aligned with recovery-oriented principles in its emphasis on empathy, empowerment, and self-directed change, directly addresses this problem. Its effects on service engagement, however, have been inconsistent with dually diagnosed populations. To explore underlying processes that may influence engagement, the present mixed methods, single case experiment studied the effects of MI on key recovery constructs: hope, meaning, and empowerment. Participants were 6 consumers enrolled in an intensive outpatient program for co-occurring disorders. Results showed statistically significant increases for half the sample on a brief hope, meaning, and empowerment survey. Grounded theory analysis also identified positive change in identity, self-efficacy, and relationships as major recovery themes discussed in MI. It also revealed positive affect associated with spirit and method of MI. Implications for attention to personal narratives, supporting persistence in change, and satisfying psychological needs proposed by self-determination theory (SDT) are discussed.

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Introduction

Statement of the Problem

Treatment drop-out and nonadherence occur at high rates among individuals with serious mental illnesses (SMI). It is estimated that up to 40% of individuals with SMI discontinue treatment prematurely (O'Brien, Fahmy, & Singh, 2009) and nearly a quarter do not regularly attend their scheduled appointments (Nosé, Barbui, & Tansella, 2003). The likelihood of disengagement increases substantially after inpatient hospitalizations. Following discharge, appointment failure and aftercare drop-out rates have been reported as ranging from 40% to 60%, with rates as high as 78% (Klinkenberg & Calsyn, 1996). Additionally, a little over half of individuals with major mental health problems choose not to take medication as prescribed (Nosé, Barbui, & Tansella, 2003). Kreyenbuhl, Nossel, and Dixon (2009) reported that slightly over 50% of individuals diagnosed with SMI had not received treatment in the previous year, suggesting that many consumers choose not to engage in services at all.

Avoidance of treatment presents a significant barrier to recovery from SMI. Early treatment termination and nonadherence to provider recommendations is often correlated with increases in the health, social, and financial burdens of illness (Kreyenbuhl et al., 2009; Mojtabai et al., 2009; Stiles, Boothroyd, Dhont, Beiler, & Green, 2009). Nonadherence has also been associated with symptom intensification, stigma, suicidality, high relapse rates, inpatient recidivism, and overall poorer prognoses (Lehner et al., 2007). The economic impact is enormous, because the effects of untreated mental illness are estimated to cost $100 billion dollars annually (NAMI, 2011). Global costs related to

hospitalizations from medication nonadherence alone have been estimated at 800 million dollars (Weiden & Olfson, 1995).

At the individual level, factors that undermine consumers' motivations to engage in treatment include hopelessness, demoralization, low self-efficacy, lack of choice in important decisions, poor therapeutic alliance, and an absence of clear or personally meaningful goals (Bradshaw, Roseborough, & Armour, 2006; O'Brien et al., 2009; Priebe, Watts, Chase, & Matanov, 2005). In particular, individuals early in the recovery process are more likely to experience pessimism about the future, along with a loss of identity and a feeling of existential emptiness (Andresen, Caputi, & Oades, 2006). This "moratorium" stage of recovery likely involves a high risk for treatment disengagement and nonadherence.

Over the past decade, clinicians and community mental health systems have increasingly addressed these concerns by adopting a recovery model when working with individuals with SMI (Ralph, 2000). The recovery orientation offers an alternative to the biologically based, dichotomous definition of recovery in which symptom remission is the sole criteria for improvement. Recovery-oriented systems of care empower consumers, emphasize the importance of hope, and promote shared decision-making in services (Davidson, Lawless, & Leary, 2005; Mahone, 2004). Consistent with the recovery model, Darlington and Bland (1999) describe a number of hope-enhancing strategies applied by experienced mental health providers: 1) working within the client's frame of reference; 2) focusing on client strengths; 3) acknowledging small gains; 4) making links to past gains; 5) being genuine and accepting, and 6) explicitly communicating hope. According to Darlington and Bland, consumers have also endorsed

the positive value of these approaches, linking them with an increased sense of empowerment and optimism.

Motivational Interviewing (MI; Miller & Rollnick, 2012) is a collaborative, person-centered counseling style designed to elicit and strengthen a person's own motivation for change, an approach that targets all of the areas identified by Darling and Bland. In supporting autonomy, expressing empathy, and empowering clients, MI is naturally aligned with the central principles of the recovery model and self-determination theory (SDT; Deci & Ryan, 2000). The MI counselor attempts to understand the client's frame of reference, clarifies the relationship between current behavior and goals, and supports self-efficacy in order to increase motivation for change. Meta-analyses have suggested that MI is efficacious across a wide range of clinical problems and populations, showing small to moderate effect sizes (Hettema, Steele, & Miller, 2005; Zuckoff & Hettema, 2007; Lundahl, Kunz, Brownell, Tollefson & Burke, 2010). MI has also been highly recommended as a part of comprehensive treatment for individuals with co-occurring psychiatric and substance use disorders (Martino & Moyers, 2008).

Although MI has shown promise in increasing referral engagement and treatment attendance in dually diagnosed individuals (Martino, Carroll, O'Malley, & Rounasville, 2000; Swanson, Pantalon, & Cohen, 1999), empirical evidence is lacking with regard to the specific correlates of change when implemented with this population. It is unknown how MI affects subjective experiences important to recovery, such as hope, self-efficacy, and meaning. Although MI is believed to advance individuals in the stages of change, no studies have examined whether it also can promote forward-movement in recovery stages proposed by Andresen and colleagues (2006). A study that clarifies the relationship

between MI, hope, empowerment, and service engagement promises insight into the optimal conditions for recovery, particularly within the client-provider relationship. It could help providers understand how they can best intervene with demoralized, disempowered clients who struggle with mental illness and substance abuse concerns. This type of research is consistent with the call for increased MI process research to explore possible cognitive and affective mechanisms of change underlying this counseling style (Arkowitz, Miller, Westra, & Rollnick, 2008; Burke, Arkowitz, & Dunn, 2002; Miller & Rollnick, 2004).

Purpose of the Study

Identifying correlates of treatment motivation could inform interventions and guide efforts to involve consumers actively in the recovery process, ultimately leading to improved psychosocial outcomes. To this end, the proposed study will implement a mixed methods, single case experimental design to evaluate the effects of MI on subjective states of hope, empowerment, and meaning in dually diagnosed individuals. It will further explore the potential association between these constructs and treatment participation. Recognizing that hopelessness places consumers at greater risk for adverse outcomes, the current study will attempt to focus on individuals early in their recoveries. This is a point at which consumers may be precontemplative about service participation and especially vulnerable to disengagement with service providers. The current study will also help clarify the extent to which MI improves consumers' sense of subjective well-being (e.g., hope, meaning, self-efficacy), appointment attendance, motivation for treatment, and movement through recovery stages.

Treatment Engagement with Individuals with Serious Mental Illness: Prevalence, Impact, and Definitions

Epidemiological research has demonstrated the importance of targeting treatment engagement and adherence in individuals with serious mental illness (SMI). Almost half of individuals with SMI discontinue treatment prematurely (O'Brien et al., 2009) and nearly a quarter do not attend their scheduled appointments (Nosé et al., 2003). Mojtabai et al. (2009) estimate that, in the United States, at least 40% of actively symptomatic individuals living with schizophrenia have inconsistent contact with needed services. Persons in the early stages of their illness or following discharge from inpatient treatment are particularly likely to separate from care. O'Brien et al. (2009) reviewed 14 studies reporting loss of service contact and found that 11 to 46% of newly diagnosed individuals dropped out of treatment. Appointment failure and aftercare drop-out rates have even ranged as high as 78% post-hospitalization (Klinkenberg & Calsyn, 1996).

Difficulty in defining "disengagement" and "nonadherence" has likely contributed to wide variation in reported rates. Regardless of its definition, treatment nonparticipation is associated with significant increases in the health, social, and financial burdens of individuals living with SMI (Kreyenbuhl et al., 2009; Mojtabai et al., 2009; Stiles et al., 2009). Global costs related to hospitalizations from medication nonadherence alone have been estimated at 800 million dollars (Weiden & Olfson, 1995). Research has correlated reduced service participation with symptom intensification, substance abuse, unemployment, suicidality, high relapse rates, inpatient recidivism, and poorer prognoses (Lehner et al., 2007; Nosé et al., 2003). In contrast, Nosé et al. (2003) have highlighted a number of positive factors associated with treatment adherence,

including fewer psychotic symptoms, better awareness of illness needs, family support, and enhanced social functioning.

It is notable that Nosé and colleagues have defined adherence as entering a treatment program, remaining in treatment, and following professional recommendations. Their definition overlaps with the concept of "compliance" from the medical model of care. Haynes (1979) defined compliance as "the extent to which a person's behavior coincides with medical or health advice" (p. 2). Lehner et al. (2007) point out that most references to treatment adherence in the literature rely on this earlier, more limited description of health behavior. When used in this manner, adherence becomes a static, dichotomous concept that ignores process factors such as therapeutic alliance and shifts in engagement over time. Adherence also implies a passive submission to expert standards.

Clinicians treating SMI populations have traditionally discussed medication nonadherence from this compliance-oriented perspective. In fact, when individuals choose not to take medication as prescribed, researchers refer to their behavior as "partial compliance" (Rummel-Kluge, Schuster, Peters, & Kissling, 2008). Widespread compliance expectations among health care systems are also reflected in how individuals with SMI access services. Pescosolido, Gardner, and Lubell (1998) describe a compliance-like passivity in which consumers "muddle through," meaning they neither actively choose nor resist entering care. Pescosolido and colleagues suggest that, when coerced or acquiescent, consumers are less likely to accept care recommendations, to return for subsequent appointments, or to view the mental health system positively.

Over the past decade, the psychiatric treatment community has increasingly adopted broader definitions of treatment engagement and adherence that recognize the importance of choice. This shift corresponds to a growing acceptance of a holistic, client-centered model of recovery. Mental illness is viewed as a multifaceted, subjective process as opposed to a dichotomous clinical outcome (Davidson et al., 2005; Ralph, 2000). Symptom reduction and restoration of functioning no longer serve as the sole criteria for successful treatment. At a systems level, providers empower mental health consumers, promote shared decision-making, value subjective experiences of mental illness, and foster hope. In studying the recovery process, Ralph (2000) identified a set of key intrapersonal dimensions such as awareness of the illness, determination to recover, and self-management of mental health. Interpersonal factors included social connectedness and support from friends, family, and care providers.

Within the interpersonal recovery domain, engagement has been conceptualized as an early treatment process of trust-building between client and service provider (Dixon, Krauss, Kernan, Lehman & DeForge, 1995). Attendance during the first three sessions may serve as an objective indicator of engagement determined, in part, by the therapeutic alliance (Lehner et al., 2007). Mowbray, Cowen, and Bybee (1993) defined engagement more broadly as a dynamic process that operates throughout treatment, progressing across three stages: initial contact, active treatment, and relapse prevention. Others have also stressed that engagement is more than just “attended appointments”; rather, it is an ongoing, collaborative involvement with providers that supports flexibility of treatment approaches (Hall, Meaden, Smith, & Jones, 2001; O’Brien et al., 2009; Spencer, Birchwood, & McGovern, 2001). Within the recovery framework, Noordsy et

al. (2002) offered an expanded meaning of medication adherence that also included these process-oriented components of engagement. The prescriber participates in education, attends closely to debilitating side-effects, offers choice of medication regimens, and views medication as an adjunctive treatment intended to maximize quality of life.

Operationally, these process-based definitions of engagement often encompass objective indicators of attendance and retention (e.g., appointments kept, overall length of stay in services). In reconciling the medical and rehabilitation models of recovery, objective and subjective descriptions of engagement can complement one another (Davidson et al., 2005). Engagement may best be understood as the result of interacting systemic, interpersonal, and intrapersonal processes that affect the degree of collaborative contact with service providers. Although contact is objectively measurable at discrete points, engagement is a dimensional construct that fluctuates over time. When assessed in quantitative and qualitative modalities, the construct is likely to reflect the ambivalence that individuals with SMI frequently experience when considering whether or not to pursue treatment (Pescosolido et al., 1998).

In this sense, one can understand treatment adherence and engagement as aspects of service participation. In studying impoverished, discouraged individuals with mental illness, Levine (1970) used the term “consumer participation” when advocating for greater client choice in mental health services. She argued that active consumer involvement in treatment planning would increase acceptance, cooperation, and positive outcomes in difficult-to-engage populations. Synonymous with Levine’s definition, shared decision-making (SDT) has become a recent focus of research in medical and psychiatric settings (Adams & Drake, 2006). Charles, Gafni, and Whelan (1997)

described SDT as a collaborative process in which a provider and consumer work together to find a "best fit" between the consumer's personal values or preferences, and the provider's clinical expertise.

Loh et al. (2007) found that this approach improved consumer satisfaction, physician-rated adherence, and consumer-rated involvement in primary care treatment for depression. Joosten et al. (2008) examined 11 randomized controlled trials of SDT, two of which included mentally ill populations. In these two studies, the investigators reported that SDT was associated with improved consumer treatment satisfaction, with lower levels of anxiety and depression, increased adherence to antidepressants at 9 and 12 months, and overall better quality of life. The investigators concluded that SDT has relatively greater benefit for individuals with chronic illnesses. It also benefited individuals involved in treatment programs, those who had more than one contact with a provider, and also those who were making longer-term decisions.

Other efforts to improve consumer-provider communication within an SDT framework have produced similar results, with consumers reporting fewer unmet needs and increased treatment satisfaction up to 1 year post-intervention (Priebe et al., 2007; van Os et al., 2004). These studies suggest a growing empirical connection between client-centered empowering strategies such as SDT, consumer motivation to participate in care, and positive psychological outcomes. Such results corroborate qualitative data indicating that consumers are more likely to disengage from services or reject recommendations when they are not listened to, or are not actively participating in treatment decisions (O'Brien et al., 2009). In general, it appears important to measure

satisfaction whenever consumers receive services, especially during initial contacts with the mental health system.

Early in recovery, negative internal experiences often present significant challenges to engagement and service participation. Non-collaborative care or unsympathetic providers can have a damaging effect on hope and subjective well-being. Individuals in an early stage of recovery are already more likely to experience hopelessness about the future, helplessness, a loss of self, and diminished awareness of personally valued goals (Andresen et al., 2006). During the first six months of treatment, a consumer's sense of disconnectedness and discouragement increases when providers are perceived as rushed, as lacking genuine concern, and as not seeing the "person" behind the illness (Bradshaw et al., 2006). Coincidentally, this period is characterized by a high risk for treatment discontinuation (Tehrani, Krussel, Borg, & Munk-Jorgensen, 1996). These links illustrate how negative interpersonal factors (e.g., poor alliance) and intrapersonal factors (e.g., hopelessness, loss of self) can interact to compromise consumer motivation to participate in services.

The recovery orientation in SMI populations encourages an expanded definition of treatment engagement that emphasizes subjective and process-oriented variables. Actively involving consumers in treatment promises to strengthen autonomy in the recovery process. This type of self-guided change is also one of the core principles of the recovery model (Ralph, 2000). Empowerment efforts such as SDT interventions can complement the model's additional emphases on hope, meaning, and well-being. Together, these factors more accurately reflect the lived experience of SMI and form a pathway for enhancing service participation. Connection with services is not an all-or-

nothing phenomenon, but one that ebbs and flows based on an interaction of individual and environmental variables. Fully understanding service participation in SMI populations requires that researchers and clinicians: 1) evaluate the goodness-of-fit of service system models in relation to recovery principles; 2) clarify the processes, conditions, and client factors which either facilitate or interfere with treatment involvement, and 3) identify efficacious interventions that increase a consumer's readiness to engage with services and providers.

Models of Service Engagement and the Role of Motivation

A variety of factors threaten to reduce a consumer's motivation to participate in services, placing them at greater risk for functional impairment and compromised quality of life. Individuals with SMI who are at risk for treatment drop-out have reported barriers to service engagement that include personal factors (e.g., major life stressors), practical and institutional constraints that limit accessibility, and interpersonal problems with providers (Drapalski, Milford, Goldberg, Brown, & Dixon, 2008). Greater psychopathology severity has also been associated with higher rates of premature treatment termination (Nosé et al., 2003; O'Brien et al., 2009). Other commonly cited reasons for drop-out include a desire for independence (e.g., wanting to solve problems without assistance), expectations that treatment would not help, and a feeling of diminished control related to medication side effects (Kessler et al., 2001; Priebe et al., 2005, Rossi et al., 2008). Collectively and individually, these variables appear to undermine motivation for seeking help. Low motivation also may act as a catalyst to some of these barriers, intensifying negative expectations of the mental health system and

weakening efforts to problem-solve around practical limitations (e.g., transportation, long wait times for providers).

Motivation is a useful construct which indicates specific ways providers can enhance engagement among individuals with SMI. DiClemente, Nidecker, and Bellack (2008) define motivation as a fundamental mechanism underlying an individual's decision to perform (or not perform) a behavior. Discussing this concept in relation to health behavior change, they argue that motivation emerges from an individual's interest or concern about change and perceived need to change, along with his or her goals and intentions. MI therapists develop collaborative, person-centered conversations with clients around these interests. In an atmosphere of compassion and acceptance, they evoke language that actively or passively expresses motivation for change, which in turn guides individuals closer to their goals (Miller & Rollnick, 2012). In addition to being an effective facilitator of change (Hettema et al., 2005; Zuckoff & Hettema, 2007; Lundahl et al., 2010), MI offers an opportunity to study motivational processes at individual and interpersonal levels.

Supporting DiClemente and colleagues' definition of motivation, psycholinguistic research has indicated that clients' change talk during MI typically falls into five categories: Ability, Commitment, Desire, Need, and Reasons for change (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003). Contributing to a clearer picture of motivation, Amrhein et al. (2003) found that the strength of commitment language at the end of sessions best predicted change. Other change talk categories—Ability, Desire, Need, and Reasons for change—directly predicted Commitment, but not behavior change. Studying MI's effects on gambling outcomes, Hodgins, Ching, and McEwen (2009) reported a

similar, uniquely predictive role of commitment language. Other research suggests that "preparatory language" (Desire, Need, Reasons, Ability) can also significantly predict behavior change, particularly Ability and Reasons in the domain of substance abuse (Baer et al., 2008; Gaume, Gmel, & Daeppen, 2008; Martin, Christopher, Houck, & Moyers, 2011).

These findings suggest that for some people, motivation to change behavior increases as they become more clearly aware of its personal importance and of their resources to succeed, which subsequently culminates in commitment. For others, the preparation phase may not be so critical a factor as is the act of making a decision and committing oneself to it. This echoes the observation that change for some people may occur quite suddenly and emerge from some underlying cognitive or affective experience, such as realizing that one's values conflict with current behavior (Miller & Rollnick, 2004; Miller & C'de Baca, 2001; Miller & Rose, 2009). As Martin et al. (2011) point out, these contradictory psycholinguistic findings also suggest that clinicians might not need to discriminate so carefully between types of change talk during MI sessions, at least during initial contacts.

Regardless of whether two distinct, consecutive phases of therapeutic change (preparation and commitment) exist, as proposed by Miller and Rollnick (2002), none of the aforementioned studies explain how commitment or preparatory language would *cause* change. Miller and Rollnick (2004) note that commitment or preparatory talk may signify underlying processes that drive behavioral change. For instance, with regard to individuals in recovery, feelings of hopefulness, connectedness with the provider, and sense of purpose could emerge along with more observable increases in Desire, Ability,

and Commitment language during MI. Limited empirical research exists with regard to the role of positive emotions in MI, but conceptually, they seem to constitute an important factor when considering motivation.

Fredrickson and Joiner (2002) have found evidence that positive emotions such as hope, connectedness, and meaning predict broadened cognitive perspectives and more flexible problem-solving. These findings support Fredrickson's (2001) "broaden-and-build" theory, which states those positive emotions, broader thinking, and positive meaning strengthen one another in a reciprocal relationship, allowing individuals to build psychological resiliency. For consumers early in recovery, MI may trigger movement from stagnation to increased engagement in recovery activities through this cognitive-affective "upward spiral" (Fredrickson & Joiner, 2002, p. 172). It makes sense that conversation around meaning, self-efficacy, and social support would stimulate positive affect. Wagner and Ingersoll (2008) have argued that MI's motivation-enhancing effects are, in large part, due to the reinforcing qualities of positive emotional states themselves. They describe MI principles outlined in Miller and Rollnick's (2002) earlier framework as natural conduits for feelings of safety and calmness (*expressing empathy*), self-acceptance (*rolling with resistance*), interest and curiosity (*developing discrepancy*), and hope (*supporting self-efficacy*). In his qualitative work, Zuckoff (2001) has reported these emotions, in turn, can foster openness to exploring change and growth, a process that may result in greater clarity about one's core values.

Other factors may moderate the strength of preparatory and commitment language, including sense of responsibility, illness awareness, external incentives, and availability of resources. In addition, for people in recovery, specific subjective

experiences such as hope may have a set of corresponding beliefs, assumptions, and emotions. When activated through MI, these phenomena may increase the likelihood of commitment or preparatory language and subsequently lead to behavioral change. Feelings of confidence may bring their own sets of beliefs and assumptions that contribute to growth-oriented thought-action tendencies. Overall increases in cognitive flexibility, as proposed in the Fredrickson model, could be considered a byproduct of specific, positive cognitive-affective pathways becoming active through MI.

The cognitive component of motivation, in general, has received a great amount of attention in theoretical discussions. Bandura (1994) hypothesized that motivation is primarily cognitive in nature, consisting of causal attributions, outcome expectancies, goal-related cognitions, and perceived self-efficacy (or beliefs about what the person can do). From this perspective, motivation is understood more clearly as an individual characteristic rather than an interpersonal one, a mechanism residing with the person and determined by intraindividual processes.

Cognitive pathways and the Health Belief Model. Although it does not explicitly address motivation, the Health Belief Model (HBM; Rosenstock, 1966; Stretcher, Champion, & Rosenstock, 1997) incorporates motivation-related cognitive variables to explain treatment-seeking behavior. According to the HBM, three main beliefs increase the likelihood of undertaking positive health-related action: 1) an illness significantly threatens one's well-being; 2) personal action can reduce the threat, and 3) few or insubstantial impediments exist to taking action. Similar to Bandura's (1994) concept of self-efficacy, whether or not someone decides to follow treatment recommendations depends on the value placed on a particular treatment goal and the person's estimate of

success in achieving that goal. In the HBM model, demographic, social, environmental, and psychological variables are thought to affect health actions indirectly. They exert their influences through one's subjective health perceptions. Thus, within the HBM framework, motivation is a cognitively determined mediator of health behavior change.

DiClemente et al. (2008) questioned whether motivation in dually diagnosed consumers operates primarily by the cognitive pathways proposed by Bandura. Cognitive impairments, limited awareness of illness, and disruptions of planning processes suggest that motivation may not function in expected ways within this population. Bellack and DiClemente (1999) speculated that behavior change among consumers may depend more on extrinsic motivation or external rewards, seem less intentional, and proceed in a haphazard fashion. Other research, however, indicates that dually diagnosed consumers' readiness for behavior change involves a decision-making process (e.g., considering pros and cons) that does not differ significantly from that observed in substance abusing individuals without SMI (Hagedorn, 2000; Nidecker, DiClemente, Bennett, & Bellack, 2008; Velasquez, Carbonari, & DiClemente, 1999).

MI may increase motivation through multiple cognitive pathways that include those proposed by Bandura and the HBM. When a client elaborates on reasons for change, this may tip the cognitive balance in favor of change. Bem's (1972) self-perception theory highlights the importance of client speech to this type of attitude formation. Observations that people become more committed to positions for which they voice support suggest that people discover and formulate their attitudes about change by listening to what they say. MI could be described as shaping a client's cognitive set in

the direction of making a change by increasing change talk relative to statements in favor of the status quo.

Another related perspective on the reasons why people change in MI involves self-regulation mechanisms that guide goal-directed activities (Karoly, 1993). One mechanism is self-monitoring behavior for discrepancies between ideal behavior and current behavior. Once a discrepancy is identified, individuals then initiate action to bring current behavior closer to the ideal. A key principle in MI involves reflecting the discrepancy between a problematic behavior, such as alcohol abuse, and an incompatible core value (Miller & Rollnick, 2012). To explain why individuals would choose to change the behavior, Rokeach's (1973) theory of value-driven change posits that behaviors or beliefs stemming from peripheral values are more likely to change when coming into conflict with more central values. It is possible that enhanced awareness of these value-behavior inconsistencies through MI facilitates important shifts in a client's intention to change. Change talk may signify a growing intention to reduce discrepancy as the client moves closer to action.

As mentioned previously, change talk elicited during MI has predicted positive clinical outcomes, whereas counter-change talk has been associated with negative outcomes (Moyers et al., 2007; Moyers, Martin, Houck, Christopher, & Tonigan, 2009). Specifically, in their study of 63 taped sessions of motivational enhancement therapy (MET), Moyers and colleagues found that client change talk has predicted reduced frequency of drinking. Change talk was also a mediator between MI-consistent therapist behaviors and drinking outcomes, accounting for approximately 30% of the effect. In an earlier study of initial MI sessions, Moyers et al. (2007) found that counterchange talk

significantly predicted self-reported days abstinent from alcohol, and that both change talk and counterchange talk predicted average number of drinks per day in the expected directions. Overall, client language (both for and against change) accounted for a substantial 34% of variance in average number of drinks per day. Additionally, MI-consistent behaviors (affirming, asking permission to give advice, emphasizing personal control) predicted an increased likelihood of change talk, which attests to a causal chain. The effect on outcomes extended up to 15 months after that initial session and across treatment modalities, indicating the robustness and spread of MI's effect.

Further supporting this causal chain, Apodaca and Longabaugh (2009) reported a medium effect size of MI-consistent therapist behaviors (e.g., reflection, empathy, open questions) on change talk and a somewhat smaller direct effect on improved outcomes. These particular findings should be considered with caution due to a lack of distinction between self-report and observational measures. As a whole, considering the corroborative work of Moyers and colleagues, this line of research suggests that what clients say in sessions matters greatly. In terms of self-perception theory, one might be more inclined to hypothesize a connection between verbal expressions about change and cognitive components of motivation (e.g., the formation of attitudes and beliefs about change). The work of Moyers and others points to the added importance of the interpersonal interaction within this chain, supporting the use of MI behaviors as opposed to confrontation and arguing.

Bem's self-perception theory, Fredrickson's broaden-and-build theory, and Rokeach's personal values theory are not mutually exclusive explanations of motivational processes. Attitude consolidation through speech, emotion-driven cognitive broadening,

heightened awareness of value-behavior conflicts, and the reinforcing properties of positive emotions could all contribute to MI's mechanisms of action, albeit at different times. Although these processes may operate less predictably among dually diagnosed consumers, it would be important to increase the systematic measurement of cognitive-affective experiences in MI that run throughout these hypothesized pathways.

Autonomy, motivation, and MI. Deci and Ryan (1980) made a further distinction between *intrinsic* and *extrinsic* motivation. Intrinsically motivated behavior is autonomous and self-regulated, with incentives that often come from aspects of the behavior itself. Extrinsically motivated behavior is determined by the rewards and punishments that others might control. Motivation can be thought of as the sum of intrinsic and extrinsic motivational forces; however, Deci and Ryan (2000) have argued that autonomous, intrinsically motivated behavior endures longer and exerts a more positive influence on subjective well-being. Their view is important because it highlights the connection between motivation and autonomy, a core principle of the recovery model. Their model also points to the role of positive or negative environmental contingencies in influencing decisions, which may include the quality of the therapeutic alliance. Supporting client autonomy is a central feature of MI spirit (Miller & Rollnick, 2012), an ingredient in the client-counselor relationship that may help build intrinsic motivation as conceptualized by Deci and Ryan.

Research on MI's mechanisms of action suggests that MI spirit may play a significant role in influencing motivation and behavior change. The recently expanded definition of spirit by Miller and Rollnick (2012) describes an interpersonal atmosphere which includes partnership, acceptance, compassion, and evocation. An MI therapist

who conveys acceptance expresses accurate empathy and sends a message that the client has unconditional worth. Affirming strengths and supporting autonomy also contributes to a person-centered climate in which an individual is less likely to feel pressured into change. In an adolescent sample, McCambridge, Day, Thomas, and Strang (2011) found that MI spirit predicted cannabis cessation 3 months after a brief MI intervention. Similarly, Gaume, Gmel, Faouzi, and Daeppen (2009) reported a significant association between global MI spirit and improved drinking outcomes at 12 months. Use of complex reflections, or reflections of client speech that add meaning to what was said, also predicted positive change in both studies.

Based on similar findings, Moyers et al. (2009) stated that MI practices of reflecting change talk, asking evocative questions, and emphasizing choice are critical to improving outcomes, and other work has pointed to the gestalt of MI spirit as equally important (Gaume et al., 2009; c.f. Miller & Rose, 2009). Of particular interest, Gaume et al. (2009) found that MI spirit and acceptance significantly strengthened the link between perceived ability to change and alcohol use outcomes. One possible interpretation is that the autonomy-supporting component of MI spirit acts as a catalyst to self-efficacy perceptions and self-directed change. Specifically, supporting autonomy around intrinsically meaningful goals may further a consumer's progression toward change by lowering resistance, leading to a more open exploration of available personal resources to obtain those goals.

In the context of helping relationships, Moyers and Rollnick (2002) have discussed resistance as a state that fluctuates based on two variables: resistance to change that the client brings to the session and the counselor's response to expressions of that

resistance. Responses involving confrontation or persuasion tend to increase resistance. The client may become less ready to change the behavior and may even verbalize a more intransigent position with regard to change. Over the past decade, Miller and Rollnick (2012) have moved away from the pathologizing label of "resistance." They instead define the phenomena as sustain talk, discord, or some combination of the two. Sustain talk is language supporting the status quo, often a normal part of the change process. Discord refers to a fracture in therapeutic relationship that can manifest as arguing, confrontation, blaming, interruption, or disengagement. Discord can foment sustain talk and the two may be intertwined.

Both discord and sustain talk can arise when the therapist infringes on a client's autonomy. Brehm and Brehm (1981) described this phenomenon as *reactance*, the drive to restore one's freedom of choice and self-direction in the face of external control. As Zuckoff (2001) observed in his qualitative work, reactance may emerge as strongly from perceived negative judgments as it does from the fear of losing control. He explains that efforts to direct an individual's behavior in a particular direction may imply a negative view of that person's current actions, and even serve as an indictment of the person. It makes sense then that the individual would vigorously defend against threats to self-worth and autonomy through discordant language or behavior. Alternatively, Miller (1983) observed that when providers communicate empathy, empower clients as the main voices of change, support their self-efficacy, and present a nonjudgmental, noncoercive interaction style, opposition to change typically decreases.

Although several MI strategies can be used to address discord, emphasizing personal choice and control is a critical one, because it most directly protects and

supports the client's freedom of choice. Notably, the collaborative, autonomy-supporting spirit of MI is synonymous with the recovery model's call for self-directed, participatory care among individuals with SMI. For individuals with SMI who are considering disengaging from treatment, perhaps as a result of previous coercive, unempathic provider experiences, the approach described by Moyers and Rollnick (2002) seems appropriate. They recommend conveying empathy with the difficulty of the choice, expressing confidence in the consumer's ability to choose wisely, focusing on choices the consumer has, and highlighting any discrepancy between the consumer's values and potential discomfort with the decision.

System-level determinants of motivation and integrative models. It is certainly possible that psychological reactance, understood in the past as "noncompliance," arises as a result of a coercive mental health system that mandates treatment. At a systems level, such disempowering provider attitudes (Corrigan, 2004), limited availability of services (McCarthy et al., 2007), care expense or lack of insurance coverage (Busby & Sajatovic, 2010), and difficulties accessing services (resource-wise or geographically) can lower motivation for service involvement. In a VA population, Drapalski et al. (2008) noted that 21% of consumers reported provider or institutional barriers as reasons for not engaging in treatment. These barriers included length of time to get care, being refused services, and not being given an appointment. In addition to long waits, the depressing or dingy clinic atmospheres can contribute to aversive treatment experiences that discourage future contact (Corrigan, Liberman, & Engel, 1990).

Unmet needs among individuals with SMI also result from discontinuities in treatment. These include high provider turn-over and provision of inadequate care due to managed care constraints (Motjabai et al., 2009). Consumers early in the stage of recovery have pointed out feeling more "unknown" and confused as a result of having multiple, inconsistent providers who see them for brief periods of time (Bradshaw et al., 2006). In their reviews of first-person accounts, Kirkpatrick et al. (1995) described how these negative experiences with the healthcare system can lead consumers to feel more hopeless. Hopelessness is a central feature of demoralization, a broader phenomenon observed in psychiatric populations that includes feelings of "impotence, isolation, and despair" (Frank, 1974, p. 271). It is often accompanied by the inhibition of action (Clarke & Kissane, 2002).

Although it does not specifically address systemic variables, the Interaction Model of Client Health Behavior (IMCHB; Cox, 1982) is one of the most integrative models of service engagement. The IMCHB framework includes both intrapersonal and interpersonal definitions of motivation, assigning equally important roles to individual characteristics and to client-provider relationship variables in determining health outcomes. Aligned with recovery principles, the IMCHB model assumes that clients are autonomous individuals with the ability to make informed, competent decisions. It stipulates, therefore, that clients should receive as much control as possible over healthcare decisions. The model proposes that a number of distal individual dimensions affect readiness to engage in services: sociodemographic variables (e.g., age, gender, ethnicity), social influence (e.g., housing, marital status, occupation), previous healthcare experience, and environmental resources. These factors influence cognitive appraisals

and affective responses, which more proximally determine intrinsic motivation for service engagement.

According to the IMCHB model, four elements of client-provider interaction also modulate intrinsic motivation: affective support, health information, decisional control (e.g., via participation in decisions with providers), and professional competence. These interpersonal variables are thought to alter an individual's cognitive and affective responses to providers, whose subsequent reactions either facilitate or weaken intrinsic motivation. There is likely an observable net effect on health outcomes such as utilization of healthcare services, satisfaction with care, and adherence to professional recommendations. Mahone (2004) discussed the IMCHB model as a useful client-centered framework for guiding decisions around medication-taking in persons with SMI. The model is applicable to overall service participation as well as to medication decisions, as it emphasizes the consumer's personal goals, values, and preferences while focusing on motivation level. This approach promises to increase quality of life among individuals with SMI in that it encourages active care involvement and facilitates greater satisfaction. Both are primary considerations in collaborative treatment planning.

Within the IMCHB, HBM, and system-based frameworks, motivation is an important factor underlying observable health and treatment-seeking behaviors. Treatment engagement is influenced by interacting interpersonal and intrapersonal factors, many of which are addressed by recovery-consistent MI behaviors: expressing empathy, honoring autonomy, supporting self-efficacy, and developing discrepancy (Miller & Rollnick, 2002). With regard to individuals with co-occurring disorders, readiness to engage in services has also been acknowledged as an important target of

integrated psychosocial treatment (Drake, O'Neal, & Wallach, 2008). Integrated dual diagnosis programs pay attention to treatment motivation and stage of change as a part of creating flexible, individualized treatment plans, often incorporating MI (Drake, Bartel, Teague, & Noordsy, 1993; Mueser, Noordy, Drake, and Fox, 2003). In addition, these programs take into account practical barriers such as housing, occupational, and financial difficulties.

This comprehensive approach has resulted in reduced hospitalizations, greater treatment participation, decreased substance use, improvement on quality of life measures, and reduced legal involvement (Mangrum, Spence, & Lopez, 2006; Mueser et al., 2003; Judd, Thoms, Schwartz, Outcalt, & Hough, 2003). In addition to providing greater consistency in services, integrated programs embrace individualization of services and champion the recovery principles of autonomy, self-worth, and empowerment. As a whole, this approach may help build intrinsic motivation for recovery activity for dually diagnosed individuals. Integrated programs also view recovery as a gradual process, requiring different interventions at different stages.

Stages of Change and Stages of Recovery: Implications for Service Participation

The transtheoretical model of change (TTM; Prochaska & DiClemente, 1983) is a widely adopted model for understanding change processes, proposing a series of stages that people pass through as they modify a behavior. The TTM does not assume that a decision to change is a single, dichotomous "yes or no" event, but states that a person moves through various levels of considering (or not considering) the change before enacting it. Even after enacting the change, people may experience different degrees of commitment and ambivalence about maintaining a new behavior (Miller & Rollnick,

2012). Resolving ambivalence appears to be one key ingredient in helping move people forward through the TTM stages, although this ambivalence may resurface at any point.

Miller and Rollnick (2009) make the distinction that MI is not based on the TTM, but state that the model provides a useful way for clinicians to think about helping people change. For instance, gauging change readiness in dually diagnosed individuals may help clinicians determine appropriate interventions. These may include help with practical barriers, harm reduction groups, or skill-building strategies (Little, Hodari, Lavender, & Berg, 2008; Osher & Kofoed, 1989). Bouis et al. (2007) observed that many triply diagnosed clients entered treatment with little readiness to change their substance use. Informed by the TTM, the researchers focused initial sessions on need-identification, trust-building, and conveying a nonjudgmental attitude.

In the TTM, precontemplation is marked by an absence of change consideration, or even a denial that change is necessary. Freeman and Dolan (2001) have further distinguished these as noncontemplation and anticontemplation stages. The next stage, contemplation, is characterized by a willingness to evaluate the arguments for and against change. Contemplators have not yet decided to make a change, but have recognized the potential need for it and are actively weighing the pros and cons. In the preparation stage, planning for the change has begun and commitment is consolidated. One might even observe small action steps toward the goal, or perusal through a menu of options. The action stage describes people who are centrally engaged in modifying their behavior, although they may still feel conflicted about their decision (DiClemente & Velasquez, 2002). The final stage is maintenance during which people work to sustain long-term change. Freeman and Dolan (2001) added that at any point in the action phase, a lapse or

relapse (e.g., return to a less committed, contemplative, or precontemplative state) may occur.

Progression through these stages is measurable (Rollnick, Heather, Gold, & Hall, 1992) and has garnered empirical support in the health behavior literature (see Whitelaw, Baldwin, Bunton, & Flynn, 2000 for a review). It likely occurs regardless of intervention type. With regard to individuals with SMI, the TTM stages have correlated with self-efficacy and perceived benefits of exercise in the expected direction, with increases on both measures as participants moved from preparation to later stages (Gorczynki, Faulkner, Greening, & Cohn, 2010). Other research has found little empirical evidence for the effectiveness of interventions based on stages of change, with a majority of trials showing mixed effects or non-significant results in comparison with non-stage-based interventions (Bridle et al., 2005). Bridle and colleagues attribute this finding primarily to poor model application and specificity. It bears noting that only one study in their review addressed treatment engagement.

West (2005) and Sutton (2001, 2005) have expressed similar concerns regarding TTM's validity. Sutton has vigorously challenged the model, particularly in addictions work, where he asserts that "stage effects" do not provide strong evidence for a stage model. Stage effects refer to the observations that those in a baseline contemplation or preparation stage are more likely to be in an action stage after treatment, relative to those who begin in a precontemplative stage. Sutton argues that an arbitrary, three-level categorization of intention to change might produce the same results, undermining any stage-specific inferences. In support of this argument, some research has indicated that rulers using a single continuous scale of readiness have excellent predictive validity, and

may even outperform stage model measures (Hogue, Dauber, & Morgenstern, 2010; LaBrie, Quinlan, Schiffman, and Earleywine, 2005) Still, Sutton does acknowledge that stage measures have a practical value, in agreement with others who support TTM as a clinical tool (Hodgins, 2005).

Ultimately, the paucity of empirical support for the TTM may indicate that, at times, a given stage includes characteristics of other stages, making it less discrete, unstable over time, and harder to operationalize and measure. This idea follows from the observation that change talk in MI sessions can be embedded within counter-change talk (Moyers et al., 2009). Moyers and colleagues refer to this as a "change-talk sandwich," a rapid flipping back-and-forth between arguments for and against change.

TTM, MI, and relevance to recovery process. Miller and Rollnick (2009) deem it unnecessary to assign individuals to a specific stage of change during or before MI to achieve positive outcomes. Supporting this assertion, some studies have found no significant predictive links between change readiness and substance use outcomes (Collins, Logan, & Neighbors, 2010; Gossop, Stewart, & Marsden, 2007). Hallgren and Moyers (2011) also found no consistent relationship between baseline stage of change and change talk within initial MI sessions. One might have expected that individuals in the contemplation stage would express more preparatory change talk, in comparison with those in a preparation or action phase, but this was not the case. Overall readiness levels were not associated with increased frequency of change talk either. Moyers and Hallgren speculate that change talk during MI or other cognitive-affective experiences may influence readiness to change, which would help explain the lack of a predictive relationship.

The possible independence of readiness and change talk does not negate the clinical utility of the TTM. This model may be more relevant in the context of services delivered within a recovery orientation where contrasts between the stages may be more discernable. For the MI counselor, the overarching message from the TTM is that different strategies are appropriate when clients express low change readiness versus high change readiness. When working with those who express sustain talk, those who might be categorized as "precontemplators," MI counselors would seek to raise problem awareness, highlight conflicts between current behavior and personally desirable goals or values, and help clients resolve ambivalence about taking action.

Decisional balance is one MI strategy for eliciting change talk when people are offering few arguments for change, a technique which can open the door for pro-change talk and promote engagement (Miller & Rollnick, 2009). As a person moves through the TTM stages, the pros of change theoretically should strengthen and arguments against it weaken (Miller, 2008). MI seeks to achieve and maintain this unbalanced ratio, during which the counselor helps the client elaborate on perceived advantages as opposed to reasons against change. Miller states that there is no empirically justified reason to explore a counterchange argument in decisional balance, because that would tip the person away from change. However, it makes sense that the counterchange side of the exercise would become helpful when encountering discord and sustain talk. Discussions around reasons *not* to change could help clients feel better understood.

Corrigan, McCracken, and Holmes (2001) endorsed a decisional balance approach to goal assessment in individuals with SMI. Whereas previous methods of goal identification in the recovery process prompted "yes or no" answers to goal-pursuit

questions, decisional balance allows a full elaboration of the client's arguments for and against change. The empathic validation of both sides can also help consumers feel more understood and valued. Corrigan and colleagues view the TTM as a useful model in explaining the reason why some consumers are ready to pursue certain goals (e.g., live independently, look for a job), yet others are not. They framed low readiness and precontemplation as resulting from too many costs associated with the proposed change, resulting in nonparticipation in recovery activities. However, a consumer who is not ready to live independent may feel ready to look for a job. Thus, the authors recommended that "rehabilitation readiness" be assessed in terms of what the consumer specifically is ready to do, as opposed to overall treatment preparedness. They suggested that listing costs and benefits can be especially helpful for consumers with cognitive impairments and disorganization. At the same time, the authors warned that common motivators may not work as well during the pro-change side of the decisional balance exercise.

In part, it appears that MI builds intrinsic motivation by evoking change talk and resolving ambivalence, but other pathways may be involved with dually diagnosed individuals. Rusch and Corrigan (2002) propose that MI can also improve one's awareness of illness. When enhancing engagement among dually diagnosed individuals, Zuckoff and Daley (2001) have described this aspect of motivation as "problem acceptance." For instance, when consumers are invited to discuss personal views about *not* having an illness, and the impact these views have on their lives (both positive and negative), the opportunity arises to develop discrepancy between their values and goals. A consumer may realize that frequent arguments with family about treatment may

conflict with the deeper value of having supportive family relationships. As a result, acknowledging the real impact of the illness may become more likely. However, as Zuckoff and Daley (2001) point out, "treatment acceptance" or readiness to accept help is a separate motivational dimension that influences whether individuals will seek services.

In reviewing research on the TTM, DiClemente and Velasquez (2002) concluded that insight-raising processes related to personal values and identity are more important in the earlier stages of change (precontemplative and contemplative). As outlined by Miller and Rollnick (2002), earlier stages typically call for increasing motivation for change by underscoring values-goals discrepancies and eliciting personal perspectives. Problem-solving and self-efficacy discussions typically occupy a more prominent role in later stages (preparation, action, and maintenance), and correspond more closely to MI's use in the planning process (Miller & Rollnick, 2012). Zuckoff and Daley (2001), however, argue that low self-efficacy can inhibit both problem acceptance and help-seeking behavior in dually diagnosed individuals, and therefore, may be particularly important to address in earlier MI processes (e.g., engagement and evoking). One might argue that building discrepancy and supporting self-efficacy are two critical MI principles that work hand-in-hand as people advance in stage of change. Aspects of the TTM, and related components of MI, are also reflected in a stage model of recovery (STOR; Andresen et al., 2006; Andresen, Oades, & Caputi, 2003).

Comparing TTM and STOR. Andresen et al. (2003) qualitatively analyzed recovery accounts of individuals with SMI and identified four core processes: 1) finding and maintaining hope; 2) the reestablishment of a positive identity; 3) finding meaning in life; and 4) taking responsibility for one's life. These processes are not stage-specific, but

refer to the psychological states of someone progressing toward greater well-being and functioning. These processes are embedded in five stages. *Moratorium*, Stage 1, is a period of loss, helplessness, and hopelessness. In *Awareness*, Stage 2, one sees the possibility of a fulfilling life. *Preparation*, Stage 3, describes individuals making early efforts to develop their coping skills. *Rebuilding*, Stage 4, signifies actively working toward meaningful goals. *Growth*, Stage 5, is marked by resiliency, a positive sense of self, and self-management of illness.

Andresen and colleagues (2006) developed a holistic self-report measure called the Stages of Recovery Instrument (STORI) that assesses where an individual is in terms of his or her recovery. Early factor analysis research with the STORI has provided empirical support for the differentiation between Stage 1, Stage 5, and a grouping of Stages 2-4. It seems that hopelessness and stagnation, preparation to engage in recovery, and active engagement in recovery-related activities represent the most distinct levels in the model.

One finds close conceptual parallels between TTM stages and stages of recovery (STOR). In the Moratorium stage in STOR and Precontemplation stage in TTM, individuals are the furthest away from change. From the recovery perspective, Moratorium involves a sense of hopelessness or helplessness that stymies active participation in one's care, corresponding to disengagement from services. Similarly, DiClemente and Velasquez (2002) identify "resigned precontemplators" as lacking energy, feeling overwhelmed by a problem, or having given up on the possibility of change. The authors suggested that instilling hope and exploring barriers to change are the most helpful strategies for these clients. Awareness (Stage 2 of STOR) mirrors

elements of Contemplation, a stage in which the person struggles to make sense of the illness, weighing personal strengths and weaknesses. At this stage, the desire to care better for oneself arises along with a developing sense of direction, hope, and identity apart from illness. Similarly, contemplators in the TTM are more hopeful and exhibit a greater openness to new information or coping strategies. However, they have not made any firm decisions and frequently vacillate between courses of action.

The third STORI stage, Preparation, carries the same name and a similar connotation in both models. With respect to recovery, an individual turns hope into a plan for action, identifies desirable goals, learns coping strategies, and nurtures an emerging new identity. In the TTM, most people in this stage will make a concerted effort to change in the near future. They may also view the past as a repository of useful learning experiences. Both Rebuilding (Stage 4 of STOR) and the Action stage of TTM describe individuals who have taken active responsibility for their lives, displaying commitment to meaningful change. In this stage, individuals with SMI are willing to take more risks, redefine who they are, and put their new confidence into use. In many respects, Growth (Stage 5 of STOR) and the Maintenance stage of TTM diverge. The Growth stage is a continuing culmination of optimism, well-being, meaning, resilience, and control over life. The TTM defines Maintenance, on the other hand, as actively sustaining changes already made. It seems true, however, that people in both the Growth stage of recovery and Maintenance stage of change are working to consolidate their progress. They practice new skills until those skills become more automatic, seeking opportunities to reinforce their confidence. Over time, positive changes in identity become more stable.

As Andresen et al. (2006) point out, a key difference between the TTM and STOR models is that the TTM focuses on change for a specific behavior. In contrast, the STOR model addresses the holistic experience of recovering from SMI without isolating any one particular behavioral outcome. Nevertheless, the models can be viewed from an integrative perspective. One might argue that behavior-specific TTM stages are nested within broader recovery stages. For instance, a consumer thinking about socializing more frequently may be in the Precontemplation stage about taking medication consistently. The same individual may be in the broader STOR Rebuilding stage in terms of independent living and goal-setting. Although the empirical basis of the TTM and STOR models are limited, they appear to be valuable clinical and conceptual guides which can help providers refine their understanding of how individuals with dual diagnoses achieve a greater sense of fulfillment and well-being..

Understanding the TTM and STOR models can guide the implementation of MI with dually diagnosed individuals, directing the counselor's attention to different points of emphasis for different treatment-related behaviors. Some consumers, for instance, may resist any implication that mental health problems affect them, but they express a high level of readiness to stop using substances (Zuckoff & Daley, 2001). This contrast would dictate that the MI therapist continue building discrepancy around mental health treatment (Precontemplation strategy), while engaging in planning or "overcoming barriers" discussions with regard to abstinence (Preparation/Action strategy). In the framework proposed by Miller and Rollnick (2012), this example illustrates working within two different MI processes, Evoking and Planning, depending on the change target.

Handmaker, Packard, and Conforti (2002) discussed an innovative outpatient treatment program for consumers that targeted different levels of readiness for different problem areas. For example, a consumer could participate both in an action planning group around preventing substance use relapse and a "talk about change" group that addressed ambivalence about entering a supportive housing program. The program also incorporated a recovery perspective into treatment, expecting that motivation for change would fluctuate, depending on a number of interacting personal and environmental factors. With the assistance of counselor feedback, consumers could identify and move among drop-in groups that best fit their current levels of motivation. Both the TTM and STOR models stipulate that stage progression may occur in a non-linear fashion, accounting for lapses, relapses, and moving backward to less change-ready states. The stage-matched drop-in groups appeared to take this factor into consideration. Although a promising approach, no empirical results of stage-matched interventions in SMI populations have been published.

Becoming more ready, willing, and able to change specific behaviors (e.g., advancing from Precontemplation to Action) would appear to confer many of the same positive subjective experiences found in an individual's movement through recovery. As effective behaviors increase across life domains, one would expect accompanying increases in hope, confidence, and self-worth. One might also observe greater congruence between one's personal values and actions. As with stage-matched interventions, research has yet to test this assertion empirically. With specific regard to service participation, Handmaker and colleagues (2002) recommended that motivational interventions with dually diagnosed individuals include the following key ingredients: 1)

affirming/eliciting awareness of the problems and the need for help; 2) exploring reasons for not using services; 3) using decisional balance exercises for elaborating costs and benefits of treatment; 4) exploring personal agency in improving; and 5) collaboratively discussing treatment options.

MI, Self-Determination Theory, and the Recovery Model

Although Miller (1983) initially proposed MI as a pragmatic, atheoretical approach to facilitate change, self-determination theory (SDT; Deci & Ryan, 1985; Deci & Ryan, 2000) helps to explain the reasons why MI would be an effective strategy in building motivation and helping individuals increase change readiness. The tenets of SDT overlap with key recovery principles, providing a theoretical foundation for understanding the ways in which MI's client-centered style can support the recovery process. In the recovery literature, self-determination refers to a client's ability to make choices freely, without coercion (Sprague & Hayes, 2000). These choices are based on personal preferences, values, desires, and needs. As elaborated by Deci and Ryan (2000), SDT presents a more comprehensive framework for understanding motivation and personal growth.

SDT proposes that individuals have an innate drive toward positive growth, fulfillment, and self-integration, a concept similar to the self-actualizing tendencies described by Carl Rogers (1961) and Abraham Maslow (1962). Deci and Ryan (2000) suggest that the psychological needs for competence, relatedness, and autonomy contribute to this drive in all human beings. The need for competence leads people to seek mastery over their environments and develop skills necessary to adapt to its challenges. Satisfying this need involves actively seeking out challenges to build one's

skill repertoire. The need for relatedness explains the tendency for people to pursue close relationships with others, as well as to seek a sense of belongingness and acceptance. High levels of relatedness may help protect against stressors and life's difficulties. When satisfied, the need for autonomy optimizes well-being by providing choice with respect to one's actions and decisions. According to the authors, people feel that they can better coordinate thoughts and actions with desired goals when autonomy is maximized. While there is an underlying assumption that individuals have goals, or are aware of their values, this may not always be the case for individuals in recovery.

The need for autonomy occupies a prominent role in SDT. The theory itself arose out of research into the autonomous regulation of behavior. Within the SDT framework, freely chosen behavior is viewed as more stable, enduring, and beneficial to one's well-being, in comparison with coerced or controlled behavior. Autonomous self-regulation of behavior exists to different degrees, depending on external contingencies (e.g., punishments and rewards). Internal factors that may include "self-esteem related contingencies" (Markland, Ryan, Tobin, & Rollnick, 2005, p. 816) also affect the degree of autonomous regulation. These contingencies involve self-imposed pressure or criticism for failing and praise for succeeding. Motivation is thought to result from both internal and external factors, but because the internal dimension involves one's personal identification with the behavior's value, it likely plays a more central role in maintaining the behavior (Deci & Ryan, 2000). This difference, in part, illustrates an important distinction between intrinsically and extrinsically motivated behaviors. MI focuses primarily on factors leading to enhanced intrinsic motivation, encompassing the three primary needs proposed by SDT. In comparing SDT with MI, very similar pathways

emerge for enhancing client motivation and structuring treatment (Britton, Patrick, Wenzel, & Williams, 2011; Markland et al., 2005; Vansteenkiste & Sheldon, 2006). SDT also overlaps with principles of recovery-oriented systems of care, particularly with regard to the essential factors of social support, self-agency, and treatment choice among individuals diagnosed with SMI (Mancini, 2008).

The role of values in MI and SDT. Both MI and SDT emphasize personal values as important determinants of motivation. Within SDT, *introjected regulation* refers to a partial identification with the value, in which the person continues to experience ambivalence about the behavior associated with the value. He or she may feel a conflict between self-imposed demands (e.g., "I should do this") and lukewarm desire (e.g., "It's only somewhat important to me"). Self-esteem related contingencies are prominent in this state. *Identification*, on the other hand, describes a more complete acceptance of the behavior's value, providing added incentive for commitment and effort on behalf of that behavior. External contingencies or regulations, on the other hand, may or may not be consistent with one's fully accepted behavioral value. SDT proposes that high external contingency-value consistency leads to a state of *integrated regulation*. Like *identification*, this more highly autonomous state is also associated with increasingly stable, self-endorsed, persistent courses of action. A large body of research has supported the connection between autonomously regulated behavior and positive outcomes across a variety of life domains, including education, sports, work, and health self-management (see Deci & Ryan, 2000 for a review).

As Miller (2008) explains, MI's focus on values brings what is most important to the forefront of a person's awareness. Values discussions can increase clarity regarding

goals and actions that serve those values. Although the attractiveness of healthy, value-consistent behaviors may grow, Miller argues that it also helps individuals achieve a broader sense of personal integrity. A feeling of satisfaction quite possibly comes from living consistently with self-chosen principles. In terms of SDT, it appears that MI moves individuals from a state of *introjected regulation*, marked by ambivalence, to one of *identification* and *integrated regulation.* The specific behavior and its associated personal value become increasingly aligned, internalized, accepted and controllable. For instance, when using MI to address suicide prevention, Britton et al. (2011) found that elaborating on reasons for living can elicit a client's deeply held values (e.g., wanting to be alive for one's children). It can also provide energy for considering self-chosen actions that satisfy this value (e.g., engaging in cognitive-behavior therapy). SDT suggests that a greater sense of autonomy accompanies increases in value-behavior consistency, leading to more durable behavioral changes.

In the context of MI, motivation may be generated in part by helping an individual define an ideal self and then juxtaposing his or her current self with that ideal. This process can offer direction and impetus for forward movement (Wagner & Sanchez, 2002). Such progression could be particularly helpful for individuals with SMI early in recovery, who often describe a lost or compromised identity related to illness. Consumers report feeling as if the "good parts" of themselves have been removed or replaced by an "unknown self," or that they experience a dichotomy between authentic self and illness-dominated self (Wisdom, Bruce, Saedi, Weis, & Green, 2008). Interviewing consumers about the effect of SMI on self-perception, Roe (2005) noted that over 70% of participants identified having a diminished sense of self. The majority

reported increased hopelessness about the future as a result, specifically with regard to confidence in their ability to accomplish goals.

MI values discussions may exert positive effects by two distinct pathways. First, they may trigger the re-discovery of a more empowered, hopeful sense of self. Values clarification alone "may induce a desire to 'recalibrate' daily behaviors to be more congruent with deeply held beliefs" (Wagner & Sanchez, 2002, p. 292). In terms of the recovery model, Roe (2005) described this process as the reintegration of self in which consumers increasingly seize "opportunities to exercise a restored skill, talent, or way of being" (p. 38). Increased values awareness can stimulate values-related action, as evidenced by one consumer who began gardening after his interest in horticulture had been revived. Clinicians using MI can point out overlap among service participation behaviors, desired changes in self, and in personal values. If a consumer begins to view treatment goals as consistent with deeply held values or interests, motivation for service participation should increase.

The second pathway has to do with the self-affirming quality that MI's empathic, nonjudgmental, evocative stance brings into these values discussions. In his self-affirmation theory, Steele (1988) proposed that people have a motivation to maintain a positive self-image, one that involves a sense of adequacy and morality. Any threats to one's integrity are met with attempts to restore or defend that self-image. Recognizing that individuals with SMI may suffer from chronically low self-worth, there might be an even greater need for self-affirming processes in this population. Koole, Smeets, van Knippenberg, and Dijksterhuis (1999) found that self-affirmation involving a personal value led to increased positive affect and reduced goal-related rumination. Not only can

people feel better about themselves through the self-affirming processes in MI (e.g., affirmation, Personal Values Card Sort), but they may find themselves more likely to experience resilience to failure and more positive goal-related thoughts. Here one finds a conceptual link between MI, self-image, positive emotions, and autonomous value-guided action that is a cornerstone of SDT.

Need for relatedness. Several parallels exist between MI and SDT with regard to the three primary hypothesized needs: autonomy, relatedness, and competence (Britton et al., 2011; Markland et al., 2005; Vansteenkiste & Sheldon, 2006). MI may satisfy the need for relatedness through the collaborative, empathic stance of the clinician. This is perhaps most evident in the engagement process of MI (Miller & Rollnick, 2012). If this process moves forward successfully, the client should feel valued and understood. Individuals with SMI have identified empathy as a desirable, but at times lacking characteristic of their service providers. Satisfied and engaged consumers, on the other hand, have reported that their case managers helped by "being in there with them," referring to the strength of the therapeutic alliance (Bradshaw et al., 2006). Aspects of a strong alliance included the provision of hope, sincere caring, information, and encouragement.

Walen (2002), a clinician with a history of chronic depression and suicidality, described a turning point of hope when a psychiatrist expressed genuine caring. The psychiatrist conveyed the idea that he understood the urgency of her struggle, rearranging a busy schedule to see her. Walen regards this active support, along with continuous optimism and firm belief in her ability to manage SMI, as essential provider qualities that foster openness and engagement. Consumers with schizophrenia similarly endorsed the

therapist's attitude of equality, understanding, confidence, and acceptance as the most important factors in their recovery (Torgalsboen, 2001). In a recent study surveying consumer perceptions of necessary provider competencies, respondents rated genuine respect, listening nonjudgmentally, trusting the authenticity of consumer experiences, and optimism about recovery as being the most significant qualities (Russinova, Rogers, Ellison, & Lyass, 2011).

MI's empathic style and simultaneous focus on personal values can increase the chance that consumers will feel understood within the therapeutic relationship. With regard to the therapist variable of expressed understanding, Myers (2000) studied the phenomenological experience of clients who reported that they felt understood in therapy relationships. Myers found that empathy was conveyed through the therapist's careful, active listening, using reflections of meaning based on what clients had said. Often referred to as complex reflections in MI (Miller & Rollnick, 2012), this form of active listening communicated the idea that the clinician was working to understand what the client meant. Interestingly, Moyers et al. (2009) found that reflective listening in MI had the strongest association with change talk, when compared with other MI-consistent behaviors such as supporting autonomy, affirming, and avoiding advice-giving.

In Myer's account, clinicians refrained from offering irrelevant personal material or interpretations that did not fit the content of what was said. Myers wrote that being listened to in this manner resulted in clients feeling validated, cared for, safe, and encouraged in self-exploration. Accurate empathy strengthened the relational bond between client and therapist and allowed the client to make sense out of his or her experience. Therapists modeling this empathic, yet unabsorbed stance toward experience

resulted in one client internalizing a similar attitude toward her own pain. This individual reported hope that she could "rise above the pain, develop a perspective on the past, and move on" (p. 167). In this qualitative account, one can more clearly see the connection between the experience of therapist empathy and preparation for behavior change.

Although clients had different personalized responses to being heard, Myers points out that the empathic interaction is often perceived as a "general relationship ambience" (Bachelor, 1988, p. 235). This ambience parallels the MI spirit of partnerships, acceptance, and evocation. It likely increases the probability that providers will connect with clients and be viewed as "teammates or colleagues in the fight against depression and despair" (Walen, 2002, p. 428). Moyers, Miller, and Hendrickson (2005) found that clinician interpersonal skills of acceptance, egalitarianism, empathy, warmth and MI spirit predicted client cooperation, disclosure, and expression of affect. Specific MI-consistent behaviors such as affirmation and reflection mattered less than these broader interpersonal constructs in determining client involvement. Other research has indicated a significant link between MI behaviors or strategies (e.g., affirmation, reflection, open questions, and building discrepancy) and high levels of therapeutic alliance (Crits-Christoph et al., 2009). Specific ways of responding appear associated with stronger therapist-client bonds

By satisfying the basic need for relatedness, MI could enhance positive self-concept and social connection which could help propel individuals forward in the stages of recovery. Experientially, MI participants have reported feeling able to express themselves openly in response to nonjudgmental inquiry, with an accompanying sense of courage, freedom, reduced fear, and increased confidence in self-expression (Angus &

Kagan, 2009; Zuckoff, 2001). Specifically, Zuckoff (2001) described how accurate, reflective summaries increased a sense of emotional safety for clients disclosing risky sexual practices, leading to greater in-depth self-disclosure. Complex reflection conveyed understanding and acceptance that strengthened trust within the therapeutic relationship and lowered the client's anxiety. The client stated, "He seemed to understanding my situation from my point of view" (p. 87).

In one study, clients who received MI before CBT were more likely to report an active, collaborative role in CBT, suggesting that MI enhanced interpersonal involvement (Kertes, Westra, Angus, & Marcus, 2010). Similarly, the participant in Angus and Kagan's study described feeling more relaxed with her children and having a greater desire to interact with others post-MI, suggesting a continuation of positive relational effects beyond the MI sessions. Consumers in Torgalsboen's (2001) study described increased hope after entering into this kind of empathic, accepting therapeutic relationship. Within its ambience, participants were able to achieve a more helpful perspective on illness and develop a sense of self independent of schizophrenia. Conveyed in large part through reflective listening, MI spirit seems to cement a trusting provider-consumer bond and engender hope, exerting positive effects beyond the immediate clinical setting.

At a process level, MI spirit appears to positively impact consumers' cognition and affect. It is associated with emotional safety, a feeling of being liked, and a greater ability to build a coherent self-narrative. Commenting on the overall experience of MI, the participant in Angus and Kagan's study described hope about the future and active purpose in redefining her priorities in life. These hope-cultivating effects mirror those

reported in Torgalsboen's (2001) research. At a broader level, Corrigan and Phelan (2004) found that professional and social support is significantly correlated with hope and goal orientation for individuals with SMI, pointing toward further research into the nature of that support. In sum, these qualitative and quantitative findings argue for a significant change-promoting role of the accepting, empathic therapist-participant bond formed in MI.

These findings support the relational hypothesis of how MI works, suggesting that an underlying humanistic spirit is essential to observed positive outcomes (Arkowitz et al., 2008). Keeping in mind that change talk bears an empirical link to outcomes (Moyers et al., 2007, 2009), the role of attitude formation in hearing oneself talk also appears to have merit. Arkowitz and colleagues astutely note that both mechanisms may contribute to overall variance in outcomes. It is quite possible that MI spirit interacts with change talk to produce the most impressive results. Positive affective states (e.g., feelings of safety, affirmation, being understood) could facilitate cognitive processes in MI related to attitude formation.

Need for autonomy and competence. In terms of treatment engagement, MI-consistent practice would advise providers not to argue with or confront clients who may not see the need for services. Ultimately, it is the consumer's choice about whether or not to participate in services. MI can enhance motivation by conveying respect for that choice, yet at the same time encouraging exploration of its implications. In a recent study of an MI-based intervention to increase safe sex practices among HIV-infected individuals, participants reported appreciation for MI's emphasis on freedom in decision-

making (Golin et al., 2010). One participant stated, "I like the way that they tell you that it's not about 'you got to do this, you got to do that.' It's about choices" (p. 241).

Autonomy-supporting strategies outlined by Miller and Rollnick (2012) for responding to sustain talk or discord may also satisfy the need for relatedness. Using reflection, exploring reasons for the status quo, and emphasizing personal control may make it more likely that the client will view the clinician as a nonjudgmental ally who wants to understand his or her concerns. Participants in the Golin et al. (2010) study stated that they felt more willing and open to talk about personal issues because counselors could "really relate" (p. 241). Shared decision-making with medication regimens is one specific application of the recovery model that incorporates respect for the consumer's personal integrity, responsibility, and humanity (Mahone, 2008). When implemented in an MI-style, collaborative decision-making may increase intrinsic motivation to participate in services by simultaneously supporting autonomy and strengthening relatedness.

MI therapists view evoking self-efficacy or confidence in one's ability to change, as another helpful way of increasing a sense of competence. This involves eliciting experiences, thoughts, and feelings that are consistent with the ability to change. Counselors help the individual review past successes, identify personal strengths, and reframe obstacles as learning experiences. In the planning process, the counselor continues to reflect the client's perceptions of effectiveness and collaboratively constructs a change plan. Within the SDT framework, all of these activities directly address the need for competence. This theme is also relevant to the third stage of the STOR model, Preparation, in which consumers focus on building confidence, learning coping

strategies, setting goals for the future, and using resources (Andresen et al., 2006). In general, supporting self-efficacy and competence is essential to strategies that facilitate empowerment among individuals with SMI (Corrigan, 2004).

With its emphasis on supporting self-efficacy, MI may increase the probability that consumers will take active roles in self-help or consumer-operated services, such as peer support and drop-in programs. Greater confidence in one's abilities makes it more likely that one will seek challenges that were avoided in a less hopeful state of recovery. Higher self-efficacy may also lead consumers to expand their social support networks, make more independent choices, and increase their contacts with services as a means of realizing valued goals. Of course, as a result of higher self-efficacy and strengthened autonomy, individuals may also elect *not* to use services to achieve their goals, especially if service delivery is not congruent with recovery-oriented practices (e.g., if consumers encounter case managers who are opposed to shared decision-making, or who do not endorse client-centered care). The MI therapist might respond to this dilemma by listening empathically to their concerns and guiding a discussion around their ideas of what would constitute more desirable helping relationships. MI therapists may not agree with service disengagement decisions that a consumer makes, but respects that choice as part of his or her autonomy, as long as there are no coinciding imminent threats to self or others (e.g., suicidality, homicidality).

In sum, the needs for autonomy, relatedness, and competence appear to interact rather than to operate independently. Actions that satisfy one need may even have a "kindling" effect by initiating other productive, need-oriented actions. SDT would predict, that as consumers advance in recovery, motivation becomes more intrinsic (e.g.,

greater values-behavior alignment) and likely spreads out across multiple life domains. MI is naturally poised to initiate and sustain momentum in this process. For individuals with SMI, increased change talk may accompany positive emotions from MI spirit and a positive shift in self-perception (e.g., seeing the self as more capable, independent, and worthwhile). Broader feelings of hope and meaning may begin to surround the context of MI-consistent client-provider interactions, contributing additional momentum to a positive "upward spiral."

Hope As a Motivational Factor in Recovery from SMI

Definitions of hope. Over the past two decades, hope has emerged as an essential factor in the recovery process for individuals with SMI (Darlington & Bland, 1999). From an intraindividual perspective, hope is an internal condition recognized as fundamental to moving forward in recovery (Jacobson & Greenley, 2001). The construct consists of attitudinal, behavioral, and existential dimensions. Consumers have described it as a "fragile spark" (p. 482) igniting possibilities of a more fulfilling life. In contrast, individuals early in recovery (e.g., Moratorium stage) have pointed to hopelessness about improvement as a significant barrier to change (Andresen et al., 2006). In reviewing 45 consumer accounts of living with mental illness, Wisdom et al. (2008) noted a common theme of hopelessness that centered around a lost sense of self and identity. This lack of hope may lead to treatment drop-out in some instances and negatively impact quality of life (Kreyenbuhl et al., 2009). The interconnectedness of attitudinal and behavioral manifestations of hope makes it a complex construct, suggesting the need for integrating multiple definitions.

In providing an integrative definition of hope, Miller and Powers (1988) referred to the same basic psychological needs described in SDT:

> Hope is an anticipation of a future which is good, based on mutuality (relationships with others), a sense of personal competence, coping ability, psychological well-being, purpose and meaning in life, and a sense of the "possible." (p. 6)

The authors go on to specify ten critical elements of hope that relate to themes of autonomy, relatedness, and competence. These include a sense of belonging and feeling loved, freedom of choice, goal achievement, and mental and physical "activation." Other theorists have presented similar conceptual models, describing hope as an interaction of cognitive, behavioral, affective, and relational processes directed toward meaningful future fulfillment (Dufault & Martoccio, 1985; Stephenson, 1991). Dufault and Martoccio further distinguished between *generalized* hope or the expectation of some nonspecific positive future development, and *particularized* hope, which is tied to a specific valued outcome. Although these definitions frame hope as a dynamic life force, they include expectancy or anticipation as a core feature, which implies an important role for cognition.

Snyder et al. (2000) defined hope as a motivational state based on two types of goal-directed cognitions. The first type is the perceived ability to identify workable pathways to one's goals (pathways thinking). Hope, in part, depends on flexibility in finding alternate routes if one is blocked. The second type involves beliefs that one can initiate and sustain progress along the pathways to desired goals (agency thinking). Agency thinking includes motivating thoughts such as, "I'm positive I can do this" and

"I'm determined to finish this." This cognitive conceptualization implies that goal-setting, strategic planning, and positive evaluations of one's abilities are necessary and sufficient for an optimal hope intervention.

Although most definitions focus primarily on cognitive-affective expectancy, Herth (2001) introduces existential aspects of hope based on the Hope Process Framework (Farran, Wilken, & Popovich, 1992). Applied to individuals experiencing a recurrence of cancer, Herth's hope intervention encourages the accessing of spiritual resources, identifying transcendent aesthetic experiences, expressing oneself creatively, and reflecting on the meaning of life, death, and suffering. Relational and cognitive-behavioral (e.g., rational) processes also factor prominently into her framework. Activities help strengthen interconnectedness and build practical skills to overcome life challenges. Herth's multidimensional approach explicitly targets relatedness and competence needs, with an implicit emphasis on autonomy through the creative and experiential choices that her protocol offers.

The added component of spiritual and meaning-making activities may further generate motivation by satisfying a need for connecting with something beyond or outside of the self, especially when faced with prolonged suffering. Yahne and Miller (1999) talk about spiritual hope as an intangible but essential experience of being human that is connected with inspiration; this spiritual hope confers a will to live, survive, recover or learn. In this context, hope takes on an existential quality in its associations with purpose in life. By successfully creating or enacting personal meanings, spiritual or otherwise, it is reasonable to believe that consumers would become more hopeful and

empowered. Yahne and Miller write about hope as a will, way, wish, horizon, and action, comparing types of hope included in Miller and Power's (1988) definition.

Multidimensional definitions of hope map onto the recovery model well. Interventions based on this hope "spectrum" seek to move individuals from future hopelessness to a more optimistic, active stance in dealing with the challenges of chronic illness. Research indicates that hope-focused interventions do improve quality of life and psychological well-being in those who suffer from chronic health or mental illnesses (Herth, 2000; Valinejad & Smith, 2008). Herth's intervention led to significant increases in participants' global quality of life, in their self-reported connectedness with others, and in their inner positive expectancies. These changes were sustained relative to a control group at 3, 6, and 9-month follow-ups. As one might expect from the many ways of experiencing hope, increasing hopefulness may not require an explicit "hope" intervention. For instance, one group wellness program grounded in recovery-oriented principles of self-determination and empowerment, significantly increased feelings of hopefulness among its participants (Fukui et al., 2011).

The various definitions of hope discussed here are not mutually exclusive, but rather synergistic and overlapping. For instance, the agentic and pathway elements in Snyder's theory have much in common with the rational elements of the Hope Process Framework adapted by Herth. Additionally, theorists seem to regard hope as essential to, if not synonymous with, motivation. Multidimensional conceptualizations of hope, in particular, have underlying autonomy, relatedness, competence, and existential themes of a future-oriented nature. It would seem difficult to discuss motivation for behavior change without referring to some aspect of hope. Hope-engendering discussions can

focus on feelings of ability, relationships with others, meaning-making, or spiritual connectedness.

Effects of provider interactions on hope. The construct of hope also has an interpersonal dimension that is especially relevant when considering service participation. First-person consumer accounts, as well as evidence that hope is associated with the quality of the provider-client relationship (see Koehn & Cutcliffe, 2007a, 2007b for a review), suggest that hope is a relational process as much as a product of cognitive-behavioral factors. Therapists and case managers can have a significant impact on how hopeful consumers feel about recovery, treatment participation, and life goals. Facilitating peer support, building social support networks, providing information about the illness, and encouraging self-management of illness symptoms are notable hope-building strategies used by providers (Kirkpatrick et al., 1995). At a process level, consumers have cited the hope-sustaining effects when their providers demonstrate specific behaviors. These include expressing encouragement and empathy, listening reflectively, and affirming that they can achieve their goals (Bradshaw et al., 2006, O'Brien et al., 2009). Yahne and Miller (1999) describe these hope-fostering therapy behaviors as educating, eliciting, and lending.

Larsen, Edey, and Lemay (2007) distinguish between implicit and explicit ways in which care providers can strengthen levels of hope. Implicit pathways resemble "therapy as usual" in which increases in hope may naturally result from focusing on a client's goals, building his or her coping repertoires, and helping him or her overcome obstacles. Establishing a warm, empathic therapeutic relationship is another implicit strategy for instilling hope. Explicit pathways, on the other hand, involve directly

addressing the subject of hope through open-ended questions and conversations. The following questions suggested by Larsen and colleagues have an evocative, supportive tone:

> Tell me about a time that something turned out better than expected?
>
> Tell me about a time when something that seemed impossible became possible?
>
> If hope was back in the morning, what would have happened?
>
> Who is someone you think of as being hopeful? (p. 412)

These hope-focused questions reflect the same strategies for eliciting change talk that constitute good MI practice. Using evocative language, elaborating, looking backward, and looking forward are often useful approaches in the evoking process, helping a person see that change is possible (Miller & Rollnick, 2012). Within the context of reflective listening, these questions also seem to generate feelings of being understood and valued. Although Larsen and colleagues do not mention direct therapist statements of hope, such as "I have hope for you" or "I have confidence that you can reach your goals," this type of affirmation represents another explicit expression of hope. Assuming they are genuine and well-timed, such affirmations are a common part of MI in building rapport and reinforcing open exploration (A. Zuckoff, personal communication, 2008).

Along similar lines, Darlington and Bland (1999) outlined a set of client-centered, hope-building strategies based on what consumers and mental health workers have said works well in practice. Working within the consumer's frame of reference has special importance and involves acknowledging the person's pain while eliciting his or her

definitions of hope. The worker explores consumer experiences with illness and shows respect for ways in which obstacles are overcome. Other provider strategies include focusing on strengths, acknowledging small gains, making links to past gains, communicating excitement about progress, being human and genuine, and having hope that change is possible. Consumers echoed the importance of this strengths-based approach and especially appreciated the quality of genuineness in their providers. The results from these interviews closely reflect the method and spirit of MI.

MI and hope. Considerable overlap exists between recovery principles, MI, SDT, and the construct of hope. MI addresses autonomy, relatedness, and competence needs that are critical to intrinsic motivation in SDT, and which are also contained in multidimensional conceptualizations of hope. Essential MI behaviors (expressing empathy, affirming strengths, reviewing past successes) match strategies that providers and consumers report as increasing hope. Herth's hope protocol, in particular, reflects one way in which MI might progress with someone who is precontemplative about change. Her intervention moves from awareness-raising, identity-oriented topics to topics related to confidence and self-efficacy. Although MI, hope, and recovery demonstrate theoretical and practical convergence, no studies have closely examined whether or not MI produces particular changes in consumers' subjective experiences of hope. Increases in hope may serve as one pathway by which MI produces readiness for change. Zuckoff (2001) describes MI as generating hope through the supporting a "sense of possibilities" (p. 117), which may be sparked by supporting self-efficacy or elaborating on expressed desire for change, even in the context of strong ambivalence.

Meaning-making, Motivation, and the Recovery Process

Several theorists have connected the perception of one's life as meaning-rich, purposeful, and goal-oriented with improved psychological adjustment (Frankl, 1955; Janoff-Bulman & Frantz, 1997). Frankl (1966) further suggested that individuals have a "will to meaning," or an inherent motivation to discover meaning in life. Based on his own experiences in a concentration camp, Frankl recognized that suffering can obscure one's sense of purpose and weaken the drive to engage in meaningful activities. Many of the same existential principles are relevant to individuals living with SMI. Following psychotic episodes, some consumers reported existential crises in which they questioned whether their lives had any purpose at all (Murphy, 2000). For individuals with SMI, rediscovering purpose at appreciative, behavioral, relational, and cognitive levels appears to be a central process in improving quality of life.

Qualitative research has supported the importance of meaning to recovery. In developing a model of recovery from SMI, Andresen et al. (2003) found that consumers endorsed finding meaning in life as important to their change process and sense of well-being. Andresen et al. (2006) subsequently identified meaning as a critical component of STORI Stages 4 and 5 (Rebuilding and Growth, respectively) in the development of their instrument. From their qualitative analysis, the authors defined "meaning" in terms of setting personally meaningful goals (Stage 4) and the "self-management of illness, resilience, and a positive sense of self" (Stage 5; p. 973). When examining items of the STORI more closely, however, one finds the theme of meaning present in each of the five stages. For instance, one item corresponding to Moratorium (Stage 1), "My life seems completely pointless now," assesses this perceived loss of meaning in life. Another item

"I'm mad that this had to happen to *me*" measures the degree to which the person is unable to find meaning in illness. Early in the recovery process, an absence of meaning may also relate to a confused, denigrated, or fractured self-concept. In Moratorium, consumers may lack awareness of unique strengths, skills, values, and hopes that would make them feel more whole and purposeful.

Making sense of illness, a form of meaning-making, is an important part of STORI Stage 2, Awareness, in which hope for improvement has begun to return. One related item asks individuals to rate the truth of the following statement: "I'm just starting to wonder if some good could come out of this." A coalescing sense of direction in life at the Awareness stage also reflects a more active form of meaning, synonymous with goal-oriented purpose. In Stages 3 through 5, the STOR model proposes that meaning continues to manifest as value clarification, goal-setting, re-definition of illness as a source of growth, and an overall clearer sense of purpose in life. Individuals at Stage 5, Growth, are thought to develop a stronger sense purpose through specific pathways (e.g., becoming a peer mentor, starting a job, moving into an independent living situation).

The STOR model captures two types of meaning that Davis, Nolen-Hoeksema, and Larson (1998) described in studying bereavement: sense-making and benefit-finding. Sense-making has to do with assimilating suffering or loss into one's presently existing worldview, making it more understandable or benign. Benefit-finding involves the transformation of adversity into strength or finding the "silver lining" in painful circumstances. A person begins to discover possibilities within suffering. In the context of recovery, this shift may involve seeing chronic illness as an opportunity to establish a

new identity, develop resiliency, re-discover forgotten values, show courage, or help others.

In her hope intervention, Herth (2001) included activities that targeted both sense-making and benefit-finding forms of meaning. Experiential activities helped participants explore the meaning of their illness through story-telling, values clarification, and connecting with others. The protocol also aimed to strengthen a sense of meaning by encouraging appreciative and productive exercises. These included goal-setting and cognitive reframing. Activities in these domains reflect the three paths to creating meaning proposed by Frankl (1966): 1) creating a work or doing a deed (goal-oriented meaning); 2) experiencing something or encountering someone (appreciative and relational meaning); 3) choosing one's attitude toward suffering (cognitive meaning). Although the Herth intervention was significantly associated with improvements in reported quality of life, the specific contributions of the meaning-making component are unknown.

Lecomte et al. (1999) designed a group self-esteem intervention for individuals with SMI that also included an existential module. The module focused on short-term and long-term goals, on the transformation of negatives into positives, and on thinking positively about oneself. With regard to Davis and colleagues' (1998) conceptualization, the module placed greater emphasis on the benefit-finding category of meaning. The intervention also included other modules on identity, competence, and relationship themes, taking a multidimensional approach similar to Herth's hope protocol. As a whole, the group sessions were associated with increases in active coping and reductions in positive symptoms of psychosis. When evaluating the intervention with a subsequent

sample of outpatients with schizophrenia, Borras et al. (2009) observed a number of positive outcomes. These included increased assertiveness, reduced psychiatric symptoms, and improved self-esteem. A qualitative analysis led the investigators to conclude that the groups worked, in part, by enabling participants to develop alternative explanations of their experiences. Psychosis was reframed along a continuum of experience in a normalizing fashion. Making sense of illness appeared to be an effective strategy. Neither study measured direct effects on perceived meaning, or the relationship between meaning and positive changes in well-being. However, if consumers draw an explicit connection between their goals, values, and treatment, it is reasonable to assume that they would be more likely to participate in services.

Relationship between meaning, hope, and mood. Some theorists view meaning and hope as related constructs, with Frankl (1966) and Miller and Powers (1988) conceptualizing meaning as a key factor contributing to an individual's sense of hope. In accordance with their definitions, a clear sense of purpose associated with personally meaningful, short and long-term goals can help create a state of positive expectancy. It is also plausible that a hopeful state creates ideal conditions for goal development, value clarification, and benefit-finding with regard to past struggles. In a prospective study with college students, Mascaro and Rosen (2005) found that self-reported purpose in life and implicit factors comprising a "meaningful life" predicted levels of hope and depressive symptoms 2 months later. Implicit factors included ratings of achievement, religiosity, intimacy, and self-acceptance.

Empirical data have further supported the connection of these constructs in individuals with SMI. Corrigan, Salzer, Ralph, Sangster, and Keck (2004) asserted that

hope and a purposeful life are the two most important aspects of recovery. They examined these constructs in a large sample of persons with SMI, using the Recovery Assessment Scale (RAS; Giffort et al., 1995) and other related measures. The investigators reported that the RAS factors of "goal and success orientation" and "personal confidence and hope" correlated significantly with the Herth Hope Index (HHI; Herth, 1991) and Meaning of Life Subscale of the Life Regard Index (LRI; Battista & Almond, 1973), although low beta values suggested the influence of other variables.

Mood may represent a third variable that influences both hopefulness and meaning. A number of studies indicate that high levels of happiness, self-esteem, and psychological well-being are associated with higher reported levels of meaning in life (see Melton & Shulenberg, 2008 for a review). Perceptions of greater meaning in one's life are also correlated with lower anxiety, neuroticism, and depression. It appears that an instrument with reduced sensitivity to mood would more accurately measure the more stable aspects of meaning. For many measures of meaning, moderate test-retest reliability coefficients at brief intervals (as low as .66) further support the rationale for controlling for mood effects (Melton & Schulenberg, 2008).

In light of substantial evidence that meaning co-varies with mood, one might question whether the construct of meaning is more state or trait-oriented. In fact, meaning may operate at both levels. Activities that contribute to one's sense of purpose (e.g., implicit indicators of meaning) may increase or decrease depending on situation, mood, symptom severity, and current stressors. In this way, implicit meaning may be more susceptible to changes in mood states and transitory stressors. These situational

fluctuations, however, may not reflect a more explicit, stable evaluation of one's over-arching meaning in life (e.g., trait level).

In addition, Mascaro and Rosen's (2005) research indicated that implicit and explicit meaning are somewhat independent from one another in terms of their effects on hope. Implicit attitudes and behaviors which comprise a "meaningful life" (e.g., achievement, intimacy, religiosity, self-acceptance) influenced dispositional and situational hope, regardless of whether or not they were accompanied by an explicit sense of meaning (e.g., agreement with statements such as "I feel like I have found a really significant meaning for leading my life"). In other words, an abstract sense of overall life purpose was not necessary for experiencing increased hopefulness at a state or trait level. At the same time, explicit meaning predicted situational hope regardless of the presence of implicit behaviors or attitudes. Awareness of a general life purpose was sufficient to influence day-to-day levels of hopefulness. The most robust finding was that an abstract awareness of life purpose and meaningful action together (e.g., variance shared by implicit and explicit forms of meaning) were most robustly linked to prospective levels of trait hope, state hope, and depressive symptoms.

Although limited in generalizability due to the nonclinical college sample, the results suggest that an MI intervention might influence hope most effectively by raising general existential awareness while reinforcing specific meaningful behaviors and attitudes. In some samples of individuals with SMI, low levels of cognitive functioning may limit the impact of a therapeutic focus on explicit meaning. However, this consideration should not preclude a dual focus on implicit and explicit expressions of life purpose, as they likely complement one another and exert additive effects on well-being.

MI, meaning, and motivation for service participation. In many respects, MI encourages the development of the two types of meaning discussed previously: sense-making and benefit-finding. In order to build motivation for change successfully, MI depends on helping individuals become more aware of core personal values that, by definition, can add significance and direction to one's life and identity. Those who suffer from SMI may have particular difficulty in identifying what is important to them, or have trouble understanding how their values are relevant to daily functioning, both from short and long-term perspectives (Wisdom et al., 2008). As a result, especially early in recovery, they may experience what Frankl (1959) called an "existential vacuum," or an absence of perceived purpose in living.

Through the Personal Values Card Sort (Miller & C'de Baca, 2001) and values clarification discussions, MI begins to remediate this void. The counselor initially asks questions that elicit meaning from the client's perspective. Second, he or she works with that information to build discrepancy between current and ideal self. After a key value is identified, for instance, the counselor asks questions in the following order: 1) "What does it mean to you?" or "How do you define it?"; 2) "In what ways is this value in your life right now?"; 3) "Is it present in your life enough, or would you want more of it?"; and 4) "How does what you are doing now fit or not fit with this value?" or "What would you do if you wanted to increase it?"

An exercise such as a values card sort promises to help consumers achieve a more meaningful sense of identity and purpose in life, while highlighting actions either consistent or inconsistent with accomplishing what is important to them. In disengaged individuals with SMI, revealing discrepancy between a core value (e.g., helping others)

and lack of treatment participation (e.g., providing peer support in group therapy) may increase intrinsic motivation to seek services. The card sort also may clarify recovery-related goals, emphasizing the individual's autonomy in choosing which valued goals they prefer to work on. Because personal meaning is explored within an empathic, client-centered context, the therapeutic contact itself may create a positive relational meaning for the consumer. Focusing on the existential aspects of the process may even counteract previous negative experiences with unsympathetic or coercive providers.

Benefit-finding existential approaches to SMI also seem to fit well with MI strategies. MI can help transform suffering into meaning by reframing obstacles (e.g., helping consumers view illness episodes as learning experiences), and by exploring alternative perspectives through strengths-focused reflective listening. Southwick, Gilmartin, McDonough, and Morrisey (2006) applied similar meaning-making strategies in the case of a veteran diagnosed with severe PTSD who saw his future as "nothing." After the intervention, he no longer viewed himself as a weak person who experienced panic attacks, but as a person who persevered through atrocities of war. Questions that spurred the shift in self-concept were: "What can you find that is worthwhile in these deeply painful experiences?" "How can what you've learned help you deal more effectively with the future?" and "What is worth working for?" These questions are similar to those typically asked in MI sessions, especially during awareness-raising discussions. MI may help clients perceive CBT therapy as an evocative experience in which the therapist facilitates the discovery of "light bulb moments" (Kertes et al., p. 61). Such moments likely refer to the sudden crystallization of new meanings about the self and one's experience.

In describing the effects of guided self-exploration, Southwick and colleagues illustrated how meaning-making led to increased hopefulness and goal-setting, which is also characteristic of later stages of recovery. The veteran realized that his most important values included fatherhood and caring for others as a nurse, which gave him a new sense of purpose. He began thinking about ways in which he could become a better father and husband. At the same time, he reframed his military service as an experience that helped him relate better to dying patients, which he wished to apply to his future work in the medical field. Sometimes self-exploration for MI participants involves making sense out of the reasons why one acts in certain ways, either in the past or present. Zuckoff's (2001) work highlights the importance of this increased self-awareness and coherence of a life view. Clarity about one's values can trigger a sense of possibility and open additional routes to life satisfaction.

With respect to recovery from SMI, meaning created through sense-making or benefit-finding represents an additional motivational component that could enhance self-determination and fuel hope. Although more empirical work is needed to understand the role of meaning in interventions, eliciting and supporting one's "will to meaning" seems to channel behavior in a positive direction. Weinstein, Ryan, and Deci (2012) do not conceptualize meaning as a separate psychological need, but as a natural consequence of satisfying autonomy, relatedness, and competence needs. They further assert that only activities that satisfy needs in these three domains can create a sense of life meaning. Their understanding echoes Frankl's (1959) own observation that "happiness cannot be pursued; it must ensue" (p. 140). It seems, however, that sources of personal meaning extend beyond these three needs. For example, meaning found in feeling good about

one's identity falls outside their framework. A sense of meaning often arises within a strong therapeutic alliance. Not only do clients say they feel understood, but they also report feeling more hopeful and empowered, as in the Southwick et al. (2006) and Zuckoff (2001) cases. Relational meaning is a crucial factor for individuals in recovery (Hendryx, Green, & Perrin, 2009). Studying the construct of meaning in MI and recovery, along with its correlates, promises to reveal other ways in which therapeutic contexts can facilitate this healing state.

The Role of Empowerment in Recovery, Self-Determination Theory, and MI

Empowerment is a third construct essential to understanding the recovery process. In the psychiatric disability literature, empowerment refers to a sense of increased personal control over a variety of life domains, including living situations, vocations, relationships, and treatment decisions (Corrigan, 2004). Sprague and Hayes (2000) define empowerment more broadly as a combination of social and intra individual factors that give a person "power to" actively influence self, relationships, and organizational structures. With regard to SMI, these factors include individual attitudes, abilities, and behaviors, as well as the transfer of choices, decisions, and directions from organizational entities (e.g., government funding agencies, service providers) to the consumers of services. There is a gathering of "power within" and transferred "power to" the individual, which increases that person's capacity to become self-determined. He or she enjoys a greater freedom to make independent choices based on inner values, needs, and thoughts.

As Corrigan notes, individuals with SMI have historically encountered coercive providers, involuntary confinement, societal stigma, and paternalistic systems that

constrain individual autonomy. As a result, consumers may experience feelings of shame, self-doubt, incapacity, and worthlessness that lead to increased dependence and poorer outcomes (Corrigan, Larson, & Rüsch, 2009; Vauth, Kleim, Wirtz, & Corrigan, 2007). Specifically, Vauth et al. (2007) found, that among outpatients with schizophrenia, a sense of disempowerment explained substantial variance in depression and quality of life. Disempowerment was also associated with decreased self-efficacy and anticipation of stigma. Corrigan et al. (2009) have labeled this the "why try" effect, referring to the reduced likelihood of consumers to pursue work, housing, and other personal aspirations. Motivational deficits are tied to internalizing negative stereotypes.

An analysis of consumer responses to the Empowerment Scale (Rogers, Chamberlin, & Ellison, 1997) suggested that efforts to combat disempowerment ought to support self-efficacy, self-esteem, community action, efforts to effect change, optimism, and control over the future. Specifically, Lecomte et al. (1999) hypothesized a connection between self-esteem and empowerment, arguing that when individuals feel positive about themselves, they are more likely to feel competent and successful in handling life stressors. Their group module for individuals with schizophrenia included separate self-esteem and competence components, which led to positive changes in both dimensions (Borras et al., 2009). After the intervention, participants reported greater self-knowledge and increased motivation to engage in activities important to them. They also described invigorated efforts to connect with others and to learn new things (through books, TV, radio). In addition, participants reported more confidence in dealing with daily problems.

Other research has supported the interconnectedness of self-esteem, empowerment, and positive expectations about the future. Studying two samples of individuals with SMI, Lecomte, Corbière, and Théroux (2010) found that high ratings of self-esteem, social support, and the capacity to engage in leisure activities explained large amounts of variance in optimism (45 to 51%). The investigators further observed that self-efficacy regarding job attainment was significantly correlated with optimism and self-esteem (.37 and .48 respectively). When examined beside the Borras et al. (2009) study, these results suggest that when individuals with SMI develop a greater awareness of what is important to them, when they feel good about who they are, and when they feel confident in their abilities to effect positive change in their lives, they tend to cope more actively and assertively. They likely experience a greater sense of independence with regard to life decisions and also an increased confidence that they can identify and achieve goals consistent with their values. Corresponding decreases in psychiatric symptom severity have also been noted (Borras et al., 2009; Lecomte et al., 1999).

In addition to its importance to life domains (e.g., work, living situation, social connection), empowerment may play a critical role in increasing service participation, as conceptualized within the recovery model. Corrigan and colleagues (1990) outlined a series of collaborative strategies that providers can use to enhance consumers' personal control with regard to treatment: 1) provide education about medication side effects and teach self-monitoring strategies; 2) involve consumers centrally in treatment plan development; 3) regularly assess goals and relevance of treatment to those goals; 4) implement services in the consumer's home or other setting; 5) help providers understand the importance of collaborative roles and consumer satisfaction, and 6) open a dialogue

with consumers and families about treatment options, providing an open forum in which they can share any concerns.

Self-efficacy, self-determination, and MI. Self-efficacy (Bandura, 1994) is a central empowerment-related construct that overlaps with MI principles, with SDT, and with cognitive conceptualizations of hope (as defined by Snyder et al. 2000). According to Bandura's model, self-efficacy results from the evaluation of one's own capacities to attain a goal. These cognitive evaluations, in turn, directly influence outcome expectancies for success or failure. High self-efficacy or a strong positive expectation of successfully attaining one's goals might be considered a key attitudinal variable that contributes to a more general condition of empowerment (as defined by Sprague and Hayes, 2000). In other words, high self-efficacy is a psychological factor that "enhances the possibilities for people to control their own lives" (Rappaport, 1981, p. 15), and as a result, helps them become more self-determined.

In Snyder et al.'s (2000) hope framework, self-efficacy is a somewhat broader concept that encompasses both agency thoughts (e.g., confidence in one's ability to attain a goal) and pathway thoughts (e.g., perceived ability to determine a route to the goal). Snyder and colleagues make an important distinction between their hope theory and Bandura's definition of self-efficacy. They argue that Bandura's self-efficacy is more situation-bound. In contrast to Bandura, the authors theorize that hope's agentic and pathway thoughts operate *across* situations, contributing to state and dispositional forms of positive outcome expectancy. Both situational and dispositional forms of self-efficacy appear to be relevant to MI, which views the immediate therapeutic interaction as a context for changing these perceptions in a lasting way.

Self-efficacy undergirds motivation from an SDT perspective. Individuals may be more likely to seek out new or challenging experiences when they view themselves as capable of succeeding. High self-efficacy seems as if it would enhance one's self-directed, action-oriented drive toward growth (e.g., taking steps toward achieving personally valued goals). One is more likely to make self-determined choices if one feels confident that those choices will successfully satisfy one's desires and values. Conversely, it is also possible that low self-efficacy frustrates the need for competence, one of the three primary motivational needs identified in SDT. The effects may even extend into the domain of autonomy, because individuals with diminished confidence in their goal attainment abilities could consequently perceive themselves as having fewer choices in life. Enhancing an overall sense of empowerment in individuals with SMI seems to depend on simultaneously strengthening self-efficacy and reinforcing autonomy.

Some research indicates that autonomy and self-efficacy have reciprocal or interacting effects. For example, offering consumers self-help services through drop-in centers has resulted in greater improvements in self-efficacy, personal empowerment, and independent social integration, in comparison with offering community services alone (Segal, Silverman, & Temkin, 2010). Barbic, Krupa, and Armstrong (2009) evaluated a 12-session recovery workbook program that focused on increasing awareness of available services, teaching coping strategies, building communication skills, and identifying pathways to goals, among other objectives. The program led to significant increases in confidence, hope, and goal-related optimism on a self-report recovery scale.

Supporting self-efficacy is a theme most commonly identified with MI's evoking and planning processes (Miller & Rollnick, 2012). Past successes are reviewed, preferred

problem-solving strategies are elicited, and potential barriers are explored, in addition to potential routes to overcoming them, particularly when readiness for change has increased. Reframing "failures" as learning experiences can circumvent self-blame and provide valuable insight into what works or does not work. It may also increase the likelihood that individuals will seek out new challenges. In terms of the cognitive conceptualization of hope, supporting self-efficacy in MI involves eliciting client language about possible pathways to change and helping individuals identify personal resources. This, in turn, could strengthen agentic thinking.

Some empirical evidence exists regarding the effects of MI on self-efficacy and empowerment. One recent qualitative study found that an adaptation of MI around diabetes self-management resulted in participants feeling more capable in creating supportive networks, regulating diet, and balancing their lives while managing illness (Minet, Lønvig, Henriksen, & Wagner, 2011). In another study, MI resulted in a greater perceived ability to abstain from drugs in positive circumstances among inpatients undergoing drug detoxification (Berman, Forsberg, Durbeej, Källmén, & Hermansson, 2010). The investigators also reported greater movement toward preparation or action stages in the MI group. Adolescents with psychiatric disorders have rated their perceived ability to quit smoking more highly following an MI intervention (Brown et al., 2003). In particular, those with anxiety disorders smoked less and were more likely to have maintained abstinence at follow-up. More investigation into MI's effects on self-efficacy in dually diagnosed populations is warranted, specifically focusing on whether feelings of hope and meaning also accompany improvements in confidence about change.

Relationship self-efficacy. Establishing a warm, empathic connection to a provider may also build a sense of relationship self-efficacy, in which the individual develops greater confidence that he or she can establish meaningful bonds with others. A genuine, caring consumer-provider relationship may translate to increased, self-initiated involvement with service providers, peers, and family. Among individuals with SMI, Hendryx and colleagues (2009) found that social support and involvement in a greater number of social activities correlated significantly with an overall stronger subjective sense of recovery (.44 and .36 respectively). Corrigan and Phelan (2004) observed that the size of an individual's social support network was positively associated with goal and success orientation on a recovery measure. Several items on this particular subscale include self-efficacy content, such as "I believe I can meet my current personal goals" and "I have my own plan for how to stay or become well." The investigators further noted that the size of the friend and professional support network, as opposed to family network size, had the strongest correlation with the goal and success subscale.

MI interventions may strengthen relationship self-efficacy through channels related to process (e.g., therapeutic relationship) and content (e.g., discussing the development of friendships). MI's relational components, or its spirit, surround more technical aspects of evoking change talk (Arkowitz et al., 2008; Miller & Rose, 2009). In supporting a consumer's perception of himself or herself as likable and cared for within the therapeutic relationship, MI spirit theoretically can foster relational hope within this context, as defined by Herth (2001). At the same time, MI can strengthen Snyder et al.'s (2000) agentic or pathway-focused hope through explicit discussions about social connectedness (e.g., the "how-to" of building relationships with others). For instance, the

work of Minet and colleagues (2011) has attested to MI's ability to increase participants' assertiveness with others, raising the likelihood that they will ask for support with illness management.

Additionally, a focus on what makes social activities meaningful for that particular individual touches on the existential dimension of hope, which can further facilitate motivation for expanding social support resources. Self-efficacy may play a crucial role in determining the importance an individual attributes to his or her behaviors. Goals that do not seem very achievable often become less important or valued by an individual. Along these same lines, Hendryx et al. (2009) defined meaningful activities that promote recovery as "pursuits that allow a person to grow in connection, confidence, and contribution through the development of skills, education, vocation, or relationships" (p. 321).

Self-efficacy, meaning, and hope seem to interact at multiple layers of a person's experience: affective, cognitive, behavioral, and spiritual. It may not be as important to distinguish the constructs from one another empirically, as it is to activate their connected pathways. When explicitly and implicitly strengthened through MI, these pathways should increase self-determination in individuals with SMI. As confidence in one's ability to build meaningful social connections increases, one would expect greater autonomous self-regulation in life domains that require social contact (e.g., treatment engagement, work, living situation).

Efficacy of Motivational Interviewing for SMI: An Overview

General efficacy, health behavior applications, and effects on service participation. Since the development of MI in 1983 with substance abusing individuals,

an evidence base of over 200 randomized controlled trials has developed in support of its efficacy (Miller & Rollnick, 2012). The empirical literature has also increasingly supported its use in promoting adaptive health behavior and treatment engagement. A typical MI intervention runs 1 to 4 sessions with session length lasting between 15 minutes and an hour (Hettema et al., 2005). Burke et al. (2002) have noted that most trials of MI incorporate other non-motivational interviewing techniques; they, therefore, recommended the use of the term "AMI" or "adaptation of Motivational Interviewing" in referring to these interventions.

In reviewing 119 AMIs over the past 25 years, Lundahl et al. (2010) concluded that this approach produces statistically significant, positive results over a wide range of problems, including substance use, healthy behaviors, and client engagement. They reported that 75% of MI participants experienced some improvement, with 50% deriving a small, meaningful effect and 25% demonstrating a moderate or strong effect. Moreover, these results can be achieved with over 100 fewer minutes of treatment, yet generate equal effects relative to other active interventions (e.g., CBT, 12-step programs). MI was further associated with improvement in subjective well-being, particularly with regard to depression and stress levels. Although MI outperformed *no treatment* and *weak treatment as usual* (TAU) groups, it did not produce significantly better results than other treatments. More MI treatment led to better outcomes, suggesting a dose effect; in addition, the results were durable from 3 months to 2 years post-treatment. The analysis also suggested that individuals from minority ethnic groups may derive greater benefits from MI. The authors speculate that this is perhaps due to the prevalence of social pressure or alienation among these groups, which makes the humanistic approach

particularly appealing. Additionally, MI may work best when used as a prelude to other treatments. In agreement with Hettema et al. (2005), Lundahl and colleagues found that using a treatment manual lessened MI's effect, possibly by diverting attention away from the individual.

In a previous meta-analysis, Hettema et al. (2005) reported strong evidence for the efficacy of MI in diverse areas, noting a wide range of effect sizes similar to Lundahl et al. (2010). The authors examined the efficacy of AMIs in 72 clinical trials and reported negligible to large post-treatment effect sizes in the domains of alcohol use (.41), drug abuse (.51) , gambling (.44), smoking (.04), treatment adherence (.42), HIV risk reduction (.71), eating disorders (-.07), and diet and exercise (.14). In the majority of studies, an AMI was combined with another intervention. These included objective feedback, education, self-help resources, cognitive therapy, skills training, stress management, or TAU. Across all studies, the investigators calculated a large overall effect size of .77 at the first post-treatment follow-up, indicating that AMIs are effective in reducing maladaptive health behavior in the short-term. Based on their results, AMI impact tends to diminish as follow-up times increase. The reasons are unclear about exactly why MI's effect varies so much across studies and populations, but possible explanations include variable MI skill levels, fidelity to MI, and study rigor.

In health and medical contexts, AMIs can improve glycemic control, weight loss, homework completion, and session attendance in diabetic patients (Channon et al., 2007; Smith, Heckemeyer, Kratt, & Mason, 1997, West, DiLillo, Bursac, Gore, & Greene, 2007), reduce fat and cholesterol intake (Berg-Smith et al., 1999; Clark & Hampson, 2001), increase physical activity and healthy diets in adults at-risk for heart disease

(Hardcastle, Taylor, Bailey, & Castle, 2008), encourage safer sexual practices among women at-risk for contracting HIV (Carey et al., 2000), and increase fruit and vegetable consumption among disadvantaged adults living in public housing (Ahluwalia et al., 2007). In a review of 37 studies of health-related AMIs, Martins and McNeil (2009) often reported positive change in the intervention groups and equivalent changes in comparison and control groups. This finding suggests that AMIs are effective as stand-alone treatments in medical populations; however, they may not be superior to other interventions, a conclusion similarly reached by Lundahl et al. (2010). Effect sizes do increase, however, when AMIs are used as preparation for another treatment (Hettema et al., 2005; Lundahl et al., 2010).

Considering the additive nature of most AMI study designs, Arkowitz and Miller (2008) argued that AMIs increase the efficacy of interventions by enhancing engagement and service participation. A growing body of empirical evidence supports their claim. Zuckoff and Hettema (2007) conducted a meta-analysis of 29 studies examining the effect of MI, specifically on treatment engagement and adherence. Although they found significant variation in effect sizes across studies, the average effect on adherence mirrored that of findings by Hettema et al. (2005) at .48. The strongest effects were noted for treatment contact (.70) and participation (.68). Notably, effects were largest for psychiatric treatment adherence and adherence to diet and exercise, in comparison with lower effects for substance abuse treatment and smoking cessation.

Zweben and Zuckoff (2002) reviewed 23 studies measuring AMI effects on treatment adherence across a variety of populations (e.g., health concerns, substance abuse, SMI). The investigators broadly defined adherence as following through on

collaborative goals, keeping appointments, attending sessions in a timely manner, taking medication as prescribed, or completing tasks in between sessions. This definition corresponds more closely to the recovery-focused definition of service participation described previously. Zweben and Zuckoff found that 12 out of 21 controlled studies produced significant and robust effects in these areas. In the only study to examine the pathway of AMI effects, Brown and Miller (1993) demonstrated that service participation mediated the relationship between an AMI and abstinence rates in alcohol abusing clients. After statistically removing variance in treatment involvement (e.g., attendance, family participation, therapist-rated goal attainment), differences in alcohol consumption between the AMI and control groups were no longer significant. Conversely, with participation included as a variable, posttreatment abstinence rates nearly doubled for the AMI group.

Other treatment participation effects have been described in the literature. Lincour, Kuettel, and Bombardier (2002) reported that clients mandated to receive substance abuse treatment attended a higher proportion of sessions and were more likely to complete treatment after receiving a group-based AMI. Their increased participation was also associated with a lower probability of meeting substance dependence criteria relative to the control group. These effects persisted even after controlling for diagnosis, employment, and age. More generally, DiMatteo, Giordani, Lepper, and Croghan (2002) examined the relationship between patient adherence and medical treatment outcomes in 63 studies, finding that 26% of patients had a better outcome when adherence was high. Adherent patients were three times more likely to experience a good outcome than

nonadherent patients, with a stronger relationship observed in chronic as opposed to acute illnesses.

Although AMIs are effective preparatory treatments for positive behavioral change and likely exert their effects by increasing treatment participation, less evidence exists for these claims with individuals diagnosed with an SMI. In addition, no studies examined whether participants in AMIs subjectively experience increases in hope, empowerment, and meaning that could affect treatment participation and outcomes.

Applications and efficacy of MI in dually diagnosed individuals. MI is a recommended evidence-based practice with individuals suffering from co-occurring psychiatric and substance abuse disorders (Bellack & DiClemente, 1999; Carey, 1996), although the approach requires certain modifications to address their complex needs. In applying MI, Martino and Moyers (2008) suggested that therapists: 1) address motivations to use substances and to cope with psychosis; 2) target concerns about medication and treatment program participation; 3) question, reflect, and summarize clearly and concisely; 4) use similes and metaphors to make sense of seemingly bizarre statements and gestures; 5) shift between skill-building and supportive interventions as needed; 6) affirm consumer's participation in the session; and 7) determine when acute psychotic symptoms make MI an inappropriate intervention.

Few clinical trials have evaluated MI in persons with SMI, and although the results seem promising, their findings are typically mixed. Using a randomized controlled design, Martino, Carroll, Nich and Rounsaville (2006) compared MI adapted for dually diagnosed patients with a standard psychiatric interview. They found that participants who received two sessions of MI as a pre-treatment reduced their cocaine use

to a significantly greater degree over time (80% versus 24.5%) and were slightly more likely to enter the dual diagnosis treatment program (79% versus 55%). Marijuana users did not seem to derive the same benefits from the MI condition, raising the possibility that MI may be more appropriate with certain subsets of dually diagnosed persons. Martino and colleagues speculated that decisional balance strategies (e.g., weighing advantages of abstinence) had a greater impact on cocaine-abusing participants given that cocaine withdrawal often produces dramatic increases in positive psychotic symptoms.

In the same study, MI participants did not differ significantly from the comparison group on medication adherence or on reduction in psychological problems, with both groups improving about equally on these measures. Because most study participants indicated high readiness to change at the outset, a motivational ceiling effect may have limited the effectiveness of MI. As a result, the investigators recommended that future research focus on consumers with initially lower levels of motivation to change. Consumers feeling discouraged or hopeless may be particularly prone to disengage from services. Consequently, they may be most receptive when encountering the empathic, client-centered style of an MI approach.

In addition to a pre-treatment approach, MI has been successfully integrated with CBT in dually diagnosed populations. Barrowclough et al. (2001) divided treatment into two distinct phases. In the first phase, counselors utilized Motivational Enhancement Therapy (MET; Miller, Zweben, Diclemente, & Rychtarik, 1992), a derivation of MI. In MET, therapists explored participant perspectives on substance misuse and mental health issues, elicited life goals, and provided feedback from assessments related to their concerns. The second phase involved developing a plan for change, based on evidence-

based CBT techniques, including strategies for relapse prevention and for coping with psychosis symptoms. When tested against standard care, the integrated treatment led to significantly higher global functioning scores, fewer positive symptoms and reduced relapse rates at the 3-month follow-up. Participants also tended to remain in treatment at a higher rate than other studies have reported (94%), suggesting higher levels of satisfaction facilitated engagement. Haddock et al. (2003) reported that participants maintained these general functioning gains at 18 months and experienced additional reductions in negative symptoms (e.g., affective flattening, anhedonia) relative to the routine care group.

In a larger version of this randomized trial, Barrowclough et al. (2010) could not replicate the MI-CBT intervention's positive effects on relapses, psychotic symptoms, global functioning, hospital admissions, and self-harm. The researchers continued to find significant differences, however, in the amount of substances used and in the readiness to change use. In particular, for the MI-CBT group, they observed a nearly 50% decrease in the number of participants categorized as precontemplative at 12 months. The percentage of participants in an action stage of change regarding their substance use also increased from 24% to 49% during this time period. These effects diminished over time, with a reduction in the number of participants identified in the action stage at 24 months. Subsequent research has indicated that integrated MI-CBT treatment reduced the use of drugs and alcohol for individuals with bipolar disorder, improved mood symptoms, and decreased impulsiveness (Jones et al., 2011). Some gains were also maintained at 6 months post-treatment.

Motivation appears to erode when individuals with long-standing, multi-layer diagnoses stop treatment, suggesting the importance of understanding other variables associated with the motivation to change. It is possible that hypothesized positive effects of MI (increased hope, meaning, and empowerment) wear off as participants experience ongoing stressors. Barrowclough and colleagues explained the lack of differential effects on clinical outcomes as resulting from unexpected improvements in the control group. It is also possible that MI clinicians focused primarily on substance abuse versus motivation to cope with mental illness, in which case psychosocial difficulties may have continued to trigger substance use. In addition, the investigators noted a generally poorer response to treatment among polysubstance diagnosed participants, compared with participants who had only an alcohol misuse disorder. This finding supports the claim that AMIs are not equally effective with all populations of individuals with SMI.

In terms of efficacy, timing of the intervention may prove as important as dimensions such as change readiness. When dually diagnosed inpatients are discharged from hospitalization, disconnection from services becomes more likely (Obrien et al., 2009). However, clients who received a single brief MI session prior to discharge were nearly twice as likely to attend their first outpatient appointment (Daley & Zuckoff, 1998). Swanson, Pantalon, and Cohen (1999) found similar results, randomizing consumers either to treatment as usual (TAU) or to TAU plus MI during their hospitalization. The combined intervention led to higher initial outpatient appointment attendance (47% vs. 21%). Non-dually diagnosed consumers in the TAU + MI condition attended more CBT groups than those in TAU (46% vs. 17%). The same effect was not observed for dually diagnosed individuals. This finding suggests, that to better facilitate

engagement, consumers with co-occurring diagnoses may require additional or multiple focused MI sessions to account for greater problem complexity. It is worth noting that the study used only a single indicator of treatment participation, lacked an attention control group, and did not include longer-term outpatient adherence measures.

In a subsequent randomized study of dually diagnosed consumers, Martino, Carroll, O'Malley, and Rounasville (2000) detailed the effects of a single preadmission MI session on engagement patterns. Participants who received the MI session instead of the standard preadmission interview attended more days of partial hospitalization, displayed significantly less tardiness, and were less likely to leave sessions early. In terms of clinical outcomes, MI recipients used substances less frequently and for fewer days. Martino and colleagues also reported a trend toward better outcomes for participants diagnosed with psychosis, in comparison with those who had mood disorders. Their findings echo the suggestion made by Barrowclough et al. (2010) that future research distinguish between MI-effects on different subpopulations of individuals with psychosis and substance abuse disorders. Although not tested statistically, the study indicated a correlation between increased service engagement through particular attendance behaviors and improved clinical outcomes.

A single-session MI intervention for smokers with schizophrenia produced similar effects on consumer-provider contact (Steinberg, Ziedonis, Krejci, & Brandon, 2004). Relative to advice-only and psychoeducational counseling conditions, a greater proportion of participants in the MI group contacted a tobacco dependence treatment provider and attended the first counseling session. Of the 32% who contacted a provider in the MI condition, half had previously indicated they had no intention of quitting in the

next 6 months (e.g., precontemplative). In fact, 75% of participants in the MI group were in the precontemplative stage of change prior to the session. Baseline levels of motivation did not predict treatment-seeking, further supporting the impact of MI on readiness to change.

Although less common, some research has evaluated MI as a stand-alone intervention in SMI populations. Graeber, Moyers, Griffith, Guajardo, and Tonigan (2003) conducted a pilot study of MI as a single treatment in consumers with schizophrenia and alcohol use disorders. Drawing their sample from inpatient and outpatient settings, Graeber and colleagues randomly assigned participants to three sessions of MI or to a three-session educational intervention. Outcomes included number of drinking days, abstinence rates, blood alcohol concentration, and total alcohol consumed at 4, 8, and 24 weeks after the interventions. Analyses showed that none of the educational intervention recipients remained abstinent throughout the follow-up period, compared with 40% of participants assigned to the MI group. MI participants also drank on significantly fewer days, although at the same intensity prior to treatment. In contrast to the high level of treatment readiness observed in the Martino et al. (2006) study, individuals who participated in this trial exhibited high levels of psychiatric symptoms and were not pursuing treatment for their substance abuse before enrollment. MI served simultaneously as an effective engagement vehicle and as a treatment modality.

Researchers have also studied MI's efficacy in increasing acceptance and active participation in antipsychotic medication regimens, although only 5 empirical studies have appeared in the literature (Drymalski & Campbell, 2009). Two studies found positive effects on medication-taking behavior (Kemp, Hayward, Applewhait, Everitt, &

David, 1996; Kemp, Kirov, Everitt, Hayward, & David, 1998), and three reported nonsignificant results (Hayward, Chan, Kemp, Youle, & David, 1995; O'Donnell et al., 2003; Byerly, Fisher, Carmody, & Rusch, 2005). Kemp et al. (1996; 1998) randomly assigned participants to nonspecific therapy or to MI specifically tailored for individuals with psychotic disorders. In the MI condition, the investigators blended traditional MI techniques with an educational component, guided problem-solving, and cognitive approaches to psychotic symptoms. Participants who received the MI developed greater awareness of their illnesses and higher ratings of active participation in neuroleptic therapy after the intervention. Their global assessments of functioning scores at 18 months post-treatment were also significantly higher than those in the control group. In the other studies mentioned, nonsignificant results could have emerged due to small sample sizes, poor therapist training in MI, and heterogeneity of diagnoses.

Substance abuse has typically been the primary goal of MI treatments with dually diagnosed individuals, with psychiatric treatment participation and coping with symptoms as a secondary or even non-existent focus. However, it is often psychiatric symptomatology that precipitates or exacerbates substance use. Consistent with the holistic nature of the recovery model, these cyclical effects underscore the importance of using MI to target consumer motivation for service participation. It seems equally important to address psychosocial challenges as it is to build commitment to reducing substance use.

Mixed results of MI's effectiveness for individuals with SMI might be explained by moderating and mediating variables related to participants' subjective experiences. Some AMIs may not have produced robust results due to insufficient increases in hope,

self-efficacy, and meaning among participants. It is also unclear whether AMIs that enhanced service engagement produced positive change in these variables. None of the outcome studies reviewed here controlled for variation in recovery stage at pre-treatment, which may have resulted in differential treatment response. The studies also did not examine participants' qualitative experiences of receiving MI. This approach may have provided clues about how the intervention affected their self-perceptions and their ideas about recovery. Gathering self-reports of hope, empowerment, and meaning over time may have offered additional insight into the reasons why some intervention effects waned at long-term follow-up.

Hypotheses

In a sample of difficult-to-engage, dually diagnosed individuals, it is hypothesized that MI will result in increased levels of hope, meaning, empowerment, forward movement in the stages of recovery, and enhanced service participation.

Hypothesis 1: Participants receiving MI will report increases in hope, meaning, and empowerment relative to Baseline. These changes will be maintained at the 4-week follow-up.

Hypothesis 2: Participants receiving MI will move forward in the stages of recovery as measured on the STORI, with greater increases in self-reported hope, meaning, and empowerment for participants who advance further in stages of recovery.

Hypothesis 3: Participants will show increased readiness to participate in treatment and intent to complete treatment during MI, and report increased internal motivation for change, help-seeking, and confidence in treatment's potential benefits.

Hypothesis 4: The MI intervention will be associated with increases in service participation as defined by number of appointments attended and self-report indices of service engagement.

Hypothesis 5: Greater service participation will be observed for participants who report greater hope, meaning, and empowerment.

Hypothesis 6: Values-related discussions in MI will be associated with subjective increases in meaning and hope, whereas supporting self-efficacy will be associated with increases in empowerment.

Method

Overview

Enhancing service participation and focusing on hope, meaning, and self-determination in individuals with SMI are desirable goals in both inpatient and outpatient settings. Because voluntary disengagement from services presents a unique risk in community outpatient care, the current study assessed the impact of MI on individuals receiving treatment in an ambulatory setting. Understanding how MI relates to subjective correlates of recovery and treatment involvement suggests the need for intrasubject data gathered over time, with a combination of quantitative and qualitative indices of change. A group comparison approach would obscure many important details of intervention response. As a result, the study employed a more individualized methodology. Also, for feasibility purposes, and to avoid ceiling effects that might prevent effective exploration of MI's effects on service engagement, the study used convenience sampling. In particular, case managers and other staff played a crucial role in identifying discouraged and difficult-to-engage consumers.

Study Design and Justification

To determine how MI specifically impacts service participation and subjective levels of hope, meaning, and autonomy, the study used a mixed methods, multiple baseline single-case experimental design (Barlow & Hersen, 1984). It included multiple participants in an ABA within-subjects, pretest-posttest design. Prior outcome studies with MI in SMI populations have used group designs, limiting the specificity of clinically useful data regarding motivation, recovery, and service participation. Through repeated measurements, a single-case experimental design is more likely to identify if (and when)

subjective experience changes in response to different MI components (e.g., values clarification versus self-efficacy/confidence discussions). Equivocal results of MI with persons in recovery further suggest the need to describe individual responses to the intervention. As Barlow and Hersen (1984) point out, group designs achieve heterogeneity of participants through random selection, but in doing so, often lose relevance to the specific person.

Consumers with SMI have reported considerable fluctuation in emotional well-being from day to day, with their moods and motivation affected by interactions with providers (Bradshaw et al., 2006). Repeated measurement allows a search for events correlated with this fluctuation, which is particularly important when introducing an interaction style that a discouraged consumer may not expect (e.g., client-centered versus hierarchical). A single-case experimental design is well-equipped to detect the relatively fast positive shifts in well-being that may occur as a result of MI.

In the present study, each individual received a brief MI intervention and completed self-report measures of hope, meaning, and empowerment before, during, and after the intervention. Indicators of service involvement included medication-taking, attitudes toward providers, participation in therapy, and attendance. These participation variables were be measured at pretreatment, at posttreatment, and at a 4-week follow-up, using client self-report and attendance records if available.

Although self-report surveys can provide useful information about whether MI is associated with changes in hope, meaning, and empowerment, a qualitative component was added to help clarify and elaborate on individual experiences of MI that might relate to these constructs. Specifically, the intent was to explore whether or not certain aspects

of MI principles, spirit, and method were associated with observed changes on self-report measures. Brief Structured Recall (BSR; Elliott & Shapiro, 1988) assisted in gathering this richer field of data with regard to a single, client-identified helpful event that occurred during one of the MI sessions.

BSR is an efficient version of tape-assisted recall, which involves reviewing a brief recorded portion of a therapy session with participants (5-10 min) and asking them to discuss what they were thinking, or feeling, during that period of time. Replaying a selected moment or event allows the participant to reflect on and form a more comprehensive representation of within-session experiences. Prior to tape review, a significant therapy event was identified using the Helpful Aspects of Therapy questionnaire (HAT; Llewelyn, Elliott, Shapiro, Firth-Cozens, & Hardy, 1988). The HAT consists of open-ended questions about what was "most helpful or important" in session, as well as its timing in session. Participants then rate how helpful the event was from "slightly to extremely" on a 5-point scale. In case studies, BSR has shown promise in clarifying the active ingredients in psychotherapy sessions, helping researchers describe and categorize the nature of therapeutic impact (e.g., problem solution versus awareness/insight or understanding; Elliott & Shapiro, 1988). The recall procedure also has been described as stimulating and worthwhile by clients and therapists.

As Elliott and Shapiro assert, providing cues for recall via these taped segments is a more powerful method than using free recall. In addition, the brief version is more practical than gathering data through an entire, taped session review, which can take up to 3 hours. This format may be especially useful for individuals with SMI whose cognitive difficulties may reduce recall accuracy. In the present study, an adapted version of the

HAT and BSR processes will be used; this further reduces the demand placed on consumers, while still providing useful data.

Participants

All study participants were dually diagnosed consumers enrolled in outpatient treatment at Sobriety Through Out Patient, Inc. (STOP) in Philadelphia, PA. The program offers group therapy, individual therapy, and psychiatric services for individuals with substance abuse and/or mental health disorders. STOP does not have set time or session limits, but, typically, consumers attend intensive outpatient services 5 days a week for four months before transitioning to a lower level of care (usually 3 days a week). After the consumer reaches this lower level of care, discharge readiness is determined collaboratively between therapist and consumer. In addition to therapy, STOP provides transportation, lunch, wellness, vocational, educational and legal services.

Inclusion criteria were: 1) adults 18 years of age or older currently enrolled in STOP, who had been attending the program for at least 2 months; 2) a co-occurring diagnosis of substance use and SMI according to the DSM-IV-TR criteria (APA, 2000); 3) identification by clinicians as difficult-to-engage, based on attendance records or participation levels in session, and 4) self-report of feeling discouraged or hopeless. Participants were excluded if they were unable to understand the consent form adequately, had an intellectual disability or organic brain damage, or discharged from the agency prior to completing at least three MI sessions.

For the purpose of this study, the presence of SMI was determined through chart review. SMI is defined as having had at some time in the prior year a diagnosable mental, behavioral, or emotional disorder that meets DSM-IV-TR criteria and results in

impairment that interferes with one or more major life activities. This definition includes all Axis I psychotic disorders, bipolar disorders, and recurrent major depressive disorder. Similarly, a participant was defined as having had a substance use disorder based on a charted diagnosis, which was also made by a STOP psychiatrist and contingent on DSM-IV-TR criteria.

Group or individual therapists initially contacted individuals who met the inclusion criteria to assess their interest in participating in the study, and to determine if they were willing to be contacted by the responsible investigator. Of the 25 consumers referred by STOP clinicians to the study, nine were subsequently unreachable by phone (36%) and eight did not meet the inclusion criteria upon further screening (14.5%). They indicated that they either felt hopeful and optimistic or that they were consistently and actively engaged with services. Thus, the sample consisted of eight dually diagnosed consumers, five females and three males.

Measures

Stages of Recovery Instrument. The Stages of Recovery Instrument (STORI; Andresen et al., 2006**)** is a 50-item self-report measure that categorizes an individual's recovery status based on four core processes of recovery (finding hope, reestablishment of positive identity, finding meaning in life, and taking responsibility for life) and five recovery stages (Moratorium, Awareness, Preparation, Rebuilding, Growth). Participants rate each item on a 6-point Likert scale for "How much each statement is true of you right now?" from "0" = "not true at all now" to "5" = "completely true now." Each recovery stage constitutes a separate subscale. Items within the Moratorium subscale include, "I don't think people with a mental illness can get better" and, "My life seems

completely pointless now." Items within the Growth subscale include, "I have a sense of 'inner peace' about life with the illness now" and "I am happy with who I am as a person." The STORI has demonstrated high internal consistency for all subscales (alpha = .88 to .94) and moderate to strong concurrent validity with related measures, including the Recovery Assessment Scale (RAS; Corrigan, Giffort, Rashid, Leary, & Okeke, 1999), Self-Identified Stage of Recovery (SISR; Andresen et al., 2003), and State Hope Scale (AHS; Snyder et al., 1996). Correlations were strongest for Stage 1 and Stage 5 in the expected directions (-.44 to .79). Pearson correlations indicated an ordinal relationship between subscale scores, with mean subscale scores increasing as stage level increases. This finding suggests acceptable construct validity for the five stage subscales, although a cluster analysis showed three distinct stage-related clusters corresponding to early (Stage 1), middle (Stages 2 to 4), and advanced recovery (Stage 5) states.

Herth Hope Index. The Herth Hope Index (HHI; Herth, 1992) is a 12-item self-report measure adapted from the Herth Hope Scale (HHS; Herth, 1991), tapping three dimensions of hope: temporality and future-orientation (cognitive-temporal), positive readiness and expectancy (affective-behavioral), and interconnectedness (affiliative-contextual). The HHI reduces the number and complexity of the HHS in an effort to make it more clinically useful. It uses a 4-point Likert scale with a score of 1 indicating "strongly disagree" and score of 4 indicating "strongly agree." In a convenience sample of 172 individuals with acute and chronic illnesses, the measure showed strong internal consistency ($\alpha = .97$) and test-retest reliability ($r = .91$) (Herth, 1992). The same study provided support for HHI's concurrent validity where the measure correlated strongly with the HHS and other measures of hope and well-being

(.81 to .92) . Factor analysis provided further evidence of construct validity, supporting the three hope dimensions, which accounted for 41% of the total variance.

Meaning in Life Questionnaire. The Meaning in Life Questionnaire (MLQ; Steger, Frazier, Oishi, & Kaler, 2006) is a 10-item self-report scale that measures the presence of, and search for, meaning in life. Items are rated on a 7-point Likert scale, ranging from 1 "Absolutely Untrue" to 7 "Absolutely True." Items related to the presence of meaning include, "I understand my life's meaning" and "I have a good sense of what makes my life meaningful." Items associated with a search for meaning include "I am looking for something that makes my life feel meaningful" and "I am seeking a purpose or mission in my life."

In comparison with the Purpose in Life Test (PIL; Crumbaugh & Maholick, 1964) and the Life Regard Index (LRI; Battista & Almond, 1973), the MLQ demonstrates less sensitivity to changes in mood or life satisfaction. This finding is based on evidence from three empirical studies conducted by Steger et al. (2006). Thus, the questionnaire appears to be a purer measure of the meaning-in-life construct and represents an improvement over previous instruments. Factor analysis in those three studies confirmed a two-factor structure. The MLQ-P subscale (5 items) assesses the presence of meaning in life and MLQ-S subscale (5 items) addresses the search for meaning and purpose. The MLQ-P subscale correlated significantly with other measures of meaning (.61 to .74), indicating that they are accessing the same construct. Steger et al. (2006) also reported that the MLQ has acceptable internal consistency (α =.86 to .87 for subscales P and S) and test-retest reliability over 1 month (α = .70 to .73 for subscales P and S). Test-retest reliability over 2 weeks increases to .80 (Steger, 2005), suggesting considerable stability

in the near-term. When examining long-term stability over 1 year, Steger and Kashdan (2007), found moderate correlations on subscales P and S (.41 and .50, respectively). In sum, the MLQ is a stable measurement of meaning, but at the same time, appears to have adequate sensitivity to life events that affect the presence of and search for meaning.

With regard to the present study, the MLQ offers a desirable level of independence from mood fluctuations, yet remains sensitive to significant therapeutic events with existential implications. Schulenberg, Strack, and Buchanan (2011) studied the MLQ for the first time in an inpatient population with SMI and found levels of internal consistency similar to previous studies (α =.81 for subscale P and α =.90 for S). Unexpectedly, they also reported significantly higher MLQ subscale means in this sample than in college samples (subscale P, M = 28.16; subscale S, M = 26.6), perhaps due to an inpatient sample that had stabilized. In this study, greater search for meaning was associated with higher levels of psychiatric symptoms. The authors further reported that as presence of meaning decreased, the relationship between meaning and psychological distress became stronger. It is worth noting that other studies have found the search for meaning positively associated with well-being in individuals who also have a high presence of meaning in life (Park, Park, & Peterson, 2010; Steger, Mann, Michels, & Cooper, 2009). This suggests that the search for meaning does not always imply hopelessness.

Empowerment Scale. The Empowerment Scale (ES; Rogers, Chamberlin, & Ellison, 1997) is a 28-item self-report measure of subjective feelings related to self-efficacy, perceived power, optimism and control over the future, and community activism. Developed with consumer focus groups, the scale consists of 28 statements

about empowerment, which respondents answer on a four-point agreement scale (4 = "strongly disagree"). Rogers, Ralph, and Salzer (2010) studied the instrument in a large community sample of consumers with SMI. The investigators reported that the ES had good internal consistency ($\alpha = .82$) as a total scale, as well as fair to strong internal consistency within each of its 5 subscales ($\alpha = .45$ to .82). ES also had acceptable test-retest reliability (.75). In terms of concurrent validity, the measure was positively correlated with measures of empowerment, hope, sense of recovery, and quality of life. The ES was inversely correlated with psychiatric symptomatology. Factor analysis revealed two main factors describing inward and outward types of empowerment, corresponding to self-efficacy and "community confidence", respectively. Corrigan, Faber, Rashid, and Leary (1999) found that the internal empowerment factor correlated significantly with quality of life, social support, and self-esteem.

Treatment Motivation Questionnaire. The Treatment Motivation Questionnaire (TMQ; Ryan, Plant, & O'Malley, 1995) is a 29-item self-report measure of an individual's reasons for entering and remaining in substance abuse treatment, tapping the constructs of self-determination and internalized motivation for engagement. Respondents rate each item on a Likert scale, with 1 corresponding to "not at all true" and 5 corresponding to "very much true." The TMQ has four subscales identified through factor analysis: 1) internalized motivation—measuring partially internalized motivation and more fully internalized or "identified" motivation; 2) external motivation—assessing for perceived pressure to engage and remain in treatment; 3) interpersonal help-seeking—assessing motivation to share problems and relate to others

during treatment, and 4) confidence—measuring expectations of a positive treatment outcome.

Ryan et al. (1995) reported acceptable internal consistency for the subscales ranging from .70 to .98. In terms of validity, internalized motivation was significantly, negatively correlated with the external motivation subscale and positively associated with help-seeking and confidence. Internalized motivation, external motivation, and interpersonal help-seeking were also significantly correlated with clinician ratings of motivation and overall distress in the expected directions. Greater problem severity was specifically associated with higher levels of internalized motivation and help-seeking. Cahill, Adinoff, Hosig, Muller, and Pulliam (2003) replicated this result in a sample of veterans seeking residential treatment for alcohol and drug dependence. McMurran, Theodosi, and Sellen (2006) reported a significant correlation between the TMQ confidence and University of Rhode Island Change Assessment's (URICA; McConnaughy, Prochaska, & Velicer, 1983) Committed Action subscale. Both subscales showed positive significant change in the expected direction after treatment in a sample of incarcerated adults.

To date, there is a lack of empirical evidence for the TMQ among individuals receiving dual diagnosis treatment; however, because the TMQ addresses motivation for treatment in general and has been used separately to assess motivation for psychiatric and substance abuse treatment, it appears appropriate to use for this particular population.

Participation Readiness Rulers. Adapted from treatment participation readiness rulers used to assess readiness to engage in exposure treatment for obsessive-compulsive disorder (Maher et al., 2012), the Participation Readiness Rulers (PRR) are 2

self-report items measuring an individual's readiness to participate fully in treatment services at STOP and readiness to complete the full recommended treatment course, respectively. Each item uses a 10-point Likert scale (1 = not ready to 10 = fully ready), following the format of the original rulers. Full treatment participation is defined for respondents as attending most scheduled individual and/or group therapy appointments, working toward goals in collaboration with providers, and openly discussing views on treatment recommendations. The second item, "seeing treatment all the way through," is defined as continuing to engage in these activities until the individual has successfully completed the treatment program.

Maher et al. (2012) found that Readiness Rulers measuring exposure and response prevention (EX/RP) readiness among individuals diagnosed with OCD significantly and independently predicted adherence behavior. Adherence to exposure treatment also mediated the effect of this predictor on post-treatment OCD severity. It is notable that the sample in this study had good insight, low levels of depression, and high adherence to EX/RP treatment. Its predictive ability has yet to be tested in less engaged, more depressed populations.

Another Readiness Ruler to assess motivation to change drinking behavior has been reported as highly and significantly correlated with the Readiness to Change Questionnaire (RCQ: Rollnick et al., 1992), suggesting both concurrent validity and practical use in settings where assessment time is limited (Heather, Smailes, & Cassidy, 2008). Using rulers measuring readiness to change alcohol use and safe sex practices, LaBrie et al. (2005) found similar concurrent validity with the RCQ. In fact, these rulers outperformed the RCQ and Stage of Change Readiness and Treatment Eagerness Scale

(SOCRATES; Miller & Tonigan, 1996) in predicting intended condom use and quantity and frequency of alcohol consumption. These rulers were based on a 10-point "Contemplation Ladder" developed to assess readiness for smoking cessation (Biener & Abrams, 1991). The Ladder has predicted participation in psychoeducational programs for smoking cessation, engagement in alcohol and substance use treatment services, and abstinence outcomes up to 1 year posttreatment (Hogue et al., 2010). Ladder scores are also significantly associated with previous attempts to quit, reported intention to quit smoking, and scores on the URICA's change stage subscales (Amodei & Lamb, 2004; Biener & Abrams, 1991).

Although the present adaptation of Readiness Rulers to assess general treatment participation and completion has yet not been empirically tested, its structure is very similar to these previously researched measures and promises to reduce assessment burden in the community outpatient treatment setting where the present investigation is occurring.

HME Composite Survey. The Hope-Meaning-Empowerment composite is a 7-item self-report index designed to track daily changes in consumers' experiences of hope, purpose in life, and self-efficacy. Items were selected from HHI (2 items), ES (2 items), MLQ (1 item), and State Hope Scale (2 items; SHS, Snyder et al., 1996), based on high loadings (over .7) on factors corresponding to the constructs of interest.

All items are rated on a Likert scale in which there are between 4 and 8 response options. Items from the HHI include, "I have a positive outlook toward life" and "I feel my life has value and worth," which load on the factors of future orientation and inner positive readiness respectively (.76 and .72). From the MLQ, the item "My life

has a clear sense of purpose" loads highly on the Presence of Meaning subscale (.71). Items from the ES include "I generally accomplish what I set out to do", which loads highest on the Self-esteem-Self-efficacy factor (.79) and the negatively-worded item "I feel powerless most of the time" loading highest on the power-powerlessness factor (.69).

In addition to the existential, more global indices of hope from the HHI, two items were selected from the SHS to capture the present-focused, cognitive, goal-oriented dimension of the construct: "There are lots of ways around any problem I am facing now" and "At the present time, I am energetically pursuing my goals." The former item loads significantly (over .70) on the SHS's pathways factor (e.g., perceiving many ways to reach a goal) and the latter item loads on the agency or self-efficacy factor (over .75). Although this composite has not been empirically tested with individuals with SMI, it possesses face validity, is easily self-administered, and substantially represents the constructs of interest.

Helpful Aspects of Therapy Questionnaire. The Helpful Aspects of Therapy Questionnaire (HAT; Llewelyn et al., 1988) is a brief, open-ended questionnaire completed by clients at the end of therapy sessions. Clients are asked to identify the most personally helpful or important event in session, which could be something either the therapist or client said or did. They are then asked to describe what made it helpful and what the client "got out of it." Clients are subsequently asked to rate the helpfulness of the event on a 9-point scale, with 1 being "extremely hindering" and 9 being "extremely helpful." They are also asked where in the session the event occurred and how long it lasted. In case studies, Elliott and Shapiro (1988) reported that the HAT yielded meaningful information about important themes for clients in therapy (e.g., interpersonal

patterns, symptoms). It also provided useful information about internal versus external attributions for significant events. The HAT is typically used in conjunction with Brief Structured Recall (BSR) to elicit further description of reactions to the significant event.

Client Participation Survey. The Client Participation survey is adapted from the Mental Health Disparities Initiative Protocol (Salzer, 2004), which gathers self-report indices of service participation. These include total number of individual and group therapy sessions that have been attended and the percentage of scheduled group and individual sessions that have been kept. It also gathers lateness or early departure information for individual and group therapy appointments and assesses reasons for missing appointments (e.g., "forgot", "did not have transportation"). Using a 5-point Likert scale with varying response descriptions, the survey also measures perceived level of participation in therapy (group and individual), degree of agreeable relations with clinicians, and quality of interaction with other consumers.

In addition to attendance information, the survey asks "Yes/No" questions about taking medications as prescribed and reasons for not taking these (e.g., "did not understand instructions from physician," "disagreed with doctor's recommendations"). It further assesses degree of perceived control and autonomy through "True/False" responses (e.g., "I felt free to do what I wanted about going to mental health treatment"). Although not part of the survey, objective attendance data were gathered through chart review and compared with self-reported attendance on the survey.

Motivational Interviewing Treatment Integrity Code. The Motivational Interviewing Treatment Integrity (MITI; Moyers, Martin, Manuel, Hendrickson, & Miller, 2005) Code is a behavioral coding system used to assess the quality and

competence of MI practice. It can be used as a treatment integrity measure, evaluating whether or not the delivered intervention was actually MI, and was also as a guide for practitioner improvement. Prior to coding, it is recommended that coders know a specific target of change for the interview.

The MITI 3.1 (Moyers, Martin, Manuel, Miller & Ernst, 2010) consists of five global scales (Collaboration, Evocation, Empathy, Autonomy/Support, Directiveness) corresponding to MI spirit and principles, rated on a 5-point Likert scale, with the intent to capture a rater's holistic sense of the practice. The second component is a count of interviewer behaviors from the beginning to the end of the segment, typically running 20 minutes in length. These behaviors are categorized either as MI Adherent (asking permission, affirm, emphasize control, support), MI Non-adherent (advise, confront, direct), Closed Question, Open Question, Simple Reflection, or Complex Reflection.

Coders calculate the percent of Complex Reflections, percent of Open questions, the Reflection-to-Question ratio, and percent of MI Adherent behaviors for reviewed segment. Summary scores include a Global Spirit Rating, which is the average of Evocation, Collaboration, and Autonomy/Support scores from the global scales. For each summary index, Moyers et al. (2010) provide beginning proficiency and competency thresholds to help interpret an interviewer's skill level. They define competency as an average Global Rating of 4, a 2:1 Reflection-to-Question ratio, 70% Open Questions, 50% Complex Reflections, and 100% MI-Adherent.

Studying the MITI Version 2, Forsberg, Berman, Kallmen, Hermansson, and Helgason (2008) reported that the MITI could differentiate between interviewers with differing levels of training and between MI practitioners and advice-giving counselors,

supporting its construct and discriminant validity. Interrater reliability was fair to excellent, ranging from .40 to .88, with 76% agreement on global scores in which the scores fell within 1 point of each other. In a more recent study examining MI's effects on cannabis cessation, McCambridge et al. (2011) also reported fair to excellent interrater reliability across global scores and behavior counts, ranging from .56 for Complex Reflections to .98 for Closed Questions. MI Spirit and proportion of Complex Reflections predicted outcomes, supporting the instrument's validity.

Procedure

Baseline phase. Participants identified by STOP clinicians as those who met the inclusion criteria for the study and who agreed to talk to the responsible investigator. They were contacted to set up an initial appointment for study enrollment. Consumers met at the agency at a date and time convenient to them. At this initial session, the consent form was reviewed and an overview and rationale of the study was provided, including information about compensation. It was explained that participants would receive a $10 gift card after completing each study session, for a potential of $100 across all 10 visits. If the potential participant chose to participate, the first set of baseline measures were completed (Participation Survey, PRR, STORI, HHI, ES, MLQ, TMQ). Following the first baseline session, study research assistants began contacting the participants by phone four times a week to administer the HME survey. The phone surveys continued through the one-month follow-up. At the initial baseline visit, a chart review was conducted to gather attendance data (if available) from the previous month.

Barlow and Hersen (1973) recommended a minimum of three separate observation points during the baseline phase to establish a trend. As a result, participants

were asked to attend four baseline measurement sessions, each separated by one week. At each baseline session, they completed the HHI, MLQ, and ES, measuring hope, meaning, and empowerment constructs respectively. Because these are primary outcome variables and are most susceptible to fluctuation, it was especially important to establish a trend with these measures. To reduce measurement burden, the STORI and TMQ was administered at baseline Sessions 1 and 4. Although Sidman (1960) suggests that rates of variability during baseline should fall within a 5 percent range, statistical methods were available in the event that variability exceeds this rate. Participants began the study at different points in time; however, the investigator attempted to maintain the same time interval between individual baseline measurements and MI sessions (one week) for all participants.

MI phase. One week after the fourth baseline measurement, participants began the MI phase of the study. The responsible investigator, a clinical psychology doctoral student with five years of experience practicing MI, served as the interviewer for all MI sessions. Every session was audio recorded for the purpose of identifying key change moments for later analysis during the BSR interview. The MI protocol for the current study was adapted for dually diagnosed consumers, incorporating elements of existing MI interventions, some of which have been modified for this specific population (Carey, Purnine, Maisto, & Carey, 2001; Graeber et al., 2003; Handmaker et al., 2002; Zuckoff, Swartz, & Grote, 2008). The protocol draws most heavily from Zuckoff et al.'s (2008) single-session engagement protocol for depression treatment and the Carey et al. (2001) manual for substance abuse-focused MI. In the Carey manual, treatment participation is addressed as a peripheral MI target and only briefly mentioned. In this respect, the

current protocol represents a substantial departure from their primary intended goal, which was to increase readiness to change in individuals with substance abuse problems.

Each of the four 45-50 minute MI sessions was flexible enough to accommodate the wide range of difficulties that participants bring into session. However, participation in services represented the general motivational focus for all participants, in addition to any factors that influenced their decisions to engage or not engage with providers. These factors could include multiple problem areas, including substance abuse, psychotic symptoms, medication concerns, life stressors, low self-efficacy, diffuse sense of identity, poor social support, practical barriers, and service system issues. The MI intervention addressed overall indecisiveness with regard to treatment services, regardless of whether those services focused on psychiatric or substance abuse concerns. Of course, it is implied in MI that the counselor follows the participant's lead in terms of which problem areas to discuss, particularly as they might relate to participation or non-participation in services. The four-session protocol was guided by a general outline of session activities, but was not manualized. Research has indicated that using a manual in MI either does not enhance outcomes or makes it significantly less effective, depending on the comparison group (Hettema et al., 2005; Lundahl et al., 2010).

In line with the recovery model and factors associated with disengagement, the MI intervention had six overarching goals: 1) develop a strong therapeutic alliance; 2) elicit and explore issues of self-definition, self-esteem, values, and life goals; 3) raise awareness of how treatment participation relates to sense of self, goals, and values (e.g., highlighting discrepancies where appropriate); 4) provide support and enhance self-efficacy; 5) assist participants in setting realistic, value-consistent goals with regard to

treatment participation and in developing plans to reach these goals; and 6) explore the meaning, role, and specifics of collaborative treatment planning with regard to autonomy and improved subjective experience.

Similar to the STOR model (Andresen et al., 2006), the protocol progressed from identity, meaning, and values-oriented topics (Sessions 1 and 2) to more action-oriented, goal-specific, and self-efficacy focused discussions (Sessions 3 and 4). This sequence mirrors the shift consumers have reported experiencing during recovery, as they move from a hopeless, diffuse identity state (Moratorium) to a more hopeful, meaning-filled, and treatment-engaged state (Rebuilding and Growth). One caveat is that self-efficacy and values-oriented discussions may not be confined to the scheduled session, since participants would likely present at different levels of readiness and progress at different speeds. Carey et al. (2001) emphasized this point when explaining the need for MI counselor flexibility within the structure of the sessions. The chosen structure for the protocol appears to fit best for participants entering the study in the Moratorium SOR when identity, meaning, and values-oriented topics may initially have highest relevance.

Immediately following MI Sessions 1 through 4, participants completed the HHI, MLQ, ES, PRR, and HAT. After MI Session 4, participants also completed the STORI and TMQ. The STORI and TMQ were not administered after every MI session to reduce the test-taking burden on participants. Additionally, following Session 4, participants completed the full battery of measures, as they did after baseline Session 1. This was considered the posttreatment measurement. At this point, the HAT was modified to ask clients "of the events which occurred in this session or past sessions, which one do you feel was the most *helpful* or *important* for you personally?"

Participants were given the option of completing the HAT verbally or in writing. Previous HAT responses were available to assist with the participant's recall, if necessary. The event identified during this HAT survey was used as the focus of the BSR interview, scheduled within one week of MI Session 4.

MI Readiness-to-Participate in Services protocol (M-REPS).

Session 1. There were six main goals for the first session: 1) introduce the intervention; 2) explore reasons for coming; 3) elicit the participant's perspectives on current difficulties and perceptions of treatment; 4) engage in a decisional balance activity around treatment participation; 5) explore thoughts and feelings about past treatment experiences, and 6) discuss personal goals for the future and identify ideas about future service participation. Open-ended questions about the participant's current attitudes, empathic understanding, rolling with resistance, and reflective listening are the hallmarks of this session, although they run throughout the intervention as part of good MI practice.

In line with Miller and Rollnick's (2009) thinking about the appropriate use of decisional balance in MI, it was used in this study as a strategy to respond to sustain talk in Session 1, prior to exploring perceived benefits of treatment participation. When sustain talk was absent, the interviewer initiated a more general discussion of reasons for change, as if focusing only on the "for change" side of decisional balance. To simplify the approach, Carey et al. (2001) recommended zeroing in on one or two strongly endorsed reasons for change, inviting further elaboration and feedback. Session 1 ended with a summary of important points, reinforcement of any key self-motivational statements, and affirmation for participating in the session.

Session 2. The second session had four main objectives: 1) review key points from the initial session; 2) inquire about thoughts, feelings, or behaviors around treatment activities in past week; 3) complete the Personal Values Card Sort (Miller & C'de Baca, 2001) and discuss values-behavior discrepancies or consistencies around treatment participation, and 4) continue building the therapeutic alliance. The purpose of values-behavior discrepancy discussions is not to suggest that discrepancy *should* exist or to create *new* discrepancy, but rather to reveal and clarify the discrepancies that already exist, relative to ambivalence about service engagement. Of course, it was equally important to elaborate on areas where treatment participation, either present or past, is consistent with deeply held values.

Similar to Session 1, the second session concluded with a transitional summary of key points, including any self-motivational statements. Toward the end of the session, if the participant connected values with treatment goals, the interviewer asked the participant a key question, such as "Where does this leave you in thinking about how you want to use treatment?" If the participant described action already taken around value-consistent goals, the interviewer guided discussion toward confidence. Importance and confidence rulers were used clinically across all sessions as part of this guiding process.

Session 3. As with the previous two sessions, Session 3 began with a review of pertinent points from earlier sessions and an introduction to the plan for that day's session (always checked collaboratively with the participant). If the participant was ready, Session 3 marked a shift away from values and identity-based focus of Sessions 1 and 2 and toward issues around self-efficacy. There were six primary goals: 1) continue to reinforce autonomy and change talk; 2) discuss current strengths, aspirations, and the

positive effects that treatment participation may have on them; 3) explore past successes and barriers overcome, as well as the meanings inherent in them; 4) begin identifying specific treatment-related activities that the participant might want to think about or act on, if he or she is not doing so already; 5) problem-solve around any barriers they might discuss related to increased participation; and 6) create a change plan if ready.

Assuming the goal of treatment involvement remained personally important, greater attention was paid to the confidence assessment, with questions such as, "What makes you as confident as a 5? Why not lower?" With enthusiasm expressed for the participant's goals, discussion centered around challenges overcome as a means of building self-efficacy. The counselor helped consumers explore past successes (Miller & Rollnick, 2002) and also obstacles overcome. Additionally, the counselor asked about hypothetical change, or what the participant believed would have worked best if goals were achieved. The interviewer also had the option of using the strategy of envisioning, or helping participants imagine what would be different if they had achieved personal goals, reinforcing ideas and positive feelings around what they would like do. Combined with an open-ended exploration of how treatment involvement might factor into this desired state could, for some people, increase self-efficacy, determination, and confidence.

Topics also included problem-solving around barriers, recruiting social support, and goal-oriented steps in planning for change. The counselor not only focused on confidence and the role of treatment participation, but also on the positive meanings the consumer may have discovered by coping with addiction and mental illness. This reflects the view that key motivational factors for individuals in recovery may include expecting

positive outcomes, feeling capable, establishing a more positive, clearly defined sense of self, and finding personal meaning in past or present experiences.

Session 4. Session 4 had four main objectives, again assuming a flexibility that is essential to competent MI delivery: 1) reinforce gains in motivation and in any positive behavioral changes or self-perception during the intervention; 2) help the participant develop a clear plan of action related to personally important goals as these relate to treatment involvement (or begin a plan if the participant was not ready in Session 3); 3) reinforce relevant service utilization or treatment activities in which he or she has expressed interest, and 4) emphasize personal choice and responsibility in recovery after the intervention.

The final session began with a review of information from previous sessions, in a summary and collaborative agenda-setting for the session. In this summary, as in those for prior sessions, activities and discussions that prompted the most vigorous or enthusiastic responses regarding treatment engagement were highlighted, as well as change talk. The interviewer emphasized advances in change readiness if they had emerged, paying special attention to any increases in service engagement that may have accompanied it.

The principle activity of Session 4 involved completing a modified version of the "Next Steps" worksheet developed by Carey et al. (2001), which is an adaptation of the Change Plan Worksheet from the Motivational Enhancement Therapy manual (Miller, Zweben, DiClemente, & Rychtarik, 1992). The adapted worksheet consists of 6 sections which pertain to looking ahead: 1) where the client wants to be in the next 90 days; 2) reasons this goal is important; 3) action steps toward the goal; 4) who will be supportive;

5) potential barriers, and 6) ways to overcome barriers. For the purposes of this study, participants were asked whether and how treatment participation fit in with these goals and what the participants specifically wanted to do. In developing concrete steps for section 3, the interviewer first elicited the participant's ideas. If he or she could not identify any, the interviewer asked permission to share information about what other people had found helpful and then offered a menu of options, asking which, if any, fit. The activity ended with an affirmation for participating in the study and an open question about general experiences over the course of the four sessions.

Post-treatment BSR interview. After participants completed the post-measures following MI Session 4, the responsible investigator scheduled a 30-minute BSR session within one week. The BSR focused on the significant event identified during the final HAT questionnaire, which could be drawn from any of the four MI sessions. A research assistant conducted the BSR session to increase openness and honesty in responses. Administering the BSR on a day different from than the final MI session helped reduce response burden and allowed the responsible investigator to locate and prepare the appropriate taped segment of the session. The BSR session was audio recorded for later qualitative analysis.

The procedure for the BSR session was adapted from the manual developed by Elliott (1988) for the Experiential Therapy of Depression Project. The interviewer initially oriented the participant, verbally, to the process using the following statement:

> In your last session, you pointed out a helpful, important, or enjoyable part in the sessions you had. I'm going to play a recording of that part to help remind you of

> what you and Scott said, and ask you some questions about what has happening for you at the time.

After this, the interviewer addressed any concerns about this process that the participant might have had, and continued only if the participant felt sufficiently comfortable. Participants then received the following instructions:

> As I play the tape back for you, I would like you to try to put yourself back into the event as much as you can. Try to remember what was going on for you then, as opposed to what you might think about it now—thoughts, feelings, images, memories. Please let me know whenever we get to something you'd like to comment on, by nodding or by saying something and I'll pause it. Or you can wait until the end. Either way is fine. Any questions?

The interviewer played the tape from the beginning of the event to the end, which lasted under 10 minutes. While the tape was playing, the interviewer looked for any nonverbal signs that the participant had something to say. If a sign emerged, the interviewer stopped the tape and invited the person to share what he or she was thinking. After the tape finished playing, these questions were asked in the following order:

1. What has happening for you during the part we just listened to?
2. What were you feeling when that was happening in the session?
3. What was going through your mind when that was happening in the session? What were you thinking?
4. What, if anything, did <u>your therapist</u> say or do during this part that stands out in your mind as helpful, important, or enjoyable?

5. What, if anything, did you say or do during this part that stands out in your mind as helpful, important, or enjoyable?

6. What effect, if any, did this have on you immediately after the session? What about in the days after the session?

7. What might possibly change for you because of this part? What might happen for you in the next month, in a few months, or in a year as a result of this part?

8. What else, if anything really stands out?

Finally, the interviewer asked whether the participant had any thoughts or feelings about the MI experience as a whole that he or she would like to share.

One month follow-up. Participants completed all initial measures (STORI, TMQ, PRR, HHI, MLQ, ES and Client Participation Survey) one month after MI Session 4. Attendance data were also gathered from charts, if available. If the participant could not attend the follow-up session in person, the responsible investigator administered these over the phone.

Data analysis.

MI fidelity. For each participant, one session was selected at random from the four possible sessions. A random 20-minute segment was then chosen for each of these sessions and sent to two independent MITI coders, each with at least several years experience with the MITI coding system.

Simulation Modeling Analysis and descriptive statistics. To test the hypothesis that participants would experience increases in hope, meaning, and empowerment from pre- to posttreatment, Simulation Modeling Analysis (SMA;

Borckardt, Nash, Murphy, Moore, & O'Neil, 2008; Wilcox, 2001) was performed on the HME composite data across baseline and intervention phases. SMA is a statistical procedure appropriate for short streams of time-series data (fewer than 30 observations per phase) that evaluates the significance of between-phase changes. It controls for autocorrelation effects that would inflate the probability of Type 1 error if parametric statistics were used. With short data streams, it provides substantially more power and more acceptable selectivity than conventional statistics (Bockardt et al., 2008).

SMA calculates the treatment effect sizes for thousands of randomly generated, simulated data streams with the same autocorrelation and sample size parameters as the study sample. It further calculates the probability that each effect size will occur by chance, which allows one to determine how likely the effect size obtained in the study would occur by chance in a null distribution. Bockardt et al. (2008) recommend a minimum of 10 to 16 total observations in the sample, with at least 5 observations per phase. SMA further provides significance tests for slope and level changes from baseline to treatment phases, in addition to vector correlations which describe slope directions within each phase.

Changes in hope, meaning, and empowerment were also assessed through descriptive statistics (means and standard deviations) for baseline and MI phases, using the more complete dependent measures (HHI, ES, MLQ), as well as through visual inspection of graphed data for these measures, comparing participants across measurement points. The same evaluative approach was taken with PRR, TMQ, and STORI results due to a small observation N (seven or less points over the study). Along with visual inspection of STORI subscale means, analysis included stage allocation at

each measurement point. Service participation data were summarized descriptively as well.

Grounded theory. As conceptualized by Corbin and Strauss (2008), grounded theory methodology was used to explore theoretical constructs within the BSR interviews. Because the interviews concerned responses to helpful, important, or enjoyable parts of MI, it was expected that central themes of hope, meaning, and empowerment would emerge in connection with MI method and spirit. Specifically, it was hypothesized that participants would associate values-related MI components (e.g., Personal Values Card Sort) with increased meaning or purpose, and self-efficacy components with a greater sense of empowerment. Through axial coding, grounded theory promised to help specify interrelationships among identified constructs (potentially hope, meaning, empowerment, MI spirit, MI methods, recovery), which in turn could shed light on how MI operates in the context of dual diagnosis recovery to affect these variables.

Each BSR interview transcript was first read and then open coded separately by three coders (two doctoral-level graduate students with qualitative research experience and the responsible investigator). Open coding involves the labeling and categorizing of concepts in the data. All three coders met biweekly for an hour and a half to discuss their codes, to come to a consensus, and resolve any disagreements. For disagreements that could not be resolved, a final code was assigned, based on a majority (two coders agreeing on a label). All final codes were entered into an Excel spreadsheet along with the corresponding interview segment. Meetings proceeded from open coding to axial coding (e.g., connecting concepts) as the available data increased; these included

distilling storylines (e.g., positive change in perceived ability and self-esteem) and identifying relationships between ideas such as MI spirit, self-disclosure, and recovery.

Coders used a number of tools suggested by Corbin and Strauss (2008) to assist in identifying themes during open coding. These included brainstorming *various meanings of a word* and selecting the best fit, given contextual factors. For instance, some participants used words such as "help," "emotional," "God," and "wow" in describing their recovery experiences, words whose elaborated meanings led to deeper interpretive significance. Work also focused on *looking at narrative structure* and *time words* because participants often jumped back and forth between talking about past periods of addiction/poor mental health and present well-being. *Far out comparisons* helped to discern new dimensions and relevant properties of a concept, such as comparing sobriety achievement to an athlete winning a gold medal after numerous failed attempts. This strategy helped clarify potential emotions and thoughts associated with the event. Coders used *sensitizing questions* to deepen the analysis, such as "What would a future role mentoring young addicts mean to this person?" and "What function does looking at NA key chains every night serve?" *Theoretical questions* assisted with axial coding or linking concepts. For instance, the question, "How might the safety felt in group therapy mirror the experience of MI's person-centered atmosphere?", helped specify desirable conditions for self-disclosure that reinforce positive self-worth and competence across contexts. Last, Ryan and Bernard (2003) talk about the importance of *indigenous categories* or terms used by interviewees that have unique meaning within a particular setting. In this study, these "in-vivo" codes (Corbin & Strauss, 2008) included phrases with particular significance within recovery communities such as, "just for today," "home

group," and "running the street."

Results

Sample Characteristics

Participants were 5 women and 3 men, ranging in age from 28 to 55 years (M = 42.62, SD = 9.68). Seven (87.5%) were African American and 1 (12.5%) was Caucasian. Length of treatment duration prior to enrolling in the study ranged from 2 months to 35 months (M = 10.25, SD = 10.51). Upon entering the study, 6 (75%) participants had a diagnosis of bipolar disorder and 2 (25%) had a diagnosis of major depressive disorder with psychotic features. Seven (87.5%) participants had a documented co-occurring diagnosis of polysubstance dependence, with 1 of these 7 carrying an additional diagnosis of alcohol dependence. The one participant without polysubstance dependence had received a diagnosis of alcohol and marijuana dependence upon admission to STOP. Additionally, two (25%) participants had a documented history of sexual or physical abuse as children. Three (37.5%) other participants had a documented history of witnessing violence or surviving domestic abuse.

Of the 8 STOP consumers who began the study, 2 dropped out during baseline data collection. One female participant left the agency to seek treatment closer to home and 1 male participant withdrew because he preferred not to complete the phone surveys. Six participants (4 females and 2 males) completed all baseline, MI, and BSR visits. MI sessions ranged from 20 to 63 minutes in duration, with an average session length of 38 minutes (SD = 12.9). Participants received average total of 148 minutes of MI across 4 sessions. For study completers, average length of abstinence from drugs or alcohol prior to entering the study was 8.2 months, ranging between 1 month and 18 months. One

withdrew from the study prior to follow-up and another could not be reached to complete follow-up. Those who completed all study visits, including follow-up, had spent a greater number of months in treatment (M = 15.0) and were slightly younger (M = 38.75) than non-completers. Also, the 2 participants diagnosed with major depressive disorder with psychotic features did not finish the study. One dropped out during baseline and the other was unreachable for follow-up.

Although every effort was made to administer the HME survey to participants four times a week, frequency of survey completion varied across baseline, MI, and post-MI phases, most often due to participant unavailability. For Participant 1, HME survey completion became less frequent during MI, with only three observation points collected during that phase. This required collapsing data collected during MI and post-MI into a single phase in order to run SMA analysis. Additionally, as a result of family emergencies, three weeks separated the last baseline session and the first MI session for Participant 3. Three weeks also separated her third and fourth MI sessions. Given the extended time of data collection over Baseline and MI phases for Participant 3, HME surveys were discontinued two weeks after MI ended in order to make the response burden roughly equivalent across participants. Participant 6 had a three-week gap between MI Sessions 3 and 4 as a result of work-related obligations; this was his only extended lapse. Two weeks separated Baseline Session 4 and MI Session 1 for Participant 4. During these gaps, a research assistant continued to collect HME survey data. Research assistants noted that participant responses to the HME items became increasingly consistent as the surveys progressed, in some cases showing little or no variation in ratings across administrations.

MI Fidelity

Across six randomly selected 20-minute segments of MI, one for each participant, MITI coding indicated competency for Global scales of Evocation (4), Collaboration (4.2), Autonomy support (4.2), and Empathy (4). Direction (3.5) was measured at a level of beginning proficiency. Competency was reached with % complex reflections (56.7%), % open-ended questions (79%), and % MI-adherent (100%). The reflections to question ratio (R:Q) fell slightly below competency at (1.84), yet still exceeded the criterion for beginning proficiency.

Effects of MI on Hope, Meaning, and Empowerment

Simulation Modeling Analysis (SMA) was utilized to determine whether the introduction or withdrawal of MI precipitated a sudden, significant change in HME scores (between-phase changes). This procedure also examined whether or not meaningful patterns of change in HME scores occurred during Baseline and MI phases (within-phase changes). In terms of between-phase changes, SMA analysis produced Pearson correlations between the dependent variable (HME scores) and a positive level-change "vector" across phase boundaries. A positive correlation with this vector signified a score *increase* between phases, whereas a negative correlation represented a *decrease*. Two sets of correlations were run, one for Baseline to MI level changes and one for MI to Follow-up level changes. Associated significance tests described the probability of obtaining these correlations by chance, and were based on 10,000 simulated samples that possessed the same *n* and autocorrelations as the individual participant's data stream.

As shown in Table 1, statistically significant increases in HME levels between Baseline and MI phases were noted for Participant 3 (Baseline, M = 18.9; MI, M = 20.5; r_L= .69, p < .01) and for Participant 4 (Baseline, M = 15.8; MI, M = 18.5; r_L = .66, p < .01). No statistically significant HME level changes were observed for any participant between MI and Follow-up phases. Participant 1's MI and Follow-up phase data were combined, allowing only for a Baseline to MI analysis.

In addition to data on level change between phases, SMA yielded information about changes in HME scores during each phase, or slope patterns. The analysis correlated HME scores with five different linear slope vectors: Vector 1, increasing in Phase A and decreasing in Phase B; Vector 2, flat during Phase A and increasing in Phase B; Vector 3, increasing in Phase A and leveling out in Phase B; Vector 4, increasing in both Phases A and B, and Vector 5, increasing then immediately dropping in Phase A followed by an increase in Phase B. Two slope vector correlations were calculated for each participant, one for Baseline and MI phases, and one for MI and Follow-up phases. Table 1 reports the "best fit" slope vectors for each participant for each phase comparison (Baseline-MI and MI-Follow-up). "Best fit" was defined as the vector with the greatest magnitude of correlation with HME scores and the lowest p-value.

HME scores for Participants 2 and 3 showed a statistically significant trend of increasing during Baseline and leveling out during MI (r_S= .67, p < .05; and r_S = .73, p < .05 respectively). Participant 5's scores were flat during Baseline and increased during MI (r_S= .36, p < .05), although the correlation with this vector was relatively small. The same vector was moderately correlated with Participant 4's scores and approached significance (r_S= .57, p = .058). A small but significant trend of HME scores increasing

during MI and dropping during Follow-up was noted for Participant 6 (r_S= .43, p < .05), and an increase-drop-increase pattern occurred across these phases for Participant 5 (r_S= .44, p < .05). No other significant slope pattern was observed over MI and Follow-up.

Also displayed in Table 1, HME average scores ranged from 14 to 24.1 in Baseline and from 14.2 to 27.9 in the MI condition. Scores of 7 to 13 are considered Low, 14 to 20 Moderate, and 20 to 28 High, based on dividing the score range into thirds. Those who entered the study in the High range (Participants 1 and 2) and Moderate range (Participants 3, 4, 5, and 6) remained there during MI. Overall, the HME average scores increased by .8% to 17% from Baseline to MI for Participants 2, 3, 4, and 5. Participants 1 and 6 had slightly lower average HME scores in MI relative to Baseline, a 1.8% and 5% decrease respectively, although these differences did not result in statistically significant level changes.

Table 1

HME Level and Slope for Simulation Modeling Analysis from Baseline to MI, and MI to Follow-Up by Participant

	Baseline		MI		Follow-up		Baseline to MI			MI to Follow-up		
Participant	*n*	*M*	*n*	*M*	*n*	*M*	r_L	r_S	v_S	r_L	r_S	v_S
1	11	23.2	14	22.0			-.31	.59	1			
2	13	24.2	11	27.9	12	28.0	.53	.67**	3	.22	.18	2
3	22	18.9	22	20.5	6	21.0	.69**	.73**	3	.42	.37	2
4	15	15.8	11	18.5	15	18.5	.66**	.57	2	.00	.62	1
5	13	14.0	11	14.2	10	14.3	.18	.36**	2	.09	.44*	5
6	14	20.3	15	19.9	8	20.0	-.22	-.28	1	.16	.43*	1

Note. MI and Follow-up observations were combined in MI condition for Participant 1. r_L = Pearson correlation for level change; r_S = Pearson correlation for slope vector; v_S = slope vector with highest magnitude correlation. Slope vector refers to phase A/phase B patterns, comparing Baseline to MI or MI to Follow-up: 1 = increase/decrease; 2 = flat/increase; 3 = increase/level out; 4 = increase/increase; 5 = increase-drop/increase.
* p < .05; ** p
.01

Mean total scores on the full measures of hope (HHI), meaning (MLQ), and empowerment (ES) over Baseline and MI administrations (4 measurements per phase) were examined descriptively for completeness. Table 2 shows that Participants 1, 2, 3, 4, and 6 began the study with moderate to high levels of hope (Baseline HHI, *M* = 29 to 34.5), meaning (Baseline MLQ, *M* = 44.3 to 63.3), and empowerment (Baseline ES, *M* = 68.5 to 82.5). At Baseline, Participant 5 had the lowest mean levels on these measures, his scores falling in the bottom third of the scoring ranges (HHI, *M* = 16, SD = 5.4; MLQ, *M* = 20, SD = 5.4; ES, *M* = 59, SD = 3.4). Participant 2 had the highest mean levels of hope, meaning, and empowerment over Baseline and MI phases.

In terms of the full measures, all participants showed positive mean changes in hope, meaning, and empowerment indices during the intervention. Differences between Baseline and MI means for each instrument were calculated, then divided by the total possible score range for that

Table 2

Hope, Meaning, and Empowerment Levels In Baseline and MI Intervention Phases by Participant

	HHI				MLQ				ES			
	Baseline		MI		Baseline		MI		Baseline		MI	
Part	*M*	*(SD)*	*M*	*(SD)*	*M*	*(SD)*	*M*	*(SD)*	*M*	*(SD)*	*M*	*(SD)*
1	34.5	(2.08)	36.5	(2.51)	46.0	(14.02)	58.5	(6.76)	79.5	(3.79)	85.3	(4.57)
2	44.0	(2.00)	48.0	(0.00)	63.3	(2.75)	67.5	(3.70)	82.5	(3.70)	94.0	(3.56)
3	29.3	(0.95)	35.8	(0.50)	44.3	(7.80)	63.0	(8.25)	68.5	(2.65)	75.5	(1.91)
4	32.3	(2.63)	40.8	(2.50)	55.5	(3.87)	61.5	(4.04)	73.5	(1.91)	86.0	(4.40)
5	16.0	(5.42)	26.5	(2.08)	20.0	(5.35)	39.8	(3.75)	59.0	(3.37)	70.3	(2.63)
6	32.0	(3.74)	35.0	(1.82)	48.3	(17.00)	59.0	(1.15)	70.5	(4.04)	73.0	(2.58)

Note. n = 4 for each participant in each phase for HHI, MLQ, and ES. Total scores were used for each measure. HHI = Herth Hope Index; MLQ = Meaning in Life Questionnaire; ES = Empowerment Scale. Total Score Ranges for HHI = 12-48; MLQ = 10-70; ES = 28-112.

measure to arrive at a change percentage. This procedure made it possible to compare change percentages meaningfully across measures with variable score ranges, preserving the appropriate proportion of change based on each instrument's range. In other words, an ES difference of 3 mean points would equal 3.6% of the possible range of 84, whereas the same absolute point difference would equal 8.1% of the HHI's 37-point range. For measures such as the HHI with smaller score ranges, an absolute difference of 3 points theoretically indicates greater change in hope than the same point difference means for empowerment.

Based on this methodology, the mean total HHI scores increased between 5.6% and 29.2% from Baseline to MI, with an average increase across all participants of 16%. Mean total MLQ scores increased the most, ranging from 7% to 33% higher in MI, in comparison with Baseline, and, overall, averaging 20% higher across participants during the intervention. Mean total ES scores increased between 3% and 14.9% from Baseline to MI, with an average increase across participants of 10%. Participant 5, who began the study with the lowest levels of hope, meaning, and empowerment, reported the greatest improvement on the hope and meaning measures (29.2% and 33% respectively), in comparison with the other participants. Participants 1 and 6 showed the least mean gains in hope and empowerment when comparing Baseline and MI phases, with less than a 9% improvement on each measure. Although Participants 2 and 4 entered the study with high levels of empowerment, their scores increased the most during MI (by 13.7% and 14.9% respectively).

Examining MLQ and ES subscale scores helped determine whether one or more specific factors accounted for a majority of change in the measures' total scores from Baseline to MI. Table 3 compares Baseline with MI means for the Presence of Meaning and Search for Meaning subscales of the MLQ. Increases in participants' present sense of significance and purpose in life ranged from 11.7% to 49.2% from Baseline to MI, with an overall sample average increase of 26.2%. Lower increases were observed for people's search for meaning, 0% to 32.5%, with a mean increase of 13.7%. Similar analysis for the ES revealed the greatest participant improvement on the Self-esteem-Self-efficacy subscale during MI, an increase over Baseline ranging from 3.7% to 27.8% and averaging 19.3% over all participants. This stands in comparison with the average Baseline to MI increases observed across all participants for the other ES subscales: Power/Powerlessness (0.9%), Righteous Anger (4.2%), Community Activism (9.3%), and Optimism/Control (10.1%).

Table 3

MLQ Presence and Search Subscales In Baseline and MI Intervention Phases by Participant

	Presence				Search			
	Baseline		MI		Baseline		MI	
Participant	*M*	*(SD)*	*M*	*(SD)*	*M*	*(SD)*	*M*	*(SD)*
1	21.0	(9.70)	30.0	(3.74)	25.0	(5.03)	28.5	(3.70)
2	28.3	(2.75)	32.5	(3.70)	35.0	(0.00)	35.0	(0.00)
3	16.8	(3.40)	31.5	(4.12)	27.5	(5.45)	31.5	(4.73)
4	23.5	(3.69)	29.3	(2.75)	32.0	(1.83)	32.3	(1.71)
5	8.3	(2.63)	18.3	(4.03)	11.8	(3.10)	21.5	(4.36)
6	21.0	(3.74)	24.5	(1.91)	27.3	(13.50)	34.5	(1.00)

Note. n = 4 for each participant in each phase. MLQ = Meaning in Life Questionnaire. Presence and Search subscale ranges 5-35.

In general, gains in hope, meaning, and empowerment were maintained one month post-MI for participants for whom data was available (Participants 2, 4, 5, and 6). Participants' follow-up total scores on the full measures (HHI, ES, MLQ) deviated 3.5% or less from their MI phase scores in either direction, with two exceptions. Participant 5 reported a 5.6% decrease in meaning and a 9.5% increase in hope at follow-up.

MI and Stages of Recovery

STORI stage allocation at each measurement point was determined by the highest mean subscale score at that point. Subscales corresponded to the Moratorium, Awareness, Preparation, Rebuilding, Growth stages. Participants were assigned to the most advanced stage in situations in which one or more stage means were equal. Based on STORI data, all participants except Participant 5 were allocated to an advanced stage of recovery at the initial Baseline session, as shown in Table 4. Participants 2, 3, and 4 were assigned to Rebuilding (Stage 4) and Participant 1 was assigned to Growth (Stage 5). Only Participant 5 was allocated to Moratorium (Stage 1) at the initial visit.

Table 4

Stage of Recovery Allocation at Baseline, Post-MI, and Follow-up

Participant	B1	B4	Post-MI	Follow-up
1	Stage 5	Stage 5	Stage 5	
2	Stage 4	Stage 4	Stage 5	Stage 5
3	Stage 4	Stage 4	Stage 5	
4	Stage 4	Stage 4	Stage 3	Stage 4
5	Stage 1	Stage 1	Stage 3	Stage 1
6	Stage 3	Stage 4	Stage 4	Stage 4

Note. If scores on two STORI subscales were equal, participant was allocated to the higher stage. B1 = Baseline measurement 1; B4 = Baseline measurement 4; Stage 1 = Moratorium; Stage 2 = Awareness; Stage 3 = Preparation; Stage 4 = Rebuilding; Stage 5 = Growth.

Stage allocations remained unchanged across Baseline for all participants except Participant 6, who advanced to Rebuilding (Stage 4) during this phase. Three participants assigned to the same recovery stage across Baseline advanced to a higher stage post-MI. Participants 2 and 3 moved into Growth (Stage 5) and Participant 5 moved from Moratorium (Stage 1) to Preparation (Stage 3) post-MI. Participant 6 had not advanced in recovery stage after the intervention or at follow-up relative to Baseline measurement 4, remaining in the Rebuilding stage (Stage 4); however, as shown in Figure 1, a comparison of stage subscale means across these administrations shows decreasing endorsement of Moratorium items (Baseline 4, M = 2.0; Post-MI, M = 1.4; Follow-up, M = 1.0) and increasing endorsement of Rebuilding items (Baseline 4, M = 3.8; Post-MI, M = 4.6; Follow-up, M = 5.0). This finding indicates a trend toward this participant being more clearly defined in the Rebuilding stage. Participant 1, who also did not advance in recovery stage, had STORI scores that reflected a similar pattern of clearer stage allocation from Baseline to post-MI (Figure 2). She was more solidly classified in the Growth stage Post-MI, as indicated by lower Moratorium subscale means (Baseline 4, M = 1.8; Post-MI, M = 0.7), and Awareness subscale means (Baseline 4, M = 3.5; Post-MI, M = 2.5).

Backward stage movement occurred for two participants. Participant 4 regressed from Rebuilding (Stage 4) at Baseline to Preparation (Stage 3) at the post-MI measurement point; however, she had returned to Rebuilding at Follow-up. Participant

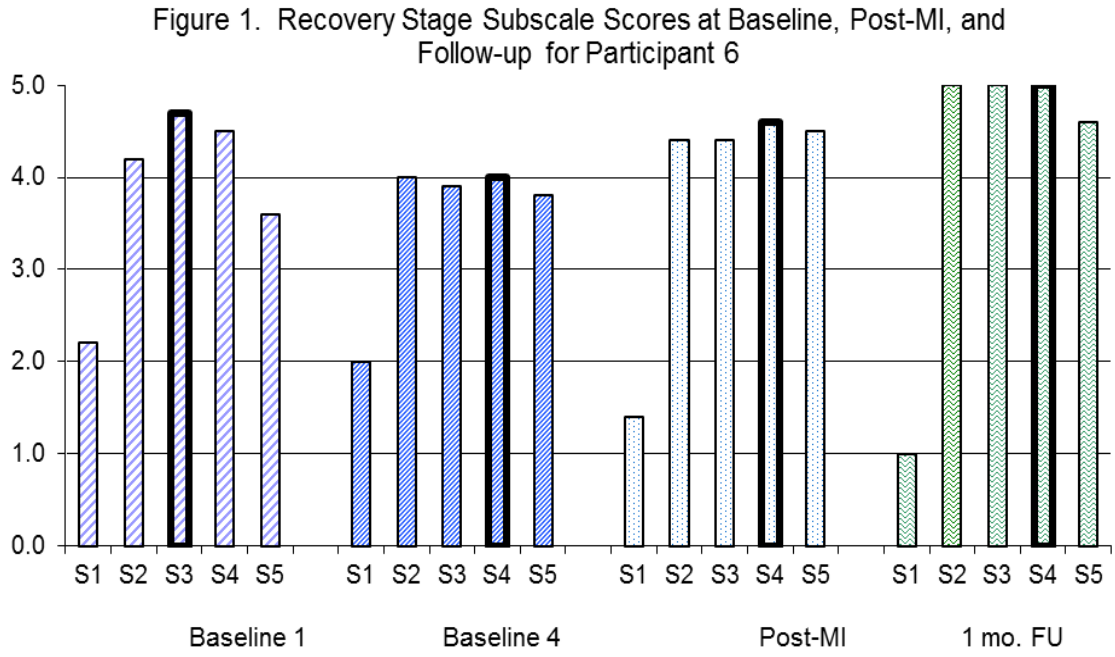


Figure 1. Mean scores on the five stage subscales of the STORI at Baseline 1, Baseline 4, Post-MI, and 1 month Follow-up. When scores for two subscales are tied, the person is allocated to the higher stage. Allocated stage for each measurement point is bolded; S1 = Stage 1, Moratorium; S2 = Stage 2, Awareness; S3 = Stage 3, Preparation; S4 = Stage 4, Rebuilding; S5 = Stage 5, Growth.

5's scores reflected backward stage movement to Moratorium (Stage 1) at Follow-up from Preparation (Stage 3) at the post-MI; however, she had returned to Rebuilding at Follow-up. Participant 5's scores reflected backward stage movement to Moratorium (Stage 1) at Follow-up from Preparation (Stage 3) at the post-MI measurement. Despite his stage regression, Participant 5 more strongly endorsed items across advanced stages (Preparation, Rebuilding, and Growth) at Follow-up relative to Baseline measurement 1, suggesting a less distinct fit with the Moratorium stage.

Participant 5's advancement of two stages during the intervention, from Moratorium to Preparation, co-occurred with greater increases on the HHI and MLQ, in

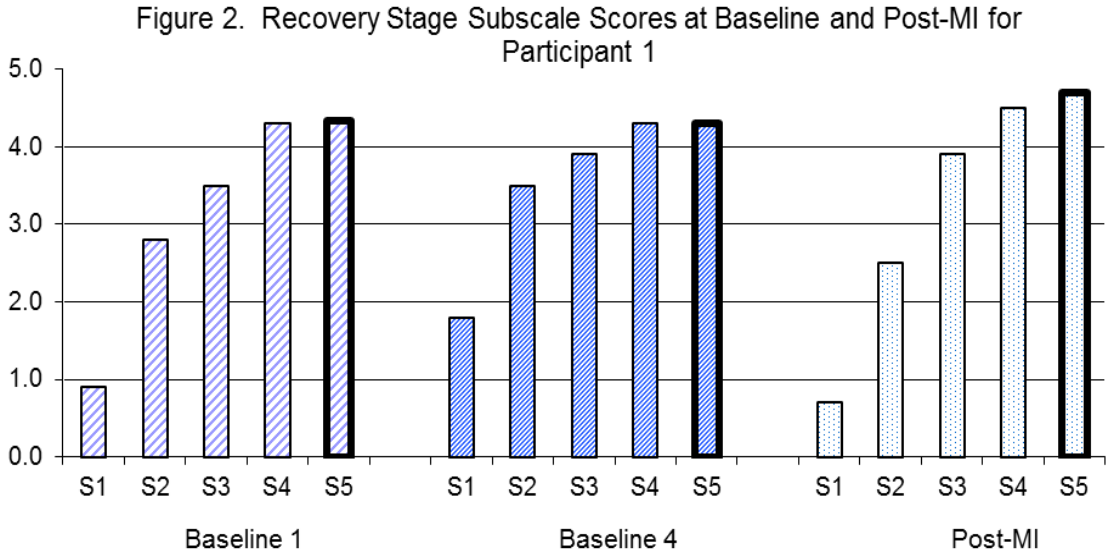


Figure 2. Mean scores on the five stage subscales of the STORI at Baseline 1, Baseline 4, and Post-MI. When scores for two subscales are tied, the person is allocated to the higher stage. Allocated stage for each measurement point is bolded; S1 = Stage 1, Moratorium; S2 = Stage 2, Awareness; S3 = Stage 3, Preparation; S4 = Stage 4, Rebuilding; S5 = Stage 5, Growth.

comparison with other participants who either advanced one stage, stayed the same, or regressed (see Table 2). To explore whether or not forward stage movement during MI, in general, was associated with greater increases on dependent measures, changes in HHI, ES, and MLQ from Baseline to MI were compared between advancers (Participants 2, 3, and 5) and non-advancers/regressors (Participants 1, 4, and 6). First, for each participant, differences between Baseline and MI means were calculated on each measure's total score. Second, average change scores for advancers and non-advancers were calculated on each measure and were compared. Advancers reported greater increases on the HHI,

ES, and MLQ than did non-advancers/regressors, although the differences were relatively small (2.5 points for HHI, 3 points for ES, and 4.6 points for MLQ).

Treatment Motivation and Readiness

TMQ results at the initial Baseline assessment (Table 5) indicated overall high levels of internal motivation for treatment engagement (*M* = 5.44, *SD* = 1.20), confidence that treatment would help (*M* = 5.27, *SD* = 1.61), and desire to share problems and relate to others in treatment (*M* = 4.56, *SD* = 1.58). Participants also entered the study reporting low external motivation or perceived pressure to participate in treatment (*M* = 1.92, *SD* = .93). From Baseline measurement 1 to Post-MI, help-seeking and confidence subscale means increased, whereas ratings of external motivation decreased. These trends continued through Follow-up, with the exception of confidence scores, which dropped at Follow-up below Baseline 1 measurements. Internal motivation ratings slightly decreased Post-MI (less than 1 SD) and rose to levels at Follow-up that were similar to Baseline measurement 1. It should be noted that Follow-up subscale means included two fewer participants, due to attrition.

Table 5

TMQ Scores by Subscale at Baseline, Post-MI, and Follow-up

	Baseline[a]							
	B1		B4		Post-MI[a]		Follow-up[b]	
TMQ Subscale	*M*	*(SD)*	*M*	*(SD)*	*M*	*(SD)*	*M*	*(SD)*
Internal	5.44	(1.20)	5.80	(0.97)	5.26	(0.80)	5.50	(0.35)
External	1.92	(0.93)	1.67	(1.08)	1.58	(0.92)	1.00	(0.00)
Help-seeking	4.56	(1.58)	5.67	(0.84)	5.72	(1.45)	6.33	(1.03)
Treatment confidence	5.27	(1.61)	5.73	(1.19)	6.43	(0.93)	4.80	(2.08)

Note. [a]*n* = 6. [b]*n* = 4

Individual changes in TMQ subscale scores were examined to further clarify treatment motivation changes prior to MI. All participants except Participant 4 reported increases in interpersonal help-seeking across Baseline, and Participants 3 and 5 displayed the most marked increase on this subscale (3.5 and 2.5 points respectively). Participants 2, 4, and 5 described greater internal motivation for treatment across Baseline, with Participant 5 showing the largest increase (1.6 points). Participants 3, 5, and 6 reported increases in treatment confidence, with Participant 3 experiencing the greatest change on this subscale (1.4 points). Prior to MI, a drop in external motivation was noted for Participants 2 and 3, but Participants 1, 4, and 5 remained at the same level. Participant 5 reported the highest degree of external motivation (M = 3.5) relative to the other participants at the initial Baseline assessment. Thus, despite trends of increasing help-seeking, confidence, and internal motivation, some participants changed more on one dimension than another, and to different degrees.

Additional changes in treatment motivation became apparent when comparing average Baseline scores (Baseline 1 and 4) with Post-MI scores. Relative to Baseline, and contrary to the expected direction, Participants 2 and 3 had the greatest decrease on the internal motivation subscale (12.1% and 21.2% respectively) during MI. Overall, five of six participants decreased on this subscale from Baseline to Post-MI. Participant 3's help-seeking mean score increased by 37.5% and Participant 2's treatment confidence score increased by 21.7%. Relative to other participants, Participant 6 had the greatest increase in treatment confidence from Baseline to Post-MI (Baseline 4, M = 4.8; Post-MI, M = 7.0) and also reported the sharpest drop in confidence from Post-MI to Follow-up, with his subscale mean decreasing from 7 to 2.2.

Along with trends of increasing confidence and help-seeking and decreasing external motivation over Baseline and MI phases, the majority of the sample reported a rising level of participation readiness on the Participation Readiness Rulers (PRR; Table 6). Comparing the last baseline measurement with Post-MI, three people (Participants 4, 5, and 6) displayed increased readiness to participate in or to complete treatment, whereas two (Participants 1 and 2) remained at the same high level of readiness on both indices. Two participants (Participants 4 and 5) who rated themselves as "unsure" about participating in services at Baseline identified themselves as "ready" or "very ready" to do so at the end of the intervention. They also showed the most dramatic increase in participation ratings, an average of 5.7 points higher. Participant 4 specified that her readiness ratings related to participation in treatment somewhere other than STOP, because she had decided to terminate her relationship with this agency at the outset of MI. As with the TMQ subscales, some self-reported change in readiness occurred during Baseline, with Participant 3 moving from "unsure" to "ready" and Participant 5 moving from "not ready" to "unsure." At the initial Baseline assessment, Participants 1 and 2 both reported feeling "very ready" to participate in services despite the indication from their therapists of low attendance or participation during screening.

In addition to greater treatment participation readiness, this sample became increasingly prepared to complete the full course of treatment over the study, with no participants falling into the "unsure" or "not ready" categories post-MI. Participants 3 and 4 described themselves as "very ready" to complete treatment Post-MI versus "unsure" at the initial Baseline assessment. As observed with participation readiness, some of this movement took place between initial Baseline and Baseline measurement 4.

Participants 3 and 4 increased their ratings from "unsure" to "ready" during this phase. In contrast, Participants 1 and 2 reported feeling "very ready" to complete treatment throughout Baseline and MI phases.

Table 6

Readiness to Participate in and Complete Treatment at Baseline, Post-MI, and Follow-up

	Participation				Completion			
Readiness	B1[a]	B4[a]	Post-Mi[a]	Fu[b]	B1[a]	B4[a]	Post-Mi[a]	Fu[b]
Very Ready	2	1	5	1	2	2	4	2
Ready	1	3	1	2	2	3	2	1
Unsure	2	2	0	1	2	1	0	1
Not Ready	1	0	0	0	0	0	0	0

Note. [a]*n* = 6, [b]n = 4; Cells reflect total number of participants in each readiness category, determined from Participation Readiness Ruler ranges: Not Ready = 1-2; Unsure = 3-5; Ready = 6-8; Very Ready = 9-10. B1 = Post-Baseline 1; B4 = Post-Baseline 4

At Follow-up, Participants 4 and 5 remained either "ready" or "very ready" to participate in and complete treatment. Participant 6, however, gave substantially lower PRR ratings, dropping from "very ready" Post-MI to "unsure" at Follow-up on both indices. Across all participants, overall readiness to participate in services was similar in Baseline and MI phases (Baseline, *M* = 6.2, SD = 2.9; MI, *M* = 7.8, SD = 2.1), with participants falling in the "ready" range. Mean readiness to complete treatment across all participants followed a similar pattern (Baseline, *M* = 7.4, SD = 2.2; MI, *M* = 8.2, SD = 1.9), also staying within the "ready" range.

Service Participation

Attendance data collected at the initial Baseline assessment and Post-MI revealed that three (50%) participants increased their attendance frequency over the course of the study, two (33.3%) decreased, and one (16.7%) remained the same (see Table 7

overview). Objective indicators of attendance (e.g., chart and billing records) did not match self-reported attendance for five of six participants. In each case of mismatch, objective indices reflected greater attendance than self-report. Because site-maintained records of attendance are considered more reliable than self-report, the attendance outcomes presented here are based on that objective source.

Of the three participants who increased treatment attendance over the intervention, Participant 2 engaged most frequently, attending four more individual appointments and seven more groups relative to Baseline. Although Participants 3 and 5 also attended more appointments during MI, their increases were minimal, with Participant 5 attending one more group and Participant 3 attending two more individual sessions and one more group session than they had during the month prior to Baseline measurement 1. Participant 6 attended one group and no individual sessions during the MI phase due to work scheduling conflicts, a sharp reduction attendance in comparison with Baseline. Participant 4 attended no treatment appointments during the intervention, having decided to withdraw from treatment at STOP due to reported tension with her individual therapist.

Self-reported level of participation in group therapy increased during MI in comparison with the month before Baseline 1 for five (83.3%) people (Participants 1, 2, 3, 5, and 6). Participants 2, 5, and 6 showed two-point scale increases in group participation ratings. Participant 2 moved from participating “sometimes a lot, other times a little” to “every chance I get,” Participant 6 from “rarely talking or participating at all” to “sometimes a lot, other times a little,” and Participant 5 from “every once in a while” to “most of the time.” As mentioned previously, although Participant 6 rated his

group participation higher, he attended only one group during MI. Along with increased group participation, three people (50%) rated themselves as getting along better with other group members at the Post-MI assessment in comparison with Baseline. Participant 1's peer relationship ratings improved from "somewhat well" to "very well," Participant 2's ratings from "very well" to "extremely well," and Participant 3's ratings from "very poorly" to "extremely well."

Self-reported engagement in individual therapy tended to be uniformly high across participants and measurement points, with participants selecting ratings of "most of the time" or "every chance I get" to describe their participation frequency. Only Participant 3 described an increase in active involvement in her individual sessions relative to her Baseline assessment, from "most of the time" to "every chance I get."

Post-MI, the majority of the sample reported improved medication-taking consistency in comparison with the Baseline. In response to a question about how well medications were taken as prescribed, ratings increased from "okay" to "very well" (Participants 1 and 5), "very well" to "extremely well" (Participant 2), and "not very well" to "okay" (Participant 3). Participant 6 reported missing his medication "only a couple of times" at Baseline and "never missing it" at the Post-MI measurement. Participant 4 reported the only decrease in medication-taking, from "okay" to "rarely take my medications."

In terms of attitudes toward treatment, Participants 1, 2, and 6 reported feeling autonomous and in control of decisions to engage in treatment both at Baseline and Post-MI, reflecting no change on these dimensions during MI. The other three participants noted a positive change in control and autonomy from Baseline to Post-MI. Participant 4

reported feeling freer to make treatment engagement decisions and having greater control over those decisions. In contrast to Baseline, Participants 3 and 5 indicated having more influence than anyone else over engaging in treatment.

Based on follow-up data, Participants 2 and 6 attended fewer groups (5 less and 1 less respectively) in the month after MI, in comparison with the month during the MI intervention. Participants 2 and 5 attended the same number of individual sessions in the month after MI as they did during MI, and Participant 5 attended the same number of groups. Participant 4 reported attending two individual sessions with a Behavioral Health Specialist during the follow-up period compared with no treatment attendance during MI. This specialist was affiliated with her primary care physician and was not a STOP provider. Three participants (50%) reported reduced medication-taking consistency at Follow-up relative to Post-MI, with Participant 4 stopping her medications, Participant 5 reporting taking medications "okay" versus "very well," and Participant 6 missing a "couple times" versus "never missing." Treatment attitudes did not change from Post-MI to Follow-up for Participants 2 and 6, with each continuing to endorse freedom, choice, and control over treatment engagement. Participant 4 indicated that she chose to go to mental health treatment at Follow-up, in contrast to her contradictory survey response post-MI. Participant 5 disagreed that he had "more influence than anyone else" on whether he went to treatment, a change from his previous agreement with this statement at the Post-MI assessment. Participant 2 rated her group therapy participation as substantially lower at Follow-up, "rarely talking or participating at all" compared with "every chance I get" at the Post-MI measurement.

Summary

At the conclusion of the study, data were available for six African American dually diagnosed adults, the majority of whom had spent 6 months or more in the STOP program prior to beginning the study, and who had been previously diagnosed with bipolar disorder and polysubstance dependence. As shown in Tables 1 and 2, five of six participants entered or completed the Baseline phase with moderate to high levels of hope, meaning, and empowerment on the HME, HHI, ES, and MLQ. Small increases in mean HME scores were observed across study phases, changes which did not exceed 17%. SMA analyses revealed that two participants with flat baseline HME scores followed by increasing scores during MI. The analyses also indicated an increasing HME score trend during Baseline for two other participants. A statistically significant HME level increase from Baseline to MI was noted for two people, despite the fact that one of the participants displayed an increasing HME score trend during Baseline.

Internal motivation, help-seeking, and treatment confidence also increased over Baseline, for equal to or greater than half the sample depending on the TMQ variable. Additionally, for four participants, readiness to participate in or complete STOP services was already high or was increasing during Baseline. Five of six participants were also allocated to an advanced Stage of Recovery (Preparation, Rebuilding, or Growth) at the initial baseline visit.

Table 7 and Figures 3 to 5 present an overview of changes in the major dependent variables for each participant. Three of five participants experienced forward Stage of Recovery movement during MI, in contrast to their unchanged stage allocation during Baseline. Analysis of the full hope, meaning, and empowerment measures revealed

higher mean scores during MI in comparison with Baseline for all participants, with increases averaging between 3% and 33%. Increases on the MLQ's Presence of Meaning and ES's Self-esteem/Self-efficacy subscales accounted for greater variance in these measures' total scores than did changes in other factors. Participant 5, who began the study with the lowest levels of meaning and hope, reported the largest degree of positive change on these two dimensions during MI.

Service participation outcomes at the Post-MI assessment indicated higher group participation levels, more positive peer relationships, increased medication-taking consistency, and greater perception of choice and control over treatment engagement; however, changes in frequency of attendance were mixed. Two participants displayed substantially reduced attendance, one due to job demands and the other as a result of deciding to terminate treatment at STOP. The four participants who completed follow-up measures reported some decreases in service participation readiness, treatment confidence, and attendance frequency, as well as one instance of recovery stage regression. Hope, meaning, and empowerment levels as measured by the HHI, ES, and MLQ, however, remained relatively steady from Post-MI to Follow-up, indicating the overall maintenance of these particular gains.

Helpful or Important Aspects of MI Sessions

Participants identified 27 helpful or important events across 24 MI sessions on the HAT form. In each case, an "event" refers to a specific topic or area of discussion in a session. Of these 27 events, participants rated the degree of helpfulness for 24 of them, with an average rating of 8.4 falling between the scale points of "greatly" and "extremely" helpful. There were some instances of participants identifying more than

Figure 3. Changes in Hope Across Phases by Participant

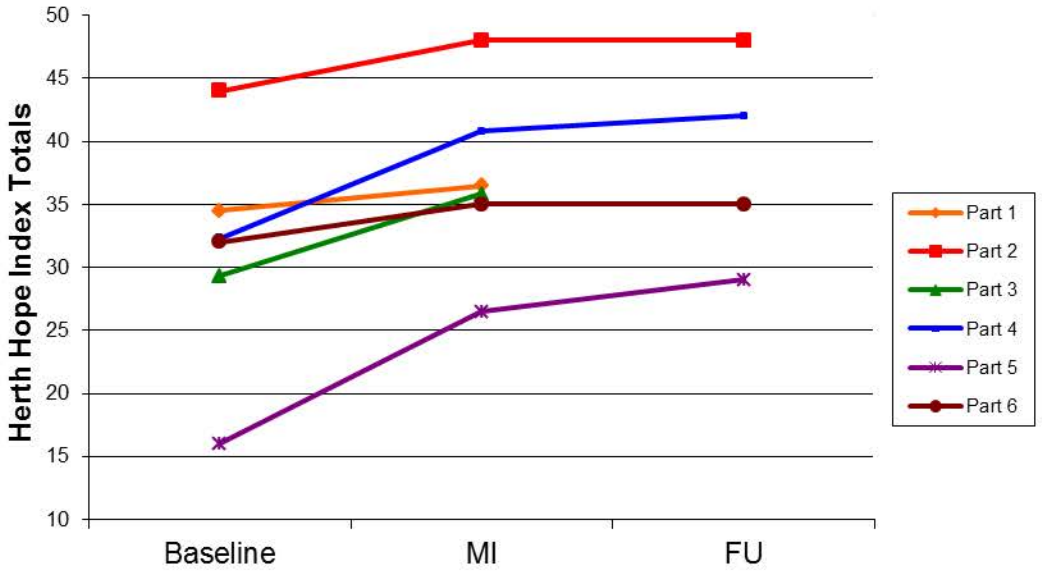


Figure 3. Changes in HHI total scores across phases by participant. Baseline and MI data points represent HHI means for those phases (n =4 for each phase). FU = Follow-up and represents a single data

Figure 4. Changes in Meaning Across Phases by Participant

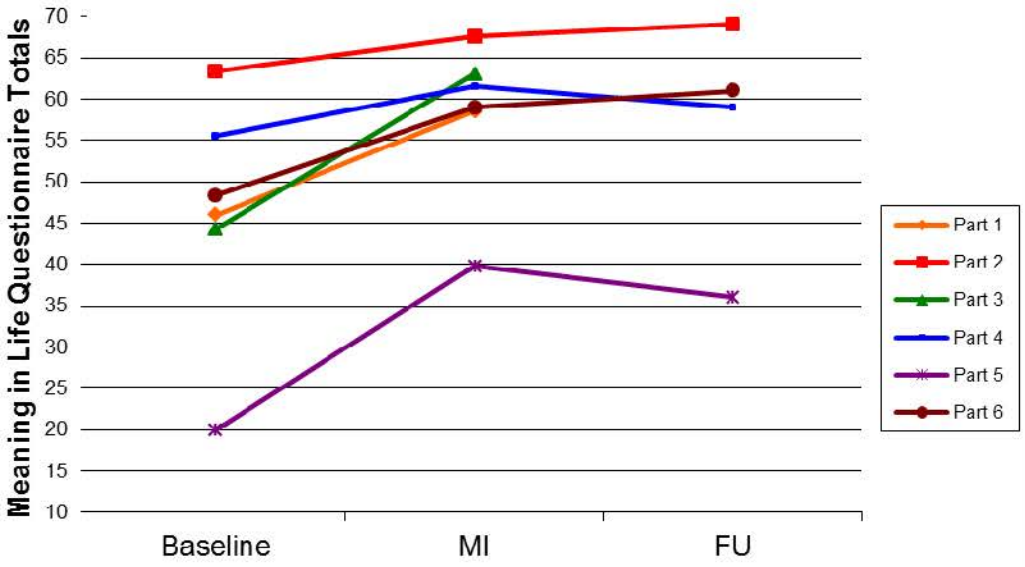


Figure 4. Changes in MLQ total scores across phases by participant. Baseline and MI data points represent MLQ means for those phases (n =4 for each phase). FU = Follow-up and represents a single data point.

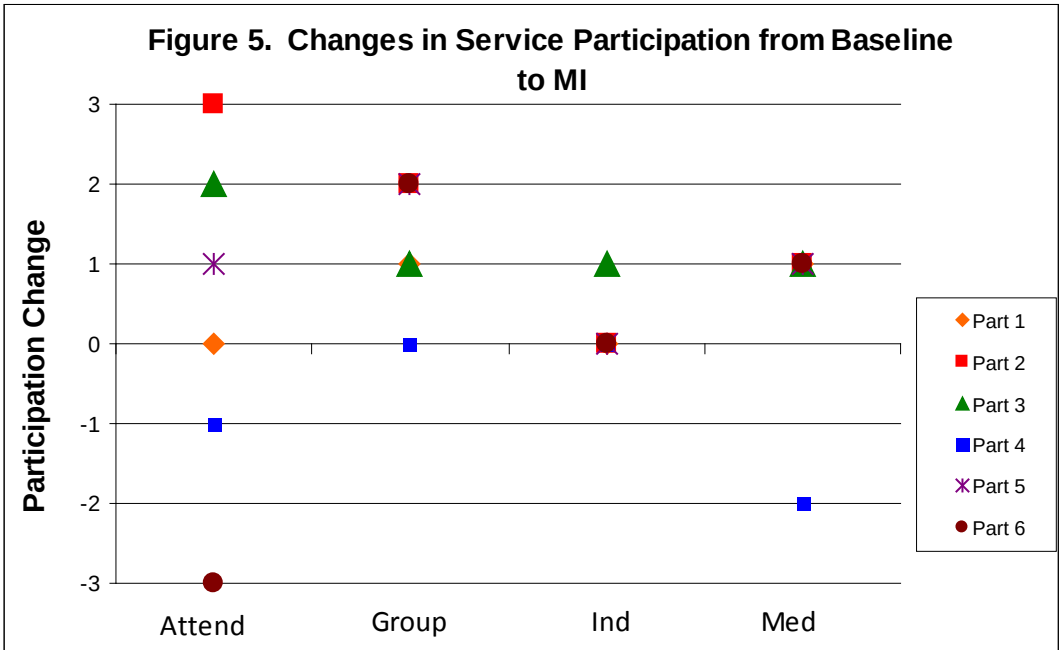


Figure 5. Increases and decreases in service participation from Baseline to MI. 1 = small change; 2 = moderate change; 3 = substantial change. Attend = change in group and individual sessions attended; Group = change in group participation; Ind = change in individual participation; Med = change in medication-taking consistency

one helpful or important event in a session, most often after MI Session 1 (for Participants 2, 4, 5, and 6). Only one participant found a session as unhelpful, relating to discord in the relationship after perceiving the interviewer as interrupting her and not hearing her accurately. The only other event identified as interfering or unhelpful was Participant 5's cell phone ringing during one session, which he rated as "slightly" hindering.

In eight of 24 MI sessions, participants identified topics that were directly treatment-related as being the most helpful or important to discuss (MI Session 1 for

Table 7

Outcomes for Hope, Meaning, Empowerment, Recovery Stage, Motivation, and Service Participation

						Baseline to MI				
	HME		STORI			Full Scales			TMQ	
Part	L	S	B_{St}	B	B-MI	MLQ	HHI	ES	Int	Ext
1	n.s.	n.s.	5	n.c.	n.c.	+20.8%	+5.6%	+6.8%	-4.5%	n.c.
2	n.s.	3**	4	n.c.	Fw_1	+7.0%	+11.1%	+13.7%	-12.1%	-10.4%
3	.69**	3**	4	n.c.	Fw_1	+31.2%	+18.1%	+8.3%	-21.2%	-6.3%
4	.66**	2[a]	4	n.c.	Bw_1	+10.0%	+23.6%	+14.9%	-.7%	n.c.
5	n.s.	2**	1	n.c.	Fw_2	+33.0%	+29.2%	+13.4%	+3.8%	-8.3%
6	n.s.	n.s.	3	Fw_1	n.c.	+17.8%	+8.3%	+3.0%	-1.5%	+4.2%

Note. Percentage increases in HHI, ES, and MLQ mean totals from Baseline to MI. n.a. = not applicable; n.s. = not significant; n.c. = no change; L = change in HME level from Baseline to MI; S = highest correlated HME slope vector; B_{St} = Baseline 1 Stage of Recovery; B = Stage of Recovery movement from Baseline 1 to 4; Fw_1 = forward movement of 1 stage; Fw_2 = forward movement of 2 stages; Bw_1 = backward movement of 1 stage; MLQ = Meaning in Life Questionnaire; HHI = Herth Hope Index; ES = Empowerment Scale;
* $p < .05$; ** $p < .01$; a = approaching significance

Table 7 cont'd

Outcomes for Hope, Meaning, Empowerment, Recovery Stage, Motivation, and Service Participation

	TMQ		Readiness		Service				
Part	Help	Conf	R_P	R_C	Attn	$Part_G$	$Part_I$	Med	Attd
1	+4.2%	n.c.	+1.3	n.c.	n.c.	+1	n.c.	+1	n.c.
2	+11.1%	+20.0%	n.c.	n.c.	+11	+2	n.c.	+1	n.c.
3	+37.5%	+11.7%	+1.0	+.8	+3	+1	+1	+1	+Inf
4	-12.5%	n.c.	+3.8	+2.3	-1	n.a.	n.a.	-2	+Ct/+Fr
5	-1.4%	+21.7%	+2.3	-.3	+1	+2	n.c.	+1	+Inf
6	+22.2%	+40.0%	+1.5	+1.2	-10	+2	+3	+1	n.c.

Note. Percentage increases in TMQ subscale totals, readiness ratings, and service participation from Baseline to MI. TMQ subscale changes calculated by averaging Baseline 1 and 4 and then determining the percentage difference from Post-MI score. Readiness to participate in (R_P) and complete (R_C) treatment represent differences between Baseline and MI mean Participation Readiness Ruler ratings.

n.a. = not applicable; n.s. = not significant; n.c. = no change; ; Int = Internal motivation on Treatment Motivation Questionnaire (TMQ); Ext = external motivation on TMQ; Help = help-seeking on TMQ; Conf = Confidence on TMQ; Attn = change in number of group and individual sessions attended; $Part_G$ = change in group participation ratings where each unit indicates a Likert scale change of 1 point; $Part_I$ = change in individual session participation ratings where each unit indicates a Likert scale change of 1 point; Med = medication-taking ratings of how well medication was taken over last month, each unit indicating a Likert scale change of 1 point; Attd = change in attitudes toward treatment autonomy; +Inf = increase in influence over engagement (False to True); + Ct = increase in personal control over treatment (False to True); +Fr = increase in perceived freedom in regards to engagement (False to True)

Participants 2, 3, and 5; MI Sessions 2, 3, and 4 for Participant 4; and MI Sessions 1 and 4 for Participant 6). These events most often centered around reasons for coming to STOP and aspects of treatment that increased the desire to engage. Relating to others through self-expression or self-disclosure represented another theme and was reported in seven MI sessions across four participants. Several statements pertained to these themes: “talking more to others” and “friendship” (Participant 5), “letting the wall down” (Participant 3), “not shutting down and opening up” and “talking to young people in the future” (Participant 2), and self-disclosure in therapy (Participant 4). This theme

did not appear to be associated more selectively with any one particular MI session (e.g., MI 1).

Self-understanding and self-affirmation represents a third category of selected helpful events, emerging in five sessions across four participants: “recognizing and identifying things that make you whole” and “getting to look at myself and what it takes to make me change” (Participant 6); “what makes me me from my youth” and “having integrity” (Participant 4), “faith in self” (Participant 2), and “maintaining self” (Participant 5). Although no particular session in the protocol seemed to elicit this theme more than others, it is notable that only one of these events occurred in MI Session 2, which included the Personal Values Card Sort.

A fourth theme of helpful events addressed recovery accomplishment and progress (past and/or future), an especially salient and recurrent theme for Participant 1 (MI Sessions 2, 3, and 4). In MI Session 3, Participant 3 identified sharing a song symbolic of her recovery progress as the most helpful event. Participants 2, 4, and 5 chose parts of sessions focused on “handling obstacles” and planning for continued success, twice in MI Session 4 and once in MI Session 3. One helpful event previously mentioned for Participant 6, regarding characteristics of himself that facilitate positive change, appeared to straddle both self-understanding and progress themes (MI Session 2).

At the end of MI Session 4, participants considered all the helpful events they had previously identified across MI sessions and selected one that stood out, above all, as the *most* important or helpful. This chosen event became the focus of the subsequent BSR. Two selected events directly related to the perceived importance of treatment participation: reasons for coming to STOP (Participant 5, MI Session 1) and what had

been learned through treatment (Participant 4, MI Session 2). Participant 2's event involved the self-disclosure/relatedness theme, regarding her aspirations to talk to young people about her recovery experiences (MI Session 1). Participants 1 and 3 identified the sharing of a recovery symbol marking personal progress as their most important event, both coming from Session 3. The event selected by Participant 6 also fell into the accomplishment/progress category and involved the value of "change" that he had discussed in MI Session 2. The BSR-selected events for the sample had an average rating of 8.2, indicating that people tended to find them "greatly" helpful.

Recovery Experience: Then vs. Now

For half the sample, MI and BSR session content focused predominantly on recovery from substance abuse and its relationship to treatment participation (Participants 1, 2, and 4). For others, mental health concerns became the primary problem focus as it related to treatment involvement (Participants 5 and 6), whereas the content was mixed for one person (Participant 3).

Positive change. In analyzing the six BSR interviews, writing the storyline (Corbin & Strauss, 2008) helped distill the primary phenomenon or core category around which other concepts were organized. As conceptualized by Corbin and Strauss, a storyline is the main narrative thread that runs through the data for a given individual. In the transcribed BSR interviews from this sample, participant storylines were strikingly similar in terms of a discernable core category. Each person described some form of positive life change associated with the content of his or her selected segment. In the BSR, participants were asked to reflect on internal experiences (e.g., thoughts, feelings, images) as they occurred during the original MI event; however, the BSR-elicited theme

of "positive change" extended beyond immediate reactions to MI. Each BSR interview contained one or more "then-now" positive contrasts that drew the outline of a broader recovery narrative. Such contrasts involved the juxtaposition of two different states of being at two different points in time. The concept of "positive change" emerged within this structure; it was closely tied to one or more content elements of the original MI segment.

For instance, Participant 1 selected a segment in which she enthusiastically shared her Narcotics Anonymous (NA) key chains with the MI counselor. In her BSR, when asked what was happening for her while sharing these, she first described feeling excited and then talked about how the key chains symbolized significant recovery progress. She proudly described numerous ways in which her present self no longer matched her former shame-filled self: "18 months later, this is *me*." Participant 2 chose an MI segment in which she played a song called "The Storm is Over" and discussed its meanings with the MI counselor. The song served as a powerful reminder that she had moved beyond the dependency of addiction and transcended the turmoil of mental illness. In the BSR, she recapitulated these meanings within a general storyline of increased mastery and connectedness with others, providing some specific examples of her transformation. As demonstrated in these chosen segments, the dichotomous "then-now" structure enabled people in the study to define, re-experience, and communicate "positive change" that constituted recovery. Through participants' elaboration in the BSR, the properties, dimensions, and meanings of these positive changes grew clearer.

All participants' BSR storylines contained some version of a "then-now" comparison; however, the distance between time points varied. Some "then" points

referred to an active phase of addiction in the past, or a past period during which mental health symptoms were worse. Other "then" comparison points referred to early treatment experiences fraught with difficulty or ambivalence in contrast to present, more advanced states of recovery. Participant 4 talked about negative childhood experiences around substance abuse, which was the most distal "then" point noted. Participants 5 and 6 brought in very recent past points (immediately before MI) and juxtaposed them with more positive feelings and thoughts after the intervention. Across the six BSRs, analysis revealed 20 of these "then-now" comparisons, with each participant making at least two separate comparisons during the BSR. At the higher end of the range, Participants 3 and 4 made four and six "then-now" comparisons, respectively.

In terms of "positive change," each participant's storyline addressed the movement from a state of greater impairment or poorer functioning to one of improved well-being. Participant 2 talked about moving from feeling lonely and helpless during her active addiction to feeling good about helping others struggling with the same issues. She wanted to continue that role in the future with young people. Participant 3's storyline centered around her achievement of sobriety after many years of unsuccessful efforts. Now no longer depending on drugs, she talked about enjoying life more, especially in light of her renewed family connections. Participant 4's story centered around the acquisition of greater self-awareness, control, and personal responsibility in recovery. She illustrated this change by drawing a stark contrast between her prostitution experiences during her active addiction and her current commitment to sobriety and healthy lifestyle choices. Participant 6 discussed establishing a more valued sense of self. Part of this change involved making more responsible choices in caring for his mother as

opposed to his perceived selfishness while using drugs. Although he referenced the "then" of "running the streets," his comparisons also focused on more positive thoughts, attitudes, and feelings after MI versus these same areas before the intervention. Also using a more proximal "then-now" comparison, Participant 5 discussed an enhanced ability of self-expression following MI that led him to feel more closely connected with others, being better understood, and known.

As reflected in these storylines, change within the recovery experience included three sub-categories: 1) a more positive sense of self (greater self-esteem, self-worth, self-respect, self-understanding, and clarity about values); 2) increased self-efficacy (perceived ability to function more independently and effectively, to solve problems, and to help others); and 3) enhanced relationships (closer family relationships, greater respect from others, increased sense of responsibility to others, improved communication). All study participants expressed ideas in each of these areas, albeit to different degrees. Tallying similarly coded interview segments across participants revealed that themes of increased self-efficacy (n = 42) and those relating to a more positive sense of self (n = 38) constituted the major subcategories of "positive change." Improved relationships (n = 23) represented a substantial, but relatively less frequent concept. Because these content areas were often interrelated, a coded segment sometimes encompassed change in more than one area, in which case the segment was counted under both concepts. For example, Participant 6's "increased perceived ability to initiate interactions with others" was coded under "self-efficacy" and "relatedness."

A more positive sense of self. In comparing active addiction or illness phases with a present state of recovery, participants described feeling more worthwhile, having

greater pride in themselves, and increased self-respect. One participant framed this change as a rapid and dramatic transformation, expressing a sense of awe about it:

> I was dirty on the inside and I didn't like me. I didn't want to be around others. I always wanted to fight. Wow, like, now look at me, 18 months later, this is *me.* I'm clean today, I got my child back, I got my own apartment.

Another person contrasted her poor self-esteem while prostituting with a more dignified, truer self in the present. "I was bummy, mad, dirty, not myself," she said of those times. She described seeing these behaviors as separate from a more positive core identity: "That's not the sum total of me, and it's not, and I don't want that." She added, "Because I made bad choices doesn't make me a bad person." She also mentioned "feeling really really good" about herself today, giving examples of positive choices she has made in helping other people. Another participant who had become involved in prostitution also achieved greater self-respect during her recovery. Newfound self-respect dictated higher standards in her relationships, as indicated by her statement, "I deserve to be treated better and I was going to demand to be treated better."

Other participants talked not only about feeling worthless during their active illness or addiction, but also about the sense of isolation that resulted. One person had thought her children "would be better off" with her "not being here." Bringing in the present as a counterpoint, she went on to say, "And now, I love it. My children are back in my life," implying the restoration of self-worth in relation to her family. She compared herself to a "flower" that had "blossomed," more beautiful self realized through recovery. It is as if nourishing conditions of recovery allowed the self to display its true nature and fullest potential. Participants also mentioned reduced negative self-

labeling, or internalized stigma as an important difference between "then" and "now." In their present states of recovery, they rejected pejorative adjectives that they had previously applied to themselves: "worthless," "stupid," "dumb," and "crazy."

As part of valuing oneself and one's experience more fully, participants sought more responsible social roles in their lives. Developing these roles seemed interwoven with improved self-esteem. "I have an awesome story to tell," one person said in reference to wanting to help others struggling with addiction and mental illness. Her life story of surviving addiction took on greater value when she saw herself already using it to help others in her community, a chosen responsibility that further strengthened her self-worth. Enhanced self-worth functioned both as a sign of her recovery's "now" pole, and as a hopeful catalyst for change in others, which could continue sustaining her positive self-regard. As another person put it, "I wanted to be a viable human being. I wanted to give back. I want to help someone." Similarly, in thinking about her progress in treatment, one person described feeling a duty to "pass it on to someone else." Other participants described themselves maturing, becoming a "more dependable, reliable parent" in one case, and "having to grow up" because "you can't do the same thing as you did back then" in another case. One person emphasized her pride in becoming secretary for her home NA group. An NA secretary is an important, highly valued position within the recovery community, someone who organizes meetings, ensures that they run smoothly, and keeps records (Narcotics Anonymous, 1988). For another participant, the development of a responsible self included caring for his ailing mother instead of "running the streets."

Greater self-awareness and appreciation of personal values accompanied these increases in positive self-regard. Values of faith, family, peace, compassion, trust, and beneficence toward others became more salient and meaningful between "then" and "now." During one "then-now" contrast, a participant talked about placing great importance on peace and honesty because while she was growing up, her family life lacked those qualities. Her awareness of honesty as a deeply held value offered a blueprint for her present actions and demeanor. "When I come away from a conversation, I want my word to mean something," she stated. "I want my reputation to mean something." In a similar vein, one participant discussed her desire to talk to groups of at-risk youth, a motivation fueled in part by her own lack of guidance as child. Awareness of her own personal history, not having had knowledge about the impact of substance use as a teen, helped clarify what was meaningful to her today: "If I had known when I was younger, I probably would've turned out better." Another person stressed the positive effect of fulfilling his values of family support and caring for others. Spending more time with his children marked a decisive shift away from an unpredictable, drug-using lifestyle, and an irresponsible sense of self. This shift was a prominent dividing line between past and present. In thinking about his choices now, he stated, "Being there [for them] means a lot."

Three participants described how new self-knowledge overwrote old, less adaptive ideas about the self. Discarding or revising an old self-definition coincided with one's values, goals, abilities, or meanings of illness coming into sharper focus. This new knowledge tended to be more experiential than conceptual. For instance, one participant told a story about approaching a young pregnant woman in recovery, offering support,

and being surprised by her positive effect on the woman. "I shared a little bit, just real brief, and now she gives me the utmost respect." The encounter expanded the participant's positive identity as "someone who can help," increasing her desire to continue offering peer support. Here the awareness of a value, a realization of the ability, and the definition of a related future goal combined to strengthen positive self-regard. In another case, new self-understanding and illness awareness bore a direct link to treatment experiences:

> [S]ince I've been here, it's like, I've been in a mental health group and it's like I realize, well not realize, I've been taught that it's okay to have the thoughts that I used to have and nobody's going to look down on me because I had those thoughts. It's just I have a mental imbalance . . .

In this example, learning about oneself and mental health disorders in a supportive group environment fostered greater self-acceptance and reduced self-stigma. Another person described the acquisition of new knowledge and insight as a major turning point in the trajectory of her actions: "Everything I do from the moment I came out and the moment I got some understanding, and mature enough to understand, I was working on saving my life." Here we find a "then-now" contrast of a mature versus immature self as the driving factor in recovery-oriented actions. In other cases, awareness of one's more positive self or possibilities of self stemmed from a spiritual source. As one participant said, "And me changing my whole lifestyle, the way I perceive things, the way I look at things, it's just a blessing and I think that spirituality plays a big part of it too."

In the BSRs, participants offered evidence that recovery involves a journey away from the sense of oneself as objectified, shame-ridden, irresponsible, unworthy, and unaware. Feeling more worthwhile, proud, self-aware, accepted, purposeful, and clearer about one's values were hallmarks of the "now" point. Those experiences that facilitated self-awareness and understanding most often involved support and positive regard from others. In this sample, positive changes in self-concept and self-esteem appeared to interact with making self-affirming choices relative to one's self-care and social environment. These choices marked a shift away from the isolative, adversarial, or self-neglecting stance common of participants' "then" points. The *awareness* of a healthier lifestyle and one's core personal values also seemed to reinforce a more enjoyable identity, particularly through contrasting "then-now" self-images. As suggested by the data, developing a more positive sense of self co-occurred with relationship and self-efficacy enhancement, likely in a synergistic, bi-directional fashion.

Increased self-efficacy. For the BSRs, participants chose MI segments that reflected a movement from helplessness to empowerment. They described a journey from feeling helpless and ineffective during past periods of active addiction or mental illness to a place of greater perceived control over their lives. In the past, they doubted their ability to cope, to overcome addictive behavior, or to handle responsibility. "I've been trying to get clean for over 30 years and I could never do it," one participant said as she reflected on the MI segment. Alluding to her perceived incompetence as a grandmother, she recounted, "They was afraid to leave the kids around me because they were scared I was going to do something." Another person referred to drug use as "so debilitating in so many ways." Statements such as "Sad. Sad. Sad. I felt helpless" and "I

couldn't solve my own problems" indicated low estimations of ability and depressed mood in the past. Elaborating on "then" experiences, participants highlighted the loss of personal control that accompanied dependence on substances. One person had felt weighed down and controlled by her environment of origin, saying "I spent a lot of years blaming the way my mother and father raised me for this happening or that happening."

These reflections on helplessness formed the background against which current perceptions of self-efficacy stood out. Participants spoke about functioning independently of drugs, establishing better living situations, and helping others. One person talked about a song that reminded her that she "didn't have to . . . get a hit to go to sleep, take a hit to wake up," and that she no longer had to resort to prostitution. She and another participant talked about how good it felt to move into their own apartments, the latter of whom also received custody of her child. One person expressed a greater capacity to care for others, saying "Things I thought I couldn't do, I'm doing now," referring to his decision to stay at home more often to help his mother. Another person felt more personally in control through supportive action in relationships. She said, "I know that now I'm not helpless and I can help somebody else. Instead of me feeling helpless, I can help somebody."

In their current places in recovery, participants saw personal efforts and positive choices as significantly impacting their quality of life and future well-being. One person discovered a formula for stability that increased her confidence in sustaining recovery. "All I got to do is trust in a higher power," she said, "Trust in my God and do the footwork . . . talk about what I'm feeling and everything and now I don't have to use it." She implied a wide range of possibilities created by her independence from substances, a

freedom to choose growth-oriented, healthy experiences. An enhanced perception of control or, as another participant called it, "being sure-footed," extended to mood as well. "I'm in charge of my happiness," she said, conveying her sense of empowerment.

Some participants directly associated greater self-efficacy with service participation. One person recalled the endurance required by initial NA attendance: "Ninety minutes, ninety days. They call it a ninety-ninety . . . you don't take no cigarette break, don't take no coffee break. You sit there and get the message and I did that." Others expressed a sense of increased confidence in seeing themselves "open up," talking more openly to therapists and peers in recovery. As one participant said, "Maybe I feel like if I'm ready to share with one, I might be able to share with two or three." Another person talked about her desire that dual-diagnosis treatment foster greater independence. She preferred therapists who recognized the time when someone was ready to apply skills on his or her own, and who encouraged opportunities for self-directed recovery. "I want someone holding my hand and telling me, but then let my hand go and let me figure it out myself," she said.

Acknowledging and celebrating progress in recovery factored into people's increasing confidence in their abilities. For the person who struggled with drug use for many years, only now to achieve a more stable sobriety, the accomplishment "felt real good." Looking at and appreciating the distance traveled between "then" and "now" occurred with therapists, family, and peers. As one might expect, doubts about coping independently may linger, making a guided reflection on progress that much more important:

> [T]hey just stepped me down, and when I say stepped me down, I was going 5 days a week. I'm only going 3 now. I was kind of scared of stepping down because I didn't think I was ready. But then one of my counselors made me look at like, you've done the work, ok? You've made all this progress.

Other participants succinctly described the feeling of moving forward in a hopeful, awestruck, or excited tone, saying, "it's progress," "you have a sense of change" and "Wow, I've really come really far." Examining progress involved holding "then" side-by-side with "now," as though looking back over one's shoulder to see how far one has climbed. "I look back at my time when I was young and I didn't have nobody to really school me and tell me right from wrong . . . I felt alone, but I got over it," one person reflected. Another participant measured her progress (and ultimately, her success) by comparing different levels of treatment involvement. "I've gone to a lot of outpatient programs before, but I never completed. Actually, I've never stayed as long as I've been here." Another person made a conscious effort to remind herself every day of her progress, likely as a continued source of positive self-esteem, motivation for recovery, and sense of control: "I look at my [NA] key chains every night."

One participant talked about her progress in connection with a solid determination not to return to a drug-using lifestyle. She did not want to risk harming relationships with her children or grandchildren, or disappoint people she encouraged to seek treatment:

> I'm alright. I'm not going to spit in God's face. I'm not going to hurt my children by going back to drugs. I'm not going to disappear out of my grandkids' life. I'm not going to disappoint the people I told about STOP.

Here she seemed to stand on a plateau surveying the landscape of her past. From this vantage, seeing how far she had come may have increased her awareness of how hard she worked. Not wanting to lose ground or give up these gains, in turn, likely strengthened her motivation to avoid relapse.

In sum, increased self-efficacy distinguished "now" from "then" in terms of independence from drugs, greater influence over decisions and behavior, a recognized ability to help others, and a heightened awareness of progress. The concept of progress was associated with acknowledging one's own accomplishments, endurance, overcoming daunting obstacles, and commitment to maintaining positive changes. Participants moved from feeling controlled by negative external conditions into more responsible, agentic, and empowered roles, at times associated with treatment participation and recovery activities. They cited evidence of their ability to move forward in recovery, pointing to enhanced relationships, more effective mood management, establishment of independent living situations, and greater treatment participation. MI segments selected for the BSRs appeared to spotlight these milestones of recovery progress.

Improved relationships. After listening to their MI segments in the BSRs, participants talked about relational challenges associated with active phases of addiction and mental illness. They reported feeling isolated, alienated, mistrustful of others, disrespected, and alone at these "then" points. "I didn't want to be around others. I always wanted to fight," one person said. Another participant explained, "It feels like everybody's against you," referring to a time before she wanted help for her substance abuse. One person gave an example of how people would gossip about her in a degrading way when she was using drugs. Some participants cited a lack of family

support, guidance, protection, and positive regard in their childhood. For one person, life in her family of origin was filled with turmoil, rejection, and put-downs: "Strangers didn't tell me I was no good. My family did." She described being surrounded by noise and people "cussing and drinking." Another participant came into the study with a strong tendency to remain socially withdrawn and wary of relationships:

> I'm just really not that sociable, you know. I talk to people in my circumference. I'm not really trying to discuss a lot of things with a lot of people . . . the majority of the time I stay in my own house, you know, so it's like basically the only thing I get to do is go on the computer, watch TV, and get on my cell phone every now and then.

The phrase "the only thing I get to do" implies perceived limitations by keeping to himself. Although his "circumference" represents a closed, trustworthy social system he could depend on for some positive interactions, he suggests that this restricted circle also requires him to sacrifice a freer, more active, socially connected existence that might enrich his quality of life and alleviate depression.

During the BSRs, participants revealed reasons for social withdrawal that included shame, an expectation of being abandoned, mistrust of others' motives, a desire to protect oneself from further hurt, and difficulty expressing oneself. Social detachment affected relationships with treatment professionals as well as with peers and family. One participant linked high therapist turn-over to her ambivalence about treatment involvement, which she felt held true for others in recovery: "A lot of us, I think, we deal with abandonment issues. We deal with issues of letting people get close, because people hurt us." In one instance, she felt disrespected by a therapist who looked at the clock

while she talked. Another participant mentioned feeling misunderstood by treatment staff when trying to work out a transportation problem.

Social reconnection demarcated "now" from "then" in participants' recovery narratives, although perhaps not as clearly as increased self-efficacy and the development of a positive sense of self. This seemed partially attributable to two participants reporting a sporadic pattern of social withdrawal during the study. Also, positive changes in relatedness often emerged as parts of the other two sub-concepts (increased self-efficacy and more positive sense of self), making this subconcept somewhat less distinct. That said, the most notable social changes between "then" and "now" points included re-establishing connections with family, being accepted and valued by peers (both within and outside of treatment contexts), helping others in treatment, receiving respect from others, and greater ease of self-expression.

Treatment was a common context in which these connections took place. Participants described some people in the treatment community as possessing the qualities of caring friends or family:

> [W]hen I interact with staff and the people that are coming in here, it's just a sense of belonging . . . Some people are like, I'll be out for a couple days, or two days or three days, they're like little man, where've you been? That means a lot to me because that means that somebody actually looked forward to seeing you.

Other people spoke of offering support to peers, who in turn, began to call them "mom" or "mama," implying the creation of an extended family as part of moving forward in recovery. These connections generated feelings of sincerity, gratitude, and affection. Describing a meaningful encounter with someone living in the same recovery house, one

person said, “I was like a mom to her, and it wasn’t nothing else but . . . we hugged and we laughed and I said ‘you followed your mom’ and I hugged her and I’m glad.”

Participants talked about how much they enjoyed being with family and their family’s positive anticipation of being with them, as opposed to times when they were using or were highly symptomatic. Restoration of bonds with children and grandchildren, an increased sense of compassion, commitment to helping others, and spending more time with family were notable themes. People in the study valued opportunities to be heard and understood by others, and sought a greater clarity, ease, and positive effects of their communication. For instance, one person mentioned the importance of a poetry radio show he ran at STOP, stating it offered a way to “really ball down and just let people know what you’re going through on a day to day basis.” Another participant marveled at the effect of sharing “a little bit” of her own experience with a pregnant teen struggling with heroin addiction. The bond they formed surprised the participant with its strength, influence, and speed of development. At another point in time, a choice to self-disclose became a crucial, positive turning point in her recovery journey, as this participant described a shift from “usually shutting down” to “letting everything that I felt in my heart out.” Another person described a conversation in which she listened to her son’s distress over a relationship and, at the same time, helped him understand her “loudness” as a coping mechanism.

Overall, the movement between “then” and “now” was one of approaching, rebuilding, and strengthening relationships versus continued isolation and withdrawal, even though some isolative behavior and mistrust remained for participants in the study. In other words, establishing stronger relational bonds was very much a work in progress.

Conflict with providers, self-protective habits of withdrawal, interpersonal mistrust, and shame threatened social connection, sometimes in the recent past of recovery, more proximal to the MI intervention. Key contextual factors associated with improved relationships included a warm, caring treatment community and safe outlets for self-expression. A prominent individual factor was a perceived value in helping others, often emerging as an embraced responsibility in the present, or a future aspiration. Stronger, more positive relationships led to feeling liked, accepted, valuable, and understood. Other key emotions included enjoyment of family and feeling respected by others, which were associated with spending more time with family and initiating conversations more frequently.

Participants' Experience of MI Process

In addition to data on the recovery experience, the BSR interview elicited reactions to the MI process, which encompassed MI's spirit and method. Corbin and Strauss (2008) write about process as the sequence, continuity, and purpose of "activities, interactions, and emotional responses" that occur in changing contexts over time. When MI is described as a process, it can be understood as the activities, interactions, and emotional responses organized around the purpose of a person-centered form of guiding to resolve ambivalence about change. The importance of process is clear, as one might expect a very different set of data to emerge in relation to a confrontational counseling style with coercive or judgmental interactions.

One caveat is that reactions to the MI process were not examined directly via a transcript of an MI session. People in the study talked about what they recalled that experience to be in a subsequent interview. Thus, MI process refers to the memory of

what MI was like as described in the BSR interview. The BSR represents a secondary process and context, which likely influenced the picture of MI experience. As a result, MI and BSR processes will be addressed separately, because both probably affected data gathered on recovery experience.

It is also important to note that the semi-structured BSR interview format did not explicitly ask participants to comment on MI, but rather questioned what the MI counselor said or did that they found important, enjoyable, or helpful (or not so helpful) in the taped MI segment. Open coding revealed three main conceptual categories related to MI process, all subsumed under the core category of "positive change:" 1) attitudes toward the counselor, style of interaction, and aspects of MI method; 2) affective experience; and 3) changes attributed to MI. Although discussed separately, these categories were closely interrelated and at times, overlapped. For instance, some affective content emerged when addressing people's perceptions about what had changed or would change as a result of MI. This affective data was discussed under "changes attributed to MI," which seemed to be the more representative category.

Attitudes toward counselor, interaction style, and MI method. Participants in the study described the counselor as "really concerned," "genuine," "caring," "sincere," "easy to talk to," not only genuinely interested in what they had to say, but also open to their perspectives. These qualities were more often attributed to the individual than to the style of interaction, as reflected by statements such as, "He's a caring person and an understanding person" and "I felt he was genuine and I think his personality is who he is outside of here." One person elaborated further on these trait attributions, saying, "He could've been anyone else and it probably wouldn't have gone as well." Participants also

sensed a sincere interest in their talents and achievements. "It felt like he really wanted to be a part of it. Like he really wanted to know about it," said one person in regard to sharing an important symbol of her recovery progress. Another participant pointed out a nonverbal cue of curiosity, stating, "He gets the open eyes." One person remarked, "When I pulled the key chains out, he was excited with me," illustrating a connection between the counselor's genuine interest and shared enthusiasm.

When asked what the counselor said or did that stood out as being helpful or important, participants addressed the concepts of open-mindedness and MI's collaborative nature. They noted having control over the session's content and feeling free to share their experiences without worrying about preconceptions, judgments, or constraints. As one person put it, "him . . . giving me a chance to tell my story for what it is. You know, not telling it how people want you to tell it." Others described it as "having room," "letting me tell him the joy that I felt," and "the ability to let me talk." One person commented several times on appreciating the counselor's empathy within this space, or as she put it, "him getting me." She added, "One of the most important things is for people to get me. I hate having to keep explaining who I am."

Other aspects of MI that elicited positive responses were the counselor's handling of discord in the relationship, values discussion, and remembering past successes. In the case of one participant, the counselor triggered discord by his occasional interruptions and inaccurate reflections. In accord with MI's approach to discord, the counselor sought to repair the working alliance by reflecting feelings, communicating respect, emphasizing personal control, and conveying the fact that he valued the participant's perspective. In response, the participant voiced a sense of emerging collaboration. The participant said,

"I guess we helped each other and he said that he learned—learned how to be quiet." Another person identified talking about her value of peace as one very salient part of a session, which led her to reflect on her family history from which that value evolved. One participant referred to remembering past successes as a key part of the session, saying, "It gives me the opportunity to actually not put myself on a pedestal, but to look at the accomplishments I've made. Actually see what I've done."

Three negative pieces of data emerged regarding the counselor and style of interaction. One person noted the counselor's intentional selectivity in evoking and responding to her motivations to engage in treatment. This came across to her as ideas originating from the counselor, given to her, rather than truly evoked: "He made it seem like it was my idea, but I know he was giving it to me. And I recognized it and I allowed it and I thank him." She describes a sense of having ideas "installed" rather than truly evoked, which would be inconsistent with MI spirit and contrary to MI's goal. The same participant also reported an impression of being "pushed at first" to talk about her thoughts and feelings about STOP, which she said she had already "put to bed." This response indicates a perceived impingement on her autonomy, which also would not align with MI spirit. Although worrisome, these comments appeared peripheral to that person's predominant experience of MI. Based on the majority of positively coded concepts for her (n = 22), she found the overall experience very helpful and rewarding. Another participant referred to discord from missed reflections and the counselor "jumping in" during the conversation. In connection with this fracture, she described the counselor as "irritating." This event seemed to have a greater negative impact on level of

MI involvement and overall attitude toward the counselor, although it did not result in that participant terminating the MI sessions.

In sum, the MI process resulted in the attribution of genuineness, interest, and caring to the counselor. Participants felt a sense of control over session content and unpressured space to explore recovery. They highlighted the collaborative nature of sessions, the counselor's flexibility, and values and efficacy-oriented discussions as being helpful or important. A greater ratio of positive to negative responses to MI was observed as well. Further, two of the three negative reactions seemed relatively minor in the context of that person's overall positive impression of the MI experience.

Positive affect in MI. All participants described positive emotional responses to MI, although the properties of those responses varied across the sample. Affective responses pertained to the interpersonal or spirit-based aspects of MI, to the recovery-related content that MI elicited, or to a general perception of the MI session or sessions. Multiple participants endorsed an overall positive affect or enjoyment of the interaction. They expressed a "good" or "really good" feeling about the session selected for the BSR, the part of the session included in the taped segment, or MI in general. One person described it as a "fun time," and several people when asked for specifics about what they enjoyed or found helpful, responded with global terms like "a lot," everything," or "the whole session." Questions about what was not as enjoyable or helpful drew similar responses, such as "nothing I can think of" and "everything was good."

Data indicated that the spirit and interpersonal style of MI helped people feel safe, comfortable, valued, and understood. One participant associated these feelings with friendship: "That's the kind of conversation you have with your friends. We're sitting

down there and I don't think nothing of it, and like real, just real give and take, and real flow." She labeled the exact feeling at another point:

> The word safe is popping up in my mind, but it's not exactly that. I want to sharpen that. It's more like comfortable. I felt comfortable. I didn't feel unease. I didn't feel rigid or not once did it go through my mind, "I hope you don't share this with nobody here."

Another participant commented indirectly on her sense of safety. For her, disclosing very personal parts of her recovery experience "in front of a total stranger" produced a "good" feeling. One person suggested feeling safe and valued during a discussion of his poetry. In a subsequent session, he brought in his notebook of poems to share. Both events stood out as being very helpful or important to him. In two cases, an underlying feeling of pleasant surprise seemed to accompany the feeling of trust that had quickly developed. "Here I am . . . coming straight out and telling the truth. And it was ok for me," said one participant.

Another person used the word "trust" itself in reference to the interaction. The same participant identified saying "absolutely" in the MI session as an indication of feeling understood, and consequently, respected: "It's two ways, people who can finish a sentence but they can finish it wrong. To me that's disrespect because they're telling you they're not interested in what you're saying." A feeling of dignity and being valued seemed to follow from the counselor's sincere interest and accurate reflections.

Participants also talked about feeling "relieved" and "lighter" after sharing their recovery experience in MI. For one person, this feeling related to envisioning a helpful role in the future and considering her expanded potential. "A little weight has been lifted

off my shoulders," she said. Here we find the MI method of envisioning her future role in recovery tied to the feeling of lightness. Another participant associated the emotion of relief with the song she shared with the MI counselor. The song symbolized enduring stability in her recovery. In commenting on the song during the BSR, she expressed her relief when she said, "All that drama was over . . . I didn't have to go through it no more." In the former sense, "lighter" meant new possibility, a positive anticipation for the future, and no longer being held down, whereas the latter statement conveyed an alleviation that comes from a long-awaited end to suffering. Another person connected feeling "lighter" with "talking" in MI, describing a felt sense of freedom from past burdens: "the honesty and the realness and talking about some things that was heavy, you know, it helped free me. It's like sitting here, talking about it with Scott, we're free from it."

In addition to generating feelings of lightness, freedom, and relief, conversations about recovery-related content during MI produced excitement, eagerness, yearning, meaningfulness, and compassion. Statements indicative of these emotions possessed a forward-looking, pull-to-action quality. These emotions arose during discussions of accomplishments, change, helping others (e.g., family, peers), spending time with family, and treatment attendance. As one participant succinctly described it, "It gave me a good feeling to talk about change, and how much you wanna change, and what you have changed . . . I wanted to come [to treatment] more, be more motivated." In reference to renewed family connection, another person stated enthusiastically, "I love it. I love it now. I look forward to spending time with them now."

Eagerness tinged with urgency characterized one participant's statements about helping young people with substance abuse and mental health concerns: "I'm so eager to be able to talk to them. So it's like I felt some kind of emotion because it's happening right now today, you know?" Along similar lines, one person described an increased feeling of compassion for others, specifically for his mother who was experiencing health problems. The subject of recovery accomplishments evoked the words "happy," "awesome," and "really exciting." In connection with their achievements, participants also used the phrases "the joy I felt," "means a lot to me," and "on that high." Other positive feelings surfaced in relation to faith. One person talked about the spiritual connection that took place when sharing her recovery symbol, saying, "I was channeling God through there." Another participant expressed a feeling of determination when she said, "I'm not going to spit in God's face" when imagining what she would lose if she relapsed.

Taken together, MI had a distinctly positive, affective component associated with its interpersonal factors, with the aspects of its method, and the recovery content it elicited. Participants described a general sense of feeling good as well as specific feelings of safety, trust, understanding, and being valued within the relationship. After and during the sessions, people reported relief and lightness that came from talking about the obstacles they overcame in recovery. They also reported eagerness and excitement, particularly when talking about their achievements and plans. Aside from one person's irritation with the counselor, no negative emotions were reported.

Positive changes attributed to MI. When asked what, if anything, changed for participants immediately after or days after the MI segment reviewed in the BSR, the

majority of the sample discussed positive effects. Although the question attempted to focus their attention on the specific BSR segment, participants often responded by describing *overall* changes they attributed to MI, referring to multiple sessions as opposed to one session or the segment. These effects primarily had to with improved relationships and abilities. No participants talked about any negative or unhelpful MI-related changes.

In terms of relationships, the participants discussed being able to share more of themselves with others and also of having greater confidence in their abilities to establish new social connections. One person said, "I'll be able to go next door and speak to the people that work there, you know, making conversations, even though the people who work there they don't know me because I'm just like a neighbor." The same person added that he could express himself better as a result of the sessions and had already approached his neighbors. Another participant credited MI with increasing her self-disclosure, post-intervention: "I'm actually opening up. I'm actually sharing [in groups]." Participants also reported feeling more capable of helping others, or actually helping others more. For instance, one person talked about her desired future role of mentoring troubled teens. When asked about what changed or might change as a result of this discussion in MI, she said, "I may save a life or two," as if envisioning the outcomes of fulfilling this role. Another person described providing greater support for his family, stating that MI led to "helping out more with my mom and helping out my kid more." He added that these actions emanated from feeling greater compassion and understanding, which he linked to conversations during the intervention.

One participant said that MI supported her independence in solving problems and increased her confidence so that she could overcome set-backs and achieve recovery-related goals. "I'm gonna have a lot more confidence that the things I want to do, I can do," she said. "I'm not going to be afraid of failure." With regard to treatment participation, she stated that MI helped her decide on a course of action that fit best for her. It offered an unpressured space in which she gained greater clarity about what she wanted to do: "He let me talk. Not my psychiatrist, not my therapist that I had up in here had that ability to let me talk. And in that, I kind of figured it out, what I kind of needed to do." Although MI enhanced the clarity she had about her attitude toward treatment, it also guided her in the direction of considering re-engagement: "As I talked about it, I realized how I thought I felt about it really isn't how I felt about it . . . you gotta kinda open your mind up." Her reference to keeping an open mind had to do with considering service engagement some place other than STOP.

In terms of breadth of coded content, changes attributed to MI did not prove as robust a content area as it was an affective experience or response to MI's interpersonal factors. In thinking about what changed as a result of MI, participants reported a stronger belief in the ability to connect with others, greater social or family involvement, increased confidence and problem-solving, enthusiasm about changes already occurring, and optimism about the future. Self-reported effects differed by participant, with no common theme other than a positive or optimistic tone.

Recovery Experience in Relation to MI: A Conceptual Framework

Having delineated concepts related to recovery experience and MI process, analysis turned to concept integration in an effort to form a coherent theory explaining

the relationship between MI and recovery in this particular sample. Developing a conceptual framework involved placing MI process and recovery concepts in a logical, sequential relationship with one another as seen through the lens of the BSR (Figure 6).

Before describing the basic *sequence* of interactions, emotional responses, and consequences in MI with this sample, the preceding context warrants a brief mention. Participants arrived for the first session of MI after a series of non-interactive sessions of filling out surveys. They understood that the purpose of the study was to learn about their thoughts, feelings, and attitudes toward treatment and that MI might or might not increase their motivation to engage. This goal was reiterated at the beginning of the first session, reminding participants that the content would center around the topic of treatment engagement. One is unsure whether this context produced feelings of trepidation, worry, uncertainty, eagerness, or something else, as no data was collected in this area.

As shown in Figure 6, participants identified a set of person-centered qualities they felt that the counselor brought to the MI interaction. The "interaction" may refer to any of the study's MI sessions, since participants did not associate these qualities with any one particular session. They described the counselor as genuinely interested, caring, sincere, nonjudgmental, and non-controlling. These perceived qualities interacted with and/or reflected the application of MI spirit in establishing a facilitative counseling environment. That is, participants described a set of experiences consistent with MI spirit and method. These included having an unpressured space to talk and a shared control over session content (MI Spirit: Partnership), feeling sincere interest in their personal perspectives and motivations (MI Spirit: Evocation), sensing flexibility and respect (MI

Spirit: Partnership; MI Method: Approaches to discord), and feeling understood through reflection (MI Method: Expressing empathy). It is possible that aspects of the person and counseling style amplified one another in a bidirectional relationship, generating positive emotions conducive to self-disclosure.

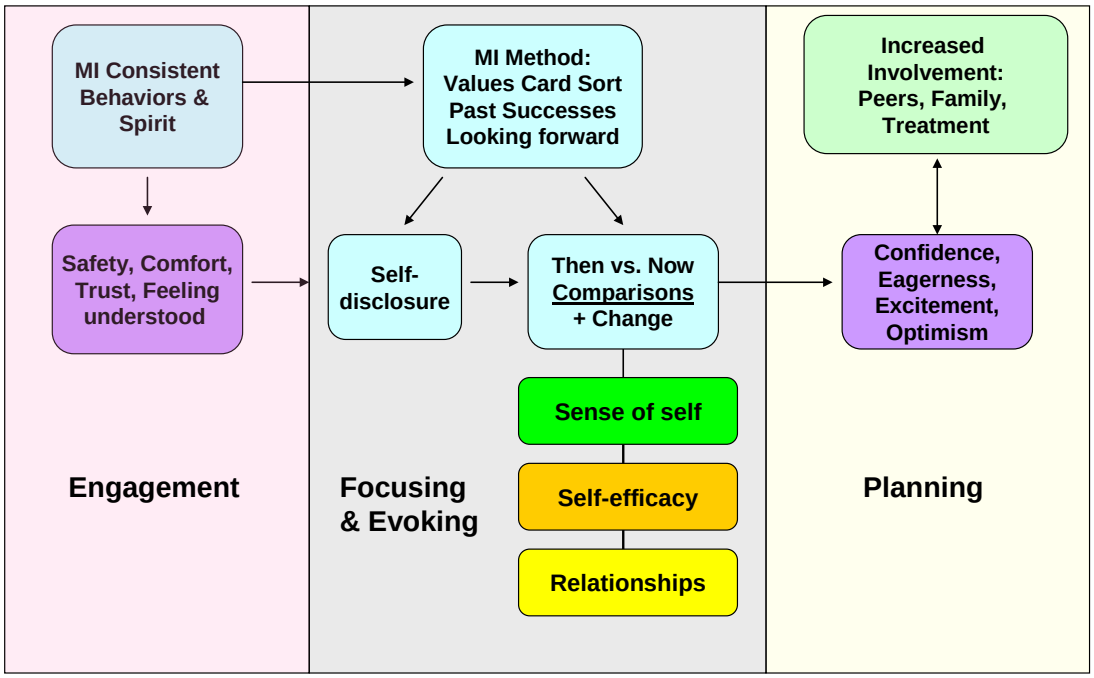
Emotions elicited by MI included feelings of safety, comfort, trust, understanding, and being valued. Most likely, these feelings co-occurred with a cognitive evaluation of the therapist and setting as "safe" or "comfortable." The consequence of having this safe, comfortable, trustworthy emotional environment was self-disclosure of recovery-related material. Within this person-centered context, the MI counselor sought to elicit change talk in the direction of treatment engagement. MI's collaborative spirit led at times to broader discussions of recovery and personal experiences, with the counselor linking the content back to treatment participation. This content emerged throughout structured sessions which moved through a sequence of decisional balance, Values Card Sort, discussion of past successes, and planning.

Out of this large pool of recovery-related content, the most helpful or important event that participants chose from their sessions represented a particularly positive experience of MI. A common thread among these selected MI events was their containment of "then-now" comparisons within a recovery narrative (e.g., discussion around NA key chains, a song called "The Storm is Over," the value of change). MI strategies or activities associated with these selected segments included decisional balance, importance and confidence rulers, the Values Card Sort, remembering past successes, and envisioning. In their BSRs, participants specifically referenced the latter

three parts of MI method, but without necessarily understanding them as technical components of a counseling style.

Amid the positive relationship ambience described here, MI strategies (e.g., values discussions, envisioning, reviewing past successes) appeared to operate as sub-processes within which "then-now" comparisons emerged. These comparisons produced a sense of positive change in one's identity, ability to succeed, and relationships. Affect more closely associated with these "then-now" contrasts (confidence, eagerness, excitement, positive anticipation, lightness, desire to change, and desire to engage in treatment) differed qualitatively from emotions tied to MI's relational components (safety, comfort, trust, feeling understood). Feelings related to MI method and "then-now" content possessed a forward-looking, action-oriented quality, compared with the more interpersonally-oriented, safety-focused, "here and now" emotions associated with the therapeutic interaction. In the conceptual framework, these positive relational emotions likely facilitate self-disclosure and, therefore, are depicted as preceding the active, future-oriented emotions generated by the content subsequently disclosed. Positive relationship-oriented emotions may also co-occur with participant self-disclosure of content, since MI spirit is hypothesized to continue throughout the interaction. It is also conceivable that positive interpersonal feelings resulted from the counselor's response to recovery content. No data emerged concerning what *point* feelings of being cared for, safe, or comfortable arose during MI. However, in terms of a conceptual framework, these feelings are theorized to have a uniquely facilitative impact on self-disclosure and self-disclosure is logically assumed as an action that gives birth to recovery content.

Figure 6. MI Process for Treatment Engagement with Individuals in Recovery



As illustrated in the framework, more active, energetic, and future-oriented feelings may have had more than one source. They may have emerged from the positive changes that participants attributed to MI sessions (increased peer and family support, more treatment-friendly attitudes), from "then-now" comparisons rooted in recovery content and elaborated on through MI method (positive changes in self-concept, self-efficacy, and relationships), and from the shared enthusiasm and affirmations of the MI counselor. As stated previously, it is quite possible that relational components of MI interacted with MI method and recovery content to elicit positive forward-looking emotions. Behavior such as increased attendance, greater group participation, and more consistent medication-taking could also have been associated with this more optimistic, energized affect, either as a cause or consequence. It also remains a possibility that the client-centered nature of the BSR process influenced the expression of positive changes, modulating the emotional intensity connected with the reviewed content, the breadth of that content, or both.

Contextual factors in MI and BSR processes. Participants' developmental histories, psychiatric symptoms, stages of recovery, and life events experienced during the course of the study could have impacted the MI process. Five of six participants in the study had documented trauma histories. They had either survived sexual or physical abuse in childhood, experienced domestic abuse as adults, or witnessed violence. One participant described some of her domestic abuse during the BSR, whereas the others did not mention their traumas either during MI or the BSR. The participant with whom discord arose in the MI relationship was the only person to have a history of sexual abuse. The prevalence of trauma in this sample could have led participants to place a

particularly high degree of importance on safety and trust within the MI interaction, giving these qualities added salience. Additionally, five of six participants carried a diagnosis of bipolar disorder, suggesting the capacity for greater emotional lability. This factor may have magnified the intensity and broadened the range of emotions experienced in MI.

Stage of recovery, living situation, and time abstinent from drugs or alcohol may have also affected the MI and BSR processes. Most participants were in an advanced stage of recovery when starting the study (Preparation, Rebuilding, or Growth), which may have increased the level of hope, meaning, or empowerment expressed in MI. In contrast, the one individual who entered Baseline in the earliest stage (Moratorium) indicated the lowest levels of hope, meaning, and empowerment. In addition, three participants had at least 12 months or more of abstinence prior to beginning the study, whereas three other participants had four months or less. One person's chart indicated he had one month of sobriety before entering the study. It is possible that longer periods of abstinence fostered increased availability of confidence-related content and emotions, and may have resulted in a greater tendency to draw "then-now" contrasts.

Significant life events and interviewer characteristics might also have affected MI and BSR processes. One participant suffered a major loss during the intervention, a death in the family occurred between MI Sessions 3 and 4 that resulted in a three week lapse between those sessions. It is quite possible that this tragic event followed by a treatment lapse attenuated MI's effect or altered it in unknown ways. Three participants acquired a more independent living situation during the course of the MI, moving into their own apartments. Another participant moved into an apartment within the year prior to

beginning the study. One person started working during the intervention. The positive emotions associated with these events may have mixed with, amplified, or obscured MI-elicited feelings.

Affect and self-disclosure in the BSR Process. In the BSR, participants exhibited different levels of self-disclosure and gave varying amounts of detail when answering questions. In two cases, the same person who conducted the weekly phone surveys also conducted the BSRs for their assigned participants, bringing a level of familiarity with them into the interview session. One participant provided a vast, tangential amount of personal content in response to open questions. This held true for both the BSR and MI contexts. Contrastingly, three other people tended to give shorter responses without as much detail in the BSR. Recovery-related material typically emerged in the early part of interviews in response to questions about what participants were thinking, feeling, and imagining during the segment. Content that was related to MI process arose later in interviews in response to questions about helpful or unhelpful therapist behaviors and about changes attributable to the sessions.

In the BSR process, some participants responded to hearing the selected MI segment with heightened emotion, sometimes to a greater degree than in the original MI segment. This emotional intensity was highest for the two participants who shared a symbol of recovery (key chains and a song). Emotional expressions were strongest soon after the tape had finished playing. When the BSR interviewer asked the first question, the participant who shared the song teared up, needing a moment to collect herself. These seemed to be tears of relief, as the content accompanying them had to do with moving past a very painful time in her life. The participant who shared her NA key

chains showed excited pleasure, laughing happily as she described to the BSR interviewer what was happening for her in the MI session: “I was like really excited.” The original feeling of excitement in MI appeared to be duplicated and magnified in the BSR session, as indicated by her laughter, which was not present with the original MI content. Intensified emotion was also reflected in the repeated verbal expression of excitement, as she used the words “excited” and “exciting” in close succession.

Another person’s first reaction to hearing her MI segment about mentoring youth was, “Wow, that was me” followed by slight laughter, and then the statement, “That’s how I felt.” Although she did not elaborate on the exact emotion, her language and light laughter suggested pleasant surprise. It is possible that this feeling resulted from hearing herself express a much-valued goal, reaffirming her passion for this possible self. Without a prompting question by the interviewer, she began talking about the personal importance of this role. She and another participant said they felt “emotional” during the MI sessions. However, they both used the word “wow” as their first word after hearing the taped segment. One of them said “wow” three times in a row. This small but significant piece of data in the BSR session, along with the laughter, suggested a higher level of emotional intensity after hearing the tape, in comparison with the conversation in the original MI session. It is perhaps worth noting that relative increases in emotional intensity were not observed in the BSR data for the two men in the study.

Relationship between BSR affect, MI process, and recovery content. The BSR’s intensification of positive emotions (relief, excitement, pleasant surprise, good feeling about self) may have affected descriptions participants gave of the MI process. Heightened emotion appeared to have a focusing and facilitative effect. Participants

immediately elaborated on the emotion-producing content, sometimes without prompting. Also, BSR interviewers responded to participants' responses with reflective listening and affirmation, which may have contributed to the magnification of certain feelings. It is difficult to ascertain how thoughts and emotions produced by this BSR process may have affected recall of the original MI experience. It is unknown whether participants attributed a higher degree of "emotionality" or a different type of positive emotion to the MI process *primarily* based on feelings experienced during the BSR. Also, one wonders whether the BSR's "then-now" recovery content with its associated thoughts, feelings, and images offered a distorted reflection of how this content operated during MI. These possibilities cannot be ruled out, given that data on specific feelings or experiences were not collected during the original MI session. It did appear that participants elaborated on their recovery experience with different details in the BSR, as compared with MI. For instance, during the BSR, one person went into greater depth about his mother's ailments, elaborating on the importance he felt in being there for her. In this way, differential selection of recovery material in the BSR might have also affected perceptions of MI in a positive direction.

Discussion

Overview

This study examined whether dually diagnosed consumers' experiences with MI could offer insight into improving service engagement and recovery outcomes. Results from the present investigation offered partial support for MI's positive effects on hope, meaning, empowerment, recovery stage, and service engagement in this population. Consistent with the mixed picture of past studies (Barrowclough et al., 2001; Barrowclough et al., 2010; Drymalski & Campbell, 2009; Martino et al., 2006), MI was associated with statistically significant positive change in hope, meaning, and empowerment for three of six participants. Null HME results for the other three participants may represent the combined influence of measurement issues and individual characteristics, such as diagnosis and recovery stage. Most participants, for example, had mental health diagnoses of bipolar disorder, which may have increased idiosyncratic responses to treatment, as noted in some research with this dual diagnosis subtype (Jones et al., 2011; Weiss et al., 2007). Additional descriptive and qualitative results attested more strongly to MI's importance in recovery. The data reflected positive change for all participants, with some robust baseline-to-MI contrasts. MI was also associated with increases on some indices of service participation, particularly related to group involvement, peer relationships, and medication-taking.

Because all but one participant entered the study with moderate to high levels of subjective well-being, hope, and readiness to participate in services, the study primarily became an opportunity to explore MI's role with people in later recovery stages (e.g.,

Rebuilding, Growth). It offered insight into how MI, relative to treatment participation might best work with dually diagnosed consumers already somewhat motivated to make, or maintain, positive changes in their lives. Qualitative data supported the validity of advanced recovery stages as measured by the STORI (Andresen et al., 2006). BSR interviews reflected themes of higher self-efficacy, a more positive sense of self, and stronger relationships for participants identified in these stages. Two of these themes directly parallel SDT's proposed basic needs of relatedness and competence (Deci & Ryan, 2000), potentially explaining enhanced motivation for recovery-related activities and improved well-being.

MI likely satisfied SDT needs at process and content levels, with different MI components (spirit and method) leading to distinguishable types of emotional experience. MI and SDT synchronicities observed in this study have implications for Fredrickson's (2001) "broaden-and-build" theory of positive emotions. Positive feelings about the therapeutic relationship and recovery progress may accumulate to create an "upward spiral" of hopeful thought-feeling-action tendencies. Additionally, some data suggested that MI has greater impact on hope, meaning, and recovery stage for individuals feeling more despondent. The person experiencing the lowest level of hope at baseline reported greater positive changes on corresponding dependent measures (HHI, MLQ, STORI). As far as the type of content that emerges and strategic ways of responding, MI may "look" different depending on an individual's recovery stage. For instance, BSR interview data reflected less self-efficacy and progress-related themes for the participant in an early recovery stage as compared with those in later stages.

The mostly hopeful, activated nature of this sample gives reason for pause. It is reasonable to wonder about the reasons why these clients would "need" or benefit from MI. Some studies, in fact, have indicated that MI either has no effect or may hinder change with people indicating greater readiness for change (Heather, Rollnick, Bell, & Richmond, 1998; Project MATCH Research Group, 1997; Rohsenow et al., 2004; Stotts, Schmitz, Rhoades, & Grabowski, 2001). Sample characteristics and MI session structures may partially account for these findings. MI likely requires certain ingredients to optimally "support persistence" in change (Miller & Rollnick, 2012) among hopeful, motivated people with dual diagnoses. Data from the present study illustrate what some of those ingredients might be (e.g., looking back, envisioning).

Regardless of initial recovery stage or hope level, participants wanted to tell their stories. Narratives take on an important role among people recovering from addictive behaviors and SMI, serving as vehicles for understanding illness and communicating this knowledge to others (Lecroy & Holschuh, 2012; Weegmann, 2010). In this study, MI spirit helped create a safe interpersonal space for recovery narratives to unfold, similar to effects noted in other studies (Angus & Kagan, 2009; Zuckoff, 2001). Listening empathically and evoking change talk encouraged further development of these narratives. As deeper meanings became clearer within the stories and positive contrasts were drawn between past and present functioning, participants articulated positive visions for the future. This offers one possible explanation for how meaning-making can spark hope, the "anticipation of a future which is good" (Miller & Powers, 1988, p. 6), within the counseling interaction. It is also consistent with evidence that meaning can predict hope (Mascaro & Rosen, 2005).

From an applied perspective, the intersection of MI, narrative approaches, meaning-making, self-efficacy, and hope point toward a recovery-oriented adaptation of MI. For consumers well on their way to building resiliency, providers may want to attend carefully to change talk within recovery narratives and emphasize themes of progress, personal agency, and a positive sense of self. Because some improvements did not persist over time in this study, this approach might work best if integrated throughout treatment and not offered only as a time-limited, stand-alone option.

Motivated and Hopeful Participants: Possible Explanations for Unexpected Sample Attributes

There are a number of potential reasons why the sample varied so much from its intended characteristics. As part of the screening process, STOP agency counselors were responsible for identifying individuals with an early recovery profile (low hope and disengagement). For all but one participant, discrepancy emerged between the referring therapist's indication of hopelessness and the participant's own self-report on this dimension across baseline measurements. Participant levels of hope were higher than the therapist indicated during the initial phase of the study. Given that psychiatric diagnoses among dually diagnosed populations are often unreliable after initial formal assessment (Carey & Correia, 1998), the less formal mode of assessment used during screening could have reduced accuracy. Additionally, adults with SMI sometimes have difficulty naming and describing feelings, complicating the effort to determine levels of hopelessness verbally (Ogrodniczuk, Piper, & Joyce, 2011). STOP also serves an inner city population that often struggles with financial challenges. If highly motivated by monetary compensation, participants may have exaggerated initial statements of hopelessness once

they learned that this was a criterion for study admission. Once entered into the study, they may have felt freer to reveal more accurate levels of optimism.

These explanations for the discrepancy seem more plausible than participants inflating their self-report of hope due to social desirability concerns (Paulhus, 1984). The desire to avoid negative appraisal could have artificially raised ratings on measures of hope, meaning, and empowerment; however, two pieces of evidence imply otherwise. Scores on these measures remained relatively stable within moderate to high ranges over the study's nine measurement points. As participants became more comfortable in the study setting, one would think social desirability concerns would ease, leading to lower self-reported levels of positive well-being (e.g., less hope, meaning, empowerment). Additionally, moderate to high scores were observed across these positively correlated constructs (Peterson & Park, 2012), coinciding with qualitative data gleaned from BSR interviews. From a convergent validity perspective, it appears that participants really did feel positive during the course of the study.

In the future, when pre-selecting study participants for an internal characteristic like hopelessness, it may help to administer a screening measure to reduce false positives. If the intention is to study individuals in earlier recovery stages, researchers may also want to exclude individuals with a long, recent period of abstinence and those who have spent considerable time in treatment. On average, participants had not used drugs or alcohol for 8 months prior to study enrollment. In addition, they had spent almost 10 months in treatment. At this stage, it may be difficult to find many people who are highly demoralized.

MI's Effects on Hope, Meaning, Empowerment, and Participation Readiness

Causation and confounds. Some quantitative and qualitative evidence pointed to a positive effect of MI on key recovery constructs. Two of six participants experienced statistically significant increases in hope, meaning, and empowerment levels at the point MI was introduced, as measured by a brief composite phone survey. A third participant also demonstrated a survey score pattern consistent with an intervention effect, in which scores remained flat during baseline but increased during MI. When full measures of hope, meaning, and empowerment variables were taken into account, improvements on these dimensions were noted for all participants during the intervention. On average, participants reported levels of hope, meaning, and empowerment that were 15 to 20% higher during MI, relative to baseline. The self-report data indicated that all study participants felt more in control, purposeful, and hopeful as they moved through the intervention phase.

Participants linked some of this change directly to MI when asked to describe how the sessions affected them. They attributed increases in hope, optimism, relationship self-efficacy, confidence about the future, clarity about goals, self-understanding, and desire to engage in treatment to their participation in the sessions. Many of these feelings have been associated with the method and spirit of MI (Angus & Kagan, 2009; Kertes et al., 2010; Zuckoff, 2001) and are part of its emotional "base" (Wagner & Ingersoll, 2008). Three participants also advanced in recovery stage during MI, but not during baseline, further supporting the conclusion that MI was associated with positive changes on measures of recovery.

The lack of statistically significant HME level changes from baseline to intervention for four out of six participants, however, weakens causal inferences regarding MI's effect on well-being. Given some psychometric concerns, this does not necessarily mean that MI was ineffective. Research assistants who administered the phone surveys noticed decreasing variability over time in item responses, suggesting a response style in which participants paid less attention to the item content as the study progressed (Paulhus, 1991). In this respect, the validity of the HME survey after repeated administrations is questionable. Because surveys began during baseline, reactivity to assessment could have obscured between-phase shifts in well-being.

Increases in internal motivation, help-seeking, treatment confidence, and participation readiness ratings during baseline also make it difficult to conclude that MI precipitated changes in treatment motivation. High pre-MI levels of positive well-being and increasingly treatment-friendly attitudes across baseline suggest possible confounding effects of non-MI factors. These may have included positive life events, an active problem-solving style, entering the study in an advanced recovery phase, and test sensitization during baseline. From a qualitative perspective, attributions of positive change to MI could also represent the influence of non-MI factors, such as feelings of greater self-confidence from acquiring an independent living situation during the intervention. This major positive life event occurred in three cases.

MI, high readiness, and questions of treatment usefulness. Overall, the study produced a snapshot of consumers who had achieved a substantial level of stability and momentum in their recovery. At the same time, two of these participants harbored some doubts about the personal utility and benefit of STOP services. They entered the study

expressing uncertainty about how service participation fit with their improvement. This either reflected a mismatch between services and personal needs, or a limited awareness of how treatment involvement had helped in the past or could help in the future. Questioning treatment's usefulness potentially leads to disengagement or reduced involvement in recovery activities, especially if providers exhibit insensitivity, inflexibility, or disregard for client satisfaction (O'Brien et al., 2009; Magura, Villano, Rosenblum, Vogel, & Betzler, 2008; Schulte, Meier, & Stirling, 2011). MI appeared to target this "question of usefulness" for a sample in which most participants reported some level of service engagement, if not to the frequency or degree recommended by their therapists. Even if participants had previously considered what they enjoyed about the STOP program, it is unlikely that they had ever verbalized the connections between their recovery successes and service participation in the manner offered by MI.

While affirming participant successes in recovery, MI focused on the link between these accomplishments and treatment involvement in the direction of continued or increased participation. For those who reported less involvement at STOP, developing positively valenced discrepancy helped them see "opportunities for betterment" (Miller & Rollnick, 2012, p. 243). During MI, one participant said she realized that she had learned more than she thought from her therapists. Seeing the potential value in acquiring more knowledge through services had created a positive discrepancy between her current and her desired level of involvement. For those actively involved in STOP, MI involved highlighting behavior-value *consistency* as a way of supporting persistence. One participant talked about the reassuring experience of receiving STOP peer support when her father died, a social connection she hoped to sustain. Thus, motivation may not

always come from perceiving room for growth, but from the realization that what one is doing already matches a deeply held value.

Four participants reported feeling ready or very ready to participate in treatment at STOP prior to MI. Given this pre-treatment characteristic, it is unsurprising that most participants experienced MI as a place to celebrate their accomplishments and, in effect, feel more inspired to continue moving forward. Increased levels of hope, meaning, and empowerment corresponded to this "supporting persistence" version of MI, which Miller and Rollnick (2012) associate with the planning or implementation processes. This was not just a matter of maintaining the status quo of an improved life. Among those who reported active involvement in treatment at baseline, service involvement continued to increase post-MI, as indicated by greater group participation, medication taking consistency, and peer collaboration and support.

As a whole, these findings contradict results of studies which have shown detrimental effects of AMIs for individuals with higher pre-treatment motivation (Rohsenow et al., 2004; Stotts et al., 2001). Stotts and colleagues found that substance dependent clients who began MET with higher readiness to change were less likely to complete detox treatment than those with lower initial readiness. In another MET trial, cocaine abusers with higher pre-treatment change readiness relapsed at a higher rate and exhibited more severe substance use than those less motivated at the outset (Rohsenow et al., 2004). The structure of the two-session MET interventions used in these studies may help explain the lack of efficacy with high-motivation participants. Counselors in both studies explored ambivalence in the first session, using decisional balance, which might have elicited sustain talk among people who had already decided to reduce their

substance use. In addition, Rohsenow and colleagues provided assessment feedback in Session 2, focusing on consequences of continued cocaine use. For clients who already regard change as important, continued efforts to build goal-behavior discrepancy through the use of feedback may cause frustration. At this point, they may feel more receptive to confidence and planning discussions.

With regard to decisional balance, there is no convincing evidence that exploring the status quo side of ambivalence promotes change (Miller, 2008; Miller & Rollnick, 2009). Although the present study's protocol also included decisional balance around treatment participation, the MI therapist explored advantages of the status quo only if the participant indicated low readiness to change, or communicated feelings of discord. As a result, the use of "decisional balance" often appeared one-sided, a discussion dominated by the participant's perceived advantages of treatment involvement, both past and present. This modification of decisional balance reflected sensitivity to the pro-treatment attitudes in this sample and in the technique's more appropriate application in MI practice. Rohsenow and colleagues might have observed better outcomes for change-ready participants if they had excluded decisional balance and focused on self-efficacy in Session 1, as opposed to waiting until the end of Session 2. It is difficult to determine, however, the level of protocol flexibility permitted in these two MET investigations.

MI, low hope, and disengagement. In the present study, MI's effects for consumers early in recovery could be tested in only one instance. This single case offered a notable contrast with other cases in terms of the relatively greater changes on the dependent quantitative measures. This participant reported a 30% increase in meaning and hope during the intervention, the largest changes observed in the sample.

He was the only participant who demonstrated a significant pattern of flat HME composite scores during baseline and an increase in those scores during MI. He also advanced the furthest in recovery, progressing from Moratorium (STORI, Stage 1) to Preparation (STORI, Stage3). The latter finding supports the hypothesis that greater increases in hope, meaning, and empowerment levels are associated with more significant stage progression.

This participant also reported the lowest average levels of treatment participation readiness across baseline. MI's comparatively larger effects for individuals presenting with lower initial motivation has some precedent (Project Match Research Group, 1997; Witkiewitz, Hartzler, & Donovan, 2010). A little more than 50% of the Project Match sample also reported another Axis I diagnosis, increasing its relevance to this study's sample. These studies found that MET, in comparison with CBT, was associated with greater reductions in drinking among participants at a 15 month follow-up for those who reported lower initial baseline readiness for change. Interestingly, this advantage did not appear in an after-care setting in which alcohol dependence was more common. Witkiewitz et al. (2010) speculate that problem severity may moderate MI's effects, at least in terms of substance use. MI may confer the greatest benefit if an individual has low readiness for change *and* low problem severity. In the present study, the individual with the lowest initial levels of readiness had a diagnostic history of marijuana dependence, potentially indicating lower drug problem severity than the other participants with cocaine dependence diagnoses. As Witkiewitz and colleagues propose, a reduced number of obstacles may have paved the way for realizing optimal benefit from MI.

In some instances, a more intensive, directive treatment may provide a better fit for individuals with complex clinical presentations. Individuals diagnosed with SMI and substance use disorders who are early in recovery and facing a confusing array of chronic psychosocial stressors (e.g., unemployment, unstable living situation) may prefer that professionals, at times, adopt a more directive stance. In some provider interactions, older and younger adults with SMI have indeed expressed preferences for a passive role in decision-making (O'Neal et al., 2008). In terms of integrating MI spirit and a directive approach, best practices would suggest that the therapist first take time to understand the client's needs and ask permission before giving advice or prescribing a course of action (Arkowitz et al., 2008).

One of the more interesting study findings was that engagement with STOP services did not always co-occur with high levels of hope, meaning, and empowerment. Two participants expressed substantial degrees of positive well-being while demonstrating low utilization of STOP services, with positive emotions tied to occupational pursuits and coping effectively without group or individual therapy. Additionally, no support was found for the hypothesis that greater increases in hope, meaning, and empowerment would correlate with larger increases in service participation. This supports the idea that, to maximize engagement, providers should continually explore consumers' individual needs and treatment preferences (Kreyenbuhl et al., 2009; O'Brien et al., 2009). They should not assume that hope and meaning alone are reliable predictors of treatment involvement. Therapists might want to assess specifically what intensity level and type of treatment consumers prefer, which may fluctuate depending on recovery phase.

Autonomy support, program flexibility, and appropriate timing of interventions may be critical determinants of whether or not clients choose to continue services. For instance, individuals with SMI have noted their preferences for autonomous decision-making with regard to employment and housing (O'Neal et al., 2008). Three participants in the study reported a recent change in living situation and a fourth person began to receive part-time work. If providers support a decision to adjust treatment due to employment opportunities or housing changes, the consumer may feel more sincerely understood and remain connected to the program. Alternatively, lack of provider flexibility and need awareness may lead to greater discouragement about treatment in general. This can add to a sense of demoralization described by Frank (1974). As one participant explained, continued pressure to participate in services when someone feels ready to "do it on their own" can undermine a sense of confidence and autonomy, as she felt it did in her case.

Avoiding services that do not meet one's needs can also represent an empowering decision for consumers, a way of exercising autonomy and expressing clarity about one's treatment-related values. In addition to her desire for greater autonomy support, the participant referred to previously wished she had experienced more consistent provider relationships that conveyed sensitivity. She discussed these desires throughout her MI sessions. At the end of Session 4, she expressed high readiness to seek a treatment environment elsewhere that might better satisfy these needs. She also expressed greater appreciation of what she had gained from her involvement at STOP. It seemed to influence her attitude positively toward treatment in general. She saw how it could benefit her under the right conditions. Guiding this individual with MI toward

engagement in services that did not meet her needs or support her autonomy would be antithetical to MI spirit. As this case demonstrates, disengagement can represent an actual success if MI leads to increased motivation among clients to find a "better fit" of services.

The use of "looking back" on this participant's STOP experiences seemed to help her reframe them. The MI therapist reflected gains and her perceived value in some of her provider interactions. Miller and Rollnick (2012) discuss "looking back" as a way of building motivation by comparing past and current states, influencing assessments of importance and confidence in change. If the past represents a time of poorer functioning, reflections might highlight improvements to support confidence. If it represents a period of well-being prior to current distress, the therapist might explore the client's reasons that a better state might be achieved again, or focus on the client's desire to return to that state. The MI therapist might also help the client recognize or clarify conditions necessary for functioning better. In the example above, instead of focusing on a past-present contrast, looking back helped the participant broaden an understanding of a past experience, a conversation in which the therapist selectively reflected the experience's positive elements. The method appeared to increase her confidence that treatment at times could be useful, even with its downsides, strengthening her motivation to engage in alternative services.

Another unexpected finding was that, despite initially high levels of hope, meaning, and empowerment, participants demonstrated further improvement on these measures during MI. If a ceiling effect existed, it proved to be a higher ceiling than one

might have expected, given their elevated initial hope, meaning, and empowerment scores.

MI, SDT, and Recovery

Data from grounded theory analysis supported the conceptual fit of SDT with MI (Markland et al., 2005; Vansteenkiste & Sheldon, 2006) and SDT with recovery principles (Mancini, 2008). MI's most helpful moments elicited recovery content around increasing competence and relatedness, two basic needs for self-motivation in SDT (Ryan & Deci, 2000). Interestingly, the theme of autonomy did not arise nearly as much as themes of relationships, identity, and self-efficacy, contradicting Mancini's (2008) suggestion that supporting autonomy is the most important recovery-related SDT need among individuals with SMI. Through an examination of "then-now" contrasts, participants reported feeling more confident in managing their lives, relationships, and moods without using substances. They also described stronger connections with family and peers. Talking about these changes in MI may have contributed to basic need satisfaction (competence and relatedness), as indicated by participants' expression of positive emotions and change talk when addressing these areas.

MI may also have increased internalized motivation by spotlighting value-behavior consistencies with regard to recovery activities, including service participation. This likely enhances *identification*, a state associated with more autonomous, enduring behavior (Deci & Ryan, 2000). At the end of MI sessions, participants often identified helpful or important moments that addressed self-understanding, typically represented by value clarification and identity discussions. One person said it was helpful to talk about her value of peace, because she grew up in a chaotic home. The discussion led her to be

more in touch with related values of forgiveness and personal responsibility, which she associated with wanting to help others in recovery contexts. Some of the self-understanding category reflected a positive sense of self when it addressed enacting core values (e.g., helping others). Another helpful therapy event category was more directly related to service participation. It included self-disclosure, positive relationships in treatment, and reasons for liking STOP. Together, these results suggest that participants learned more about themselves through MI and also recognized, or increasingly accepted, the personal importance of service participation.

This qualitative data conflicted somewhat with the TMQ Internal subscale pattern, which reflected decreasing scores across participants during MI. Reasons for the decline may relate to how internalized motivation for treatment was measured on this particular subscale. Some items addressed treatment-seeking reasons based on self-esteem related consequences, such as "I'll feel very bad about myself if I didn't" and "I would feel like a failure if I don't." Participants were less likely to endorse this subset of items during MI, reducing TMQ Internal scores. They reported a positive sense of self in their current recovery activities, a newfound self-esteem often sustained through helping others and positive family relationships. Scores on the Self-esteem-Self-efficacy subscale of the ES also increased, implying consolidation of gains on this dimension of recovery during the intervention. It is possible that participants had developed enough sources of feeling good about themselves that any decision not to pursue treatment presented a low threat to self-esteem. Decreasing scores observed on the internal subscale could correspond to self-esteem which was increasingly independent of treatment engagement decisions and

more firmly rooted in stable recovery accomplishments. In the language of SDT, participants displayed less *introjected* motivation over the course of the study.

The post-MI decrease in the Internal motivation scale could also correspond to an increasing external focus on help-seeking as the intervention progressed, a TMQ subscale that rose steadily from baseline to follow-up. The more fully the participants' attention became outwardly directed toward help-seeking behavior, the less they may have referenced internal reasons for engaging in treatment, reflected in lower Internal subscale scores. Additionally, the drop in TMQ Confidence scores at follow-up could represent a negative contrast effect when participants returned to treatment as usual after the MI sessions. The majority of counselors at the program had not received formal MI training, increasing the possibility that treatment-as-usual seemed less person-centered and more pressured in comparison. Through the intervention, participants may have discovered a desired quality of interaction, which when removed, triggered feelings of discouragement or a belief that other styles of treatment delivery would not be as helpful. This supports the argument for efforts to integrate MI throughout systems of care rather than only offering it as an adjunct (Miller & Rollnick, 2013).

Qualitative evidence also highlighted the importance of MI's interpersonal factors, or its spirit, in satisfying the need for relatedness, particularly through the use of empathy and affirmation. Interview data indicated that MI fostered emotions commonly experienced in safe, trustworthy, and valuing relationships. This finding is consistent with other data on MI participant experiences (Angus & Kagan, 2009; Zuckoff, 2001) and with conceptual frameworks addressing MI, emotions, and SDT (Britton et al., 2011; Markland et al., 2005; Vansteenkiste & Sheldon, 2006; Wagner & Ingersoll, 2008). In

this study, two distinct sets of emotions emerged in response to MI, one tied to interpersonal factors and the other more closely associated with content elicited by MI method (e.g., looking back, envisioning, values discussions). Both sets of emotions may contribute to increased hope, meaning, and empowerment in dually diagnosed individuals, in a sequential and additive manner.

Along with a sense of safety and trust within the working alliance, participants reported feeling that life was more meaningful, reflected in their MLQ responses and in the interview data. It is notable that self-reported purpose in life increased more than ratings of hope and empowerment during the intervention. Many of the discussions in MI related to future visions participants had for themselves, speaking to overarching life goals. These sometimes intersected with reasons for seeking treatment. Participants appeared very much receptive to meaning-oriented activities and discussions, as if these aspects of MI fulfilled a broader need for a sense of purpose. Results from this study suggest that clinicians may want to address meaning in life explicitly throughout the recovery process, not only early in recovery when it may be most lacking (Andresen et al., 2006). Additionally, purpose in life may occupy a more critical place within multidimensional concepts of hope when studied in individuals with chronic illness and trauma histories. Consumers have identified the loss of meaning as one of the central threats of SMI, traumatic life experiences, and persistent periods of substance use (Cruce, Ojehagen, & Nordstrom, 2008; Noordsy et al., 2002; Murphy, 2000), whereas meaning-making has been associated with recovery and improved psychological functioning (Davis et al., 1998; Mascaro & Rosen, 2005; Stolovy, Lev-Wiesel, Doron, & Gelkopf, 2009; Southwick et al., 2006).

Although empowerment ratings increased less in this sample during MI, an average of 10% across participants, relative to meaning (20%) and hope (16%) increases, most of the change occurred within the Self-esteem-Self-efficacy subscale of the ES. This finding makes sense, considering that greater self-efficacy and a more positive sense of self represented two core recovery content themes from the BSR interviews. The correspondence of these qualitative and quantitative findings suggest that talking about one's recovery accomplishments and positive changes in self-image may have positively influenced beliefs about the self. Relative to baseline, participants were more likely to agree with statements such as, "I see myself as a capable person" and "I feel I am a person of worth" immediately after an MI session. Among many individuals coping with chronic mental illness, rediscovering a valued and capable sense of self becomes an essential recovery task (Bradshaw et al., 2006; Davidson & Strauss, 1992; Roe, 2005; Wisdom et al., 2008). Analyzing recovery narratives, Roe (2005) points out that "exercising restored skills, talents, or ways of being" (p. 39) facilitates the re-valuing process and commonly takes place in the context of affirming, supportive relationships. MI creates this type of relational environment, particularly through its empathic attunement (Angus & Kagan, 2009), which can reawaken positive self-regard and ignite agentic thinking.

Relationship of MI Session Structure to Hope, Meaning, and Empowerment

No support emerged for the hypotheses that greater increases in hope and meaning scores (HHI and MLQ), relative to empowerment scores (ES), would follow values-related discussions (Sessions 1 and 2) and that greater increases in ES scores would follow confidence and self-efficacy discussions (Sessions 3 and 4). Values-

oriented and self-efficacy topics often surfaced together throughout the course of MI, making a session-based distinction virtually impossible. For example, recovery accomplishments frequently became the subject of the first session, perhaps attributable to participants entering the study in later stages of recovery. These discussions sometimes led quickly to considering underlying values, self-guiding principles, and the meaning of progress. Similarly, values discussions did not stop after Session 2, a meeting in which participants completed the Personal Values Card Sort. Values content reappeared in subsequent sessions at deeper, more elaborated levels as change talk touched upon reasons and desires. The co-occurrence of self-efficacy and values-oriented content might be expected, given MI's flexible guiding style, in which the counselor follows content offered by participants while gently steering the conversation toward change. A more strict protocol-driven application of MI might have confined confidence-related discussions to later sessions, potentially reducing the intervention's effect (Hettema et al., 2005; Lundahl et al., 2010).

Gains in Hope, Meaning, and Empowerment: MI's Durability at 1 Month

Although causality remains questionable, MI appeared to be associated with durable short-term gains in hope, meaning, and empowerment through follow-up, as indicated by relatively stable HME survey responses and total scores on the full measures of these variables. Withdrawal of MI did not precipitate significant HME survey level changes, although a response set previously mentioned may have obscured any negative withdrawal effects. HME survey scores significantly decreased in the month following MI only for one participant. After the MI phase, another participant exhibited an immediate drop in HME scores followed by a subsequent increase over that month. The

three other participants for whom data were available maintained their gains both on the phone survey and full measures. These findings support meta-analytic work demonstrating the maintenance of positive MI effects over the first month post-intervention (Hettema et al., 2005; Lundahl et al., 2010; Vasilaki, Hosier, & Cox, 2006).

As a note of caution when considering MI's durability, Hettema's meta-analysis reported a substantial decrease in effect size between 1 and 3 months post-MI (.77 to .39). When evaluating alcohol treatment studies, Vasilaki and colleagues likewise reported an eroding effect of MI, with a loss of significant differences between MI and no treatment at 6 months. They further found that excluding clients with greater problem severity increased MI's effect, in comparison with a control condition at 3 months post-intervention. Considering the clinical complexity of present sample, one might worry about the longer-term stability of gains that may have resulted from MI. The recovery stage regression noted at follow-up for the participant with lowest levels of hope is particularly concerning. For this participant, whose MLQ score decreased more than the MLQ scores of other participants, the end of MI may have represented the loss of a supportive, affirming environment that helped him create meaning in his life. In some respects, finishing the study may have introduced a jarring sense of discontinuity, opening a void that "treatment as usual" could not fill.

It is interesting to note that when MI is added to another treatment, effects are more likely to be sustained and may even increase over time (Hettema et al., 2005). One of the most common additive approaches involves combining MI with cognitive-behavioral treatment, offering it prior to CBT (Miller & Rollnick, 2012). One wonders whether MI might have had a more powerful effect if it had preceded or was woven

throughout STOP treatment instead of targeting service participation once difficulties arose. For instance, the participant with the lowest levels of hope indicated relational meaning as an especially important part of his recovery. A system sensitive to these relatedness needs might emphasize ongoing collaborative, person-centered care with an MI-trained therapist. This type of MI integration would likely feel more streamlined to the client, if difficult to incorporate in a rushed clinic setting where overusing directive communication helps meet demands (Miller & Rollnick, 2012). MI spirit shared across clinic staff could enhance a relational continuity, an overall provider ambience of partnership, acceptance, and compassion. These qualities have helped individuals with SMI feel more "known" and connected with providers (Bradshaw et al., 2006), and as a result, could foster increased participation.

Acknowledging and Elaborating on Recovery Progress in MI

Ability and confidence: "now I'm not helpless." This study's results support the importance of the self-efficacy dimension of hope, an aspect emphasized by a number of authors. Miller and Rollnick (2012) describe hope as "the belief that change is possible" (p. 213) and the perception of one's ability to facilitate that change. This definition echoes Snyder et al.'s (2000) concept of agentic thinking as one of the two essential components of hope. Similarly, Miller and Powers (1988) identify a sense of competence and coping ability as foundational elements of the construct. In the present study, agentic hope emerged when people discussed positive change that was already occurring as a result of their actions. Participants talked about overcoming major behavioral hurdles, such as finally sustaining sobriety after 30 years of unsuccessful efforts, choosing to spend time with family rather than "running the streets," and no

longer resorting to prostitution. Statements evaluating these "then-now" contrasts largely consisted of ability change talk: "I can," "I'm in charge," "I might be able to," "[I can] figure it out myself," "I've really come far," and "don't have to go through it."

In MI, reviewing accomplishments is one way of developing positive contrasts that support self-efficacy, which in turn can have empowering and hope-producing effects. This process may facilitate the "enhancement of possibilities" (Rappaport, 1981). According to Snyder et al. (2000), individuals may experience hope by seeing more pathways toward their goals. One participant expressed this sense of possibility when she said, "I know that now I'm not helpless . . . I can help somebody." Ability change talk might signal that the therapeutic interaction has evoked hope and is simultaneously satisfying the basic human need for competence, as proposed by SDT. The emergence of Ability language also may differentiate early recovery stages (Moratorium) from later ones (Preparation, Rebuilding, Growth). Later stages are characterized by increasing confidence, illness self-management, and active pursuit of goals, a distinct departure from the helplessness often expressed in Moratorium (Andresen et al., 2006). Here we find a conceptual link between MI, hope, recovery, and SDT. Although not measured systematically, the frequent occurrence of Ability change talk in the BSRs is consistent with participants' classification in later STORI stages (Stages 4 and 5).

Although reviewing past successes appeared to ignite cognitive pathways to future well-being, it also produced a specific set of positive emotions. As a result of talking about their progress, participants reported feeling lightness, freedom, relief, excitement, eagerness, happiness, and a greater desire to engage with others, either at home or in treatment settings. A connection likely exists between MI counselor behavior

and these feelings. Celebrating accomplishments often triggered discussions about what the participant was currently doing positively for his or her recovery (e.g., participating in an online recovery group, opening up in groups). The counselor typically responded with Action Reflections (ARs; Resnicow, McMaster, & Rollnick, 2012) aimed at supporting autonomy, confidence, next-step formulation, and persistence. Reflecting on past or current recovery activity also became a springboard for looking forward. For one participant, ARs focused on her plan to share her recovery experiences with youth. Because she had not given much thought to *how* she might specifically begin or prepare for this role, open questions and ARs guided her in seeing treatment groups as a practice opportunity. This approach allowed her to "inject . . . energy, enthusiasm, and commitment" (p. 477) into a plan that coincided with increased treatment participation.

Research has indicated that positive feelings such as these can, in fact, predict more flexible problem-solving and the adoption of broader perspectives (Fredrickson & Joiner, 2002). In this study, discussing symbols of progress (e.g., NA key chains, a song called "The Storm Is Over") often elicited positive feelings, such as happiness, joy, pride, and excitement. Addressing past successes may have been especially important in building an emotional "sense of the 'possible'" (Miller & Powers, 1988, p. 6) for individuals with trauma histories and chronic life stressors. Sharing one's past successes with a caring, genuinely interested person who responded with complex reflections of feeling and ARs likely had the effect of deepening and sustaining hope. Based on "broaden-and-build" theory, this amplification of positive affect may have expanded the number of visible recovery pathways, thereby increasing the sense of confidence in further change. To the extent that individuals perceived treatment participation as part of

these newly articulated recovery pathways, it could have also promoted increased engagement in services. Celebrating progress in this fashion fits with MI's role in supporting persistence throughout the change implementation process (Miller & Rollnick, 2012). This may be even more crucial for individuals with bipolar disorder who experience rapid fluctuations of affect and motivation, either between or within sessions (Jones et al., 2011).

In general, confidence represents a crucial factor in motivation for change (Miller & Rollnick, 2012), with a recent study indicating that self-efficacy mediates the effect of MI on behavior change (Chariyeva, Golin, Earp, & Suchindran, 2012). The more MI that participants received, the greater self-efficacy they reported in practicing safer sex. In MI, spotlighting past successes also offers an opportunity to identify skills and strengths in one's accomplishments. In this study, self-efficacy discussions revealed qualities of perseverance ("You sit there and get the message and I did that") and value to others ("I can help somebody else"). An awareness of enduring positive traits based on one's abilities may not only enhance confidence in one's actions, but may also simultaneously strengthen self-worth as a person, thus moving beyond the Moratorium stage of recovery.

Re-valuing self: "a flower had blossomed." In addition to eliciting ability-related hope, "then-now" contrasts reflected improvements in self-worth. Comparing active illness or addiction states with present functioning, participants described feeling greater self-respect, pride, and value in their identities. One participant likened her change in self-image to a "flower [that] had blossomed." Other consumer accounts have noted a similar recovery process of re-establishing a positive identity (Andresen et al., 2003; Roe, 2005). Whereas Andresen and colleagues talk about self re-definition as a

key part of this change, the present study found more evidence of improved feelings toward the self or expanded possibilities of self, rather than a fundamental shift in identity (e.g., total loss of self to knowing *a* self, or discovering a self separate from illness). The shift in self-regard for these participants involved dropping pejorative labels such as "dirty," "bummy," "stupid," "dumb," and "crazy." New possibilities of self included being a youth mentor, helpful son, NA leader, and social person, roles which carried with them a sense of pride.

Zuckoff (2001) identified a participant's experience of pride as one of the most powerful emotional moments in an MI session. This moment occurred following a review of information that reflected the individual's successful abstinence from drugs, an accomplishment that also represented a positive aspect of himself. It was not only the accomplishment that created the feeling, but also its recognition by the MI therapist. The shared acknowledgement of change stood out from the rest of the session, originating in a peak moment of positive self-regard: "I finally felt a little bit proud of something for the first time in the entire session" (p. 128). Sharing progress around one's ability to make a difficult change appeared to strengthen self-worth, an example of MI content (e.g., achieving abstinence) and process (e.g., discussing it) interacting to produce the emotion. Exploring "then-now" comparisons in this study had a similar impact. As in Zuckoff's data, participants in this investigation appeared eager to talk about changes that cast the self in a positive light. One individual described the pleasure and hope-instilling quality of seeing himself as a more compassionate son in comparison with when he was when using drugs: "It gave me a good feeling to talk about change . . . and what you have changed, and to just try to look forward to your goals, your next accomplishments."

The movement from negative to positive self-focused feelings (e.g., "Wow, like, now look at me, 18 months later, this is *me*") is consistent with recovery stage differences in self-esteem. Responses characteristic of Moratorium, STORI Stage 1, include "negative identity" in comparison with the "self-actualization" and "improved self" of Growth, STORI Stage 5. Rebuilding, STORI Stage 4, addresses the work invested in reaching this state of positive self-regard. Two participants moved from Stage 4 to 5 after MI, with two other participants remaining in Stage 4 or 5 at post-MI measurement. These results suggest that MI may help some participants feel happier with who they are, or at least help them maintain satisfaction about themselves in the face of stressful life circumstances. Positive self-regard factors into a holistic definition of hope as well, with three items on the HHI directly assessing self-esteem related concepts (Herth, 1991). Improved self-esteem realized through MI conversations about recovery accomplishments may instill hope. It is conceivable that trait-based self-evaluation (e.g., worthy, capable, likable) could increase positive anticipation of the future. These qualities suggest the presence of a stable resource during periods of situational distress.

There is reason to believe that MI's relational process (spirit and microskills) also contributed to a positive sense of self in this sample. Participants described the MI therapist as "genuinely interested," "caring," "really concerned," and "like a friend." Their use of these descriptors suggests they felt valued and liked by the therapist. This may have been particularly important when considering the sociocultural differences between the therapist (Caucasian) and study participants (African American). Some research has indicated that MI may be more effective with ethnic minority groups, perhaps as a result of a spirit that conveys respect and emphasizes understanding client

perspectives from a nonjudgmental point of view (Hettema et al., 2005; Lundahl et al., 2010). Such an approach could greatly lower mistrust or guardedness, and in turn, promote self-disclosure.

One might argue that the personality characteristics of the therapist could have accounted for participants' positive attributions rather than MI (Ackerman & Hilsenroth, 2003). Some research, however, has not found a link between specific therapist attributes and outcome differences (Gaume et al., 2009; Project MATCH Research Group, 1998). More likely, therapist behaviors conveying acceptance, curiosity, and compassion created a sense that participants mattered, and that their stories had importance and worth. In one case study, a woman with Generalized Anxiety Disorder reported feeling "liked and prized" by her MI therapist (Angus & Kagan, 2009). The therapist's empathic attunement through the use of reflection further validated the importance of her concerns: "I felt that she was really listening to what I am, you know, saying and what I try to say" (p. 1161).

Wagner and Ingersoll (2008) propose that this kind of selfless listening and valuing promotes clients' "deep acceptance of themselves as humans, independent of any discontent they may feel about the choices they made" (p. 197). The authors hypothesize that this can, in turn, encourage action toward self-improvement. As Steele's (1988) self-affirmation theory suggests, the desire to maintain a positive self-image may indeed constitute a motivation or need which MI fulfills. The implication is that one will seek out experiences that sustain or strengthen positive self-regard. In sessions, MI spirit has actually predicted client cooperation, disclosure, involvement, emotional expression, and interest (Moyers et al., 2005). Therapist acceptance, collaboration, and empathy may

make it more likely that clients will remain connected with services, perhaps in part because clients feel better about themselves through this relationship. Specifically, MI skills of reflection, affirmation, and support of personal control appear to build a self-affirming climate reminiscent of two of Rogers' (1957) necessary and sufficient conditions for change: empathy and unconditional positive regard. Such MI-consistent behaviors have predicted change talk or improved treatment outcomes (Gaume et al, 2009; Moyers et al., 2009; Moyers & Martin, 2006) and stronger working alliances (Crits-Christoph et al., 2009); however, the potential mediating role of enhanced self-esteem has not yet been explored.

In contrast to self-affirmation theory, SDT does not consider feeling good about oneself as a basic psychological need whose satisfaction affects motivation. Nonetheless, it is possible that satisfying one's competence, relatedness, and autonomy needs will lead to self-affirming feelings. Self-worth likely extends beyond an appreciation of one's abilities and connection to others. It would be implausible to assume that we base our self-evaluations only on our accomplishments, autonomous choices, and social interactions. There are potentially motivating effects of knowing, liking, and accepting oneself, a core process in the journey back to well-being for individuals with SMI (Bradshaw et al., 2006; Roe, 2005; Wisdom et al., 2008). In one study of dually diagnosed adults, feeling guilty or ashamed ranked as the second most commonly endorsed substance-misuse related consequence (Nidecker, Bennett, Gjonbalaj-Marovic, Rachbeisel, & Bellack, 2009). Clearly, some populations are more likely to enter treatment with strong negative self-regard, which may require more explicit intervention at an experiential, relational level.

An especially strong need to reconstruct a positive self-image may exist for participants in recovery who have experienced extensive histories of rejection and alienation. As one individual poignantly stated, “Strangers didn’t tell me I was no good. My family did.” Four of six participants in this study had suffered some form of sexual or physical abuse, either as adults or children. Negative self-esteem and unsafe environments were common themes at pre-recovery “then” points. For individuals who have struggled with anxiety, trauma, or the threat of social stigma, MI may provide a powerful corrective emotional experience by creating a safe, nonjudgmental, affirming atmosphere (Angus & Kagan, 2009; Zuckoff, 2001). Consistent with the findings of Zuckoff and others, participants in this sample described feeling safe, trusting, and respected in the MI relationship.

For trauma survivors, being prized and understood in such an atmosphere may facilitate valuing the self in a manner virtually impossible in the past. When one survivor of sexual and domestic abuse spoke about her experiences in MI, she described dramatic changes in self-worth, stating, “I feel good about myself today in comparison to when I was really self-loathing, when I came here” (Hughes & Rasmussen, 2010, p. 312). She remarked that the counselor validated her experience and asked questions that fostered self-discovery. For her, the end result was increased self-acceptance. Comparing MI experiences with those of controls, the authors further found that those in the MI group placed stronger emphasis on their personal strengths.

Although no participants in the present study directly referenced greater self-love or self-acceptance as a result of MI, improvements on this dimension could be logically inferred from their BSR data. They were also corroborated by positive changes on the

Self-esteem-Self-efficacy scale on the ES. The pre-treatment self-loathing expressed by participants in Hughes and Rasmussen's research was similar to the low self-esteem described in early recovery by many participants in the present study, who came from similar backgrounds. It could be that MI's self-affirming effects are particularly salient for individuals with these characteristics. In addition to the positive sense of self that emerges from acknowledging recovery progress, a parallel process of valuing within the therapeutic relationship may help consumers with histories of abuse consolidate gains in self-worth. Both channels may sustain the sense of hope and motivation for continued change.

Stronger relationships: "my children are back in my life." Qualitative results indicated that, early in recovery, low self-worth accompanied a reduced desire to engage with others, weaker relationships, and greater isolation. In discussing the past, one participant poignantly illustrated this connection between self-esteem and relationships, associating feeling "dirty on the inside" with avoiding others. Conversely, participants associated increases in self-worth with renewed social involvement via family reconnection or helping others. Roe (2005) documents a similar link between supportive interactions with others and a positive sense of self. One person in Roe's research connected "talking to someone" and feeling more "real" or authentic. In the present study, a more likable self may have acted as a catalyst for rejoining peer and family systems. In turn, stronger relationships may have fueled a sense of hope, as conceptualized by various authors (Dufault & Martoccio, 1985; Herth, 2001; Miller & Powers, 1988; Stephenson, 1991). Participants may have felt more positive about the future based on a fundamental sense of belonging and being loved or needed.

Analyzing accounts of people recovering from mental illness, Hobbs and Baker (2012) elaborated on hope's interpersonal dimension. Major relational hope themes included feeling connected to people through a greater sense of responsibility, or through the desire to help. The latter theme appeared prominently in this study, with "then-now" contrasts highlighting greater acceptance of responsibility in one's recovery community and family. One person spoke about becoming an NA secretary, whereas two other participants discussed mentoring young people struggling with addiction. A fourth person described staying home more to help his mother. Some research links these kinds of positive relationships directly to adaptive recovery behaviors. Drake et al. (2008) reviewed 8 studies of group interventions for dually diagnosed adults, all of which contained a peer support component, and found consistent positive effects on substance use outcomes. Groh, Jason, and Keys (2008) similarly found that social support mediated abstinence outcomes, particularly in terms of stronger friend networks.

The present study's data suggest that ease of self-expression may influence strength of social support, both in treatment and non-treatment contexts. Two participants described greater confidence in their ability to express themselves as a result of their MI involvement. Comments included "I might be able to share with two or three" and "I'll be able to go next door and speak to the people that work there." The latter remark came from the participant who began the study in the earliest recovery stage, Moratorium, suggesting the importance of treatment experiences that enhance social self-efficacy. One might speculate that the greater one's confidence in self-expression, the more likely one would willingly share personal experiences in group and individual therapy. Of the notable changes observed in service participation post-MI,

five participants reported increased group therapy participation. Half of the sample also rated themselves as getting along better with other group members.

In general, the data indicate that the emotional bond formed with the MI therapist and the self-disclosure in this relationship may have positive effects on social self-efficacy that extend beyond MI. Zuckoff and Daley (2001) explain that MI may facilitate treatment acceptance among dually diagnosed adults by reversing negative "relationship expectancies" in which clinicians are viewed as potentially critical, judgmental, or insincere. The authors point to central features of MI spirit as remedies: empathy, autonomy support, and compassion. Although the majority of this sample was in a Rebuilding or Growth stage of recovery and most reported positive experiences with STOP staff, there was some indication that helping relationships were approached cautiously. Coming into the study, two participants noted strong feelings of being misunderstood by staff, with one person separating from the program as a result. Furthermore, if individuals come to MI with abuse histories, as many did in this sample, they may require numerous corrective interpersonal experiences across multiple contexts for enduring change in their expectancies.

Increased self-disclosure may signal the fact that individuals feel ready to "let others in." The accepting, affirming, and autonomy-supporting climate of MI likely creates that necessary sense of safety. One participant alluded to the pleasant surprise of letting down her guard quickly with someone she hardly knew: "Here I am coming straight out and telling the truth. And it was ok for me." Interest and genuine caring were tied to a desire to share recovery experiences. Participants also identified feelings of comfort and enjoyment around talking. One person saw MI as "a chance to speak" and

have his voice heard, which he felt began at the first session. These experiences address the foundational process of engagement in MI, which precedes focusing and evoking change talk. Miller and Rollnick (2012) define engagement as "the degree to which someone feels like a comfortable and active participant" (p. 37) and relies in part on communicated warmth, value, and respect. Evidence from this study and Moyers et al. (2005) supports this connection.

Participants in the present investigation also indicated that the therapist joined with their enthusiasm for change, and in understanding essential parts of their experience. Remarks like "He was excited with me," "He gets the wide open eyes," and "him getting me" echo an important relational theme in Angus and Kagan's (2009) case. The individual they studied described the effect of the MI therapist's empathic attunement in a similar way: "She carries with me, the experience" (p. 1161). This person reported being better able to "continue" in the conversation, moving forward in her story as a result. Through the use of complex reflections, empathy in MI involves offering back unspoken meanings of what the person has been saying. This is thought to promote comprehension at deeper levels in the relationship.

This operational definition of empathy is consistent with Rogers' (1961) concept of empathy as "sensing the feelings and personal meanings which the client is experiencing in each moment" (p. 62) and communicating them back. In this study, the feedback of these meanings often encompassed a shared positive emotion, which may have amplified the participant's sense that the therapist both understands and values the source of that emotion (e.g., becoming a youth mentor or achieving a sobriety milestone). People early in recovery have attested to the importance of "being known" within the

therapeutic alliance, feeling the most closely connected to providers who make a sincere effort to learn about their needs (Bradshaw et al., 2006). For individuals recovering from mental illness, MI may increase the likelihood of participants feeling that the therapist is "in there" (p. 126) with them.

A person-centered atmosphere is not unique to MI. It includes factors such as collaboration and trust that are inherent in strong working alliances across therapeutic modalities (Bordin, 1979). Some research has positively correlated the strength of working alliance with service participation. In a recent study of women with PTSD and substance abuse problems, alliance ratings were associated with higher attendance and symptom reduction (Ruglass et al., 2012). With its emphasis on spirit and thoughtful use of specific clinical skills, MI guides clinicians in strengthening that alliance. The current study points out important feelings and behaviors to look for in participants that signal positive relationship development. Clinicians who learn to track positive effects coming from both the relationship and specific therapy content may become more adept at deciding how best to weave together MI skills and strategies. For instance, one part of a session may call more for reflective listening to convey the understanding of experience, whereas another part of the same session may be more conducive to eliciting "then-now" contrasts to support self-efficacy.

Meaning-making, Recovery Narratives, and MI

One of the four core recovery processes identified by Andresen et al. (2003) involves finding meaning in life. People with SMI have described a wide range of activities that strengthen a sense of meaning, including employment, creative endeavors, family involvement, and peer support (Andresen et al., 2003; Hendryx et al., 2009). Each

of these themes emerged during MI in this study, often demarcating "now" from "then" in terms of recovery progress. Participants referenced newfound purpose in terms of restored identity through family reconnection, taking responsibility, and helping others.

It is notable that participants chose these meaning-based content areas as the most important or helpful moments in MI. The very act of sharing these realized or aspirational values with the MI counselor seemed to impute an additional layer of meaning, because these stood out as "peak experiences" within the MI process. On the MLQ, participants also reported a greater overall sense of meaning in life during the intervention. Relative to baseline, participants more strongly endorsed global statements such as "My life has a clear sense of purpose" and "I have a good sense of what makes my life meaningful." Together, these results suggest that something happening in MI positively affected existential well-being.

Effects appeared stronger with the individual who entered the study in the earliest stage of recovery, Moratorium. His MLQ total score showed the sharpest increase during MI, corresponding to his progression from Moratorium to Preparation. It is possible that a greater sense of meaning in life drove his forward recovery stage movement, and to a degree that exceeded the movement of other participants. Consistent with Andresen et al.'s (2006) research with the STORI, later recovery stages (Preparation, Rebuilding, and Growth) are partially defined by restored meaning through goal-setting, making sense of illness, engagement in life, and a re-discovered sense of direction.

Talking about recovery progress in MI may increase self-reported purpose in life via several routes: generating positive emotions (King, Hicks, Krull, & Del Gaiso, 2006), building a meaningful life narrative (Ridge, 2012; Weegmann, 2012), and satisfying basic

psychological needs proposed by SDT (Weinstein et al., 2012). These pathways may interact with one another to strengthen an overall sense of existential well-being. For instance, exploring a life story with the MI therapist may simultaneously produce positive affect and a sense of meaning. When narrative themes center around self-efficacy and improved relationships, the conversation likely satisfies basic needs for relatedness and competence. Need satisfaction within narratives and the therapeutic relationship may further spark positive feelings of confidence and connection, which can enhance perceptions of meaning.

Among these interacting pathways, positive affect bears the closest link to enhanced meaning. King et al. (2006) reported robust correlations between positive affect and meaning-related measures, ranging from .45 to .80. Positive emotions induced experimentally have also predicted a heightened sense of meaning in life (Hicks & King, 2007). In the present study, MI's relational and content-oriented components were associated with a wide array of positive emotions. These included feelings of safety, comfort, trust, confidence, eagerness, and enthusiasm. Emotional experiences in MI may have directly influenced MLQ scores, which were measured immediately after the session. This is a point at which affect likely remained strong. One of the justifications for selecting the MLQ was its lower susceptibility to changes in mood. Based on the qualitative results, meaning and positive emotions seem interwoven in MI. From an applied perspective, it may not be necessary to separate the constructs of positive affect and meaning, especially if they augment one another.

As a mediating variable, the pursuit of value-driven goals may help explain the relationship between meaning and positive affect (King & Hicks, 2012). Some research,

for instance, has linked religious commitment to happiness and meaning in life (Steger & Frazier, 2005). Values discussions occurred frequently during the MI intervention, extending beyond the Session 2 Personal Values Card Sort. They may have promoted ideal versus current state discrepancies that increased motivation to reduce these gaps (Higgins, 1987). For instance, when one participant talked about the importance of being there more for his mother, he described a heightened desire to enact this change. In general, an MI strategy like envisioning may have helped by juxtaposing people's more ideal recovery states (e.g., speaking to large groups of young people) with current, less involved states.

In addition to creating discrepancy, focusing on values led to positive affect. The same participant, mentioned previously, described a "good feeling" from talking about what he "wanted to change." Although some research has indicated that actual versus ideal differences produce shame and other negative emotions (Bessenoff & Snow, 2006; Castonguay, Brunet, Ferguson, & Sabiston, 2012), discrepancy might produce positive affect when accompanied by high self-efficacy. For instance, the participant's statement about positive feelings concerning future change was preceded by his mention of feeling good about past successful changes. MI's dual emphasis on self-efficacy and values may play a critical complementary role in producing positive feelings when discrepancies emerge. In other words, identifying a purpose in life related to one's values may feel good, but seeing those purposes as achievable may augment that feeling considerably. It is important to note that this sample was primarily composed of participants already invested in recovery activity. For them, highlighting current values-behavior *consistencies* in MI could have supported continued action toward building a more

fulfilling life. MI may have enabled people in an advanced stage of recovery to reaffirm a meaningful pathway toward achieving "more of a good thing."

Organizing personal events into a story is another way that individuals create a sense of meaning (Lilgendahl & McAdams, 2011). Substance abuse and SMI can disrupt one's story in fundamental ways, eroding self-coherence and life trajectories (Flora, 2012; Wisdom et al., 2008). In the current investigation, when referring to "then" points of early recovery, participants spoke about a dehumanized self often trapped in neglectful or invalidating situations. Some alluded to an "existential vacuum" (Frankl, 1959) when discussing a past that revolved around "running the streets," needing "a hit to go to sleep . . . a hit to wake up," and prostitution. These accounts mirrored the "tough life" narratives shared by other individuals in treatment for addiction (Flora, 2012). MI provided an opportunity for participants to contrast this state of poorer functioning with a "now" point of healthy, purposeful activity and positive self-regard. Flora found that individuals who had remained in treatment longer tended to have more "balanced" narratives, with difficulties balanced by successes. A similar finding emerged in this investigation, as most participants shared a story that had taken a hopeful turn. These balanced stories contained both a beginning (e.g., early recovery struggles) and middle (e.g., recovery accomplishments). Lilgendahl and McAdams (2011) reported a significant positive correlation between subjective well-being and narratives with a variety of self-growth themes. Narratives that contained only positive events did not show the same relationship, suggesting the importance of the contrast. Openness was also uniquely and positively associated with this "then-now" processing. In fostering openness and trust,

MI spirit appears to facilitate the exploratory processing needed for a variety of positive narrative meanings to emerge.

The role of MI in elucidating brief narrative "arcs" extends beyond its spirit. Participants shared their narratives with an interested, caring therapist who reflected and elaborated on change talk within the stories. As a result, participants seemed to appreciate more fully the magnitude of their positive transformations. From one participant's perspective, MI helped him enact his value of family involvement while confirming a positive identity as someone who is valued, loved, and helpful. The intervention furthered a process of re-valuing self, similar to a narrative therapy approach for trauma survivors:

> In order to construct self-narratives, we need not only the words with which to tell our stories, but also an audience able and willing to hear us and to understand our words as we intend them. This aspect of remaking a self in the aftermath of trauma highlights the dependency of self on others and helps to explain why it is so difficult for survivors to recover when others are unwilling to listen to what they endured. (Brison, 2002, p. 51)

The importance that Brison places on understanding the speaker's intended meanings mirrors the emphasis placed on accurate empathy in MI. In this study, accurate empathy may have taken on special significance in the process of "remaking self", given the trauma histories that most participants reported.

Study data reflected numerous "then-now" comparisons in each participant's BSR interview. In response to tape review, people in the study repeatedly revisited positive change while communicating parts of their story. This may represent a more general

effort to satisfy competence, relatedness, or identity-affirming needs through a dialogue with a caring, interested audience. Theoretically, re-experiencing progress-related recovery content at a cognitive and affective level in MI should help satisfy these needs. Weinstein et al. (2012) argue that this type of need satisfaction leads to a sense of meaning. In other words, meaning follows from experiences that support mastery, connectedness, and self-directed action. Results from the current study suggest that talking about these experiences may have a similar effect. Some meaning emerges from the interpersonal process, a social interaction that shapes what gets told (Kelland, 2012), and some from the shared content of recovery.

The participant who began the study with lowest levels of meaning on the MLQ appreciated MI, "giving [him] the chance to tell [his] story for what it is." He added, "You know, not just telling it the way people want you to tell it." The most important moment he selected for the BSR involved him sharing his poetry with the MI therapist. As Weegmann (2010) has described, poetry is one narrative resource "for figuring a way forward and constructing a meaningful life" (p. 33). In this instance, the process of sharing it acted as a conduit for social connection and self-expression. The poem itself transformed his past struggles on the street into personally meaningful art. Davis et al. (1998) would consider this an example of meaning-making through benefit-finding or discovering positive value in the difficult events of one's life.

As with sharing one's poetry, presenting a personal narrative to peers enhances relational meaning. They become witnesses to positive self-transformation. Narratives play a significant role in the culture of recovery groups such as NA and AA, where participants tell unique stories with elements that often resonate with others (O'Halloran,

2008). Williams-Clay, West-Olatunji, and Cooley (2001) also cite the traditionally therapeutic role of narratives for African Americans in healing from oppression. Together, these factors may help explain the particular importance of incorporating narratives into motivational interventions for African American individuals in recovery. To the extent that MI allows space for recovery narratives, skillfully underscoring change talk within them, it could also encourage participants to develop their stories in other service and community contexts. The participant who shared his poetry, for instance, expressed increased confidence that he could talk to others as a result of MI. In addition to re-establishing a valued self and turning past struggles into art, story-telling through poetry was his "way of creating community" (Schneider, 2010, p. 14).

In sum, meaning and positive affect appear to strengthen one another in MI, particularly through the person-centered exploration of personal narratives. The story comes into clearer focus as the MI therapist expresses empathy and elicits personal values from examples of recovery progress. In this study, the reflection and elaboration of "then-now" contrasts supported agency while affirming positive life trajectories. Because MI is typically directional in nature, the therapist reflected change talk within narratives toward service participation, supporting persistence for those already engaged in treatment.

Limitations and Future Directions

A number of factors in this study limit conclusions about MI's effect on service engagement and recovery-related outcomes. Usually, single case experimental designs offer the advantage of demonstrating causality, with multiple baselines often increasing the clarity of an intervention's effect (Kazdin, 2003). In this case, statistically significant

increases in HME level upon introduction of MI were *not* observed in four of six cases. Descriptive and qualitative data, on the other hand, indicated that improvements in hope, meaning, and empowerment were associated with the intervention. Taking into account data from both methods, a clouded picture remains with regard to MI's effect for dually diagnosed consumers in outpatient treatment. Response to MI varied despite the sample's overall homogeneity of ethnicity, diagnostic picture, and recovery stage. Variability in MI's effect size across studies, clinicians, and sites suggests that contextual factors have a large impact on outcomes (Miller & Rollnick, 2012). Such factors likely exerted influence within this study as well, particularly in terms of differences in practical obstacles some participants faced (e.g., transportation issues) and major life events.

As Kazdin (2003) points out, single case experimental designs are seldom able to reveal individual characteristics which may have moderated outcomes, such as time in treatment or life events. Three participants moved into a more desirable living situation either immediately before or during the intervention, which could have sustained a sense of well-being independently of MI. Two of these three individuals did not show statistically significant increases in hope, meaning, and empowerment when the intervention began. They remained at relatively high levels on these indices across phases, possibly indicating a ceiling effect. In addition, one showed a significant slope increase in HME scores during baseline, further suggesting the impact of positive life events. If MI had been introduced prior to these events, one wonders whether clearer effects would have emerged. For the five individuals in an advanced recovery stage, one might expect increases in hope and meaning to occur as mainly a result of a naturally unfolding recovery process rather than MI participation.

Along with the confounds of history and measurement timing, the HME survey instrument itself was a composite measure whose reliability and validity have not been previously tested. Anecdotal evidence suggests that reactivity to the survey occurred in the form of response sets, in which some participants seemed more likely to provide the same ratings as the study progressed, even when the items were administered in a different order. Future research using repeated measurement should incorporate brief, easily administered measures with sound psychometric characteristics. Researchers may also want to rethink the mode of administration because phone surveys felt intrusive for a couple of participants. The use of electronic media or diaries in which participants control the time when they respond may be more acceptable.

Another notable limitation relates to the generality of results, a common caveat with single case designs. Considering the mixed findings observed in this study, one might hesitate to conclude that MI would improve outcomes in other samples of dually diagnosed individuals. Additionally, substance use and mental health diagnoses were not verified for the current research purposes; thus, the sample may be less homogenous than it seems. As a result, findings may be less applicable to other clients with bipolar disorder and polysubstance dependence, the two most common diagnoses recorded in this study based on chart review.

The relatively larger effect of MI with the participant who was initially allocated to Moratorium suggests that MI may have the greatest impact when people are feeling more hopeless and disengaged; however, this would require replication in future research. Ideally, to test the study's hypotheses more accurately, the participants in future single case experiments should enter the study with low levels of hope, meaning, and

empowerment, as well as low levels of engagement following referral. This may require a screening process with multiple sources of information to avoid response sets aimed at gaining entry to the study.

An additional concern in this study was the fact that the MI therapist served as the principal investigator, introducing the possibility of experimenter expectancy effects. The investigator believed in MI's general effectiveness as well as its positive influence on subjective well-being, as observed informally in prior clinical work. When administering measures for completion after MI sessions, the investigator's tone of voice, posture, or facial expressions may have positively influenced responses in the expected direction. The investigator was aware of these concerns and made a concerted effort to maintain a neutral demeanor during data collection. Unintended influence on participants cannot be ruled out. Ideally, experimental designs should use multiple therapists, and others, different from than the principal investigator, to help minimize expectancy effects as well as increase confidence that effects came from MI and not from the characteristics of a single therapist. Also, with regard to fidelity, a limited number of MI sessions (6 out of 24) were coded with a formal rating system to assess MI-adherence. Thoroughly assessing the level of MI competency is a key recommendation for MI research, especially noting that competency may fluctuate from session to session or between clients (Miller & Rollnick, 2012).

In drawing conclusions about the process of MI, it is critical to remember that the BSR interviews represented a secondary source of data about in-session MI experience. It is possible that participants confused emotions and attitudes elicited by the BSR with what they actually experienced in MI. One can infer from some participant exclamations

(e.g., “Wow!”) that tape review intensified emotional experiences. This intensification may have, in turn, positively affected perceptions of MI. Unlike the tape review process from other studies (Elliott & Shapiro, 1988; Zuckoff, 2001), the BSRs in this study did not involve step-by-step explication of reactions, during which the interviewer stopped the tape and queried the participant’s experience. This was attributable, in part, to the BSR interviewers’ brief training and lack of experience with this method. Additionally, none of the participants asked the interviewers to stop the recorded segment, although they were instructed to do so if they had a reaction. Furthermore, no systematic attempt was made to determine whether or not participants added recovery-related content in the BSRs that was not present in the MI sessions.

For a more direct understanding of clients’ experiences of MI, it may be preferable to code actual transcripts of MI sessions for positive emotions and in-the-moment reactions to MI microskills and strategies. The Client Evaluation of Motivational Interviewing scale (CEMI; Madson et al., 2012) is a promising quantitative measure of clients’ MI experience that can complement these efforts. The scale is capable of differentiating MI-consistent from MI-inconsistent therapist behavior. Future research might explore how well ratings of MI fidelity correlate with MI experience from the client’s perspective, as indicated on the CEMI. One might also evaluate whether differences within the CEMI’s Relational factor are associated in-session variation in the strength or frequency of MI-consistent behaviors (e.g., the use of more affirmations, complex reflections).

In light of the enhanced positive, emotional responses noted when participants heard themselves talk about positive changes, future investigations may want to explore

the use of tape review as an intervention in addition to a research tool. If MI's effects rely on attitude formation based upon hearing one's own speech (Bem, 1972), it is plausible that an MI-consistent exploration of recorded change-oriented content would promote positive outcomes. Introducing this intervention toward the end of a treatment course may allow individuals to reflect on their progress in a more focused, evocative manner than would free recall alone.

BSR interview analysis revealed two categories of positive emotions, one relational in nature and the other more forward-looking and content-driven. Future studies might investigate whether or not these emotional sets are differentially associated with treatment involvement and ratings of hope, meaning, and empowerment. One wonders whether or not certain emotions such as joy or excitement might have a greater impact on change behavior than would "less active" emotions such as comfort or safety. Research might also focus on what particular aspects of MI engender these feelings. Another future research direction would involve disentangling the relative contributions of change talk and expressed emotions to outcomes. To the extent that evidence continues to support an emotional foundation of MI, clinicians may want to "listen for" and elaborate on feelings as much as they do for change talk (Wagner & Ingersoll, 2008). In applying MI, Chris Wagner describes a process of searching for a "spark" in the client, a positive emotional resonance that can drive conversations about change (Porter, 2012). In contrast to research on client change language, there is a surprising absence of data on the role of affect.

A better understanding of MI also depends on clarifying how spirit or general factors interact with the evocation of change talk to foster healthier choices. In MI,

empathy, collaboration, positive regard, and goal consensus are evidence-based elements of the relationship that contribute to effective therapy (Norcross & Wampold, 2011). One might argue that effects on hope, meaning, empowerment and service outcomes observed in this study could have emerged primarily due to strong therapeutic alliances. Indeed, participants reported self-disclosing more in connection with feeling safe, trusting, and valued. DeFife and Hilsenroth (2011) argue that common factors of positive expectancies and goal agreement loom particularly large early in the psychotherapy process, which in terms of the MI and recovery framework presented here, likely opened the door to deeper engagement in MI activities (e.g., looking back, envisioning). With individuals in recovery, the degree to which positive expectancy, low fear of judgment, and partnership can help restore a sense of meaning and well-being is unclear, although a likely candidate is the mediator of service participation. Maher et al. (2012) found that therapeutic alliance predicted improved outcomes for exposure therapy, an effect mediated by treatment adherence. Systematically studying cognitive and affective experiences within a strong working alliance could further inform clinicians' efforts to establish safe counseling environments for difficult-to-engage populations, elucidating the participation-positive outcome link.

Although general factors are important, a recent study across therapy modalities and orientations found that therapeutic alliance scores correlated only modestly with depressive symptom reduction (Beutler, Forrester, Gallagher-Thompson, Thompson, & Tomlins, 2012), suggesting that a significant portion of variance is accounted for by other factors, including specific or technical ones. Partialing out effects of MI's spirit and its

technical components promises to reveal additional mediators and moderators of change that can guide clinical intervention.

Conclusion

Overall, this study's findings support the "good fit" of MI with recovery-oriented principles and the value of interventions that attend to meaning, hope, and empowerment with dually diagnosed individuals. As consumers strive to create fulfilling lives, they are more likely to engage with nonjudgmental, empathic allies who will guide them in making changes that are consistent with the consumer's personal values.

Within a narrow sample of dually diagnosed African American clients with trauma histories, who were predominantly in an advanced recovery stage, MI functioned primarily as a means of supporting persistence in change and resolving ambivalence about degree of involvement in services. From a process standpoint, safety and trust established through MI spirit appears to open the doorway to self-exploration. As clients reveal more of themselves, MI-trained clinicians can skillfully support feelings of competence, relatedness, and self-worth within their stories. MI is one therapeutic approach that appears to help generate meaning through basic need satisfaction of autonomy, relatedness, and competence.

Reflecting action-value consistencies in the direction of continued treatment involvement seems crucial for clients at greater risk of sudden mood shifts or major life stressors that can derail treatment motivation. With regard to participants who are already engaged in services and motivated for recovery, one should not automatically assume that they have a clear awareness of the link between their service involvement, values, and sense of well-being. Individuals in advanced recovery stages may also still

feel ambivalent about level or type of service participation. MI can help the "rushed" clinician maintain sensitivity to this ambivalence. It also offers a means for conveying respect and acceptance of participants' right not to seek services, especially if providers have created invalidating or coercive environments.

This study contributes to an emergent branch of MI process research that focuses on client experiences in MI. Future research that connects behavior change, change talk, and clients' internal reactions promises to reveal a fuller picture of how this "way of being" with people promotes growth. Miller and Rose (2009) suggest the presence of third variables that may influence change talk and behavior change. They propose acceptance, readiness, reaching a decision, and changes in self-perception as possible "covert antecedent events" (p. 534). Positive feelings about the self and relationships, including one's abilities and possibilities, are also likely candidates for the list. They seem just as integral to maintaining a hopeful, active stance toward chronic stressors and illness.

Appendix: BSR Interview Transcripts

Participant 1

Interviewer: First, I want to thank you for all the work you've done. I know that the phone calls were annoying, and you've been so helpful.

Interviewee: My phone was off, I just got it turned back on.

Interviewer: It happens. It's okay. I know that Scott had another way to contact you, that's good, but things happen. So it's no big deal. So just thank you so much.

Interviewee: You're welcome.

Interviewer: You know it's because of your participation and some of the other participants here helping us out that we are going to learn a lot and hopefully be able to you know, help a lot more people and improve the process for people in recovery, because that is really what this research is all about.

Interviewee: Okay.

Interviewer: So, this is only going to take a few minutes, hopefully not more than fifteen or twenty.

Interviewee: Okay.

Interviewer: In your last session with Scott you pointed out helpful moment, or something that you found really meaningful or enjoyable --.

Interviewee: My key chains.

Interviewer: Yeah, your key chains, and he gave me a recorded clip of that. That is the only part of your session that I've ever heard, the rest of it is totally confidential, but I want to play that back for you and while it's playing, I would like you to think about how you are feeling in that moment, what was going through your head and then I am going to ask you some questions about it. Okay. If at any point you want me to stop, just so that we can talk about something right then, just let me know, tell me to pause it or give me a nod.

Interviewee: Okay.

Interviewer: Or, we can play through the whole.

Interviewee: Yeah, play the whole thing.

Interviewer: Okay, play the whole thing that works. Now this should be all cued up to go. Can you hear it?

[**Plays the tape]**

Interviewee: I was saying that it was glow-in-the-dark.

Interviewer: Yeah.

Interviewer: And I know that you are having a problem with your tooth at that point, but we don't need to talk about that, but, you know there is a very specific reason--

Interviewee: That's--I was like really excited [laughing happily]

Interviewer: [laughing also] I know, when I heard it I was like this is powerful, I got a little emotional. I am like, I am so happy for the person that I've never met.

Interviewee: It does, it sounds really exciting.

Interviewer: It does, it sounds like a really – a wonderful reminder for you. So yeah, what were you – what were you feeling when you described those?

Interviewee: Excited. Happy. Uh, you know, I am proud of myself. It's progress. You know? Coming from - just for the day – just for the day, I went in there, I was – I was skinny, dirty, well I wasn't dirty like that, I washed up, but I was dirty on the inside and I didn't like me. I didn't want to be around others. I always wanted to fight. Wow like, now, look at me, 18 months later, this is *me*. I'm clean today, I got my child back, I got my own apartment, I'm - I'm secretary for my home group. I praise things. I worshiped God today and that's like, wow.

Interviewer: Wow. So you - that's a really strong reminder of how far you've come.

Interviewee: Yeah.

Interviewer: It must be an incredible feeling.

Interviewee: Yes, and I – and I look at my keychains every night and I have a calendar up on my – when we was - when I was in the program, we had to do a calendar for three months, and I - I just keep it because when I first went in, it was up there and I did a ninety-ninety, a ninety-ninety, when you first get clean you have to do ninety minutes in ninety days. It is ninety minutes, ninety days.

Interviewer: Okay.

Interviewee: And I did that.

Interviewer: Wow.

Interviewee: I did that. I went to a meeting every day of the week.

Interviewer: For ninety days?

Interviewee: Ninety.

Interviewer: For three months.

Interviewee: Yeah, ninety minutes, ninety days. They call it a ninety-ninety. So you go in a meeting and you sit for ninety seconds, you sit and you don't take no cigarette break. Of course if you have to go to the bathroom.

Interviewer: Yeah.

Interviewee: You don't take no cigarette break, don't take no coffee break, you sit there and you get the message and I did that. So now when I just look back, like, wow, I've really come really far.

Interviewer: Oh yeah. You are exactly right. It totally came through on that – that clip how happy and how proud you are. You were – you have a really darn good reason to be so happy and so proud and so excited, so, I mean, for us, it's a wonderful thing to be a part of it, to share that moment with you, but you know in terms of - of helping out the study, to isolate moments like that are also really helpful, so. I already talked about what's going through your mind. So is there anything that Scott said or did during this part out – during this part that really stood out for you, you know, while you were describing your keychains?

Interviewee: Well, Scott is irritating. [laughs] I'm sorry.

Interviewer: It's okay.

Interviewee: But, um, a couple of times I really had to, like, put him in his place. I said no to Scott. And I cooperated. This is how trusting - I cooperated, I come safely, I take a phone call and everything. I say, "Please stop answering my questions. Ask me any question that you want, and answer the question." I said, Scott, please, so he did real good with letting me tell him the joy that I felt from those keychains and it was itchin' him, but he didn't say nothing, he didn't. He did real good. Like he - I guess we helped each other and he said that he learned – learned how to be quiet. And I am like, please, you know. But other than that, like, the first two times I was like, I am not going to be coming here, because Mr. Scott [**inaudible**].

Interviewer: Oh, no.

Interviewee: But I got through it.

Interviewer: So, it was really - really meaningful for you for him to display that he can just sit and listen?

Interviewee: And listen. You know, you talk, he'll finish your sentence. I don't like a person, that – that - that's just so annoying. Like, why are you even talking to me if you already have the answer?

Interviewer: Well, it seemed like in that clip that he really sat and listened to you.

Interviewee: Yeah. And that made me – that made me feel nice. I felt happy. I was channeling God through there. And he was even getting excited.

Interviewer: He was.

Interviewee: When I pulled out my keychains, he was excited with me. Um, you know, he gave me positive feedback, you know and told me that that was good and keep doing what I am doing and just you know, keep it up. It felt like he really wanted to be a part of it. Like he really wanted to know about it.

Interviewer: Okay.

Interviewee: Yeah. It felt like he was really concerned.

Interviewer: Yeah.

Interviewee: I know that it was just a study, but that is what I felt.

Interviewer: No, I know Scott. I know he really does. He really is, you know, he wants – he wants to see what's helpful for you and he also wants you to have those positive feelings about yourself, because you've done so much work. So I am sure for him it was exciting and I - for you, I am very glad that he was able to give you what you needed in terms of sitting and listening –

Interviewee: He was.

Interviewer: - and being in the moment with you.

Interviewee: Right.

Interviewer: So it seems like that was, you know, what was best for you that came out of – of that. Okay. Um, so what did you do or say during this part that really stood out in your mind as helpful? Is there anything that you did that, you know, you

thought maybe furthered the session that you thought that you contributed besides, you know -

Interviewee: Just – just talking about the keychains thing.

Interviewer: Okay. Was it maybe that you brought them in, because I know that is something maybe you don't always do. You usually don't carry them with you.

Interviewee: Right, I brought them in.

Interviewer: Okay. Yeah, how did it feel to actually bring them in and show them to Scott and your other therapist

Interviewee: I felt good. I felt good doing it. It felt good.

Interviewer: All right, good. Okay. So let's see. Did this - did that particular moment, like showing your keychains and having him sit back and listen – um, I know you said that it made you – you happy and it made you feel like you really connected with him and that he got it, so, immediately after the session, how did you feel?

Interviewee: I felt the same. I just went on and went back to the group.

Interviewer: Okay. So, just business as usual? What about maybe like a day later or a couple of days later after you left, did any - did this little instance stick with you or was - did you just, you know, went on, kept on, keeping on?

Interviewee: No, I felt good.

Interviewer: All right. All right. And, um, do you think anything will change for you because of this session?

Interviewee: Huh-uh. I'm not going to change.

Interviewer: Okay. Well you seem like you've been doing, you know, a really great job. You have 18 months I am assuming that it's been?

Interviewee: My 18 months is Monday.

Interviewer: Monday, okay. So you're close. You're this close to 18 months, and it seems like you've been doing a really good job, so you don't really think that anything is going to change?

Interviewee: Huh-uh.

Interviewer: And that might be - that might be good. You are doing it. You are doing your thing, why broke – why fix what isn't broken. um, so was there anything else that was helpful or enjoyable during that session that you remember?

Interviewee: No, that's it.

Interviewer: Okay. And um, were there things maybe that weren't so enjoyable? I know you had mentioned that sometimes it seems like Scott finishes your sentences for you. Is there anything else that happens that isn't so helpful?

Interviewee: Uh-uh.

Interviewer: Okay.

Interviewee: I want to get to eat.

Interviewer: You're hungry; I know you're hungry. Do you think that Scott had gotten better at being a little less antsy and a little -

Interviewee: Yeah.

Interviewer: Okay. Well, that's good. I am glad that, you know, things that work - might work in other instances aren't working for you and that what works for you won't work for some other people, so it's really good to that he was able to adapt and I know it's your lunchtime and you're hungry. So, that's, you know, all the questions that I have.

Interviewee: I mean, I've been in this room 45 minutes already.

Interviewer: Okay, that - that's all the questions that I have. So I want you to go and get to lunch.

Interviewee: Okay.

Interviewer: Um, so yeah. Thank you for that, and -

Interviewee: I'm free the rest of the day?

Interviewer: Yeah, I was just going to ask you.

Interviewee: I mean, do I do – oh, so today I don't have to do that --

Interviewer: Yeah, I have all sorts of stuff for you.

Interviewee: I did that.

Interviewer: I have this that I need you to sign and I have a pen.

Interviewee: Okay.

Interviewer: Could I have you answer our normal survey question too? Do you want me to read them to you, or do you want to just put the number next to the question? Either works.

Interviewee: You can read it.

Interviewer: Okay. Well you do that, and I need my pen back.

Interviewee: Yeah, because I like pens.

Interviewer: Okay. So I am just going to ask you these study questions. Um, first, I have a positive outlook toward life. Do you remember the scale?

Interviewee: I agree.

Interviewer: You agree. Okay. And, I feel my life has worth and value.

Interviewee: Agreed.

Interviewer: Agreed. My life has a clear sense of purpose.

Interviewee: Agreed.

Interviewer: Agreed. I generally accomplish what I set out to do.

Interviewee: Absolutely agreed.

Interviewer: Okay. I feel powerless most of the time?

Interviewee: I'll agree.

Interviewer: Okay. There lots of ways around any problem that I am facing right now?

Interviewee: Agreed.

Interviewer: And at the present time, I am energetically pursuing my goals?

Interviewee: Absolutely agreed.

Interviewer: Alright, thank you very much.

Participant 2

Interviewer: Alright, it's on.

Interviewee: Ok.

Interviewer: So first of all I want to thank you for meeting with me today,

Interviewee: Mhmm

Interviewer: and also take the time to thank you for all the hard work you've put into the study so far. Um, I think your patience…

Interviewee: [inaudible at 0:18 with phone ring tone]

Interviewer: Oops, that's ok [laughing].

Interviewee: I'll look at that later.

Interviewer: Sure

Interviewee: I'm ready

Interviewer: So your participation is really going to help us understand, um, what it is about therapy that works for people.

Interviewee: Mhmm

Interviewer: What helps other people in recovery. So I do want to thank you so much for taking the time to do this.

Interviewee: No problem.

Interviewer: Um, the more we understand about what talking about something in therapy feels like…

Interviewee: Mhmm

Interviewer: …the better we can understand what helps people recover.

Interviewee: Ok

Interviewer: Ok, um, so in your last session with Scott you pointed out either a helpful, important, or enjoyable part of the session and I'm going to play you a recording of that part of the session to help remind you of what you said and what he said, ok?

Interviewee: Mhmm

Interviewer: Um and them I'm going to ask some questions about what was happening at that time for you. Now, I want you to think of, um, when you're answering the questions, how were you when that session was happening. So, don't look at it as today as we're looking back but look at it how it was for you in that moment, ok?

Interviewee: Ok.

Interviewer: Does that make sense?

Interviewee: Mhmm.

Interviewer: Ok, um, so this is the only part of the session that I've heard. I know Scott has told you at the end of the session everything will be erased, ok? Um, so let me know if you have any questions.

Interviewee: Ok.

Interviewer: I'll start playing it now and if there is a point while we're listening to it where there is something that you want to say right then and there just give me a head nod or let me know and I can pause it. Otherwise you can just wait until the end when we get done listening to it…

Interviewee: Ok

Interviewer: …and then um, you can tell me anything that you're feeling then. I'll have some questions for you.

Interviewee: Alright.

Interviewer: Ok? Alright.

[tape plays here]

Interviewer: Are you able to hear that?

Interviewee: [inaudible response at 2:10]

[tape continues to play]

Interviewer: Ok

Interviewee: Wow.

Interviewer: [Laughter]

Interviewee: That was me. [Slight laughter] That's how I felt.

Interviewer: Yeah.

Interviewee: You know, I would like to talk to, talk to [inaudible at 6:53] and, and teenagers and talk to them and tell them, um, what I've been through, 'cause I've been through a lot, you know, and that um, it's hard. Especially if you're using or you have mental health problems and you don't want to go get help for it it's hard. It feels like everybody's against you.

Interviewer: Mhmm

Interviewee: But if you go get some help, and, you know, and, I don't know. I feel that talking to somebody, it might, it might save their life. Somebody now talked to me and it saved my life.

Interviewer: Mhmm

Interviewee: But if I had known when I was younger I probably would've turned out better.

Interviewer: You said you would've had more time to kind of maybe make some changes.

Interviewee: Mhmm. Yep. Yep.

Interviewer: So it sounds like it's something that's really important for you to be able to reach out to younger people who are struggling, kind of maybe lead by, lead by example.

Interviewee: Mhmm. It would be, it would be, it would be very important to me and I try, you know, to pursue that goal.

Interviewer: Mhmm. When you think back to when you were sitting there with Scott, what do you think was happening for you…

Interviewee: I got a little emotional..

Interviewer: …during that session?

Interviewee: My emotions.

Interviewer: What kind of emotions were you feeling?

Interviewee: Um, ‘cause so many people, there’s so many young people out there today that are struggling and that are, um, on drugs and have mental illness and might need help for it, and it’s like, I’m so eager to be able to talk to them. So it’s like I felt some kind of emotion because it’s happening right now today, you know?

Interviewer: Mhmm. Can you pinpoint what that emotion was for you?

Interviewee: Just that I look back at my time when I was young and I didn’t have nobody to really school me and tell me the right from wrong. I felt, uh…I felt alone [inaudible at 8:42], but I got over it, you know. I got over it, ‘cause I know that um

Interviewer: How did you do that?

Interviewee: I don’t know. It just, just, I just bounced back. Usually I shut down, but I didn’t shut down that day. That day I let everything that I felt in my heart out, so…

Interviewer: Ok. What were some of the thoughts or images that were going through your mind while you were sharing that piece?

Interviewee: I don’t know what kind of thought. Like, maybe I’d be at some podium and have a group of teens, talking to them and, ‘cause I have sold my life story to like um doctors, and doctors and lawyers. I had to convince them that they wanted me to speak, and I spoke about my life story in bits and pieces but I told them about myself but, um, I broke it down where it was a short story but they understood it was a long story, you know.

Interviewer: Ok.

Interviewee: Stuff like that.

Interviewer: Ok, so during your session with Scott you kind of saw yourself in the future, um, talking to a group of, what did you say, children?

Interviewee: Yeah. Teenagers. Yeah. Some of the, one or two people, one out of every ten, is gonna be a hard button, he’s not gonna, you don’t want to listen. Maybe two or three out of every ten, you know what I’m saying, is gonna say I don’t care what he says, I’m going to do it anyway, and then half the time they end up dead or behind bars.

Interviewer: But then again there are lots of lives that could be saved.

Interviewee: Mhmm. I feel there is, you know, and I think I have an awesome story to tell. I think I do.

Interviewer: Ok. Um, what would you say is something that Scott said or did during the session we just listened to that stands out in your mind as something helpful, important or enjoyable? Is there anything specifically that Scott said or did?

Interviewee: [noise that means “no”]

Interviewer: Ok.

Interviewee: Everything he said stood out, you know, basically, so I can’t pinpoint that one, one thing.

Interviewer: Ok. Is there anything that you said or did during the point that we listened to, um, that stands out to you as important, enjoyable?

Interviewee: Everything that’s, so,

Interviewer: Ok.

Interviewee: So it’s not just one specific thing.

Interviewer: Yeah it kind of sounds like from what we’ve talked about already just the fact that you actually opened up and shared versus bottling it up may have been significant in itself. Would you agree with that?

Interviewee: Mhmm. Mhmm.

Interviewer: Ok.

Interviewee: Instead of shutting down.

-Interviewer: hmm. Yeah. How does that feel to you, to open up for the first time?

Interviewee: It felt good. It felt good. I mean, I didn’t know Scott {inaudible at 11:31] and here I am and, you know, coming straight out and telling the truth. And it was ok for me.

Interviewer: So it could’ve been even a little scary at first, not knowing how it would turn out?

Interviewee: Mhmm, exactly.

Interviewer: He was a stranger.

Interviewee: Right.

Interviewer: But in the end you felt better.

Interviewee: Mhmm.

Interviewer: Ok. I have a couple more questions for you. Um, I want to talk about the effect that that moment in the session had on you. Um, did you notice any effect immediately following the session? Any differences in emotions or maybe even empowerment?

Interviewee: [Noise that means "no"]

Interviewer: Ok.

Interviewee: Nope. I don't think so.

Interviewer: So think about you just shared your story with somebody for the first time and your vision for the future.

Interviewee: Maybe I feel like if I'm ready to share with one I might be able to share with two or three. I probably feel like a little weight has been lifted up off my shoulders.

Interviewer: Ok.

Interviewee: You know?

Interviewer: Yeah.

Interviewee: Or I just need to keep moving forward and talk. So yeah, I did feel like a little weight has been, was lifted off my shoulders. I don't know who Scott is. I don't know him from anything, or anybody, I'm just like [inaudible word at 12:41].

Interviewer: So maybe the next, you walked away thinking that the next time you share that it'll be a little bit easier and it'll keep getting easier as the weight gets lifted off.

Interviewee: Mhmm. Yeah. Yeah.

Interviewer: Ok. Any feeling that you can identify? Any actions that you took immediately following because of that moment?

Interviewee: [Noise that means "no"] No.

Interviewer: Ok. Um, what do you think might possibly change for you because of the opportunity to share your story with Scott? Was there any, was there things that you think may happen in the next few weeks or months or even years?

Interviewee: No. I may save a life or two but no.

Interviewer: Ok. That's big!

Interviewee: That's about it.

Interviewer: That's big. So it sounds like you kind of, you have an intent to, um, find some struggling youth and share your story with them.

Interviewee: Mhmm. Like, I did, um…Not long ago, this young girl, she's pregnant, I think she's um, she goes to the methadone clinic, and she, um, were popping pills. They put you on methadone because it's an opiate. So, so, she was talking to one of the staff where I stay and then I came outside and we started talking and now she calls me [inaudible at 13:50] and she says "well you didn't speak to me the other day" but I kinda, kinda, kinda told her where I was, where I've been, being pregnant and being out there and having to go from here to there so it's like, I, uh, shared a little bit, just brief, just real brief, and now she gives me the utmost respect.

Interviewer: How was that for you?

Interviewee: That makes me feel good. It's amazing. It's amazing because I only had like maybe a conversation with her for like two minutes…

Interviewer: Yeah, so even, even

Interviewee: …and now she's like "hi mom how you doin?" so it's like wow, ok, maybe I just saved her life.

Interviewer: Yeah.

Interviewee: You know, and that baby's life.

Interviewer: I feel like that would be a very, very empowering kind of opportunity to do that.

Interviewee: Yeah.

Interviewer: And very reinforcing for you personally.

Interviewee: Yeah. Mhmm.

Interviewer: So it sounds like, and I know we've talked about how you kind of pictured yourself in the future talking to a bunch of people, but I'm wondering how you just said that, did you also picture yourself in the past and where you were?

Interviewee: A little bit.

Interviewer: And what kind of image did you see at that point?

Interviewee: Me, walking, being pregnant, really nowhere to go. Kind of seemed that.

Interviewer: Mhmm.

Interviewee: And that's not a good sight, you know?

Interviewer: Yeah. What kind of feeling does that image bring up for you?

Interviewee: Sad. Sad. Sad. I felt helpless, but I know that now I'm not helpless and I can help somebody else. Instead of me feeling helpless, I can help somebody. So, that's just how it goes.

Interviewer: And that's a great attitude to have, a great perspective to take on that, being able to see where you were, where you are now, and what the future holds, being able to change a life. Um, do you have any other comments? Anything else you'd like to share? Um, feelings or thoughts?

Interviewee: No. I just enjoyed doing the surveys.

Interviewer: Yeah?

Interviewee: I enjoyed it.

Interviewer: [Laughter]

Interviewee: It was different but I enjoyed it a lot.

Interviewer: Any last comments on the experience of that session, what was going through your mind, being able to share with him?

Interviewee: None, just that I'm actually opening up. I'm actually sharing. 'Cause, you know, I have room, and, in this same room here [Laughter]

Interviewer: Yeah. [Laughter]

Interviewee: And this is like, I'll open up a little bit and then I'll, I'll, some days I just pass, but for me to just be coming, like I said, in front of a total stranger and letting him know where I'm at and how I feel and this and that, I felt kind of good from it.

Interviewer: Mhmm.

Interviewee: Yep. Oh god… [Phone rings. Interviewee answers. Says to person on phone: Can you call me back, hun? I'm in a session right now. I've been doing my survey. I'm in a session right now. Ok. Alright.] That's my boyfriend. He's in recovery, in a recovery house

Interviewer: Oh, ok.

Interviewee: Yeah, so he don't get that much chance to talk to me so, but

Interviewer: No problem, that's fine. That really completes what I wanted to touch on today. Now, I will still be calling you.

Interviewee: Ok, that's fine.

Interviewer: We have to finish up this week and then we have a couple weeks of the post, um, MI surveys that we'll be doing, so about another month.

Interviewee: Ok! That's fine.

Interviewer: [Laughter] Um, so I will be reaching out to you every now and then but other than that you're all set. Thank you so much for your time

Interviewee: You're welcome

Interviewer: and being able to share how that moment affected you, and like I said it's really going to help us a lot

Interviewee: Ok.

Interviewer: with understanding other people and hopefully being able to help them, so

Interviewee: Good. Good.

Interviewer: Ok? Um, so, I just need you to sign this.

Interviewee: Oh, ok.

Interviewer: Will you fill out this here [inaudible at 17:31]

Interviewee: Ok.

Participant 3

Interviewer: So first off I would like to thank you for your participation in Scott's research. You know, it's because of participants like you that we're really going to learn a lot about the process of recovery and what counseling means to you, so we're going to be able to better serve people in the future. So first I really want to thank you for that.

Interviewee: Ok.

Interviewer: Do you have any questions before we get started?

Interviewee: [Noise implying no.]

Interviewer: Ok. So in your last session with Scott you pointed out a helpful or important or particularly enjoyable moment that you guys had in session. I'm actually going to play a recording of that back to you.

Interviewee: Ok.

Interviewer: This is the only part of your session with Scott that I'm ever going to hear. I actually haven't heard it yet. So we're going to go through this together.

Interviewee: Ok.

Interviewer: While you're listening back I'd like you to think about specific reasons why this moment was important or enjoyable or really special to you. The more we can understand about what we're talking about or what therapy feels like on your end, the better we can understand how it actually helps and facilitates recover. Again, this is the only part that I've heard and will ever hear. Anything you talk about with Scott is totally confidential.

Interviewee: Ok.

Interviewer: As I play back the session for you I'd like for you to try as much as you can to put yourself back in that moment.

Interviewee: Ok.

Interviewer: Think about what you were thinking, how you were feeling, both physically and emotionally because that's all very relevant, and trying to remember what was going on then as opposed to now. So at any point let me know if you want me to stop or you can listen through the whole clip. I understand he played a song.

Interviewee: Yeah.

Interviewer: So we can go back through the whole song or you can stop me at any point and then we'll keep going with the interview, ok?

Interviewee: Alright.

Interviewer: This should be all queued up for me.

[Tape plays here. Begin at 1:49. End at 9:00]

Interviewer: Ok. So that was the first time I heard that song too, so wow, that's an incredibly powerful song.

Interviewee: It is.

Interviewer: That's great to have with you. So what were you thinking, what were you feeling as you played the song and sat there and sort of talked through it with Scott?

Interviewee: Well…[extended pause] That it was all over. I didn't have to go to sleep at night, get a hit to go to sleep, take a hit to wake up, you know. Phew, excuse me…

Interviewer: That's alright. It's alright.

Interviewee: That I didn't have to sell my body anymore. You know, um, that I deserve to be treated better and that I was going to demand to be treated better at the point that I am.

Interviewer: What does that feel like to come to that place, because those are some…that's an incredible journey that you've had just from that tiny little snippet.

Interviewee: Actually it feels real good because I've been trying to get clean for almost 30 years, you know, and I could never do it. I have to apologize because hearing it, I have it on my phone and I listen to it, but actually hearing it like that, it was like, awesome.

Interviewer: Does it feel different to hear it?

Interviewee: Yeah, yeah.

Interviewer: What's different about it?

Interviewee: Its like a confirmation, you know, that all I got to do is trust in a higher power. Trust in my God and do the footwork.

Interviewer: Yeah.

Interviewee: Talk about what I'm feeling and everything and now I don't have to use it.

Interviewer: Yeah. I heard you talk about that in the beginning, the doing the footwork to getting back into school, or getting back into church, and that can be sometimes the toughest, most least rewarding part is doing all the red tape and everything.

Interviewee: Actually, it's an accomplishment for me because since I've been here with Scott. I also have a mental issue. I'm bipolar. And it was real hard for me to accept that I had a mental issue. I just thought I was crazy and didn't nobody understand. But since I've been here it's like I'm a mental health group and it's like I realize, well not realize. That I've been thought that it's ok to have the thoughts that I used to have and nobody's going to look down on me because I had those thoughts. It's just I have a mental imbalance and as long as I'm still on my medication and everything, I'm cool.

Interviewer: Sounds like this place has really helped you to accept that circumstance of having bipolar.

Interviewee: Yes, it has, because a lot of days I used to wake up and not want to be here. I have 6 beautiful children. I have 8 grandchildren. And it was like in my addiction they didn't even matter. I thought they would be better off with me not being here, you know. And now, I love it. My children are back in my life. My grandbabies, I can't get rid of them. I have one granddaughter, let me tell you, I call her my diva and it's like when she's at the house it's "mama, mama, mama, mama" and I love it. I love it now. I look forward to spending time with them now.

Interviewer: It's great to hear that you have things to look forward to. From what I'm gathering, from what you're telling me is it's different, vastly different, from when you were using.

Interviewee: Yes. When I was using they didn't want to be around me. They was afraid to leave the kids around because they were scared I was going to do something. It's like now they call me and "ma, you want to come get the babies?"

Interviewer: How does that feel to have your childrens' confidence again, and their trust? How does that feel?

Interviewee: It feels real good. It feels good. You know, I'm…hmm…it's indescribable really.

Interviewer: Like I said, that's an incredible journey that you've had and I can see you getting emotional as you listened back to that song. So, as you were playing it for Scott, was there anything specific that was going through your mind?

Interviewee: That it was over. That all that drama was over. That I didn't have to go through it no more. Moving on.

Interviewer: Great. So can you describe what was most helpful or what was most important or enjoyable during this session?

Interviewee: About the song?

Interviewer: Well during the whole session. It could be the song, it could be before or after.

Interviewee: Actually, the whole session because I like talking with Scott, I really do.

Interviewer: Great! I'm glad!

Interviewee: It gives me the opportunity to actually not put myself on a pedestal, but to look at the accomplishments I've made. Actually see what I've done.

Interviewer: Oh great, so it gives you some time to reflect that you may not be getting anywhere else?

Interviewee: Yeah.

Interviewer: Ok. That's great. It's always really good to have time to look back and reflect on yourself.

Interviewee: Because, like, they just stepped me down, and when I say stepped me down, I was going 5 days a week. I'm only going 3 now. I was kind of scared of stepping down because I didn't think I was ready. But then one of my counselors made me look at like, you've done the work, ok? You've made all this progress. It's time for you to pass it on to someone else.

Interviewer: Was there anything that Scott did or said during the session that stood out to you?

Interviewee: That he was real proud of me. That feels good to see that those who really really don't know me but only through our conversations that say they're real proud of me. I haven't heard that a lot.

Interviewer: Yeah, that's got to mean a lot, like you said, coming from someone who's not like a stranger, but somebody who's not family, not somebody who's known you your whole life.

Interviewee: Yeah. Mhmm.

Interviewer: Is there anything that you can remember you did you think that stands out in some way? Either you did something that made you proud or you did something you thought was really helpful or beneficial.

Interviewee: Not giving up on salvation. Because I've gone to a lot of outpatient programs before, but I never completed. Actually, I never stayed as long as I've been here. But the fact that I'm sticking it out. That I'm still here.

Interviewer: Was there anything during that particular session that you did or were able to do with Scott that stands out?

Interviewee: That answer's about basically the same.

Interviewer: The next couple of questions that I have are about how you felt after the session with Scott, so like immediately after, when you left, to go home or to see your grandbabies or to see your kids, how did you feel immediately after you left?

Interviewee: That I conquered one more hurdle.

Interviewer: Yeah?

Interviewee: Yeah. That I conquered a hurdle. Because like I said, actually before, like I said, the song, it's been in my phone for the longest, and like I said, I was in a lunch line and said I was just gonna do it and I did it and realized that all that is over with. It's like a flower had blossomed.

Interviewer: That's a good visual. Oh, I like that.

Interviewee: Yeah.

Interviewer: Reminds me of those time-lapse videos that you see on tv. I like that. That's a really good one. So, how did you feel then, as opposed to immediately after, maybe a couple days after or within the next few days?

Interviewee: I was still on that high.

Interviewer: Still feeling it?

Interviewee: Yeah.

Interviewer: That's great. Ok, was there anything else that stood out for you during that session?

Interviewee: [Noise implying no.]

Interviewer: Ok. Have there been other things that have been particularly enjoyable or helpful throughout…

Interviewee: I just like period now. I just enjoy everything. I enjoy everything.

Interviewer: Yeah, I can just see it. You have this wonderful energy.

Interviewee: And since the last time I was here with Scott I signed the lease for my apartment.

Interviewer: Oh wow. Congratulations!

Interviewee: And I'm moving in Saturday. I have somebody in my life now that treats me like a queen and that's good.

Interviewer: A lot of good things. A lot of good things. Is there anything that maybe Scott could do differently to help you even more?

Interviewee: No.

Interviewer: Great. Well, it sounds like you are having amazing success both here and just in your life in general.

Interviewee: Well, I gotta take it, I have to also, I gotta be, I guess, what's the word…prepared…because I know my disease has not hit me yet but I know it's gonna creep up on me. Things are just going too good, they're just going too good and I know it's going to creep up on me, and I just have to be prepared for it and not run like I normally, like I used to do. I'll be alright.

Interviewer: Well that's good, that you know the reality. It sounds like you're really enjoying life now.

Interviewee: Yeah.

Interviewer: But you know you do have a condition that could at some point take a different turn but it sounds like you're really prepared for that.

Interviewee: Yeah.

Interviewer: Great. Well, thank you so much for doing this interview. It was great to talk to you.

Interviewee: Thank you.

Interviewer: I know Scott would like to talk to you…

Participant 4

Interviewer: Ok. So, first off, thank you for meeting with me today. It's so nice to finally get to see you.

Interviewee: Absolutely, yes.

Interviewer: I get to put a face with the voice now.

Interviewee: That's always nice.

Interviewer: And I also want to thank you for all of your work so far in the study. It really means a lot to us.

Interviewee: Thank you.

Interviewer: It's really because of your participation that we are going to be able to learn things to help other people in recovery.

Interviewee: Good.

Interviewer: So the more we understand about what talking to someone in therapy feels like, the better we understand what exactly it is that helps people recover.

Interviewee: Ok.

Interviewer: Ok?

Interviewee: Ok.

Interviewer: So in your last session with Scott, he had you point out something that was helpful, important or enjoyable in some of the sessions you guys had together.

Interviewee: Mhmm.

Interviewer: So what we're going to do is we're going to play part of that session, the part that you pointed out, to help you remember what exactly you said and what Scott said and then I'm going to ask you some questions about what was happening for you at that time. Ok?

Interviewee: Ok. Let's turn this down. I'm listening. [I think she's turning her cell phone ringer down at this point.]

Interviewer: So this is the only part of the session that I've heard, and as Scott has told you previously all of the recordings will be destroyed at the end of the study. And the really important part of this is when I play it back for you, I want you to try to put yourself, as much as you can, back into that moment, ok? Try to remember what was going on then as opposed to now. So really put yourself into sitting there with Scott and what was going through your mind, and try to recall your thoughts, feelings, images and memories.

Interviewee: Ok.

Interviewer: And if we get to something while we're listening to the recording, if you want to put up a hand or nod to me I could stop it and you could comment on it at that time, or if you want we could wait until the very end and then whatever's on your mind you could kind of talk about it then.

Interviewee: Cool.

Ok? So either way is fine. Do you have any questions?

Interviewee: Nope.

Interviewer: Alright, so let's start listening. I think it's about 6 minutes long, ok?

[Recording plays here. 2:03-8:20]

Interviewee: Wow. Wow. Wow. I see me and Scott and it's nice. It's nice, Kim.

Interviewer: Can you comment on what was happening for you at that moment?

Interviewee: Emotional. It's very emotional.

Interviewer: What were you feeling?

Interviewee: I felt like I'm not alone. I felt, I felt, um, that I'm not as bad as I thought I was. I'm not worthless. I'm not stupid. I'm not dumb.

Interviewer: So it was almost comforting in a sense?

Interviewee: Yeah. The tears, the emotion I felt, the emotion I feel is good, you know because I always stated, and not all the time verbally, but I never wanted to get to the point where I used to be where I never felt anything. And just feeling like drugs are so debilitating in so many ways, you know. The different layers of it, the ugliness of it. One of the things that bothered me but at the same time was a definite catalyst to wanting to get clean was that I didn't like having one thought. One. This long before, I hadn't gotten all my understanding [INAUDIBLE at 10:06-10:08]. But as I learned different things, he was always there but just like one thought. And I'd take it step back here like, I'm dressing to go out and use. My conversation, I talked a certain way. I held my body a certain way. In the mirror, looking at how my, you know, as a woman, one of the things, it's crazy, but one of the things I was most proud was, I had a gentleman, at [inaudible at 10:46], and he's walking with an associate of mine and they were laughing, and you know, I'm not one of those people who think people are talking about me, you know, really, every now and again you do, but I could care less. Another language I could care less, so this one I was like, walking behind them and she came up to me and she said, "You know what he said about you?" and I said, "What?" And he told her that I was no good at performing oral sex. Who wants to get an A in that? Who wants a gold star in that?

Interviewer: Right.

Interviewee: But so many women do. That's the sum total, no that's not the sum total of me, and it's not and I don't want that.

Interviewer: It sounds like using was almost an escape for you to kind of stop those thoughts about yourself and to stop those feelings from surfacing, whereas in that moment with Scott those thoughts and those feelings were there and that was ok.

Interviewee: Yeah, yeah. Exactly. And it's like more or less people, strangers, didn't tell me I was no good. My family did.

Interviewer: That hurts.

Interviewee: Yeah, and you know like, yeah, you believe it because that's your family and maybe they know. You know, who should know me better than your family. And like I have older brothers and sisters, there's 8 of us and I'm number 6. There's 2 under me. So my brother, "You hard-headed." Hm. Hard-headed? I must be hard-headed.

Interviewer: So how do you feel now about yourself?

Interviewee: Sigh. I feel really really good. I feel free. It's been so long, Kim. You know, you go to meetings, you know my therapist listens to all my meetings, and meetings. The best thing for me is to make my own choice and be conscious of what Marsha needs without someone standing there and telling me. I don't want…yes, I want someone holding my hand and telling me but then let my hand go and let me figure it out myself.

Interviewer: No one knows you better than you.

Interviewee: Yeah, and if I don't well then I'm left with me. You can't go on with me. You can't walk, I can't put you in my back pocket, so you know, you know, I've always been the type of person where I was analytical. Analytical, that's the word. But when I listened to the tape, one of the things that helped me, that I appreciate in this first start is talking about peace. Peace. That's very very essential to me. I grew up with a lot of noise. People cussing, drinking, you know, smoke in the air. I don't know if they were smoking crack back then, I don't know, but it could've been anything. Just with no kind of dignity with kids around. You know, that was how we were raised. What that puts me in touch with was the blame game. I spent a lot of years blaming the way my mother and father raised me for this happening or that happening. It's not nobody's fault. It's the bad choices I made. Bad choices I made and because I made bad choices doesn't make me a bad person. And that's good, and like freedom. I can't blame this father for introducing me to the coke guy. I liked it. I can't blame this father for not being around.

Interviewer: You kind of went from pointing fingers and saying I can't change because it's their fault, to getting into motion, like you said during the part.

Interviewee: And like, ok, if I stay here I'm going to get beat up. That's like somebody telling you today, you know, stay right here, I'll be right back, and they [inaudible at 14:59]. That's talking about diseases. You stay right here. I got something for you. And I stayed right there a lot of days, and I got beat up. Shake and move, mhmm.

I got my teeth out in 2005. I wasn't in a good place mentally because my mom had been missing and things were going in motion for me. But in essence it was the right thing for

me to do, using. Well, but then I became self-conscious, and let that be, when I said, you know, everything you do isn't based on what you look like, what I look like. Of course it's important to have a nice smile, of course, but it's not something that I can't get. You know, it's not like I'm asking to be 30 again. It's doable. So, I recognize that, one thing I recognize is that I just avoid, I spend a lot of time mulling over stuff that didn't benefit me, that didn't get me to where I wanted to be at. I always wanted something. I wanted to be a viable human being. I want to give back. I want to help someone if they're young [inaudible at 16:20] right there? I was her house-mother when I first came to recovery in 2000. Her house-mother. And I see her on the street and I hug her. They call her, her name is Marci, my name is Marsha, and you know, and we, and she's like, mama, I was like a mom to her, and it wasn't nothing else but [inaudible at 16:41-16:45]. And we hugged and we laughed and I said you followed your mom, and I hugged her and I'm glad. I don't have to go in the hood and literally look for people and worry about them.

Interviewer: You talked about that part about passing people in the halls at [word that sounds like "stop" at 17:03…name of rehab center..?], and those people did so much for you.

Interviewee: Absolutely. Absolutely. I talked to, um….I've always been a people-person, and I found out that I got the most good out of just testing the waters. It's a therapeutic community. You know, sitting in here, my therapist might not have been in that day, my therapist might've been busy. My one-on-one therapist might've canceled on me, so what does that mean? That means I don't talk to anybody? I know in the couple years that I've been here, the couple therapists who left for whatever reasons, they said well we're going to be going here x, y and z days, this and that, but if you want to you can hook up with somebody. They left it our choice. And a lot of us I found we didn't take that up but looking back on it why not. But you had to get to that place. A lot of us I think we deal with abandonment issues, we deal with issues of letting people get close because people hurt us, but you know, hey listen, that's part of being an imperfect human being. We're going to hurt you, we're going to let you down.

Interviewer: And you mentioned that during that segment you felt like you weren't alone.

Interviewee: Yeah, yeah. Listening to that, I mean, like, Scott and I, we're not friends. But he sounds like a friend. That's the kind of conversation you have with your friends. We're sitting down there and I don't think nothing of it, and like real, just real give and take, and real flow. I was telling my son last night that one of the most important things for me is for people to get me. I hate having to keep explaining who I am. If you and I have known each other for ten years, why are we still at what's your favorite color? If you like how I treat you, treat me just the same, and we're friends, we know how to treat each other. I shouldn't have to worry about Kerry messing with my boyfriend, or me taking your shoes that you told me not to. Little stupid stuff like that. But I said it's important just for people that's close to get me. Maybe that's not a good thing. But time will tell. Like with my husband. How have we known each other 17 years on and off, we've been married, and you don't know my dress size? Ok, I gained some weight, but

so what? I'm telling him now, it's important for you to get me a personal gift. A dress, a blouse, a pair of shoes, you know, a bra and panty set. Because it's important that number one I want to know that you think about me, and that you know me.

Interviewer: So you felt like you were able to connect with Scott?

Interviewee: Yeah. And I'm listening to that and you and I talk like that on the phone, and like, Kerry, I don't feel good today, and like, Marsha, I hope you feel better and this and that and it's so easy talking to you guys. And that in itself is everything. And this process, recovery, therapy, clinical studies, all that. We have a saying in recovery. Half measures will fill you nothing. You heard it?

Interviewer: No.

Interviewee: Yeah, if you only tell half the truth, what are you gonna get back? Half an answer.

Interviewer: Makes sense.

Interviewee: Yeah. So, like, I try to apply that and if I tell you everything about me, like my doctor, this and that, and I tell you, doc I'm still using, or I had two drinks last night, that doc can give you, if you don't tell them, they, it's like my cousin. I had a cousin who was in his mid-20's. His oldest brother had died from the direct use of alcoholism. We were all together, my mom, I was talking about the funeral, what day it was and everything, seeing each other, they hadn't seen each other in awhile, and he was getting ready to go in the house, the house with cooperation. In and out, short procedure, and he's a big guy. A big guy in the osh kosh bagosh jeans, the overalls, so all I see is this big young boy. He died on the operating table. He didn't tell his doctor that he snorted cocaine. Like, like it's crazy.

Interviewer: So it sounds like, from past experience even, you've come to really value truthfulness, honesty, sincerity,

Interviewee: And life. Yeah, because we're talking about your life. Every day you wake up you make choices, you live or die, you know. If I put coke, if I, if I pick up, if I go and get a rock today, I've chose to die that day because I don't know if that rocks going to bust my heart. I don't know. If I go into a bad neighborhood, yeah, I want to live. It's all about my life. Everything I do from the moment I came out and the moment I got some understanding, and mature enough to understand, I was working on saving my life. The choices that I made that were contrary to that, I was trying to die.

Interviewer: So putting yourself back into that moment with Scott. Thinking back at it, what do you think was the most helpful, the most important, or the most enjoyable part about that session and talking to him about that?

Interviewee: Well, um, feeling lighter. Feeling lighter. Hearing myself talk. Like, I recognize me, but the honesty, the honesty and the realness and talking about some things that was heavy, you know, it helped free me. It's like sitting here, talking about it with Scott, we're free from it. But hearing it, it empowered me. It empowered me. It's not like your voice is over there, or Les Brown. That's Marsha's voice, talking about Marsha's real feelings and formulas, and hit-or-miss, I use those expressions, and tried and true and true and false and it's like I've actually done some research. It's not like I sat back and let somebody tell me. I've practiced what I was taught and I found what worked. What works. And so, empowerment. I feel empowered.

Interviewer: Was there anything Scott said or did during that segment that kind of stands out to you as helpful, important or enjoyable?

Interviewee: Scott said a lot of things. Nothing pops out because it was a lot, but there was one thing I should've asked you to stop it, where we were talking, and him getting me. The last few sessions with Scott, after the first one, you know getting, working out the kinks.

Interviewer: And what did he do or say for you to understand that he gets you?

Interviewee: When we're talking there's a couple times where we're talking in here and I was saying something and he would respond and I would say, "Absolutely."

Interviewer: There was a part in there where you were saying, "Absolutely. Absolutely."

Interviewee: There was a couple. Yeah, and that means so much to me. Because I will say, no that's not what I mean, that's not what I mean. That gives me a crease in my brain, when I have to be like, NO. And sometimes people finish a sentence. It's two ways, people who can finish a sentence but they can finish it wrong. To me, that's disrespect because they're telling you they're not interested in what you're saying.

Interviewer: So he understood.

Interviewee: Yep, that's right.

Interviewer: Is there anything that you said or did during that segment that stands out as helpful, enjoyable, or important?

Interviewee: Being in motion. That's very important. Being in motion. Yeah. Can't be there sitting and waiting for something to happen all day. If you're playing the lottery, you're playing the lottery. You gotta go put the numbers in so come on now. You have to play to win. I like that. You have to play to win. You have to play to win, I like that slogan from the lottery but that's life. You gotta play to win. You know, if you wanna be in the game you gotta play, and I want to live.

Interviewer: In this conversation with Scott there, what effect if any did it have on you immediately after the session? Do you remember getting up and leaving that day and what that was like for you?

Interviewee: Well, yeah. I think one or two sessions I left I was kind of balled up because I didn't realize the impact of what we talked about, how it was going to affect me. But more so than that, the word safe comes up. The word safe is popping up in my mind, but it's not exactly that. I want to sharpen that. It's more like comfortable. I felt comfortable. I didn't feel at unease. I didn't feel rigid or not once did it go through my mind, "I hope you don't share this with nobody here."

Interviewer: You trust him.

Interviewee: Yeah, trust. Thank you. Thank you. That's what I felt. Trust. Exactly. I was trying to sharpen it. There's a word I wanted to say: I trust. I trust that he genuinely wants to help me and he's sincere. Sincerity. And that's important to me. I don't say things I don't mean. I really try not to. I really don't say things I don't mean and I recognize when people doing that to me and I don't like it. It doesn't make for a good relationship, whether that's a boyfriend, whatever type of relationship. You're not going to develop a real relationship with people, just a corner store friend, if you're just b.s.'ing. I don't think there's any situation where truth doesn't trump. You know, I guess that's my belief system, being one of Jehovah's witnesses, I know for a fact that telling the truth because like I said, you know, I'm the same way. I'm looking for people that buy into that. Like, even if you say something to me that hurts my feelings, if it's the truth, I'm going to respect it.

Interviewer: The story that you shared before, telling the truth can save your life.

Interviewee: Yeah yeah yeah, absolutely. Absolutely. I heard a young lady in recover at a meeting one day say she had like 11 years and she stood up and said everything I know about life, everything I was taught about life I use, and she went further to say that everybody that she knew lied to her. At that time it struck me, it was powerful and it affected me. But as I've looked at it and used and listened to that and placed it, personally for me how I feel about that, like I said, the blame game. It's not so much that everybody lied, this or that, I believe that my parents did the best they could, but they were ignorant. I'll use that word not to be demeaning, but they were ignorant. They didn't know a lot of things and they did the best they could. But as a child you don't know that. You feel let down, you feel betrayed, you feel like you want everybody else's parents to be your parents. I wanted Bob and Carol on the Brady Bunch to be my parents. I wanted Leave it to Beaver's parents. I don't want anyone to tease me. But as I got older I could appreciate them a little bit more. But that still doesn't detract from don't lie to me. Don't lie to me. Not on a whim, this or that, just don't lie to me.

Why? Lie to someone, why? You lie to save their life. They're gonna die anyway. I just don't see…my brain is locked on that. This is how I'm gonna carry myself. When people talk to me, when people come away from having a conversation, I want my word

to mean something. I want my reputation to mean something. Marsha said go to Kohl's at ten o'clock. They're going to give you $100. I want all my people to know that because Marsha said that.

Interviewer: You want people to listen, and trust you and rely on you.

Interviewee: Yeah, and then you say rely on me. Why would you think that of me? Right? But it comes back to me being a very sensitive little girl. A very sensitive little girl, kind of lost in the middle, and you know, I kind of made my own way, figuring stuff out on my own. I had very little respect for my mom because she drank and my father used to beat her up. That's traumatizing. I'm ten years old seeing my mother punched in the face. That's not normal. What is and what ain't, but that's not normal.

Interviewer: Right, just living through that and seeing how, I mean, you probably had no trust for anybody at that point in time. And to see how far you've come where you're able to trust and use that as an example, I know that that is real.

Interviewee: And not to be so hard on people. That's it. I think, not that if I say not to lie to me, this, that, I don't think that's having a severe, it's not that, it's just that I'm not going to lie to you. And I'm not hard on people. I'm not holding you, if you feel that you need to lie to me or to b.s. me and flatter me profusely I' going to look at you and investigate why you feel the need to but I feel bad for you. I feel bad for you, because listen, I don't need nobody to pump me up. I don't need nobody to flatter me. I don't need nobody to tell me what I look like and it's so refreshing to be here. It's so refreshing to be here. I was always here, but my personality I felt like I was too much for a lot of people. A lot of people were like woah, that can't really be her. My daughter's boyfriend said to me years ago, "That's that North Philly." I was like ok, that's cool. I remember one incident, this young man, coming across 4th street. My using area was down Girard Avenue, down that way, and I was coming, he told me within 30 seconds of talking to him he just got out of jail. So I'm like, oh, you know, mama, did drugs, added behavior, the whole, he must be looking for a girl, this and that, he just got out, and I didn't care anyway because I'm trying to trick him anyway out of his money. I ain't doing nothing. I had to be smart. So we're walking. We must've walked at least a block and we're talking and he went in his pocket and handed me some money and said, "You're too hip for me." And I laughed, and I had that happen a couple of times.

A couple of times, and one time was late night I was in a car with a guy and I had the ability to get him to talk to me like he was going through something with his girl, his wife and he was hurt and we was talking and I said, "you don't want to do this" not because I didn't want to because I was going to do whatever it took to get the money to get one more, but I just felt like he needed someone to talk him out of it. And he looked at me, and actually, I wouldn't say I made a friend, but I made a difference that night. Now, I don't know what he did after that. Yeah we were something and here I was bummy, mad, dirty, not myself, in a car late-night, ready to perform whatever sex act, get a couple dollars, and he gave it to me just because I talked to him and I made him realize before he did something he didn't want to do.

Interviewer: So you realized that you can be powerful with your voice and by talking to people and making that connection and being there for them.

Interviewee: Yeah, a lot of people, since I was younger, you know, that's how they would look to me. A lot of people looked at me, Marsha, tell me about boys, tell me about sex, little things. And they brought their little problems to me, and I was like the problem solver. They were too much. It was too much. I couldn't solve my own problems. But that was good for me because it helped me wear this mask for so many years. I was a problem solver, people came to me, I was a big sister, I was this. Woah.. Hold it! Where's Marsha?? I'm your mother, I'm his sister, I'm his girlfriend, I'm her big sister, I'm her play mom, but who is Marsha??

Interviewer: So all of this is about finding yourself?

Interviewee: Yeah, all of it! I got all these hats and people love me so good.

Interviewer: You have to care for yourself as well.

Interviewee: Yeah. I'm like, when I fall, who caught my back? Who caught my back?

Interviewer: So what do you think might possibly change for you because of that conversation with Scott?

Interviewee: Because of talking to Scott and him being easy to talk to, he said some stuff, he wasn't always all sweet and kind, always agreeing with me, but basically what Scott did for me is what I haven't had done in awhile. He let me talk. Not my psychiatrist, not my therapist that I had up in here had that ability to let me talk. And in that, I kind of figure it out, what I kind of needed to do. As he gave me two print outs of things, he assessed, and he put it together perfectly. This is what you need to do. My biggest problem with wanting to be discharged, my biggest reason for wanting to be discharged from {name of center here…? Sounds like "stop"}, I had two conversations with my last therapist. One, I was talking about god. I approached the subject, like, go to meet his belief system. Well, wait a minute. I'm the client. And then, unfortunately, he was one who watched the clock. The clock was over my shoulder.

Interviewer: You could tell that he was looking at the clock and not you.

Interviewee: Yeah. Yeah. And I thought that that was just a little bit much.

Interviewer: Right.

Interviewee: But I said you know what, I said it was time to make a decision. Everything that I've learned, everything that I've been through, all the different therapists I've had here, all the different people I've talked to on the side bar about this, that, and the third, I even stopped smoking while I was here, I got married while I was at [name

that sounds like “stop” again]. A lot of good things happened to me walking these halls coming here. Met some good, good people. That’s the second person that I’ve seen that I knew, and it makes me feel really, really good. I know [name of person here, at 39:14]. She’s going through some good things here. She’s safe. She applied herself.

But with all that, I always believed, even when I was I recovery houses, recovery all starts when you hit the bricks. Ok, I’m safe. Right here I’m safe with you, Scott sitting there in the waiting lobby room and everything, but what am I going to do when I go outside, because that’s when I’m faced with all that stuff. Waking from here to Broad, from here to Lehigh, 5 people could approach, proposition me to get high, or you know, want to tell me I look nice. It depends on where I’m at with me, I’ll either fall for it or I stand. So like I said, I trust that everything I learned, including with you, my session with you and Scott, cause one of the things like I said to you, the survey you did with me meant so much because like I said, it means, on that day, you and Scott sitting here, the part on how you’re feeling that day, today.

Interviewer: That day. Right, right.

Interviewee: And I’m like, ok, ok. I’m cool, ok. How am I feeling today? And I didn’t know. I don’t feel like I’m energetic. No, I don’t. And then when I feel energetic I’m like yeah, I feel it. So like, that was good. That was good.

Interviewer: It’ll reflect on your feelings as well.

Interviewee: Yeah and it’s perfect because like with me, being discharged from here and finishing with you guys, that’s like the icing on the cake. I’m ready. I’m ready.

Interviewer: So, speaking of that, what specific things do you think might happen to you in the next few weeks, months, years, because of this?

Interviewee: I’m gonna have a lot more confidence that the things that I want to do I can do. I’m not going to be afraid of failure. I’m not going to be afraid of failure because scraping your knees is ok.

Interviewer: It looks like you found yourself and you believe in yourself.

Interviewee: Yeah, I do. I do. And I had a conversation with my 26 year old son last night. He left a relationship because he felt he was going insane and he noticed about me last night, he said, “Ma, you talk loud.” I said I hear that, I hear that, son, believe me. I mean, I hear it, but I said that has a lot to do with my living arrangements. You know, when you’re around a lot of people and they all want something from you, and the negativity and that kind of…

Interviewer: It’ll take a toll on you.

Interviewee: It do, but it's not their fault. But like I said with getting my social security now, a blessing, I'll be able to make some decisions. Some concrete ones, not just like, you know, make some things happen. Because I'm in charge of my happiness. You know, getting people to feel sorry, and about my husband using, and this and that. I was telling him today I said you know, that's not cool, you're just taking a break from your illness. He lays in the bed like he's doing me a favor for 2 days. It's Friday night. It's Friday. Active addicts, they get dressed up and go post up on Friday night like they worked all week. So I'm looking for him, looking around. So, um, my next move, I'm being sure-footed because my next move involves me doing me. Now, my husband you wanna come, you wanna be a part of that, you have to get some maintenance on yourself.

Interviewer: He's not gonna hold you back.

Interviewee: No. I'm like, I'm not coming in the house accumulating a laptop and this and that, I said everything that we've had in this house since we've been married, my sister gave us a car, for 2 and some thousand, you sold that. We had a television, he sold the computer, he sold the computer, what else, something else.

Interviewer: Enough is enough.

Interviewee: And I'm like I had everything I had and I'm accumulating more because I'm standing in the right lane. You, you know, I said, but I'm not happy with you. You cannot look me in the face and say you're tired. I don't care if you're tired. It ain't about me. Do it for you. He has twins. He went and held his twin grandchildren for the first time yesterday. Good. But they aren't going to keep you clean. I' not going to get you clean. So basically I'm just saying, that's my heart. My husband, I love him. I don't like what he's doing. But if he's not where I think he should be at, I'm leaving. I'm done with this battle. So I'm just preparing him I guess.

I'm alright. I'm not going to spit in gods face. I'm not going to hurt my children by going back to drugs. I'm not going to disappear out of my grandkids life. I'm not going to disappoint the people I told about [name that sounds like "stop" again]. I'm not going to any of that. I'm not going to do any of that. But most important. If you're not willing to do what you need to do to help you to live, because that's all it is, helping you live and be a better person, then I can't be with you. I gave you a year. How much more you want?? A year's a long time. So you're sitting there waiting to see, we've been to therapy, couples' therapy, I said I'm not interested. I don't feel like it. I don't feel like, I don't know, just the drugs, it's like you've got to be kidding. And he pulled me into it. That's the sad part. He pulled me into it indirectly and I thought that's the right thing to do because I'm married. And it's said it's a lot of suffering and patience. The bible talks about the fusion of spirits, patience, love, you know, all that, but I'm like, self control. I'm not doing it.

Interviewer: Any final comments on what that was like to talk to Scott about that, and the will-power, the getting into action, feeling free? Anything else you'd like to share about that?

Interviewee: I just thank Scott for being Scott because he could've been anybody else and it probably wouldn't have gone as well, I don't know. But Scott I felt he was genuine. I felt he was genuine and I think his personality is who he is outside of here.

Interviewer: He wasn't fake to you. He was real. That was important.

Interviewee: Yeah, very important. And that gave me the strength I needed, the strength to push and push some stuff out that I didn't even know was there. Because actually, what Scott did, allowed me to do, was finish up and then say some things that I wish I could've said to my therapist here. In doing that, I might've been angry when it first came out, it might've been a self-righteous type of thing, but I actually

Interviewer: You're able to process it and learn from it and be yourself.

Interviewee: Yeah and you know I'm not angry. What it is is he was doing his job, that was his technique, that's his way of, you know, so like I said, I was here, I was leaving [name that sounds like "stop"] saying I they make me sick, I got to get out of here, I was like I'm leaving. Leaving good feelings, I recommend someone to come here, stop in if I'm allowed, because I know they have rules like somebody else said, you know come by and see different people, see how they're doing, and have good thoughts. Have good thoughts, because so many are out there using again because they left for the wrong reasons.

Yeah. So you feel like you're leaving for the right reason.

Interviewee: Absolutely. Absolutely. It's fine.

Interviewer: Is there anything Scott did that wasn't helpful or that kind of rubbed you the wrong way that you want to mention or comment on? Maybe it's something that he did wrong at first but then you realized that it was a good thing.

Interviewee: Scott thinks he's slick. Scott thinks he's slick. He made it seem like it was my idea but I know he was giving it to me. And I recognized it and I allowed it and I thank him. He actually helped me change my mind but he did it in a way that gave me dignity. I didn't like it. It rubbed me the wrong way. I didn't like it because it seemed like he was pushing me at first, he was pushing me toward something that I really didn't want to talk about. How I felt about ["stop"], this and that, and I like put it to bed. He said to me, you know, you can still come here after you leave ["stop"], cause I was concerned about that. I was being proper. And I would sit here and we were talking and he would like conversationally like we do and you say something and I would talk about it and as I talked about it I realized how I thought I felt about it isn't really how I felt about it and I appreciate that. I appreciate that. He helped me to not have a bitter taste in my mouth about hopefully, hopefully god willing and me applying myself, will be my last time in treatment. And I appreciate that more than anything. Cause I probably would've like, ["stop, stop, stop,"] and it was leaving a bitter taste in my mouth. But he

helped me to see it for really like what it was, then that survey I do is "Am I ready to fulfill my treatment." I was like, that's not talking about me personally how I feel about personally. That's overall. And you know, you gotta kind of open your mind up, because you see if you close your mind down you can't take in anything so you can't get nothing out. So, opening up my mind and looking at it and I took time to ask him, um, what does this mean because I'm not sure how to answer this. And he was like, ok. Rather than like, ok, I think I know what this means so I'm just going to answer it. But I'm answering it wrong if that's not what it means.

Interviewer: Right. Right. Gotta be truthful.

Interviewee: Right. Yeah, just assuming. You know what assuming is. You know what I learned about that. Ok, never assume. Always ask questions and keep on asking.

Interviewer: Well thanks so much. That completes the questions I have for you about that.

Interviewee: Thank you.

Participant 5

Interviewer: Thank you for meeting with me today. It seems like you had a little struggle getting here but you're here so that's all that matters. And I also want to thank you for your work in the study so far. It's really because of your participation that we're going to be able to learn a lot of stuff about people in recovery and what works for them, especially when it comes to understanding what talking about something in therapy feels like. So it's going to help us better understand what helps people recover.
So in your last session with Scott he had you point out something that was helpful, important or enjoyable in the sessions that you've had with him. So, what I'm gonna do now is play a recording back of that session that you picked to help remind you of what you and Scott said.

Interviewee: Do I need this?

Interviewer: That's your appointment reminder from today.

Interviewee: Ok.

Interviewer: So I'm going to play a part back to help remind you of what you and Scott said during that session, and then I'm going to follow up by asking some questions about what was happening for you at that time, ok? So answer the questions in the manner of what was going through your head at that time that day when you were sitting there with Scott. Ok, does that make sense? This is the only part of the session that I've heard and as Scott's told you previously, everything's going to be erased at the end of the study. If you hear something that you want to comment on while we're playing it just let me know

and I'll stop it, otherwise you can hold your comments until the end. It's totally up to you. Ok, do you have any questions? Alright, let's give it a listen.

[Tape plays here at 1:38 - 8:12]

Interviewer: Ok. So, again, answering in a fashion as what was going thorugh your mind in that session with Scott on that day, what you just got done talking about, you know the graffitti art, expressing yourself, the radio show. What was happening for you during that moment?

Interviewee: What? Emotionally or Physically?

Interviewer: Yeah, both. Both. What were you feeling? What were you thinking?

Interviewee: Basically I was just dealing with the effect of, basically some of the good things that have come at STOP. To get out of the program, there was a couple things that was good, like the radio show, giving me a chance to like really ball down and just let people know what you're going through on a day to day basis. We all go through trials and tribulations in whatever we do. We might see the light on the other side of the rainbow and get on the other side. So it's just like that. It's different strokes for different folks. Basically that's the best I can say it.

Interviewer: What kind of feeling? What were you feeling at that time?

Interviewee: I had a lot of feelings. Mad, sad, glad, happy, you know. It does as the term, my mood fluctuates.

Interviewer: So through that conversation you were feeling a lot of different ways all at the same time? Looking at different sides of the rainbow, like you said, you know, is there a light there, is it gonna be dark when I get there? That itself could bring those feelings of happiness or sadness, so it sounds like it was a mixture of things for you. Was there anything during the part that we listened to, was there anything that Scott said or did that really stands out to you as being very helpful or important. Was there anything that he said or did there?

Interviewee: Him talking, giving me a chance to tell my story for what it is. You know, not just telling it how people want you to tell it, you know. Giving a play by play, you know. That is all.

Interviewer: Ok. Was there anything that he said that kind of meant something to you or kind of stood out?

Interviewee: Probably about the part where he was talking about the radio show and stuff like that. Where he was talking about that poetry thing. Cause after that I did have him read some of my poetry.

Interviewer: Really?

Interviewee: Yeah. But yeah the poetry thing stood out to me.

Interviewer: Ok. Cause he was interested.

Interviewee: Yeah.

Interviewer: And he wanted to see your work and he had a sincere interest in you sharing that.

Interviewee: Yeah.

Interviewer: Is there anything that you said or did that stands out to you as something that was helpful or important or enjoyable?

Interviewee: Probably our first session. Giving me a chance to speak.

Interviewer: How about during what we just listened to.

Interviewee: About in there?

Interviewer: Mhmm.

Interviewee: Basically the poetry thing. The radio. Computer class. Art therapy. All this, you know, it's just all bunched up, like, people see it different weays. Some people see that it's upside down and to meet them I just see everything in a jumble. It's just what I do.

Interviewer: So just being able to sort through that and say it out loud to another person and share the things that have helped you. That's kind of meaningful to you. Ok. What effect, if any, did sharing with Scott about the radio show have on you immediately after this session? Can you think of any actions, thoughts, feelings, or relationships with others that could have changed immediately following because of being able to share that with somebody?

Interviewee: A feeling of relief. A feeling of expression. [Coughing…]

Interviewer: Getting sick?

Interviewee: I am sick. I was sick last week. Stuff I got, it ain't up to nobody else.

Interviewer: Allergies?

Interviewee: I don't know what it is. I think it's an allergy because I've been sniffling, I've been coughing.

Interviewer: Yeah.

Interviewee: It's because the weather changed.

Interviewer: Yeah. Warm and cold, warm and cold.

Interviewee: Yeah. You don't know what to dress.

Interviewer: Mhmm.

Interviewee: I'm about to dress in some shorts, some pull-up socks.

Interviewer: Ok, so you went to that you felt relieved afterwards immediately. Anything else?

Interviewee: Yeah, relieved, expression, you know. Being able to talk things out a little bit better than normal.

Interviewer: Were you able to talk to other people better?

Interviewee: Mhmm. I'm just really not that sociable, you know. I talk to people in my circumference. I'm not really trying to discuss a lot of things with a lot of people. Some things are meant to be discussed and some things are not meant to be discussed.

Interviewer: Ok. That's fair. How about any changes or any effect on you after that session with Scott the following days after the session? I know you said immediately following it you've been good just being able to talk to somebody. Was there anything you noticed a couple days later that kind of persisted?

Interviewee: The majority of the time I stay in my own house, you know, so it's like, basically the only thing I get to do is get on my computer, watch tv, and get on my cell phone every now and then. But for the most part, a lot of things, a lot of things changed, you know. I'll be able to go next door and speak to the people that work there, you know, making conversations, even though the people who work there they don't know me because I'm just like a neighbor. I just moved in. I go over there and I speak to them, I talk to them, I take a smoke with them.

Interviewer: That's great. So it sounds like you're starting to open up more.

Interviewee: Yeah, you know, I get a chance to speak, talk things out, stuff like that.

Interviewer: Share a little bit of personal information, like the things you're into, like poetry and graffiti art.

Interviewee: Yeah, the only thing they say is more important.

Interviewer: Yeah?

Interviewee: It's a nice little cozy cave.

Interviewer: Good. So what do you think might possibly change for you after having the experience of talking to Scott, him sharing those things with you? I know you said you even were comfortable enough to bring your poetry in and share it with him. But what kind of effect might that have on you? Like thinking of the next few months or even the years to come. Do you think that'll have a profound effect on you?
Interviewee: Yeah, it gave me a chance to express myself a little bit better outside of the walls that I've, of my circumference.

Interviewer: So it sounds like you had a positive experience sharing personal stuff with another person and because of that you're kind of experimenting with sharing with more people a little at a time.

Interviewee: Yep.

Interviewer: Kind of opening up. Do you have any other comments that you'd like to share, feelings or thoughts that you'd like to say?

Interviewee: None right now but um, just, um, this helps out people. People get a chance through the talks and stories we weave, stuff like that, because I went through a number of lifestyles and a number of different ways of life and I've been to a number of different states so I have a shield of view, you know what I'm saying?

Interviewer: You have a lot of experience it sounds. A lot of things to share. A lot of lessons that you've learned.

Interviewee: Yeah.

Interviewer: And you think other people could benefit from hearing that?

Interviewee: Yeah. It's always, you know, the best thing I've ever actually experienced in my life was traveling. Being able to get up and go somewhere else. It's always a new experience everywhere I went to. Everywhere I traveled was a different experience. Different talks, different looks, different walks, different everything. It ain't like the same, you know? Everywhere you go, you may touch down here and it's not the same as like, you know, I've gone from the east to the west, from the west to the north, down south, a little bit of northeast, not northeast, yeah, I was in northeast and I was in northwest. A little bit of south, southeast.

Interviewer: You're all over the place.

Interviewee: I did a lot of southwest too down there. There's only a couple, about a good 27 states I haven't been to, but I've been to about 22, 24, yeah probably 24.

Interviewer: So are you going to travel again?

Interviewee: Yeah. I guess it's when everything, you know, I have a little but of money to the side and be able to, you know. I can't do it like I used to. I used to do the free ride. But I had to grow up, you know. Can't do the same thing as you did back then as you're doing now because it's two different, two different…

Interviewer: Different stage of your life.

Interviewee: No it's just growing up. It's like a road of passage.

Interviewer: Was there anything that had happened that wasn't so good? Anything Scott said or did that maybe rubbed you the wrong way or anything that you didn't like?

Interviewee: Nothing I can think of. We always had a fun time. We had a personal, you know, it's just like owning a comedian show. It's just one on one. Not really had, I don't know.

Interviewer: What kept you coming? I know it was pretty long to get here and kind of a struggle and you said you had a long walk that would take you about an hour.

Interviewee: I remember what you're getting at, being able to help other people. That's basically.

Interviewer: I know you had some issues with the STOP program itself but you still came and saw Scott.

Interviewee: Yeah. Taking my little walk up here. I just had a lot of arguments and you know, like, I've tried to tell them, it costs me more money to get up here than, you know, you all are gonna drive my gas, drive me back and forth and home.

Interviewer: But you kept coming.

Interviewee: Yeah.

Interviewer: So even though it was a struggle for you and maybe a little annoying to have to make the trip you still felt that it was going to be valuable for you?

Interviewee: Yeah. I even walked a couple times so yeah.

Interviewer: That's dedication.

Interviewee: I done walk a couple times. Yeah I walked up here.

Interviewer: So if you don't have any final questions, that's all I have for you. Do you want to say anything else? That's that then, alright.

Participant 6

Interviewer: Alright, well thank you for meeting with me and I also want to thank you for all the hard work you put into the study so far.

Interviewee: Yes ma'am.

Interviewer: It's really because of your participation that we think that we're going to be able to learn what helps other people in recovery. The more we can understand what talking about something in therapy feels like, the better we can understand what helps people recover. Ok?

So in your last session with Scott he had you point out a helpful, important, or enjoyable part in the sessions that you had.

Interviewee: Yeah.

Interviewer: I'm gonna play that recording back for you here together to help remind you of what you and Scott said, and then I'm gonna ask you some questions about what was happening for you during that session. Ok? This is the only part of the session that I've heard and as Scott has told you, all of the recordings will be erased at the end of the study.

Interviewee: Ok.

Interviewer: Ok? So please let me know if we get to something that you'd like to comment on. I could pause it right then and there, or else we could wait until the end and then if you have any comments you can share them at that point.

Interviewee: Ok.

Interviewer: Either way is fine. Alright. Do you have any questions?

Interviewee: No.

Interviewer: Alright, let's get started then.

[tape plays here at 1:11 - 6:05]

Interviewer: So, putting yourself back into that moment, what was happening for you?

Interviewee: Just a sense of having a change. Like, needing a change. Or, by coming to STOP I started looking at things differently. So when I show up and I see things differently and then when I interact with the staff and the people that are coming in here it's just like a sense of belonging. You have a sense of change and helping people. Some people are like, I'll be out for a couple days, or two days or three days, they're like little man, where've you been? That means a lot to me because that means that somebody actually looked forward to seeing you. And me changing my whole lifestyle, the way I perceive things, the way I look at things, it's just a blessing and I think that spirituality plays a big part of it too.

Interviewer: And when you were sharing that with Scott what were you feeling?

Interviewee: I was feeling like really good about having to change. It gave me a good feeling to talk about change, and how much you wanna change and what you have changed, and just try to look forward to your goals, your next goals and accomplishments.

Interviewer: Alright, so that sounds like it was a little bit motivating, too.

Interviewee: Yeah.

Interviewer: Was there anything that Scott said or did during this part that kind of stands out in your mind as being helpful, important or enjoyable?

Interviewee: Just the way he talks. The way he is. He's a caring person, so…

Interviewer: Could you say more about that?

Interviewee: Huh?

Interviewer: Could you say more about that?

Interviewee: Yeah. He's really a caring person so it seems like he's a caring person and an understanding person. And he gets the open eyes and looks at things differently.

Interviewer: Ok.

Interviewee: Just the way he is. He's a good guy.

Interviewer: Is there anything during that part that you said or did that kind of stood out to you?

Interviewee: Yeah, just becoming a better parent. Becoming a better parent, a more dependable, reliable parent.

Interviewer: So the part of talking about your family and that?

Interviewee: Yeah. So the family part is a real big piece in there.

Interviewer: Ok. What effect, if any, did this have on you immediately after the session?

Interviewee: It had a real positive effect. I started looking at things differently. I wanted to come more, be more motivated, showing up more, helping out more with my mom and helping out my kid more. Just being there for them even more. Like taking time away from myself and the things that I enjoy doing and spending that time with my kid, so that really helped out. Being there means a lot.

Interviewer: Was there anything that kind of persisted in days after the session versus immediately afterwards that kind of kept…

Interviewee: Oh yeah. The way I just transitioned and I became more helpful with my parent, with my kid, my parenting skills.

Interviewer: Ok.

Interviewee: That was a big thing.

Interviewer: Sounds like a change in relationships?

Interviewee: Yes.

Interviewer: Ok. Is there any other comments that you'd like to make about your feelings or thoughts about being able to share how important that change was to you and the family with Scott?

Interviewee: I think that it has made me a better person. I look at myself totally different. Like things I thought I couldn't do I'm doing now. And I think that means a lot.

Interviewer: Ok. Is there an example of that that you'd like to share?

Interviewee: Just being there for my mom. Like my mom has, her right eye is like, she's gone blind in her right eye, but being here more, not running the street and leaving her by her self a lot is a good thing because usually I'd be like, ok mom, you alright, and she'd be like yeah, I'm ok, but now I look at it though, I hear her saying my eye sight is failing me a little bit more, so I have to stay closer to home. So I think that it just gave me compassion, to be understanding that everything can't be, even though I'm grown, sometimes you gotta slow down being grown and take care of your own, and other people who need you. So, that's one thing.

Interviewer: Ok. Is there any other things that were helpful, important or enjoyable during your sessions with Scott, or anything else that really stands out? Anything else that he said throughout the process that you'd like to comment on?

Interviewee: Anything else he said. He said like, just about me changing he said just go forward. He told me to just go forward. Don't worry about what you did in the past or how your past used to be. Just look at the person you are now and keep that in mind. Just live for the day.

Interviewer: And that really meant something to you?

Interviewee: Yeah it meant something to me.

Interviewer: Ok. Was there anything that wasn't so enjoyable, important or helpful that you'd like to bring to our attention?

Interviewee: No. Nothing. Nothing. Everything was good.

Interviewer: That's great. Alright, well thank you so much for coming in. We're all set. At this point I know Scott wanted to meet with you yet so I'll go grab him.

Interviewee: Ok.

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