THE EFFECTS OF PERCEIVED COERCION AND EMPOWERMENT ON MOTIVATIONAL PROCESSES FOR ADULTS ORDERED TO ATTEND SUBSTANCE ABUSE TREATMENT: A MIXED METHODS ANALYSIS

by

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ABSTRACT

Substance abuse treatment agencies increasingly work with clients who are mandated to treatment by the criminal justice system. This trend has necessitated a better understanding of the impact of clients' subjective perceptions of coercion on motivation for treatment and recovery. The present study utilized a mixed methods approach to understand the impact of both perceived coercion and empowerment on motivational processes for adults ordered by the criminal justice system to attend substance abuse treatment. Data were collected from 98 adults ordered to undergo assessment and treatment for substance abuse problems as the result of a drug-related offense. It was hypothesized that perceived coercion and empowerment would be negatively correlated. While these variables were negatively correlated, they value of the correlation was not significant. It was also hypothesized that perceived coercion and empowerment would predict motivational processes, including motivational readiness-to-change levels and whether or not motivation was internalized. Multiple and logistic regression analyses indicated that, as hypothesized, perceived coercion was a significant predictor of these processes: Higher perceived coercion predicted lower motivation levels and *noninternalized* motivation. Contrary to this hypothesis, however, empowerment was not a significant predictor of motivational processes. A grounded theory analysis of 11 participant interviews (from the original sample of 98 participants) resulted in the emergence of 6 themes that further developed the relationship among perceived coercion,

empowerment, and motivation. The grounded theory model provided good validation of the statistical findings, suggesting that when participants spoke of feeling coerced into treatment, they spoke of a negative impact on motivation. However, the majority of interviewees, regardless of their feelings about the court order, had high expectations for treatment and anticipated addressing mental health issues and other "tools" of treatment. In further support of the statistical findings, interview participants also had a difficult time describing empowerment as impacting motivation. Instead, many participants suggested that as they worked toward recovery, which reflected a foundation of motivation, they often felt more empowered as a result.

Dedicated to Nancy and Marty Merrill, Dylan Esson, and the memory of
Bob and Mary Walker.

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INTRODUCTION

Understanding motivational processes among clients in treatment for substance abuse has proved elusive for researchers and clinicians alike. As a growing proportion of those in treatment for drug and alcohol problems arrive at treatment through mandates from the criminal justice system, motivation for changing substance abuse and/or dependence problems is an especially salient issue. California's 2000 Substance Abuse and Crime Prevention Act, which mandates nonviolent drug offenders into substance abuse treatment as an alternative to incarceration, has provided a model for many other states in the last decade. Some estimates indicate that nearly half of those in substance abuse treatment at any given time are there as a result of a legal mandate or court order (Marlowe, Glass, & Merikle, 2001). Consequently, increasing demands are put on treatment agencies to work with a client population that is often resistant to treatment.

Motivation for change is consistently shown to be one of the most important predictors of substance abuse treatment outcome, including length of stay, engagement in treatment, and relapse and/or rearrest rates (DiClemente, Schlundt, & Gemmell, 2004). It is commonly assumed that those who are objectively coerced into treatment (for example, upon a court order or as a condition of probation or parole) are less likely to be motivated to engage in treatment and to desire abstinence. However, research on perceptions of coercion somewhat disrupts this assumption, as many clients who experience objective

coercion for treatment do not necessarily perceive themselves to be subjectively coerced. Although the literature on perceived coercion is growing with respect to predicting treatment outcome and relapse rates from levels of subjective coercion, there is little research detailing how perceived coercion and motivation are related. Does perceived coercion predict motivation, and if so, how?

Another predictor of substance abuse treatment outcome appears to be psychological empowerment, and substantive research findings that support empowerment as critical to the recovery process are beginning to make an addition to research on substance abuse. Whereas perceived coercion implies a lack of control or choice over one's life, particularly with respect to treatment, empowerment indicates a sense of personal control, self-determination, dignity, and power sharing. Among mental health outpatients, empowerment is correlated with hope, a sense of recovery, and quality of life (Rogers, Ralph, & Salzer, 2010). Given the emphasis in the literature on perceived coercion and its impact on motivational processes and treatment outcome, it is surprising that empowerment has not been considered within this same body of research as another factor that might impact motivation and therefore outcome. Additionally, little is known about the ways in which empowerment and perceived coercion relate to one another.

This dissertation proposed a mixed method approach to such questions as a way to begin understanding how all three constructs related to one another in a substance-using population involved with the criminal justice system. Research questions included the following: 1) What is the statistical relationship between empowerment and perceived coercion? How much variance do they share? 2) Do empowerment and/or perceived coercion predict a client's motivation, including stage of change and extent of

internalization, as they begin mandated substance abuse treatment?; and, lastly, 3) How do clients make sense of being ordered by the criminal justice system to attend treatment? How does this status impact the way they think about motivation? Do they feel empowered in their lives in general, and how might this relate to understandings of their substance abuse and motivation to change behavior related to use?

Although the motivation and substance abuse literature has looked at motivational processes for alcohol, nicotine, and drug users, the difficulties with assessing motivation and readiness to change with the latter group are well documented in the literature (DiClemente, Schlundt, & Gemmell, 2004), and many researchers call for particular attention to this population. This study, therefore, focused on exploring the relationship among motivation, perceived coercion, and empowerment among individuals who were involved in the criminal justice system due to drug-related offenses and who had recently used illegal substances.

Literature Review

The following review of the literature considers, first, the large body of research on motivation within the substance abuse field. It attempts to provide a detailed understanding of motivation from the Transtheoretical Model of Change (Prochaska & DiClemente, 1982), including how this model defines motivation, provides a theoretical basis to explain motivational processes, captures motivation from an assessment perspective, and uses the concept of motivation for research and clinical purposes, including process and outcome work. Given some of the limitations of understanding motivation from the Transtheoretical Model of Change, this literature review will also consider a supplemental understanding of motivation using Self-Determination Theory,

including the ways in which this theory has prompted new understandings of motivation among a substance abusing population.

The applicability of motivational processes to individuals involved in the criminal justice system will then be considered, given the salience of this issue on a national level. Research on coerced treatment, including subjective and objective understandings of coercion, is central to this discussion. As a corollary to the literature on coercion, or lack of control and choice regarding treatment, literature on empowerment as an alternative model for understanding substance abuse treatment issues will also be explored. Throughout, the vagaries surrounding the relationship among motivation, perceived coercion, and empowerment among a substance abusing population will be apparent.

Motivation

The concept of motivation has guided a vast body of research within the field of psychology, particularly substance abuse. Although the literature reflects many different understandings of this construct, motivation is best understood as a dimension of change. In a 2004 review of nearly 20 years of research on motivation, especially within the substance abuse field, DiClemente, Schlundt, and Gemmel defined motivation as the "personal considerations, commitments, reasons, and intentions that move individuals to perform certain behaviors" (pp. 103-104). Motivation, then, directs the process of intentional behavior change.

Indeed, in the early 1980s researchers began understanding motivation in terms of change, readiness to change, and/or stages of change. Prochaska and DiClemente's Transtheoretical Model of Change (TTM; 1982) developed out of this understanding and

has been the dominant theory of motivation and change within the addiction field. It is to this model the review will now turn.

Motivation as Conceptualized by the Transtheoretical Model of Change

The Transtheoretical Model of Change (TTM) offers a conceptual framework for understanding how individuals modify cognitions and behavior over time. The TTM asserts that motivation is a central construct driving intentional behavior change. Although motivation as a construct has been defined and operationalized according to several different psychological and behavioral theories, the TTM has inspired an extensive and continually expanding body of research that understands motivation as a central component of movement away from problematic behaviors, in general, and toward recovery from substance abuse, in particular. This review will first consider the stages of change (SOC) model and related research. It will then consider a more general concept of motivation under the TTM, motivational readiness to change, which underlies the stages of change.

DiClemente and Prochaska (1983; 1984) initially proposed the TTM as a result of research on smokers' processes of change regarding smoking cessation without therapeutic intervention. This research imposed categorical groupings on individuals based on their responses to questions about their smoking behavior, including both use and cessation. Participants' responses formed five categories or groups that led to the identification of stages within the progression of change, from low or no readiness to change to full readiness to change (DiClemente, 2003). These stages are discussed below and shown in Table 1 with their associated tasks and goals.

Table 1

Stages of Change (SOC) and Associated Tasks and Goals

Precontemplation: Stage in which there is little or no current interest in considering change.	**Task**: Increase in concern about the current behavior and increase in awareness about the need to change. **Goa**l: A serious consideration of change in problem behavior.
Contemplation: Stage in which there is a risk-reward analysis as the individual considers the behavior and the possibility of change.	**Task**: Analysis of pros and cons of behavior and benefits/costs of change. **Goal**: Decision to change based on a careful evaluation.
Preparation: Stage in which commitment to change is made and a strategy and plan to change is made.	**Task**: Increase commitment to change and develop a change plan. **Goal**: A plan of action to be implemented in the next stage.
Action: Stage in which the plan is implemented and steps are taken to change the problem behavior.	**Task**: Strategies for change are implemented and plan is revised as needed. **Goal**: Successful action toward change; a new pattern of behavior is established (3-6 months).
Maintenance: Stage in which the new behavior is sustained at length and becomes normative.	**Task**: Change is sustained over time and situation.; slips and relapses to the old behavior are avoided; new behavior is integrated into lifestyle. **Goa**l: Long-term change of problem behavior and establishment of new behavior.

Note. The table above was adapted and modified from *Addiction and Change: How Addictions Develop and Addicted People Recover* (p. 27), by C. C. DiClemente, 2003, New York: Guilford. Copyright 2003 by Guilford Press.

In the *Precontemplation* stage, the individual often lacks awareness that a problem behavior exists. There is typically no intent or motivation to change behavior in this stage. Upon becoming aware that one's behavior may be problematic, individuals generally exhibit ambivalence about the problem behavior and thus enter the *Contemplation* stage. This stage is characterized by an evaluation of the pros and cons of changing behavior but a lack of commitment to change. Once an individual decides to commit to change, according to the TTM they have entered the *Preparation* stage. They demonstrate a firm commitment to change in this stage and begin to gather information and make plans related to behavior change. *Action* is the next stage, and here individuals

implement the plan made in *Preparation* and begin taking steps toward changing their behaviors. Tasks associated with this stage include reevaluating and revising plans as needed and maintaining the commitment to change despite obstacles. After 3-6 months of Action, the individual may be considered to have moved into the *Maintenanc*e stage, where the new behavior is not only sustained for an extended period of time but becomes part of the individual's lifestyle.

The motivational tasks and goals of the above stages are enacted through 10 processes-of-change (POC) that occur throughout the entire process of behavior change. These POC are divided into two categories, including behavioral processes and cognitive/experiential processes (see Table 2; DiClemente, 2003). Behavioral processes include observable behaviors and styles of interactions that characterize greater responsibility, a stronger sense of how to utilize support networks, and understanding connections between behaviors and positive and negative reinforcement. Cognitive/experiential processes are more insight-oriented, and include an increased awareness of risks of current behavior, emotional responses to behavior and considerations of change, and an understanding of social alternatives that help initiate and sustain change.

Applicability of the TTM to Addiction Research

Because the stages and processes of change are conceptually appealing to researchers and clinicians who study human behavior, the TTM has been used widely to study change as it relates to a range of topics, including domestic violence (Alexander &

Table 2

Processes of Change (POC): Cognitive/Experiential and Behavioral

Cognitive/Experiential Processes	
Consciousness raising:	Increased awareness of risks of current behavior and benefits of new behavior.
Emotional arousal:	Emotional reactions are experienced about the current behavior and the possibility of new behavior.
Self-reevaluation:	Seeing current and new behavior from a new perspective, including how both relate to values and sense of self
Environmental reevaluation:	Seeing how current and new behaviors affect those around one, and how others affect one's own behavior.
Social liberation:	Awareness and use of social alternatives/resources that that support change.
Behavioral Processes	
Self-liberation:	Making choices and commitments; taking responsibility.
Stimulus generalization and control:	Avoiding and changing response to cues that trigger/support old behavior; creating cues that support new behavior.
Conditioning and Counter-conditioning:	Developing new connections between cues and behavior; developing new behaviors and activities as a response to old cues.
Reinforcement managing:	Identifying and utilizing positive and negative reinforces; creating system of rewards.
Helping relationships:	Searching out and accepting support from others that reinforces new behavior.

Note. The table above was adapted and modified from *Addiction and Change: How Addictions Develop and Addicted People Recover* (p. 34), by C. C. DiClemente, 2003, New York: Guilford. Copyright 2003 by Guilford Press.

Morris, 2009; Levesque, Driskell, Prochaska, & Prochaska, 2008), exercise (Berry, Naylor, & Wharf-Higgins, 2005; Garner & Page, 2005; Wadsworth & Hallam, 2007), HIV-risk behaviors (Harlow et al., 1999), and weight control (Buchanan & Coulson, 2007; Jackson, Asimakopoulou, & Scammell, 2007), among others.

The addictions literature, however, appears to have made the most use of the TTM, particularly since the TTM developed out of research on nicotine addiction and smoking cessation. Major research areas of addiction that have incorporated the TTM include nicotine addiction, but also both alcohol and drug abuse and dependence, with the most recent literature looking at polysubstance abuse and dependence. Most significantly, research on substance abuse that utilizes a TTM approach is often interested in the

predictive validity of the stages of change in terms of treatment engagement, treatment completion, rates of relapse, and subsequent arrest or rearrest for drug and/or alcohol violations. This review will now briefly discuss the research supporting the concept of TTM in these areas.

In 1988, Marlatt, Baier, Joh, Donovan, and Kivlahan recognized the stages of change as discrete developmental stages in the modification of addiction. This call to understand motivational changes in addictive behavior through the lens of the stages of change was set amid a strong research body beginning in the early 1980s that examined change behaviors related to smoking cessation. Prochaska and DiClemente began this process with attempts to identify psychological and behavioral change and to measure and use these change principles in both a clinical and research setting (DiClemente & Prochaska, 1982; 1983; 1984; 1986; DiClemente, Prochaska, & Gibertini, 1985; Velicer, DiClemente, & Prochaska, 1985; Velicer, Prochaska, Rossi, et al., 1995). This body of literature was instrumental in creating categories that were consistent with the types of behavioral and cognitive processes identified in and noted by research participants. These categories were assigned stage names based on their progress toward making significant changes related to smoking behavior. Early measurement methods were developed concurrently with this early research, including several questions assessing behaviors related to change toward smoking cessation and change in general (DiClemente, Prochaska, Fairhurst, et al., 1991). Such methods predated the development of more formal change measures, three of which will be discussed later.

From this early research, however, it was evident that movement through the stages of change was not linear (Carbonari, DiClemente, & Sewell, 1999; Velicer,

Prochaska, Rossi, et al., 1995). While some smokers moved consistently through the stages, from precontemplation to action, most moved back and forth from stages in a more cyclical pattern. This pattern of "recycling" through the stages, however, should not reduce the significance of identifying stages in the process of recovery: "Knowing both where an individual currently is in terms of stage tasks and how often…he has recycled through the stages is important clinically and for our understanding of the process of change. Current stage status represents a changeable state rather than a static trait" (DiClemente, Schlundt, & Gemmell, 2004, p. 108).

In 1990, DiClemente and Hughes attempted to discern stages-of-change profiles among individuals in an outpatient alcohol treatment center, using the same principles of change as those identified with nicotine users. These principles of change were then extended to those in treatment for drug abuse and dependence as well. However, compared with those seeking smoking cessation help, a clear understanding of motivational processes for individuals in substance abuse treatment centers has tended to be more complicated. This complication arises out of the fact that individuals with alcohol and/or drug problems who are in treatment tend to minimize the extent to which their use is problematic, appear more ambivalent about change, and sometimes overestimate their motivation or commitment to make changes (DiClemente, Schlundt, & Gemmell, 2004). Nonetheless, a wide body of literature has supported the use of the motivational concept of stages of change for those with both alcohol and/or drug abuse or dependence (Carbonari & DiClemente, 2000; Connors, DiClemente, Dermen, et al., 2000; DiClemente & Hughes, 1990; Isenhart, 1997; Miller & Tonigan, 1996; Willoughby & Edens, 1996).

Given some of the theoretical and measurement problems posed by research on the utility of SOC, discussed further below, researchers have conceptualized motivation, or readiness to change, as a continuum rather than a series of discrete stages. Motivational readiness to change, rooted in the TTM, is a more generic concept than stages of change and "indicates willingness or openness to engage in a particular process or to adopt a particular behavior" (DiClemente, Schlundt, & Gemmell, 2004, p. 104). More akin to preparedness, motivational readiness to change as a concept is based on accomplishing the tasks relevant to the stages of change discussed above. In a study on treatment matching among patients undergoing treatment for alcoholism, the continuous readiness-to-change score was one of the strongest predictors of frequency and intensity of drinking outcomes (DiClemente, Carroll, Miller, Connors, & Donovan, 2003.

Research on motivation and change among individuals with alcohol and drug problems has tended to focus around 1) developing assessment tools that are more sensitive to ambivalence throughout the change process, and 2) using such tools to validate the concept of the stage model and/or readiness to change among different types of substance users. This review will now discuss several of these tools, including the URICA, the SOCRATES, and the Readiness to Change Questionnaire, before turning to a discussion of the research that uses these tools to assess motivation among alcohol and drug dependent populations.

Measuring Motivation Using the TTM

Of the three major assessment tools that measure motivation from the perspective of the TTM, the University of Rhode Island Change Assessment Scale (URICA) has been the most widely used and is supported by the largest body of research. The URICA is a

32-item scale that assesses for stage of change position based on tasks relevant to the TTM (McConnaughy, Prochaska, & Velicer, 1983). Although ideally reflecting the five stages of change discussed above, psychometric analyses of the URICA have consistently shown only four change profiles: precontemplation, contemplation, action, and maintenance. The instrument is worded generically such that an individual may respond to any problematic behavior that is the focus of change, and responses are used to identify the individual's stage of change. However, DiClemente and Hughes (1992) adapted the instrument to be used specifically with individuals identified as having drug and/or alcohol problems. The majority of research using the URICA has focused on this population. The URICA has shown moderate to excellent internal reliability (McConnaughy et al., 1983; Napper, Wood, Jaffe, Fisher, Reynolds, & Klahn, 2008) and good test-retest reliability (Abellanas & McLellan, 1993). However, the predictive validity of the URICA, or ability to use the URICA to place individuals in a stage that is consistent with actual behavior related to drug or alcohol use, has not been demonstrated across settings and populations (Blanchard, Morgenstern, Morgan, Labouvie, & Bux, 2003; Henderson, Saules, & Galen, 2004; Pantalon & Swanson, 2003).

To address some of the problematic validity and measurement issues associated with using discrete stages of change, Carbonari, DiClemente, and Zweben (1994) derived a scoring procedure using the URICA in order to create a single score that measures motivational readiness to change based on the URICA subscales. This scoring procedure was used in analysis of data from Project MATCH, a federally funded, 8-year, multisite study sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) that investigated the significance of matching treatment types to clients based on various

client characteristics. Analysis showed that motivational readiness scores were predictive of drinking outcomes at the 1- and 3-year follow-up among outpatients. The continuous readiness-to-change score was one of the strongest predictors of frequency and intensity of drinking outcomes (DiClemente, Carroll, Miller, Connors, & Donovan, 2003) and predicted working alliance and patient process of change as well (Carbonari, DiClemente, & Zweben, 1994).

In an attempt to create an SOC assessment tool with items specific to drug and/or alcohol use, Miller and Tonigan (1996) developed the Stages of Change, Readiness, and Treatment Eagerness Scale (SOCRATES). Like the URICA, however, factor analysis has not shown consistency with the five SOC profiles. Instead, the factor structure for the SOCRATES has mostly supported a three-factor model including Recognition, Taking Steps, and Ambivalence. Action items correspond to the Taking Steps scale, precontemplation and preparation to the Recognition scale, and contemplation to the Ambivalence scale. Two studies utilizing the SOCRATES have shown a two-factor model (Figlie, Dunn, & Laranjeira, 2005; Maisto, Conigliaro, McNeil, Kraemer, O'Connor, & Kelley, 1999). Evidence for predictive and construct validity is, like the URICA, mixed (Carey, Purnine, Maesto, & Carey, 1999) and internal reliability has shown to be poor-to-moderate (Napper et al., 2008).

The Readiness to Change Questionnaire (RCQ) was also developed to assess for stage status specific to alcohol and drug use (Addington, el-Guebaly, Duchak, & Hodgins, 1999). It shows good internal reliability for three subscales: precontemplation, contemplation, and action. However, these profiles are not strongly supported among those seeking treatment (Gavin, Sobell, & Sobell, 1998).

A recent investigation into assessment tools relevant to the TTM compared the psychometric properties of the URICA, SOCRATES, and RCQ (Napper et al., 2008). Examining the responses of 605 out-of-treatment drug users accessing an HIV-prevention program, the researchers used multitrait-multimethod analysis to examine the validity and reliability of the drug-use versions of the three measures. Of the three measures, the URICA demonstrated the strongest internal reliability and showed strong convergent validity with the RCQ. The SOCRATES, in contrast, demonstrated weak convergent validity with the URICA and the RCQ, suggesting it might be assessing different but related constructs. Construct validity of all scales was relatively poor, however, although the URICA showed some consistency with behavior in that those in the action stage injected drugs at a significantly less rate than those in contemplation. Overall, however, the authors concluded they could not make specific recommendations about which measure is best. Additionally, they concluded that on the basis of their findings, "Practitioners should use caution when they employ stage-of-change questionnaires to assign clients to treatments" (p. 370).

Utility of SOC Profiles and Readiness-to-Change Scores

Addictions research that utilizes a SOC-based approach has demonstrated some utility in matching clients' motivational levels with treatment types. Prochaska and DiClemente (1996) proposed that using processes of change as therapeutic interventions that are congruent with a client's stage of change may reduce both resistance in the client and frustration in the therapist. In a study of 388 smokers, Perz, DiClemente, and Carbonari (1996) found that interventions based on processes of change relevant to the contemplation or preparation stage of change helped individuals move forward through

the stage model. A meta-analysis of six across-behavior studies showed that tailored, stage-based intervention led to more significant progression through the stages of change than did nontailored, nonstage-based intervention (Ashworth, 1997).

SOC research has also been important in validating the presence of motivational profiles among differing primary substance using groups. For example, administration of the URICA to polysubstance-using veterans (with primary drug identified as alcohol, cocaine, or opiate) supported the basic four-factor structure, including Precontemplation, Contemplation, Action, and Maintenance (Carney & Kivlahan, 1995). The four profile clusters showed no significant differences based on primary addiction (drug or alcohol), previous substance use, or prior drug/alcohol treatment.

Another study, however, supported only three distinct motivational profiles. Using the URICA to identify motivational types among crack cocaine users, Siegal, Li, Rapp, and Saha assessed stage of change status with a group of 235 crack cocaine users in treatment (2001). Three subgroups representing differing levels of readiness to change were identified. These groups were Preparation (scored above average on Precontemplation but below average on the other three scales), Participation (above average on Contemplation and Action but below average on Maintenance), and Maintenance (high scores on Maintenance).

SOC-based research has also shown motivation to be an important factor in predicting both length of stay in treatment and relapse rates. Using Project MATCH data, Carbonari and DiClemente found that high Maintenance scores predicted abstinence by the end of treatment (2000). They also found that an increase on the Action scale score from pre- to post-treatment was a predictor of positive outcome.

Examining the predictive validity of the URICA specifically, and an SOC model in general, Henderson, Saules, and Galen (2004) assessed motivation at the beginning of a 29-week treatment program among heroin-addicted, polysubstance-using participants. Using scores from the URICA, multivariate regression analysis indicated that motivational score at pretreatment contributed significant variance to the prediction of heroin- and cocaine-negative urine samples throughout treatment. Scores also approached significance toward predicting a longer stay in treatment, particularly for those who began in Maintenance. Another study using the URICA, however, showed that motivational type and level at pretreatment was not predictive of 6-month posttreatment Addiction Severity Index scores in a study with crack cocaine users (Siegal, Li, Rapp, & Saha, 2001).

Although not explicitly a study designed to predict outcome from motivational subtype, Ball, Carroll, Canning-Ball, and Rounsaville (2006) utilized a motivational perspective in their examination of the reasons related to dropout from substance abuse treatment. In this NIDA-supported study, the researchers used interview and self-assessment data from 24 clients who had prematurely terminated outpatient treatment. The sample represented individuals with both drug and/or alcohol problems who had been referred for treatment by either the criminal justice system or by self. Participants overwhelmingly cited motivational problems as reasons for dropout, and low readiness-to-change (as assessed by the URICA) scores supported this. In addition, motivational problems were the most frequently noted on the Reasons for Leaving Treatment Questionnaire, with 46% endorsing “I had no good reason to stop using alcohol or

drugs," 54% endorsing "I did not feel motivated enough to keep coming," and 54% endorsing "I lost hope in my ability to change right now."

Although several studies have therefore highlighted the importance of using motivation as a predictor of outcome, few studies have actually looked at predictors of motivation. One recent effort, by Slesnick et al. (2009), highlights the importance of gaining a more complex picture of motivation from a predictive perspective, as a substantial body of literature shows that a "higher level of motivation for changing substance use is associated with greater substance abuse treatment success" (p. 675). In their examination of predictors of motivation for changing substance use behavior, the researchers looked at 140 adolescents who had run away from home and identified as drug users. Data analysis found that an increase in depressive symptoms among adolescents, mediated in part by parent distress and conflict within the family environment, predicted greater motivation to change drug use. More research into the predictors of motivation needs to be done; the current study attempted to do that.

Despite the predictive utility shown by some of the above research, significant challenges to the validity of the TTM have arisen in the last decade (Callaghan & Taylor, 2006; Callaghan, Taylor, & Cunningham, 2007). Many of these challenges, however, are related to the methodological difficulties noted above with respect to measures of motivation. As no single assessment tool has shown both consistency across populations and strong construct and predictive validity, it makes sense that the underlying model of SOC has been challenged as the dominant paradigm for understanding motivation and change. Yet, this model still makes conceptual sense to researchers and clinicians alike,

and the wealth of literature supporting the underlying mechanism of motivational stage profiles continues to be attractive.

Looking at other models of motivation in conjunction with the TTM's stage model allows us to address some of the limitations of the model while utilizing many of its strengths. In an as-yet unpublished dissertation from 2009, Keith-Dunlap argued for a broader understanding and more clinically relevant framework of motivation as it relates to substance abuse; she provided a compelling call for the merging of the motivational models offered by both the TTM's stage model and the process of internalization described by Self-Determination Theory. It is to the motivational model offered by Self-Determination Theory that this review will now turn.

Motivation from a Self-Determination Theory Perspective

Self-determination theory (SDT; Deci & Ryan, 1985) provides another paradigm through which to view motivation, one that has a growing body of supportive literature. It is an attractive motivational model for a substance abusing population because it considers the "functional significance," or context, in which individuals operate as they navigate issues related to their substance abuse and/or dependency.

SDT accounts for a spectrum of externalized and internalized reasons that underlie motivation. For example, in the case of an individual court ordered to attend substance abuse treatment, there would clearly be external pressures that lead to an individual's motivation to enter and participate in treatment. At the same time, there may also be internal pressures as well, including finally feeling "fed up" with the consequences related to use. Self-determination theory offers an attractive model for understanding how external and internal motivation guide behaviors.

A subtheory comprising SDT, Organismic Integration Theory (OIT), utilizes an "integrative" approach to describe the continuous process by which one is able to integrate one's experiences into a unified sense of self (Deci & Ryan, 1985). Integration results from the process of internalization, or the process by which an individual internalizes values, attitudes, and behaviors. The more one has internalized values and beliefs into one's psychological framework, including values and beliefs that are congruent with the environment in which one lives, the more one can be said to have reached this integration. The individual is able, through internalization, to achieve the core needs of autonomy, competence, and relatedness. These needs, according to Deci and Ryan, drive human change, or motivate motivation. Internalization is the product, then, of the drive to internalize values, attitudes, and behaviors that move one to achieve autonomy, competence, and relatedness.

The continuum of internalization proposed by Deci and Ryan (1985) identifies four regulatory styles that are consistent with the type of motivationally-based behavior (psychological and physical) a person exhibits. Each style reflects the extent to which the attitude, value, or behavior in question is internalized.

Reflecting the least degree of internalization, attitudes and behaviors that fall under *external* regulation are controlled by external sources. Material rewards or some extent of punishment guide such attitudes and/or behaviors. An *introjected* regulatory style represents a style of attitudes and behaviors, reinforced by internal processes such as guilt, shame, or anxiety, that are internal representations of external sources (parents, children, partner, probation officer). On the contrary, *identified* regulation reflects more internalized motivation and encompasses those attitudes or behaviors that are more

congruent with a person's values, goals, and sense of self. *Integrated* regulation represents the most sophisticated degree of internalization of a behavior that had previously been primarily under external regulation. Attitudes and behaviors regulated by this style are not merely congruent with core values but are consistent with schemas of the self.

Like addiction research that utilizes the TTM as a paradigm for understanding motivation, a growing body of research has begun to explore the utility of using an SDT-based motivational approach to understand the complexities of behavior related to substance abuse.

Examining the relationship between internalized motivation at treatment entry and dropout rates, Ryan, Plant, and O'Malley (1995) looked at 98 clients participating in outpatient alcohol abuse treatment. More internalized motivation (i.e., identified and integrated regulation types) was negatively correlated with dropping out of treatment and positively related to attendance and treatment persistence. An interaction effect between internal and external motivation was noted, as those with high internal and external motivation were more likely to remain in treatment. External motivation positively predicted treatment, but only if internal motivation was also present.

In a study that underscored this relationship between internalized motivation and treatment outcome, Zeldman, Ryan, and Friscella (2004) examined the connection between internalized motivation and treatment outcomes for clients in a methadone maintenance treatment program. External motivators such as court orders predicted less adherence to and engagement in the program as well as an increased likelihood of being absent from treatment. Conversely, more internalized motivation predicted higher

retention in the program and lower relapse rates. Interestingly, those with both high internal *and* external motivation showed the best outcome with regard to treatment completion and relapse rates.

In an unpublished dissertation, Kennedy (2005) examined the relationship between stages of change as proposed by the TTM and extent of internalized motivation as understood by self-determination theory. Using data from the Drug Abuse Treatment Outcome Study (DATOS) collected between 1991 and 1993, Kennedy used logistic regression analysis and found a significant relationship at intake between internalized motivation, or "source" of motivation, and stage of change. Those with higher degrees of internalized motivation tended to be in the action stage, according to the SOC model. Further data analysis at 12-month follow-up, however, showed no relationship between degree of internalized motivation and treatment completion or relapse.

Another unpublished dissertation (Keith-Dunlap, 2009) examined the relationship between stages of change as proposed by the TTM and the spectrum toward internalization as proposed by SDT. Looking at 237 adults in a court-ordered substance abuse treatment program, the author found that a significant relationship existed between stage position and degree of internalization relating to abstinence from drugs and/or alcohol. In other words, movement through the stages of change was associated with a greater internalization (from external and introjected regulatory style to identified regulatory style) of the values, attitudes, and behaviors associated with abstinence.

Measuring Motivation from an Internalization Perspective

Several scales exist to measure the motivational components of SDT. The 5-item Treatment Self-Regulation Questionnaire (TSRQ) assesses for autonomous motivation

(Ryan & Connell, 1989) and has been used with school-aged children and for individuals in a smoking cessation program (Williams et al., 2002). The Treatment Motivation Questionnaire (TMQ; Ryan, Plant, & O'Malley, 1995) contains two motivational factors, one representing internal motivation and the other external motivation. In a study by the authors of 100 participants in outpatient treatment for alcohol abuse, solid internal consistency representing each factor was found.

The Treatment Entry Questionnaire (TEQ), as distinguished by the above instruments, shows the most promise for a population engaging in substance abuse treatment, and it also distinguishes among stages of internalization. Wild, Cunningham, and Ryan (2006) developed this measure with three internalization subscales, including external regulation, introjected regulation, and identified regulation. Among a sample of 300 individuals in substance abuse treatment, the measure showed strong internal consistency values and promising convergent and divergent validity. This measure will be discussed further in the next chapter.

Motivation as operationalized by both the TTM's stages of change/readiness to change framework and SDT's concept of internalization allows for a more nuanced understanding of the process by which individuals work toward developing greater commitment to change. Although the TTM is founded on the concept that motivation for change is indeed engaged in by the client, it does not necessarily establish *how* motivation facilitates processes of change and movement through the stages of change. SDT, however, provides a theoretical basis for how it is that individuals internalize substance-abuse recovery and/or change-related values, attitudes, and behaviors, thereby moving through the stages of change and engaging in relevant processes related to that

change. An understanding of both frameworks of motivation appears necessary in order to capture the dynamic and complex process of motivationally based change.

Motivation and Coerced Substance Abuse Treatment

One of the largest growing bodies of research on motivational processes in substance abuse relates to the unique and complex issue of court-mandated or legally coerced treatment for drug abuse. Much of this research has developed out of two major studies highlighting the potential impact of coerced or mandated treatment on treatment process and outcome. The Drug Abuse Treatment Outcome Studies (DATOS) represented a body of multisite studies of treatment effectiveness, identifying and comparing clients with criminal justice referrals in both residential and outpatient programs to those not involved in the criminal justice system. Analysis found that 57% of clients in outpatient programs and 64% in residential programs were involved with the criminal justice system, and 42% of the outpatient clients and 33% of the residential clients were in treatment as a result of a referral by a criminal justice program or agency (Craddock, Rounds-Bryant, & Flynn, 1997). The implications of treatment effectiveness became more important following California's passage of Proposition 36, the Substance Abuse and Crime Prevention Act (SACPA), in 2000. Under SACPA, first- or second-time nonviolent drug offenders are required to participate in licensed substance abuse treatment and aftercare as an alternative to incarceration, with state funds allocated to pay for treatment endeavors (http://www.adp.ca.gov/SACPA/prop36.shtml). In addition to California, over 23 states have passed or are trying to pass similar legislation, and nearly all states have established community drug courts, sentencing reform, and/or TASC (Treatment Alternatives for Safer Communities) offender management (Rinaldo, 2005).

With overwhelming numbers of individuals participating in substance abuse treatment mandated by the criminal justice system (by judges or probation/parole officers), the motivational processes related to engaging in treatment and achieving abstinence from drugs are especially relevant. It is often assumed that those who are legally coerced into treatment (as an alternative to incarceration) are either 1) lacking in motivation to stop using drugs or to participate in treatment, or 2) participating in treatment against their will. In fact, research has suggested that legal pressures or coercion are often not related to clients' perception of agency around treatment and/or achieving abstinence. DATOS data suggest that 40% of individuals with criminal justice referrals to treatment believe they "would have entered drug treatment without pressure from the criminal justice system" (Farabee, Prendergast, & Anglin, 1998). Wild, Newton-Taylor, and Alletto (1998) found that 35% of individuals in substance abuse treatment from an external referral source (primarily legal) did not report feeling coerced into treatment.

The subjective perception of treatment coercion has thus begun to be distinguished from objective indicators of coercion, such as legal referral, etc. A growing body of research uses the concept of perceived coercion as a way to discriminate between subjective and objective coerced statuses. Perceived coercion, then, refers to the extent to which clients subjectively perceive themselves to be entering treatment against their will (Prendergast, Greenwell, Farabee, & Hser, 2008), and several measures have been developed to assess for levels of perceived coercion (Gardner, Hoge, Bennett, et al., 1993). As the concept of perceived coercion has assumed increasing significance in the literature related to substance abuse, largely as a result of the DATOS studies and

SACPA, it has begun to play a role within literature on motivation of clients with legal mandates to participate in substance abuse treatment. To date, this literature has been mixed, suggesting the relationship between perceived coercion and motivation and the predictive utility of perceived coercion with regard to treatment outcome and relapse remains vague.

One major effort to understand motivation and perceived coercion among clients ordered to treatment comes from Prendergast, Greenwell, Farabee, and Hser's (2008) study of 7,416 substance abusing offenders who were tracked through treatment by a NIDA-funded study assessing the impact of California's Substance Abuse and Crime Prevention Act (SACPA; 2000) on treatment effectiveness. Prendergast et al. hypothesized that perceived coercion and motivation were separate constructs and that both would predict treatment completion and subsequent rearrest on drug-related offenses.

The authors operationalized motivation by using scores from the SOCRATES assessment tool, which was given to clients at the beginning of treatment and indicated levels of ambivalence, recognition, and taking steps. They assessed levels of perceived coercion from scores on the MacArthur Perceived Coercion Scale. Bivariate correlation values between perceived coercion and motivation indicated that perceived coercion and motivation were separate constructs; however, those with higher levels of perceived coercion did, as expected, show lower levels of motivation. Contrary to the hypothesis, logistic regression showed that neither motivation nor perceived coercion were significant predictors of treatment retention or completion. Higher recognition scores at treatment entry, however, were predictive of fewer rearrests for drug-related offenses

during treatment and after. Some problems with this research are evident, however, and acknowledged by the authors. One major weakness relates to the use of SOCRATES to measure motivation for a court-ordered population. Because one of the three motivational subscales of the SOCRATES is 'Taking Steps,' and because most court-ordered clients are undergoing frequent drug screening as part of their probational status, they may score high on this subscale not necessarily as reflection of motivation to change but rather out of adherence to terms of probation, where using means violating these terms and violation might mean going to prison instead of treatment.

Contrary to the findings indicated above, Brocato and Wagner (2008) found that motivation predicted treatment retention in an alternative-to-prison substance abuse treatment program. Looking at predictors of retention among 141 felony offenders (primarily cocaine users, but some heroin and marijuana users) mandated to a community-based, long-term residential treatment center with a minimum stay of 90 days, the researchers used the SOCRATES at both intake and after 90 days to measure motivation. Higher scores at intake around problem recognition, or the 'Recognition' subscale of the SOCRATES, were positively predictive of length of stay in treatment and treatment completion. Overall motivation scores at intake were also positively related to therapeutic alliance. Although alliance itself was not predictive of treatment retention, positive changes in motivation after 90 days were related to alliance. Interestingly, outcome data suggested that the presence of a comorbid Axis I diagnosis (in addition to a substance abuse or dependence diagnosis) was the most compelling predictor of treatment dropout.

Perceived coercion implies that clients experience an absence of control, particularly regarding their decision to enter treatment. No literature to date, however, looks at perceptions of the presence of control and choice around such processes, let alone how feelings of control and choice might impact motivation and therefore treatment outcome in a population ordered by the criminal justice system to participate in substance abuse treatment. Empowerment as a psychological construct entails feelings of competence, power, choice, and ability to make decisions in one's life, including decisions about treatment. While the literature on perceived coercion has grown in the last decade, including within the substance abuse field, there has been no effort in this literature to look at empowerment as a corollary to perceived coercion, particularly how empowerment might interact with perceived coercion and motivation for treatment.

Empowerment

The body of literature on empowerment as it relates to mental health is vast. There are as many different definitions of empowerment as there are mental health interventions based around ideas of empowerment. To add to the vagaries of the term, empowerment is often used to describe characteristics and attributes at a macro level, institutional and program level, and personal level. This review will focus on discussions of empowerment relevant to the personal level, or psychological level, incorporating ideas relevant to empowerment on a sociopolitical level where applicable to personal empowerment.

Regarding empowerment among individuals involved in community mental health, Zimmerman (1995) proposed three components through which psychological empowerment operates. The intrapersonal component relates to perceived competence,

control, and self-efficacy (Zimmerman & Zahniser, 1991). The interactional component refers to one's ability to understand and relate to the social environment, particularly in a way that leads to a critical understanding and knowledge of the resources and methods required to produce social change (Zimmerman, 1995). Lastly, the behavioral component includes empowering behaviors that allow one to meet one's needs at a personal level or on a community level.

In an attempt to clarify the concept of empowerment as it applies to a mental health population, Clark and Krupa (2002) reviewed relevant literature and identified five components of empowerment, including personal control, action, power sharing, dignity, and equity. Clark and Krupa utilize a power theory framework in discussing empowerment, one derived from Foucault's theory of social power and further expanded on by Labonte (1996). The five components of empowerment noted above thus work amid a complex nexus of power relations, where an individual's "power-to" (personal power equated with self-efficacy, sense of mastery, and internal locus of control) might be said to represent empowerment, as opposed to perpetuating or being the object of "power-over" (explicit or implicit dominance over and exploitation of others; resistance may or may not be a component).

Feminist multicultural analyses of empowerment further develop the concept of empowerment as a construct deeply embedded in the power structures that comprise daily life. Although discussions of empowerment in general are typically congruent with a feminist lens, a more explicit feminist analysis of empowerment furthers our understanding of the importance of empowerment on a sociopolitical level, especially as this relates to a sense of personal or psychological empowerment. Barriers at the

institutional and cultural level (for example, laws, norms, sanctions, and prejudices that privilege certain groups over others) perpetuate social injustice and affect individuals in a profoundly disempowering way. According to Morrow and Hawxhurst (1998), "When the social/political level is unacknowledged, an individual is likely to blame her/himself for life circumstances" (p. 45). Therefore, achieving personal or psychological empowerment may be much more difficult, especially for those lacking power and/or privileged identities, without an understanding of larger societal issues that preclude social equity and justice. Social/political empowerment, then, "requires group support, action, and movement in order to ultimately move beyond or through the barriers imposed by the existing social/political structures and functions" (Morrow & Hawxhurst, p. 45). As part of Morrow and Hawxhurst's empowerment framework, three conditions make up the dimension of sociopolitical empowerment, or power in society: permission (for example, "Do I grant myself permission to analyze or identify societal messages about racism?"), enablement (for example, "Am I able to identify the resources in my community that will help keep me safe?"), and information ("What do I need to know about getting information about services for survivors?").

Based on a meta-review of descriptive literature and empirical studies on empowerment, Dickerson (1998) identified three attributes of psychological or personal empowerment that include the dimension of social/political empowerment noted above. The first, sense of personal competence, indicates a person shows positive self-esteem, endorses an internal locus of control, and is accepting of his or her psychiatric challenges (which reflects the opposite of self-stigma around mental health diagnoses). Personal competence, overall, reflects literature on empowerment suggesting that self-esteem and

a sense of control are at the center of empowerment. The second major component of empowerment, based on Dickerson's review, is self-determination, operationalized by actively making personal life decisions, making choices about treatment, and having influence over the planning and organization of services they receive. The final component, social engagement, reflects identification with and support of others, particularly of peers in treatment. It also reflects an awareness of stigma and injustice, leading to a developing sense of "righteous anger" that may lead to participation in social activism on a large scale, or, at the very least, participation in advocacy issues around mental health treatment. Dickerson's discussion of empowerment is important for this study as it provides the theoretical basis on which Rogers, Ralph, and Salzer developed the Empowerment Scale (1999; 2010), the measure of empowerment that was utilized during data collection in the current study. This review will now consider measurements of empowerment, with a focus on the Empowerment Scale.

Measuring Empowerment

A few assessment tools exist that operationalize empowerment based on many of the above concepts. These include the Personal Progress Scale, the Psychological Empowerment Scale, and the Empowerment Scale, all discussed below.

Worell and Chandler (1998) developed the Personal Progress Scale (PPS) to assess for outcome of empowerment-based interventions. The PPS is based on the four domains of Worell's Empowerment Model (1992; 2003), which includes exploring the intersections between women's personal and social identities, addressing issues around gender stereotyping, acknowledging unequal status between men and women, and addressing the need for women's perspectives to be valued. The PPS is designed

specifically to measure empowerment in women and to assess for outcome related to the 10 major goals of feminist therapy. Although the PPS emphasizes empowerment on a personal and social/political level, because it has only been used with women (and is designed specifically for women) and because it is intended as an outcome measure, it will not be utilized for this study.

The Psychological Empowerment Scale, designed by Spreitzer in 1995, measures psychological empowerment based on four dimensions of empowerment (see Thomas & Velthouse, 1990). The four dimensions are (1) *meaning* – congruence between what one has to do (one's role) and one's beliefs, values, and behaviors, (2) *competence* – goal-specific self-efficacy, (3) *self-determination* – the extent to which one feels one has options and choices in initiating action, and (4) *impact* – the degree to which one can influence outcome. Although the above constructs reflect an important component of personal empowerment, they do not expand this concept to a social/political level. Spreitzer also initially designed this measure to be used in a workplace setting, and although the measure has been adapted for other settings, the psychometric properties of the instrument are based on research from use of the measure in the workplace.

In response to the vagaries of the usage of empowerment in the mental health literature, and to the lack of appropriate assessment tools relevant to a population of individuals seeking mental health treatment, Rogers, Ralph and Salzer (1999; 2010) developed and validated the Empowerment Scale. This represented an effort to "operationalize and measure personal empowerment" (p. 933), particularly utilizing the major components of empowerment noted by Dickerson and discussed above. Noting that empowerment is an essential component in recovery from mental health problems,

Rogers, Ralph and Salzer constructed the scale for consumers of mental health services, who have often experienced lack of choice and powerlessness navigating such services.

Using a population of mental health clients with a DSM-IV axis I or II diagnosis that would be considered to constitute serious mental illness, confirmatory factor analysis of the Empowerment Scale yielded five factors, or subscales, of the measure. All five subscales reflect an integration of many of the above discussions of empowerment, including personal/psychological and sociopolitical empowerment. These subscales include self-esteem, power and powerlessness, community activism and autonomy, optimism and control over the future, and righteous anger. As the authors expected, the Empowerment Scale was moderately correlated with hope, a sense of recovery, quality of life, and personal empowerment as measured by the Segal measure of personal empowerment. It was correlated less strongly but still significantly with social acceptance and inclusion.

The authors of the scale concluded the Empowerment Scale should be "considered for use in studies and evaluations in which empowerment is viewed as a mediating or outcome variable" (p. 936). Although the scale has not been validated with a substance abusing population, the principles on which it is based appear to fit well with an adult population court ordered to attend substance abuse treatment, a population that indeed experiences a high level of perceived coercion regarding treatment. The Empowerment Scale, discussed further in the next chapter, was used to measure empowerment in this study.

Empowerment and Substance Abuse

The body of literature examining empowerment and substance abuse has increased in the last several years. An overall theme from this literature suggests that empowerment, although often poorly defined and/or operationalized, may be an effective predictor of important processes and outcomes related to substance abuse treatment. As noted above, none of this literature looks at empowerment as it relates to motivation or to objective or subjective coercion for treatment.

Lafave, Desportes, and McBride (2009) employed a mixed-method analysis to examine treatment outcomes and benefits of a women's substance abuse treatment program that aimed to empower clients. At the time of publication, "A Woman's Place" (AWP) was a day treatment program for women with substance abuse and dependence. Primarily utilizing a strengths-based approach that emphasized self-growth, acceptance, and control over one's life, AWP incorporated therapeutic strategies from Feminist Therapy, Solution-Focused Therapy, and Motivational Enhancement Therapy. In conducting this research on outcome, the authors adhered to a Feminist Therapy and strengths-based perspective by assessing clients' perceptions of growth from treatment. Consequently, they did not make explicit use of pre- and postmeasures of drug use. Instead, for the quantitative component of the study, data analysis looked at change scores on the Progress Evaluation Scale (PES), which assesses respondents' perceptions of strengths and current functioning in many areas of life, including recovery from substances. Results from 50 participants' profiles indicated that perception of recovery showed the most significant change from pre- to posttest. Qualitative analysis, based on data from six interviews with clients in treatment about their experiences at AWP,

revealed several themes indicative of growth in empowerment (including realization of choice with respect to use, increased ability to accept responsibility for behavior, increased valuing of self) and, most significant to understandings of empowerment and substance use, a resolution or diminishment of ambivalence about use and achievement of abstinence, which four of six participants stated they had achieved over the course of treatment. While not addressing motivation explicitly, the results indicate that empowerment was an important factor in reducing ambivalence about use.

Toussaint, VanDeMark, Bornemann, and Graeber (2007) examined the efficacy of a treatment model, which was also developed using empowerment theory, for women with histories of substance abuse. Although initially designed for female trauma survivors with severe mental disorders, the Trauma Recovery and Empowerment Model (TREM) is a manualized group intervention that a mental health agency in Colorado implemented for use with a women's substance abuse treatment program. As an intervention, the TREM addresses issues around enhancing survivor empowerment, including strengthening peer support and interpersonal boundaries, building self-esteem, and exploring issues around gender identity and sexuality. Toussaint et al. evaluated outcome data from this agency with respect to the efficacy of TREM as a substance abuse intervention. Looking at change in ASI scores, the researchers found that participants in the treatment group utilizing TREM did not show significant differences in terms of change in alcohol or drug abuse compared with a treatment-as-usual control group. However, both groups did show a reduction in alcohol and drug use, thus indicating improvement, and the TREM group showed a greater improvement than the control

group with respect to mental health functioning, including self-esteem, and trauma-related symptoms.

Resnick and Rosenheck (2008) showed a relationship between empowerment and recovery in their study of veterans engaged in a peer-run mental health program affiliated with the New England VA mental health program. Veterans participating in this program showed an increase in general empowerment (as captured by the Making Decisions Scale) over a control group receiving treatment as usual. As this cohort of veterans was tracked through a follow-up program, they showed a decrease in alcohol use patterns that also distinguished them from the control group follow-up participants. Although methodological shortcomings prohibited Resnick and Rosenheck from making stronger claims about their findings, their research showed an important connection between empowerment and recovery behavior.

Several studies examining the relationships between empowerment and substance abuse recovery have looked specifically at women with trauma histories, including histories of sexual assault and intimate partner violence. The remainder of the literature reviewed here utilized data from the Women, Co-occurring Disorders, and Violence Study (WCDVS; McHugo et al., 2005), a federally funded, multisite study attempting to develop trauma-specific interventions for this population and to evaluate the effectiveness of such interventions. Despite variability among sites, at a minimum interventions included trauma-specific counseling, resource coordination around trauma, and integration of trauma work with other services provided, specifically general mental health and substance abuse counseling. Although not explicitly stated, this type of intervention incorporated empowerment theory as it posited that enhancing individual

and interpersonal empowerment during treatment would lead to better outcome in terms of overall mental health and substance abuse.

Using WCDVS data, three studies evaluated outcome of trauma interventions on substance abuse, among other indicators of mental health, at the 6-month mark and the 12-month mark. Morrissey, Jackson, et al. (2005) examined program- and person-specific variables and found that after 6 months of treatment, participants in treatment sites that used stronger integration of trauma-based counseling showed a significant decrease in drug use compared with control sites. Additionally, participants showed dramatic drops in alcohol use, but significance in effect size was related to baseline use levels. Looking exclusively at program effects from the WCDVS data, Cocozza (2005) again found that, for programs implementing higher levels of integrative trauma treatment, client participants' alcohol and drug use severity decreased significantly more than those in control groups. Morrissey, Ellis, et al. (2005) employed meta-analysis to capture site-to-site variability in outcome and hierarchical linear modeling to predict outcome using person-level variables such as demographics, trauma history, substance abuse history, and mental health. With respect to substance use, women with more severe trauma symptoms at baseline showed a significant decrease in drug and alcohol use severity after 6 months. By 12 months, however, treatment effects had leveled off, but overall substance use did not revert to baseline.

VanDeMark (2007) also utilized data from the WCDVS and employed a mixed-method approach to gain a clearer understanding of predictors of relapse and recovery among 350 women with histories of substance abuse. This study analyzed three variables as predictors of relapse and recovery: instrumental support, affective support, and

participation in ‘typical’ (work, parenting, student, and citizen) roles. Although VanDeMark did not explicitly tie affective and instrumental support to empowerment, the questions reflective of these variables were very congruent with models of empowerment. Such questions asked about recent physical abuse; recent discrimination based on race/ethnicity, gender, sexual orientation, or religion; participation in peer support or self-help services; feelings of safety in one’s community; and, finally, food and housing security. Logistic regression indicated that affective and instrumental support were strong predictors of drug abuse relapse. As affective and instrumental support decreased, women were twice as likely to report relapse. Enriching such understandings of relapse and recovery predictors, inductive qualitative analysis of two open-ended questions (What helped in your healing and recovery? And what hurt your healing and recovery?) identified several themes that were again consistent with models of empowerment. Assertiveness and self-confidence were touted by participants as integral to recovery. Interestingly, participants also identified readiness to make needed changes as important to recovery. Finally, women who reported being coerced by courts into treatment indicated mixed feelings about such coercion, with some participants stating coercion was not necessarily indicative of feeling a loss of control in one’s life and it often helped them focus on treatment and priorities related to recovery. Finally, VanDeMark discussed and analyzed the role of shaming during treatment, identified as punitive measures such as withholding financial resources, separating women from their children, and using shaming language to understand substance abuse and dependence. They concluded that although the quantitative data did not support a direct relationship between punitive measures and relapse, at the very least, “punitive policies are not

effective in decreasing the propensity to relapse" (p. 387). Additionally, qualitative findings indicated that women cited these punitive policies as major barriers to recovery. Although the author did not provide an explicit framework of empowerment for their findings, it is clear that participants in this study who experienced higher levels of empowerment both in and out of treatment more adeptly moved through recovery and were less likely to relapse.

Given the above literature, empowerment appears to be a factor that is important in facilitating treatment adherence and recovery, particularly when it is integrated into substance abuse interventions. It is unclear, however, how empowerment impacts motivation for change, as defined and discussed above. It is also unclear from the literature how empowerment and perceived coercion are related to one another as constructs that impact motivation for individuals ordered to substance abuse treatment by the criminal justice system. This study addressed many of these vagaries by using statistical analysis to explore the relationship between perceived coercion and empowerment and to understand if perceived coercion and empowerment predicted motivation at pretreatment. This study also acknowledged some of the methodological shortcomings of measurements of motivation and self-reports, and, in an attempt to gain a deeper and more nuanced understanding of these issues, utilized a qualitative approach to understand the complexity of the relationship among perceive coercion, empowerment, and motivation. The following chapter further describes the research questions and proposed hypotheses. It also provides a methodological overview of the mixed methods design and analysis that the project implemented.

CHAPTER 2

METHOD

This study utilized a mixed methods approach in order to understand the effects of perceived coercion and empowerment on motivation for adults who were ordered by the criminal justice system to attend substance abuse treatment. I asked three primary research questions in order to work toward such an understanding. Research questions 1 and 2 were addressed through quantitative data collection and analysis, and question 3 through qualitative data collection and analysis. Research questions and hypotheses were the following:

1) What is the relation between perceived coercion and empowerment? How strongly are they related?

Hypothesis: Perceived coercion and empowerment will have a modest but significant negative correlation.

2) At pretreatment, do perceived coercion and empowerment predict motivation in general and internalized motivation, in particular?

Hypothesis: At pretreatment, both perceived coercion and empowerment will predict general motivation level as well as internalized motivation. Specifically, higher levels of perceived coercion will predict lower levels of motivation and *noninternalized* motivation. Higher levels of

empowerment will predict higher motivation level and more internalized motivation.

3) How do individuals with legal mandates for substance abuse treatment make sense of being legally coerced into treatment? How does this impact one's sense of motivation to change drug use behavior? How is empowerment generally understood to operate in one's life, and how does this impact, first, one's understandings of being mandated into treatment, and second, motivation to change drug use behavior?

Hypothesis: Individuals will express complex and nuanced understandings of the relationships between perceived coercion, empowerment, and motivation. Qualitative data will generally corroborate the hypotheses associated with research questions 1 and 2, and will deepen our understanding of the relationships among all variables.

Mixed Methods Rationale

In order to address the above questions, a mixed methods approach was selected to make use of methodological triangulation, or the "use of both qualitative and quantitative methods and data to study the same phenomena within the same study or in different complementary studies" (Tashakkori & Teddlie, 1998, p. 18). As Hanson, Creswell, Clark, Petska and Creswell (2005) stated, using both forms of data allows researchers to "simultaneously generalize results from a sample to a population and to gain a deeper understanding of the phenomenon of interest" (p. 224).

This chapter begins by describing the paradigmatic underpinnings of the study. I will then discuss research design, recruitment and participant information, data

collection, data analysis, data integration, the role of the researcher, and ethical considerations. Throughout, I will make an effort to identify issues when they are specifically pertinent to quantitative data and analysis, to qualitative data and analysis, and to an integration of both types of data and analysis.

Paradigm

As it is typical in qualitative research to identify the philosophical paradigm on which the study is based, including the research questions, data collection, and analysis, scholars of methodology have discussed and debated the applicability of paradigms to a mixed methods research design (Reichardt & Rallis, 1994). Hanson et al. (2005) called for an honoring of a multitude of paradigms, even those that appear contradictory (for example, positivist and constructivist) in mixed methods research, as "such oppositions reflect different ways of making knowledge claims, and we advocate for honoring and respecting the different paradigmatic perspectives that researchers bring to bear on a study" (p. 226).

Consistent with this call for an integration of applicable paradigms and an acknowledgement of various methods of generating knowledge, this study primarily utilized a pragmatist perspective, as set forth by Tashakkori and Teddlie (1998; 2003). It also utilized elements of both a constructivist and a feminist perspective.

Pragmatism

As a philosophical worldview, pragmatism understands that the process of collecting knowledge is multifaceted and dependent upon several other philosophical paradigms, including positivism, postpositivism, constructivism, and even critical or

emancipatory paradigms. Pragmatism, as an approach to knowledge generation, emphasizes the practical considerations of "whatever works" in allowing further insight into a phenomena of interest. It values diverse approaches to gaining knowledge and thus values both objective and subjective ways of knowing (Hanson et al., 2006). Tashakkori and Teddlie (2003) have emphasized that pragmatism is the best paradigm for mixed methods research, as, at its core, it prioritizes the research question above methodological and theoretical issues. Pragmatism, additionally, values both deductive and inductive logic, understands that the values of the researcher and the society at large play a role in the interpretation of results, and asserts that an external reality does indeed exist, with the caveat that we may never be able to cleanly identify relationships, particularly causal, among social phenomena. Both the quantitative and qualitative components of this study, and especially their integration, were congruent with such tenets of a pragmatist philosophy.

Constructivism and Feminism

This study also subscribed to a constructivist and feminist worldview, particularly by the qualitative component. Qualitative methodology has the potential to capture, understand, and explain the experiences of participants in a manner that acknowledges the meanings they make of their experiences are "multiple and diverse, and that the social world is complex and contingent" (Morrow & Smith, 2000, p. 201). The qualitative component of this study made use of this potential by subscribing to a constructivist research paradigm. Such a paradigm underscores the existence of more than one reality or "truth," the unique and multiple meanings that people make of their experiences, and the constructed nature of reality that is contingent upon social and cultural context. For

this study, the implications of working through a constructivist lens were such that the participants and I, through interviews, worked to uncover participants' constructed meanings about their experiences around motivation for substance abuse treatment as a result of involvement with the criminal justice system. Instead of encouraging participants to reveal the "truth" of what it meant to be ordered to substance abuse treatment, the data-gathering process worked to capture and understand the meaning participants made of this experience within the context of their daily lives. While honoring the uniqueness and multiplicity of participant meaning, the data analysis process identified common themes and categories of such meaning that captured the essence of participants' narratives (Wertz, 2005). Also consistent with a worldview that emphasizes context, this study simultaneously utilized a feminist paradigm in its attempt to understand the experiences of individuals ordered to treatment. Such a paradigm reflects the importance of empowerment in the daily lives of all people. By attempting to understand the relationship between empowerment, perceived coercion, and motivation, the quantitative component of this study situated the role of empowerment as a potential critical factor for motivation in the face of perceived coercion. The qualitative component, in encouraging participants to talk about their experiences of empowerment during the interviews, was also consistent with a feminist paradigm in that it allowed a space for individuals to verbalize understandings of empowerment, to identify areas of their lives where empowerment was operative, and to work with me to uncover the relationship between empowerment, mandated treatment, and motivation for change regarding substance abuse. The implications of the study, based on analysis of both quantitative and qualitative data, elaborate further on the role empowerment plays in the

recovery process and provide suggestions for incorporating empowerment-based interventions into treatment programs.

Research Design

This study utilized a concurrent triangulation research design, identified by Creswell, Clark, Gutmann, and Hanson (2003) as one of the six major mixed methods designs. Such a design prioritizes both qualitative and quantitative data collection and analysis, as opposed to a concurrent nested design, which gives priority to one form of data over the other. In a concurrent triangulation design, both types of data are collected concurrently. However, analyses of both types of data are typically conducted separately. Integration of the data, therefore, occurs at the data interpretation stage, which involves identifying and discussing the ways in which the data triangulate, or converge, to confirm, cross-validate, and/or corroborate study findings. For this study, however, I made a slight variation to this design. As I conducted interviews, I began looking at quantitative data (including scores for empowerment, perceived coercion, and motivation) for that interviewee in order to gain a deeper understanding of the ways in which the interview data were challenging, confirming, or enriching the information gathered by the measures. This will be discussed further in data analysis.

The quantitative component of the study design was a cross-sectional correlational field study. The correlational field study is designed to look at relationships between and among variables as they occur naturally. Although frequently used in counseling psychology research, correlational studies do not manipulate variables and so do not provide strong interpretations about causality (Gelso & Fretz, 2001). However,

statistical analysis can assist in such interpretations about causal inference, described below in data analysis.

The qualitative component of the study design was conducted according to the methods of grounded theory, as set forth by Glaser and Strauss (1967) and Strauss and Corbin (1998), and further developed by Charmaz (2006). The purpose of utilizing a grounded theory approach in this study was to create a theory that is "grounded" in the data, or lived experiences, of the participants (Fassinger, 2005). To this end, the research process was congruent with the grounded theory approach, from the conceptualization of the study to the final levels of analyses to the checks used to monitor the research process.

Glaser and Straus (1967) developed the tenets of grounded theory methods as a way to develop theory from data collected about the phenomenon of interest. The process of conducting research according to grounded theory is a highly inductive one, with theory development occurring while data collection and analysis are simultaneously underway. Other defining characteristics of grounded theory practice, which were used in this study, include constructing analytic codes and categories from data; using the constant comparative method, a method of analysis in which concepts in the data are compared with one another; analytic memo-writing to elaborate the properties of and relationships between categories; and the development of a conceptual model that relates emergent themes to one another and generates a core "story" of participant experiences.

Institutional Review Board Approval

Prior to data collection, the University of Utah Institutional Review Board granted approval for this study on August 24, 2011. The Utah State Department of Human

Services Institutional Review Board granted approval on September 11, 2011. This second approval required an in-person presentation and discussion of the study to board members in August 2011.

Participants and Recruitment

Participants were recruited over a 9-month period, from October 2011 to June 2012. All participants for this study were recruited from Assessment & Referral Services (ARS), a clinic within the Department of Psychiatry at the University of Utah in Salt Lake City that provides substance abuse assessments and treatment referrals primarily for individuals involved in the criminal justice system as the result of a drug-related charge. Consequent to a court order or upon condition of probation or parole, the majority of ARS clients are required to undergo a substance abuse evaluation at ARS and to comply with a treatment referral. Treatment referrals are typically made to treatment agencies within Salt Lake County, and many clients, due to financial limitations, are referred for treatment through county funding sources.

Participants were recruited from ARS during the clinic's twice weekly screening sessions, in which clients referred to ARS meet briefly with a staff member to ensure they are eligible for the services provided by ARS. If eligible, an assessment is scheduled for approximately 3 weeks from the date of the screening, depending on client volume.

While clients were waiting for their screening and to schedule their assessment appointment, I passed out fliers about my study (see Appendix A) and provided information to those who were interested in participating. I emphasized, as the flier indicated, that 1) the study was independent of ARS, although the director of ARS was a member of my research committee, 2) all information would be kept confidential and

anonymous, and 3) participating in the study would have no implication whatsoever on an individual's criminal justice status or for an individual's assessment or treatment referral, and neither criminal justice personnel nor clinical staff at ARS would know of an individual's participation in the study unless that individual disclosed such participation. Prospective participants were also informed of an incentive to participate, as indicated on the flier, which consisted of being entered into a drawing to win one of four $50 gift cards to Smith's Marketplace, a large downtown store in Salt Lake City that sells groceries, clothing, electronics, and home goods.

If a client was interested in participating, I reviewed with them the questions on the flier to see if they met the qualifications. Qualifications included the following: a drug-related offense resulting in involvement in the criminal justice system, an order to participate in substance abuse treatment based on this offense, current or recent drug use (within the last three months), and the identification of a drug (as opposed to alcohol) as the most problematic substance. No action was taken to further verify that participants were eligible other than their self-report.

For individuals meeting qualifications and showing interest in the study, I reviewed consent forms (see Appendix B) and answered any questions they had about the study. They were then asked to sign consent forms. Upon doing so, they were given a packet of surveys and escorted to another group room or provided a space in the room where I was seated. They then filled out the surveys, which took approximately 30 minutes to complete.

Following completion of the surveys, participants were asked of their interest in participating in a 60-minute interview with me about their experiences related to being in

the criminal justice system and being required to undergo treatment for substance abuse. Because at any given time approximately half of the clientele at ARS indicates no permanent residence, and therefore has contact information that is frequently changing, I asked if it was possible to conduct the interview that afternoon in the same location. All participants who agreed to provide an interview were able to participate in the interview the same day. The interviews were held in a private group room within the ARS office suite.

For the quantitative component of the study, the number of participants recruited was based on a preliminary power analysis. This analysis, for a regression model, indicated that with 6 predictor variables (perceived coercion, empowerment, age, sex/gender, # of prior treatment episodes, recent substance use; discussed below under analysis) with power of .90 and a medium effect size of .25, 100 participants were necessary. One hundred one participants completed surveys and 98 were counted in the final analysis.

For the qualitative component of the study, participants were recruited and data collected until the data analysis, which was concurrent with recruitment, began to yield saturation of themes and categories based on the tenets of grounded theory. Saturation is typically reached and data collection usually ceased when "the categories [are] dense and complex enough to capture all of the variations in participants' experiences and when the relationships among categories have been delineated satisfactorily" (Fassinger, 2005, p. 160). This study initially proposed to interview 12-15 participants in order to reach saturation. Of the 101 participants who filled out surveys, 12 agreed to participate in interviews. However, full interview data were collected for only 11 as the 12th

interviewee was unable to complete the interview. Because saturation appeared to be reached at that point, no further attempts to recruit participants were made.

Prior to data collection, demographics for typical ARS clients in the spring of 2011 indicated the following: 98% of clients were involved in the criminal justice system; 50% indicated no permanent residence; 70% were male; 60% had a high school education, with a majority of the remaining 40% reporting an education level below a high school level; the average age was approximately 40; and, lastly, 70% were White (non-Hispanic), 13% Hispanic, 4% American Indian or Alaskan Native, 3% Black/African American, and about 3% Multiracial or Unknown/Other (K. Lundberg, personal communication, April 4, 2011).

For the final sample, participant demographics were roughly similar to the above. The final sample consisted of 63 male and 34 female adults, with one adult identifying their sex as 'other.' The average age of participants was 33.40 years (*SD* = 9.206) and the age range was 18-60. The majority of participants identified as White/Caucasian. Religious affiliation and sexual orientation were optional: 69% of participants provided no response for religious affiliation and 4% provided no response for sexual orientation. Table 3 provides demographic information with regard to race/ethnicity, religious affiliation, and sexual orientation.

Highest education level was collected beginning only halfway through the study as it was thought this might be a variable of interest in the final analysis. Forty-eight

Table 3

Participant Demographics: Race/Ethnicity, Religious Affiliation, and Sexual Orientation

Variable	Categories	Frequency	% of Sample
Race/Ethnicity	White/Caucasian	62	63.3
	Hispanic/Latino	10	10.2
	Pacific Islander	6	6.1
	African American	5	5.1
	American Indian	5	5.1
	Bi/Multiracial	5	5.1
	Other	5	5.1
	Asian	1	1.0
Religious Affiliation (optional)	Latter-Day Saint	18	18.4
	Christian	8	8.1
	Baptist	1	1.1
	Catholic	1	1.1
	Islamic/Muslim	1	1.1
Sexual Orientation (optional)	Heterosexual	86	87.8
	Bisexual	3	3.1
	Other	3	3.1
	Prefer not to say	2	2.0

participants provided education information as follows: 15 did not complete high school (15.3%), 13 had a high school degree (13.3%), 13 had completed some college (13.1%), 5 had a GED (5.1%), 1 had an associate's degree (1%), and 1 had a bachelor's degree (1%).

With regard to substance use and arrest/treatment history, descriptive statistics indicated that 38% of participants identified amphetamines as their most problematic drug. Figure 1 provides information about which drugs participants identified as most problematic. Recent use, or the average number of times used within the last 3 months, was 20.63 (*SD* = 12.624) and the range was 1-31 (31 = 'more than 30 times'). The majority of respondents had participated in one or more treatment programs for substance

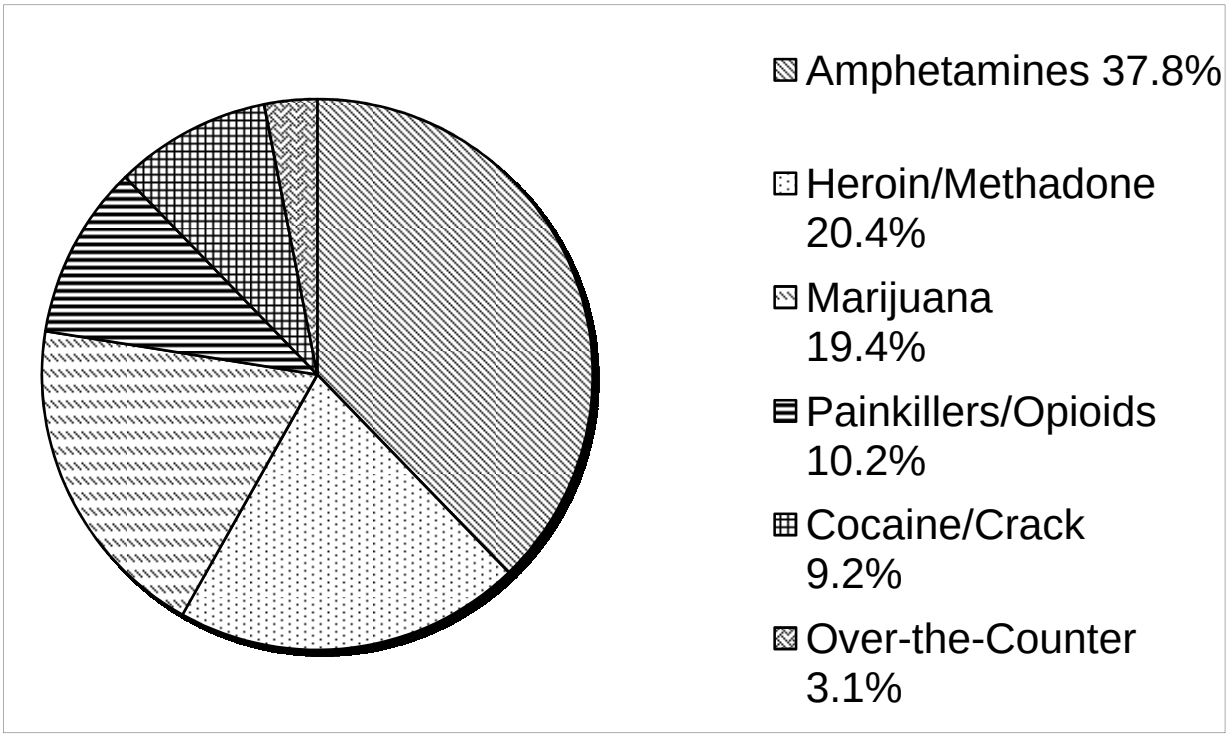

Figure 1. 'Most Problematic Drug' as a Percentage of the Sample

abuse (either partially or fully completed). The average number of treatment programs was 1.84 (*SD* = 2.009) and the range was 0-10. The average number of drug-related arrests was 4.64 (*SD* = 7.052) and the range was 1-50. Of the above 98 participants, 12 agreed to take part in an interview following survey completion and 11 completed the interview. One hour was scheduled for each interview, and the 11 interviews ranged between 45 and 65 minutes. Age and drug-use information along with pseudonyms for interview participants is provided in Table 4. Demographics for this group are as follows: 5 identified as male and 6 as female, 8 identified their racial/ethnic group as Caucasian, 1 as African American, 1 as Hispanic, and 1 as Other. Eight did not identify a religious affiliation, 2 identified as LDS, and 1 as Christian. All 11 identified as heterosexual. The average age of participants who elected to interview was 38.09 (*SD* = 9.502), the average number of times used in the last 3 months was 26.54 (*SD* = 9.266),

Table 4

Demographic Information for Interviewed Participants

Pseudonym	**Age**	**Sex**	**Most problematic drug**	**# times used in last 3 months**	**# of previous treatment episodes**
"Utah"	52	M	Marijuana	30 or more	3
"Eugene"	38	M	Heroin	30 or more	0
"Terran"	46	F	Marijuana	30 or more	0
"Sam"	32	F	Methamphetamine	6	2
"Century"	26	F	Methamphetamine	30 or more	0
"Jenna"	22	F	Methamphetamine	30 or more	0
"Earl"	49	M	Cocaine/Crack	30 or more	2
"Casi"	38	F	Methamphetamine	10	8
"Philip"	36	M	OxyContin	30 or more	5
"Bob"	50	M	Cocaine/Crack	5	1
"Stacie"	34	F	Heroin/Methadone	30 or more	6

the average number of treatment programs completed was 2.82 (*SD* = 2.822), and the average number of arrests was 3.82 (*SD* = 4.143). With regard to most problematic drug, 4 participants identified amphetamines, 3 identified heroin, 2 marijuana, 1 cocaine or crack, and 1 prescription medications/opioids. Six participants provided data about their highest education level: 3 had a high school degree, 2 had completed some college, and 1 had an associate's degree.

Sources of Data and Data Collection

Quantitative Data

Data for quantitative analysis were collected in the form of self-report surveys administered to participants on the day they were recruited to join the study. The following section describes the measures that were used, including their psychometric properties. Where applicable, Cronbach's alpha coefficients are provided for this sample. Descriptive statistics for the response patterns of this sample will be provided in the Results chapter.

Demographics Questionnaire

This brief questionnaire was developed for this study and asked participants several basic demographic questions, including age, gender, sexual orientation, race/ethnicity, and religious affiliation (see Appendix C). It also asked for additional drug-related information, including how many previous substance abuse treatment programs the participant had been in (completed or not) and how many times the participant had been arrested for a drug-related offense. Halfway through data collection, a question was added asking for highest education level. Although education level was

not included in the final analysis as a predictor variable, this information was thought to be of interest and so was queried at that time.

Drug Use Index

This 13–item self-report questionnaire was used to assess drug and alcohol use among participants (see Appendix D). It was modified from the National Youth Survey (Elliott, Huizinga, & Menard, 1989) by Burrow-Sanchez for use with adolescents (2010). The measure asks respondents to indicate how often they have used a variety of drugs on a scale ranging from never to several times a day in the previous month, in the previous year, and in their lifetime. Burrow-Sanchez updated the Drug Use Index by adding new drugs (crystal meth, ecstasy) and removing outdated terminology. For this study, the questionnaire was modified in the following way: A question was added at the beginning asking which drug the respondent has found to cause the most trouble for him/her. Recent drug use was assessed with an additional question asking how many times they used the most problematic drug within the last month, last 3 months, and lifetime.

The University of Rhode Island Change Assessment Scale (URICA)

Of the three major assessment tools that measure motivation from the perspective of the transtheoretical model of change, the URICA, developed by McConnaughy, Prochaska, and Velicer (1983), has been the most widely used and is supported by the largest body of research. Although ideally reflecting the five stages of change discussed above, psychometric analyses of the URICA have consistently shown only four change profiles: Precontemplation, Contemplation, Action, and Maintenance. The instrument is worded generically such that an individual may respond to any problematic behavior that

is the focus of change, and responses are used to identify the individual's stage of change. However, DiClemente and Hughes (1992) adapted the instrument to be used specifically with individuals identified as having drug and/or alcohol problems. The majority of research using the URICA has focused on this population.

The URICA is a 32-item self-report measure, with 28 items that specifically assess for a respondent's stage of change based on the four change profiles noted above (see Appendix E). In this study, a 28-item version of the scale was used as the four items unrelated to change processes were discarded. An example from the Precontemplation subscale is #11, "I guess I have faults, but there is nothing that I really need to change." An example from the Contemplation subscale is #17, "I wish I had more ideas on how to solve my problem." An Action subscale example is #15, "Even though I'm not always successful in changing, I am at least working on my problem." Finally, an example from the Maintenance subscale is #24, "I'm here to prevent myself from having a relapse of my problem."

All subscales are made up of 7 items, presented to the respondent as a statement. The respondent uses a 5-point scale to reflect how well the statement applies to him/her (1=Strongly Disagree; 2=Disagree; 3=Undecided; 4=Agree; 5=Strongly Agree). The URICA is scored by using the following steps, recommended by DiClemente, Schlundt, and Gemmell (2004): 1) Calculate the mean scores for each of the subscales measuring Precontemplation, Contemplation, Action, and Maintenance; 2) Sum the mean scores of only the Contemplation, Action, and Maintenance subscales; 3) Subtract from the sum generated from the second step the mean score of the Precontemplation subscale (e.g., [Avg. of C + Avg. of A + Avg. of M] – Avg. of PC) to determine the readiness-to-change

score, or continuous motivation level, with higher scores indicating greater readiness to change; and lastly, to classify into stages, 4) Compare the readiness-to-change score to the following ranges of mean values developed from the original research: Precontemplation. -2 – 10.15; Contemplation, 10.16 – 11.80; Action, 11.81 – 13.41; and Maintenance, 13.41 – 15. These mean values serve as norm-based "cut-off" scores that help identify respondents' stage of change based on their responses.

While the predictive validity and utility of the URICA as a stage-of-change measure have been called into question (Littell & Girvin, 2002; Sutton, 2000), the continuous readiness-to-change score has been shown to be a strong predictor of frequency and intensity of alcohol use. The readiness score is best used prior to treatment to predict outcome (DiClemente, Schlundt, & Gemmell, 2004). It is not as effectively used to reflect progress during treatment or as an end-of-treatment predictor of outcome; the action and maintenance subscale scores and not the readiness score should be used instead (DiClemente, Schlundt, & Gemmell, 2004). The readiness-to-change score was utilized in this study to represent motivation level., rather than a stage of change score. Blanchard, Morgenstern, Morgan, and Labouvie (2003) found that using the URICA as a continuous measure of motivation showed better concurrent validity in a population of 252 polysubstance users in treatment than did using the URICA as a stage of change measure. The continuous readiness-to-change score correlated well with both baseline characteristics, such as understanding the negative consequences of use, and change processes while in treatment, such as commitment to abstinence and intention to avoid high-risk situations. Predictive ability of the URICA, used as a continuous measure of motivation or a measure of stage of change, was poor with regard to treatment outcome,

however.

The URICA has shown moderate to excellent internal reliability, with the most recent psychometric analysis based on an indigent, out-of-treatment, drug-using population (Napper, Wood, Jaffe, et al., 2008). The following Cronbach's alphas were reported, per scale: Precontemplation, .82; Contemplation, .87; Action, .90; and Maintenance, .81. The URICA also demonstrated good test-retest reliability (Abellanas & McLellan, 1993) in a sample of opioid, cocaine, and cigarette users, with lower reliability after 3-5 days on Contemplation but higher reliability on the other three subscales. Napper et al. (2008) found the URICA to have good convergent validity with another measure of change instrument, the Readiness to Change Questionnaire (r=.761). Like other measures of change, however, the URICA has not demonstrated particularly strong construct validity, although in the recent analysis by Napper et al. (2008), URICA scores for injection drug users showed some consistency with reported behavior, particularly for the Contemplation and Action stages. In the current study, Cronbach's alpha for the overall scale was .75, demonstrating adequate reliability. With regard to individual scales, Cronbach's alpha was .79 for the Precontemplation scale, .86 for the Contemplation scale, .84 for the Action scale, and .87 for the Maintenance scale.

Treatment Entry Questionnaire (TEQ)

The TEQ is a 42-item scale, 27 of which are designed to distinguish among clients whose values, attitudes, behaviors, and beliefs reflect the constructs relevant to the construct of internalization, or spectrum of motivation from a self-determination theory perspective. These include *External* Regulation, *Introjected* Regulation, and *Identified* Regulation. Designed by Wild, Cunningham, and Ryan (2006), the 27 items reflect a

spectrum of motivation relevant to participation in substance abuse treatment. The remaining 15 items are not related to internalization. This study used a 27-item version, excluding the other 15 items.

The External Regulation subscale of the TEQ consists of 12 items that measure the extent to which one's substance abuse treatment values, attitudes, or behaviors are influenced by contingencies, or external demands. An example is #12, "I have agreed to follow a program because I want others to see that I am really trying to deal with my habit." The Introjected Regulation subscale of the TEQ is comprised of 6 items, which measure the degree to which the values, attitudes, and behaviors relevant to substance abuse treatment are influenced by internal representations of external demands or expectations by self or others that generate guilt or shame. An example is #16, "If I remain in treatment it will probably be because I'll feel like a failure if I don't." The Identified Regulation subscale, consisting of 9 items, purports to measure the extent to which one's substance abuse treatment values, attitudes, or behaviors are chosen as a result of their congruence with other values, attitudes, or behaviors that have already been adopted by the respondent. These items measure the extent to which one's treatment-related values, attitudes, or behaviors are not influenced by external demands, or the extent to which motivation is internalized. An example is #19, "I decided to enter a program because it feels important for me personally to deal with my substance abuse problem."

All TEQ items are presented as statements, with a 7-point scale representing degree of agreement with the statement (1=Strongly Disagree; 3=Neutral; 7=Strongly Agree). The respondent's score is calculated by summing the responses within each of the three

subscales and dividing the sum by the number of items within that subscale in order to obtain a mean score per subscale. The subscale with the highest mean is then identified as representing the level of internalization of the respondent.

Wild, Cunningham and Ryan (2006) used the TEQ with 300 individuals seeking substance abuse treatment. Psychometric analysis showed that the TEQ shows adequate internal consistency for the subscales (Cronbach's alpha = .89 for external regulation; .85 for introjected regulation; and .84 for identified regulation). Convergent and divergent validity for the TEQ also appears promising. Analysis of variance indicated the external and introjected regulation subscales show a relationship with the Social Pressure Index (Polcin & Weisner, 1999) and type of referral source (r=.24-.39, p <.01), while the identified regulation subscale had no relationship. Additionally, the external subscale was negatively correlated with self-reports of perceived alcohol dependency (r=-.22, p<.01) and uncorrelated with perceived drug dependence. The identified subscale, however, was positively correlated with participants' self-report of both perceived alcohol dependence (r=.22, p<.01) and perceived drug dependence (r=.25, p<.001). For the current study, Cronbach's alpha was .89 for the full scale, indicating good internal consistency. With regard to the individual subscales, Cronbach's alpha was .79 for the external regulation subscale, .89 for the introjected regulation subscale, and .94 for the identified regulation subscale.

Empowerment Scale

The Empowerment Scale (Rogers, Ralph, & Salzer, 2010) is a 28-item measure that attempts to operationalize and measure personal empowerment, particularly utilizing the major components of empowerment noted by Dickerson and discussed above. Noting

that empowerment is an essential component in recovery from mental health problems, Rogers, Ralph and Salzer constructed the scale for consumers of mental health services, who have often experienced lack of choice and powerlessness navigating such services.

Using a population of mental health clients with a DSM-IV Axis I or II diagnosis that would be considered to constitute serious mental illness, confirmatory factor analysis of the Empowerment Scale yielded five factors, or subscales, of the measure. All five subscales reflect an integration of many of the above discussions of empowerment. These subscales include self-esteem, power and powerlessness, community activism and autonomy, optimism and control over the future, and righteous anger. Internal consistency on the full scale yielded good internal consistency, with a Cronbach's alpha of .82. Factor analysis of subscales was more variable, with standardized alphas of .82 for self-esteem, .59 for power and powerlessness, .59 for community activism and autonomy, .45 for optimism and control over the future, and .64 for righteous anger. The measure showed good convergent and divergent validity. As the authors expected, the Empowerment Scale was moderately correlated with hope (r=.67 with the Herth Hope Index), a sense of recovery (r=.67 with the Recovery Assessment Scale), quality of life (r=.47 with the Lehman Quality of Life Scale), and personal empowerment as measured by the Segal measure of personal empowerment. It was correlated less strongly but still significantly with social acceptance and inclusion. Also, as hypothesized, the Empowerment Scale was negatively correlated with measures of symptomatology, including the Colorado measure of psychotic symptoms (r=-.39) and the Hopkins depression subscale (r=-.46).

Use of the Empowerment Scale with both outpatient and inpatient samples has shown a stable factor structure and good internal consistency, with alphas ranging between .73 and .85 (Strack et al., 2007; Wowra & McCarter, 1999). The authors of the scale concluded the Empowerment Scale should be "considered for use in studies and evaluations in which empowerment is viewed as a mediating or outcome variable" (p. 936). Although the scale has not been validated with a substance abusing population, the principles on which it is based appeared to fit well with an adult population court ordered to attend substance abuse treatment, a population that indeed experiences a higher level of perceived coercion regarding treatment than any other. In the current study, Cronbach's alpha for the overall scale was .68, indicating fair internal consistency. Cronbach's alpha was .87 for the Self-Esteem subscale and .77 for the Community Activism and Autonomy subscale, indicating adequate-to-good internal consistency. Cronbach's alpha was .61 for the Optimism and Control Over the Future subscale, .51 for the Righteous Anger subscale, and .39 for the Power/Powerlessness scale, all indicating fair-to-poor internal consistency.

MacArthur Perceived Coercion Scale

The MacArthur Perceived Coercion Scale is a 5-item, true/false measure that assesses whether clients believe they have influence, control, choice, freedom, and initiation over going to treatment (Gardner, Hoge, Bennett, et al., 1993). Item scores are summed for an overall score between zero (0) and five (5), with a higher score indicating a higher level of perceived coercion. Originally developed for an inpatient population, the scale was adapted to an outpatient population with good internal consistency (alpha = .85) and a stable factor structure (Rain, Steadman, & Robbins, 2003; Steadman et al.,

2001). Although the original scale asked about inpatients' perception of coercion regarding their admission to the hospital (sample item, "I had a lot of control over whether I went to the hospital"), subsequent usage of the scale has changed the wording slightly to reflect the appropriate setting, with no associated change in psychometric properties. For example, in their study of perceived coercion and treatment outcome among substance-abusing offenders, Prendergast, Greenwell, Farabee, and Hser (2008) changed the above sample item wording to read, "I have a lot of control over whether I go to treatment." This study used the wording associated with the Prendergast et al. study, substituting "treatment" for "hospital." Cronbach's alpha in the current study was .81, indicating good internal consistency.

Qualitative Data

Data for qualitative analysis were collected from semistructured interviews conducted with participants who, after filling out the above surveys, agreed to participate in interviews. Interviews were held at the ARS clinic in a group room. They were audio recorded and an informal note-taking method was utilized during the interview.

Follow-up interviews are generally utilized in grounded theory research as a way to clarify information, collect additional information, and verify theory development. However, based on the demographic information for ARS clients at the time this study was proposed, it was expected that participants would be unlikely to have a stable place of residence or contact information. Additionally, as the majority of participants were expected to be in treatment within 2-3 months of our initial interview, follow-up interviews were not scheduled.

Individual Interviews

The interviews in this study followed Charmaz's (2006) guidelines for intensive interviewing. According to these guidelines, the interviewer's questions are in-depth and encourage participants to identify, describe, and reflect on their experiences in a way that is unlike everyday conversation. Indeed, interviewing is a directed conversation (Loftland & Loftland, 1995) that attempts to capture an interpretation by the participant of her or his experience. Intensive interviewing also complements the grounded theory analytical methods that will be described below. According to Charmaz (2006), "Both grounded theory methods and intensive interviewing are open-ended yet directed, shaped yet emergent, and paced yet unrestricted" (p. 28).

For this study, interviews were semistructured in that they encouraged participants to convey their experiences, but to do so within the parameters of the questions that I asked. The interview questions fell generally into three main categories: initial open-ended questions, intermediate questions, and ending questions (Charmaz, 2006). This structure comes from Strauss and Corbin's (1998) so-called funnel approach, which begins with broad, open-ended questions, and then clarifies with more directive questions. For this study, the initial, open-ended questions were designed to get a sense of where the participant was regarding feelings of coercion and motivation. A question from this subset was also designed to introduce the concept of empowerment to the participants and encourage them to identify where they saw, or didn't see, empowerment in their lives. The intermediate questions were less open-ended, and they were designed to encourage participants to explore the relationships, if any, among empowerment, perceived coercion, and motivation. A particular theme to this subset of questions asked

what influence, if any, did perceived coercion and empowerment have on motivation to change drug use behavior. The concluding questions were designed to assess for anything else the participants wanted to add that was relevant to the study, thus encouraging them to take some control of the interview and identify previously unaddressed issues of importance.

The following questions comprised the interview guide that was used during data collection. The guide was designed to be flexible in that not every question was asked, depending on how fully participants responded, and the questions were not always asked in the order they appear here. Consistent with the paradigms described above, particularly the constructivist worldview, it was important to understand how participants made meaning of their experiences; it was also important to honor the emphasis that some participants placed on certain topics and their levels of willingness to talk about certain issues. The interview guide that was used is as follows.

Initial open-ended question(s):

1. You identified X as the drug that has been the most problematic for you. Tell me about your motivation to change your use of this drug. What is your motivation like for treatment related to your use of this drug?
2. What is it like to be mandated to treatment for drug use? Do you feel pressure from your referral source (judge and/or probation/parole officer) to get into treatment?
3. Lots of times in the field of counseling, we talk about empowerment, or the feeling that you're in control of your life, that you have power, that you have support from others, and that you feel good about yourself. Let's talk about

this general idea of empowerment and how you might or might not feel empowered. Identify areas in your life where you feel empowered and where you don't.

Intermediate question(s):

1. How does being mandated to treatment affect your motivation for treatment? Do you think motivation is related to being ordered to treatment? If so, how?
2. Have you begun to make any changes regarding your drug use? How related do you think these changes are to being mandated to treatment?
3. We talked about empowerment in your life. How do you think your levels of empowerment affect your motivation for treatment, or how ready you feel to make some changes? Do you think there's a connection between your feelings of empowerment, or lack of, and your motivation level for treatment?
4. You mentioned you've begun to make X changes regarding your drug use. How related do you think these changes are to feeling empowered, or not?
5. In general, do you think that feeling empowered or not (refer to the level of empowerment participant discussed, and/or the areas in which she or he noted feeling empowered or areas lacking in empowerment) has anything to do with your ability to start making changes related to your drug use? If so, how?
6. Is there anything that could be done to help you feel more empowered? Specifically, to help you feel more empowered so that you're more likely to make some changes to your drug use patterns?

Concluding question(s):

1. Is there anything else you think would be helpful for me to know? Is there anything you would like to add or delete?

Data Analysis

Analysis of both quantitative and qualitative data will be discussed here based on the three major research questions. Research questions 1 and 2 were answered using the Statistical Package for the Social Sciences (SPSS; Version 20.0) and research question 3 was answered using ATLAS.ti 6.0 (Muhr, 2004).

Research Question 1

A bivariate correlation was calculated and a Pearson product-moment correlation coefficient produced in order to answer the first research question, "What is the relation between perceived coercion and empowerment? How much variance do they share?" The strength and direction of the correlation between these two variables was evaluated.

Research Question 2

Multiple and logistic regression were used to answer the second research question, "Do perceived coercion and empowerment predict motivational processes at pretreatment?"

Specifically, multiple regression was used to determine the predictive nature of perceived coercion and empowerment on motivation level. Multiple regression is used to predict the amount of variance in the dependent variable that can be accounted for by multiple independent variables (Harris, 1998). Maximized correlation scores are calculated between each of the independent variables and the dependent variable in order

to determine if the independent variables explained a significant proportion of the variance in the dependent variable (Levin & Fox, 2000).

In this study, the independent variables in the regression equation were perceived coercion, empowerment, and four other predictor variables known to bear a relationship to motivation: sex, age, number of previous treatment episodes, and recent drug use (measured by number of times used in the last 3 months). The dependent variable was motivation level, represented by the readiness-to-change score from the URICA. Hierarchical multiple regression was used specifically to determine the amount of variance in motivation level that each variable or set of variables predicted, after the previous variables were controlled for. Once all sets of variables were entered (Block 1: age, sex, number of previous treatment episodes, recent use; Block 2: empowerment; Blok 3: perceived coercion), the overall model was assessed in terms of its ability to predict motivation level (Tabachnick & Fidell, 2007).

With regard to internalized motivation, because the TEQ produced scores indicating membership in categorical groups (regulation types indicating extent of internalization of motivation), logistic regression was used to determine the predictive ability of perceived coercion, empowerment, and the other four predictor variables on membership in these groups.

Logistic regression allows one to test models to predict categorical outcomes with two or more categories (Tabachnick & Fidell, 2007). It helps to estimate the likelihood of a certain event occurring; for the present study, it helped predict which factors influenced whether or not a participant showed internalized or *noninternalized* motivation. More specifically, this model helped to demonstrate how likely the observed values of the

dependent variable could be predicted from the observed values of the independent variable. The goal of logistic regression is to correctly predict the category of outcome for individual cases, so for this study whether or not the participant showed internalized motivation.

Specifically, hierarchical logistic regression was used to test the likelihood that blocks of predictor variables would predict membership in the groups representing noninternalized motivation (external and introjected regulation types) and internalized motivation (identified regulation type). The Enter method was used, which forces the entry of all variables into the equation regardless of their significant contribution in order to examine the contribution of each variable. In this analysis, the TEQ regulation type was the dichotomous dependent variable (0=noninternalized motivation; 1=internalized motivation), and the independent variables were age, sex, number of previous treatment episodes, recent drug use, perceived coercion, and empowerment. All of the independent variables were entered into the analysis in a series of three blocks using the indicator contrasting method and used the first category as the reference category.

Research Question 3

This question addressed the complexities and nuances around how participants saw the relationships among their feelings of coercion, empowerment, and motivation. Grounded theory methods were used to analyze the qualitative data that were collected through interviews.

One tenet of grounded theory analysis is that the researcher becomes immersed in the data throughout the project, from the very beginning of data collection to the final analyses. Immersion implies becoming “intimately familiar” with the data through a

"heightened awareness of the data, a focused attention to those data, and an openness to the subtle, tacit undercurrents of [it]" (Marshall & Rossman, 2006). In order to work toward immersion, I conducted all interviews by myself, transcribed all of the interviews by hand, and listened to each tape to verify the transcript. I also read through each transcript and my notes from the interviews two or three times prior to beginning formal analysis.

Analysis of interview data was conducted using the software program ATLAS.ti 6.0 (Muhr, 2004). A "hermeneutic unit" was created for the project and transcripts were added one by one and classified as primary documents. Codes, as discussed below, were created and maintained in the hermeneutic unit and grouped and regrouped accordingly as data analysis proceeded.

The data analysis for this study followed Fassinger's (2005) discussion of open, axial, and selective coding methods in grounded theory. After the interviews were transcribed and imported into ATLAS.ti, open coding was used to break the data down into units of meaning, also referred to as concepts. Utilizing the language of the participants as much as possible, I labeled these concepts, referred to as "codes" in ATLAS.ti, with a short phrase that tried to capture the general meaning conveyed by the participant. Examples include "Realization one is getting too old to keep using," or "Court order kills motivation." Utilizing ATLAS.ti meant that concepts or codes were 1) created by selecting excerpts of text, referred to as "quotations," that portrayed a single concept, and 2) given a label and saved in ATLAS.ti into the Code database. Once all transcripts were analyzed, concepts or codes were then compared with one another and

finally grouped together into larger categories of similar concepts, called “families” in ATLAS.ti.

In addition to encouraging simultaneous data collection and analysis, grounded theory methods urge researchers to make use of the constant comparative method (Glaser & Strauss, 1967). This means that one first compares incoming data with collected data, and then with larger core categories, and finally with emergent theory as the latter becomes more and more articulated. The purpose of constant comparison is to ground the emerging theory in the participants’ experiences, expressed here as transcribed data.

Axial coding is the second level of coding and entails exploring the relationship between categories of concepts, particularly by bringing the divided pieces of data back together (Strauss & Corbin, 1990). Here, one begins to see larger, more encompassing categories that can account for other categories, or now, subcategories. These categories are then grouped into overarching themes. For this study, two examples of categories encoded through axial coding were “a different person when using” and “changes to be made to make recovery more likely.” These then became categories for two themes, *Incongruence Between Using Drugs and the Core Self*, and *Critique of the “System” in Order to Promote Recovery*, respectively.

Lastly, selective coding signals the final stage of data analysis in grounded theory. “Selective” means that a central or core category is selected that integrates all of the other categories into an explanatory whole. A core “story” is generated, which is a brief narrative of the most important aspects of the data (Fassinger, 2005; Strauss & Corbin, 1998). For the present study, a conceptual model emerged that presented this core

"story" and offered a picture of experiences related to coerced treatment, empowerment and motivation for participants.

In addition to the constant comparative process, I monitored my confirmatory biases by looking for disconfirming evidence, or examples in the data that disconfirmed the emerging theories. This process served to test emerging theories against incoming data as they continued to be analyzed and coded into categories and themes (Morrow, 2005).

Data Integration

Early in the analysis of qualitative data, I attempted to informally integrate data by referring to interviewee's scores on the assessment tools to gain a clearer understanding of how interview data confirmed, disconfirmed, or deepened and enriched the quantitative data.

Following both quantitative analysis and emergence of a theory grounded in the data, further attempts were made to integrate both quantitative and qualitative data. Although no formal procedure was followed to integrate the data, I utilized qualitative results to deepen and enrich the relationships among the variables found through statistical analysis. The grounded theory that emerged helped confirm and/or challenge such results, while also helping explain the phenomena in richer detail. Quantitative findings, on the other hand, helped clarify and explain some of the nuances the grounded theory analysis yields. Because the grounded theory that emerged was a composite of all interviewee's responses, I did not develop a theory for each interviewee with which to compare against their quantitative data. However, I considered descriptive statistics for

individual interviewees and compared these findings with interviewee's discussions of their experiences related to motivational processes.

Researcher as Instrument

As discussed above, the research paradigms utilized in this study viewed the interaction between researcher and participant as significant to the process of constructing theory and effecting change. For this reason, the role of the researcher will be further elaborated in this section.

Researcher reflexivity refers to the methods used by the researcher to reflect on her or his research experience. Such experience includes formulation of the topic, decisions about research paradigm and research design, selection of criterion for sampling, formulation of interview questions, style and process of data analysis, and conceptualization of the data into core stories about the topic of interest. These methods of reflection inform the reader of the extent to which the researcher was involved in the process, including her or his biases, assumptions, and interest in the topic (Charmaz, 2006). To begin this process, I will discuss my background and experiences, including my assumptions and biases that were relevant to my interactions with participants and my involvement in the research process. I will also mention two checks to those assumptions and biases that are common in qualitative research, a self-reflective journal and a peer research team.

Personal Background and Biases

My research interests in substance abuse and empowerment theory are well represented in this topic. As a 3rd-year counseling psychology doctoral student, I

completed a clinical practicum at Assessment & Referral Services, described above. During my year at ARS, I completed two assessments per week, which included a structured interview following ASI (Addiction Severity Index) guidelines. The purpose of each interview was to gain a clear understanding of the client's current and past substance use and to evaluate the consequent level of needed treatment. Following each assessment, I met with my supervisor at the time, Dr. Kelly Lundberg, and reviewed the assessment report I had written for each client, which included treatment referrals. We would then discuss the referral and designate an appropriate treatment site for the client. In addition to completing twice weekly assessments, I also facilitated for 1 year a weekly interim group for clients of ARS. The Interim Group Service (IGS) was designed to serve the pretreatment needs of ARS clients during the wait between receiving a treatment referral and beginning treatment. IGS developed because the wait to begin county-funded treatment often takes several months, and clients had nowhere to go in the meantime for support related to reducing their dependence on drugs and/or alcohol. It was during facilitation of interim groups that I become interested in the idea of motivation and was especially attuned to clients' expression of the ways in which their criminal justice involvement either helped or hindered their motivation to reduce drug use. At this time, and through these experiences, I developed a strong interest in and commitment to working with a substance abusing population in future clinical settings. During that same year, I also completed a practicum at the Women's Resource Center at the University of Utah. This practicum offers training in multicultural feminist therapy and utilizes a framework of empowerment (at the personal, interpersonal, socio/political, and cultural levels) in order to conceptualize clients' distress and guide interventions. I

worked with approximately 20 clients for individual psychotherapy using the empowerment model; I also co-facilitated two groups that further utilized this model. The following year, I completed a practicum at the Salt Lake VA in the PT*SD* clinic. Through this clinic, I co-facilitated a weekly group for 6 months for veterans with comorbid diagnoses of PT*SD* and substance dependence. This allowed me to further develop empowerment-based conceptualizations and interventions with a substance-dependent clientele. During data analysis and the final writing process for this study, I was completing my psychology internship at the Salt Lake VA, which included a 3-month rotation in an inpatient substance abuse treatment program. During this rotation, I facilitated relapse prevention groups and worked with clients individually. Although I am not quite sure what draws me to this kind of work, I wonder if my own background, which includes a naiveté about drug use and a lack of familiarity with people suffering from dependence, possibly contributed. Also, theories and practices consistent with feminist multicultural therapy inform my work as a therapist and researcher and I believe strongly in the role of empowerment as an essential component of the therapeutic process.

Self-Reflective Journal

Self-reflection by researchers is often carried out by many different methods in qualitative research. One such method is through a self-reflective journal. Morrow (2005) described this process as an "ongoing record of [the researcher's] experiences, reactions, and emerging awareness of any assumptions or biases that come to the fore" in order for the researcher's reflections to "be examined and set aside to a certain extent or consciously incorporated into the analysis" (p. 254). For this study, I maintained an

informal written journal and utilized the memo function in ATLAS.ti, both of which provided the opportunity to reflect on personal biases, experiences with participants, emerging theoretical developments and "hunches," and future questions I am interested in exploring related to this work.

Peer Research Team and Consultation

Research teams offer a source of feedback and checks on data as they are analyzed and incorporated into emerging theory (Hill, Knox, & Thompson, 2005). Attending Professor Susan L. Morrow's qualitative research group approximately twice per month provided a way to check my biases with others, discuss developing theory as data were being analyzed, and receive assistance on data analysis issues. Professor Morrow's research team was comprised of other graduate students, the majority of whom were working on dissertations and identified themselves primarily as qualitative researchers. I also consulted twice with an advanced doctoral student and TA for statistics in my department in order to verify that I was following correct analytic procedures. I also met several times with Professor Jason Burrow-Sanchez for additional support during data analysis, and this provided the opportunity for further checks on this process.

Ethical Considerations

During the research process, from participant recruitment through data analysis, I maintained a familiarity with the APA 2002 Ethics Code, particularly the sections on informed consent, confidentiality, competence, and research processes. Although the Code is considered by many qualitative researchers to promote a positivist understanding of ethics, Haverkamp (2005) noted that the language of the Code is written in a way that

can also guide qualitative procedures. The addition of modifiers like *reasonably*, *appropriate*, and *potentially* encourages the researcher to engage in ethical decisions in a thoughtful manner that often involves deep reflection and/or collaboration with colleagues. No ethical dilemmas or difficulties arose during the course of this study. As a further check on ethical practice, I also obtained approval from both the State of Utah and the University of Utah's Institutional Review Boards before data collection began.

In order to maintain confidentiality and safety of data collected, I purchased a small cabinet with a lock that Dr. Lundberg allowed me to keep in her secured office within the ARS offices. All signed informed consent forms and deidentified data sets were stored in this cabinet.

CHAPTER 3

RESULTS

> Here's the thing, [the court order for treatment] is debilitating… It's like someone grabbing your throat and saying, "Hey, you will do this." So it's part of the reason that I'm here, but I also recognize that I'd like to set it [marijuana] down and get on with my life, because this is obviously something that's been- I mean, my whole life has been just stumbling stones. ("Utah," 11/10/2011)

The purpose of this study was to explore the relationship among motivation, perceived coercion, and empowerment for individuals involved in the criminal justice system as the result of drug-related offenses. Using a mixed methods approach, this study first used statistical analysis to address the following research questions: 1) What is the relation between perceived coercion and empowerment? and 2) Do perceived coercion and/or empowerment predict motivation at pretreatment? The study then utilized a qualitative, grounded theory approach to address the third research question(s): What are participants' motivational processes like given the background of a court order for treatment? How do participants understand and make sense of being ordered to attend treatment? How do they understand empowerment to operate given this context, and how does empowerment or lack of affect motivation for treatment?

This chapter provides an analysis of both survey data and participant interviews in order to address the above questions. It begins with a statistical analysis of the relationship between perceived coercion and empowerment. It then uses multiple and

logistic regression in order to understand the predictive ability of perceived coercion and empowerment on motivation. A grounded theory analysis of interview data follows, which identifies the major themes that emerged from interview transcripts in an attempt to identify both the divergences and convergences of experiences. Within this section, the themes are then integrated into a conceptual model that attempts to capture the nuances and depth of the experiences conveyed. Finally, quantitative and qualitative data are integrated with findings from each method used to clarify, explain, or deepen understanding of the relationships among perceived coercion, empowerment, and motivation.

Research Questions 1 and 2: Statistical Analysis

Statistical analysis was used to understand the relationship between perceived coercion and empowerment as well as the predictive abilities of these two variables on motivational processes. Research question one was examined using bivariate correlation; research question two was addressed using multiple and logistic regression. Data analysis was completed using the Statistical Package for the Social Sciences (SPSS), Version 20.

Data Screening and Inspection

Because participants were screened for eligibility criteria before completing surveys, none of the cases were deleted due to lack of meeting study criteria. One hundred and one individuals completed surveys. Prior to analysis, data were analyzed for missing items and normality. Two participants had completed less than half of their surveys and were deleted from the data set. Between 4-6% of the sample had minor

missing data on recent use, perceived coercion, or empowerment but remained in the dataset.

A preliminary linear regression was conducted to examine multicollinearity. Bivariate correlations among independent variables did not exceed the recommended value of .7 (Tabachnick & Fidell, 2007). All variables were retained for further analysis. To further investigate multicollinearity, values for Tolerance and Variance Inflation Factor (VIF) were identified and checked against recommended values. Tolerance was above .10 and VIF was below 10, further indicating that multicollinearity was not a problem (Tabachnik & Fidell, 2007).

Outliers were checked by identifying the Mahalanobis distance, using values recommended by Tabachnick and Fidell (2007) for six independent variables. One case (number 32) exceeded the critical value of 22.46 and was therefore eliminated from the data set, resulting in 98 remaining cases. Normal Probability Plot of the Regression Standardised Residual and a Scatterplot were requested and no major deviations from normality were noted.

Following deletion of 2 cases for incompleteness and 1 case for being an outlier, 98 cases were included in the final dataset. Descriptive statistics for independent and dependent variables are presented in Table 5.

Scale and Variable Transformation

The URICA provides a stage of change score for each participant, from precontemplation through maintenance (1-4), and this information is provided in Table 6. In order for the dependent variable to be continuous for the purposes of multiple

Table 5

Descriptive Statistics for IVs and DVs

	Frequency	Percent	Total
Sex			98
M	63	64.3	
F	34	34.7	
Other	1	1	
	Mean	Standard Deviation	Range
Age	33.40	9.206	18-60
# of Tx Episodes	1.84	2.009	0-10
Recent Use (# times used in last 3 months)	20.63	12.624	1-31
Perceived Coercion	7.2917	1.8689	5-10
Empowerment	2.9505	.27914	1.29-3.54
Motivation Level (URICA – Readiness to Change Score)	9.6181	2.55672	1.86-14.00

Table 6

Descriptive Statistics for Stage of Change and Regulation Type

	Frequency	Percent	Cumulative Percent
Stage of Change			
Precontemplation	54	55.1	55.1
Contemplation	24	24.5	79.6
Action	14	14.3	93.9
Maintenance	6	6.1	100
Regulation Type			
External	19	19.4	19.4
Introjected	18	18.4	37.8
Identified	60	61.2	99.0
Tied on all three	1	1	100

regression, however, each participant's score was recalculated to represent level of motivation on a continuum. The readiness-to-change score was calculated by using DiClemente's scoring guidelines from the Project MATCH research (Carbonari, DiClemente, & Zweben, 1994; DiClemente, Schlundt, & Gemmell, 2004). This calculation was performed by calculating the mean scores for each of the subscales measuring Precontemplation, Action, and Maintenance, summing the mean scores for these scales, and then subtracting from this sum the mean score of the Precontemplation subscale. The possible score range for readiness-to-change scores is -2-15; the score range for this sample was 1.86-14.00. Thus, the final variable used for regression was the readiness-to-change score, which represented motivation level based on the stages of change theory, rather than placement in one of four stages.

Scores on the Treatment Entry Questionnaire (TEQ) indicated three motivational subtypes: external, introjected, or identified. Because scores were highly uneven across these subtypes, with the majority being identified, the external and introjected subtypes were collapsed into one category to represent nonidentified. Collapsing these categories allowed for the research question to be answered, namely to address the predictive nature of perceived coercion and empowerment on motivational type, represented here as not internalized (nonidentified regulation types; coded as 0) and internalized (identified regulation type; coded as 1).

Research Question 1: Relationship Between Perceived Coercion and Empowerment

In order to answer the first research question, a bivariate correlation was calculated producing a Pearson product-moment correlation coefficient. There was a

small, nonsignificant, negative correlation between the two variables, r = -.170, indicating these variables share only 2.9 % of variance (see Table 7). Although nonsignificant, the sign of the correlation was in the expected direction, indicating that higher levels of perceived coercion correlated with lower levels of empowerment or vice versa. This result suggests, as hypothesized, these variables are negatively correlated. However, unlike the hypothesis, the correlation was not significant.

Research Question 2: Predicting Motivation with Empowerment and Perceived Coercion

The second research question was addressed using multiple and logistic regression to determine the predictive nature of perceived coercion and empowerment on motivational processes, including level and internalization status. Four other predictor variables known to bear a relationship to motivation were included in the analyses: sex, age, number of previous treatment episodes, and recent drug use (measured by number of times used in the last 3 months). A correlation table for predictor and dependent variables is presented in Table 7.

Perceived Coercion, Empowerment, and Motivation Level

In order to address the predictive abilities of perceived coercion and empowerment on motivation level, a hierarchical multiple regression was employed to identify the amount of variance in motivation levels explained by these variables and the four other variables identified above. The dependent variable was the readiness-to-change score for the URICA as described above. Age, sex, number of previous treatment

Table 7

Intercorrelations Between Perceived Coercion, Empowerment, Motivation, and Demographic/Use History Variables

	1	2	3	4	5	6	7	8
1. Age	1							
2. Sex	-.100	1						
3. # of Treatment Episodes	.174	.092	1					
4. # of Times Used in Last 3 Months	.133	-.081	.082	1				
5. Perceived Coercion	-.123	.115	-.042	-.090	1			
6. Empowerment	-.174	.267**	.212*	-.062	-.170	1		
7. Motivation Level (URICA)	169	-.017	.175	.082	-.537**	.107	1	
8. Motivation Type (TEQ)	.160	-.018	. 048	.095	-.394**	.030	.419**	1

* = $p < .05$, ** = $p < .01$

episodes, and recent drug use were entered at Step 1, explaining 5.3% of the variance in motivation. After entry of empowerment at Step 2, when the above 4 variables were controlled for, the total variance explained by the model was 8.3%. Perceived coercion was entered at Step 3 and the total variance explained by the model was 33%.

Perceived coercion explained an additional 24% of the variance in the model, *R squared change* = .242, *F change* (1, 83) = 29.768, $p < .001$. In the final model, including all predictor variables, only perceived coercion was statistically significant, with a beta value of -.509, $p < .001$. The semipartial correlation coefficient indicates that 24% of the variance was uniquely explained by perceived coercion (*Part* = $-.492^2$). A summary of the regression model is presented in Table 8 and the regression coefficients in Table 9.

Perceived Coercion, Empowerment, and Internalized Motivation

In order to understand if perceived coercion and empowerment predicted whether motivation was internalized or not, a hierarchical logistic regression analysis was conducted. The Enter method was used, which forces the entry of all variables into the equation regardless of their significant contribution in order to examine the contribution of each variable. The dependent variable was represented as either 'nonidentified' or 'identified' regulation type (0=nonidentified regulation type and 1= identified regulation type). Nonidentified type represents motivation that has not been internalized, and identified type represents internalized motivation. The independent variables were entered into the analysis in a series of 3 blocks (block 1 = sex, age, # of treatment episodes, recent use; block 2 = empowerment; block 3 = perceived coercion). All of the independent variables were entered into the model using the indicator contrasting method and used the first category as the reference category.

Table 8

Hierarchical Regression Model Summary

Model	*R*	R^2	R^2adj	ΔR^2	*F Change*	*df1*	*df2*
1	.231[a]	.053	.009	.053	1.192	4	85
2	.289[b]	.083	.029	.030	2.759	1	84
3	.570[c]	.325	.276	.242	29.768	1	83

a. Predictors: (Constant), Recent Use, Sex, Tx Programs, Age
b. Predictors: (Constant), Recent Use, Sex, Tx Programs, Age, Empowerment
c. Predictors: (Constant), Recent Use, Sex, Tx Programs, Age, Empowerment, Coercion
d. Dependent Variable: Motivation Level (URICA - Readiness to Change Score)

Table 9

Hierarchical Regression: Coefficients for Models 1-3

Model	*B*	*Beta*	*t*	*Sig.*	*Part*
1 (Constant)	7.899	--	5.710	.000	--
Age	.037	.135	1.243	.217	.131
Sex	-.069	-.013	-.121	.904	-.013
# Tx Programs	.189	.148	1.371	.174	.145
Recent Use	.010	.051	.479	.633	.051
2 (Constant)	2.084	--	.554	.581	--
Age	.046	.166	1.524	.131	.159
Sex	.204	.038	.346	.730	.036
# Tx Programs	.225	.177	1.632	.106	.170
Recent Use	.012	.060	.570	.570	.060
Empowerment	1.712	.187	1.661	.100	.174
3 (Constant)	7.067	--	2.097	.039	--
Age	.028	.099	1.045	.299	.094
Sex	.335	.063	.658	.512	.059
# Tx Programs	.187	.147	1.565	.121	.141
Recent Use	.004	.022	.238	.812	.021
Empowerment	.793	.087	.876	.384	.079
Coercion	-.696	-.509	-5.456	.000	-.492

a. Dependent Variable: Motivation Level (URICA – Readiness-to-Change Score)

The logistic regression results indicate that only the final model, with perceived coercion entered as a predictor variable, was statistically significant, χ^2 (6, N=90) = 16.356, $p < .05$. When perceived coercion was added, the model was able to distinguish between participants with internalized motivation and those without. The final model as a whole explained between 16.6% (Cox and Snell R square) and 22.5% (Nagelkerke R square) of the variance in internalized motivation status, and correctly classified 72.2% of cases. The logistic regression results for the final model (block 3) are summarized in Table 10. Empowerment did not contribute significantly to the model, nor did age, sex, # of treatment programs, or recent use. Perceived coercion was the only predictor variable to make a unique statistically significant contribution to the model, with the Wald test indicating significance at the .001 level. Perceived coercion recorded an odds ratio of .622, indicating that for each unit increase in coercion, the odds of reporting internalized motivation decrease by a factor of .622.

Table 10

Logistic Regression Predicting Likelihood of Internalized Motivation

Predictor Variable	*B*	*S.E.*	Wald	*df*	*p*	Odds Ratio
Final Model (Block 3)						
Age	.022	.027	.627	1	.428	1.022
Sex	-.175	.520	.113	1	.737	.840
# of Tx Expisodes	.003	.125	.001	1	.978	1.003
Recent Use	.008	.019	.193	1	.661	1.008
Empowerment	-.234	.930	.063	1	.802	.792
Perceived Coercion	-.475	.139	11.714	1	.001	.622

a. Dependent Variable: Motivation Type (TEQ)

Research Question 3: Grounded Theory Analysis

Themes

Following grounded theory analysis of interview data, six themes emerged that captured how participants understood and expressed their experiences around motivational processes, coercion, and empowerment given the court order for treatment. The themes include (1) *Positive Motivational Factors,* including the social, interpersonal, and personal issues motivating participants to move toward recovery; (2) *The Court Order Impacts Motivation "For Better or Worse,"* which details the ambivalence nearly all participants expressed about the court order's impact on motivation; (3) *Incongruence Between Using Drugs and the Core Self,* including the ways in which drug use alters or obscures who one "really is"; (4) *Anticipating Substance Abuse Treatment,* including addressing mental health issues and looking forward to the "tools" of treatment; (5) *Critique of the "System" in Order to Promote Recovery,* including critical feedback about and suggestions for improving treatment programs and community awareness; and, lastly, (6) *Personal Power, Choice, and the Role of Recovery in Promoting Empowerment,* including a discussion of how early steps toward recovery enhance feelings of empowerment. Brackets (i.e., []) indicate changes made to excerpts of participants' quotes for clarification purposes.

Theme 1 - Positive Motivational Factors

Participants spoke of several factors, aside from the court order but within the context of it, that motivated them toward recovery. This section details the factors that positively impacted motivation and inspired participants to reduce their use and/or attend substance abuse treatment. These factors involved primarily social, interpersonal, and

personal issues, including how participants saw themselves in relation to others. The largest of the six themes, this theme incorporates several subthemes, including awareness of age-appropriateness and "normal" developmental milestones; a desire to be rid of "drama"; preserving, rebuilding, and/or creating a family; and shame and awareness of being labeled. As a general note, participants rarely made a distinction between motivation for recovery and motivation for treatment. When such a distinction was made, it will be indicated below.

Awareness of Age-Appropriateness and "Normal" Developmental Milestones as a Motivating Factor

Many participants spoke of an awareness of their own developmental milestones they felt were delayed because of drug use. Included in this awareness was a sense of age-appropriateness, such as feeling one was "too old" to continue using. As part of this subtheme, many participants noted a desire to move forward with their lives and to start engaging in typical developmental processes around relationships, family life, work, and the acquisition of possessions that might signify maturity, such as owning a house or car. They expressed a desire for a "normal" life, one that was free of drugs.

Age awareness. Four participants spoke directly about age awareness. For Stacie, heroin use had led to relationship conflict, the loss of a young daughter to the State, and feelings of dependency on her family of origin. In reference to these problems and her continued drug use, she stated, "It's got to the point where I'm too old to have to deal with, um, the drug use," including everything it had entailed. For Terran, who had experienced similar family conflict with her adult children, her first answer to a question about motivation was similarly age-related: "What's motivating me? Well, for one, my

age. I mean, I am getting a lot older and I don't want my children upset with me anymore."

Philip, who had undergone a lengthy incarceration, expressed a similar sentiment. Following his release from prison, he became a dad for the first time and he linked his past, his new identity as a father, and his drug use together: "Before [having children] I was just roaming the streets, thinking I was young again, you know, trying to relive my youth… And now, now it's like…I gotta grow up." In reference to his motivation to stay clean and avoid being incarcerated again, he added, "And plus, being locked up, I'm getting too old for it." Also referring to a history of serving prison time due to drug use, Earl echoed this idea as he spoke of beginning yet another round of court-ordered substance abuse treatment: "So right now, this is the third time, gotta be a charm. You know what I mean? I'm just done, I'll be 49 this year."

Awareness of a 'normal' life and appropriate development. Related to this sub-theme of age awareness was an awareness of what a "normal" life entailed and how drug use and/or legal problems related to such use had been an obstacle to achieving appropriate developmental milestones. For example, Philip made reference to his long drug-related incarceration and spoke about having a "normal life." He mentioned he was "slowly losing [his] prison mentality" and "growing up, learning things, like how to talk to other people." Overall, he said he was working on "slowly adjusting back to a normal life, you know." Sam wanted to rent an apartment and insure a vehicle, referred to as "all the normal stuff," which she felt was especially "difficult and discouraging…for addicts." For Earl, motivation to quit using came from an awareness that he should have this "normal stuff." In discussing his move toward sobriety after several relapses, he said,

"And you know, actually, I see it the way society sees it: At my age, I should have a house, a car, you know, insurance, life insurance – I should have all of those things."

Not having the "normal stuff" was often a major source of discomfort and struggle. Century discussed finally getting an apartment through the Road Home, but "beyond that, it's just been a constant struggle because of [methamphetamine use]." For her, "trying to be a normal member of society and being that heavy into drugs" had led to a "constant balancing act that was just not working out." In reference to her drug dependence, she lamented not knowing how to do what "normal people" know how to do, and in the following quotation she linked these feelings of ignorance to relapse:

> You just, you don't do anything with your time, and so when you're trying to quit, you don't know what to do with your time, like, you know, you don't even know how to live your life 'cause you don't know what normal people do anymore. Like, I have a hard time paying my bills, I have a hard time watching my money, stuff like that, you know, and so it's like that's one of the things that you get frustrated and that, you know, causes you to relapse 'cause you're like, "I don't even know how to live, so I may as well just go get high."

Century went on to talk about being a mother and some of the difficulties with this role as a result of use. She said about parenting, "That's one of the other things I struggle with, the parenting skills." She spoke of not knowing how to relate to her 6-year-old daughter: "I don't know the best way to approach a six-year-old because I've been so inside my entire life" due to drug use. Philip also echoed how drug use and "getting high" affected parenting: "So, I look at it like, okay, I could be…super hung over the next day and lose time hanging out with my kids…or I could stay sober and then spend time with my kids, like at the park." Here he referenced the "normal" things that a parent should do with their children and how this encouraged him to stay clean.

On a more general note but in keeping with the overall theme of normalcy, Utah expressed a desire to move forward with his life and he perceived that his use had been an obstacle to achieving many typical developmental processes. In recognizing his life had been "stumbling stones" due to chronic marijuana use, he expressed motivation in saying, "I'd like to set it down and get on with my life." Casi also addressed motivation in her answer to the question of what was motivating her to stop using. She expressed a desire for a calm and predictable home life:

> Um, I thought about what do I really want right now. And what I really want is just to live a calm life. I want to go to work and I want to come home and relax, sit down…and watch TV, relax, eat dinner, go to bed. If I work graves, okay, watch a little TV when I get home…hold my man, go to sleep. I look at myself now and tell myself that is what you want. And that's- right now, in the last couple of weeks, that's what's keeping me away from [methamphetamine].

Getting on with one's life, having the things that "normal" people have, and learning skills related to appropriate development, such as parenting or paying bills, all contributed to motivation to stop using.

Desire to be Rid of Drama

Several participants noted the "drama" that accompanies drug use. Far from an appealing aspect of use, the desire to rid oneself of this drama served as an important motivating factor in one's quest for sobriety. Participants discussing the drama of drug use noted the chaos it brought into their lives and homes, the lack of control they felt over the drama, and the desire to lead a calm life.

For Terran, who had dealt methamphetamine and had become involved with Aryan gangs and the FBI in the process, the drama had become intolerable. She said of cocaine and methamphetamine, "They're the worst drugs…they really are. For some

reason…the people that do these drugs, their lives are so chaotic, you know what I mean, so you open up your door and you have all this chaos too." This chaos, however, helped her acquire a mindset that she would no longer deal or use methamphetamine. About this, she stated, "I don't want chaos in my life anymore" because it brought "drama, a lot of drama and the drama never stops, it just increases and increases, so you've got to set your mind to say, 'I've had enough- enough's enough!'" Terran, for whom the prospect of a long prison sentence loomed, expressed determination to change her lifestyle in part because of this chaos and drama.

For more ambivalent participants like Jenna, the drama of using helped to move her in the direction of getting clean. Although she repeatedly stated "I can stop whenever I want," she noted getting "sick of doing it" in part because the "drama is unbelievable." She described this further, saying,

> It gets astronomically stupid, and…I can't stand it, and that's the main thing about it, if I could stay at home and do it [use] all day long and not see one person, perfect! Instead, I got my phone blowing off the hook 24 hours a day just for someone to tell me this happened, and someone did this…

In one poignant segment of her interview, she noted she cannot "control that aspect" of her use, referring to the drama, and said "I'm almost there" in reference to deciding to quit. She attributed this directly to being unable "to stand" so much drama. So although she acknowledged she wasn't sure yet if she were ready to quit and she would continue to use if she could "not see one person," Jenna was contemplating change because of the chaos and drama associated with use.

Living a calm, drama-free life motivated Casi in her consideration of what she "really wants." As indicated in the previous section, she stated a strong desire to "live a calm life" and noted how significant this was in motivating her to stop using. She

contrasted the calm life she wanted with her typical busy and chaotic life: " 'Cause I have all kinds of friends out there, and I can text whoever I want, and, you know- I could get whatever I want… But it's not there for me right now."

The desire to live a calm life and to be drama-free helped many participants move toward a decision to stop using.

Family as a Motivating Factor: Preserving, Rebuilding, and Creating a Family

All participants talked about family as significant to their motivation. Family included children, parents, siblings, partners, and/or spouses. In these discussions, nearly all interviewees noted that family increased their motivation to get or remain clean, although some participants expressed ambivalence about the role family played in their sobriety. Analysis of interview data suggests that narratives about family can be grouped into four major categories: specific family member such as children acting as motivating factors; the prospect of having or creating a family as a motivating factor; the desire to repair broken or strained family relationships as a motivating factor; and uncertainty about the role family has played in motivation.

Motivation related to specific family members. A majority of participants attributed their motivation to specific family members, primarily children. For Sam, her children were named as her "biggest motivation" and for Century, her daughter was the "number one thing" when it came to reasons to stop using. Motivation to stay clean from heroin, for Stacie, came from her 7-year-old daughter: "It's all basically for her." When asked what got Philip to the point where he had "no more desire to do drugs," he stated his mom and his kids, because he'd let them down too many times before. In speaking

about his kids, a 1- and a 2-year-old, he said, "So now that's my motivation, taking care of them. I don't want them to see me all, you know, on pills and stuff and drinking. So that's my number one motivation: being in their lives, being a positive influence."

Motivated by the prospect of having or creating a family. The prospect of having or creating a family was also a strong motivator. Several participants linked continued drug use to future ability to have or care for family. The prospect of having a family, as seen by Jenna and Century, served to motivate them toward sobriety. Although Jenna generally remained ambivalent about quitting drugs, she referred to her new niece, born to the girlfriend of Jenna's incarcerated brother, as a major reason to stop using. When asked how this niece helped her feel motivated to not use, Jenna stated she might "have to get her," referring to potentially gaining custody of her niece. She acknowledged that getting custody would "change things" in terms of reducing her drug use: " 'Cause I don't want her getting sent to no foster care when she can be with family."

Century was similarly motivated to stay clean because of the prospect of family. She expressed a strong desire to have a husband and children but feared her choices to use "had ruined that opportunity" and she would "never find a good man that would want to merge his life with [hers] because [she'd] made so many mistakes." About a month prior to this interview, however, she met a "good man" and they had talked about "merging [their] lives" and having children. Century stated his presence in her life and his lack of judgment about her past had "totally changed everything" in terms of her motivation to stay clean.

Motivated by desire to repair family relationships. Participants' desires to repair broken and strained family relationships served as perhaps the strongest motivator to

change drug use patterns. A majority of participants discussed this motivating factor. For Jenna, Terran, and Casi, 3 participants who expressed ambivalence, taking responsibility for strained family relationships and desiring to make things better helped them engage in change talk. Jenna, likely the most ambivalent participant, had had numerous fights with her mother over her use, including a "blowout" after Jenna's boyfriend stole thousands of dollars in jewelry from Jenna's mother's home. Yet, Jenna valued her relationship with her mother. About her 2-week period of sobriety, enforced by urinalyses by her probation officer, she stated with some pride, "To actually have a normal, civilized conversation with my mom is kind of crazy. We were fighting a lot [Jo: When you were using more?] Yeah. And I was never home, I'd be gone weeks at a time…" On the day of her interview, Jenna had just been given a key back to her mom's home, which led to excitement and talk of motivation to remain sober.

For Terran, less ambivalent than Jenna but still weighing the benefits of staying clean, her history of selling and using methamphetamine had led to major relationship difficulties with her children, especially her eldest son. In reference to her most recent charge, which included FBI infiltration of her distribution circles, Terran talked about the heartbreak associated with her poor relationship with her son. When discussing what was motivating her to "cut meth out," she stated,

> Having to call my children in Nebraska, especially my eldest son, and telling them I had just gotten in trouble and was doing thirty days, and I'm sending you my credit card, and will you take the responsibility of my cats, my house, my bills, and me and my eldest son…because of my problem with meth, there was a big gap there, and, you know, we just started to build that friendship back when I had to call him and tell him. And then I had to call and tell him about the felonies.

This experience served to push Terran toward the decision to stop using and selling methamphetamine. With regard to her continued marijuana use, Terran insisted there was no motivation to stop using, not even from family ("my whole entire family gets stoned"). However, she acknowledged feeling a double standard in teaching her children "valuable lessons and stuff." Of this, she said, "You know, you sit there and you lecture, and then all the sudden you get in trouble, it's like…don't follow me… You can never throw a brick at a glass house; they break." So while Terran was not making changes with her marijuana use at the time of interview, her role as a mother and her sense of some discomfort around throwing "a brick at a glass house" appeared to move her toward contemplation about the impact of her continued use.

Similar to Terran and Jenna, Casi also expressed some ambivalence around use but engaged in change talk when considering the family relationships she had strained after years of heavy use. Having recently learned she would become a grandmother, she felt "excited, very excited" because her son, who was having his first child, had told Casi this was her "second chance." Upon further prompting, Casi referred to their broken relationship and explained, "I think that it's come to a point where he's tired of his mom being on paper. I've been on paper for twelve years." This was due to drug use and associated criminal behaviors. She linked her attempts to rebuild her relationship with her son to her reasons to stop using, noting the alternatives: "Prison, I'll go back to prison. If my son finds out, he kicks me out of his life, out of my grandbaby's life. My parents will kick me out of their house." The desire to improve her relationship with her son and the prospect of being out of his life and her grandchild's life because of continued use and legal consequences helped Casi engage in some change talk.

For participants who were more motivated to make lasting changes to their drug use, repairing and improving upon family relationships also acted as significant sources of motivation. Earl, Philip, Bob, and Century articulated this motivation very clearly. Earl described his life as "in rambles" because his ex-wife had taken his five children to Las Vegas "after [he] screwed it up again," in reference to relapsing and facing new criminal charges. About his children he said, "I made a promise to them. I told them next year this time, they'll be able to come to my place and if they want to choose, to stay with their mom or with me…" He articulated his motivation to stay clean, referring to his kids having this option: "So that's my number one goal right now."

Philip was similarly motivated to improve his relationships, not only with his children but with his family of origin as well. After serving a lengthy prison sentence, he had worked hard to turn his life around and to become an active father to his two small children. His parenting helped his family see another side of him. In speaking of his sisters and mother, he said, "They've never seen me like this; they usually just see me as a little gang banger running around. Now they see me like making a big change, you know, working and stuff like that." In reference to his parenting, he said he "gets comments, like my mom texts me, she's like 'I'm proud of you' and stuff like that. And my sisters and my family too… It's cool…" The reinforcement Philip was getting from his family, coupled with his desire to be a positive influence in his children's lives (as noted above), helped him stay sober.

Bob was more concerned with maintaining the family life he had salvaged from a period of heavy cocaine and heroin use years before his most recent relapse. He was still able to see his two children from his divorce and had rebuilt relationships with them, but

then “something goes wrong up here” and he repeatedly put it all “at risk.” He noted that at the time of interview, he was speaking with his children and “had it good now, a good girl…and job” but continued to worry that he couldn’t “put it down.” He was motivated for treatment in order to preserve his relationships with family.

Century, who showed high motivation for both staying clean and going to treatment, was inspired to improve her relationship with her young daughter. About her methamphetamine use, she described getting “too wrapped up” and “not taking proper care” of her daughter: “Because of my use she’s suffered, she has behavioral problems.” Century continued, disclosing a painful decision she had almost made,

> I was coming to the conclusion that I was not going to be able to stop using drugs, and, because I didn’t want that so badly for my daughter’s life, I’d almost given up, and I want her to have a good life, you know, so I was starting to come to the conclusion that I needed to give her up, so that she could have a good life and I could- continuing in my use was what I wanted to do, and that’s what I was going to do, but I wasn’t going to drag her through it. So, you know, that’s about where I was…and I realized, you know what, that’s the last thing I want. My daughter would be so- she’d be, I mean, she would just die if I gave her up, so…

This process helped motivate Century toward sobriety as she realized if she couldn’t stop using for her daughter, she wouldn’t be able to stop for any reason. About those concerns, she said, “I mean, to me, that’s the one thing that would ever knock me down so far in my life that I wouldn’t want to get up, ‘cause if I couldn’t do it for her, then who? I don’t even have the words to express how that made me feel as a person, as a mother.” Reinforcing the connection between her motivation and her desire to repair her relationship with her daughter, Century said of her “no-tolerance probation” that she would go back to jail if she “[got] another dirty.” She reported strong motivation to stay clean, stating emphatically, “I don’t want to go there. I don’t want my daughter to have to go through that again. It was hell the first time [reference to daughter in foster care], I

can't do it again." Continuing to develop a strong relationship with her daughter and making up for past neglect and feelings of abandonment drove Century to stay motivated.

Uncertainty about family's role in motivation. For several participants, family difficulties had a more nuanced impact on motivation. For Stacie, Eugene, and Casi, expectations about family led to disappointments that had the potential to erode their motivation. Stacie noted the need to come to terms with her family's lack of support, saying,

> And you know how everybody says, "Oh, you know, the support system and your family?" But, and it does help me to talk to them, you know, but, like, I need to come to grips with the fact that my family is not going to help me get better. It's not going to happen. If anything, it's gonna make it worse, so I gotta not focus on that anymore and be depressed by that, because it's never going to happen. [Jo: They're not the answer to your sobriety?] Exactly!

Although she recognized the importance of family and had hoped hers would help her achieve sobriety, Stacie was able to acknowledge that continuing to have high expectations would set her back and could negatively impact her motivation.

Eugene had similar expectations for his family, which he defined to include his parents, his girlfriend, and her parents. In a conversation about some of his anticipated setbacks, he referred to feeling let down and unsupported by family: "They just keep nagging me about getting sober…and then they- something happens and you start getting sober, it's like they just let go, and you're on your own now and they don't care anymore, you know?" He later referred to his family's lack of education about substance dependence as a "problem," noting specifically that his girlfriend "doesn't want to be educated or knowledgeable about any of it. It's pretty frustrating." While Eugene expressed disappointment with his family, he acknowledged the powerful impact his

family could have on his sobriety if only they could provide the support he felt he needed.

In the quotes that follow, Casi illustrated the importance of family on motivation and the devastating impact expectations about family can have. In discussing her relapse history, she mentioned being pregnant with triplets. About finding this out and in anticipation of becoming a mother, she stated, "I was ready to stop and put my life on the right track," which she did, staying clean for a few months. She continued, "About four and a half months in I lost them. It was a high-risk pregnancy and I just lost them… And, and I think that's where I started to- I just didn't give a crap anymore." Linking her current use to this incident, she stated, "Yeah, it was hard. I don't think I've really dealt with it. Maybe that's where some of my attitude when it comes to drugs comes from. [Jo: The pain is still there?] Oh yeah…" For Casi, the prospect of becoming a mother and having a family motivated her to stop using. She stayed clean for almost 5 months until she miscarried. The emotional pain and the loss of motivation she had from expectations around having a family played a role in leading her back to a devastating 20-year history of use.

Shame and Awareness of Being Labeled: The Consequences of Use

Many participants spoke of the shame and stigma that accompanied a history of drug use and associated felon status. This included being labeled by others, feeling shame and/or embarrassment, having difficulty finding employment and state services, and feeling hopeless about family and the future. Participants' discussion of such experiences allowed them to discuss the consequences of their use and the obstacles they

would face in the future as a result. Such a discussion helped many participants convey their motivation to stop using.

Sam, already concerned about her ability to do the "normal stuff" in life, related an experience at Check City where she tried unsuccessfully to get a check cashed. With some embarrassment, she said, "They focused on one bad incident [related to legal problems from drug use] and didn't acknowledge years of good credit history." She talked about feeling as though everyone was looking at her and judging her; although this was upsetting, it led to change talk during the interview. Utah expressed a similar feeling of embarrassment. In discussing his NA meetings, he noted feeling like he was "living a lie" by "falling off the horse." He related being in a meeting and feeling a sense of shame: "…you know, my name's Utah and then, every time you go in there they ask everyone who's had less than 30 days to identify yourself, and it's kind of embarrassing, to say every time, 'My name's Utah, and I'm still a loser…'" Utah conveyed this story when asked about his motivation to stop using, which he felt was "strong." The above story followed that answer.

Several participants also noted feelings of shame and stigma in the workplace and/or in getting a job. Utah continued his discussion above by talking about how the stigma associated with being a felon for drug convictions would follow him if he tried to find a job after completing a program to become a licensed substance abuse counselor (LSAC). He speculated,

> Once you graduated though, you know, put a resume in, "Yeah, I have SEVEN different arrests for possession, yeah, I'd like to help someone, with [their use]…" You know, I just didn't know how that would- if that would disqualify me, I mean, not so much from the program, they would probably allow me to do the program, but how would employers look at me, because everyone wants a

> criminal background [search] now, it's like, "Well, I don't know, maybe get clean and get five years," so I don't know…

Terran echoed this concern based on an experience she had about a year prior to participating in this interview in which her boss dismissed her after finding out about her drug use history. Speaking about employers in general, she said, "They'll throw your past back in your face, you know, 'Well you used drugs and you did this and did that….' It's gonna take a long time to not be labeled by everyone." She continued this discussion about being labeled and judged in her interactions with friends and family, emphasizing the stigma of a past that included drug use: "Not to mention the way people look at you, and they pre-judge you, I mean, you could be using for long periods of time, and then not use for long periods of time, but they still judge your past, they don't judge your present, [it] makes it hard…" Although Terran was deeply ambivalent overall with regard to motivation, she acknowledged the negative consequences of her use and the difficulty it would take to overcome their lasting effects.

Other participants also described being labeled or judged and felt this was life changing and difficult. Century referred to her feelings of hopelessness on "some days" because of the "label I now have to carry [and] the things it has now changed in my life." She provided an example of this: "There's things that I don't qualify for, like I can't get housing for me and my daughter because I'm a felon now…enough already." The consequences of being labeled helped move Century toward sobriety.

Employment and state services were not the only areas impacted by one's drug use history. Hopes for the future around family were also impacted by the stigma around use. Century further described feelings of hopelessness about this, noting that "having a family and a good husband" were important to her. Yet, as she said, until recently, "I

thought that because of my choices [to use] that I had ruined that opportunity for myself, that I would never find a good man that would want to merge his life with mine, because I've made so many mistakes." She followed this by mentioning she had just recently met someone, and her work to overcome the stigma of her past was motivating her to stay clean.

Caveat About Motivation

This section has illustrated the important factors in participants' motivation to stop drug use, including awareness of developmentally appropriate behavior, a desire to rid one's life of drama, the move toward rebuilding, strengthening, and/or creating family, and wanting to avoid the shame and stigma of being labeled. All participants expressed one or more of the above motivating factors. Yet for several, an awareness of the dangers of too much motivation was also conveyed. This often took the form of expressing concerns that excessive motivation could be a "set-up" to fail; as an antidote to this, many expressed a "one-day-at-a-time" mentality.

Participants issuing this caveat about motivation seemed wary of being too motivated, as though it were a "set-up" for failure. Eugene expressed this well: "I don't want to feel too motivated, because when I feel too motivated it seems like it all crashes down." Casi also expressed a similar sentiment, referring to her past: "I'm not gonna sit here and lie again and say, 'No, I'm never going to use again,' because that just, that just sets me up…I probably won't get all, like, gung ho like I did before." When queried more about this, she stated, "Yeah, I thought that for the first six years that I was in treatment. And it's really- it's a set-up for yourself…and that didn't work very long."

In discussing past relapses and treatment episodes, Earl acknowledged being very

motivated at the time of interview but cautioned, “I’m just taking it one day at a time right now.” Philip was highly motivated to stay clean, yet after discussing all of the factors that motivated him, he emphasized the importance of the present in his quest to maintain sobriety:

> I don’t feel like I have everything in place, ‘cause like a person’s gonna grow regardless, but I feel like I’m at the point this time where I have enough to stay sober *today*, you know, but I can’t speak for forever, because I don’t know. I’m hoping I still learn then, and each day I learn something that’s gonna keep me from using…

Stacie also restrained herself from feeling too motivated, acknowledging it had not always helped her in the past. After discussing all the progress she’d like to make in the next year or so, she checked herself, stating “Say I have all my mental health problems under control and I’m dealing with them, then maybe *a year later* I will go to school…into criminal justice, like forensics…” She also acknowledged the importance of not being “too gung ho” with regard to motivation.

Theme 2 - The Court Order Impacts Motivation “For Better or Worse”

All participants saw the court order as having an impact on their motivation for substance abuse treatment and/or recovery. The majority expressed ambivalence about the court order’s impact on motivation, speaking of it as both positively and negatively affecting motivation, often at the same time. Unlike in the above theme, participants tended to make more distinctions between motivation for treatment and motivation for sobriety/recovery. They spoke primarily about motivation (or lack of) for treatment as a result of the court order. In some cases, however, the distinction between motivation for treatment and for sobriety was less clear. Attempts are made below to clarify.

Court Order as a Positive Motivating Factor

While most participants viewed the court order with ambivalence, 9 participants were able to see the court order as positively impacting motivation. In many cases, a statement about the positive impact would be followed by a statement about the negative impact, but nonetheless several positive subthemes emerged out of this analysis. These subthemes include the court order serving as a needed "push," increasing awareness that they wouldn't go to treatment without it, and reminding them of their reluctance to go to jail/prison. Participants spoke primarily of motivation for treatment in these subthemes, and appeared to see treatment as a necessary step toward their recovery.

A needed "push." While some participants admitted the court order could negatively impact motivation, they credited the court order and/or legal involvement with being a needed "push" for treatment. Sam described her court order as a "kind of push" and acknowledged that while being court ordered may be resented by some, the "reality is we all know we need it." She concluded by weighing the costs and benefits of being ordered to treatment, saying, "For better or worse…the extra push from the courts helps people more than it doesn't."

In describing the inertia that followed his release from prison, Philip also acknowledged the needed "push" from his court order and parole status:

> Yeah, I think it's affecting me a little bit, because when I first got out, I wasn't doing much, I was just hanging out, know what I mean, and now that I'm forced to do classes [treatment groups]…and everything, it's helping me along the way, know what I mean? It's like, motivating me. So, it's kind of like a push, you know?

Eugene didn't use the term "push" to describe the impact of his court order and legal involvement on his use, but it was evident he felt this way. He had cut his use down

approximately a week-and-a-half prior to this interview. When asked when he was court-ordered to start undergoing urinalyses and attending treatment, he stated "a couple weeks ago." He acknowledged there was clearly a link between his recent decision to stop using and the court order.

Although Utah felt coerced by the court order, discussed later, he acknowledged that his legal involvement gave him "a little more motivation [to go to treatment]…knowing that I have to follow through, instead of just catching a meeting here and there." About his most recent relapse for driving under the influence of marijuana and alcohol, where he acknowledged he "could have killed someone that night," he credited the importance of the role the legal system played. He felt that "it was probably a good thing" he was arrested because "it was the catalyst…and the last straw" to controlling a problem he thought he "had under control." He admitted that he was at ARS undergoing an assessment and treatment referral because of the court order.

Awareness they wouldn't have gone to treatment without court order. Although most participants implicitly acknowledged they wouldn't be in treatment without a court order, Century and Sam explicitly stated so. Sam first generalized that "a lot of people wouldn't come, or wouldn't try, if they weren't ordered." She then admitted, "I'm very aware that I wouldn't have gone…" without being ordered. Century went further, noting she was first in denial about being ordered but then, "in accepting it," had "come to be happy that I got this charge, and be happy that they're ordering me to do treatment, because it isn't something that I would have done on my own."

Motivated for court-ordered treatment in order to avoid jail/prison. Several participants described a desire to avoid jail/prison as an external motivator to go to court-

mandated treatment. The following exchange with Jenna reflects this subtheme:

> Jo: And do you feel motivated to do treatment?
> Jenna: Well yeah, I don't want to go to jail for a year (laughs).
> Jo: Okay, so that's why you're here, basically, it's either treatment or jail?
> Jenna: Yup, and ADC (Adult Detention Center) sucks; four days was enough for me, I ain't never going back.
> Jo: Okay, so you'll do treatment if that's what it takes?
> Jenna: Yeah (laughs). I'm never going back, never.

Although Century had moved along a spectrum of motivation, she acknowledged avoiding prison was an early motivator: "My motivation has changed… Now it's to have a better life…before it was just to not go to prison." She later admitted, however, how strongly she did not want to be incarcerated: "I'm on a no-tolerance probation. And, if I get another dirty, there is just no question in my mind they're going to put me back in jail…and I don't want to go there."

For Casi, who had 1 more year of being on parole, or "on paper," the desire to avoid prison was motivating her to follow through with her court requirements. When asked specifically about her motivation for treatment, she described her motivation in the following way,

> Motivation is just to do the program until they stay off my back. Um, while I'm on paper I'm not going to be using no more. I'm not going to go back to prison for something stupid like that. So…yeah, I'm motivated to stay clean until I'm just about done. I have to.

Court Order as Negatively Impacting Motivation

Seven participants spoke of the court order as negatively impacting their motivation for treatment (and to some extent for general sobriety). However, just like the participants who emphasized the positive impact of the court order on motivation, these individuals also expressed significant ambivalence. In some cases, a statement about

how the court order negatively impacted motivation would be followed by an acknowledgment of the positive consequences from the court order as well. This section details the negative reactions participants had about court orders for treatment. It reflects a general sense of perceived coercion for treatment, which, according to the following participants, had a negative impact on motivation overall.

Negative motivation for self. Although Stacie was motivated to stop using heroin for many reasons, she conveyed reluctance to begin court-ordered treatment. When asked about her motivation to go to treatment after being ordered, she described being "kinda upset, negative maybe." She then spoke directly about motivation: "I don't think being ordered gives you any motivation at all, do you know what I mean?" When asked if she thought it negatively impacted motivation, she responded in the affirmative. She likened being ordered to treatment to having to wake up in the morning to an "alarm," noting "it's easy to wake up when you don't have to," but when you set an alarm in order "to be up at a certain time…it sucks to know you have to get out of bed."

Philip used a similar analogy to express the negative motivation he felt for treatment as a result of being court ordered. Like Stacie he was motivated to stay clean, but he described his court order for treatment as feeling "like you're now on someone else's time… It kind of feels like a job…so you don't really want to do something that your supervisor wants you to do but you got to do it 'cause he's your boss, so that's what it feels like."

When asked about her motivation for treatment as a result of being court ordered, Jenna became irritated and replied, "Yeah, I don't have any." Sam also acknowledged that although she felt motivated to work toward recovery, the court order was "upsetting"

and threatened to "ruin it" for her, in terms of motivation for treatment. Similarly, Casi described feeling "mad" and "irritated" by her court order for treatment. When asked specifically about her motivation for treatment as a result of being ordered, she stated, "Um, it kind of kills it, for me… Being threatened to do it is just not no motivation at all." She clearly expressed a sense of perceived coercion for treatment, which "kill[ed]" her motivation for treatment. She then referred to the authorities as "throwing [her] out to hang," implying her court order set her up to fail.

Terran continued with this idea of being set up to fail, noting how the difficulties of complying with the treatment order can backfire and lead to more use:

> When life's going bad a lot of people drink to cover it up, okay, well, meth and coke you use when things start getting really bad, there's no hope because shit, you can't pay for the classes, you can't pay for the drug testing, shit, why not, might as well just do it and do it good [right…], then you go to prison, it's easier to get drugs in prison than it is on the streets.

About her own court order, she expressed defiance: "They can order all they want. I know what makes sense… I can play the game…tell them exactly what they want to hear."

Although Bob was motivated for treatment at the time of the interview, he recounted an experience in the past where an experience in court-ordered treatment negatively impacted his motivation. This incidence of court-ordered treatment required that he shave his head and wear a sign stating, "I'm a baby." He noted how demoralizing this experience was and feeling so "upset" that he became "turned off from treatment" for a significant time period. In his case, the negative experience he had while in court-ordered treatment led to a reduction in his motivation.

The incompatibility of court-ordered treatment and human "nature." Participants channeled their own dismay about the court order into a generalized critique of why people don't respond well to court orders. Several expressed the opinion that being ordered or "forced" to do something is antithetical to human nature.

Jenna stated with exasperation, "Being pushed into it is not going to benefit anybody, because they're being forced to do it, it's nature to not want to do it… If they don't think that it's a problem, then they're not gonna seek help for it." Stacie expressed a similar sentiment, noting that this tendency is especially strong in addicts: "If someone's telling you to do something, especially being an addict, you're like, 'I don't have to do that.'" She speculated further about feeling "stuck," which reflected both her own feelings about her court order as well as a generalizing statement about being ordered to treatment: "You just feel stuck, I guess, if someone's telling you to do something and you don't want to." Casi also generalized in the third-person voice, noting that although she didn't "see the problem getting clean, and people getting help and stuff," in those circumstances when "you're ordered to do it - either do this or this is going to happen - I think it kinda kills it for you." Terran went further, expressing not only the above thoughts but a subversive turn on being ordered to treatment, where one "play[s] the game." She stated, "You know, you can either take these things and really want to change, or you can come and play the game, you can tell them what they want to hear." At the time of this interview, Terran was indeed "playing the game" by complying with her parole officer, reducing her use of marijuana, and going to treatment. She maintained, however, that she would never stop using marijuana and would return to regular use after she "got off paper."

Participants in general spoke of the court order as impacting motivation in both a positive and negative way. The majority appeared deeply ambivalent. While the court order was viewed often as a "needed push," it was also perceived as coercive and antithetical to human nature.

Theme 3 - Incongruence Between Using and the Core Self

Nearly all participants spoke of the ways in which drug use altered or obscured the core self. Although participants didn't necessarily discuss this theme as an explicit motivating factor, the acknowledgment of the ways in which drug use was incongruent with the core self conveyed deeply personal reasons why participants wanted to work toward recovery. Essentially, this theme conveys the depth at which participants felt using was contradictory with who they "really are." Minor subthemes emerged out of this theme, including identifying as a "different person" when using, inability to make good decisions for oneself when using, and anger/disappointment with oneself for using.

A Different Person on Drugs: "When I'm Using, I'm Not the Same Person"

Many participants spoke of the ways in which they were "a different person" when under the influence of drugs. Casi described being a "totally different person….not an asshole…but a totally different person." She described how she came across when using: "I'm bouncing off the walls and not listening to anybody, doing what I want to do, you know? And I know everything, and I'm gonna do everything, you know?" She expressed surprise that her parents didn't know the extent of her use because of this: "I'm surprised there's times that my parents didn't know that I was using, when I was using." Earl conveyed a similar experience of being a different person, acknowledging he's "real

selfish" when he's "in [his] addiction" and this is one of the ways he knows he's back in the cycle of addiction. He concluded, "When I'm using, I'm not the same person, you know what I mean?"

Philip engaged in a prolonged conversation about the ways in which drug use altered his core self. He spoke of feeling "weak, weak-minded…cause I was getting into the drugs and alcohol and the streets and the gang stuff." About his sense of self and drug use, he likened being on drugs to being a "zombie":

> It was low, just like, I felt like a zombie, know what I mean? 'Cause I was just too high, you know, every single day I was high. Like, I was here physically, but mentally and spiritually, I was gone, you know what I mean, I was in a whole different world 'cause I was high... But when you're under the influence of drugs or alcohol, your whole morals, your everything, your values go down, and you just, it's like, like your soul disappears, you just don't care about nothing.

He spoke further of the ways his drug use and prison sentence had altered him, stating that while in prison he had become cold and detached, unlike the person he felt he really was:

> I felt like my heart was getting cold, know what I mean…and there was times when a family member would die when I was there, and I wouldn't cry, and I was thinking to myself, 'Am I that cold to where I can't even cry for a death in the family no more?' …but I didn't want to be that way…

His reluctance for things to "be that way" had played a strong role in his motivation for recovery. He described being able to "see better" and "having feelings" again as a result, which contributed to his desire to stay clean.

Inability to Make Good Choices When Using

Several participants spoke about the connection between using and making poor decisions, reflecting the extent to which drug use obscures one's ability to act in accord with one's "true self." Sam referred to never having been "in trouble" before her drug

use: “And now I got a charge, and it was of course due to me using, or I wouldn’t have been making bad choices and doing something out there that I would have got charged for.” Eugene expressed a similar understanding of the connection between using and making decisions. He stated emphatically that he doesn’t make any decisions when “high.” Furthermore, he stated, “If there’s something big that comes up in my life I’ll go out and get opinions from others, ‘cause usually when I make decisions for myself [when using] they usually turn out bad.” He connected this to reasons why he was motivated for recovery. Philip echoed this as well, linking drug use to peer pressure and not being “true” to himself. Upon being sober and out of prison, he noted he can now “make the right, or better, choices.”

Anger and/or Disappointment with Self for Using

A last subtheme was anger and/or disappointment with oneself for using. Participants who expressed this type of dismay with themselves were reflecting the larger theme of discordance between using and the core self.

Both Jenna and Terran, somewhat ambivalent about their use, reflected this sense of anger/disappointment with themselves. When asked how she felt about herself after using, Jenna stated, “Oh, a little pissed. I’m like, ‘What the hell are you doing?!’” Terran too stated, “I’m disappointed with myself, you know, because…I have not been on solid drugs like that…for a year.”

Century and Earl went further with their expressions of disappointment, linking this to increasing insight about the reasons for use. About her recent relapse, Century wondered about her ability to stay clean. She stated, “And now, this is, it scares me because I’ve been here before, I’ve been where I was like ‘you’re so stupid, how can you’

- I mean, even if I can just quit using enough to get probation…I still get confused a little bit so you'll have to excuse me." Earl took responsibility for his cycles of relapse, noting that "it's [his] choice" but wanting to know why he made that choice. He wondered, "The thing that'd correct it is knowing why I choose this when I know it's garbage… I came to the conclusion I never got nothing out of it except misery, pain, [and] trouble with the people that love me…that didn't love what I had or what I got, but really loved me…"

Anger and/or disappointment with self for using, inability to make good choices, and feeling like a "different person" when using all conveyed the extent to which active drug use was incongruent with the core self.

Theme 4 - Anticipating the "Tools" of Treatment

Given all participants were court ordered to begin substance abuse treatment, many of them worked to make meaning of this treatment even if they acknowledged negative feelings about the court order. They spoke of several therapeutic issues, including their hopes for what they would get out of treatment. Two subthemes emerged out of this larger theme: addressing untreated mental health problems and gaining "tools" for sobriety and overall well-being.

Connecting Mental Health Issues with Use: Hopes for Treatment

Several participants understood their addiction as the result or expression of untreated, underlying mental health issues. Anticipating treatment for many meant addressing these challenges as a way to gain sobriety.

Jenna described herself as a “backwards” user. When asked to describe what this meant, she discussed a friend of hers with attention deficit disorder, who, when using methamphetamine, would become calm and “mellow.” She indicated she believed this was the case for her as well, mentioning that when she didn’t use, she was “high strung” and “skinny.” When she used meth, she noted gaining weight, being more calm and less stressed, and doing a better job at work. During the interview, purportedly abstinent, she was fidgety and restless. About this, she stated, “I mean, I’m always high strung and like I’m high all the time, but I’m not. Like right now [while sober], I can’t sit still.” We discussed together how untreated attention deficit disorder and/or anxiety might be contributing to her use, and she was encouraged to mention these mental health concerns when she had her assessment; she agreed this was important. She noted being “so proud” of her friend when he “checked into VOA [Volunteers of America]” for substance abuse treatment that would address mental health issues. She “hoped” she would be able to do this as well, despite reluctance for treatment.

Earl also expressed a similar understanding of his use in terms of medicating some of his anxiety. Despite awareness that drugs brought him “nothing but misery,” he acknowledged the dependence he formed in order to ease his worries: “And most of my life, your medications would be marijuana and beer, and you’re cool and you don’t worry about your problems or whatever you’re trying to suppress.” He was finally ready, through treatment, to begin the process of “knowing why do I choose this when I know it’s garbage.”

For Casi, the pain of losing triplets late in pregnancy in her 20s played in to her drug use. Of her miscarriage, she stated, “Yeah, it was hard. I don’t think I’ve really

dealt with it. Maybe that's where some of my attitude when it comes to drugs comes from." She spoke about her long-lived psychological distress: "My doctor, he, what is it called? He said I have PT*SD*. I wake up in the night screaming and running and crying… And I've dealt with depression for probably like the last 20 years…" She connected her mental health concerns to her outlook on substance abuse treatment, which she had done in the past and would be doing again as the result of her most recent charge:

> I am messed up in my head. There's a lot of issues going on up there…that I know I need to deal with that I don't know how to deal with… And I would like to explore that a little more, because I do think I have a mental illness. I don't know if it has to do with drugs… I'd like to explore that a little more, and find out more information on that, and I think, uh, I think classes can help you [do that].

Given Casi's ambivalence about treatment and the negative impact she felt the court order had on her motivation, her acknowledgement that "classes can help" was especially impactful.

Stacie made a strong connection between her drug use and her mental health history, and she further tied this to treatment. She mentioned having been diagnosed with depression, anxiety, and obsessive-compulsive disorder while hospitalized on an inpatient psychiatric unit. She also mentioned a history of cutting, which she felt she could control with heroin. About substance abuse treatment for heroin dependence, she understood well the need to treat her underlying mental health issues:

> You know, my treatment is gonna start with my mental health… That's where I'm gonna get treatment for- And if I have to open up some old wounds to get through, you know, that's what I'll do, 'cause it's gonna help me stay clean… 'Cause this is gonna be with me for the rest of my life, it's not gonna go away. I'm always gonna be a drug addict, but I can be a recovering addict.

The "Tools" of Treatment

Participants anticipated gaining many "tools" and skills from treatment. This subtheme emerged over many participants' discussion of their decisions to "make the best" of being ordered to treatment, even if they felt ambivalent or even resentful about having to go. Philip noted wanting to get out of treatment "certain tools." Utah referred to treatment as giving him "more tools in the bag." Century, struggling through another relapse, said she was preparing for treatment by realizing the following: "Hey, I can't keep myself clean; I don't know how, I don't have the tools."

With regard to specific tools, many participants noted they looked forward to working on "thinking errors" in treatment. They also anticipated gaining confidence and improving self-esteem over the course of treatment.

"Thinking errors." Several participants noted they would learn ways to reduce thinking errors while in treatment. Stacie said with enthusiasm about treatment, "There's many classes, you know, on thinking errors…so I'm excited to do that." In his anticipation of treatment, Philip referred to previous treatment with a therapist: "So, he just throws a lot of stuff out there so we can look at things differently, instead of thinking in the old ways." Asked about what she was looking forward to getting out of treatment, Sam again emphasized working on thinking errors: "Like rethinking, you know, changing my thinking, you know." As an example, she stated, "When I'm having a bad day, instead of just running to go get, you know, numb or whatever, like addicts do, I can deal with it differently… I think that's one of the big things with treatment, it helps you deal with things in an appropriate and healthier way…" Bob repeatedly stated he needed to learn "why." He had gotten his life back in order yet couldn't "put it down." His hope

for treatment was that he would be able to learn "new thoughts, new answers" to address why he was unable to stop using.

Improving self-esteem. Confidence, positivity, and self-esteem were also mentioned by participants as components of treatment expectations. In reference to the "classes" Stacie was court-ordered to begin, she noted looking forward to developing "a higher self-esteem and more confidence" in herself. As part of his AA meetings and in preparation for further treatment, Utah also emphasized the importance of enhancing confidence: "I mean, I've been trying to get into positive readings and listening to positive books and stuff, I mean, that's the only way you're going to…quit putting yourself down."

General tools. Other participants noted additional ways they expected treatment to help them in overcoming their addiction. Jenna, who was generally reluctant to go to treatment, insisted she was "sure" she would "get *something*" out of treatment, including "a different aspect and different outlook on things." She admitted to the possibility of learning new coping skills for dealing with urges:

> You never know when you might run across something that might help you on the way, and maybe they have other ways of dealing with it, maybe they have better ways of staying- you know, keeping- if you do get them urges, they have different ways of coping…

Eugene wanted very specific help for overcoming heroin use, as he had been able to "just quit everything else, like smoking pot, meth, acid, ecstasy, all that stuff…but heroin has been like the hardest one…I need help." He noted wanting more out of treatment this time "instead of just giving me the drug that prevents me wanting to use [referring to methadone]." He also emphasized how important it would be during

treatment to have his girlfriend included in family treatment groups: “My support needs to be educated as well, that’s my main problem.”

Utah acknowledged the need for a more intense treatment than he was getting from AA, which he likened to a “band-aid.” He wanted the tools to deal with some of the issues underlying his marijuana use, in particular a “broken heart”:

> I’ve always used AA and NA or whatever as a band-aid, instead of a lifelong program. It’s kind of, you know, go in there, kind of clean up there a bit. And I thought maybe the reason why I don’t stay clean is ‘cause I don’t stick with it…but you can’t put a band-aid on a broken heart…

In general, participants expressed high expectations for treatment and were hopeful that it would address the underlying issues that contributed to use, even when conveying ambivalence for the court order. Although there were some exceptions, most participants genuinely displayed respect for the treatment process and believed they could learn valuable tools, despite how “ready or not” they felt for treatment.

Theme 5 - Critique of the “System” in Order to Promote Recovery

All participants engaged in a discussion of what they felt could be done on a systemic level in order to promote recovery and prevent relapse. Critiques were not focused on one issue but on a diverse array of topics. Analysis showed some emerging commonalities, however, which represent subthemes for this section. These subthemes include a critique of the financial aspect of the “system,” questioning the legality of certain drugs, calling for gender-specific changes in treatment, an increased awareness in the community around the challenges to recovery, and, lastly, a request for those in positions of authority to encourage honesty from clients around drug use.

Financial Burden: "It's Just Money, Money, Money"

Many participants lamented the high costs associated with court-ordered treatment, including urinalyses, assessment, and classes. Terran referred to the court "system" as a "money-making scam," one that does not look at the "person as a person." In order to go through the process, she stated, "You gotta pay thirteen dollars a test, fifteen dollars for this panel or that, then you gotta go through these assessments and then you gotta do this and then you gotta do that, and it's just money, money, money!" She connected the financial hardships of this process with continued use, saying if "you can't pay for the classes, you can't pay for the drug testing, shit, why not- might as well just do it [relapse] and do it good…"

Eugene had a similar critique of the financial component of treatment. He had noticed that for individuals court ordered to treatment but not qualifying for county funding, "they [officials] want your money." The process of court-ordered treatment then, according to him, becomes "more about taking your money than it is about getting you treatment or help."

Questioning Legality of Drugs

Several participants were critical of the ways in which marijuana use is prosecuted compared with alcohol use. This represented a willingness to question the system while also acknowledging the danger of alcohol and other drugs. Utah admitted the severity of the crime he committed while driving intoxicated, noting he "could have killed people." About his DUI arrest, he stated, "Yeah, I could see alcohol as- I mean alcohol *is* more dangerous. People don't black out from smoking weed and getting in accidents and killing people." Terran expressed a similar thought, asking, "How many

times do you…open up a newspaper and it says ‘pot smoker killed kid?’ You know what I mean?” She then defended the use of marijuana, maintaining she would “fight people til the end.” All the while, she acknowledged that “they should make alcohol [an illegal] drug” and that “they have a good point when it comes to meth and coke, a very good point.”

Gender-Specific Needs for Women

Sam and Stacie both called for treatment facilities to acknowledge issues specific to women. Sam’s critique was more general, as she noted it had been difficult for her to find a facility for detoxification services because “they got 80 beds for men and 12 for women.” She also referenced the time she was homeless and the difficulty she had feeling safe in the shelter:

> There’s the Rescue Mission for men, which is extremely huge, and you can go in there and shower and eat… There’s not many places for a single female to go, meaning that are safe. I think they need a little bit more of a broader thing for women, ‘cause [for] men, there’s lots more than there is for women.

Stacie’s critique was more specific as she felt that a local treatment facility made no distinction among the female clients. As a mother in her mid-30s, she felt out of place because “those girls who are there only go there ‘cause they got their child taken away. And they’re young and they haven’t been through what I’ve been through… Yeah, we’re all addicts, but I’ve seen a lot at this point…” She wanted a treatment facility specifically for women with children so she could address parenting issues, including learning parenting skills, and not simply custodial issues.

Better Awareness in the Community Around Recovery Issues

Many participants noted the lack of awareness people in the community, the court system, and the family unit often had around issues related to recovery. Sam, in recounting her story of being shamed by some of the financial hardships she experienced in trying to pay her court fines and treatment costs, called for a "better recording of progress that you *are* making and trying to make, and some acknowledgment by the system of just how hard it can be." She also wanted to "wake up" people around her to the realization that drug use is "not always a choice." Instead, she noted, "We need to be informing the community that this is a sickness." Century reflected a similar call to action, noting that she wanted to "make some changes" so that the community as a whole was more aware of "the injustices that happen to people who are labeled as drug addicts…and not just the problems that drug addicts face…but they [other people] don't realize how hard it is to overcome those things." She also spoke of the widespread nature of drug use and wanted to remind people that "drug use isn't only a problem for people who are homeless and living off of other people's taxes… I think that it's very widespread and people need to be aware." She again reiterated wanting to make changes, stating, "Eventually I will find a way. I write a lot, so through my writing is definitely how I hope to do it."

Both Eugene and Sam talked about the importance of substance abuse treatment involving education for family members. Eugene noted how "frustrating" it was that his girlfriend and her family didn't seem to "want to be educated or knowledgeable about any of it." He called on treatment agencies to include families because "support needs to be educated" in order to make any lasting changes. Sam also recommended treatment

agencies distribute information to family members or hold special groups for families so they are aware of the challenges their addicted family member is facing.

"Let People Like Me Be More Comfortable With Honesty"

A majority of participants noted throughout their interviews the value of honesty. Casi and Century specifically addressed the importance of honesty in their critique of treatment. Casi directly challenged treatment providers to allow their clients to be honest about their use. She articulated a need for therapists and probation officers to encourage their clients' honesty, even when it is uncomfortable, in order to make progress toward sobriety:

> I think that people like you, like in your profession, need to be more honest with people like that and let people like me be more comfortable with that honesty, and just do that up front. Yeah, I'm gonna use again, and that's not gonna come back and bam, slam me in the head… The thing is to be more honest with ourselves. That's how we could do it. They sit there and say, "Tell the truth and be honest with everything." Most of us, and I know how it is, we're just going to tell you what you want to hear.. But honestly, if we want to really, really help ourselves, or do it right, we have to be honest with ourselves and the person that we're talking to. If I'm talking to you and I'm lying to you, I'm not being honest with myself and that's just going to make me go out and use.

Century also reflected the importance of being "completely honest" while in treatment, but noted that sometimes honesty is "really hard because, it's like, it's demeaning." She wanted a treatment facility that would encourage her to be as honest as possible without being punitive, because "you have to realize how far down you let yourself get" in order to work toward recovery.

Participants felt strongly about the ways in which treatment and the "system" could be improved in order to promote recovery. Critiques of the financial aspect of treatment, the legality of drugs, gender-specific treatment issues, community awareness,

and the role of honesty all conveyed participants' thoughts about how they could be better served from a systems level.

Theme 6 - Personal Power, Choice, and the Role of Recovery in Promoting Empowerment

Analysis of interview data did not support empowerment as a predictor of motivation to reduce use and/or participate in substance abuse treatment. Nonetheless, participants had a lot to say with regard to the importance of the various domains of empowerment and the relationship empowerment had with recovery. Three subthemes emerged out of this analysis: 1) the importance of choice, competence, and personal power in the journey toward recovery; 2) self-esteem as important but not connected to use or ability to stop using; and 3) the reduction of use itself leads to higher empowerment.

The Importance of Choice, Competence, and Personal Power

The importance of choice, competence, and ability to exert personal power recurred over several participant interviews. Sam, Philip, Utah, and Earl all spoke explicitly about their feelings of competence, personal power and the ability to make choices. The quotes below illustrate how important they felt this component of empowerment was to their recovery. Philip noted that in getting clean, although he believed in God, "Ultimately, when it comes right down to it, you're the one that has your own power, you know?" He agreed that his recent sobriety was evidence of that power. He reflected on being sober and getting out of prison:

> I feel like I'm getting stronger, mentally and- I can make the right, or better choices, instead of just being weak and getting peer-pressured into running around

> and doing stuff to please other people. I'm just getting more independent, you know?

Utah spoke of being more than a statistic in terms of use, noting he has "more to offer than that," including "education…and life experiences" that he felt he could use to help others. Earl also expressed a strong sense of personal power, tying this directly to his sobriety:

> Right now, I'm not gonna sit up here and lie to you, it's really hard out there, with being almost three years clean and my recovery, I mean, I fell off and picked myself back up. And then I fell off again, so… But, you know what's keeping me in tune [is] knowing that I can rise above all this… [and] the fact that I know who I am, you know what I mean?

Sam valued having a sense of choice, expressed in the following assertion of feeling empowered: "I know no matter what I'm the one that gets to make the choice… I feel like I have control 'cause I'm making a lot of choices." She identified having choices in regard to not using, to showing up for her assessment, and in planning to play an active role in determining where she attended her court-ordered treatment.

The lack of choice was also significant for participants. As noted above, Casi felt like a "robot" given her parole status, mandated treatment, and certain other requirements she was meeting. Compared with the other participants mentioned in this section, she lamented her loss of choice and personal control. She continued to link choice to use, however, hypothesizing that she would be less likely to use if she had a stronger sense of choice and freedom:

> And I think honestly, if I could do- if I could just make my own decisions and I wouldn't have everyone behind me back telling me this and that, I really honestly think that I would do good, I do. It wouldn't be a temptation for me. Who would I be trying to piss off? I just think that, I think having a choice will help me a lot more [with not using].

Self-Esteem as Important But Not Connected to Sobriety

The majority of participants noted they felt good about themselves and had moderate-to-high self-esteem. While this represents an important component of empowerment, many participants did not appear to connect self-esteem to their use. They did not see self-esteem as impacting motivation to reduce use or to feelings of competence about being able to stop using, although, as discussed above, Stacie did hope to improve her self-esteem in treatment.

Casi was a good example of the lack of connection between self-esteem and ability to stop using. She noted she had confidence and her "self-esteem is up there." However, when it came to feelings of personal power, she stated, "I don't feel like I have power for myself. I feel…like I said, like a robot. I'm a robot." As discussed above, Casi linked this notion of personal power (or lack of) to her use.

Being Sober Promotes Empowerment

Participants' discussions seemed to indicate an unexpected relationship among empowerment and use: Heavy use led to lower feelings of empowerment while reducing use led to increased self-esteem, feelings of choice, and personal power. This implies that perhaps motivation to reduce use precedes or allows for an increased sense of empowerment.

Only 1 participant, Stacie, directly supported the research hypothesis by positing that her increased sense of empowerment motivated her to reduce her drug use. Stacie noted that in the past, when her self-esteem was low, her motivation was negatively impacted:

> Well I think…with me, 'cause having a low self-esteem, you know, you don't believe in yourself so you're not going to have any motivation to get up, you know, and go to treatment because it's kind of an attitude, like, why bother? Am I good enough, am I ever going to get better? And that's what I said so many times to myself, you know, "Why get up and go?"

She discussed how since she had been feeling "better" about herself in terms of self-esteem and confidence, it "help[ed] give" her more motivation and an attitude of "Hey, maybe I am worth it." Stacie, however, was the only participant who made this connection between enhanced empowerment and motivation.

The remainder of this section will illustrate how participants made connections between use and empowerment. Several participants detailed connections between heavy use and feeling a lack of empowerment. Some furthered this relationship by highlighting how taking steps toward recovery led to feeling more empowered in terms of increased self-efficacy, feelings of choice, and a personal sense of power.

Using, loss of control, and the "mirage" of power. Many participants noted that heavy use made them feel out of control and powerless. Philip provided a provocative metaphor about his use and a false sense of control. He stated that when on drugs, "You think you're strong and powerful and stuff…but that's just a mirage, that's just a- that's just the drugs playing tricks on you, know what I mean?"

Eugene also noted feeling out of control and having no power when he used: "Yeah, when I do meth, I feel pretty powerless." He further developed the connection between empowerment and use by emphasizing his lack of confidence and ability to make decisions when using: "If there's something big that comes up in my life [when using], I'll go out and get opinions from others, 'cause usually when I make decisions for myself they usually turn out bad."

Utah worried about becoming "another statistic," by which he meant another person "powerless" over their addiction. When asked specifically about his feelings of personal power and control over his life, he felt he was in the process of feeling more empowered but still struggled because of his addiction, which he noted "gets in the way": "I think [I'm getting there] to the most part, but I think this addiction, you know, it gets in the way, it's one other reason I'd like to, you know, set it down a little bit. Instead of just being another statistic."

Sam noted she couldn't find a connection between feeling empowered and, as a result, motivated. However, she further emphasized the idea that using led to a lack of power and control. She referred to a burgeoning sense of personal control, but this was tempered by her recent use:

> I'm not all messed up right now, so I can say- If I was probably on drugs right now and came in, I'd probably totally feel like I was out of control…'cause when you're on drugs, you feel like you don't have control and the drug really does have more control over you.

The selected quotes above emphasize the ways in which participants felt drug use compromised one's sense of personal power and control over their lives. Sometimes a "mirage," addiction was understood by many participants as reducing their ability to make choices, feel in control, and exert personal power.

Getting clean is "taking control." As Sam stated above, heavy use caused her to feel out of control. However, being in the early stages of recovery was empowering. She emphasized the ways in which getting clean made her feel more in control of her life: "[I]t's empowering that I have some tools in the way I think *because* of being sober, you know?" She felt a newly developed sense of control over her life, affirming that

"choosing to not get high [is] empowering, 'cause right there you're taking control, period… [you] can feel empowered if you can just do that first step."

Century, also in the early stages of recovery, reflected a similar sentiment: "Yeah, I definitely feel like I have a voice... For a long time I didn't." She referred to her arrest and long history of use, stating "…the effect that it had on me is really starting to fade away and I'm starting to become more who I was before it happened."

For Philip, who stated that using was like a "mirage" that tricked him into feeling powerful, getting clean helped lead to a sense of mastery and competence. In the following quote, he makes a distinction between "before" when he was using and in prison versus "now" where he was becoming a better and more involved father: "I feel positive, feel like I can, like, do things. Before I didn't know how to do a lot of things and I'd just give up, but now it's like I just tell myself I gotta learn. Learn it, study it, and then I'll know it." As an example, he talked about not knowing how to use a cell phone when he got out of prison. He reflected pride and a sense of mastery in the following: "It was all high tech and it was frustrating, but after taking some time I learned it, and now I mastered texting." As discussed in the earlier section on family, Philip also referenced becoming a good father and learning parenting skills after becoming clean and serving his prison sentence.

Although participants did not express a sense that empowerment preceded or predicted motivation to reduce use, they nonetheless noted the strong relationship among empowerment and use/recovery. In general, feelings of personal power, self-efficacy, and control were lower when use was high. Taking steps toward recovery often led to an increase in these domains of empowerment.

A Conceptual Model of Participant Experiences

The following section proposes a conceptual model that portrays the relationship among the above 6 themes. The model proposed here (see Figure 2) reflects my attempt to configure the themes in such a way that they portray participants' lived experiences around motivational processes, empowerment, and treatment/recovery given the background of a court order for treatment. The model does not attempt to capture the totality of experiences conveyed by each participant, but instead synthesizes the major components of their contributions. This section will describe how all components of the model fit together to form a core "story" reflecting participants' experiences.

Model Configuration: Treatment/Recovery Center and Themes

All six themes discuss or develop the idea of treatment and/or recovery, very often recovery by way of treatment but not always. Therefore, the model is conceptualized with treatment and recovery in the center, represented separately on either end but merged in the center. This portion of the model is fluid, with treatment and recovery blending together to represent how the majority of participants spoke of their experiences. This portion of the model will be referred to as treatment/recovery.

The six themes are configured around the treatment/recovery center as they all relate to this experience. Motivational processes played a major role in three of the six themes and the ways in which they relate to treatment/recovery. These themes are situated along the bottom of the model, representing both negative and positive aspects of motivational processes and how such processes relate to treatment/recovery. On the top

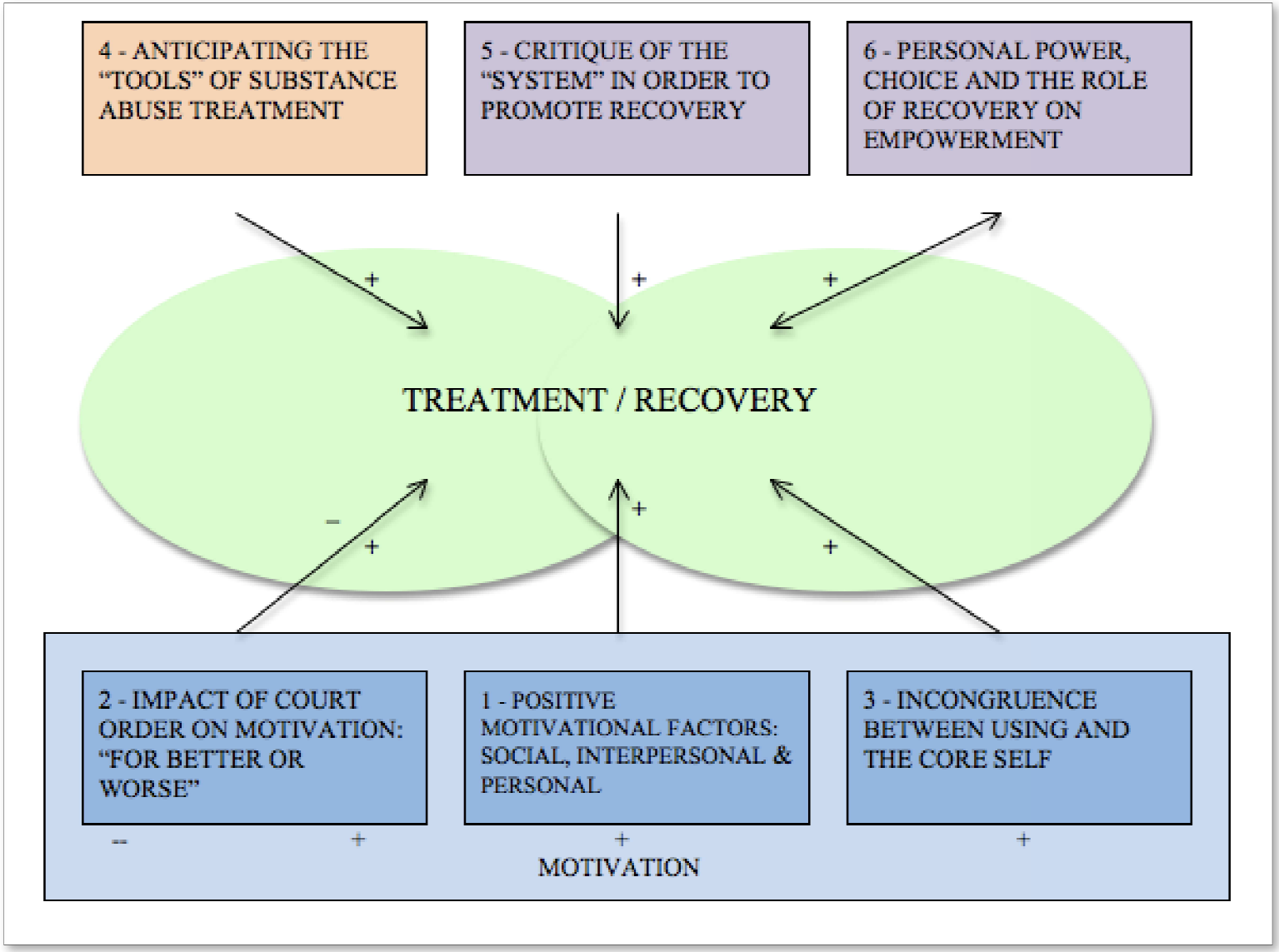

Figure 2. Conceptual Model of Themes

center and right are the two themes that reflect notions of empowerment and its relation to treatment/recovery. On the top left is a stand-alone theme representing anticipation/expectations for treatment. Arrows and '+' and '-' signs indicate how each theme relates to or informs the notion of treatment/recovery, with the bottom three themes reflecting motivational processes. All themes and their configuration in the model will be discussed below.

Motivational Themes

Themes 1-3 express participants' experiences with motivation for substance abuse treatment and/or recovery. These themes portray the extent to which motivation could be negative or positive, often at the same time. The themes can also be conceptualized as moving from more external factors (such as the court order), to more interpersonal pressures (positive motivational factors), to deeply personal factors (incongruence between self and using).

The court order. Impacting motivation in both negative and positive ways, the majority of participants expressed ambivalence about the impact the court order had on motivation, primarily for treatment. This theme is placed to the left side of the motivational themes for this reason, as this placement helps account for the negative impact the court order has on motivation on one hand, and the positive impact on the other. For participants who tended to indicate their motivation was negatively impacted by the court order overall, a stronger sense of perceived coercion was expressed. This sense of coercion served to discourage participants from wanting to attend treatment and, for a couple of participants, led to increased desire to use. However, many participants

also felt the court order was a "needed push" that would encourage them to seek treatment, and hence work toward recovery. They noted that without the order, they likely would not go to treatment or work toward sobriety.

Positive motivational factors. All participants spoke at length about some of the positive motivational factors that were salient in their lives at the time of the court order. These primarily included the interpersonal issues motivating people to be drug-free. This theme was the most developed and spoke to both treatment and recovery, often as the same process. The theme is therefore placed in the center of the motivational themes, most closely to the point where treatment and recovery are discussed as the same process.

Incongruence with the core self. The notion that using was incongruent with the core self was the last theme to focus strongly on motivation. Unlike the other two themes discussed above, this theme developed the motivating factors around recovery that were truly personal, relating to one's sense of self. This theme is placed to the right of the motivational themes, expressing the personal component of motivation as well as the theme's focus on recovery.

Anticipating the "tools" of treatment. Regardless of motivation levels, many participants still held high expectations for treatment and anticipated the "tools" they would be receiving that would facilitate recovery. These hopes and expectations were expressed even when motivation appeared to be negatively impacted by the court order and there was a strong sense of perceived coercion. This theme is represented in the model as standing apart from the three motivational themes discussed above, and it stands apart from the two discussed below, which relate more to empowerment. The theme is situated on the top left of the model in order to convey its relationship more to the

treatment focus of treatment/recovery and to capture the extent to which it can be an important factor even in the case of negative motivation.

Empowerment Themes

The last two themes also fall outside the continuum of motivation, although they continue to relate to expectations about treatment and recovery. As the interview data support, empowerment was not as relevant to the process of motivation as hypothesized. In fact, participants who were already motivated to take steps toward recovery experienced an enhancement of personal empowerment as a result.

Critique of the system. The second to last theme, critique of the system, captures the ways in which participants provided critiques or analyses of the legal system, treatment centers, and community issues around drugs and alcohol. Although this theme was not named by participants as empowerment, it is consistent with theories of empowerment that suggest a political or sociopolitical component to enhanced empowerment. The theme is placed in the center of the treatment/recovery process as it consists of critiques by participants that are intended to improve the process of treatment and help facilitate recovery on a systemic level.

Choice, personal power, and competence. The last theme expresses several key components of empowerment on a more personal level. It is placed in the upper right corner, closer to the recovery component of treatment/recovery, and separate from the motivational themes. This theme suggested a unique perspective on empowerment, namely that heavy use was consistent with low levels of empowerment but taking action toward recovery led to enhanced feelings of empowerment. In other words, rather than empowerment leading to or facilitating motivation, motivation to work toward recovery

instead appeared to result in enhanced empowerment, namely increased sense of choice, competence, and personal power. A majority of participants noted the ways in which these components of empowerment promoted recovery once that process was already begun. Thus, the arrow between this theme and treatment/recovery is double-headed, indicating this two-way relationship between personal empowerment and recovery.

The major themes discussed in this section together offer an understanding of how participants made meaning of their experiences with motivation and treatment/recovery within the context of a court-order for substance abuse treatment.

Integration of Results

Together, the statistical and grounded theory analyses provide good cross validation of the findings, namely that empowerment was not predictive of motivation while perceived coercion was. This section attempts to integrate the findings from both types of analyses in order to further clarify the relationship among perceived coercion, empowerment, and motivation. In order to detail the convergences and divergences of the mixed methods results, this section will informally consider several different areas in order to integrate data. First, it will address group differences between those who interviewed and those who did not. This section will then look closely at the relationship of perceived coercion and empowerment with motivation, using findings from both methods to elaborate and clarify these relationships. Emergent themes will then be compared with the constructs from the surveys, where applicable. This section will then look at the descriptive statistics for individual interviewees and compare these findings with interviewee's discussions of their experiences related to motivation. Lastly, data

will be integrated by mapping the statistical findings on to the grounded theory conceptual model described above.

Group Differences

A one-way analysis of variance (ANOVA) was conducted to investigate any significant group differences between the 11 participants who provided interviews (coded as 1 for 'interviewed') and the remaining 87 participants who did not (coded as 2 for 'did not interview'). Recent drug use (within the last 3 months) was the only variable that showed a significant difference, with individuals who opted to interview using on average 26.64 times (SD = 9.266) within the last 3 months as opposed to individuals who did not participate in interviews using on average 19.85 times (SD = 12.835) within the last 3 months. A Brown-Forsythe adjusted ANOVA showed the difference between groups with regard to recent drug use to be significant at the $p < .05$ level. However, given the group that interviewed consisted of only 11 individuals, results should be interpreted cautiously.

Cross Validation of Findings

With regard to the variables of interest, both the statistical and grounded theory analyses provided good cross-validation. The findings with regard to empowerment and perceived coercion according to both methods will be discussed below.

Empowerment

Statistical analysis showed that empowerment did not contribute significantly to the variance in motivation level, as measured by the URICA. It also did not predict whether or not someone showed internalized motivation. The grounded theory analysis

confirmed this finding. Participants had a difficult time discussing a direct relationship between empowerment and motivation. The grounded theory analysis, however, is helpful in explaining a more nuanced relationship between empowerment and motivation. It was only through this analysis that we could see such a relationship. As the conceptual model suggests, participants who were motivated to take steps toward recovery felt more empowered as a result. As Sam stated, "Choosing to not get high [is] empowering, 'cause right there you're taking control, period… [you] can feel empowered if you can just do that first step." Participants who continued using, thus showing lower motivation for change, felt more disempowered when it came to feelings of competence, confidence, and choice. Eugene described feeling "powerless" when using methamphetamine; he talked of needing to get advice from others in order to make important decisions in his life. Therefore, while the statistical analysis answered the question of whether empowerment was a predictor of motivation, it provided no further information about the relationship between empowerment and motivation. The grounded theory model helps deepen and enrich our understanding of how participants felt empowerment and motivation were related.

Perceived Coercion

The statistical analyses confirm the hypothesis that perceived coercion would impact motivation. Multiple regression showed that perceived coercion contributed significantly to variance in motivation level, while logistic regression showed that perceived coercion was the only variable that was predictive of internalized motivation, with lower levels of perceived coercion predicting internalized motivation. The grounded theory analysis showed a similar but more nuanced relationship. When participants

expressed feelings of resentment or anger about the court order (indicating higher levels of perceived coercion), they discussed subsequent negative impacts on motivation for treatment and/or recovery. When asked about her motivation as a result of the court order, Casi stated, "Um, it kind of kills it, for me… Being threatened to do it is just not no motivation at all." The grounded theory analysis provided further information, however, about how participants approached treatment even when they felt coerced. Theme 4 (*Anticipating the "Tools" of Treatment*) indicates that even for participants with low motivation due to feelings of coercion, there were still many expectations for treatment and a general sense of hope that treatment would be helpful. Stacie anticipated her treatment would "start with [her] mental health" as it would "help [her] stay clean," and Jenna admitted she would "get *something*" out of treatment. Even Casi acknowledged that "classes can help" and that she wanted to explore in treatment the connections between her mental health issues and drug use.

Comparing Themes to Survey Constructs

Another area for data integration involved looking at themes from the grounded theory analysis and comparing them with constructs from the questionnaire. In this study, the strongest comparison is between the regulation types from the Treatment Entry Questionnaire, which represent extent of internalized motivation, and the motivational themes from the interview data, Themes 1-3. The external regulation type, which reflects external coercion, is well represented by Theme 2 (*Court Order Impacts Motivation "for Better or Worse"*). This theme reflects external motivational factors as participants described their experiences with the court order as "a needed push" for treatment or a motivator to stay out of jail/prison. The introjected regulation type, which reflects

internalized representations of external motivating factors, is reflected in some of the subthemes of Theme 1 (*Positive Motivational Factors*). In particular, sensitivity to not being age-appropriate or not having the "normal stuff" may represent introjected motivation as one works toward recovery in order to meet society's expectations of where one "should be" developmentally. Additionally, shame and awareness of being labeled also represent external demands that have been internalized, but do not fully represent internalized motivation. Sam's acknowledgement of the embarrassment she felt at being "labeled" as a user during a check cashing incident provided her with more motivation to stay clean, but this is consistent with an internal representation of external demands. Some of the subthemes of Theme 1, including family values and responsibility, are more reflective of the identified regulation type, or that style in which one's motivation for recovery is consistent with one's personal beliefs and values. Additionally, Theme 3 (*Incongruence Between Using and the Core Self*) more adeptly represents the idea of identified, or internalized, motivation: One's motivation to change behavior is driven by an understanding that using is antithetical to who one "really is," or contrary to one's sense of self. In Philip's description of feeling like a "zombie" when using, he noted the "coldness" in his heart and "lack of values" were inconsistent with his sense of self and led to his motivational statement, "But I didn't want to be that way…"

Comparing Descriptive Statistics and Interview Excerpts

Data integration can also be accomplished by looking at the individual survey scores of interviewed participants and comparing/contrasting these scores with information provided in the interview. See Table 11 for scores of participants who interviewed. Jenna, Terran, and Casi were the 3 participants who, during their

interviews, expressed the least motivation for treatment and the most resentment for the court order. Their scores on survey data show lower motivation levels overall, and all 3 fell in the precontemplation stage according to the URICA. Similarly, regulation type for all 3 is not internalized, or 'nonidentified,' with Jenna and Terran as external and Casi as introjected. Perceived coercion levels are high for these 3 participants, with Jenna at a 9 and Terran and Casi both at 10. In contrast, Sam and Century conveyed more motivation for treatment than many of the other interviewees, despite or sometimes because of the court order. Their scores on survey data suggest a more nuanced relationship between the variables of interest, but still confirm the relationship between perceived coercion and regulation type. Sam and Century had lower perceived coercion scores (7 and 6, respectively) and scored in the identified regulation type, showing

Table 11

Scores on Survey Data for Interviewed Participants

Participant	Level of perceived coercion (5=low; 10=high; *M*=7.18; *SD*=2.08)	Empowerment score (*M*=2.9; *SD*=.265)	Motivation Level: Readiness to Change (*M*=9.61; *SD*=2.55)	Stage of change	Regulation type
"Utah"	5	2.79	13.14	Action	Identified
"Eugene"	5	3.00	12.86	Action	Identified
"Terran"	10	2.82	6.14	Precontemplation	External
"Sam"	7	3.29	11.86	Action	Identified
"Century"	6	3.0	9.71	Precontemplation	Identified
"Jenna"	9	3.36	8.86	Precontemplation	External
"Earl"	5	2.82	10.86	Contemplation	Identified
"Casi"	10	2.5	8.00	Precontemplation	Introjected
"Philip"	8	3.11	13.71	Maintenance	Introjected
"Bob"	5	2.79	10.57	Contemplation	Identified
"Stacie"	9	2.61	12.42	Action	Identified

internalized motivation. Their motivation level/readiness to change and stages of change were more variable, however, with Sam slightly above the mean in terms of motivation level and in the Action stage. Century's motivation level was slightly below the mean and she fell in the Precontemplation stage. Further validation for the statistical analysis and the grounded theory model comes from looking at the interview participants with the lowest levels of perceived coercion: Utah, Eugene, Earl, and Bob. All 4 showed internalized motivation, with regulation type as identified. Utah and Eugene had high readiness-to-change scores and were in the Action stage of change while Earl and Bob were in Contemplation. The survey profile for Stacie and Philip was less clear and challenged statistical results more. While both had higher levels of perceived coercion, they showed high motivation scores and were in higher stages of change, with Stacie's regulation type as identified or internalized, and Philip's as introjected, or less internalized. This inconsistency is reflected in Philip's statements, many of which seemed to represent internalized motivation (or an identified regulation type), yet his score on the Treatment Entry Questionnaire placed him in the introjected regulation type.

Integration of Conceptual Model and Statistical Analysis

One final approach to data integration involved looking at the conceptual model, which relates all of the themes from the grounded theory analysis, and mapping onto this model some of the statistical findings. Figure 3 represents an attempt at this type of integration, with statistical findings (in red) presented alongside the conceptual model. Along the left side of the model, where the court order is discussed and motivation is more typically negative, perceived coercion exerts the most influence. As the statistical results suggest, higher perceived coercion predicted lower levels of motivation.

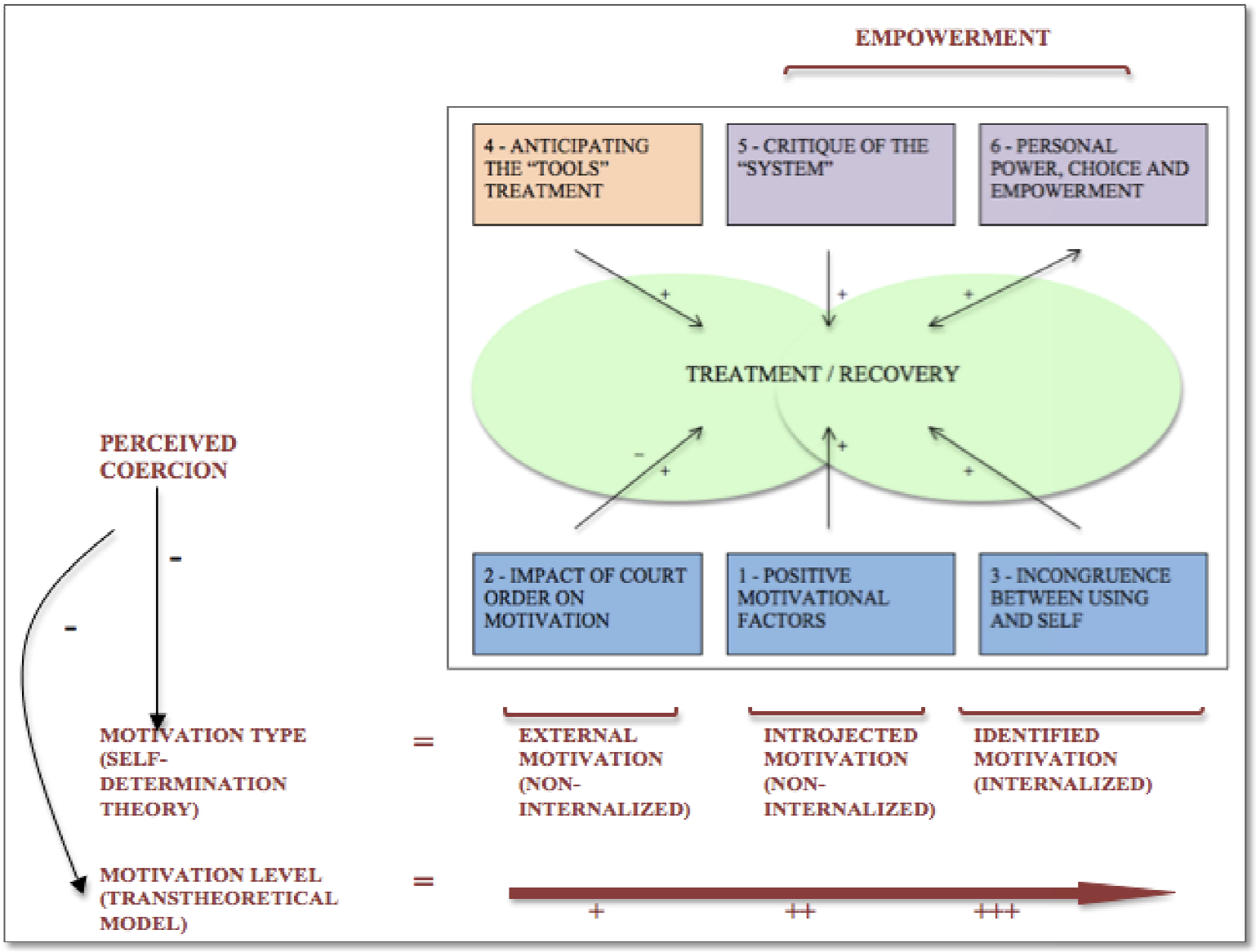

Figure 3. Integration of Conceptual Model and Statistical Findings

Additionally, perceived coercion is shown as exerting a negative influence on internalized motivation, as statistical results suggest higher perceived coercion predicts motivation that is *noninternalized* (external and introjected regulation types). Additionally, the constructs from the Treatment Entry Questionnaire representing extent of internalized motivation are placed in alignment with the qualitative themes they best represent, as discussed above. Motivation level was also positively correlated with more internalized motivation, and this statistical finding is depicted in the model as well. Finally, empowerment stands at the top of the model, unrelated directly to motivation. As statistical results showed, empowerment had no significant relationship to motivation and it did not predict motivation level or internalization at pretreatment. However, as discussed in the grounded theory section, analysis of interviews showed that when participants were more motivated to take steps toward recovery, they felt a subsequent increase in empowerment as a result.

CHAPTER 4

DISCUSSION

This study explored the impact of perceived coercion and empowerment on motivational processes for adults ordered through the criminal justice system to attend substance abuse treatment as the result of a drug-related offense. A mixed methods approach was used, employing both statistical and grounded theory analysis. Ninety-eight participants completed measures of perceived coercion, empowerment, and motivation as well as demographic and drug use history questionnaires. Eleven of the 98 participants took part in interviews. Survey data were analyzed using bivariate correlation, multiple regression, and logistic regression analyses. Interview data were transcribed and analyzed using grounded theory analysis and a conceptual model of emergent themes was created in order to generate a core "story," or brief narrative of the most important aspects of the data.

Results from the quantitative analysis provided support for the hypothesis that perceived coercion would predict level of motivation and whether or not motivation was internalized. Results did not support the hypothesis that empowerment would predict motivational processes; empowerment did not predict motivation level or internalization status of participants. Additionally, empowerment and perceived coercion were

correlated in the negative direction, as hypothesized. Unlike the hypothesis, however, the correlation was not significant.

Qualitative analysis yielded six themes, several of which provided further support for the above findings while also allowing a richer understanding of the relationship among perceived coercion, empowerment, and motivation. In *The Court Order Impacts Motivation "For Better or Worse,"* participants discussed the court order in part as coercive and contributing negatively to their motivation for substance abuse treatment and/or recovery. However, many participants also saw the court order as a "needed push" and a positive motivating factor for treatment. Two additional themes further expressed participants' motivation for treatment and/or recovery, including *Positive Motivational Factors* and *Using as Incongruent with the Core Self*. One theme, *Anticipating the "Tools" of Treatment*, indicated that even when participants felt coerced and subsequently had low motivation for treatment, they still held high expectations for treatment. In further support of the quantitative results, interview participants had a difficult time discussing a direct relationship between empowerment and motivation. One theme, *Personal Power, Choice, and the Role of Recovery in Promoting Empowerment*, detailed a more nuanced relationship between empowerment and motivation, however, namely that taking steps toward recovery led to enhanced feelings of empowerment. A second empowerment-related theme, *Critique of the System in Order to Promote Recovery*, offered critical feedback about and suggestions for improving treatment programs and community awareness. In general, the six themes and the conceptual model confirmed findings from the statistical analysis. They also

provided an expanded understanding of the relationship among perceived coercion, empowerment, and motivational processes for individuals at pretreatment.

The results will be further summarized below and discussed within the context of existing literature. Where appropriate, attempts will be made to discuss the integration of both quantitative and qualitative findings.

Summary and Discussion of Major Findings

Research Questions 1 and 2

This section details the current study's findings with regard to the statistical relationship between perceived coercion and empowerment as well as the predictive ability of these two variables on motivational processes. It attempts to situate the findings within the larger literature base and, where appropriate, the grounded theory results from this study.

Perceived Coercion and Empowerment

With regard to the statistical relationship between perceived coercion and empowerment, these two variables were found to share little variance and to correlate with one another in the expected negative directions. This correlation was not significant, however. While few studies have looked at the statistical relationship between perceived coercion and empowerment, this finding is consistent with the existing literature. Although not completed with a substance abuse population, Strack and Schulenberg (2009) examined the relationship between perceived coercion for treatment and levels of empowerment among individuals who were placed in inpatient treatment due to serious mental illness. Results indicated a negative but nonsignificant relationship,

consistent with this study. Using qualitative analysis, VanDeMark (2007) found that women who were court ordered to substance abuse treatment stated that being coerced was not necessarily indicative of feelings of loss of control in one's life, again consistent with this study. However, VanDeMark's findings were in reference to an objective source of coercion and did not distinguish among levels of perceived coercion.

The hypothesis that perceived coercion and empowerment would be moderately correlated was not supported. This hypothesis was based on an understanding that perceived coercion suggests a lack of control and choice while empowerment suggests the presence of both. In reality, empowerment is likely a far more complex construct and encompasses more than feelings of control and choice. The measure used to capture empowerment in this study, the Empowerment Scale, is in part based on Dickerson's (1998) conceptualization of psychological empowerment and incorporates a wide nexus of components, including self-esteem, power/powerlessness, optimism and control over the future, community activism and autonomy, and righteous anger. This conceptualization includes, to some extent, a sociopolitical critique of institutional and cultural barriers, discussed further by Morrow and Hawxhurst (1998). As a whole then, the construct of empowerment goes beyond control and choice and therefore may have little to do with a sense of coercion into treatment or not.

Perceived Coercion and Motivation

The results of this study confirmed the hypothesis that perceived coercion would predict motivational processes at pretreatment, including motivation level and internalized status of motivation.

Hierarchical multiple regression analysis indicated that higher levels of perceived coercion could predict lower levels of motivation (readiness to change) and vice versa. Perceived coercion was the only significant predictor variable in a model consisting of sex, age, number of past treatment episodes, recent use, and empowerment level. Given the void in the literature regarding the relationship of perceived coercion and motivation, the results of this study represent a new contribution.

Although there is little research available with which to compare the results directly, there is a growing body of research about the impact of perceived coercion on treatment willingness and engagement, most of which suggests perceived coercion does not play a role in these treatment processes. Cusack, Steadman, and Herring (2010) found that levels of perceived coercion for a jail diversion program consisting of outpatient mental health services did not impact the amount of services utilized or level of treatment engagement. In other words, high perceived coercion at baseline did not appear to negatively impact use of or engagement in treatment services. Likewise, Prendergast et al. (2008) found that perceived coercion was not a significant predictor of treatment completion for those mandated to substance abuse treatment by the criminal justice system. The qualitative findings from the current study may explain this, particularly the theme developing participants' perceptions that despite feeling coerced into treatment, many had high expectations and/or hopes for treatment with regard to improving overall mental health.

Although perceived coercion predicted motivation in this study, the literature referenced above suggests perceived coercion does not impact treatment engagement and completion rates. However, literature also suggests that motivation level is a predictor of

treatment engagement, participation, completion, and substance use outcome (De Leon, Melnick, and Tims, 2001; Klag, O'Callaghan, and Creed, 2004; Knight et al., 2003; Simpson & Joe, 1993). If perceived coercion predicts motivation but does not predict treatment engagement and completion (while motivation does), there may be other important intervening variables that play a role in keeping individuals with high levels of coercion engaged in treatment and committed to sobriety afterward. Future research exploring these variables is needed in order to better understand the complex process of mandated treatment.

Perceived coercion and motivation level were also found to have a large negative correlation in this study, indicating that higher levels of perceived coercion were associated with lower levels of motivation and vice versa. Prendergast et al. (2008) found a small negative correlation between the two constructs in a large population of clients court-mandated to substance abuse treatment. The results of the current study confirm the negative correlation, as expected, but indicate a stronger relationship between perceived coercion and motivation than previously found in the literature. This may represent an especially significant finding given Prendergast et al. used the SOCRATES as a motivation measure, which includes the subscale Taking Steps. Use of this subscale may have artificially inflated overall motivation level in a population already beginning court-ordered treatment, and therefore the correlation value may have also been inflated. The current study suggests perceived coercion and motivation may be even more strongly correlated than thought.

Results of this study also indicated that levels of perceived coercion were able to predict whether or not an individual's motivation level was internalized. Higher levels of

perceived coercion predicted nonidentified regulation type (representing *noninternalized* motivation), and lower levels predicted identified regulation type (representing internalized motivation). Perceived coercion was negatively correlated with regulation type, meaning that higher perceived coercion levels were related to less internalized motivation and vice versa. These findings complement the study by Wild, Cunningham, and Ryan (2006) which found that identified regulation type (representing internalized motivation) was negatively correlated with individuals' subjective sense of coercion. They also found that identified regulation type predicted more awareness of the benefits of reducing substance use, attempts to reduce drinking and drug use, and interest in engaging in upcoming treatment.

Consistent with other research on coercion, results of the present study suggest that individuals who are ordered through the criminal justice system for treatment do not all perceive themselves to be coerced into treatment (Wild, Newton-Taylor, & Alletto, 1998). All 98 participants in this study were ordered by a judge or a parole/probation officer to participate in substance abuse assessment and treatment as a result of a drug-related offense. However, responses on the MacArthur Perceived Coercion scale showed a fairly normal distribution of perceived coercion levels, indicating that not all participants felt a subjective sense of coercion. This is consistent with the study by Prendergast et al. (2008) where the mean perceived coercion score was lower than hypothesized, indicating that despite being under pressure to enter court-mandated treatment, many individuals perceived their level of coercion for treatment was low. Similarly, Wild, Newton-Taylor, and Alletto (1998) found that 35% of participants undergoing substance abuse treatment under external order from the courts did not report

feeling coerced, while 35% who were self-referred for treatment did report coercion. Although not a study of motivation levels, data from the Drug Abuse and Treatment Outcome Studies (DATOS) indicated that 40% of clients referred to treatment by the criminal justice system agreed with the statement that they "would have entered drug treatment without pressure from the criminal justice system" (Farabee, Prendergast, & Anglin, 1998). The grounded theory results from the current study further develop this idea, particularly in the second theme where participants described feeling that the court order was a "needed push" and contributed positively to their motivation for recovery. All of this underscores the importance of understanding coercion from the subjective perspective of the client as he/she prepares to enter treatment.

Empowerment and Motivation

With regard to the predictive ability of empowerment on motivation, results suggest that empowerment was unable to predict motivational processes for individuals at the pretreatment stage. Contrary to the hypothesis, empowerment did not predict variance in motivation level or whether or not a participant showed internalized motivation. Additionally, correlation coefficients did not show a significant relationship between empowerment and motivation level or extent of internalization.

To date, there is no literature detailing empowerment's predictive abilities on motivation for treatment/recovery for individuals with substance abuse problems. This study is unique in exploring this relationship. However, the literature on empowerment in substance abuse treatment indicates that there is a relationship, although somewhat unclear, between empowerment, treatment processes, and recovery. A few studies have suggested that incorporating empowerment-based interventions during substance abuse

treatment can enhance empowerment and contribute to positive outcome, including more treatment engagement and reduced use. Three studies suggest this is the case for women with trauma histories undergoing substance abuse treatment (Cocozza, 2005; Morissey, Jackson et al., 2005; VanDeMark, 2007). Additionally, in a study of veterans with alcohol problems, Resnick and Rosenheck (2008) incorporated an empowerment-enhancement approach during group therapy and found that those who received this intervention showed an increase in empowerment and a decrease in alcohol use compared with the control group. While the directionality between reduced use and empowerment cannot be assumed from their results, the authors proposed a connection between empowerment and recovery. Finally, in a qualitative analysis of individuals in substance abuse treatment, Lafave, Desportes, and McBride (2009) found that those in a treatment group receiving empowerment-based interventions indicated reduced ambivalence about use, indicating enhanced motivation. There was no control group with which to compare the outcome, however. Given some of this research, the current study hypothesized that empowerment might play a role in predicting participants' motivational processes; results suggest this is not the case. Nonetheless, empowerment is likely an important factor during the recovery process and in maintaining sobriety.

Grounded theory analysis further supported the statistical finding that empowerment did not predict motivation or share a statistical relationship with either motivation level or internalized motivation status. Analysis of interviews suggested that participants had a difficult time discussing a direct relationship between empowerment and their motivation for both treatment and recovery. However, grounded theory findings did suggest that once participants took steps toward recovery, indicating the

presence of motivation, they felt more empowered as a result, particularly with regard to choice and competence. This may help explain the above research findings more clearly, namely that individuals may be more receptive to empowerment-based interventions as they work toward recovery and begin to feel a sense of mastery over their addiction.

The complex construct of empowerment, based on Dickerson's (1998) conceptualization and as measured by this study, may have little to do with motivational processes. However, as participants suggested, motivation for reducing use and working toward recovery may help facilitate feelings of control, power, and self-esteem. Empowerment may be an important end result of motivation for treatment/recovery. More research in this area is needed.

Research Question 3

The third research question, or set of questions, was intended to delve more deeply into the relationship between perceived coercion, empowerment, and motivation. This was achieved by interviewing participants about their experiences in these areas given the background of an order through the criminal justice system for substance abuse treatment. Six themes emerged that captured the complexity of experiences with regard to subjective feelings of coercion, motivation for treatment/recovery, and the role of empowerment in one's life. Together, they form the model discussed in the results section and comprise a "core story" of participant experiences. The six themes are summarized and discussed below within the context of existing literature and the quantitative findings for this study, where relevant.

Themes 1-3 express participants' experiences with motivation for substance abuse treatment and/or recovery. Theme 1, or *Positive Motivational Factors*, was the largest

and most developed theme. All participants provided accounts of factors other than the court order, but within the context of it, that contributed to their motivation for treatment and/or recovery. Positive motivational factors mainly included the social, interpersonal and personal issues motivating people toward recovery. These issues included a desire to be seen as age appropriate, to have a "normal" life, to build and/or repair relationships with family members, and to avoid the shame related to being seen by others as a user. A strong component of this theme was an understanding of the consequences of use: broken family relationships, shame and embarrassment, and not having a "normal" life. This is consistent with literature suggesting that perceived harms of future use to self and others (including threats to health, job, family, and friendships) is one of the strongest predictors of commitment to abstinence (Hser, 2007; Laudet & Stanick, 2010). Participants indeed spoke of these concerns as perceived harms of continued use. This theme is also consistent with the conceptualization of motivation provided by Self-Determination Theory (SDT), which sees motivation represented as a continuum of internalization (Deci & Ryan, 1985). Both the introjected and identified regulation types seem to be represented within this theme. Introjected regulation represents motivation as internal representations of external demands. For participants in this study, subthemes such as wanting to be seen as age appropriate, having expectations of what a "normal life" should entail, and feeling shame from using are all consistent with introjected motivation. Contrasted with introjected regulation is identified, or internalized, regulation type where motivation comes from attitudes and behaviors that are congruent with a person's values and goals and reflect sense of self. Participants' motivation to stop using for the sake of family values and goals related to rebuilding or creating family seems consistent with

identified, or internalized, motivation. This type of motivation is further developed in Theme 3, discussed below.

Theme 2, or *The Court Order Impacts Motivation "For Better or Worse,"* details participants' perceptions about the court order's impact on motivation. The majority of participants expressed ambivalence about the impact the court order had on motivation, speaking of the court order as both positively and negatively affecting motivation, often at the same time. For participants who indicated their motivation was more negatively impacted by the court order overall, a stronger sense of perceived coercion was expressed. This sense of coercion served to discourage participants from wanting to attend treatment and, for a couple of participants, led to increased desire to use. This is consistent with the statistical findings for this study, which showed that sample higher perceived coercion predicted lower motivation levels and *noninternalized* motivation (or motivation coming primarily from external sources). However, many participants also felt the court order was a "needed push" that would encourage them to seek treatment, and hence work toward recovery. They noted that without the order, they likely would not go to treatment or work toward sobriety. This theme and the statistical results further illustrate the concept of external motivation developed by Self-Determination Theory. When individuals in this sample experienced higher levels of perceived coercion, they were more likely to show *noninternalized* motivation. The literature suggests that external motivation is predictive of absence from treatment and associated with poorer outcome (Zeldman, Ryan, & Friscella, 2004). It was also found to be higher among individuals with legal referrals to treatment, and positively correlated with social network pressures to quit, cut down, and/or enter treatment (Wild, Cunningham, & Ryan, 2006).

However, some of this same literature suggests external motivation can strongly impact recovery behavior in a positive manner when individuals also show high internal motivation at the same time (Zeldman, Ryan, & Friscella, 2004). The "needed push" acknowledged by interviewees in this study is likely a critical factor in recovery.

The third theme, *Incongruence Between Using and the Core Self*, was the last theme to focus strongly on motivation. Unlike the other two themes discussed above, this theme developed the motivating factors around recovery that were truly personal, relating to one's sense of self. The observed incongruence between who one was while using as opposed to who one was when sober was discussed as a motivating factor for sobriety. Participants described being "a different person" when using, being unable to make good decisions for oneself when using, and feeling anger/disappointment with oneself for using. These subthemes effectively illustrate the identified regulation type from the Self-Determination Theory's model of internalized motivation, which sees motivation as coming from attitudes and behaviors that are congruent with a person's values and goals and reflect that person's sense of self. When participants are motivated to stop using because they see drug use as incongruent with who they "really" are, they are expressing internalized motivation. Literature supports a connection between internalized motivation and behaviors consistent with recovery. Internalized motivation predicted higher retention in treatment and lower relapse rates for clients in a methadone maintenance program (Zeldman, Ryan, & Friscella, 2004) and in an alcohol abuse program (Ryan, Plant, & O'Malley, 1995).

Regardless of motivation levels, in fact, even when motivation appeared to be negatively impacted by the court order, many participants still held high expectations for

treatment. The fourth theme, *Anticipating the "Tools" of Substance Abuse Treatment*, develops these expectations. Many participants anticipated receiving general "tools" that would help would facilitate recovery. They also hoped to address mental health issues they felt were connected to their use. This theme stood apart from the motivational themes discussed above, and it stands apart from the two discussed below, which relate more to empowerment. Nonetheless, this theme illustrates the hope and high expectations many participants had for court-ordered treatment, even when they felt coerced and/or felt the court order negatively impacted their motivation to attend treatment and work toward recovery. Literature suggests that expectations for treatment may be an important factor in individuals' recovery efforts. DiClemente, Doyle, and Donovan (2009) found that positive treatment expectancies were related to higher motivation to change drinking behavior. High expectations may also predict a positive working alliance early in treatment (Connors et al., 1997) and lower treatment dropout rates (Edens & Willoughby, 2000). In general, the findings related to this theme are significant for our understanding of the effects of mandated or coerced treatment. Even when complaining of negative effects of the court order, participants in this study continued to be hopeful they would, in Jenna's words, "get *something*" out of treatment.

The last two themes also fall outside the continuum of motivation, although they continue to relate to expectations about treatment and recovery. The fifth theme, *Critique of the "System" in Order to Promote Recovery*, develops participants' critical feedback about and suggestions for improving treatment programs and community awareness. Although participants did not name this theme as empowerment, it is consistent with theories of empowerment that suggest a political or sociopolitical component to this

complex construct. Morrow and Hawxhurst (1998) argued that empowerment involves an understanding of larger societal issues. Accordingly, when the "social/political level is unacknowledged, an individual is likely to blame her/himself for life circumstances" (Morrow & Hawxhurst, 1998; p. 45). Participants acknowledged the social/political level by critiquing the financial component of court-ordered treatment, questioning the legal status of drugs and alcohol, proposing gender-specific treatment programs, calling for more awareness in the community about substance abuse, and encouraging treatment providers to promote honesty from clients. The goal of such critiques was generally to make treatment more effective in order to facilitate recovery. Further research is needed that encourages individuals involved in substance abuse treatment to identify barriers at the social/political level. Identifying such barriers, particularly those that perpetuate social injustice, could lead to improved efforts at a systemic level to enhance the recovery experience for all people.

One interesting finding that did not relate to the original research question but emerged as part of Theme 5 was the need for gender-specific treatment for women. Female interview participants spoke of some of the barriers to treatment, including reduced access to detoxification services and a need to focus on the development of parenting skills while in treatment. Statistical results from this study also showed that being female was correlated with lower levels of empowerment, which may capture female participants' perception that they have more limited access to resources. The literature suggests that women typically face more barriers to substance abuse treatment than do men, including fear of losing custody of children, stigma associated with being a woman or mother with addiction, concerns related to pregnancy, fear of prosecution, and

childcare problems (Ashley, Mardsen, & Brady, 2003; Brienza & Stein, 2002; Greenfield, 2007; Jackson & Shannon, 2012; Tuchman, 2010). Additionally, women with addiction typically have fewer resources than do men, including lower employment, education, and income (Tomás-Rosselló et al., 2010). Also, while social support buffers the impact of stress for many populations, this is not true for women with substance abuse problems who are economically disadvantaged (Mulia et al., 2008).

The last theme, *Personal Power, Choice, and the Role of Recovery in Promoting Empowerment*, expressed several key components of empowerment, including the role of choice, personal power, and competence as important during recovery. Instead of providing support for the original hypothesis, that empowerment would predict motivation levels for recovery, this theme suggested a unique function of empowerment, namely that it resulted from action toward recovery. In other words, motivation to work toward recovery appeared to facilitate enhanced empowerment, namely increased sense of choice, competence, self-esteem, and personal power. A majority of participants noted the ways in which these components of empowerment promoted recovery once that process was already begun. As discussed above, the literature on empowerment and recovery does not suggest a direct relationship between empowerment and motivation, and the statistical findings from the current study suggest that empowerment is not a predictor of motivation at pretreatment. Nonetheless, a growing body of research does indicate that empowerment may play a role in recovery, namely treatment engagement and/or reduction of use (Cocozza, 2005; Morissey, Jackson, et al., 2005; Resnick & Rosenheck, 2008; VanDeMark, 2007). This role is not yet clear in the existing literature. However, in a study by Toussaint, VanDeMark, Borneman, and Graeber (2007),

individuals in substance abuse who were treated under the Trauma Recovery and Empowerment Model showed better mental health functioning with regard to self-esteem and reduction of trauma-related symptoms. It may be that as individuals work through addiction treatment and take steps toward recovery, they experience an increase in empowerment and as a result exhibit better psychological functioning, which helps with further efforts to achieve and/or maintain sobriety. Further research examining the function of empowerment during the treatment process will help elucidate its role in recovery.

Limitations and Implications for Research

One major limitation to this research was the use of self-report measures without a measure of social desirability. This may have compromised the validity of the measures, including the Drug Use Inventory, URICA, TEQ, and the Empowerment Scale. Given that all participants were involved in the legal system for drug-related offenses and faced potential consequences for continued use, it is possible that reports of current drug use may have been minimized and reports of motivational behavior on the surveys, such as taking steps to reduce use, may have been exaggerated. While efforts were made to inform and reassure participants about confidentiality, this response pattern may still have impacted results. Including a measure of social desirability, such as the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960), may have allowed data analysis to control for this variable.

The Empowerment Scale showed fair-to-poor internal consistency with this sample, especially among the individual subscales, which represents another limitation in interpreting the results. Although this measure has not been validated with a substance

abusing population, it showed good internal consistency with individuals with mental health issues in both inpatient and outpatient settings. Given the scale's reliability issues with the population in this study, however, empowerment may not have been adequately measured during data collection. Other empowerment scales that have been validated with a substance abusing population, or those involved in the criminal justice system, may have yielded different findings. However, at this time, no such measure exists. Future research efforts at developing such a measure would be beneficial.

Although the Treatment Entry Questionnaire showed good internal consistency with this population, general concerns remain about the TEQ's ability to fully capture Deci and Ryan's (1985) continuum of internalization. The most advanced stage of internalized motivation (Integrated regulation type) is not measured by the TEQ. Also, collapsing the three regulation types into two as done in this study may have represented the loss of some information and prevented results from saying more about how perceived coercion and empowerment predicted the extent of internalization of motivation. Given the very unequal distribution of scores across types, however, this was a necessary step as it still allowed analysis to answer the research question. Also, the scoring procedure for the TEQ does not account for high or similar mean values across the three subscales. An individual could be similarly high in introjected and identified regulation, but placed in the identified category if the mean score on this scale is slightly higher. This does not account for the possibility that individuals fit into more than one regulation type at once, though literature suggests this is indeed the case (Zeldman, Ryan, & Friscella, 2004). There may be other methods of assessing the applicability of Deci and Ryan's continuum of internalization besides a self-report measure. Future qualitative

research might consider questions that are aimed at better understanding the process by which motivation becomes internalized. Such questions might specifically ask how attitudes and behaviors related to motivation reflect values, goals, and sense of self.

Another limitation refers to the use of the TEQ and the URICA in this study. Most research using these scales, indeed the research in which they were both validated, uses the TEQ and the URICA as predictor variables, not dependent variables. Further research that uses these scales as dependent variables, or outcome variables, would allow for a more robust understanding of their usage with a substance abusing population.

The majority of participants in this sample identified as White/Caucasian. The homogeneity with regard to race/ethnicity represents a limitation. Although the racial and ethnic demographics of the sample are representative of the clientele at Assessment and Referral Services and the wider Salt Lake county, the findings may be limited with regard to their relevance to groups with more racial and ethnic diversity. Additionally, 8 of the 11 participants who interviewed identified as White/Caucasian and all 11 identified as heterosexual. More research with LGBT individuals with substance abuse problems is needed, particularly in understanding expectations about and perceived barriers to treatment/recovery.

The cross-sectional design of this study limits the conclusions that can be drawn since causal relationships cannot be inferred. Although perceived coercion predicted motivation in this sample, we cannot conclude that higher perceived coercion causes lower motivation or vice versa. It may be that individuals who show low motivation for change tend to interpret their court order for treatment as more coercive than individuals who are ready for change. A more rigorous design such as a longitudinal or experimental

design would improve the ability of researchers to examine causal relationships. Future research utilizing such designs is needed in order to make conclusions about the causal relationships between perceived coercion, empowerment, and motivational processes.

With regard to grounded theory analysis, follow-up interviews and/or a focus group with interview participants may have allowed further development and clarification of the themes and the model. Given the housing situation for the majority of ARS clients is unstable, which includes limited ability for contact via phone call, plans for follow-up interviews or focus groups were not included in the proposal. As expected, many of the participants were unable to provide permanent phone numbers for the drawing, instead providing phone numbers or emails of individuals who could be in touch with them should they be selected in the drawing. Nonetheless, engaging participants in the analysis process in order to verify findings is often typical of grounded theory analysis and allows for more data sources as well as the opportunity to clarify and enrich initial findings.

In general, more qualitative research is needed that looks at motivational processes of individuals ordered to substance abuse treatment. Because of the limitations around self-report measures in general and the psychometrics of motivation measures specifically, qualitative research provides a way to further investigate and understand the complexity of motivational processes. While this study provided a good initial investigation into the relationship among perceived coercion, empowerment, and motivation, further research that looks more deeply at any one of these topics among individuals with substance abuse problems would be valuable.

Strengths

This study represents a unique contribution to the literature in that it used a mixed methods approach to better understand how perceived coercion and empowerment relate to motivation. This approach allowed data from both quantitative and qualitative findings to be cross-validated and integrated, which helped enrich the findings. For example, perceived coercion was found to be a strong predictor of motivation level and internalization in the quantitative findings. While the qualitative findings provided support for this relationship, they also suggested that even when perceived coercion is high and motivation is low and less internalized, individuals still hold strong expectations for substance abuse treatment with regard to addressing mental health issues and learning the "tools" of treatment.

The study also looked at motivation from two different theories, the Transtheoretical Model of Change (Prochaska & DiClemente, 1982) and Self-Determination Theory (Deci & Ryan, 1985). By exploring both motivation level and internalized motivation status, the results provide a more comprehensive understanding of motivational processes. The quantitative findings are consistent across both constructs of motivation and suggest that perceived coercion predicts both motivation level and whether or not motivation is internalized. Additionally, the grounded theory model provided good support for the construct of an internalized motivation continuum, with Themes 1-3 representing external, introjected, and internalized motivation. Finally, with regard to motivation, this study used a continuous readiness to change score instead of stages of change, which, as discussed by Blanchard, Morgenstern, Morgan and Labouvie (2003), provided a stronger indicator of motivation than categorical subtypes.

Participants in this study identified hard drugs as their primary problem as opposed to alcohol use. Consequently, their involvement in the criminal justice system resulted from a drug-related offense. Much of the literature on substance abuse and motivational processes has looked at individuals with either alcohol or mixed drug- and alcohol-use problems. The current study helps distinguish a population of individuals who identify drug use as their primary problem.

Finally, this study makes a contribution to the literature on empowerment and substance abuse. Although the hypothesis that empowerment would predict motivational processes was not supported, the results still suggest that empowerment plays an important role in the recovery process. Taking action to reduce one's substance use may lead to feelings of enhanced competence, choice, and self-esteem. Given empowerment has been shown to be an important factor in outcome during substance abuse treatment, this study suggests that empowerment-based interventions may be most effective when individuals are already working toward recovery.

Implications for Clinical Work and Social Justice

Given the increase in clients who are participating in mandated substance abuse, it is important for clinicians to understand the subjective perception of coercion for their clients. An objective source of coercion (i.e., legal mandate) does not necessarily imply that clients will feel coerced. Assuming that individuals who are mandated to treatment feel coerced and subsequently have low motivation is not correct. However, when clinicians are able to effectively understand subjective perceptions of coercion, they can work with individuals who do feel coerced to enhance motivation by using motivational interviewing techniques to help clients develop change talk. Additionally, as the

grounded theory analysis in this study indicates, even when individuals feel strongly coerced into treatment (and subsequently show lower motivation), they may still hold high expectations for treatment and maintain hope that they can address mental health issues and gain important skills as a result of treatment. Capitalizing on clients' hope and expectations, even when they have low motivation, may offer clinicians an effective route toward working with clients and enhancing treatment engagement. Asking questions such as, "You're here under some pressure and you don't feel particularly motivated, but what are some things you think you can still get out of treatment?" may be a way to achieve this goal.

The finding that women in this sample had lower levels of empowerment than their male counterparts is cause for concern. An important subtheme that developed from the interview data highlighted some of the limitations to treatment that women experienced, which may negatively impact their feelings of empowerment. Treatment programs should work to address these limitations, particularly around child-rearing and custodial issues, and to enhance empowerment among female clients.

The results suggest that empowerment may be an important result of motivation, specifically of taking steps toward recovery. Although empowerment may not predict motivation at pretreatment, efforts to enhance empowerment during treatment may be more possible as clients begin the process of recovery. This is significant given we know empowerment can play an important role in treatment retention and outcome. Therefore, interventions aimed at increasing empowerment will be more effective for individuals who are already exhibiting some behaviors consistent with motivation. Lastly, from the perspective of empowerment on a sociopolitical level, treatment agencies and policy

makers should consider participants' critiques of "the system." This would allow those in positions of power to understand and address the barriers that many individuals face as they navigate the complexity of the criminal justice system, mandated treatment, and addiction.

Conclusion

This mixed methods dissertation attempted to understand the impact of perceived coercion and empowerment on motivational processes for adults ordered by the criminal justice system to attend substance abuse treatment. Data were collected from 98 adults ordered by a probation/parole officer or judge to undergo assessment and treatment for substance abuse problems as the result of a drug-related offense. It was hypothesized that perceived coercion and empowerment would be negatively correlated and share a significant amount of variance. This hypothesis was not supported by the data: Perceived coercion and empowerment were correlated in the expected direction but were not significantly correlated. It was also hypothesized that perceived coercion and empowerment would predict motivation level and whether or not motivation was internalized. Perceived coercion was a predictor of both processes while empowerment was predictive of neither. A grounded theory analysis of 11 participant interviews resulted in the emergence of six themes that further developed the relationship among perceived coercion, empowerment, and motivation. The grounded theory model provided good validation of the statistical findings, suggesting that when participants spoke of feeling coerced into treatment, they spoke of a negative impact on motivation. However, the majority of interviewees, regardless of their feelings about the court order, had high expectations for treatment and anticipated addressing mental health issues and

other “tools” of treatment. In further support of the statistical findings, interview participants also had a difficult time describing empowerment as impacting motivation. Instead, many participants suggested that as they worked toward recovery, which reflected a foundation of motivation, they often felt more empowered as a result.

This study contributes to the literature on motivational processes for individuals who are involved in the criminal justice system and beginning substance abuse treatment as the result of drug-related offenses. It suggests that perceived coercion has a stronger impact on motivation, both readiness for change and extent to which motivation is internalized, than other studies have theorized or shown. It also suggests that empowerment and perceived coercion are unrelated constructs and that empowerment, while not predicting motivational processes, may in fact be enhanced by motivationally-based behavior toward recovery.

APPENDIX A

RECRUITMENT FLIER

Research on Motivation, Drug Use, and Individuals Ordered to Treatment

Have you been ordered to attend substance abuse treatment?

- Are you involved in the criminal justice system for a drug-related offense?
- Are you currently using drugs or have you used drugs within the last 3 months?

If you answered **yes to all of the above**, are you willing to participate in research about the effects of being ordered to treatment on motivation?

Participation involves the following:
- (Required) Answering 6 questionnaires for approximately 60-90 minutes.
- (Optional) Participating in a 60-90 minute individual interview with the researcher about your experiences related to motivation around substance abuse treatment

*Your participation in this study is voluntary and confidential. Participating will **not** impact the results of your evaluation or treatment referral at Assessment & Referral Services.*

Compensation in the form of a drawing will be offered. Participants will be entered into a drawing to win one of four **$50 gift certificates to Smith's Marketplace** in Salt Lake City.

I am a doctoral student in the Counseling Psychology Program at the University of Utah, where this research is being conducted. My advisor is Professor Susan L. Morrow. If you have questions or concerns, please contact us (Jo Merrill or Professor Morrow) at 801-581-7148.

APPENDIX B

IRB INFORMED CONSENT DOCUMENT

BACKGROUND

You are being asked to take part in a research study on motivation for substance abuse treatment for individuals ordered to attend treatment as the result of a drug-related charge. This research is being done to fulfill the requirements for a doctoral dissertation at the University of Utah and is supported by the researcher's faculty advisor.

This study is independent of Assessment & Referral Services. Your decision to participate in this study will not affect the assessment or treatment recommendations you will receive from ARS, nor will it affect your status in the criminal justice system in any way.

Before you decide to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully, and ask if there is anything that is not clear or if you would like more information. Take time to decide whether you want to volunteer to take part in this study.

The purpose of this study is to learn more about the motivational processes of adults, ages 18 and above, who have been ordered to attend substance abuse treatment as the result of a drug-related charge. In this study, motivational processes consist of an individual's thoughts, beliefs, and behaviors related to drug use. This study will also look at how being ordered to treatment may affect motivation for changing drug use patterns. It will also look at how feelings of personal empowerment may affect motivation for change. In this study, empowerment refers to an individual's feelings of power, choice, and ability to make decisions. We hope to use this research to provide information to researchers and treatment providers about the effects of being ordered to treatment on motivation. The researcher hopes to recruit about 120 participants.

STUDY PROCEDURE

Your participation in this study will take from 1 to 1.5 hours; and, if you decide you want to take part in the interview, it will involve an additional 1 to 1.5 hours of your time, for a total of 2 to 3 hours maximum. You will be asked to:

- Complete a packet of surveys provided to you by the researcher. The packet will also contain a form asking about your current drug use and a brief demographic questionnaire, which asks about general characteristics like age, gender, and race. This will take approximately 1 to 1.5 hours. All survey information you provide is anonymous.
- Optional: Take part in an individual interview in which you will be asked about your thoughts, feelings, and experiences regarding motivation, empowerment, and being ordered to attend substance abuse treatment. The

interview will take approximately 1 to 1.5 hours and will be audio recorded. Your name will not be recorded as part of the interview; you may use a pseudonym if you would like.

RISKS

The risks of taking part in this study are considered minimal. It is possible that you may feel upset talking about personal information related to your experiences with substance use and being ordered to attend treatment. These risks are similar to those you experience when discussing personal information with others. If you feel upset from this experience, you can tell the researcher, and she will tell you about resources available to help.

BENEFITS

The researcher cannot promise any direct benefit for taking part in this study. However, our experience is that having the opportunity to talk about these kinds of issues may result in increased self-awareness and positive feelings about sharing your thoughts and feelings with other people and the possibility of sharing information that will help others.

COSTS AND COMPENSATION TO PARTICIPANTS

There will not be any financial costs to you for participating in this study.

By choosing to participate in the study, you will be automatically entered into a drawing to win one of four $50 gift cards to Smith's Marketplace. I will give you a number when you decide to participate, and I will keep a copy of that number along with a phone number where you may be reached in several months. After I have completed data collection in approximately three-to-four months, I will randomly draw four numbers and contact participants who have won. Gift cards will be available for pick-up at the front desk of Assessment & Referral Services, 450 South 900 East, Suite 300, Salt Lake City, UT. Each participant will only be entered into the drawing once, regardless of your decision to participate in the interview portion of the study, which is optional.

CONFIDENTIALITY

The information you share will be kept confidential. Surveys, contact information for the drawing, signed consent forms, and audio recordings and transcripts will be stored in a locked filing cabinet or on a password protected computer located in the researcher's work space. Only the researcher will have access to this information.

Should you choose to participate in the interview, your interview will be recorded with a digital voice recorder. The recordings will be used so the researcher can make a typed transcript of each interview in order to better analyze the results. The recording and transcript will be assigned a code name (which you may choose if you wish), which will be kept with your interview. At the end of the study, the surveys, audio recordings and contact information for the drawing will be destroyed. In the case of publications, only your code name will be used, and every effort will be made to protect your identity by removing identifying information from quotes, etc., that are used in publication.

There are some exceptions to the guarantee of confidentiality. One exception is if you disclose actual or suspected abuse, neglect, or exploitation of a child or disabled or elderly adult, the researcher must and will report this to Child Protective Services (CPS), Adult Protective Services (APS) or the nearest law enforcement agency. A second exception to the guarantee of confidentiality is if you report having a communicable disease, the researcher must report that disease to the Utah State Department of

Health. A third exception is if you report the intent to harm yourself or someone else, the researcher must make a report to the nearest law enforcement agency. The fourth exception to the guarantee of confidentiality is in the case of a suspected ethical violation in accordance with American Psychological Association Code of Conduct. The researcher will notify the supervising staff of the suspected ethical violation.

PERSON TO CONTACT

If you have questions, complaints, or concerns about this study, or if you feel you have been harmed by taking part in the research, you can contact Jo Merrill by email at tiffany.merrill@utah.edu; however, you should be aware that e-mail is not a confidential form of communication. If, for any reason, you wish to discuss this study with Jo's research advisor, you may contact Dr. Sue Morrow at 801-581-3400 or by e-mail at sue.morrow@utah.edu.

Institutional Review Board: Contact the Institutional Review Board (IRB) if you have questions regarding your rights as a research participant. Also, contact the IRB if you have questions, complaints or concerns which you do not feel you can discuss with the investigator. The University of Utah IRB may be reached by phone at (801) 581-3655 or by e-mail at irb@hsc.utah.edu. You may reach the Utah Department of Human Services IRB by contacting Brenda Ahlemann at (801) 528-9868.

Research Participant Advocate: You may also contact the Research Participant Advocate (RPA) by phone at (801) 581-3803 or by email at participant.advocate@hsc.utah.edu.

VOLUNTARY PARTICIPATION

It is entirely up to you to decide whether to take part in this study. If you decide not to take part, or if you withdraw from the study after starting, there will be no penalty or loss of benefits of any kind, nor will it affect your relationship with the researchers. If you decide to stop after you have agreed to participate, just inform the researcher, either in person or at tiffany.merrill@utah.edu. We will destroy the interview tape and any transcripts we have made.

Participation in this study is unrelated to and will not affect the outcome of your assessment and treatment referral by Assessment & Referral Services.

TERMINATION OF PARTICIPATION

Although it is not anticipated, the researcher will end your participation in the study in the event that you become extremely distressed by either discussing your experiences or filling out the surveys. You will still be eligible for the drawing, however.

CONSENT

By signing this consent form, I confirm I have read the information in this consent form and have had the opportunity to ask questions. I will be given a signed copy of this consent form. I voluntarily agree to take part in this study.

_____
Printed Name of Participant

_____ _____
Signature of Participant Date

_____
Printed Name of Person Obtaining Consent

_____ _____
Signature of Person Obtaining Consent Date

APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE

Thank you for participating in this study. Please read all instructions, fill out the following information, and let me know if you have any questions.

Age: _____

Gender (please circle): Male Female Other

Race/Ethnicity (please circle):

African American	Hispanic
Asian	Pacific Islander
American Indian	Bi/multiracial
Caucasian	Other

Religious Affiliation - optional:

Sexual Orientation - optional (please circle):

Heterosexual	Bisexual
Lesbian	Asexual
Gay	Other

Highest education level (please circle):

Didn't complete high school	Associate's degree
High school degree	Bachelor's degree
GED	Master's degree
Some college	Doctorate

How many drug/alcohol treatment programs have you attended in the past, if any?

How many times have you been arrested for a drug- or alcohol-related offense?

APPENDIX D

DRUG USE INDEX

Instructions:
Read each question carefully and circle the number that best fits your level of use for each drug.

1. What is the drug that has caused you the most trouble, i.e. legal trouble, relationship problems, and/or work problems. **Circle only one.**

   Marijuana (pot, weed)

   Tranquilizers (Valium, Xanax, Librium, sleeping pills)

   Barbiturates (phenobarbital, barbs, phennies)

   Amphetamines (speed, meth, crystal meth)

   Heroin or Methadone

   Cocaine or crack

   Hallucinogens (L*SD*, mushrooms, ecstasy, club drugs)

   Prescription medications/pain killers (Vicodin, Oxycontin, Lortab, Demerol, Percocet)

   Over-the-counter drugs (cold & cough medicine, muscle relaxants, diet pills, etc.)

2. How many times have you used the drug you circled above**:**

In the Past Month? (Circle one number)

0–1–2–3–4–5–6–7–8–9–10–11–12–13–14–15–16–17–18–19–20–21–22–23–24–25–26–27–28–29–30 -- 30 or more

In the Past Three Months? (Circle one number)

0–1–2–3–4–5–6–7–8–9–10–11–12–13–14–15–16–17–18–19–20–21–22–23–24–25–26–27–28–29–30 -- 30 or more

In Your Life? (Circle one number)

0–1–2–3–4–5–6–7–8–9–10–11–12–13–14–15–16–17–18–19–20–21–22–23–24–25–26–27–28–29–30 – 30 or more

APPENDIX E

UNIVERSITY OF RHODE ISLAND CHANGE ASSESSMENT (URICA)

Survey #1

Each statement describes how a person might feel when starting therapy/treatment or approaching problems in their lives. Please indicate the extent to which you tend to agree or disagree with each statement. In each case, make your choice in terms of how you feel right now, not what you have felt in the past or would like to feel.

For all the statements that refer to your "problem," **answer in terms of your drug use**. In these questions, the word "here" refers to being ordered to attend treatment.

There are FIVE possible responses to each of the items in the questionnaire:
1 – Strongly Disagree
2 – Disagree
3 – Undecided
4 – Agree
5 – Strongly Agree

Circle the response that best describes how much you agree or disagree with each statement.

1. As far as I am concerned, I don't have any problem (related to drug use) that needs changing.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

2. I think I might be ready for some self-improvement.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

3. I am doing something about the problems that have been bothering me.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

4. I am not the one with a problem. It doesn't make much sense for me to be here.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

5. It worries me that I might slip back on a problem I have already changed, so I am here to seek help.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

6. I am finally doing some work on my problem.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

7. I've been thinking that I might want to change something about myself.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

8. At times my problem is difficult, but I'm working on it.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

9. Being here is pretty much of a waste of time for me because the problem doesn't have to do with me.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

10. I'm hoping this place will help me to better understand myself.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

11. I guess I have faults, but there is nothing that I really need to change.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

12. I am really working hard to change.

1	2	3	4	5

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

13. I have a problem and I really think I should work on it.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

14. I'm not following through with what I had already changed as well as I had hoped, and I'm here to prevent a relapse of the problem.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

15. Even though I'm not always successful in changing, I am at least working on my problem.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

16. I thought once I had resolved the problem I would be free of it, but sometimes I still find myself struggling with it.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

17. I wish I had more ideas on how to solve my problem.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

18. Maybe this place will be able to help me.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

19. I may need a boost right now to help me maintain the changes I've already made.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

20. I may be part of the problem, but I don't really think I am.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

21. I hope that someone here will have some good advice for me.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

22. Anyone can talk about changing; I'm actually doing something about it.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

23. All this talk about psychology is boring. Why can't people just forget about their problems?

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

24. I'm here to prevent myself from having a relapse of my problem.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

25. It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

26. I have worries but so does the next guy. Why spend time thinking about them?

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

27. I am actively working on my problem.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

28. After all I have done to try to change my problem, every now and again it comes back to haunt me.

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

APPENDIX F

AUDIT TRAIL

Fall 2010:	Conceptualization of research question, formation of committee, and initial literature review
Spring 2011:	Introduction and Methods chapters written
May 2011:	Dissertation proposal and revisions by committee
August 2011:	IRB application to University of Utah and the Utah State Department of Human Services
September 2011:	IRB approval from both boards
October 2011:	Data collection begun
June 2012:	Data collection completed
July-August 2012:	Transcriptions of interviews completed; survey data entry completed
Fall 2012:	Qualitative data analysis and writing of qualitative results
November 2012:	Drawing completed using random.org; participants notified and gift cards left at ARS for pick-up.
January-February 2013:	Statistical analysis of data and results chapter completed
March 2013:	Discussion chapter completed and Chapters 1 and 2 revised
April 2013:	Editing and final revisions
May 2013:	Defense scheduled

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