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Direct Care Provider Perceptions of Factors Influencing Treatment Motivation of Dual-Diagnosed Female Offenders

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Abstract

Direct Care Provider Perceptions of Factors Influencing Treatment Motivation of Dual-Diagnosed Female Offenders

by

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MS, Walden University 2012

BS, University of Phoenix, 2011

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Dual-diagnosed female offenders (DDFOs) present direct care providers with complex psychosocial needs and challenges that result in a serious lack of motivation to attain, sustain, and continue treatment after release from prison. Unsuccessful treatment of DDFOs represents a significant public health and safety risk including continuing criminal acts, increased health care costs, accidents related to substance abuse, and poor reintegration. Through in-depth semistructured interviews with direct care providers, this phenomenological study's focus was on examining the motivational facilitators associated with treatment adherence, barriers to treatment adherence, and approaches for enhancing treatment motivation. Nine major themes emerged from this research, including the importance of an empathetic approach and a strong therapeutic alliance as motivational facilitators; lack of insight and acceptance of the need for treatment, lack of resiliency, and the role of external system factors in barriers to treatment adherence; and using an empathetic approach, building rapport, instilling hope, and avoiding confrontation as approaches for enhancing treatment motivation. These findings may inform theory and practice related to the treatment of DDFOs in U.S. prisons. These findings contribute to social change by identifying outcomes related to treatment attendance, continuity of care, and completion and may help reduce recidivism associated with DDFOs, decrease costs of care, and lower public risks such as accidents related to substance use. The study provides reference points that may inform recommendations to state correctional departments regarding effective programming strategies for DDFOs.

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Dedication

This study is dedicated to my beloved son, Lucas. Because of you, I have learned patience, understanding, and the true meaning of unconditional love. Your smile, laughter, and support have made this journey an amazing adventure. Mommy loves you to the moon and back.

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I would like to thank my husband, Bo. Without hesitation or question, you took on all of the daily challenges—housework, laundry, shopping—and most of all supported me even when I wondered if it was all worth it. I would have never been able to do this without you. Your unconditional support and love through this entire process sustained my work, efforts, and continuous progress. To my mother, this project is the culmination of years of love, understanding, and your unwavering support in everything I do. I could not have done this without any of you. For this, I am always grateful, forever indebted to you, and ever thankful for all you have given me. I love you.

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Chapter 1: Introduction to the Study

Nearly 80% of women in the U.S. criminal justice system with substance abuse disorders have also been diagnosed with a major clinical disorder (James & Glaze, 2006). Dual-diagnosed female offenders (DDFOs) with major clinical disorders typically enter programs in forensic settings designed to address various disorders including alcoholism, cocaine addiction, and opioid abuse (Baillargeon, Binswanger, Penn, Williams, & Murray, 2009; Lynch, DeHart, Belknap, & Green, 2012). According to Johnson et al. (2015), DDFOs experience more intense and severe substance dependence than women without major clinical disorders (e.g., bipolar disorder, major depressive disorder (MDD), or personality disorders). DDFOs present direct care providers with increased service needs and high psychosocial risks. When DDFO needs are unmet, the increased psychosocial risks can lead to postrelease problems (Johnson et al., 2015; Kienast, Stoffers, Bermpohl, & Lieb, 2014; Peters, Wexler, & Lurigio, 2015; Prins, 2014).

Nowotny, Belknap, Lynch, and DeHart (2014) found that 29% of DDFOs received dual diagnosis treatment while incarcerated. However, treatment in forensic settings can be unreliable, and it can be difficult to provide the necessary level of care in these settings (Nowotny et al., 2014). Unreliable services pose a significant challenge for direct care providers as they can adversely influence attitudes and offender behaviors that require stability to be successful (Johnson et al., 2015). Instability furthers the need to understand motivational facilitators, which can be underlying inspirations or behaviors related to desires to get and stay in treatment, successfully complete treatment, and continue treatment as necessary after release from prison. The challenges related to

providing appropriate services to address DDFOs' complex treatment needs are also unclear. Motivational challenges include denial of substance abuse or mental health problems, refusal to accept readiness to change, refusal to participate in treatment, and refusal to obtain sobriety (Gee & Reed, 2013; Priester et al., 2016).

DDFO behaviors such as denying substance abuse or mental health problems can adversely impact their motivation for treatment and can make these women more likely to refuse aftercare treatment than women without dual diagnosis. Balyakina et al. (2014) and Grella and Rodriguez (2011) showed that continuity of care, length of stay, and participation in community aftercare programs significantly increased the likelihood of effective long-term care. However, many individuals released from correctional care do not enroll in, attend, or complete postprison treatment, even when correctional departments pay the costs for care (Prendergast et al., 2009). Because of this, DDFOs are more likely to violate probation and parole and be rearrested within 1 year of release than women without dual diagnosis. DDFOs experience the *revolving door*, which means exiting the correctional system with a lack of appropriate resources only to reenter the system with the same problems (Balyakina et al., 2014; Grella & Rodriguez, 2011; Johnson et al., 2015; Peters et al., 2015). The need to understand and explore direct care providers' perceptions of the unique motivational barriers associated with attrition and the motivational facilitators associated with treatment adherence represents a gap in the literature that was addressed in this study. Examining behavioral interventions that have helped direct care providers improve motivation and treatment adherence among DDFOs while in correctional care settings was also a focus of this study.

Chapter 1 includes the study overview, problem statement, study purpose, research questions, and the conceptual framework. Also in Chapter 1 are definitions of terms and a discussion of the study's significance in the context of positive social change. The study's implications, assumptions, and limitations are also presented.

Background

Continuity of care for DDFOs is imperative for long-term success (Balyakina et al., 2014; Grella & Rodriguez, 2011; Johnson et al., 2015), yet motivation that may lead to increased treatment adherence during and after incarceration among DDFOs has received little study. Researchers have yet to explore factors such as motivational facilitators and barriers that may contribute to treatment adherence and attrition for DDFOs (Gee & Reed, 2013; Johnson et al., 2015; Matheson, Doherty, & Grant, 2011). For example, Gee and Reed (2013) discussed the severe complexity of symptoms DDFOs present, the strict environment of the forensic setting and its influence on treatment attrition, and the need to continue appropriate treatment after release from prison. Gee and Reed (2013) also suggested that DDFOs who complete treatment programs may be more motivated than others and encouraged further analysis of the reasons why women stay engaged or drop out of treatment. Johnson et al. (2015) examined provider perceptions of unmet treatment needs of incarcerated women about to be released. The themes that emerged from their research showed that providers consider women with dual diagnosis as vulnerable and reflected the need for a more thorough care continuum for this population upon reentry to community life. Johnson et al. (2015) endorsed the idea that DDFOs differ in their symptom severity and treatment needs and suggested

ideas for optimal aftercare. This post care can include constant contact with primary direct care providers both before and after release, critical care oversight for 24–72 hr after release, and crisis prevention (Johnson et al., 2015).

Kienast et al. (2014) examined the significance and severity of substance abuse issues and treatment for DDFOs with borderline personality disorder (BPD) and suggested adopting a standard protocol for treating substance disorders. Inability to commit to treatment plans in DDFO populations adversely affects rehabilitation outcomes. In Canada, Matheson et al. (2011) evaluated community relapse prevention programming and indicated that motivations for treatment in correctional care must be better understood. Matheson et al. asserted that the most self-reflective and honest clients were the likeliest candidates to complete treatment. The authors further stated the necessity for identifying approaches such as motivational interviewing (MI) that will enhance female offenders' readiness to change and recommended using these strategies across correctional in-prison care as well as in aftercare (Matheson et al., 2011). Miller and Rose (2009) stated that MI breaks down clinical practice mechanics into two major elements: a relational component that emphasizes empathetic perspective and interpersonal self-reflection and a technical element that focuses on the evocation and reinforcement of client *change talk*. Miller and Rose found that MI is effective for reducing maladaptive coping mechanisms and increasing prosocial behavior changes. However, the therapist's perspective, training, and approach can either significantly improve or degrade client outcomes (Miller & Rose, 2009). Additionally, Miller and Rose postulated that while MI and counseling styles can uniquely impact client

outcomes, only the most self-reflective and honest clients will effectively respond to this treatment approach. Findings from Miller and Rose and Matheson et al. support the need for further research on the motivational facilitators behind entering and completing treatment while incarcerated and after and factors that can lead to treatment attrition among DDFOs. Findings from Miller and Rose also support the need to understand the complex delivery challenges for direct care providers who care for DDFOs. This research may prove useful for DDFO treatment success as findings may help reduce recidivism seen with this population, decrease costs of care, and lower public risks such as accidents related to substance use.

Gee and Reed (2013), Grella and Rodriguez (2011), and Steadman et al. (2013) found that while direct care providers begin dual diagnosis management during incarceration, DDFOs are typically detained for shorter periods than women with single disorders. Shorter detainment periods result in deficient provider care and subsequently lower motivation to continue treatment (Gee & Reed, 2013; Grella & Rodriguez, 2011; Johnson et al., 2015; Steadman et al., 2013). In a study of provider and inmate perspectives on dual diagnosis treatment needs in Canada, Therien, Lavarenne, and Lecomte (2014) found that many direct care providers suggested the need to "find a spark" (p. 4) to motivate this population. Therien et al. also reported that direct care providers felt they faced the biggest obstacles when allowing clients opportunities for creating the motivation or spark for continued treatment due to the complex nature of their comorbidities and the appearances of multiple illnesses. Approximately 40% of

DDFOs will take advantage of postrelease mental health services while only one third will continue with substance abuse treatment (Mallik-Kane & Visher, 2008).

Until recently, little was known about the provision of correctional care services and the challenges related to attrition of female offenders with major clinical dual diagnosis (Gee & Reed, 2013; Grella & Rodriguez, 2011; Johnson et al., 2015). In 2005, the Substance Abuse and Mental Health Services Administration (SAMHSA) established standards for provider services that would ensure achieving a certain level of quality care for DDFOs. However, these standards did not specify effective or clear protocols for achieving these standards (Johnson et al., 2015). Grella and Rodriguez (2011) explored motivations behind participation in aftercare programs for women entering the community after incarceration and found that factors such as having children involved in the welfare system, previous treatment history, and previous prison sentences were common motivational variables among these women. Although Grella and Rodriguez identified possible motivational factors that direct care providers could rely on to improve continuity of care, more research into such factors is still needed.

Johnson et al. (2015) took a phenomenological approach to investigate how behavioral interventions could be increased for aftercare among DDFOs diagnosed with MDD and substance abuse. The authors explored barriers to continuity of care by interviewing direct care providers who assisted DDFOs in connecting to postprison services such as transitional housing, housing assistance, and substance abuse and mental health provider services in the community. Johnson et al. found various aftercare challenges for direct care providers such as clients returning to people and places that

lead to relapse, lack of support, and negative ongoing romantic relationships related to a lack of provider ability to sustain motivation for treatment. Johnson et al. did not include clinical disorders commonly found in this prison population (e.g., bipolar and personality disorders). Their study focus was primarily on transition issues.

Unsuccessful DDFO treatment represents significant public health and safety risks such as continuing criminal acts, increased health care costs, accidents related to substance abuse, and poor reintegration into society (Johnson et al., 2015; National Institute on Drug Abuse [NIDA], 2005; Peters et al., 2015). Increasing knowledge of motivational barriers and facilitators, as perceived by direct care treatment providers who work with DDFOs, may help reduce these public health risks (Gee & Reed, 2013; Johnson et al., 2015; Peters et al., 2015).

The present study is significant in the field of forensic psychology because mental health professionals and substance abuse counselors must be able to attend to the complex treatment needs of DDFOs in prison settings. This study's focus was on providing insights into the challenges direct care providers face when attempting to motivate DDFOs to participate in and complete treatment after leaving prison. Such insights may help clinical staff formulate targeted treatment planning and behavioral interventions that can better facilitate motivation and that may reduce attrition and recidivism.

Problem Statement

DDFOs incur high rates of repeat offenses and will likely refuse substance abuse treatment upon release into the community from correctional care (Gee & Reed, 2013;

Kienast et al., 2014; Priester et al., 2016). However, the motivational facilitators involved in treatment adherence and factors associated with attrition issues for DDFOs are still unknown (Gee & Reed, 2013; Priester et al., 2016). Clinical staff struggle to motivate DDFOs to participate in and complete services that will lead to decreasing significant psychosocial risks such as impulsivity, depression, and issues related to childhood trauma and increasing social support networks, self-esteem, and self-efficacy (Gee & Reed, 2013; Kienast et al., 2014; Wnuk et al., 2013). Lower social functioning, higher psychopathological disruption (e.g., anxiety, depression, hostility/aggression, paranoid ideation, and social/interpersonal sensitivity), and frequent suicidal behavior by DDFOs exceed the service needs of women without a dual diagnosis, which results in high treatment attrition (Gee & Reed, 2013; Kienast et al., 2014; NIDA, 2010; Peters et al., 2015; Wnuk et al., 2013).

Purpose of the Study

The purpose of this phenomenological study was to explore and understand direct care providers' perspectives of the unique motivational barriers and facilitators associated with DDFO treatment. For the purposes of this research, direct care providers selected to participate in interviews included substance abuse counselors and program directors for substance abuse programs who treat women with dual diagnosis in the state of Delaware's Department of Correction. These direct care providers encourage, support, and guide the recovery process through the various obstacles these women confront in treatment (Johnson et al., 2015). Understanding motivational facilitators and barriers among DDFOs as well as strategies to improve motivation and treatment adherence

among DDFOs is imperative. An interpretive examination of direct care provider experiences may uncover strategies to enhance motivation and reduce attrition (Asberg & Renk, 2012; Johnson et al., 2015; Trucco, Connery, Griffin, & Greenfield, 2007).

Research Questions

The following research questions were formulated to guide this study:

RQ1: According to direct care treatment providers, what are the motivational facilitators associated with treatment adherence among DDFOs?

RQ2: What are the motivational barriers to treatment adherence that contribute to treatment attrition among DDFOs?

RQ3: What are effective strategies or elements of interventions that enhance motivation and reduce attrition among DDFOs?

Conceptual Framework

Motivation is the driving force behind goal attainment. Motivation plays a significant role in initiating goals, maintaining the drive to attain a goal, and sustaining goal-oriented behaviors (Grella & Rodriguez, 2011). It is imperative to understand how this driving force is incorporated in the clinical treatment approaches direct care providers use when working with DDFOs.

This study's conceptual framework was based on specific theories that were used as foundations for interpreting the data: Maslow's hierarchy of needs, incentive theory, and MI (Hettema, Steele, & Miller, 2005; Winfree & Abadinsky, 2003). Maslow's hierarchy of needs consists of five levels of need that reflect human growth stages. Starting at the hierarchy pyramid base, these levels are physiological needs, safety needs,

love and belongingness needs, esteem needs, and self-actualization (Winfree & Abadinsky, 2003). Based on Maslow's theory, DDFOs are provided the bottom tiers of the traditional pyramid (i.e., physiological and safety needs) by the facility where they are housed. Meeting these basic needs allows DDFOs to grow and move to higher tiers of need. More specifically, direct care providers extend care and concern for the DDFOs they treat and create feelings of devotion and belonging that are expressed to the inmates through the treatment approaches employed. These feelings of devotion and belonging help to build rapport and motivation for treatment. Consequently, with increasing feelings of belonging, DDFOs should be able to begin building on esteem and work toward Maslow's concept of self-actualization.

Incentive theory requires the presence of external rewards to perform a task that typically reflects a pleasure-seeking lifestyle (Winfree & Abadinsky, 2003). Direct care treatment providers typically employ incentives and motivational elements for DDFO treatment engagement, compliance, adherence, and completion (Miller & Rose, 2009). The traditional understanding of encouragement or motivation to engage in and complete treatment is directly related to the extent to which providers can empathize, sympathize, and attend to the needs of female offenders (Gee & Reed, 2013; Johnson et al., 2015). Direct care providers learn to express unconditional acceptance toward the women to teach them that in a world where no one has cared for them, direct care providers do care (Johnson et al., 2015). Direct care providers care for their clients until they can learn to care for themselves (Johnson et al., 2015; Priester et al., 2016). According to incentive theory, the assumed incentives that DDFOs receive are attention, care, and concern for

the whole person. Direct care providers will continue their efforts to motivate and offer encouragement to these women through teaching skills, providing supportive encouragement, and through unconditional acceptance in treatment and recovery (Gee & Reed, 2013; Johnson et al., 2015; Kienast et al., 2014).

MI is used to improve treatment outcomes by eliciting information, promoting engagement in counseling, and generating client histories that are rich in detail during the intake process (Hettema et al., 2005; Ivey, Ivey, & Zalaquett, 2010). The philosophy behind MI is to reduce a person's maladaptive behaviors such as substance use and HIV-related high-risk behaviors and promote positive prosocial behaviors such as medication management, physical health, and nutritional care, which may assist the longevity of treatment adherence if successfully implemented (Miller & Rose, 2009).

The present study's framework was designed to help elicit experiences from direct care providers. The discussion was unique and unstructured in order to facilitate an interpretive approach and to allow for expanded insight into the perceived motivational facilitators for DDFO treatment adherence that directly spoke to the research questions. By understanding the motivational facilitators and possible perceived barriers in DDFO treatment, a stronger, more integrated treatment approach that supports long-term success and continuity of care can be achieved.

Nature of the Study

A qualitative phenomenological approach was employed in the present study for investigating direct care treatment providers' experiences of what motivates DDFOs to remain in treatment and adhere to program goals as well as for examining the reasons for

treatment and program attrition. The selected methodology stemmed from the need to focus on direct care providers' experiences with the phenomenon of interest (Bailey, 2007). Phenomenological research is consistent with understanding and examining the experiences and themes surrounding treatment attrition for DDFOs, which was this study's primary focus. Direct care providers were asked about their ideas for addressing attrition and recidivism rates for DDFOs. Interviews were conducted with eight direct care treatment providers to obtain diversification in data collection and to emphasize the phenomenon of interest, which was what motivates DDFOs to commit to and remain in treatment and what causes their treatment noncompliance and attrition.

Definition of Terms

The following terms were used in this study and are defined here for the reader's convenience.

Barriers: Refers to specific reasons females do not utilize addiction or mental health treatment services or fail to modify individualized target behaviors in treatment (Greenfield et al., 2007)

Bipolar disorder: A brain disorder that can cause shifts in mood and interfere with abilities to function on a daily basis, also known as manic depressive illness (American Psychiatric Association [APA], 2013).

Comorbidity: The presence of two or more disorders or illnesses in the same person, either sequentially or simultaneously (NIDA, 2010).

Dual diagnosis: An individual with co-occurring severe mental illness and substance use disorder (SAMHSA, 2005).

Dual-diagnosed female offender (DDFO): A female inmate who is enrolled in a treatment program and who meets the criteria for having one or more concurrent mental health or substance use disorders; specifically, major clinical disorders such as BPD, MDD, or a personality disorder.

Major depressive disorder (MDD): Clinical depression that includes marked mood swings, sudden emotional swings (i.e., excessive crying), and depression (APA, 2013).

Motivational barriers: Any treatment boundary or impediment, obstacle, or limit that direct care providers may clinically link to DDFO treatment and program attrition.

Motivational challenges: Any symptoms, behaviors, or clinically linked impediments that may hinder DDFO abilities to adhere to treatment, regardless of interventions used to assist in overcoming the challenge.

Motivational facilitators: The concepts, ideas, or behavioral interventions that are found to directly impact motivation in treatment.

Motivational interviewing (MI): A counseling style that includes empathizing with a client with a supportive, direct approach. This counseling style employs engagement and focuses on an individual's desire to change by resolving ambivalence about treatment (Center for Substance Abuse Treatment [CSAT], 2009).

Motivational strategies: The various behavioral or treatment interventions that direct care providers may use to enhance treatment attendance and adherence.

Personality disorder: A personality dysfunction or impairment (interpersonal and self-related) with a presentation of pathological personality traits (e.g., hostility,

callousness, deceitfulness, or manipulation) as well as the presence of disinhibition (APA, 2013).

Assumptions

A key study assumption was that all participants answered the interview questions to the best of their clinical and professional abilities and noted their treatment biases in an open and honest manner. It was also assumed that all participants openly explored their experiences working with DDFOs in their respective substance abuse programs. Finally, it was assumed that this study's qualitative and interpretive study design resulted in revealing knowledge and information that did not previously exist in the literature.

Scope and Delimitations

The purpose of this study was to examine the motivational facilitators that may contribute to treatment success and the possible barriers to success during DDFO treatment. The literature review for this study showed that continuity of care is imperative to DDFO long-term success (Gee & Reed, 2013; Johnson et al., 2015; SAMHSA, 2014). However, researchers have not addressed the perceived motivational factors that may contribute to treatment adherence or the barriers that may contribute to treatment and program noncompliance and attrition (Gee & Reed, 2013; Houser & Welsh, 2014; Johnson et al., 2015). These key elements directly connect to the long-term continuity of care for DDFOs and their treatment success, which may decrease negative social implications such as relapse, recidivism, and increased cost of care for repeat offenders. As this study's focus was on women with dual diagnosis in correctional care settings, the findings may not be transferable outside the scope of the intended population.

While there is little agreement about the prospect of transferability (generalizability) of qualitative research findings, it is important to note the possible broader application of this research approach (Santiago-Delefosse, Gavin, Bruchez, Roux, & Stephen, 2016). The specific sample in question may be limited in geography or location; however, themes were identified in this study that may serve as hypotheses for potential future research with other samples that would further contribute to the literature. Thick description strategies were also used to encourage other researchers to determine the extent to which the findings may be transferable to other settings; this determination of transferability is solely intended for those who apply the findings to their own research settings (Petty, Thompson, & Stew, 2012). Further, the contextual meanings behind the experiences as seen by the direct care providers should be considered context specific, and therefore would not focus on attempts to generalize or transfer the findings (Petty et al., 2012).

Limitations

It was assumed that investigating the sample chosen for this study would provide new insights and information specific to this sample and the experiences of the individuals therein and would not represent the total population of direct care providers. Also, qualitative research is subject to interpretation, which can be considered unintentional biases (Santiago-Delefosse et al., 2016). These interpretations must be considered a limitation in the scope of the information or application of the knowledge that may be obtained in a study (Santiago-Delefosse et al., 2016). The researcher's biases may lead to predetermined interpretations (Santiago-Delefosse et al., 2016). To address

possible researcher bias, all data collected and all interpretation of interview summaries were presented to study participants for confirmation or revisions (i.e., member checking). Bracketing, which is the process of suspending assumptions and judgment so the focus can be maintained solely on the experiences of study participants (Chan, Fung, & Chien, 2013), was also used.

Significance

Results from this study provided valuable insights into the challenges of treating DDFOs while in correctional care as seen by direct care providers as these professionals attempt to motivate clients to participate in treatment in prison and complete treatment after leaving prison. The information from this study could help clinical and counseling staff develop appropriate treatment plans and interventions that target the unique motivational factors associated with treatment attrition and highlight psychosocial elements relating to attrition and dropout rates among DDFOs. Furthermore, these insights may provide support and encouragement to DDFOs related to treatment engagement while in prison and for continuity of postrelease care. Study findings may also assist efforts of transitional counseling personnel by identifying various elements that lead to successful postrelease care.

Summary

Research is clearly needed on what facilitates and prevents DDFO treatment adherence as well as the factors of postrelease care continuity that lead to long-term success. In Chapter 1, the justification for conducting a study of this nature was presented through the gaps in literature reflecting unmet DDFO treatment needs, which suggest that

more research is needed to understand motivation in treatment for DDFOs and, more specifically, for offenders with major clinical disorders. Chapter 2 is a discussion of the literature reviewed for the present study. This review supported the need for better understanding DDFO treatment motivators and barriers so that positive outcomes can be achieved in both prisons and communities following release.

Chapter 2: Literature Review

The review of the literature presented in Chapter 2 establishes the need for continued research to better understand motivational facilitators related to treating DDFOs from the perspective of direct care providers as well as to identify barriers to motivation that can affect treatment attrition. The problem addressed in this study is that DDFOs present direct care providers with unique and difficult challenges regarding treatment motivation, treatment adherence, and successful continuity of care upon release. This study's purpose was to identify motivational facilitators that can result in treatment adherence as well as perceived barriers to motivation from the direct care provider perspective. Study findings revealed key motivational concepts that can be applied to treatment planning, transitioning out of prison, and aftercare services to increase the likelihood of long-term success for DDFOs after release from prison.

Researchers have indicated significant gaps in aftercare services offered for DDFOs and a lack of service utilization among this population (Johnson et al., 2015; Priester et al., 2016). Mallik-Kane and Visher (2008) found that fewer than one third of DDFOs continued substance abuse treatment after release from correctional care. Even fewer DDFOs obtain dual diagnosis management after release from correctional care (Grella & Rodriguez, 2011; Johnson et al., 2015; Priester et al., 2016). Researchers have suggested that the most motivated clients will be successful in dual diagnosis care while incarcerated (Gee & Reed, 2013), yet the statistics for aftercare are low (Grella & Rodriguez, 2011). Direct care providers who oversee DDFOs transitioning from incarceration to the community have consistently identified continuity of care issues with

DDFOs and suggested that the issues with these clients are different from those among women with a single diagnosis (Johnson et al., 2015; Priester et al., 2016). Care issues are also present when there is a significant lack of motivation when facing reintegration into society (Johnson et al., 2015; Priester et al., 2016).

The present study's goal was to identify themes among direct care provider perceptions of motivational facilitators or barriers to treatment among women with dual diagnosis. Incentive theory, Maslow's hierarchy of needs, and motivational interviewing (MI) were used as the study's conceptual framework and to illustrate how perceived motivational facilitators assist treatment adherence or adversely effect motivation during treatment. Using resources from a variety of studies regarding motivation, offender treatment, and offender retention in treatment, including studies involving perceived challenges in DDFO treatment and continuity of care, results from this literature review provided foundational elements for understanding the need for further research into motivational facilitators. Establishing a better understanding of motivational facilitators and perceived barriers to motivation may assist in developing behavioral interventions aimed at increasing treatment motivation, which could aid treatment adherence and completion. A better understanding of these motivational facilitators may also help identify perceived barriers to treatment that result in treatment attrition among DDFOs.

The review of literature in this chapter helped to build the foundation for the present study's relevance. It begins with an overview of the literature search strategy, including databases searched and key terms and topics used to direct the search. Next is a discussion of the theoretical foundations that provided the rationale for the perspectives

used in this study. Key concepts are examined in the conceptual framework section, which includes a definition of the phenomenon of interest and a discussion of the fundamental relationships to the framework and how these concepts were applied in previous studies as well as how they relate to the present study. The literature review section includes an examination of key concepts, related terms, current studies, and previous research approaches. The rationale for this study and a complete synthesis of the current literature that is consistent with the scope of this study are also presented. The review includes a summary of the literature findings, a discussion on what is known and still unknown about the research topic, and a discussion of the gap in the literature and how the findings from the present study would address this gap.

Literature Search Strategy

Literature searches were conducted using Boolean indicators. The following search terms were used: *alcoholism*, *alcohol drinking*, *drug abuse*, *drug dependency*, *dual diagnosis*, *female offender*, *forensic treatment*, *incentive theory of motivation*, *Maslow's hierarchy of needs*, *motivational interviewing*, *offender aftercare*, *opioid disorders*, *prison treatment*, *substance use disorders*, *substance use treatment*, *treatment entry*, *treatment retention*, and *women*. General Internet web searches using Bing and Google were also conducted. The searches focused solely on literature in English. After completing the general search, the same terms were used to search the Walden University and Open WorldCat library via Google Scholar. The PsychINFO, Lexus Nexus, Sage Premier, and PsychArticles Academic databases were also searched. The initial searches were not restricted to publication date criteria; however, a search for sources published

after 2011 was done to narrow results after the initial searches were concluded and to ensure that the cited resources represented the most current research related to DDFO treatment motivation, perceived barriers to motivation, and treatment attrition in the fields of psychology, forensic psychology, correctional psychology, and correctional counseling. Several key works published before 2011 were also included as their information regarding forensic treatment of DDFOs, Maslow's hierarchy of needs, incentive theory, and MI was still relevant. Some books were reviewed regarding motivation, MI, intentional interviewing, and counseling style to gain a clearer understanding of the current status of motivation in treatment. Topics such as provider styles as they relate to how motivation plays a role in treatment, how to engage female clients, the uniqueness of client-counselor expectations of women in treatment, and possible barriers to treatment for women were also explored. In cases where little or no current research was available, concepts related to the topic were explored and compared.

Conceptual Framework

Much of the drug treatment programming in the United States focuses on court-referred or mandated clients (Prendergast et al., 2009). Gee and Reed (2013) noted the importance of examining the challenges of treatment engagement, perceived motivational facilitators to treatment adherence, and perceived barriers tied to attrition. The conceptual framework for the present study was based on the idea that the most motivated individuals will likely attend treatment, adhere to treatment requirements, and attain continuity of care. This belief reflects the concepts of incentive theory, Maslow's hierarchy of needs, and MI as they relate to treatment persistence and attrition. This

conceptual framework is grounded in motivational concepts, which suggest that a reward must be present to elicit drive and that the reward should include elements related to the hierarchy of needs. The conceptual framework also suggests that the reward should elicit engagement between care direct care providers and clients to be successful (Hettema et al., 2005; Ivey et al., 2010; Winfree & Abadinsky, 2003).

Incentive Theory

Incentive theory suggests that internal desires drive one's behaviors for an external reward (Bernstein, 2011). Toward this end, incentive theory posits that behaviors resulting in positive rewards are more likely to occur than behaviors associated with negative consequences (Bernstein, 2011). Furthermore, behaviors may vary from person to person but can be directly linked to available incentives and individual values at that moment in time (Bernstein, 2011). Behaviors are driven by external rewards of recognition or status such as those found in promotional reward systems used in business (Hockenbury & Hockenbury, 2003). Incentive theory can also be applied to the values placed on sobriety, family, and socioeconomic gain (Hockenbury & Hockenbury, 2003).

Direct care providers strive to promote growth in treatment as this growth can provide motivation for staying in a program. Direct care providers use incentive theory to motivate DDFOs toward sobriety and a sober lifestyle change by acknowledging personal development and short- and long-term goals. Certificates of treatment completion and graduation ceremonies are also used as motivation (Houser & Welsh, 2014). Incentive theory can also be used to cease unwanted or negative behaviors. Examples of incentive theory in practice include implementing privileges for individuals who obtain certain

goals, levels of care, and treatment growth (Bernstein, 2011). It is important to note that incentive drives motivation and that rewards can change over time and across experiences. As such, incentive and motivation are directly related to the direct care provider efforts to manage the needs, wants, and desires of all individuals enrolled in treatment programs (Bernstein, 2011; Houser & Welsh, 2014; Steadman et al., 2013).

Maslow's Hierarchy of Needs

Maslow (1967) first created the concept of a hierarchy to address how one's actions directly correlate with achieving specific core needs. Many psychological perspectives focus on an individual's deficiencies. Maslow's theory is that one needs to fulfill foundational or basic human needs before moving toward fulfilling higher levels of need (Maslow, 1967). His theory is typically presented as a pyramid. Looking closely at this hierarchy of needs for DDFOs, one could postulate that lower levels of the pyramid, which include physical requirements such as food, water, and sleep, are sustained by the facilities (prisons) in which these women are housed.

Maslow's hierarchy becomes a lifelong quest for reaching one's fullest potential. In treatment, direct care providers help DDFOs move toward higher levels of need in treatment such as safety, security of self, and self-esteem. Direct care providers must identify each DDFO's pyramid level to create positive goals and reward systems for motivating the DDFO toward treatment completion. During this climb, direct care providers must attend to all motivational changes, value these changes, and direct treatment variations to support continued motivational changes that can lead to treatment completion and continuing treatment after release. When applying the concept of

Maslow's hierarchy of needs to DDFOs in treatment, for example, care providers would not delve into a DDFO's negative childhood experiences when she is simply struggling to find housing once released. It would be more imperative and efficient to assist in fulfilling the lower level of the DDFO's pyramid, housing and security, before attempting to fulfill higher levels such as those related to acceptance of her negative life experiences. Once DDFOs begin climbing the pyramid, goals will shift from housing (safety and security) to social and psychological attention (love, relationships, and self-esteem).

Motivational Interviewing (MI)

Recognizing the extreme difficulty direct care providers experience in treating substance use disorders spurred MI's creation (Ivey et al., 2010). The main challenge in treating substance use disorders is motivating individuals to change negative behaviors versus simply talking about the behaviors (Ivey et al., 2010). MI techniques can help motivate DDFOs to decide to change, also known as readiness to change, and is MI's foundational element. However, readiness to change is only one of many key elements in successful treatment outcomes for DDFOs. The client's readiness introduces the possibility of change while informing the provider about the depth of interest or motivation to do so (Ivey et al., 2010).

A vital component of successful MI is introducing the idea that change is possible, which involves creating and achieving simple objectives over time (Ivey et al., 2010). Implanting the idea of change allows clients to see that they can change their behavior (Ivey et al., 2010). In other words, MI involves goal setting as a significant step especially when treating substance abuse or mental health disorders. Eliciting change

over time also requires improving on the strategies that clinicians use with two main goals: to decrease the barriers experienced by DDFOs and to develop alternate means around potential barriers DDFOs may encounter while in treatment. Therefore, when creating goals for DDFOs, direct care providers must consistently attend to each offender's needs, wants, and aspirations in treatment to successfully capture her readiness to change. Seizing the client's desires, hopes, and interest is critical in establishing the motivation to change.

Just as direct care providers must establish where the client is on Maslow's pyramid to effectively address the client's level of need, so too must they establish each client's motivation as well as the amount of effort the client might put toward recovery. Various instruments are used for this purpose (Prendergast et al., 2009). These instruments include the Recovery Attitude and Treatment Evaluator, the University of Rhode Island Change Assessment, and the Readiness to Change Questionnaire (Prendergast et al., 2009). Looking at the Recovery Attitude and Treatment Evaluator, for example, using a scale of 1 *(not very interested or motivated)* to 10 *(highly interested or motivated),* the client can indicate her buy-in levels regarding sobriety, change, and motivation (Prendergast et al., 2009). The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) is a self-report measurement tool designed to help establish motivation (Prendergast et al., 2009). However, SOCRATES does not reflect the traditional transtheoretical model's five stages of change, which include precontemplation, contemplation, preparation, action, and maintenance stages, as Prendergast et al. (2009) originally expected. Instead, SOCRATES clarifies how

motivational processes can be continuously distributed as an underlying mechanism for change (Prendergast et al., 2009).

Literature Review Related to Key Variables and Concepts

The literature review is structured around four key areas that are relevant for the participant population that was studied in this project. The four areas are profile of the DDFO, forensic treatment challenges of DDFOs, possible barriers to engagement, and DDFO motivation for treatment. The section on the profile of the DDFO includes the typical clinical picture seen among current DDFO populations in U.S. prison systems. This area of interest covers persistence of mental illness and severity differences between DDFOs and female offenders without major clinical dual diagnosis as well as specific major clinical disorders as they are found in forensic populations currently. The section on forensic treatment challenges encompasses the various obstacles often faced by DDFOs enrolled in forensic treatment settings such as high rates of aggravated behaviors, stressors that affect mood, and challenges related to the structure of prison life. The section on barriers to engagement is a detailed look at the psychosocial challenges DDFOs in treatment programs experience. These challenges include interpersonal relationships, family problems, and lack of social support systems, which are often problems for women with low socioeconomic status. In the section on motivation for treatment, areas of motivation or inspiration for treatment as well as challenges experienced with motivation are examined. These motivational concerns are related to the need to further explore the issues related to the DDFO engagement in treatment and the

motivation to sustain a treatment program through completion while incarcerated and after release.

Profile of Female Offenders With Dual Diagnosis

The convergence of serious mental illness and substance use disorders in the criminal justice system has resulted in higher numbers of incarcerated individuals with dual diagnosis (Balyakina et al., 2014; Kienast et al., 2014). Dual-diagnosed individuals with major clinical disorders (bipolar disorder, personality disorders, and MDD) present various challenges to direct care providers. These offenders have been associated with increased complexity, severity, and overall persistence of both substance use and mental health disorders (Kienast et al., 2014; Therien et al., 2014). Other key issues among DDFOs include high rates of treatment noncompliance, significantly high relapse rates, increased psychotic symptoms, cognitive deficiencies, depression, social withdrawal, and increased suicidal ideation (Kienast et al., 2014; Therien et al., 2014). Balyakina et al. (2014) suggested that individuals who suffer from complex disorders such as substance use disorder combined with bipolar disorder, MDD, or personality disorders were at significantly greater risk of committing future crimes and for recidivism within 1 year of release. These offenders are also at a greater risk of violating conditions such as probation or parole typically placed for community care (Balyakina et al., 2014).

Kienast et al. (2014) found that many professionals struggle to attend to all of the needs of women with personality disorders, especially those with borderline personality disorder, due to increases in impulsivity, suicidal behavior, and greater likelihood of treatment dropout among this population. In their literature review, Kienast et al. focused

on using randomized controlled trials and Cochrane Review methodology to examine the complex challenges involved in treating adults with borderline personality disorder combined with addiction. The authors noted that the minimal data available on treatment efficacy of psychotherapy or pharmacotherapy for adults with personality disorders compound the ability for clinicians or direct care providers to enact effective strategies for treatment planning (Kienast et al., 2014). Kienast et al. stated that the lack of available evidence of treatment efficacy related to major clinical disorders suggests that the clinical picture painted by direct care providers is more complex than initially thought. Findings from Verona, Bresin, and Patrick (2013) who discussed lack of knowledge related to general treatment approaches in forensic settings, in addition to the problem of incomplete complex clinical picture requires more research to understand the phenomenon associated with the care of DDFOs about motivation for positive treatment outcomes.

Researchers have found alarming increases in the numbers of women incarcerated with severe persistent mental illness and substance use disorders, which are often further complicated by trauma history, socioeconomic challenges, and gender-related social role expectations (Asberg & Renk, 2012; Baillargeon et al., 2009; Nowotny et al., 2014). Nowotny et al. (2014) studied 490 female offenders to identify risk factors and to provide a general profile of female offenders that direct care providers could use to create targeted behavioral interventions to better assist this population. According to the findings, the demographic information at the time of the study suggested that the average age of the female offender was 35 years old. Further, the average female offender was

single, had one or more children under age 18 years, and had a high school diploma or equivalent (Nowotny et al., 2014). Women who presented with sever persistent mental illness and substance use disorders (32% and 53%, respectively) also reported significantly higher previous incarceration histories than female offenders without dual diagnosis (Nowotny et al., 2014).

Therien et al. (2014) found that traumatic events reported by DDFOs often related to Cluster B personality disorders (e.g., up to 83% of DDFOs with borderline personality disorder reported childhood sexual abuse), which has been linked to a higher risk of substance abuse. The clinical picture generated by direct care providers includes antisocial personality traits and behaviors, which have also been associated with greater risk of substance abuse, housing instability, homelessness, violence, and extensive legal troubles (Kienast et al., 2014; Nowotny et al., 2014; Therien et al., 2014). Approximately 9 in 10 DDFOs have experienced physical abuse by a member of her family, and 8 in 10 have presented with intimate-partner violence such as rape or sexual assault (Johnson et al., 2015; Nowotny et al., 2014). Trauma makes the profiles of DDFOs in treatment even more complex and challenging for direct care providers, especially regarding engagement with their care provider and trust in the therapeutic alliance.

Research by Asberg and Renk (2012) supports the findings of Johnson et al. (2015) and Nowotny et al. (2014) regarding trauma and related complications in DDFO treatment and that trauma and related complications add to substance abuse risk in DDFO populations. Asberg and Renk's findings in combination with previously mentioned findings from other studies have clearly demonstrated the need to incorporate trauma,

substance abuse, and mental health histories into interventions for DDFOs. Baillargeon et al. (2009) suggested that inmates who meet the criteria for major clinicial disorders such as schizophrenia, MDD, bipolar disorder, and nonschizophrenic psychotic disorders are also at a substantially higher risk for multiple incarcerations than inmates who do not have a major clinical disorder. Baillargeon et al.'s findings suggest that DDFOs are at risk for recidivism directly related to substance use disorders, trauma, and mental health issues, which makes the need for effective treatment approaches, increased motivation toward treatment, and the need for a reduction of attrition a public health crisis. Baillargeon et al. suggested that few researchers have examined the associations between recidivism and major psychiatric disorders, which also supports the importance of adding to the body of literature regarding DDFOs. Putkonen, Komulainen, Virkkunen, Eronen, and Lönnqvist (2003) found that female inmates with major clinical disorders, especially psychotic disorders, experience an increased risk in repeat offenses and that DDFOs would likely experience this increased risk immediately upon release versus female inmates who have no psychotic or major clincial disorders. Putkonen et al. also found that adding substance use disorders to major clinical disorders in forensic settings equaled a critical crisis requiring research attention.

Establishing a therapeutic relationship is vital to all components of treatment motivation from engagement to postrelease care. In DDFOs, factors such as lacking education and practical job skills coupled with previous victimization history and the stigma often related to a criminal background contribute to low self-esteem and lack of treatment motivation (Gee & Reed, 2013; Johnson et al., 2015). Gee and Reed (2013)

found that, in particular, female offenders with personality disorders presented with chaotic lifestyles that included high drug misuse, trauma, and domestic violence as well as prostitution. Female offenders with backgrounds like these also experience additional stressors from instability in the home and have childcare issues, which can result in less access to postrelease psychotherapeutic treatment among this population (Gee & Reed, 2013). To further complicate DDFO treatment needs, Gee and Reed (2013) found that DDFOs will benefit most from intense case management services and treatment modalities including cognitive behavioral therapy and dialectical behavioral therapy. These therapeutic interventions require longer periods of contact with a client, and challenges are then exacerbated by the lack of time associated with shorter prison sentences for female offenders (Gee & Reed, 2013). Shorter incarceration periods can also adversely affect the opportunity to build therapeutic relationships between direct care providers and DDFOs, which Gee and Reed (2013) strongly suggested must be further examined in order to establish what motivates DDFOs to seek or stay in treatment. A clearer understanding of DDFO motivation would help shed light on more effective treatment modalities and how to establish the trusting relationship required to attend to their needs.

Verona, Bresin, and Patrick (2013) found that DDFOs, when compared to female offenders in general, exhibited less empathetic response and less emotional control than that required to actively participate in treatment. Less empathy and problems with social interactions create additional obstacles to constructing the therapeutic relationship. DDFOs may not buy into traditional counseling approaches, which can make building

trust between DDFOs and direct care providers, engaging DDFOs in the treatment process, and motivating them to stay in treatment challenging. Addressing these challenges requires extensive knowledge and experience on the part of direct care providers (Verona et al., 2013). Verona et al.'s findings are consistent with the assertion that disorder-specific traits may significantly contribute to lack of motivation and treatment adherence as well as attrition problems in some way and suggest that the more complicated the mental health diagnosis, the more direct care providers are challenged to motivate accordingly.

Female Offender Treatment Challenges

There is little to no research focused on forensic settings that directly addresses inmate dual diagnosis treatment, specific to major clinical disorders, through the lens of motivation. In order to understand the phenomenon as best as possible, research closely related to each main topic (e.g., motivation in treatment, female offenders, and challenges in treatment) was reviewed to create the most accurate clinical picture related to the problem as possible. It is increasingly imperative to understand this gap in the literature as women in the criminal justice system have become the fastest growing population (James & Glaze, 2006). It is vital to understand the need for research that will help address issues that exist across institutions for offenders with dual diagnosis, especially women, with previous incarceration histories (Hartwell et al., 2013). Furthermore, study findings revealed little insight into the specific topic of complex dual diagnosis, and little is known about how this clinical issue is dealt with in forensic settings. Most findings have shown that the correctional system is not designed to handle complex clinical

services (Grella & Rodriguez, 2011). The lack of literature related to complex dual diagnosis, especially in forensic treatment settings, specifically supports the need to investigate how direct care providers perceive DDFO motivational facilitators and barriers related to treatment engagement, adherence, completion, and attrition. This information will help foster behavioral interventions that direct care providers can adopt across forensic settings to deal with the complexities found among the DDFOs they work with.

Hunt, Peters, and Kremling (2015) found a general lack of adequate behavioral health care services for individuals with substance use disorders and serious and persistent mental illness and service utilization among offender populations. While prior treatment history, length of stay and previous arrests has been shown to increase treatment adherence while incarcerated and to increase aftercare enrollment, no study findings have suggested motivational facilitators that may influence these factors. Hunt et al. suggested research focusing on motivational factors related to treatment engagement, program adherence, and aftercare. The authors also suggested researching the motivational barriers offenders with dual diagnosis encounter and researching previous treatment history to assist direct care providers in understanding what works and what does not work for DDFOs enrolled in treatment programs. Hunt et al.'s findings affirm the gap between DDFO behavioral intervention service needs and direct care providers' efforts to meet these needs.

The most dominant treatment programming for women in forensic settings is the modified therapeutic community (MTC), which is considered an evidence-based model

for treating drug-dependent offenders (Houser & Welsh, 2014). MTCs are specifically designed to treat offenders holistically through using the peer community system, which is designed as a structured society closed off from all other non-MTC offenders in a prison (Houser & Welsh, 2014). An MTC schedule typically includes programming designed specifically for women that encompasses trauma-informed care and gender-responsive treatment to address substance use disorders. The design is meant to elicit responsibility and promote self-control. Participants must successfully complete phase work, which includes essays on self-reflection, worksheets based on substance abuse topics, and journal entries about their challenges. Participants are also required to attend individual and group therapy to complete the program and continue to after-care settings (Houser & Welsh, 2014).

While MTCs have been suggested as the most effective forensic treatment form for offenders with substance use disorders, there is contradicting evidence about their efficacy, especially when mental health disorders are also present (Houser & Welsh, 2014). More specifically, study findings have not shown any effective advantage of using MTCs to reduce recidivism among offender populations as well to address psychiatric disorder-specific challenges among substance-dependent offenders (Houser & Welsh, 2014; Zhang, Roberts, & McCollister, 2011). Mahoney, Chouliara, and Karatzias (2015) investigated efficacy of MTCs and treatment approaches for female offenders in an MTC forensic setting from a qualitative perspective and found similar unmet challenges as those shown in previous studies. Mahoney et al. found that women use maladaptive coping mechanisms when faced with primary psychosocial risk factors that can result in,

for example, substance abuse. Mahoney et al. suggested three areas for further research on female offender treatment: motivation (acceptance and ambivalence), facilitator relationship (referred to as therapeutic alliance), and deficits and disruptions in the treatment process. For the present study's purposes, motivation is the primary concern and key focus. Mahoney et al. interviewed several female offenders in an overseas treatment program and found that motivational concerns ran deep among them, mostly related to historical challenges including psychosocial risks in recovery and their current recovery approach.

Ambivalence in treatment refers to the back and forth or ebb and flow of motivation toward the recovery process and can include contradictions in beliefs, attitudes, and emotions (Peters et al., 2015). Treatment requires that a client challenge maladaptive coping skills, beliefs, and thoughts with healthy new behaviors, thoughts, and feelings (changes in cognitive behaviors) about sober lifestyles (Nowotny et al., 2014; Peters et al., 2015). Researchers have found that the longer the length of stay in treatment, the better the treatment outcome, which includes increased service utilization after release from prison (Greenfield et al., 2007; Nowotny et al., 2014; Peters et al., 2015). Participants in Mahoney et al.'s 2015 study felt that the longer they were in the treatment program, the more motivation they were able to build and sustain. However, Mahoney et al.'s study did not include women with a major clinical diagnosis, which suggests the need to expand their research to include DDFOs. Interestingly, Mahoney et al.'s study includes participant statements showing resistance to early treatment stages, specifically related to court-ordered attendance. However, the participants also reported

that as more time passed, they completed more treatment assignments and the more they bought in to the process (Mahoney et al., 2015). Mahoney et al. also discussed how this resistance and lack of motivation can eventually be overcome with specific treatment plans that target holistic treatment needs on an individual basis. Mahoney et al.'s findings support the importance of holistic treatment that includes mental health goals, which could target many DDFO needs.

Mahoney et al. (2015) also found that therapeutic alliances significantly strengthened motivation for attendance, promoted feelings of comfort in the recovery process, and improved offenders' chances of completing treatment programs. However, Mahoney et al. did not discuss what motivational facilitators need to be in place or that direct care providers should use to establish or sustain this process. Participants did state that feeling coerced into the treatment process weakened their motivation, which suggests that forensic settings may be the most complex environment in which to provide appropriate care and services (Mahoney et al., 2015). Forensic treatment challenges combined with the complexities and severity of symptoms DDFOs experience indicate that DDFOs will continue to face a significant lack of services that are appropriate for their specific needs unless further research is conducted (Greenfield et al., 2007; Houser & Welsh, 2014; Johnson et al., 2015; Prendergast et al., 2009).

Therapeutic community-based (TC) treatment has been found to aggravate mental health symptoms among DDFOs, especially major clinical disorders such as bipolar disorder and major depression, resulting in lack of treatment progress, behavior regression, and voluntary program termination (Baillargeon et al., 2009; Houser &

Welsh, 2014; Prins, 2014). The structured expectations in these programs appear to strain the already difficult experiences for DDFOs in forensic systems, suggesting that while therapeutic communities may be the most common practice for treating DDFOs, they are still not the best. Modifying therapeutic community-based approach has improved the quality and approach to treatment of DDFO care, but such modifications fail to address the signficant challenges surrounding major clinical disorders (Baillargeon et al., 2009; Golder et al., 2014).

Researchers have suggested that therapeutic communities do not consider factors such as the course of recovery for DDFOs and the significant complexities related to their individual self-change (Golder et al., 2014; Greenfield et al., 2007; Grella & Rodriguez, 2011). Individual self-change refers to the personalized process of recovery that is unique to every person; this concept is contradicted by a therapeutic community approach that encompasses more of the one-size fits all method (Greenfield et al., 2007; Mahoney et al., 2015). Transitioning back into their communities after prison poses additional challenges for DDFOs that introduce new stressors related to access of care and available resources. While aftercare is a target transitional element, it is still unknown whether DDFOs regularly access aftercare enrollment, evidenced by study findings that continue to reflect low service utilization after prison treatment completion as well as recividism issues (Baillargeon et al., 2009; Nowotny et al., 2014). Direct care providers face a number of challenges regarding connecting DDFOs to adequate substance and mental health care upon release. DDFOs are unlikely to be motivated enough to continue care on their own accord (Baillargeon et al., 2009).

Lurigio (2011) assessed the likelihood that female offenders will obtain postrelease substance and mental health treatment and found a significant lack in targeted dual diagnosis management in forensic institutions, which contributed to aftercare problems. It can be assumed that a lack in dual diagnostic management would pose similar or worse challenge to DDFOs due to the increased complexities in symptoms and symptom management. Lurigio stated that while direct care providers assist in both substance use disorder and mental health treatment needs as much as possible in forensic settings, these professionals consistently contend with lack of services for offenders, offenders not accessing available treatment services, and extremely large caseloads. Resources and services offered in forensic settings rarely meet the demands for psychiatric treatment let alone dual diagnostic management (Council of State Governments, 2012, 2013). This lack of resources and services in forensic treatment settings would suggest that failing to better understand and address DDFO's motivational challenges related to treatment will result in increasingly negative social implications such as high risk of substance abuse disorder-related accidents, higher incarceration costs, and community safety.

Possible reasons for treatment failure lean toward issues surrounding the inability to overcome stigma that may add to shortened attempts to treat substance use disorders and major clinical mental illnesses in forensic settings (Hartwell et al., 2013). CSAT (2009) suggested that stigma is a key engagement barrier that has yet to be successfully understood and that research is needed to better understand the motivation needed to overcome the fear of stigma and to determine interventions that may alleviate this fear

and better facilitate treatment engagement during incarceration and after release. Fear is likely to be exacerbated among DDFO populations as DDFOs will experience significant trust issues related to trauma and abuse histories and are likely to have the personality characteristics that further complicate how emotions are expressed or ignored (Nowotny et al., 2014; Verona et al., 2013).

Findings regarding motivation for treatment while incarcerated are sparse; however, even less is known about motivational challenges from direct care provider perspectives. The likelihood that DDFO insights might provide researchers with the necessary information to better understand this phenomenon is slight. Therefore, it is of utmost importance to understand motivation for treatment from the closest possible source: direct care providers. Insights from direct care providers can aid the development of newer target treatments by identifying specific challenges of and suitable treatments for DDFOs.

Baillargeon et al. (2009) found that offenders with major clinical disorders were at an increased risk for reincarceration compared with inmates who did not present with psychiatric disorders, especially bipolar disorder. The authors suggested including inmates with severe psychiatric disorders in future DDFO research. Baillargeon et al. further suggested that to best treat this complex population, research must be expanded to encompass motivation for treatment in order to increase appropriate mental health care practices in forensic settings as well as post-prison-release interventions specific to DDFO needs.

Gee and Reed (2013) found that the forensic setting's strict environment added to DDFOs' already complex diagnostic pictures and likely played a role in treatment attrition. Denial of personal property, sleep interruption, security lockdowns, and various personality differences among correctional officers were found to contribute to helplessness, hopelessness, and low self-esteem among DDFOs (Gee & Reed, 2013). These issues influence trust and a personal sense of security while incarcerated (Gee & Reed, 2013). Direct care providers must manage symptoms and security in addition to substance use disorders and severe persistent mental illness-related behaviors in order to create a therapeutic alliance. Gee and Reed (2013) also suggested that DDFOs who complete programming while incarcerated "may include the most motivated clients" and that "in particular, an analysis of the issues that keep women engaged, or cause them to drop out" must be researched (p. 248). Gee and Reed's findings further support the present study's research questions and support the hypothesis that with a better understanding of what best motivates DDFOs, key factors leading to the most effective treatment approaches may be identified. These findings also support that identifying motivational barriers will help create targeted behavioral interventions specifically designed to address DDFO treatment challenges.

Barriers to Engagement

Appel, Ellison, Jansky, and Oldak (2004) and Hunt et al. (2015) suggested that women will encounter obstacles and barriers to treatment more often than males. For the purposes of this review, the term "barrier" refers to the specific reasons women do not utilize addiction or mental health treatment services or fail to modify individualized

target behaviors in treatment (Greenfield et al., 2007). Many of these obstacles are not necessarily unique to women. However, when women encounter these obstacles they typically exhibit more intense psychological symptoms due to the various pressures associated with everyday caregiver roles as well as socioeconomic factors and medical health conditions. These symptoms are even more problematic for women with a dual diagnosis (Hartwell et al., 2013).

Many of the treatment challenges specific to women are experienced more intensely among offender populations and play significant roles in treatment engagement and initiation for DDFOs. According to the results from the 2013 National Survey on Drug Use and Health (SAMHSA, 2014), women historically report multiple factors that can adversely affect treatment entrance at various levels. Interpersonal and intrapersonal barriers such as health or relationship issues; sociocultural issues related to biases, stigmas, or attitudes toward health care; and structural issues related to program infrastructure, treatment policies, and restrictions all affect treatment entrance (CSAT, 2009; SAMHSA, 2005).

Interpersonal barriers. Many of the interpersonal issues facing women in outpatient treatment can also be assumed for forensic populations. The inability to enter treatment or discouragement from treatment due to the caregiver role they play deters many offenders who are mothers from attending to critical treatment needs (CSAT, 2009; Gee & Reed, 2013; Johnson et al., 2015). The caregiver role essentially entails the role as mother and the expectations placed on women with children such as housekeeping, paying bills, buying groceries, preparing meals, and providing school clothing for their

children as necessary (CSAT, 2009). In other words, the caregiver role encompasses all responsibilities mothers have for supporting their family financially, emotionally, and physically. Stressors from caregiver responsibilities can play a role in treatment adherence, the motivation to continue postrelease treatment, and in long-term sobriety (CSAT, 2009). Enrolling in a treatment program while incarcerated is often secondary to holding prison facility jobs due to the women's socioeconomic needs (CSAT, 2009). Women are social in nature (CSAT, 2009). Therefore, it is expected that challenges related to social drug use would also add DDFOs' complex needs when preparing to leave the security of forensic treatment facilities. Family support systems are generally at the center of drug-use history and can present various obstacles for direct care providers in motivating clients to adhere to sober lifestyles as the family group is likely to offer little to no encouragement to sobriety (CSAT, 2009; Johnson et al., 2015). These obstacles add to the complex challenges direct care providers face when treating DDFOs as well as motivating DDFOs to stay in treatment upon release from prison. Study findings have also shown that treatment enrollment can cause the loss of intimate partner relationships among DDFOs, especially when entering prison, and can continue to influence DDFOs throughout the treatment process (Johnson et al., 2015). As DDFOs deal with social stigma, reactions by intimate partners to sober lifestyle choices and resistance in asking for help after release become problematic (CSAT, 2009; Johnson et al., 2015). While the general literature reflects a basic understanding of interpersonal barriers, research efforts are typically not focused on forensic populations. Nor does the literature reflect research on interpersonal challenges DDFOs specifically experience.

The lack of insight into interpersonal challenges in forensic settings supports the need for a fuller understanding of these issues to better address DDFO treatment issues and to add to the current body of literature.

Intrapersonal barriers. Intrapersonal issues such as guilt and shame related to previous substance abuse have been shown to play a role in treatment motivation, engagement, and successful completion (CSAT, 2009). Personal health issues such as hepatitis C, HIV/AIDS, and other medical issues; feelings of helplessness; losing custody of children, and fear associated with previous treatment failure are also interpersonal concerns that affect treatment motivation (CSAT, 2009). Not being able to use substances to cope with stressors is a significant factor that may impede treatment motivation for DDFOs and may contribute to the lack of treatment commitment (Miller & Rollick, 2002). Researchers also consider female medical issues related to gynecological or obstetric needs as impediments in treatment attendance likely contributing to stigma, embarrassment, and guilt and shame surrounding substance use behaviors, trauma, and life choices (CSAT, 2009; Johnson et al., 2015; Nowotny et al., 2014). All of these intrapersonal barriers should be considered significant obstacles for most women in treatment but may be even more severe for DDFOs. Research in this area, again, has not focused on forensic settings and does not reflect consideration of these barriers regarding DDFOs' increased treatment needs. These interpersonal issues continue to support the need for research to better understand the motivational facilitators, possible barriers to motivation, and recommendations for effective interventions through direct care providers' experiences.

Sociocultural barriers. Researchers have found women are more susceptible to stigma related to substance use disorders than men and have been termed as lax in moral character, sexually promiscuous, and neglectful in parenting (CSAT, 2009; Nowotny et al., 2014). Stigmas can increase feelings of anxiety-related guilt and shame, which have been found to significantly impact DDFO treatment and that complicate treatment interventions and protocols used by direct care providers (CSAT, 2009; Johnson et al., 2015; Nowotny et al., 2014). Researchers have found that women in substance use disorder treatment programs experience feelings of inadequacy and fear, especially related to children in the foster care system, and perceptions associated with irresponsible parenting (Asberg & Renk, 2012; Greenfield et al., 2007). These feelings will complicate treatment challenges related to the guilt and shame female offenders may already experience, which may also negatively affect the desire to stay away from bad people, places, or drug lifestyles (Asberg & Renk, 2012; Greenfield et al., 2007; Johnson et al., 2015). Feelings experienced by female offenders are vital components that direct care providers must meticulously attend to ensure that treatment is goal oriented and supported with crisis intervention plans to increase the likelihood of continued motivation in pre- and postrelease treatment.

Structural or programmatic issues. Specific barriers to treating women in forensic settings include challenges related to waiting lists. Some offenders are court ordered to treatment by a judge while other offenders may be found to meet treatment requirements by classification officers in the prison using structured tools to determine treatment need such as the Level of Service Inventory and be classified to complete an

appropriate treatment program (CSAT, 2009). Once incarcerated, both court-ordered and classified offenders may have to wait to enter the treatment program they are scheduled to complete because of various issues specific to forensic settings. Delayed admission interferes with the family system (e.g., time away from children, increased chance of custody challenges, etc.), and a lack of resources contributes to severe space limitations in prison programs and complicates the ability to effectively serve DDFOs (CSAT, 2009; Johnson et al., 2015). Essentially, there is a lack of funding and training for direct care providers to treat in forensic settings (CSAT, 2009). There have been some strides in gender-focused treatment and trauma-informed care for female offender (CSAT, 2009; Johnson et al., 2015). However, a serious lack of appropriate clinical services to address offenders with dual diagnosis, especially DDFOs, has continued to challenge the criminal justice system.

CSAT (2009) and SAMHSA (2014) research findings illustrate the importance of identifying strategies to help overcome barriers in three areas: clinical support services, clinical treatment services, and community support systems. These concepts are discussed throughout the literature as well as specifically by CSAT and were established to help spur clinical treatment approaches and more effective programming for female offenders (CSAT, 2009). Clinical support services staff for forensic populations recognize that the extent and severity of female offenders' addiction histories differ between prison and jail levels and stress that female offenders enrolled in forensic treatment should be considered a distinct population (SAMHSA, 2014). Primary areas of concern for female offenders consist of drug addiction and social and cognitive deficits as

well as specific criminogenic behaviors that surpass the level of care required of any other population in substance abuse disorder treatment (CSAT, 2009; SAMHSA, 2014). Women who enroll in substance use disorder treatment outside of prison are likely to have shorter addiction histories, lower symptom severity, and shorter criminal background histories (SAMHSA, 2014). Research has shown how substance abuse disorders are best addressed in forensic settings with one exception: coexisting major psychiatric disorders (CSAT, 2009; SAMHSA, 2014). Incarcerated women suffering from substance use disorders with major clinical disorders such as schizophrenia or personality disorders were not admitted into such treatment programs in the past as this population was considered too complex to treat within such programming (CSAT, 2009). However, by 2005, SAMHSA and CSAT supported DDFOs entering into forensic treatment programs provided that these women were stabilized on appropriate psychiatric medications (CSAT, 2009). CSAT's research has supported the assertion that DDFOs require more extensive clinical support and support from program staff and mental health staff. These women also typically need extended time in the programs to increase the likelihood of successful treatment completion (CSAT, 2009). Lack of extensive and appropriate training, resources, space, and other institutional barriers often results in denial of these services and early release from prison related to shorter prison sentences (CSAT, 2009; Gee & Reed, 2013; Grella & Rodriguez, 2011; Johnson et al., 2015; SAMHSA, 2014).

Clinical treatment for DDFOs requires combination approaches that include pharmaceutical interventions and psychotherapy as well as specific behavioral

interventions to help DDFOs deal with the challenges they experience in recovery (Kelly & Daley, 2013). Some of the specific challenges include negative symptoms affecting social relationships, severe persistent psychotic symptoms, substance cravings, and peer pressure related to unhealthy social relationships (Kelly & Daley, 2013). Using the CSAT and SAMHSA guidelines, clinical treatment must address the aforementioned challenges in order to meet all DDFO needs. This means that all clinical treatment staff should be cross-trained in mental health and substance dependence to successfully treat this population. Again, lack of administrative support and funding, few to no resources to provide such training, and poor implementation of behavioral interventions make the goal of cross-training all treatment staff nearly unattainable (Kelly & Daley, 2013). Essentially, direct care providers are forced to create behavioral interventions with the resources they do have, even if insufficient, to address DDFO treatment needs. It is imperative to understand direct care provider perspectives and experiences and gain a clearer sense of what works and what does not work when it comes to treatment services for DDFOs.

One of the most important elements in transitioning a female offender from prison to the community is immediate access to treatment services (CSAT, 2009). Women who wait even a few hours to enter community treatment can be a lost cause (CSAT, 2009). Wait lists can also complicate immediate treatment service access after release, which can result in not going directly to community-based substance use disorder programs (CSAT, 2009). CSAT (2009) suggested that female offenders released from forensic care should have an interim plan for providing safe and secure housing and supervision as

well as a short-term treatment approach (CSAT, 2009). Grella and Rodriguez (2011) researched the continuum of care challenges in California related to female offender's motivation toward aftercare services and found that 38.6% of 1,158 women in a California Female Offender Treatment and Employment Program returned to prison within 12 months after discharge from treatment. While appropriate services during incarceration are a vital component to substance use disorder treatment, they are merely a starting point. Female offenders need significant assistance when transitioning from forensic placement into the community as this transition affects their feelings of safety and security, and adverse experiences related to unsafe environments often stem from trauma, and previous negative histories (CSAT, 2009; Grella & Rodriguez, 2011; Johnson et al., 2015; Mahoney et al., 2015). Adverse life experiences and negative feelings related to trauma, and historical experiences are expected in female offender populations, but DDFOs have not been widely studied. If it is accepted that DDFO needs are more complex than those offenders who have one or no clinical disorders, it could be asked why so little research has been done on this population. The gap in the literature further supports the current study's importance as to why its focus was on identifying motivational facilitators and barriers specific to DDFO needs, which should translate into improved correctional clinical practices as well as a continuum of care after release.

Motivation for Treatment

Much of the criminal justice system's treatment programs focus on individuals who are court mandated to such programs. Being mandated to treatment could be seen as another factor that can adversely affect treatment motivation because these individuals

are not voluntarily attending programs. It is known that court-ordered treatment can be equally as effective as voluntary; however, the motivational factors that may contribute to this effectiveness, especially for DDFOs, is unknown (Prendergast et. al., 2009). Most female offenders will encounter challenges such as securing housing and employment as well as other psychosocial issues when facing community reentry and reintegration. However, researchers have not specifically addressed motivational facilitators that may help overcome these challenges. It is clear that DDFOs experience more intense substance dependence and psychosocial challenges (Baillargeon et al., 2009; Johnson et al., 2015; Kienast et al., 2014); therefore, it can be assumed that the barriers they encounter may also be more severe than those encountered by female offenders with a single mental health disorder or none (Johnson et al., 2015; Mahoney et al., 2015; Prendergast et al., 2009). Direct care providers serve voluntary and court-ordered DDFOs. Consequently, direct care providers must attend to motivational factors for both types of DDFOs patient groups.

Grella and Rodriguez (2011) researched motivation for treatment and aftercare services from a quantitative perspective using self-report-style surveys. Their focus was on understanding what female offenders in California found more appealing: attending substance use disorder treatment while incarcerated or continuing treatment after release. Motivation to enter postrelease treatment was measured using a 20-item scale regarding the following areas: problem recognition, desire for help, and readiness to treatment, which are consistent with the stages of change model for substance abuse treatment (Grella & Rodriguez, 2011). A multivariate linear regression model using the sum of all

items predicted treatment motivation scores determined by the answers participants provided on the surveys (Grella & Rodriguez, 2011).

Grella and Rodriguez's (2011) findings suggested that female offenders with children in the welfare system were more likely to attend treatment, which is consistent with the findings reported throughout the present study's literature review. Additionally, female offenders with prior treatment history and those with a history of using substances such as cocaine, opiates, or methamphetamine were associated with higher treatment motivation compared to female offenders who only used marijuana or drank alcohol (Grella & Rodriguez, 2011). Interestingly, Grella and Rodriguez also found that lower treatment motivation associated with African American offenders, Hispanic offenders, or offenders who identified as other compared with European American offenders (Grella & Rodriguez, 2011). The authors found no real difference in motivation between women who were incarcerated for the first time and those with multiple incarcerations (Grella & Rodriguez, 2011). These findings are important to consider as motivation is still vaguely understood, and while these findings provide insights that support many challenges, they still do not reflect an in-depth examination of these areas, nor do they reflect a population with major clinical disorders in treatment settings. While Grella and Rodriguez clearly supported the fact that there are challenges in treating female offenders, they did not address major clinical disorders that should be considered a prevalent standard to meet DDFO treatment needs in today's U.S. correctional systems.

Prendergast et al. (2009) found that while some inmates involved in treatment during incarceration were motivated to learn about addressing a drug problem, most did

not recognize their drug issues and expressed ambivalence toward self-identifying as a drug user. Similar findings reported by Johnson et al. (2015) suggested that simply talking about drug problems was more likely to occur than true self-reflection and acceptance of a drug problem. These findings reflect the lack of insight among many DDFOs who present direct care providers with problems related to motivation to change behaviors. If a DDFO fails to recognize that she has a substance or mental health problem, as seen with severe persistent clinical disorders such as personality disorders, the challenges for direct care providers to appropriately treat DDFOs become very difficult to overcome. In subsequent treatment attempts, clients with serious drug preferences such as cocaine, opiates, or heroin may be less motivated to continue treatment due to their previous inability to complete treatment, failed interventions, and failed past sobriety (Grella & Rodriguez, 2011; Peters et al., 2015; Prendergast et. al., 2009). This lack of knowledge about the motivational facilitators that may encourage treatment engagement, attendance, and completion among DDFOs further supported the present study's purpose.

Summary

Many key findings were highlighted in this literature review. The review showed that researchers have identified the challenges female offenders experience, which has spurred the development of gender-responsive care in forensic and community settings. Recognizing the differences between male and female offender treatment is a milestone in the creation of integrated approaches that have been implemented in substance abuse programs nationwide. Additionally, researchers have uncovered traumatic histories

among female offender populations that have significantly impacted the extent of required treatment and, essentially, the outcomes of treatment attempts. Integrating both genders in treatment and trauma-informed care allows direct care providers to meet specific needs and requirement guidelines in treatment approaches both in forensic and community settings. However, even with such positive movement in female offender treatment, research is still needed on the needs and specific challenges related to treating women with dual diagnosis, especially women diagnosed with major clinical disorders such as bipolar disorder, major depression, and personality disorders.

Findings from renowned researchers such as Gee and Reed (2013), Grella and Rodriguez (2011), Johnson et al. (2015), and Peters et al. (2015) allow for insights into the difficulties that DDFOs may encounter in treatment such as transitional housing, employment, and psychosocial stressors related to previous lifestyles. However, research efforts have not recognized the significant impact of major clinical disorders and how these disorders impact treatment motivation, attendance, and attrition among DDFOs. Researchers have found that motivational factors must be clearly identified and understood early in the treatment process and must be continuously attended to in order to maximize treatment outcomes.

Experiences of direct care professionals provides the closest clinical picture of the needs, challenges, and motivational factors involved in treating DDFOs. By exploring the qualitative experiences of the day-to-day provider, this study reflected an accurate, real-life picture of the motivational challenges in DDFO care. Understanding this phenomenon through the experiences of direct care providers and identifying

motivational barriers, facilitators, and strategies through their perspectives can further aid in the effective reduction of treatment attrition and development of specific treatment modalities that account for the complexities seen in DDFOs. Study methodology is discussed in detail in Chapter 3 with specific attention on to research design, rationale, researcher role, and analysis plans.

Chapter 3: Research Method

The purpose of this study was to better understand and explore direct care providers' perspectives of the unique motivational facilitators related to treatment adherence and the motivational barriers associated with attrition among DDFOs. Also examined were effective behavioral interventions or strategies that direct care providers use to improve motivation and treatment adherence among DDFOs. For this study's purposes, study participants were program directors and substance abuse counselors who treat DDFOs in the state of Delaware's Department of Correction. Direct care providers encourage, support, and guide DDFOs' recovery processes and assist DDFOs with the various challenges they experience while in treatment (Johnson et al., 2015; Mahoney et al., 2015). Understanding direct care provider experiences of the motivational facilitators and barriers when providing treatment to DDFOs may assist in developing behavioral interventions specifically targeted to DDFO needs. By exploring these strategies through provider perceptions, themes emerged regarding motivational facilitators, barriers, and enhancements to treatment that reduce attrition. This study's research design and rationale, my role as researcher, study methodology, participant selection, trustworthiness concerns, and data collection and analysis are discussed in this chapter.

Research Design and Rationale

The purpose of this phenomenological study was to develop an understanding of the challenges DDFOs experience in substance use disorder treatment in forensic settings. This knowledge may be used to develop more effective treatment for DDFOs in these

settings. Three research questions governed this study and were used to help develop a better understanding of the concepts and phenomenon of interest:

RQ1: According to treatment direct care providers, what are the motivational facilitators associated with treatment adherence among DDFOs?

RQ2: What are the motivational barriers to treatment adherence that contribute to treatment attrition among DDFOs?

RQ3: What are effective strategies or elements of interventions that enhance motivation and reduce attrition among DDFOs?

The best research helps to develop theories (Moustakas, 1994). These theories then guide scholars to better understand a specific phenomenon (Moustakas, 1994). Moreover, research allows for formulating and testing theoretical concepts while searching emerging patterns that can be applied realistically (Bailey, 2007; Moustakas, 1994). In the present study, using the interpreted experiences of direct care providers who work with DDFOs increased the understanding of how to render effective treatment and encourage and provide motivation throughout treatment as well as increase treatment adherence.

By investigating the research questions developed for this study, the concepts of motivational facilitators and barriers as experienced by DDFOs and as seen through the eyes of direct care providers offered greater insight into ways to improve treatment and treatment outcomes. Motivational facilitators, which are behavioral interventions or ideas that influence treatment motivation, can be used to provide more effective intervention and treatment and can bring about positive prosocial changes in DDFO behaviors.

Barriers in treatment motivation include concepts such as negative social networks and low socioeconomic status, among others (Griva et al., 2012). Thus far, researchers examining barriers specific to DDFOs treatment have not explored this population's complex challenges. Hence, findings from this study also provided a greater understanding of these challenges and concepts as they relate to DDFO care, effective strategies, and interventions used by direct care providers. Ideally, these motivational enhancements may be added to the range of treatment modalities geared toward DDFOs' specific care needs in the future and may contribute to reductions in attrition and recidivism. Semistructured interviewing is appropriate for smaller research studies as this approach allows flexibility in the interview process (Drever, 1995). Eight direct care providers were interviewed for this study. More participants were not needed as a larger-scale approach was not appropriate for this study, and data collection became overwhelming at eight participants. Adding more participants when data saturation is reached could affect study integrity or goals (Drever, 1995).

Other researchers have used qualitative research methods when investigating themes regarding direct care providers. Johnson et al. (2015) used semistructured interviews to uncover emergent themes direct care providers experienced when connecting women to appropriate services after release from prison. In addition, qualitative inquiry helped to elicit rich information from the interviews that added to the depth of understanding regarding motivational facilitators and barriers that DDFOs experience. Direct care provider suggestions offered in flexible interviews, as recommended by Moustakas (1994), allowed me to expand on their understanding and

experiences with strategies that have worked, which added to the literature for successful treatment of DDFOs in correctional care settings and aftercare programming as well as in community-level care.

Determining the data collection method was based on the research questions and how study findings would be used. Purposeful sampling uses specific cases that elicit the most information (Creswell, 2012; Moustakas, 1994). In the present study, the vast experiences of direct care providers were used to extrapolate information about DDFO motivational facilitators, barriers to treatment adherence, and attrition. The findings helped to identify issues confronting DDFOs in real life but from an outsider's perspective. This exemplified the rationale behind selecting phenomenology to examine the concepts of interest for this study.

Phenomenological research is fundamentally rooted in inquiries that guide and focus a core meaning of established themes though questioning that upholds continued research and inquiry and that sustains passion for prosocial change in the area or phenomenon of interest (Moustakas, 1994). By understanding direct care provider experiences of DDFO treatment motivation or barriers to DDFO treatment motivation, practitioners may now be able to implement more effective strategies for improving DDFO care in substance abuse treatment and more accurately attend to the challenges these women face.

Role of the Researcher

For this study's purposes, I was the primary collection instrument as I interviewed selected participants who met the study participation criteria. Amerson (2011) suggested

that immersion into the process allows a solid foundation for evidence collection in a study and places the researcher as the primary interpreter of all information collected. My role was to communicate with direct care providers, develop questions, probe, elicit information directly related to the research questions, and disseminate the information obtained to any interested parties, including the study participants. While I have worked extensively in mental health care and substance use disorder treatment in Delaware, I did not interview anyone I have directly supervised to avoid any concerns regarding bias or power over the participants selected. I used bracketing during the data collection process to set aside any judgments or expectations I may have had regarding the phenomenon and allowed the process itself to unveil any meanings or understanding related to this study's key questions. Journaling, note taking, and interview summaries assisted this process and helped establish trustworthiness in the findings. Colleagues at my professional level were considered for participation for this study. Participants were required to work in facilities I had not previously worked in or in different programs in the state of Delaware's correctional system that treat female offenders. By adhering to the interview protocol and the study's clearly stated intentions and boundaries, professionalism was upheld throughout the interview process. Using an interview protocol relieved unnecessary directions or misguidance in the interview process that could have been viewed as bias. Additionally, all questions were asked in the same order and expanded on in the same areas for all interviews, which ensured that any undue misdirection or loss of topic control (talking about something off topic) did not occur during the interviews.

The interviews were not conducted in any forensic facilities in the state of Delaware. Not conducting interviews in forensic facilities removed any unintentional biases related to such settings. Participants were interviewed via telephone. Telephone interviews have been shown to promote higher participant comfort levels in addition to being convenient for interviewer and interviewee. They can allow participants to speak more freely during the interview process and increase participant disclosures of intimate information related to the interview questions (Novick, 2008). The calls were audio recorded for transcription purposes, and the participants were advised that the interview would be recorded prior to their scheduled interview date. I also maintained handwritten notes during the interviews in order to record as much information as possible.

Methodology

Sampling and Strategy

A convenience sample of licensed or certified substance abuse counselors, mental health counselors, program directors, clinical supervisors, and direct observational staff who were working with or had worked with DDFOs in a forensic institution was used for this study. The phenomenon of interest was direct care providers' interpretations of DDFOs' life experiences and the therapeutic interventions or relationships associated with treatment motivation that have impacted DDFOs. Eight participants were interviewed using semistructured and open-ended interview questions (see Appendix A). This design was best suited for this research study as it facilitated gaining the most information from direct care providers during the interview process. Using direct care providers to shed light on the challenges DDFOs experience did not expose DDFOs as a

vulnerable population and protected them while still allowing insights into their life experiences that relate to motivational facilitators or barriers in treatment. It was noted that the direct care providers remain removed from the problems DDFOs experience, and their interpretations provided a more clinical description of the issues or experiences of treatment motivation or attrition than the DDFOs who actually live the experience. The secondary perspective of direct care providers added to the clinical knowledge and understanding of the phenomenon, captured depth and insights into encouraging and enhancing care approaches and treatment, and suggested future implications for programs and policies developed for DDFOs.

Participants were selected using the most recent state of Delaware contractor's position control list. This list is public information and available to anyone seeking facts on the programs offered in the state's correctional system and community treatment systems. Names, emails, and direct phone contact information were provided for all programs in the state of Delaware and served as the primary sources for participant recruitment. Individuals who provide four levels of care in the state of Delaware's correctional system and community treatment systems were considered for this study to facilitate data triangulation and to avoid any site peculiarities as possible biases. This included professionals who worked with minimum-, medium-, and maximum-level inmates in Level 5 facilities (the highest security sites) and professionals who worked in transitional areas of the continuum of care model such as Level 4 facilities (lower security levels) running modified TCs. Also, male and female direct care providers were considered for this study to avoid any gender-responsive biases that can occur when one

gender is excluded. Participants had to meet specific criteria to be considered for this study, and all participants' professional credentials and experience were considered. The public provider lists that included experience, credentials, and professional backgrounds allowed for easy selection of possible participants.

An invitation email was sent to potential participants with information about the intended research and details on study criteria. Once interested participants were identified, they were called and briefly interviewed to determine if they met the study criteria. If they did, an interview date and time were scheduled. When the identified sample size was met and the data began to show signs of saturation, the interview process was complete, and data analysis began. The sample size, as previously mentioned, was eight participants. Consistency in information revealed by the interviewees, relative conformity of answers, and suggestions that entertained the same issues or challenges were considered signs of saturation.

Instrumentation

Data were collected using telephone interviews, which were conducted in a semistructured, informal manner that gave the participants opportunities to expand on their thoughts, feelings, and beliefs about the presented subjects. These interviews were scheduled for approximately 1 to 1.5 hr to allow the participants to expand on their answers as they felt necessary without being pressed for time. In some cases, the interviews did not take up the entire time allotted. There were other instances where the time frame was met, but it was never exceeded. The interviews were audio recorded to ensure correct data transcription. Notes were taken during the interviews to facilitate

collecting as much information as possible. Audio recording was used to allow for a more thorough examination of nuances that could have been missed during the interviews. Data collected during the interviews were transcribed verbatim and coded for specific themes such as substance abuse, mental health disorders, goals, and criminality issues.

Data Analysis Plan

Yin (2003) stated that data analysis consists of three components: examining the data, categorizing the information, and testing the evidence to address the study's initial intent. In qualitative research, data reduction is an integral part of the process and allows for honing the information, sorting through the information to clarify the focus of the findings, and organizing the data (Moustakas, 1994; Yin, 2003). These procedures allow the data to be presented in an organized, concise manner for drawing conclusions (Moustakas, 1994; Yin, 2003). To this end, qualitative data analysis can be considered a continual process that includes data reduction, data display, and conclusion formulation, resulting in useable information.

Generally, data collection for qualitative methods is rich and complex. Qualitative data may be difficult to comprehend without data compression via coding and thematic immersion (Moustakas, 1994; Yin, 2003). Systemic categorization of the present study's data created a clearer picture of the phenomenon of interest. Data analysis included pattern matching, coding for content, interpretation of participant responses, and subject matter interpretation as well as narrative summaries. Narrative summary encouraged better understanding of the data's context. Findings were coded into emerging thematic

patterns and analyzed into expressive elements in keeping with guidance from Yin (2003).

Data collected from each interview were verified via member checking to ensure their accuracy prior to starting data analysis. After transcription and coding, all information was presented to study participants to debrief them on the thematic elements that were found and to ensure information accuracy. Once debriefed, there was no further contact with the participants as they had completed all that was required of them. Qualitative research methods cannot realistically be replicated as quantitative works, but the findings do encourage future research that can use similar methods to add to the depth and richness of a body of knowledge (Denzin, 2006). By confirming the findings in this study, I assured that they were an accurate depiction of participants' views, perspectives, and responses and were not biased by my predispositions.

Issues of Trustworthiness

Frameworks that ensure rigor in qualitative research methods are used to enhance the findings and trustworthiness of qualitative data (Denzin, 2006). Examining issues of trustworthiness in qualitative research provides insights for readers regarding a study's accuracy. The four primary concepts of trustworthiness in qualitative research are credibility, transferability, dependability, and confirmability (Denzin, 2006).

Credibility

Credibility, the authenticity of the quality of the approach/method employed to conduct and assess this study, was established via saturation, member checking, and theoretical triangulation. Saturation is achieved once an effort to attain new or additional

information from the participants is exhausted and when further coding is no longer useful (Fusch & Ness, 2015). Member checking further established credibility in the present study. Study participants were asked to confirm the resulting themes from the interviews. Member checking is a standard quality control process in qualitative research methods that adds to the validity and transferability of the elicited information (Moustakas, 1994). Member checking also helps to reduce the risk of biases in the data analysis process (Morse, 2015).

Theory triangulation involves interpreting the data collected using three theoretical perspectives (Pitre & Kushner, 2015). For this study, incentive theory, Maslow's hierarchy of needs, and MI were used to triangulate the data and to further increase credibility. This assured the research's validity via three distinct perspectives in order to capture the different dimensions of the phenomenon in this study, in keeping with guidance by Pitre and Kushner (2015). It is important to address the various components and viewpoints of study findings to add to the depth of the information collected versus attempting to cross-validate findings for viewpoints (Pitre & Kushner, 2015). Triangulation increased the richness of the data because it evolved through interpretation that reflected three theories. The more diverse the findings, the more that can be known about the phenomenon of interest (Denzin, 2006); in this study's case, the challenges and motives behind the experiences of DDFOs in treatment.

Transferability

Thick description was used throughout the interview phase to assist in explaining the behaviors observed and the context of those behaviors so that the meaning behind the

noted behaviors can become meaningful to outside readers. Combining observation and experiential meaning of behaviors, beliefs, and feelings offers a deeper, richer meaning to the phenomenon under study (Morse, 2015; Petty et al., 2012). Thick description allowed study findings to become meaningful to others outside of direct care providers who work with DDFOs. By revealing the contextual meanings behind experiences, as was done in this study, study findings are considered to be context specific and therefore do not reflect attempts to generalize or transfer the findings (Petty et al., 2012). To encourage depth and richness of the phenomenon, purposive sampling ensures that multiple angles reveal a range of perspectives (Petty et al., 2012) and was employed in this study. It is important to note that thick description of a phenomenon encourages other researchers to determine the extent to which the findings may be transferable to another setting. This determination of transferability is solely intended for individuals who apply the findings to their own research settings (Petty et al., 2012).

Dependability

Using environmental triangulation and theory triangulation added to the dependability of the findings in this study. Environmental triangulation encourages using different settings, locations, or key identified factors to determine if the phenomenon under study remains the same or changes across settings (Guion, Diehl, & McDonald, 2011). In the present study, including direct care providers from different programs reflected environmental triangulation. Capturing the experiences of direct care providers through more than one perspective lens and different areas of care allowed for a much deeper and complex version of the phenomenon. The challenges and barriers as well as

motivational facilitators remained the same across all levels of care; therefore, the findings are considered trustworthy. As discussed in the section on credibility, the more information that is collected about this phenomenon, the more can be learned about the complex challenges that DDFOs face during treatment and the barriers that are linked to attrition. An audit log was used to track all the events, records, and sources used in this study to document evidence of the sequential activities used in the course of this research. This audit log provided a transparent record of all study-related aspects such as raw data and data analysis tools such as notes and interview summaries as well the data synthesis that covered definitions, themes, and relationships.

Confirmability

Denzin (2006) stated that researchers can never truly be separated from their research and that researchers can only interpret as no phenomenon can speak for itself. The qualitative research process denies researchers the ability to remain outside of their research. I therefore acknowledged that my presence in this study had some effect. Essentially, I considered the role I played in all study areas and accounted for the impact of my role in notes, journal entries, and interview summaries. I remained aware of the influence, intentional or not, that my own interpretations may have had on the study findings. A secondary reflexive analysis was performed on the definitions, themes, and relationships I uncovered to identify any areas of influence my presence may have had in the analysis process.

Ethical Procedures

Procedures for minimizing any potential risks to study participants included providing informed consent, ensuring confidentiality, debriefing the participants, accurately representing participant perspectives, and maintaining confidentiality throughout all reported study results. These procedures reflected the ethical principles established by the American Psychological Association (2002). I ensured that these standards were adhered to through obtaining approval for this study from Walden University's Institutional Review Board. Participants were identified by using public information; therefore, no ethical concerns were directly related to recruitment for this study. In addition, participation was completely voluntary; therefore, providers who chose to participate were informed that they could exit the study at any time without repercussion. These procedures reduced any risk or challenges related recruiting participants for this study.

Informed Consent

Informed consent forms (see Appendix B) were provided to all study participants. The form covered all essential study information, the study purpose, and all participant rights. The following elements were detailed in the informed consent form: (a) the study goals, (b) the voluntary nature of study participation, (c) an opt-out option that participants could exercise at any time during the course of the study, (d) data collection procedures, (e) the expected time commitment for the interviews, and (f) confidentiality and understanding for participation. The informed consent form also advised that interviews would be audio taped and that no compensation for participation would be

provided. Upon initial conversations with each participant, informed consent was reviewed through email and verified over the phone, and authorizations were obtained from all participants and sent back via email prior to all interviews.

Confidentiality

Initials for each participant combined with date codes provided participant confidentiality. As an example, an interview conducted with Mary Smith on May 5, 2016 was coded as MS05016. Using this coding approach and advising study participants that such coding would be used also increased the chance of honesty as a fundamental component of the informed consent process. Raw electronic data were stored in password-protected electronic files, and paper transcripts, notes, and interview handwritten summaries were stored in a fireproof safe. I stored all audio tapes, digital file backups, and paper file backups in locked files that I will retain for a minimum of 5 years after study completion. All data will be destroyed after this period.

Summary

Chapter 3 included a review of the research questions, definitions of the study concepts, and details on the phenomenon under study. My role as researcher was discussed and detailed, including the procedures I followed to avoid biases in data collection and analysis. Participant selection and recruiting processes were also detailed as well the importance of data saturation and sample size relationships. Study instrumentation was explained. Issues of trustworthiness were addressed by providing details of the methods used to avoid biases in data collection and analysis, which added to the credibility of the findings.

Chapter 4 presents the thematic analysis of the interview responses. Participant demographics are detailed, and data collection processes are reiterated. Evidence of trustworthiness in the findings is discussed with specific references to the methods that were used for establishing credibility, transferability, dependability, and confirmability.

Chapter 4: Results

The purpose of this phenomenological study was to explore and understand direct care providers' perspectives of the unique motivational barriers and facilitators associated with DDFO treatment. Three central research questions governed this study:

RQ1: According to direct care treatment providers, what are the motivational facilitators associated with treatment adherence among DDFOs?

RQ2: What are the motivational barriers to treatment adherence that contribute to treatment attrition among DDFOs?

RQ3: What are effective strategies or elements of interventions that enhance motivation and reduce attrition among DDFOs?

Chapter 4 presents the results from the thematic analysis of the interview responses. Also included in this chapter are details on the research setting, participant demographics, and the data collection process. Evidence of trustworthiness in the findings is discussed with specific reference to the methods used for establishing credibility, transferability, dependability, and confirmability.

Setting

Interviews were conducted by phone for the participants' convenience. In addition to convenience, the informal nature of these semistructured interviews allowed for a more open dialogue between study participants and me in an environment intended to foster confidentiality. This setting allowed for a free discussion on direct care providers' perspectives of professional areas of growth and treatment approaches and facilitated discussion on any issues that participants may have faced that might not have been as

easily discussed in a face-to-face setting. Phone interviews allowed for a sense of anonymity that added to the confidentiality upheld in this study, which was exemplified by the candid thoughts study participants shared in their interviews.

Demographics

Eight direct care providers who worked with DDFOs in forensic institutions in the state of Delaware participated in this study. Each participant possessed a current substance abuse and/or mental health care certification or was licensed to provide therapeutic treatment in a forensic setting in the state of Delaware. Participants were two licensed practical counselors of mental health, two licensed clinical psychologists, two certified alcohol and drug counselors, one licensed marriage and family therapist counselor with dual certification in alcohol and drug counseling, and one certified co-occurring disorders professional who was also dual certified in advanced alcohol and drug counseling.

The eight participants included two maximum-security-level direct care providers, two medium-security-level direct care providers, two minimum-security-level direct care providers, and two transitional-level direct care providers. Study participants collectively had 65 years of experience in treating DDFOs in forensic settings. Each participant met the inclusion criteria set forth to participate in this study. This participant selection represented a vast array of professional insights, backgrounds, and areas of expertise that were intended to allow for richer perspectives on the study's research questions. There were three male participants and five female participants, which helped to provide the most accurate, unbiased, and richest form of data for the purposes of this study.

Data Collection

I initially anticipated having up to 12 participants in this study. However, due to saturation cues reached prior to the anticipated maximum participant count, only eight individuals were included in this study. All eight interviews were completed via telephone, which was the most convenient approach for interviewing these participants.

I received IRB approval (#08-09-16-0292033) for this study in August 2016 and immediately began the participant selection process by reviewing the most recent position control lists. Possible candidates were highlighted for consideration. Once 12 possible candidates were identified and highlighted, I established a final list and began sending emails to recruit participants. These emails detailed the research study criteria, provided an overview of the study's purpose and approach, and stated that participation was voluntary. Ten potential participants responded. By the time I received the last two emails, I had already established several saturation cues in eight interviews, and, after conferring with my dissertation committee, I determined that any further interviews would risk flooding of the data and possible loss of richness and depth. As such, no further interviews were conducted after I transcribed the interviews from the first eight respondents.

I responded to all emails within 24 hr of receiving them and set up times for brief phone calls with all potential participants to ensure all inclusion criteria would be met for consideration in this study. All potential participants I spoke with met the study criteria, and all eight candidates agreed to continue with the study. Informed consent forms were

then emailed to all participants with directions for them to sign and return the document to me prior to their interview.

Data collection began on August 17, 2016, and lasted for 2 weeks. I anticipated that each interview would require approximately 1 to 1.5 hr and scheduled them accordingly to allow enough time so that participants would not feel rushed. All interviews began with a brief review of the informed consent process. I asked semistructured questions and encouraged participants to expand on their thoughts as they desired. An interesting observation from this process was that the shortest interviews were with the licensed clinical psychologists, which may have reflected their training and reporting standards, including clear, concise, and to-the-point responses. Conversely, the interview with the participant with the marriage and family therapy background was the longest of all, which may also have reflected this individual's therapeutic background. All interviews were recorded with a digital recorder fitted with a secure memory stick that was housed in a secure thumb drive. I also took notes during the interviews to jot down any specific concepts that appeared of interest.

After the interviews were completed, I transcribed them using Microsoft Word. I saved the transcriptions to a secure thumb drive using the file code approach described in Chapter 3. I completed each transcription within 10 days from the time of the interview. Completed interview transcripts and a brief update on the study status were emailed to the respective participants within 10 days after their interview. Participants were asked to review their respective transcriptions for any errors, concerns, or areas that might need further discussion or clarification. Participants were asked to simply respond "yes" to the

email if there were no issues. If there were any concerns, participants were instructed to reply to the email with a suggested time for going over their concerns. All participants responded yes to the emails. Their approval meant I could go forward with my analysis. Summaries based on participants' full transcripts were saved in Microsoft Word. These summaries were then coded and saved in separate document folders on a password-protected thumb drive.

The data collection procedures did not vary from the methods presented in Chapter 3. No unusual, inconvenient, or unplanned circumstances were encountered during the data collection or processing stages. All participants actively engaged in the recruitment, informed consent, and interview processes in a timely, professional, and topic-supportive manner. All participants expressed a great deal of interest in sharing their experiences and the findings for this research topic.

Data Analysis

Data analysis began with reviewing all recorded interviews. Complete verbatim transcriptions allowed for an in-depth review and a deeper, richer perspective of the data. As I took notes during the interviews, I identified words and terms that interviewees consistently used. I listed these words and terms by frequency of use and kept the list by me during transcription. This allowed me to reflect on what I had heard while I typed the transcriptions. Once the verbatim transcriptions were completed, I printed out each transcript and began detailed reviews of each.

Study participants often used the following terms: trust, rapport, listen to her, hear her, care, take time, be real, connect, reactive, emotional, boundaries, helpless, and

hopeless. I highlighted these terms in yellow to indicate where they repeated in the transcripts. I then expanded these terms to respective terms or small ideas that related to each other. Each transcription was then reviewed for respective or related terms and phrases. These were highlighted in green to show relationships between ideas. Blue highlighting was used to identify specific quotes that best represented these ideas. Note taking during transcript review fell into two areas: one included ideas and reference points to the other transcriptions in an effort to triangulate concepts, while the other area reflected my conceptual interpretation of the ideas as they emerged.

Initially, the simple coding I used included the concepts of help, hope, challenge, and strategy. Participant 6 said that she had "no hope, no hope at all." Participant 5 said that "helplessness and hopelessness are two huge factors that tell me whether or not her prognosis will be positive." These quotes both expressed the importance of the concept of hope in the data. From the simple coding process, each concept under these umbrella terms were expanded to include related terms, ideas, and cross-referenced quotes that supported each developing category. From the umbrella coding, larger categories of related information emerged that reflected concepts direct care providers expressed under the concepts of motivational helpers and suggestions, motivational challenges or obstacles, and suggested effective treatment strategies.

Evidence of Trustworthiness

Examining the evidence of trustworthiness in this study provides insights into the accuracy of the findings. Four concepts of trustworthiness, as mentioned in Chapter 3,

were considered: credibility, transferability, dependability, and confirmability. They are discussed next.

Credibility

As discussed in Chapter 3, authenticity of the quality of this research was achieved using saturation, member checking, and data triangulation. Saturation cues were emerging prior to interviewing the 12 participants originally anticipated for this study, which is why I stopped interviewing after the eighth participant. Once no new information was forthcoming and no new coding was emerging, the participant interviews were considered exhausted, signifying saturation had been met. Any further data collected after that point would have significantly risked data flooding or loss of richness in the findings.

Member checking helped establish transcription credibility and study findings. All participants were asked to confirm their respective results. This quality control process is often used in qualitative methods and allowed me to ensure that my interpretation was correct and accurate and helped to reduce the risk of unintentional biases in my data analysis process.

Theoretical triangulation of the data involved interpreting the data through three theoretical perspectives. The incentive theory, Maslow's hierarchy of needs, and MI theories were all used in triangulation, which increased the study's credibility. This process ensured the validity of my findings via three perspectives used to capture various dimensions of the phenomenon of interest. By using these perspectives for triangulation, I addressed these various dimensions and viewpoints to add depth and richness of the

findings collected versus attempting to cross-validate for perspectives. The diverse information that emerged from this added to the body of knowledge about motivational challenges and barriers to treatment for DDFOs.

Transferability

Thick description was used throughout the data analysis process to allow for interpretation of social and contextual meanings, by outside readers, of the information provided by the study participants. Combining observation and experiential meanings of behaviors, beliefs, and provider feelings related to the research questions offered a deeper, richer meaning of the phenomenon that was examined in this study. By describing the phenomenon in sufficient detail, I allowed the findings to become meaningful to people other than direct care providers. The revealed meanings of the findings should remain context specific and were not focused on generalizing or transferring the study findings. To ensure and encourage depth and richness in this study, I used purposive sampling so that multiple perspectives and views were included. In addition, the thick description in this study should encourage other scholars to determine if my findings are transferable to other settings. Determination of transferability is solely intended for others who might apply my findings to their own research settings.

Dependability

The use of environmental and theory triangulation ensured dependability of the findings in this study. Environmental triangulation helped to mitigate any site-specific peculiarities and bias as participants came from different institutions and treatment programs and worked in programs with security levels ranging from minimum to

maximum. This helped confirm that DDFO challenges and motivations were expressed accurately and remained the same across settings. I focused on capturing direct care providers' experiences through multiple perspective lenses, which added to the richness and complexity of the findings. The challenges, barriers, and motivations remained the same across all levels of care, institutions, and treatment programs and therefore should be considered trustworthy. I maintain secured records of all aspects related to this study for recruitment, collection, raw data, data analysis, notes, and summaries to provide audit trailed information to establish study dependability and credibility.

Confirmability

As mentioned in Chapter 3, it is understood that no phenomenon can speak for itself, but that it requires interpretation (Denzin, 2006). I, at no time, could consider myself separate or outside of my research study, so I had to acknowledge that my presence in this study may have had some effect on study outcomes. I considered my role in all areas of this research study and account for such impacts in notes, journaling, and summaries. I remained aware, at all times, of the influence I may have had, intentional or not, on my interpretations and findings. I used reflexive analysis on definitions, themes, and relationships I uncovered to attempt to identify any possible influence my presence may have had.

Results

In exploring direct care providers' perceptions of motivational facilitators, barriers to treatment, and effective treatment strategies when working with DDFOs, nine major themes emerged to answer this study's three central research questions. These

themes are detailed in Table 1 and are discussed next. Themes under motivational facilitators are discussed first, followed by themes under motivational barriers. Themes under effective strategies complete this discussion.

Table 1

Study Themes and Descriptions

Theme	Description
Motivational facilitators	
Theme 1: Empathetic approach and strong therapeutic alliance	Appears to play a significant role in DDFO motivational buy-in to substance treatment programs.
Theme 2: Hitting rock bottom	A large aspect of perceived facilitators experienced by DDFOs, suggesting that reaching extreme low points in one's life plays a role in increasing the motivation to move forward.
Motivational barriers	
Theme 3: Lack of insight and acceptance	Two of the strongest barriers perceived by direct care providers that DDFOs experience that lead to decreased motivation in treatment, lack of treatment adherence, and eventual drop out.
Theme 4: Lack of resiliency	The inability to bounce back from natural life stressors such as inconsistent support systems are significant issues facing DDFOs that direct care providers attribute to continuing issues directly related to treatment resistance, extremely diffuse boundaries, and returning to the same people, places, and things.
Theme 5: External system challenges	Unexpected insights from direct care providers revealed that external system factors are believed to be significant perceived barriers to treatment adherence and thought to negatively impact DDFO motivation.
Effective treatment strategies	
Theme 6: Employing empathetic approaches Theme 7: Rapport-building Theme 8: Engendering hope Theme 9: Avoiding confrontation	Techniques that work with DDFOs such as encouraging a warm and inviting atmosphere, using unconditional positive regard toward clients, engendering hope through encouragement and boundaries, and avoiding confrontation strategies were identified as the most effective strategies or combination of strategies for treating DDFOs.

Motivational Facilitators

The first research question focused on exploring DDFO motivational facilitators to treatment as perceived by direct care providers. Using this lens, two major themes emerged: empathetic approach and strong therapeutic alliance, and hitting rock bottom. Study participants suggested that without these elements, DDFO treatment motivation is lower. These themes are discussed next.

Theme 1: Empathetic Approach and Strong Therapeutic Alliance

All study participants discussed the importance of an empathetic treatment approach and a strong therapeutic alliance with their clients as foundational elements to building and increasing treatment motivation in DDFOs. Overall, this was one of the clearest and most widely conceptualized topics throughout the interviews, suggesting that these roles may truly be the groundwork for clinical treatment staff to establish motivational buy-in as well as to build on for increased motivation in treatment adherence. Some of the important variations in this theme were apparent in the ways that the direct care providers perceived motivational facilitators in treatment adherence, whether or not genuine approach to treatment and therapeutic alliance were personally important to the direct care providers themselves. In the following sections, experiential elements in the participant discussions that suggested genuine empathetic approaches as ways to create a strong therapeutic alliance and increase treatment motivation are discussed in depth.

Subtheme: Being genuine. Direct care providers spoke at great length about and provided many details on the importance of a genuinely caring, nurturing, and empathetic

approach for DDFOs in treatment. They also discussed how this approach increases buy-in to treatment and eventually adds to DDFO treatment adherence upon release. Their views closely aligned with traditional elements of psychotherapeutic approaches to treatment. Study participants felt that DDFOs need to be understood as best as possible through their experiences so that they learn that their providers really care about why they are incarcerated, why they are in treatment, what their goals are, and why they need to change.

Study participants all discussed how much these concepts weigh heavily on the DDFO's likelihood to be open to treatment options, continue in her programming, and eventually move on to community-based interventions after prison release. Direct care providers felt that it is important to understand the DDFO's background and also respect the experiences that caused her to be where she is in her life. Direct care providers felt that the DDFO's experiences might affect her perceptions of treatment and attitudes toward recovery as well as the decisions she will make about her future sobriety and treatment goal adherence.

Several direct care providers described these experiences and the importance of an empathetic approach and a strong therapeutic alliance as a means to build a foundation for motivation in treatment. Participant 5 said,

> I really believe that the treatment of this population begins with establishing a strong sense of rapport and trust in the therapeutic reliance, a relationship in which you can conduct a thorough investigation and evaluation that recognizes the influence of both types of disorders [substance and mental health] and looks

> closely at the relationship between the substance use and the psychopathology. What is important to me is the experience of the individual, and not necessarily of what the "objective records" would show . . . you have to calculate your intervention based on the strength of your relationship . . . [your approach] needs to be incredibly calculated and very thoughtful.

Participant 3 discussed the significant need for genuineness required of a provider to hopefully increase buy-in to substance and mental health motivational efforts.

> Not only do I have to convince her to stop using substances, which has been her only coping mechanism for who knows how many years, and I have to build up their own way of coping with mental health symptoms they have. It's not just telling them or motivating them not to use, but telling her "Okay, this is the crutch you have been using for such a long time, and now I am going to take that crutch away, and you are going to be crippled. I am going to teach you how to walk again." It is that much harder when you have something that breaks you down inside. It's harder . . . you are basically taking away someone's ability to walk. I think the biggest thing is you have to individualize her treatment, and in order to tailor treatment you have to ask questions, which take trust. Trust that she does not have . . . but you can't effectively tailor treatment until you understand, and you have to understand why she uses what she uses.

Participant 2 further elaborated on the buy-in concept by comparing the relationship that these women have to the providers' own support systems. Participant 2 suggested, as other participants also did, that if direct care providers can tap into the

reality that DDFOs are just like their own families, the providers can build even more motivation because the DDFOs realize that the providers care about them.

> They need to know and to feel that you are genuine. When they see that, they buy in. You have to remember that these women are people. They are real women. These could be your daughters, your sisters, your mothers. These are women that have a story, a life, children, maybe grandchildren . . . that didn't chose to take this life path. If you can break through that with her, then she knows you care and she learns to care the way she sees you care, and the relationship grows, you grow, she grows…it is just amazing to see how that builds her confidence. She gets it and she wants more, and if you can get her there, you can help her go anywhere.

Subtheme: Be real with her. Three study participants discussed in detail the concept of being real with DDFOs as a means to build rapport, strengthen the dyad between provider and client, and improve motivation in treatment. From the perspectives of study participants, understanding where a DDFO is coming from and where she wants to be in her process of recovery includes having heart- to-heart conversations with these women. Participant 4 expounded on her experiences and this approach to increase client motivation:

> I think that you cannot just be manualized and simply read questions from a book. It has to be a conversation. A real conversation, person to person, sincere. It doesn't need to go in some exact order that some form has, like A, B, C . . . No, I need to sit down with you and be real. This needs to be real, person to person. Not

> looking at some paper or typing . . . not writing away on some pad of paper . . . that is so not the way to connect to someone—no one would like that! To have a real conversation with her, and to be a real woman, and talk woman to woman is huge. I am not saying a male cannot, but I think that it is especially appropriate to have a successful woman who is confident and able to live a very prosocial life having a woman-to-woman conversation and being accepting, open, and having unconditional positive regard. That motivates her. Get real with her. Show her you care and you are willing to teach her how to care for herself the same way.

Another study participant elaborated on the theme of getting real and shared that the most common approach with successful outcomes and increased motivation is to get clients to open up to the process, to trust, and to understand the underlying core issues.

Subtheme: Embracing and acceptance. One very prominent concept heard throughout the interviews related to the idea of embracing the past and accepting the things that have happened as a large component of motivation to continue treatment. Many study participants shared stories of how accepting the experiences DDFOs have lived through built solid foundations for enhanced motivation in treatment. All of these perspectives reflected two key factors: a strong therapeutic alliance/relationship and an empathetic approach to the treatment process. The element of embracing and accepting past experiences ties into Maslow's hierarchy of needs theory in that in fulfilling the basic needs of these women, direct care providers allow for enhanced motivation, increased buy-in, and, most likely, better long-term outcomes.

Participant 6 expanded on the ideas of trust, acceptance, and embracing the feelings of guilt and shame DDFOs associate with their disorders. The suggestion that learning with the client how to embrace feelings and learn to accept what happened to move on is a strong factor in how well a DDFO will contribute to her own recovery process, and her motivation to move forward with treatment after she is released. Participant 6 said,

> What I find is, with most of these women, they really just want someone to listen and identify with them. They spent so many of their lives being tossed out, and shunned, and just being worn like a rag doll. They've never had the focus on them. More so, they never really had someone that was truly interested in them and what was going on with them. And, I find when they get that, even a little piece of that, it's amazing. It's like a light comes on, and they want to talk, and it's like feeding them. They want the knowledge, they want to understand, they want the help. But, they have to trust. Its all about trust with DDFOs. They have to trust you to completely open up with you. And, they have to know and feel that you are genuine. And when they do see that in a person, in a program, they buy in. You know? Because they are hoping . . . they don't really want to live like that! There comes a point where they know . . . like they are selling their bodies, you know human trafficking in real. They are doing all kinds of things to get that drug, and the feelings of what they have done to themselves, and to their families, they are so ashamed. And, my thing is to try and teach them how to embrace that shame, because what's done is done. You have to learn to deal with that and

> accept that, and only with [dealing and accepting] can you ever be able to move on and change.

Subtheme: Hope and insight. A major concept shared by all participants was the importance of DDFOs being insightful about their needs, their ability to establish goals, their belief in being able to attain those goals, and their hope for the future. All of the study participants discussed their perspectives on the most common motivational "tell-tale" and shared that when a DDFO can, at the very least, discuss small goals and show hope through talking about the future, it leads to a better prognosis. Study participants used similar terms such as hope, help, open, willing, and future. This suggests that according to direct care providers, when these elements are present in a DDFO she is more likely to be successful in treatment, sustain motivation throughout treatment, and seek treatment upon release from prison. The following comments from Participant 5 reflect study participant views on insight, hope, and thoughts about the future to create, sustain, and further build motivation in treatment.

> I look for more than anything else . . . I look for insight and hope. I would define insight as someone's ability to recognize how events in her past have impacted her present and inform her future. Being able to tie a red thread or identify a theme that has been consistent throughout their lives that has led them to where they are today. Also, the willingness to explore the impact on their future. Then hope. I define as future orientation. Are they able to describe, authentically, a life that they want? Specific goals that they want to explore both long term and short term, and then two questions: One, are they able to identify the steps they need to

> do to reach that goal? and two, Do they believe that they have the ability to effectuate that change in their life? So, I would say again, hope and insight are the two most important things you see in those DDFOs that will likely have a better chance.

Theme 2: Hitting Rock Bottom

Six study participants said they felt DDFOs have to experience hitting rock bottom in order to really appreciate the opportunity of recovery and be open to building motivation toward treatment. Participant 1 expanded on the circumstances DDFOs experience that contribute to the underlying desire to obtain treatment.

> They feel hopeless, and there are very few people in the prison system that give them hope. They feel hopeless and helpless, and they feel like shit about themselves. They are filled with shame and guilt, and they don't have ties with their families, so you have to be able to somehow engender the positive. Most of these women are not motivated because their attitude is "What's the point? I am just going to get out there and do it again." They just don't see the point. A lot of them feel like this is just their destiny, that they are just going to be this way, and they'll even say, "I tried to overdose like seven times" and she wasn't successful, so it's kind of like if they are not given some kind of hope that it can be different, it's almost like a new mind or thought disorder! It's not loading her up with fancy places to stay, either. It's great if you can give them long-term treatment, especially a heroin addict; if you can give them long-term treatment, its better, but it starts with a thought: "I'm worthless, and a drink will make it better. . . . I am

> hopeless. . . . I need to take a drug to get up and clean my house." It is really like a whole new issue that adds a thought disorder to the mix. On top of all the other things she has going on, and its insanity! The fact that she has to hit that rock bottom place just to get it, it just sad.

Participant 6 referred to the similar context of hitting rock bottom and noted very similar challenges that a DDFO needs to experience to move toward recovery with the right support in place.

> They already feel all the way to the bottom. They don't see the point on why they have to do anything anymore. I mean, half the time their children have already been taken from them, and they can't get them back until after probation or parole is over . . . those kinds of things. They have no one to go home and take care of. They have no families to look forward to either, and with incarceration there is little opportunity for employment, they frown upon it, and these women get judged more by what their charges are or what they have done rather than what they are trying to do. But, so many times this is the story you hear over and over again. And, when you hear it, you know. She has a better chance to make it this time . . . she's been there, you know? She has experienced a personal dark place, and she can respect a different option at this point because she has nothing else to hold on to. Those women . . . those stories are the ones that you know will change. Even just a little bit, she will have a better chance. If you can help her understand that, you are golden.

Many of the experiences shared by study participants assist a clearer understanding of the elements necessary for creating a perfect opportunity to build on motivation in treatment. All of the concepts discussed here are supported by experiences that have worked for study participants to increase DDFO buy-in toward the treatment process, increase motivation to complete treatment, and continue seeking treatment after release. The important pieces that these direct care providers have found to be necessary ingredients to successful motivation in DDFO treatment approaches include appreciation of experiencing rock bottom and movement toward respecting the client's past in order to facilitate motivation for a better future. Understanding clients' life stories, respecting their experiences, and humbling oneself to clients' process as equals with whom one works together to achieve a common goal were the most successful approaches for increasing treatment motivation among DDFOs.

Motivational barriers as seen by study participants are discussed next. Many of the aforementioned motivational facilitators encompass elements that are examined. Overcoming these challenges will likely even more so increase the chances of successful treatment and motivation to continue treatment after release. With every success, there must be a struggle, which can be seen in the comments from study participants.

Motivational Barriers

The second research question focused on the motivational barriers DDFOs experience from the direct care providers' perspectives. Three major themes emerged from the interviews: lack of insight and acceptance, lack of resiliency, and, interestingly and unexpectedly, barriers related to external system factors. Perceived motivational

barriers are discussed in this section as they were reflected in subthemes that also emerged related to the three major themes.

Theme 3: Lack of Insight and Acceptance

A significant theme in almost all study participant interviews was how DDFOs' lack of insight into mental health needs and their lack of acceptance of their behaviors and thinking patterns play a negative role in their motivation for treatment in many ways. According to several participants, not being able to identify a future, not believing that goals are obtainable, and lacking insight poses greater risks for failure among DDFOs. Several study participants shared their experiences with DDFOs' lack of insight and acceptance. Their thoughts help to develop a clearer understanding of why some DDFOs continue to fail in treatment, lack motivation to try further, and will not obtain treatment after leaving prison. Participant 2 described how the lack of insight into mental health and substance abuse treatment needs among some DDFOs creates barriers to treatment through stigma and personal failure.

> I think many times, it's just acceptance. A lot of times they just don't want to accept the fact that they did something wrong because of the way society makes people feel when you have any of these issues, that there is something wrong with you. And, there's not, it's just something that is not balanced within you, and that doesn't mean that anything is "wrong with you" personally. She is literally forced to feel failure through her social community. And, a lot of people want to ignore it. They want to ignore their diagnosis. They don't think it's a problem. This feeds the beast, really. And, the other part of it is a lot of them don't want to address

> their issues; they want to forget. That is typically why they turn to the substance use because they don't want to rehash all that! They want to act like it never happened.

Participant 7 described this concept further and shared that many DDFOs lack the ability to accept they have mental health care needs and that the lack of social acceptance feeds this barrier.

> These women want to believe they are not living with an illness . . . they refuse to think that it's never going away. I think it may be part of the stigma of mental health and the way that we look at those who have it . . . I think it's the lack of social acceptance of mental illnesses and substance use disorders. Either way, if she does not believe in illness or that she has a mental health need like so many of these women do, we can never break through that. Until she gets to a place where she is open to the idea that something may not be right, or that more so, she can mentally be better, there is no motivation.

Participant 8's comments reflected similar concepts. "I think that it's something that they want to be cured from. When they feel good they're cured . . . and they stopped [taking medications] because they're cured. They don't need it! It's a lack of long-term insight and acceptance." Lack of insight and acceptance is a very common barrier theme and suggests that lack of insight into mental health and substance abuse needs contributes to lack of acceptance simply because DDFOs do not see or understand their need for treatment. If one cannot see something, there is nothing to believe. According to

Participant 8, motivation in treatment must include attaining insights at some level to eventually work toward acceptance.

Subtheme: Coercion and lack of acceptance. Six study participants discussed the negative impact of coercion on motivation. The participants expressed that the setting itself is one of the biggest challenges when talking about accepting one's history, accepting treatment, and accepting goals. Study participants shared elements of coercion in their interviews that fell into three areas: prison as coercion, court-ordered versus voluntary treatment, and forced sobriety.

Prison as coercion. Participant 5 expanded on the concept of prison as coercion. This participants' thoughts aligned with several other mentions of the facility setting causing challenges toward motivation.

> Anytime you are dealing with an incarcerated population, you are dealing with someone that just does not want to be there. You are intrinsically going to be dealing with motivation problems. And, I am not going to be able to convince you that you want to be here. It's just really complicated to do any work in that environment, in that kind of coercive setting.

Overall, the providers shared the perception that DDFOs are rather unaccepting simply due to the setting. Participant 4 detailed concerns specific to the institutional level that was eluded to in several interviews. This participant shared perceptions related to environmental stressors, specifically related to the challenges of navigating correctional officers' perceptions of their clients and the setting.

> We have criminalized mental health and substance use disorders. We set ourselves up. It's not only challenging for our DDFO, but it's the staff DOC what we are allowed to talk about, and what we are not allowed to talk about. They DOC don't want to admit that our facilities are filled with dual-diagnosed . . . we are a giant treatment center! We have criminalized mental health and substance use, but this is where our people are now! It's hard because DOC has just not come around to fully recognizing that yet.

Court-ordered versus voluntary treatment. Several study participants shared perceptions regarding coercion's impact on sentencing. Participant 3's comments summarize the perspectives on this concept.

> When you are dealing with someone that is court ordered or classified, there is always a sense of coercion. Especially if she is in a court-ordered program and their only other option is to be in violation of that court order and serve more time. It's hard to motivate women or for them to get motivated on their own when you give them a choice of doing it my way, or you serve more time. She really probably doesn't want to be there, and she feels that she is being pressured to do something she doesn't want to do. I would much rather these programs have an aspect that is much more client driven and motivational without the element of the client feeling as through if she gets the wrong answer she is going to serve more time. I don't know too many people that are going to be truly intrinsically motivated to do this if they could get more time. That to me is just not a good way to learn.

Forced sobriety. In addition to the coercion concepts previously discussed, the concern of forced sobriety arose in several interviews. Study participants strongly felt that forcibly removing individuals from their addiction (incarceration) adversely affects the concepts of readiness to change. Participant 6 clearly stated the feelings voiced by nearly all study participants when discussing forced sobriety.

> She didn't sign up for this, like this. She didn't sign up for this right now. How does that impact her readiness to change? Probably not so good. She was literally forcibly ripped from her addiction. Yes, she probably couldn't or wouldn't have stopped on her own right then, but that's my point. The only reason she is here is because she got caught up, and that's it.

Subtheme: Externalizing thoughts and behaviors. According to study participants, negative behaviors and resistance to treatment generally relate to lack of insight into mental health needs. Several study participants shared stories of clients they had worked closely with during their careers who exhibited sometimes-violent behaviors and thought patterns. Their experiences exemplify the difficulty in working with individuals who do not have insights into their mental health needs or who do not realize that they are externalizing thoughts in an inappropriate or socially unacceptable manner. Some of the terms used in these interviews were *extreme, reactive, emotional, and explosive,* suggesting that individuals who have severe mental disorders need even more attention to care than individuals with less complicated diagnoses. In recalling a DDFO who presented with complex and severe symptoms, an inability to control her behaviors,

and a long history of substance abuse to self-medicate symptom management, Participant 7 said,

> She just lashed out. She would just talk a lot to herself, and she would yell, scream, kick, pant, and slobber at the mouth. She would sing and speak in what sounded like tongues. She just did not want to comply, but it wasn't that, even, she just couldn't comply. She had little to no insight. I don't think, even when she would be medication compliant, that she knew or could acknowledge something wasn't right within her. All she knew is that she needed her drug to keep her symptoms at bay. To take that away and make her feel and experience drug withdrawal and symptom increase . . . it is just so much on her. A lot of these women don't utilize medication as part of her treatment and that it is a major part of their treatment . . . then they don't take their medication and they start to deteriorate, and she did.

Subtheme: Trauma history. As found throughout the literature and in the review of recent research conducted for this study, trauma histories are one of the most impactful elements found in women with substance abuse disorders. Every study participant discussed the impact that trauma had on the women they worked with as well as the DDFO population in general. Many study participants felt as though trauma histories play significant roles in damaging DDFOs' understanding of healthy relationships and boundaries and generally skew their perspectives on what unconditional love really means. This theme also ties into an emergent theme discussed by many study participants that direct care providers need to be passionate in their work to assist in building healthy

boundaries, and increasing healthy understanding of safety. Participants shared that passionate approaches naturally increase empathetic attitudes toward helping to construct a more appropriate and healthy understanding of relationships for their clients.

Participant 5 described some of the most common trauma-related elements that pose barriers to treatment motivation and tied these elements to the need to build strength in the therapeutic alliance. In Participant 5's view, these barriers cannot be treated without this strength.

> With these women, what you are going to find are chronic histories of trauma, chronic histories of diffuse boundaries, boundary violations everywhere, prostitution, human trafficking, and just unimaginable terror in the developmental lives of these women. I believe that the reparative approach can happen only through a very strong relationship, one in which we work through the problems of interpersonal relationships that get brought into the dyad between the therapist and the patient. They are played out in that dyad and resolved. It can become a model for relationships elsewhere. But it is important to say, personally, I really enjoy working with these women because people with severe history of persistent trauma can be very professionally rewarding to work with. There is a challenge there that is really unique, but at the same time, being a male, to recognize my ability to provide a holding environment different than one that most of these women have ever experienced. I find that being a male can challenge some of the schemas that they have formed over the years, which I believe are really core areas of their addictions and the acuity of the mental illness.

Participant 6 explained that as a professional, recognizing the traumatic events in a DDFO's life impacts both the DDFO's mental health and substance abuse future. This participant also spoke of the challenge to overcome this barrier when the client presents as mentally and emotionally stuck at the age when the trauma likely occurred.

> Generally, with the severe persistent mental illness and the co-occurring disorders, I find that substance abuse is generally triggered by some kind of trauma. And so you compound things, and I find that sometimes it is a result of whatever the trauma was. So, whether that trauma happened when she was an adult, or that trauma happened to you as a child, it's generally a trauma, and they are emotionally stunted to whatever age it was that they started using. So, then you're not dealing with the brain of a 25-year-old or a 45-year-old woman. You are dealing with the brain of the 14-year-old girl that was raped by her father.

Participant 3 shared the consistent theme of trauma backgrounds complicating the clinical picture, skewing the outcomes, and impacting the ability to attain and sustain motivation in treatment.

> I'd say one of the most glaring things that most of the incarcerated population have is substantial trauma background. [In] many instances, their reasons for even beginning to use is related to their trauma. Some might have started using to try and forget or to try and suppress some of those trauma memories. Those experiences, they run so deep and then with DDFOs, sometimes a lot of the reasons they are in the prison are associated with their substance use and drug-associated criminality. These are definitely things that appear a commonality

> among women who start using and wind up spending all their money using, ending up having to steal or having to shoplift or whichever to try and maintain her habit. Whether it is to maintain not feeling anything [numb] from their trauma, symptoms or just hold off withdrawal symptoms.

Theme 4: Lack of Resiliency

Resiliency encompasses the ability to adapt and overcome one's surroundings, obstacles, and challenges during the process of change. A significant theme that emerged across all of the interviews reflected the concept of DDFOs' lack of resiliency or inability to adapt to life challenges such as trauma, criminal lifestyles, addiction lifestyles, and the resulting aftermath of these experiences. Aftermath may include increased symptoms; increased drug use; loss of children to the court system; losing contact with family support; and eventually returning to the same people, places, and things. All study participants discussed a DDFO's inability to adapt to change successfully as a significant barrier to motivation in treatment and suggested that this inability plays a negative role in the motivation to change. Many participants shared stories of clients who feared change and maladaptively learned to cope with adverse life events by using substances, resulting in unsuccessful adaptation. Participant 8 said,

> Many times, she will just go back to the old environment . . . a number of them go back to the old environment. That environment was chaotic before they left, and families are not being treated, and so they go back to that chaos. They feel as if they can't change it, it's just . . . it is what it is. They don't know where to turn, and some don't follow through on their mental health needs, so they stop taking

> their medications. Now, even though they are sometimes able to be given medication on their way out the door [from prison], it doesn't mean that she will definitely follow through. They stop taking their medications, and they return back to incarceration. It's like a fear epidemic that they don't even realize. She doesn't even calculate there is another way. It's very sad.

When elaborating on how these resiliency issues may be different from women with one or no substance abuse issues or mental health issues versus a DDFO, Participant 3 said,

> I think it makes it harder for them. If you are dealing with a lot of stress, your focus becomes very narrow, and you have this tunnel vision making it harder for you to look at other choices, or better alternatives. It's like she can't even realize there is another option. Your ability to tolerate stress is that much less. This goes back to that resiliency checklist. When that happens, you tend to have a lot of narrowing of behavioral choices or things to consider, so I would definitely say it's quite different and clearly more pervasive.

Subtheme: Lack of support. Lack of support, which was a consistent theme across all interviews, is clearly a serious barrier to treatment motivation in DDFOs. Support was variously described as family support and involvement in the treatment process and as treatment provider support while incarcerated through post release. Participant 2 said,

> What I really think is missing . . . what I really think would enhance better outcomes is if we were involved in the aftercare process. These women need

> support, and they just don't have it. Unfortunately, we are not involved in that process. While they are inside the prison we have to give them what we can, but once they leave prison we are no longer a part of the process. It's like oh, now they are done with us. And, I think if we were able to continue with them, it would result in better outcomes because they know they have someone that has them in their best interest.

Subtheme: Treatment resistance. Treatment resistance was a significant theme that emerged from several participant interviews. While the definitions of treatment resistance varied slightly, all study participants had common views regarding DDFOs' lack of insight and acceptance of past adverse experiences. Participant 2 shared a perspective that captured the overall theme discussed across interviews.

> Treatment resistance for me is unacceptance. If you don't think you have a problem, you can't fix the problem. You feel that the problem doesn't exist. You have people that feel like, oh, that may work for you but that won't work for me. No! Maybe that particular thing won't work for you, but there's something that we can try. It goes back to willingness to change, and you have to be willing to try and accept there is a problem. If you don't do any of those things, then treatment is not possible because you aren't even open to the idea.

Theme 5: External System Challenges

In addition to client-related facilitators and barriers or challenges that result from substance abuse or mental health concerns, nearly all study participants discussed a few key points worth mentioning as they were unexpected. Overall, this study's focus was on

identifying the most effective approaches for increasing motivation in DDFOs who are enrolled in substance abuse treatment programs in the state of Delaware. Expected study findings included suggestions for increasing motivation, successful treatment approaches, and what direct care providers feel are ways to facilitate motivation in treatment. What was not expected was the revelation of system-level problems that almost every study participant discussed. These providers expounded on their system-related concerns that adversely affect the network of problems DDFOs will face when attempting to complete treatment and when seeking treatment post release.

It is not known if these concerns relate to current policies or challenges that may be present in the facilities or the bodies that govern correctional health care, and treatment. However, it is important to include these elements in this study's findings as they add to the already clinically complex picture for DDFOs. Study participants stressed that these system challenges may make it even more difficult to address the experiences and futures of these women if issues in the system itself are not addressed.

Unexpected information can come about in any study. While expectations maintain the focus on the concepts related directly to the research questions, it was imperative to remain open to the data in this case. With nearly every study participant voicing concerns regarding the lack of provider communication, follow up, and serious medical coverage gaps, I felt these concepts needed to be included. Including study participant views on these issues may further help to influence policies and procedures for treating female offenders in the state of Delaware as well as legislation regarding gaps in medical insurance coverage for incarcerated persons. It is important to mention that

even though the study participants discussed experiences related to the care of female offenders, it can be assumed that these same concerns would bridge over to the care of male offenders in treatment. In addition, all incarcerated Delawareans are subject to the concerns related medical care coverage gaps. Therefore, medical coverage for recently released offenders in the state poses a future area for research.

Two major themes emerged from interviews with the seven study participants who shared concerns over system-level challenges. These challenges include lack of provider communication and follow-up. Lack of adequate services and issues related to medical insurance for incarcerated individuals in Delaware were also noted.

Subtheme: Lack of provider communication and follow up. A significant theme that emerged was providers did not communicate with each other on client care. Study participants explained that the current treatment approach for DDFOs lacks integrated treatment options that include both mental health and substance abuse components. Participant 5 discussed concerns about separate mental health and substance treatment providers as well as what is missing in current treatment.

> Well, as professionals unfortunately we are very siloed in our approaches, and we are very territorial, and so the first thing that comes out of me regarding treatment of these women is that there are very few true integrated treatment options for co-occurring disorders, it's one or the other. Unfortunately, we live in a world where the treatment for these offenders, especially with serious mental health needs, are treated as distinct and separate. So, I would say that that is a most important thing [to look at]. These are serious problems. You know, it's very interesting that we

> talk so much about co-occurring disorders, but we have entirely different departments for mental health and substance use disorders.

Participant 4's comments on lack of consistent treatment for DDFOs reflected other participants' comments on system-level challenges.

> The system just lacks integration, which is hard because we don't have other disciplines at your fingertips, but integration is so important. There is [clinical] information that we all need to know and be on the same page with that we just don't have to really treat this woman all around. I wish it were much more of a case management approach. We are moving there, but we are definitely not as integrated as I would like to be. Treatment planning could be great if we all knew what each other were doing, and I think it would be really helpful when we eventually do have integrated records, that we see what we are all working on.

Subtheme: Issues with medical insurance coverage for incarcerated Delawareans. Several study participants expressed serious concerns regarding the lack of medical coverage upon release from prison. Study participants viewed the gap in medical coverage for incarcerated individuals as one of the most challenging issues that impact treatment motivation during incarceration and post release. Many study participants stated that their clients often exhibit a "why bother" attitude toward treatment simply because they are incarcerated and they know they have to wait a minimum of 6 weeks to obtain an appointment to have medical coverage reinstated post release.

The first 24 hr or so are the most critical in establishing and maintaining motivation for a clean and sober lifestyle (Johnson et al., 2015). Gaps in medical

coverage directly violate the expectations of traditional mental health and substance treatment and likely adversely affects treatment outcomes across this and other incarcerated populations. It is important to note these issues as many other states terminate medical coverage when individuals enter correctional facilities. Participant 5 elaborated on this issue.

> First of all, one of the biggest issues that will plague us is that we are a Medicaid termination state, meaning that when you come into jail your Medicaid gets terminated. You have to reapply for it, but you can't do that until you are released, and then you have to wait 6 weeks for your appointment . . . you get out of prison you can't go to get treatment until you get Medicaid. The first 6 weeks post release and you can't get what you need . . . then your risk for recidivism goes through the roof. But then again, that's probably why we have an 87% or something ridiculous, of a recidivism rate for over three years in Delaware. They just can't get the care they need. So, the state needs to change that, and the oppositional concept is to make this what is called a suspension state where you get arrested and incarcerated, then your Medicaid gets flipped off like a light switch. The day you hit the street it gets flipped back on like a light switch.
>
> I have a lot more, but this one would literally immediately help with everyone that gets out of prison, I think that this is a pretty simple intervention you know? It could almost completely bridge the gap on access to services, aftercare, and continuum of care issues we see. The other thing is to be able to get a community provider to come into the prison before the inmate is even released

> to begin set up for their programming, to engage transportation services like Logisticare that can get paid through Medicaid. The state should know this client is being released, through a communication system, so she can literally get picked up from prison and go directly to her intake appointment before she even gets to go home. There are many things we should do to improve [continuity of] care, but you cannot do any of that if the person does not have any insurance.

Strategies for Enhancing DDFO Treatment Motivation

The following section is a discussion of the major themes related to strategies that may enhance DDFO treatment motivation. Some strategies were consistently mentioned in many interviews, and there was direct opposition to these strategies in two interviews. It is important to note that while there was opposition to these strategies, both study participants had the same perspectives on using or not using these strategies that were heavily based on the strength of the therapeutic relationship.

During data analysis, it became clear that many of the perspectives on motivational barriers study participants discussed also aligned with strategies that can be used to enhance motivation. As previously mentioned, some of these strategies echoed throughout the findings and directly related to four themes: empathetic approach, building rapport, instilling hope, and avoiding confrontational methods. Avoiding confrontational methods was mentioned by six study participants, but it was important to include the opposition to this approach voiced by two study participants as their views also reflected major study themes.

Theme 6: Using an Empathetic Approach

Study participants shared a major theme in that using an empathetic approach with DDFOs is the most effective strategy for improving treatment motivation and outcomes. Participant 3 said,

> Being able to connect with an individual regardless of why they are there [prison] and why they are in front of me, either legally, clinically, whatever the case is. I don't really get too bothered by whatever it is they present with, which I think allows me a unique connection with them to help them identify with what might actually be going on. You have to be able to establish a talking point and open dialogue with her that allows her to feel safe in her environment. Recognize her trauma background and work with her, together.

In addition to empathy being effective for increasing motivation, it is important to mention that every study participant relayed feelings of passion and drive to work in the field that cares for DDFOs. Their interviews yielded rich insights into their feelings that exemplified their passion for their work and the attitudes and beliefs they perceive as influential in motivating treatment.

Participant 4 shared similar feelings about passion and stated that the women being treated can be adversely affected if the providers are not passionate about their work. This participant's perspectives reflected what other study participants alluded to, that unconditional positive regard can only happen with a real passion and drive to help these women.

> I feel like if you come into this field in this setting because for any other reason but to really help DDFOs, this isn't for you. You are not really always here to find answers. Sometimes you are just here to sit with someone else and be okay with it. Sometimes it's just coming to the point where you say "You know, this fucking sucks, and I don't know the answer either, and I am not here to be the all knowing, but I am going to be here. And, I am going to stay with you through this." We are going to do this together. Perseverance, passion, and you just can't lose focus. And, especially, take care of yourself because if you are not taking care of yourself, you cannot take care of someone else or help someone else. You exude this unhealthy aura, and our women feed off that. It's hard to maintain all at once, but if you want to be there, you will be. It's not something we all are, but we strive to be at least aware of it. Keeping your own personal awareness is the only way to be effective in helping others. We can sometimes lack our own personal awareness, and that can be very damaging to the women we are trying to help.

In a powerful discussion, Participant 6 stated,

> If there was ever a group of women that needed to feel that they were listened to and loved, it's this population. You have to remember when you are trying to treat these women, they are starving for someone to just care about them and listen to them. If you do that, all the rest of the stuff will fall into place. That's what I would say.

This is a strong summary of the feelings study participants had about treatment approaches that will affect motivation of DDFOs in treatment and post release. Teaching DDFOs that there are people who care and that there is another way was the strongest undertone across all interviews.

Theme 7: Building Rapport

Many study participants expounded on strategies that they believe enhance the treatment process and enhance motivation. Participant 5 said:

> I really advocate for the value of the relationship between the therapist and the patient in order to establish a sense of safety and trust in which you can address the goals of treatment. You have to be able to allow for an environment that she feels safe both physically and mentally so that she can learn to grow in a healthier way. She has to be able to establish that trust and relationship with me or it just won't work like it could. There is less chance of success when you can't establish rapport with her. She needs to learn what that security feels like. Once you establish that, you can move on to attaining those goals you establish together, in treatment.

From a similar perspective, Participant 8 discussed the importance of building rapport as a strategy for enhancing treatment motivation among DDFOs. This participant said that if treatment providers feel that they are failing their client, the client will never trust the provider again.

> It's almost like if I feel like I failed you, you're never going to trust me to help you again. It's that serious; the client therapist relationship is literally life or death

> here. These women really take the time to develop trust in you and your relationship . . . and it's hard because you work a really long time to develop that, and I am going to take it that serious. I think that these women have been let down in every aspect of their lives. That's why it is so imperative that you work hard to build that rapport and trust with her because eventually it allows you to develop a new way of thinking, new expectations, and new thought patterns about trust and relationships in general.

Theme 8: Instilling Hope

In addition to building rapport as an effective strategy for increasing treatment motivation, study participants felt that instilling hope in their clients was important. This concept was mentioned throughout the interviews, suggesting that even though study participants recognized that many women do not enter into treatment with hope, encouraging hope through the therapeutic process and relationship increases the likelihood that DDFOs will be motivated to continue in treatment. According to study participants, instilling hope can be done through therapeutic techniques, psychotherapy sessions, and constant motivational reminders. As Participant 3 shared,

> A lot of it has to do with motivational reminders in treatment. Discussing and understanding why they are deciding not to use, why we are telling them not to use. You have to be able to show them that there is a different way so they understand the way we understand that sobriety is important. So that it doesn't perpetuate their issues or problems, making it that much harder for them to function in the long term, and overall really trying to motivate them to understand

> their reasons for wanting to change and do different. This gives them so much more hope. And, so many times they do not come in [to prison] with hope, but you can give it to them in so many ways. So that when it comes time they are presented with a choice that they will be able to think it through instead of going back to impulsively giving in to relapse.

When discussing hopelessness and how to motivate against those feelings, Participant 6 suggested that hope can be instilled at many levels and in many ways.

> There is no hope in this setting, most of the time. You have to make hope happen. I think the correctional staff, not all, but the majority of DOC staff feel like these women are criminals, and they are in here to be punished and to atone for what they did on the outside that was wrong. And because there is a lot of repeat offenders the attitude toward those women are that they are hopeless cases . . . "Oh, she'll be back. She has been in here seven times. She will be back." There is no hope there. But there's a way to engender hope by just saying "I am listening," "I am going to see you again next week," "I am hearing you," but, you know, there is limited resources, and a lot of that is, honestly, just the way it is, it's the reality of it. But, I think it's more or less a criminal mindset toward DDFOs. I have even heard the warden . . . well, I guess I shouldn't say that, but maybe I'll say I have heard other people on the staff say to women when they try to raise an issue or complaint they respond with "Well, you know this is prison" . . . duh! They know it's prison. You're really going to tell them that as an answer? Well, this is prison? And you are like "Okay, we understand it's prison," but there is an

> issue here that she just wants someone to even listen to her, maybe not change it but to hear her. By giving her just that little piece, it gives her hope that change can happen. It sounds wild, I know, but it happens every day.

Theme 9: Avoiding Confrontation

This last strategy was shared by six of the study participants. Interestingly, nearly all of the them shared negative experiences stemming from interactions with clients that adversely impacted motivation for treatment and significantly affected the client-therapist relationship in a sort of "backfire" experience. Overall, study participants shared the feeling that confrontation should not be used as it may have also played a role in previous traumatic experiences, which can affect how clients may react to current challenges. Nearly all study participants gave similar examples of their experiences when attempting to implement confrontation strategies with pervasive disorders, especially with borderline personality disorder, which is common among the DDFO population, generally resulting in a lash out of negative behaviors.

Some of the DDFO behaviors study participants described included aggressive or defensive actions such as challenging the direct care providers' insights as if they were accusations or even taking on the perspective that if the counselor thinks this way, the DDFO might as well just give in to it and be that way. Participant 6 elegantly summarized the concepts shared by most study participants.

> The confrontational approach is really passé . . . it really doesn't work well with addicts. Women with addictions and alcoholism combined with mental health issues have a lot of chaos, a lot of heartache, and a lot of ruined relationships as a

> result of their addiction. They already see themselves as not as good. They identify as a criminal . . . "I am a criminal." So, that doesn't do much good for your self-esteem. So, let us try and directly confront you on something and see what happens? No. That isn't a healthy choice; there are so many other ways to work with a DDFO. Confrontation breeds negativity in so many ways if you are not careful, and, unfortunately, there is no real way to gauge every possibility. I just feel that it is very passé, and there are other options.

Participant 5 voiced concern about using confrontation and explained that its use would have to be weighed against the relationship the provider has with a patient. Using confrontational strategies may result in a backfired attempt; however, Participant 5 went on to suggest that in some clinical cases using this intervention and having it backfire is actually a breakthrough in the treatment process. "Sometimes people explode and get very upset, 'are you calling me a liar?' . . . sort of thing, which isn't necessarily a bad thing, because often times those impasses become the most fertile ground for recovery in the long run."

In contrast, other providers shared experiences of increases in mental health symptoms and increases in depressive behaviors and expanded on the guilt and shame elements of criminally addictive lifestyles and how confrontation can be averse to the treatment process and healing. Participant 6 said,

> With DDFOs specifically, you know for a fact that when you are talking to them that the two biggest emotions that they have are shame and guilt. [The] biggest emotion that they can identify with is anger. So, you confront them on something.

> And the other thing is that alcohol and drug addicts are very sensitive to criticism. It seems like it would be the opposite, but they are very sensitive to criticism. So you call them out on something, and it's just . . . even if it's a negative . . . it's basically a negative energy going out that immediately brings up a defense or anger or already feeds into the shame and guilt they have. You are not going to get a positive response. The more positive responses you get, the more/better chance you have for people to experience life without addiction in a positive way.

In only one interview did a direct care provider (Participant 5) advocate for using confrontation approaches in treatment.

> Treatment of a borderline patient, for example . . . once that therapeutic alliance is established I am definitely using interventions such as confrontations. Of course, I am referring to presenting the client with [for example] two different pieces of evidence that she has presented me with and asking her to reconcile those different pieces of information, sort of reflecting back to them the inconsistencies that they are providing to me. Not judging them, but just providing them with the information that they have actually said to me. When you resolve an issue like this that has been brought up in the therapy, you can actually move forward in leaps and bounds. Many times when you have established a strong relationship, and you present someone with inconsistencies like this in a confrontational manner, often what happens is that the person realizes that these things are inconsistent and they are now able to explore that with you and get to the underlying cause of the inconsistencies that they are reporting. But, that is just

part of working with women that have these kinds of disorders. The relationship you establish with her is really summed up best by the statement "I hate you, I hate you, I love you, don't leave me." It really is.

Summary

Nine major themes emerged from discussing the motivational facilitators, barriers, and effective strategies for increasing DDFO treatment motivation through the eyes of direct care providers. For motivational facilitators, empathetic approach, strong therapeutic alliance, and hitting rock bottom were the strongest themes that emerged from the interviews. Overall, study participants reflected on the importance of an empathetic approach as a means to add to the therapeutic experience. An emphatic approach also leads into building a strong therapeutic alliance or relationship that allows clients to feel safe and comfortable and allows trust to be established in a pervasive life pattern of distrust and negative influence. Nearly all study participants discussed the concept of hitting rock bottom as an experience they felt DDFOs needed to honestly prepare for and willingly engage in the treatment process. An important takeaway is the care and passion that all study participants felt were necessary to include in their treatment approaches. Study participants shared experiences supporting that an empathetic approach was key to starting the motivational process and helping it grow.

For motivational barriers, the lack of insight and acceptance and lack of resiliency were the emerging themes. Study providers discussed the challenges they experienced with DDFOs' lack of insight on their mental health and substance abuse treatment needs. All study participants stated that it is extremely difficult to build motivation toward

treatment and change when DDFOs see no need for treatment. Additionally, the concept of acceptance was widely used and referred to as a barrier to motivation in DDFO treatment. Refusal to accept change, refusal to accept life events, and lacking the ability to bounce back from those events were significant themes in several interviews. Study participants. The direct care providers shared that serious challenges DDFOs experience are due to the problems they have accepting what has happened to them, the decisions they have made, and the steps needed to alleviate the symptoms they experience as a result of their problems.

External system factors were an unexpected theme that emerged across all interviews with study participants. These discussions unexpectedly yielded elements that were not anticipated to be a part of this research study as they reflect a focus that was not originally part of the study's design. However, however given the context and implications perceived by study participants, it was important to include external system factors as they relate to motivational barriers to treatment. External system factors included challenges associated with lack of communication between providers and follow up. Nearly all study participants shared concerns about mental health and substance abuse issues being treated separately and distinctly and that doing so affects DDFOs' treatment options.

The lack of bridged medical coverage for incarcerated individuals was mentioned in every interview. Study participants expounded on state-level issues, including that incarcerated individuals lose their medical coverage when entering prison. The lack of medical care compounds already complex case management because it can be a barrier to

obtaining services immediately after release. Study participants articulated concerns about DDFOs not being able to truly buy into treatment concepts when they know that they will have to wait several weeks before even getting an appointment to reinstate medical coverage after they are released from prison. Study participants elaborated on this concern as it relates to critical release timeframes suggesting that DDFOs should be connected with services within 24 hr after release. But, no services can be had without effective medical coverage in place. Study participants also discussed how these issues may affect motivation to change and continue with care post release and their perceptions of how DDFOs will continue to fail in long-term outcomes because of these issues.

All study participants offered their views on strategies to enhance treatment motivation. Four themes emerged regarding these strategies: employing empathetic approaches, rapport building, engendering hope, and avoiding confrontation. All study participant comments contained similar themes about ways to create emphatic approaches for working with DDFOS and to effect positive change. These discussions nearly merged with effective ways to build and establish rapport to strengthen the therapeutic alliance and enhance motivation in treatment. Engendering hope or instilling hope was also a common theme across all interviews as study participants shared their thoughts on ways to create hope, create positive thoughts, and eventually build unconditional positive regard.

Avoiding confrontational approaches to treatment was identified as an effective strategy by most study participants. Six study participants clearly felt that confrontational approaches were unhealthy with this population and alluded to other possibilities as they

saw these approaches as outmoded and ineffective. Two study participants stated that confrontation may backfire in treatment, affirming the views of other study participants. One participant stated that with DDFOs, especially women with personality disorders, confrontation approaches can elicit defensive responses that may result in the most fertile groundwork for effective change.

In Chapter 5, I discuss the study findings. Conclusions and recommendations are also presented. The chapter ends with a summary and thoughts for further study.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to explore the perceived experiences of motivational facilitators and barriers of DDFOs in substance abuse treatment through the eyes of direct care providers. Another study focus was on identifying effective strategies for enhancing motivation in substance abuse treatment that may lead to increased treatment adherence and higher treatment completion rates for DDFOs. The central research questions were:

RQ1: According to direct care treatment providers, what are the motivational facilitators associated with treatment adherence among DDFOs?

RQ2: What are the motivational barriers to treatment adherence that contribute to treatment attrition among DDFOs?

RQ3: What are effective strategies or elements of interventions that enhance motivation and reduce attrition among DDFOs?

Key findings reflected three areas of importance related to the research questions: motivational facilitators, barriers, and effective strategies. Themes related to motivational facilitators included using an empathetic approach and developing a strong therapeutic alliance. These two concepts suggest that empathy and the client-therapist relationship play a significant role in DDFOs buying into substance abuse treatment programs according to study participants. Study participants stated that using empathy and an empathetic approach toward DDFOs as a means to increase rapport and support and to influence the therapeutic relationship is vital to the overall motivational process. Study participants also perceived a strong therapeutic alliance founded in trust and

understanding as the most encouraging and motivationally enhancing aspect to caring for DDFOs in this setting. The second theme related to motivational facilitators suggested that hitting rock bottom, or an extreme low point in life also plays a role in DDFOs' motivation for attending treatment. Study participants stated that the DDFOs who reveal that they have experienced rock bottom are among the most likely to be open to enhancing their lives, building motivation, and completing treatment. Study participants stated that this rock bottom experience presents clients with feelings that life cannot get any worse and creates a respect for life and a healthy fear of avoiding a return to their old lifestyles. Without this experience, DDFOs may feel as though they have "one more run" in them, in Participant 4's words.

Themes 3 and 4 presented information that study participants believe adds to treatment barriers DDFOs experience related to lack of insight regarding their mental health and substance abuse treatment needs and their acceptance that they need treatment. These themes also reflected issues such as coercion and trauma and how they play a role in DDFOs' lack of resiliency. Study participants stated that lack of insight and acceptance negatively impact treatment adherence and can lead to DDFOs dropping out of treatment. According to study participants, lack of resiliency, or the inability to adapt and overcome normal life challenges, also decreases motivation for DDFOs enrolled in treatment. Inconsistent support systems resulting from chaotic lifestyles can also adversely influence treatment adherence, completion, and postrelease follow-up. Participants expressed that these barriers reflect DDFOs' continuing issues directly related to treatment resistance, their extremely diffuse boundaries in their personal and therapeutic relationships, and the

likelihood that they will eventually return to negative people, relationships, places, and lifestyles.

Unexpected findings related to external system factors also emerged from participant interviews. These findings were unforeseen as external system factors were not a focus in this study. These unpredicted insights revealed that study participants believe that system challenges such as the forensic environment, coercion, lack of communication between providers, and medical health insurance obstacles all negatively influence DDFO treatment motivation. This theme is important because it reflects a collective idea that external factors further complicate DDFO outcomes. Without rectifying external system issues, study participants stated that DDFOs will likely continue to face health care challenges, lack of support in transitioning to the community, and barriers to follow-up for mental health care after release and may not be able to maintain sobriety.

Four themes related to effective treatment strategies emerged from participant interviews. These themes include an empathetic approach, building rapport, instilling hope, and avoiding confrontation, which study participants believe will increase treatment motivation in DDFO populations. These findings provided key insights into the most effective approaches for motivating and treating DDFOs while incarcerated and after release. Additionally, the findings encourage more effective training approaches for direct care providers regarding how to address treatment barriers, employ treatment modalities that work for DDFOs, and increase treatment quality and outcomes.

Interpretation of Findings—Motivational Factors

The first research question focused on exploring DDFO motivational facilitators to treatment as perceived by direct care providers. Through this motivational lens, two major themes emerged: empathetic approach and strong therapeutic alliance, and hitting rock bottom. Participants have suggested that without empathetic approach and a strong therapeutic relationship, as well as the experience of reaching rock bottom, DDFO treatment motivation is lower. These themes are discussed next.

Theme 1: Empathetic Approach and Strong Therapeutic Alliance

Carl Rogers presented a theory of personality in the late 1950s. In his theory, he suggested that providing a warm and welcoming experience for every aspect of a clients' life provides the most fertile grounds for a strong therapeutic alliance. In the process of creating a strong therapeutic relationship, the client eventually learns how to make positive, prosocial, and safe life choices through practice within that safe relationship and that practice is expected to be imitated in other relationships the client may ultimately experience (Rogers, 1959). This concept is referred to as unconditional positive regard (UPR) and has been widely accepted as the core of person-centered therapeutic interventions (Bozarth, 2007). The theory is that clients can positively move forward in their process of self-efficacy when therapists show respect and warmth toward every aspect of their clients' lives (Bozarth, 2007). The first theme that emerged in the present study clearly reflects Rogers's concepts of person centered-therapy and UPR. All study participants shared the belief that creating an environment that encourages trust, empathy, and understanding is the foundation to creating buy-in to the process of change.

Study participants all discussed important elements that they feel enhance or encourage motivation through trust and strong therapeutic alliance. Trust cannot be established, according to study participants, until the client feels she is being heard, understood, and cared for. These elements also touch on the concepts in Maslow's hierarchy of needs in the second tier as direct care providers attempt to provide a safe, comforting environment through the therapeutic dyad that envelops UPR for their client, eventually building trust and rapport to share experiences and work through therapeutic challenges. As previously mentioned, the first tier of Maslow's hierarchy of needs—physiological needs such as food, water, warmth, and rest—is established and maintained by the environment these women are housed in.

Many study participants discussed experiences clients have shared that involved years and even a lifetime full of trauma, hurt, and fear. Clients expressed strong elements of shame and guilt related to their experiences, which is consistent with the literature that that suggested clients who present with histories filled with trauma, pain, and fear are among the most difficult to establish rapport in a therapeutic alliance (Johnson et al., 2015; Kienast et al., 2014; Nowotny et al., 2013). Breaking through the schemas that DDFOs create requires that therapists work to make these women feel they are being heard and that their stories matter (Houser & Welsh, 2014; Johnson et al., 2015; Mahoney et al., 2015). This type of schematic breakthrough leads into similar concepts of MI, suggesting that once the therapeutic alliance is created, direct care providers have already begun to demonstrate that change is possible simply through exemplifying change in the therapeutic relationship (Bernstein, 2011; Grella & Rodriguez, 2011).

These elements are all based on the idea that the client is seeking an external reward (visible therapeutic alliance) in an effort to achieve internal change (Bernstein, 2011; Hockenbury & Hockenbury, 2003). The findings from Bernstein (2011) and Hockenbury and Hockenbury (2003) tie into the incentive theory as direct care providers strive to help clients achieve their goals and then recognize their clients' progress, creating the strong aspects of help, warmth, and positive change.

Almost all of the study participants shared experiences that directly support UPR concepts and person-centered therapeutic approaches, suggesting that building trust and rapport is significant in motivating buy-in. Without buy-in, there can be no real progress in acknowledgment and acceptance of life experiences and motivation toward achieving self-efficacy (Gee & Reed, 2013; Hunt et al., 2015; Mahoney et al., 2015). The idea of acknowledgement and acceptance of experiences and motivational elements that build desires toward self-efficacy is important to recognize in training for anyone who would provide services to DDFOs while they are incarcerated as well as post release. There are several different forms of counseling, all focusing on certain elements of treatment. For example, a substance abuse counselor focuses mainly on substance, addiction, and general counseling styles. Findings from the present study suggest that UPR and person-centered therapy may offer direct care providers the strongest educational background in practices that work for DDFOs while incarcerated and after release.

Theme 2: Hitting Rock Bottom

Study participants perceived that reaching an extreme low point in one's life can play a key role in creating motivational foundations for change in DDFO treatment

outcomes. Several direct care providers referred to the term hitting rock bottom, however cliché, as a necessary event in a DDFO's life in order to increase the chances that she will attend, adhere to, and complete substance abuse treatment while incarcerated and after release. Balyakina et al. (2014) and Kienast el al. (2014) both touched on issues DDFOs experience such as impulsivity, suicidal thoughts or behaviors, and increased symptoms. According to study participants, these events appear to create extreme low points that allow DDFOs to later reflect on the negative impacts or adverse emotional connections related to these behaviors and symptoms.

Trauma, which further complicates symptoms and symptom management for DDFOs, also adds to the experiences that cause DDFOs to use and continue to return to old relationships, negative places, and situations (Johnson et al., 2015; Nowotny et al., 2014). Study participants expressed that DDFOs present with often chaotic and unstable histories, life events, and pathways. The concept of chaotic and unstable history ties into negative life experiences or extreme low points, which study participants believe will increase the likelihood of motivation and success. Participants shared that DDFOs presenting with these types of stories are more likely to be encouraged to adhere to and complete the treatment process. Nearly all study participants discussed the concepts of chaos and instability as positive identifiers that DDFOs presenting with stories of their own personal hell, as Participant 8 put, will be more open to the idea of change, more open to creating a therapeutic relationship, and most likely to be motivated to complete treatment of some kind.

Trauma has provided direct care providers complex and chaotic treatment challenges for many years. As noted by Kienast et al. (2014), Nowotny et al. (2014), and Therien et al. (2014), DDFOs often experience adverse childhood events such as sexual, physical, and emotional abuse. These experiences often result in a clinical picture that includes antisocial personality traits, inability to trust, and greater risk of severe substance use. According to participants in the present study, the deeper and darker the experiences that DDFOs are able to safely reflect upon and work through, the greater their positive response to the treatment process and the better the outcomes.

Interpretation of Findings—Motivational Barriers

For this study's purposes, any treatment boundary, impediment, obstacle, or limit that may be clinically linked to DDFO treatment attrition was considered a motivational barrier. Motivational barriers or challenges also included any symptoms, behaviors, or clinically linked impediments that may hinder DDFO ability to adhere to treatment, regardless of interventions used to help overcome the challenge. I discuss these barriers and challenges next.

Theme 3: Lack of Insight and Acceptance

Study participants stated that two of the strongest barriers DDFOs experience are lack of insight into their mental health care needs and accepting their mental health, trauma, and substance abuse histories. Study participants perceived that these two barriers lead to decreased motivation in treatment, decreased treatment adherence, and eventual drop out. While these barriers pose clear treatment concerns during incarceration, perceptions of the direct care providers in this study reflect those of other

researchers. Putkonen et al. (2003) found that DDFOs who suffer from especially severe psychotic disorders experience even greater risks upon release than their nonpsychotic counterparts. Hunt et al. (2015) and Verona et al. (2013), who also found increased risks related to severity of symptoms, stated the need for more research in this area and especially research focusing on women with psychotic disorders.

Additionally, just as Gee and Reed (2013) found with DDFOs who suffer from personality disorders, participants in the present study all mentioned extreme challenges when treating DDFOs because they are so difficult to treat overall. Participant 5 expressly discussed personality-disordered DDFOs as part of this participant's professional area of expertise, sharing that

> Not only are personality-disordered female offenders difficult to assess, but she presents with such diverse, adverse background that trying to establish the extent of her lack of insight is often cumbersome and diluted simply due to the inability to establish trust, rapport, and acceptance that she needs help.

Essentially, for DDFOs who do not believe they have issues, treatment and recovery are not an option until they can attain some level of insight into their needs for mental health and substance abuse treatment. These findings are consistent with literature on treatment attempts for severe persistent patients (Gee & Reed, 2013; Grella & Rodriguez, 2011; Mahoney et al., 2015; Nowotny et al., 2014; Therien et al., 2014). Until these insights can be experienced, it is unlikely, according to the participants in this study, that a DDFO will be able to successfully engage in, adhere to, and complete treatment for her own level of care and need.

According to study participants, before substance abuse treatment can truly begin, DDFOs must be thoroughly evaluated for mental health needs, and attempts to stabilize them should be made. This perspective supports findings by Bozarth (2007), Gee and Reed (2013), Johnson et al. (2015), and Therien et al. (2014) and suggests that accurate assessment and evaluation must be completed prior to attempting to treat for either mental health or substance abuse issues. Participants in this study stated that long-term success may be possible after an in-depth professional evaluation can be completed where a level of insight can be experienced by a DDFO and established by a provider. This would be evidenced by a DDFO verbalizing acknowledgment and accepting her needs for mental health and substance abuse treatment. Lack of insight and acceptance contributes to attrition, according to study participants, simply due to the complex nature of the symptoms DDFOs experience and the instability these symptoms cause. This perspective is affirmed throughout the literature as a significant gap in treatment capacity that can result in adverse outcomes for severe persistent individuals. Because of lack of insight and acceptance, DDFOs will access fewer appropriate services and aftercare programs (Gee & Reed, 2013; Johnson et al., 2015; Mahoney et al., 2015).

The element of coercion was very prevalent in this study's findings, with six participants reflecting on challenges related to this barrier. The concept of coercion means that DDFOs are intrinsically challenged by issues that go directly against building motivation simply due to the experience of being incarcerated (Johnson et al., 2015; Mahoney et al., 2015). Several study participants stated that the forensic setting itself creates an antimotivational experience for clients enrolled in programming for two

reasons: court-ordered versus voluntary treatment and forced sobriety. As perceived by study participants, the forensic environment presents challenges for offenders and plays a large role in behavioral issues that are common in this setting (negative thoughts, antisocial cognitions, and physical violence were mentioned). Participants shared reflections of client complaints that suggest being told when to wake up, when to eat, and when to sleep naturally challenge DDFOs because most of these women have lived a lifestyle that allowed them to experience independence. However, while all of the participants shared common perceptions about environmental challenges as barriers to treatment for DDFOs, all participants also shared Participant 6's perspective about how this situation is experienced: "It just is what it is."

Court-ordered versus voluntary treatment in Delaware poses an interesting and significant talking point: All offenders, whether court ordered or volunteer, are classified into treatment programs. Classification includes evaluating the offender's criminogenic needs to pair the offender with the most appropriate programs (Martinez-Catena, Redondo, Frerich, & Beech, 2016). These programs can include substance use treatment, education, and parenting programs among others (Johnson et al., 2015; Martinez-Catena et al., 2016; Nowotny et al., 2014). Participants shared that with this process, regardless of a court order stipulating treatment or voluntary entrance into a program, DDFOs will be enrolled into each program through the classification processes. According to the participants, the underlying issue with this procedure is that classified offenders are then subject to administrative or disciplinary action if they do not successfully complete treatment, which often adversely affects motivation. The idea of classification is a

perceived threat to the concept of voluntary enrollment, and study participants suggested that the state Department of Correction should reconsider this process entirely as it should more reflect voluntary admissions to be more effective in treatment outcomes. Participants expressed that if the Department of Correction does not revisit this process, DDFOs will likely continue to incur barriers related to access of care, treatment enrollment, and motivation.

Mahoney et al. (2015) and Kienast et al. (2014) stated that motivation must occur within a personal experience of change and therefore should not be forced. However, when faced with incarceration, DDFOs are not in a position to choose whether they become sober or not and when. The concept of forced sobriety has been the subject of other studies. Pizitz and McCullaugh (2012) discussed the concept of forced sobriety in the context of court-ordered treatment focused on addressing behaviors and cognitive distortions that lead to legal system involvement. While Pizitz and McCullaugh suggested that few researchers have focused on discerning differences in motivational outcomes between forced versus voluntary treatment, they also stated that intrinsic motivation (one's genuine desire to attend treatment) is not required for the treatment to be considered successful. Pizitz and McCullaugh discussed the importance of design and structural interventions that focus on meeting the client's motivational level. This means that while internal desire to become sober may increase motivation toward treatment, it is not required to successfully complete treatment.

Participants in the present study expressed that, in their experience, DDFOs did not respond well to forced sobriety. Pizitz and McCullaugh (2012) suggested the opposite

concept expressing that forced sobriety is effective, and, in fact, participants in this study shared they believed that forced sobriety adversely affected treatment motivation for DDFOs. Stevens (2016) looked at the concept of forced sobriety related to drunk driving incidents in the state of Montana, which was ranked the nation's most deadly state for DUI offenses in 2008. Using forced abstinence, education, and treatment, Montana designed a program aimed at decreasing DUI-related incidents; however, Stevens found no significant differences in the effect of the forced program versus voluntary or no treatment.

While forced sobriety is controversial, participants in the present study stated that coercion adversely affects DDFOs and can increase the risk of negative behaviors. Pizitz and McCullaugh (2012) postulated that intrinsic motivation is not a prerequisite for successful treatment; however, participants in the present study expressed that the internal drive/reward system, in this context, would likely be considered unattainable due to DDFOs' lack of insight into mental health symptoms. This insight suggests that participants believe that lack of insight into mental health and substance abuse treatment needs impedes the internal reward system. Study participants mentioned external rewards such as successful completion certificates, completion of court sentences, or early release from prison for completing a treatment program that they felt should play a role in building treatment motivation. However, study participants stated that internal impediments complicate the external reward system simply due to the complexities of symptoms DDFOs experience.

Study participants suggested that moving toward true voluntary programming for DDFOs, which would not include any factors that may impact sentence length or punishment, may increase motivation to attend treatment because the association of disciplinary action is removed. The classification processes and forced sobriety concerns participants expressed may prove to be a strong area for future research on motivation for treatment, treatment adherence, and increased motivation to complete programming for DDFOs.

Theme 4: Lack of Resiliency

The inability to adapt and overcome the various life challenges DDFOs often experience was a key concept presented in the study findings. Not only did the study participants discuss various challenges related to access of care; lack of insight to overcome challenges; and socioeconomic barriers related to job, child care, and medical insurance; they also discussed a very significant issue related to lack of resiliency. When an adverse or threatening event is experienced, one of two outcomes typically occur: Either a person will face the challenge and positively adapt and overcome the issue or the person will not confront the issue and run (Daniels, 2016). This is also known as the *fight or flight response,* and research has shown that this psychological, physical, and physiological reaction is often exacerbated in women, especially surrounding trauma and PTSD (Daniels, 2016; Gee & Reed, 2013).

As shared by nearly all of the participants in the present study, trauma is a significant issue among DDFOs. Trauma, according to the study participants, does not always simply include events such as a fight, rape, or accident. Traumas can be negative

experiences that have adversely affected a DDFO in some way such as a boyfriend who was physically abusive, a mother who left when the DDFO was a child, or growing up with no friends. Study participants suggested that for DDFOs, trauma experiences such as these can result in vastly different outcomes if resiliency is not present. These outcomes include negative, unhealthy relationships, broken families, and little to no social support, which can lead to maladaptive coping mechanisms and result in more trauma such as excessive drug or alcohol use, prostitution, or worse (Johnson et al., 2015; Kienast et al., 2014; Mahoney et al., 2015, SAMHSA, 2014).

According to Daniels (2016), when events such as trauma, rape, or any other form of abuse occur, the body's limbic system perceives a life-threatening issue. When the brain later categorizes this issue or files it in memory, psychological and physiological responses are also associated with the traumatic event (Daniels, 2016; Nowotny et al., 2014). For DDFOs, even if they are not in a traumatic or life-threatening event, anything can pose a threat that can activate one of the many memories and responses she has previously experienced, which can result in extremely chaotic life styles, poor decision-making, and possible relapse (Daniels, 2016; Johnson et al., 2015). Participants in the present study shared perceptions that these types of situations lead to maladaptive coping such as self-medicating and, interestingly, returning to the same environment that caused traumatic memories for DDFOs in the first place.

Nearly all of the study participants discussed the concept of returning to negative people, places, and lifestyles to some degree. This suggests that even though DDFOs pose increased treatment challenges related to lack of resiliency (Balyakina et al., 2014),

there is a significant chance that the maladaptive coping mechanisms they learn will lead them right back to where they were before treatment (Kienast et al., 2014). Study participants referred to interventions designed to address these challenges such as temporary transitional housing, support groups, and ongoing treatment adherence for both mental health and substance abuse needs, just as Johnson et al. (2015) referred to. However, while study participants suggested ways to address these barriers, these efforts still fail to consistently achieve the desired goals as evidenced by the constant return of DDFOs to the criminal justice system. This means that the treatment approaches currently considered as the best means to meet these challenges are still not strong enough or honed enough to result in more consistent, positive outcomes. Better understanding of how perceived threats, combined with trauma events, negative experiences, and maladaptive coping mechanisms, can be more effectively addressed in treatment may lead to better treatment access, adherence, and outcomes. Coupled with these challenges, external system factors have also been noted as perceived barriers to treatment. These external challenges are discussed next.

Theme 5: External System Challenges

This study's main focus was on exploring perceived motivational facilitators and barriers to treatment experienced by DDFOs enrolled in substance abuse treatment programs in the state of Delaware. Another key focus was on identifying effective strategies for enhancing DDFO treatment. An unexpected finding was that nearly all of the study participants expressed that external system factors, or challenges outside of the therapeutic relationship, were significant barriers to treatment adherence and negatively

impacted DDFO motivation. While I was not aware of any associations between the findings regarding external system factors and current policies, changes, or staffing problems in the state of Delaware, it is important to discuss these factors as they were perceived to have significantly negative impacts on DDFO treatment outcomes.

Study participants expounded on the concerns they believe adversely affect DDFOs through two major themes. These concerns fell into two areas: lack of provider communication and follow-up, and medical insurance care problems for incarcerated persons in the state of Delaware. Several of the direct care providers expressed serious concerns over decreased motivation in treatment caused by having to face multiple mental health and substance abuse counselors or staff. These inconstancies of care in the forensic setting have been found problematic by authors such Hunt et al. (2015), who noted that these issues tend to result in lack of adequate services, decrease in access to services that are available, and decreased follow-up treatment. One provider in the present study shared concerns about DDFOs being seen by a different provider (psychologist or psychiatrist) every time they have a mental health visit and about constant changes in medication, resulting in no opportunities for DDFOs to recover. This suggests that lack of resiliency may also tie to the external system factor of poor provider communication and follow-up. Issues such as these create even greater challenges related to adequate care and services in Delaware's forensic settings.

Interestingly, other researchers have noted that length of stay directly influences motivation to change and attend to treatment needs (Hartwell et al., 2013; Hunt et al., 2015; Johnson et al., 2015; Mahoney et al., 2015). However, many of the present study's

participants mentioned having little time to work with DDFOs, suggesting that the DDFO's average length of stay in the state of Delaware's prison system is too short. Study participants stated their desire to increase the length of stay for DDFOs so they could better meet these women's treatment needs. However, study participants noted that the length of treatment stay was recently shortened, which directly goes against the suggestions found in the literature that recommends at least 12 months to two years for successful outcomes.

Length of stay has been found to be a significant aspect in treatment outcomes. Study findings have shown that the longer the stay, the better the outcome (Gee & Reed, 2013; Hunt et al., 2015; Mahoney et al., 2015). Participant 2 in the present study stated that "It's just so hard when you only have such a short window of opportunity to even help [her]; sometimes, anymore . . . we only get them for 45 days, 9 months . . . and that is without any behavioral issues." Short lengths of stay can lead to a multitude of service areas being missed simply due to the shorter time periods these women are incarcerated for and inadequacies in provider communications.

Breaks in provider communications yield a breeding ground for decreased motivation simply due to the challenges associated with medication changes, stress related to lack of the ability to create therapeutic alliance and rapport, and lack of clinical evaluations that include holistic approaches and follow-up with DDFOs. Several study participants suggested that implementing more of a case management approach to treatment may alleviate these issues, but until this change can be made, DDFOs will continue to experience challenges related to multiple providers, lack of therapeutic

relationships, lack of trust, and likely decreased motivation to continue to attend to treatment due to these barriers.

Aside from barriers related to the forensic setting and the providers operating in this environment, study participants in this study overwhelmingly identified concerns related to the lack of adequate medical coverage after release from prison. This issue stems from Delaware's policy that all incarcerated persons lose all rights to health insurance while incarcerated and are instead covered by the state's Medicaid insurance issued to inmates through the Bureau of Correctional Healthcare Services and the Bureau of Prisons (Vestal, 2013). Lack of adequate medical coverage was expressed by nearly every study participant as one of the largest external system barriers to DDFO success and motivation. As several participants stated, offenders tend to develop a "why bother" attitude toward treatment as they have to wait 6 weeks after prison release to access medical coverage so they can attend to their treatment needs. This gap in services also adds to the systemic issue mentioned throughout the literature and in findings from this study. The most important window for motivation and treatment access is 24 to 72 hr after prison release, but it is not met on most releases for ex-offenders in the state of Delaware, regardless of charges, gender, or health care needs.

As previously mentioned, unexpected information and insights can come about in any research study. Expectations were maintained regarding this study's focus on the research questions and concepts regarding motivational facilitators and barriers related to the problems DDFOs experience. However, study findings revealed that so some degree,

internal and external challenges to motivation cannot be separated when examining forensic populations.

Interpretation of Findings—Strategies for Enhancing DDFO Treatment Motivation

Techniques that work for enhancing DDFO treatment motivation included empathy in the therapeutic alliance, building rapport, instilling hope, and avoiding confrontation and were strong points made in every interview. Study participants suggested that these interventional approaches may result in the most effective strategies or combination of strategies to treat DDFOs. These strategies are discussed next.

To assist in a holistic treatment approach, participants shared a great deal about the importance of having a clear understanding, or clearer picture, of DDFOs' clinical needs. This requires dedicating time to understanding the DDFO's current clinical picture as well as historical information to develop treatment approaches that address all areas of need. In essence, study participants suggested that before substance abuse treatment can begin, DDFOs should be accurately assessed and evaluated for mental health needs and attempts should be made to stabilize mental health symptoms. Once an in-depth professional evaluation can be completed, and a level of insight can be reached by a DDFO, then she is likely better able to accept her treatment needs and goals and that long-term success is possible Bozarth, 2007; Gee & Reed, 2013; Johnson et al., 2015; Mahoney et al., 2015; Nowotny et al., 2014; Therien et al., 2014). The barrier of lack of insight and acceptance is also considered a significant contributor to the extensive gaps in access and adherence to aftercare services among DDFOs (Gee & Reed, 2013; Johnson et al., 2015; Mahoney et al., 2015). According to study participants, when a DDFO does not

see that she has a mental health or substance abuse treatment need, she will be less likely to attend to treatment to help her overcome that barrier and will eventually fail to access services that are available to her (Houser & Welsh, 2014; Hunt et al., 2015; Priester et al., 2016). Ideally, increased insight increases acceptance of mental health, substance, trauma, and other adverse historical issues and would also likely increase better outcomes for DDFO treatment (Gee & Reed, 2013; Hunt et al., 2015; Houser & Welsh, 2014; Mahoney et al., 2015; Therien et al., 2014).

To assist this process, many of the direct care providers in this study referenced using MI and counseling styles that include the ability to take pieces of information and directly present contradictory elements to a DDFO. This approach can increase the DDFO's understanding of her problems (Bernstein, 2011; Steadman et al., 2013). When two pieces of conflicting information are presented in the therapeutic dyad, the DDFO, according to the study participants, is forced to look at both pieces and address why they do not make sense. This increases insight and envelops ideas of acceptance that create a breeding ground for rapport and a sense of trust (Gee & Reed, 2013; Mahoney et al., 2015). Through the lens of motivational theories, these concepts should increase the positive outcomes that direct care providers seek to achieve in all efforts they use to treat DDFOs while incarcerated and after release (Gee & Reed, 2013; Hettema et al., 2005; Hockenbury & Hockenbury, 2003; Houser & Welsh, 2014).

Theme 6: Using an Empathetic Approach

Study participants consistently referred to effective therapeutic interventions for DDFOs that can increase motivation and treatment adherence. Using an empathetic

approach to increase motivation to treatment was consistent in all study participant comments. Empathy echoes a therapeutic environment that encourages healthy and safe boundaries and understanding. Study participants stated that empathy increases rapport and trust in the therapeutic dyad.

Study participants stated that empathetic approach requires a certain type of person to work in this environment and to be successful in emulating empathy in relationships with DDFOs. Study participants further suggested the need for passion and drive for anyone who counsels DDFOs. They also mentioned the need for passion in their daily work as well as their attitudes and beliefs that they perceive as influential to the motivational treatment process. Their comments reflect concepts of unconditional positive regard, support of the client, empathy, and strong therapeutic alliance in the treatment process to enhance motivation to treatment for DDFOs (Bozarth, 2016; Gee & Reed, 2013; Johnson et al., 2015; Mahoney et al., 2015). The concepts of passion in daily work for direct care providers would suggest that, just as Gee and Reed (2013) expressed, only the most motivated clients will successfully attend treatment. So too do only the most motivated direct care providers successfully address aspects of treatment that envelope effective treatment strategies study participants identified as being essential to the motivational process for DDFOs.

Theme 7: Rapport Building

Study participants consistently mentioned the importance of providing a safe and secure environment that fosters trust and rapport building. Their perceptions support Mahoney et al.'s (2015) findings, which suggested that the therapeutic alliance had a

significant effect on stronger motivation for treatment attendance. Study participants also stated that patience in rapport building, encouraging trust, and taking the time to allow rapport to grow are fundamental for motivating DDFOs in treatment. These findings support those of Gee and Reed (2013), Kienast et al. (2014), and Mahoney et al., who also discussed the importance of a safe environment for growing a therapeutic relationship as fundamental to success in treatment.

Study participants also expressed the belief that if a provider fails a DDFO in any way, even once, this will likely result in the DDFO refusing to trust that provider in the future. Participants suggested that the idea of failing a client, which can result in detrimental therapeutic outcomes and can contribute to continued negative life experiences, should be in the forefront of every provider's mind when meeting with clients to foster the safest place for clients to grow.

Theme 8: Instilling Hope

Study participants reflected on the need to instill hope as an important strategy when working with DDFOs and on the serious lack of hope when working with incarcerated populations simply due to the circumstances of incarceration. Significantly strong psychotherapy sessions and constant motivational reminders were two factors that study participants identified as helping to provide more effective treatment outcomes. Open discussions in psychotherapy sessions, according to the participants, offer DDFOs opportunities to reflect on why they used substances and on why they do not want to return to their old ways. These open discussions, according to study participants, enhances motivation through motivational reminders, positive self-reflection, and

creating safe space in the therapeutic relationship. Study participants strongly suggested using phrases such as “I hear you,” and “I am listening,” and suggested asking DDFOs how they feel about situations. These approaches can show DDFOs that the direct care provider is really paying attention and wants the DDFO to open up, and can encourage motivation to interact in the therapeutic dyad.

Theme 9: Avoiding Confrontation

One of the more controversial topics study participants discussed was the use of confrontational strategies. Most of the study participants expressed their dislike of confrontational strategies and even used terms such as passé when reflecting on using such techniques. This overall theme directly correlates with the significant trauma histories that are commonly associated with DDFOs (Asberg & Renk, 2012; Johnson et al., 2015; Kienast et al., 2014; Nowotny et al., 2014). Attempting to implement such techniques, according to study participants, often result in defensive behaviors, increased aggression, and agitation, and in some cases violent behaviors. This aligns with findings from Gee and Reed (2013), Kienast et al. (2014), and Therien et al. (2014).

All of the participants in this study identified common themes regarding effective strategies that include using techniques such as empathetic approach, rapport building, engendering hope, and avoiding confrontation strategies in most cases. These strategies can be effectively included in therapeutic treatment approaches for DDFOs with the expectation that correct use and direction will increase client buy-in, enhance therapeutic alliances, increase motivation to treatment, and will likely increase successful treatment outcomes for DDFOs. By encouraging reflection on negative events in a safe

environment, DDFOs are able to connect adverse and unwanted emotions and memories, which can increase the likelihood that the DDFO will not want to relive those experiences again. This therapeutic approach mirrors the concept that instilling hope through safe examination of adverse life experiences in a strong therapeutic relationship can create the most fertile grounds for sobriety and positive treatment outcomes (Johnson et al., 2015; Mahoney et al., 2015).

Interpretation Summary

This study's conceptual base was that a better understanding of the perceived motivational facilitators, barriers, and effective treatment strategies for DDFOs was needed. By exploring the perceived experiences through the eyes of direct care providers in making sense of the phenomenon of interest, findings from this study extended the academic literature and practical information regarding effective treatment modalities and approaches for enhancing motivation in DDFO substance abuse treatment during incarceration and after release. The key conclusions from this study are as follows.

Conclusions—Motivational Facilitators

Motivational facilitators as perceived by direct care provider participants in this study are as follows.

Theme 1: Strong empathetic approach and therapeutic alliance. Key points are the following:

- A genuine approach to therapy and therapeutic interventions enhance rapport building and trust, thus motivating toward positive aspects of change.

- Being real with a DDFO helps to build motivation toward self-esteem and confidence in the therapeutic dyad that can eventually be learned and mimicked outside of this relationship.
- Embracing past experiences and coming to terms with events that have happened in the life of a DDFO can lead to fundamental growth in the treatment process and improve motivation to continue postrelease treatment.
- Instilling hope and insight can increase DDFO motivation for treatment as the positive challenges experienced in the therapeutic alliance allow for growth, goal setting, and, eventually, goal attainment.

Theme 2: Hitting rock bottom. Whether or not motivation toward treatment can be achieved is substantially weighed against the DDFO's experiences. Reaching extreme lows and creating adverse feelings toward extreme negative life experiences is a sign that a DDFO is more likely to be motivated to change and access treatment.

Conclusions—Motivational Barriers

Motivational barriers as perceived by the direct care providers in this study are listed next.

Theme 3: Lack of insight and acceptance. Key takeaways are the following:

- Lack of insight into mental health and substance abuse treatment needs as well as refusal to accept life events decrease motivation to treatment and play significant roles in negative prognosis for DDFO recovery, both short and long term.
- Coercion plays a negative role in the motivational drives of incarcerated populations and should not be viewed differently for DDFOs. Furthermore,

DDFOs will more likely experience increased symptoms and negative feelings associated with treatment than female offenders with one or no diagnosis due to the increase in mental health agitation, lack of insight, and refusal to accept life circumstances.

- Externalizing thoughts and behaviors DDFOs often experience exacerbate the already challenging barriers these women face while incarcerated and pose additional treatment barriers for direct care providers.
- Trauma histories pose unique challenges to motivation in treatment for many DDFOs. Direct care providers must use unconditional positive regard and constant support to overcome barriers associated with DDFO treatment motivation.

Theme 4: Lack of resiliency. Important factors associated with resiliency issues are as follows:

- Inability to adapt and overcome to necessary life change will likely result in negative or adverse outcomes that directly decrease motivation in treatment and often result in relapse.
- Lack of support experienced by DDFOs makes recovery processes very chaotic and unstable. The shared concept of "burning bridges" leads to little or no social or community support systems to enhance treatment motivation and adherence. If not attended to, this barrier will likely result in decreased motivation in treatment and relapse.

- Treatment resistance is often experienced as a means to refuse to accept one's situation. Willingness to change and open-mindedness to an alternative lifestyle are key in identifying variables that increase motivation to treatment.

Theme 5: External system challenges. Key elements in this barrier were noted as lack of communication between providers, substance abuse clinicians, doctors, and psychologists or psychiatrists, which should occur regularly to holistically and ethically treat DDFOs successfully in the forensic setting. Lack of communication between these entities leads to unstable treatment approaches, ineffective efforts, and significant decrease in treatment motivation for DDFOs. Medical insurance coverage gaps for DDFOs who are released from prison pose the most dangerous and life-threatening barrier to success for treatment in the state of Delaware. A 6-week postrelease waiting period decreases motivation and increases risk of relapse.

Conclusions—Effective Treatment Strategies

Treatment strategies that participants believe will increase motivation in the treatment process, increase likelihood of treatment adherence, and support successful treatment completion are as follows.

Theme 6: Using an empathetic approach. Use of empathetic approach and unconditional positive regard allows DDFOs to learn about healthy relationships and boundaries and increases motivation in treatment and openness to the treatment process. Use of empathy increases motivation to treatment, enhances the therapeutic alliance, and strengthens the client-therapist relationship, encouraging positive outcomes.

Theme 7: Building rapport. Encouraging a safe environment and healthy boundaries increases rapport and rapport-building strategies, resulting in better outcomes and increased motivation to attend treatment appointments.

Theme 8: Instilling hope. Encouraging hope in the therapeutic process allows DDFOs to challenge previous negative schemas and learn healthy and positive coping skills that increase treatment motivation.

Theme 9: Avoiding confrontation. Avoiding confrontation when treating DDFOs increases the therapeutic alliance, encourages healthy communication, decreases negative environment concerns, and decreases risks associated with violent behaviors.

Fundamentally, findings from this study provide a better understanding of DDFO challenges and barriers regarding treatment motivation. Findings extend the academic and practical literature by providing a number of ways that direct care providers can modify and incorporate effective therapeutic interventions. Direct care provider perspectives expressed in this study confirm the need for passionate providers, patience in the treatment processes, patience and respect toward the therapeutic relationship, the need for implementing unconditional positive regard, and enhancing effective motivational facilitators in DDFO treatment approaches.

Limitations of the Study

This study was a phenomenological exploration of the perceived experiences of DDFOs through the eyes of direct care providers who care for them. The study was designed to address issues that needed further study based on the literature reviewed for this investigation. The direct care providers in this study were purposefully chosen as

individuals who have worked in all levels of incarceration facilities in the state of Delaware and with DDFOs in substance use disorder treatment. The results, therefore, cannot be assumed to be generalizable beyond this specific population or area of research. Thick descriptions that used direct quotes from the study participants were provided. Readers of this study can decide whether or not the results may be applicable for their own settings and uses.

The study was both limited and enhanced by the forensic settings of the population included in this research as well as the direct care providers who participated. Certain limitations were inherent in the direct care providers' general approaches such as the natural coercive environment and the backgrounds of the population of interest. However, study findings were enhanced by the prevalence of passion and overall concern shown by all of the participants toward the populations they serve as well as the refusal to give up on their clients even when faced with relapse, setbacks, and even death of some DDFOs whom study participants have cared for.

The resulting direct care provider experiences provided rich information about working with DDFOs in substance abuse treatment programs while incarcerated. It is important to note that the perceptions of the direct care providers in this study should also be considered a limitation as the offenders themselves were not interviewed. In the study results, the influences of unconditional positive regard, direct care provider passion, and refusal to give up that were evident throughout all interviews were explained so that readers of this study can make informed decisions about how the information may be helpful in their own settings.

The procedures to ensure the trustworthiness of the study were implemented as planned; these are described in detail in Chapter 4. There were no limitations to trustworthiness in the execution of this research study.

Implications for Social Change

The implications for social change based on study results are significant because study findings add to clinical treatment knowledge that calls for changes in theory and practice regarding DDFO treatment. These findings include a deeper understanding of how DDFO treatment is approached and how DDFO needs are therapeutically addressed while incarcerated and after release. This study is the first of its kind. The findings provide a basic understanding of what direct care providers who treat DDFOs perceive as experiences of treatment attrition and how to address those adverse outcomes to enhance better treatment adherence among DDFOs. Study findings provide insights into treatment modalities that have been found to increase treatment motivation, increase treatment adherence, and improve outcomes for DDFOs after release from prison.

This study provides information about how adverse life experiences, trauma, and severe mental health symptoms have negatively affected DDFOs throughout the course of their lives and how they directly reflect the negative outcomes often seen in this population. Furthermore, participant insights provide clinical understanding of the treatment approaches that have worked for increasing motivation in the treatment process. In describing their clinical perceptions of DDFO experiences, the direct care providers in this study provided rich and practical information about the challenges experienced in DDFO treatment and positive and deep insights into motivational

facilitators. These insights can inform theory and practice regarding DDFO treatment while incarcerated and after release.

Through exploration of direct care provider's perception of DDFOs experiences, this study contributes to topics that remain unresolved in the literature and in practice, including motivational facilitators that can improve treatment outcomes, DDFO motivational barriers and challenges, and how these treatment obstacles can be overcome by effective motivational strategies. Each of these topics is important in the ethical, moral, and beneficent treatment of DDFOs in clinical practice. Additionally, the insights gathered from this study provide a clear need for increased research on motivational treatment of DDFOs. Any changes to clinical approach and practice in these areas would directly affect DDFO treatment and may increase positive outcomes for this population.

The experiences of the direct care providers who participated in this study may help policymakers and providers of mental health and substance use disorder treatment determine enhanced guidelines, training, and resource allocation for the clinical motivational treatment of DDFOs while incarcerated and after release. For example, the direct care providers' perceived experiences demonstrated successful ways to increase rapport, strengthen the therapeutic alliance, increase motivation, and overcome motivational barriers in DDFO treatment. Key concepts were also identified regarding the clinical implications of the forensic setting as well as state-wide challenges of medical health care coverage issues that may eventually help redefine the types of training clinicians receive, the allocation of funding for programs for incarcerated populations,

and legislation related to medical health care coverage policies for inmates. Recommendations for clinical theory and practice are discussed next.

Recommendations for Action

This study's focus was on increasing what is known about clinical treatment for DDFOs in correctional settings and after release from prison. The results, combined with findings of other researchers, suggest recommendations for future action. As also suggested by Pizitz and McCullaugh (2012), these recommendations include designing and structuring interventions that focus on meeting the client at her own motivational level and increasing enhancements from that point. Specific recommendations are discussed next.

Rapport building, empathetic approach, and strong therapeutic relationship need to be emphasized in therapeutic methodology for DDFOs. Strong therapeutic alliance significantly enhances motivation in treatment attendance, feelings of comfort, and trust in the recovery process. Combined with a strong therapeutic relationship, these factors are believed to increase the chances of treatment completion. Providing a supportive and welcoming experience for a client, coupled with unconditional positive regard, is believed to increase prosocial change and lead to more positive outcomes (Bozarth, 2007; Daniels, 2016; Gee & Reed, 2013; Johnson et al., 2015; Mahoney et al., 2015; Rogers, 1959). This study was conducted using participants who have worked in some of the most conservative forensic environments. Even in these settings, the results confirmed that there is relevant information and perspective on motivation even in what participants believe to be a naturally coercive situation.

At a minimum, clinical substance abuse treatment should incorporate empathetic and unconditional positive regard when working with DDFOs. Researchers have demonstrated that empathy, a positive and safe environment, and unconditional positive regard all increase motivation toward the treatment process. Specific training related to the complexities of working with major clinical disorders should be considered as recommended action as symptom management may be counterproductive to recovery and treatment processes in some cases (Baillargeon et al., 2009; Bozarth, 2007; Gee & Reed, 2013; Johnson et al., 2015; Mahoney et al., 2015; Nowotny et al., 2014).

Participants in this study provided many practical examples for working with such challenges as unhealthy thinking, lack of motivation, and lack of insight. They also provided insights into instilling hope, encouraging acceptance of one's situation and needs, and strategies for enhancing the treatment process. Study results include treatment recommendations, suggests that may provide an increase in motivation toward the treatment process through direct care providers extending to community-based services. These services, such as transitional housing, support groups in local communities, and connecting DDFOs to postrelease mental health and substance counseling should occur prior to these women leaving prison. Facilitating these connections would require that direct care providers become familiar with their community resource networks to create a more holistic treatment approach and facilitate better service continuation after release. These efforts may also help address the gap in services that typically occurs post release if appointments can be made in the window of time (24–72 hr) that has been identified as ideal. These efforts can help establish the next steps for DDFOs, including where she has

to go and whom she has to see and can provide a sense of support and purpose upon exiting of the forensic setting that may increase her motivation to continue treatment after release.

These recommendations for practice are important for all mental health, substance abuse, and direct care professionals who oversee the care of DDFOs in treatment as well as policymakers who set treatment priorities, guidelines, and ethical standards for care in facilities that house DDFOs. A short summary of the findings and recommendations will be shared with the study participants as well as the larger community of direct care providers who work with DDFOs. For example, I plan to share the summary findings with direct care providers in the substance abuse and behavioral modification programs located in the state of Delaware. Results may be disseminated through research publications, presentations at behavioral health facilities, and American Psychological Association or Walden University poster sessions.

Recommendations for Further Study

Results from this study indicate that motivational facilitators and barriers to treatment for DDFOs warrant further investigation. While study results furthered the understanding of many of DDFO motivational facilitators and barriers through the eyes of the study participants, these findings only relate to the state of Delaware and only to DDFOs. Further research and inquiry should extend to other geographic areas and facilities and eventually should include interviews with DDFOs while incarcerated and after release, which would provide a longitudinal perspective on the findings. Exploring

factors related to treatment motivation by interviewing the inmates themselves should be considered for future research.

While this study's focus was on identifying techniques for enhancing motivation for treatment among DDFOs, further research is needed on how these techniques actually affect treatment processes and outcomes, both short term and long term. This would include qualitative as well as quantitative research that would provide a deeper, richer, and statistically supported picture of motivational facilitators, barriers, and treatment strategies that may assist in effecting policy changes and treatment guidelines and may influence changes in DDFO treatment.

Gee and Reed (2013) stated that only the most motivated clients will attend to their holistic treatment needs and that more research was needed to understand the facilitators of and barriers to successful treatment outcomes. While the present study's findings offer substantial insights into the issues presented in the study's research questions, one study does not affect policy change. It can, however, begin to effect a movement toward increased knowledge and further inquiry and eventually lead to policy creation for treating offenders with dual diagnosis of both genders who are enrolled in forensic substance abuse treatment programs. It is imperative that as practicing professionals expand their repertoire of clinical practice in the field, they are up to date on the most current and effective methods for holistically treating their clients. As Mahoney et al. (2015), Nowotny et al. (2014), and Prendergast et al. (2009) suggested, offenders with dual diagnosis are no longer the exception to the world of forensic treatment and care; they are the norm. Therefore, the more information and understanding

that can be obtained about the most effective methods to treat this population, the better clinical strategies will become, further increasing positive long-term outcomes.

This study provided information about perceived motivational facilitators, barriers to treatment, and more effective treatment approaches for DDFOs. These findings confirm the need to better understand motivational facilitators and treatment barriers as well as the importance of incorporating these findings into everyday clinical approaches in DDFO treatment. Practicing professionals strive to attend to client needs to the best of their professional ability, which includes maintaining the most current treatment training and understanding of clinical subjects. Insights from this study expand current professional understanding and capacity.

Conclusion

This study was a phenomenological exploration of the perceived motivational facilitators and barriers to treatment and strategies for motivating treatment among DDFOs from the perspectives of eight credentialed direct care providers in the state of Delaware. The selected participants have experience working in forensic settings that endorse traditional treatment models for DDFOs and for offenders with major clinical disorders.

While researchers have recommended various strategies for treatment offenders with dual diagnosis, women with major clinical disorders have not been extensively studied; thus, a significant piece of the clinical puzzle to treat these offender populations was missing. Additionally, because the current body of research related to DDFO treatment excludes major clinical disorders, current treatment recommendations are

generally not applicable or effective for this population, nor are they consistently implemented. This is particularly true for forensic settings, which are increasingly becoming treatment facilities but are ill equipped to handle the needs of the fast-growing population of offenders needing treatment.

Findings from this study provide clinical insights and information that expand current literature and practice on motivational facilitators, barriers, and strategies for addressing the holistic treatment needs of DDFOs while incarcerated and after release. They provide practical information on how study participants have addressed treatment motivation and barriers in practice.

There have been questions about how to further enhance treatment motivation, especially regarding coercion in the forensic setting, external system factors, and natural barriers related to lack of insight and acceptance among DDFOs. The practical experiences of the participants in this study contribute to the debate regarding clinicians' worldviews and the importance of unconditional positive regard in the treatment process. Study findings reflect key elements of motivational facilitators and barriers in DDFO treatment and offer suggestions for enhancing treatment motivation from the perspective of individuals who are in the trenches with these offenders, so to speak.

This study does not represent the experiences of all direct care providers working with DDFOs with major clinical disorders or all direct care providers working with forensic clients. It provided insights from the study participants on motivational facilitators, barriers, and effective strategies for treating DDFOs in substance abuse programs in the state of Delaware. The shared experiences of the direct care providers in

this study support other researchers' suggestions and recommendations that better understanding of motivation's role in treatment and perceived barriers to treatment is an important part of clinical work with DDFOs who have major clinical disorders.

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Appendix A: Interview Questions Derived From Research Questions

Semistructured Interview Protocol

The interview questions (IQ) were designed to be open ended and elicit more conversation than the simplified questions found herein. This was designed to pull out or draw out more information during the interview process in order to break away from the structure of question/answer and into expansive, rich data.

Central question	Subquestions	Follow-ups/probes
RQ1: According to direct care treatment providers, what are the motivational facilitators associated with treatment adherence among DDFOs?	IQ1: (rapport) How long have you worked with DDFOs in SUD treatment?	
	IQ2: (rapport) Can you tell me some things that you enjoy about working with DDFOs? (rapport)	
	IQ3: (rapport) Can you tell me some of the difficulties in working with female offenders with SUD? (Challenges)	3a. (probing) How do DDFOs differ from those offenders who have one or no mental health issues?
		3b. (probing) What do you believe is the hardest challenge you are faced with when working with DDFOs compared to women without major clinical disorders? Why so?

Central question	Subquestions	Follow-ups/probes
	IQ4: What do you think happens to DDFOs when they leave the prison? Can you tell me a bit about who you think will continue to do well in their sobriety? Who do you believe does poorly in their process once they leave prison? Why do you think that?	4a. (probing) Does this outcome differ for women with major clinical disorders? How?
RQ2: What are the motivational barriers to treatment adherence that contribute to treatment attrition among DDFOs?	IQ5: Have you ever seen women who have gone through your program relapse and return to prison? Do you notice any common themes among these women? What happens with or to these women?	5a. (probing) Does this differ in any way for DDFOs? How?
	IQ6: Do you think it's useful to treat major clinical comorbidities while in prison or that merely staying clean/sober once leaving prison will solve the various life problems experienced by DDFOs?	6a. Why do you think it's useful to treat DDFOs in prison?
RQ3: What are effective strategies or elements of interventions that enhance motivation and reduce attrition among DDFOs?	IQ7: What aspects of treatment and treatment planning do you believe are the most helpful for female DDFOs?	7a. (probing) Does this change when you are working with a DDFO who meets criteria for major clinical disorder versus women who do not? 7b. (probing) How does this change, and why?

Central question	Subquestions	Follow-ups/probes
	IQ8: What aspects of SUD treatment are most helpful for female offenders once they leave prison?	8a. Does this differ from DDFOs?
		8b. How does this differ from DDFOs?
		8c. Why does this differ from DDFOs?
	IQ9: If you were able to develop a treatment program designed solely to address the complex needs of DDFOs that includes both prison-based and after-care components, what would you do? Money is no object.	9a. (probing) How would you attempt to motivate these women while in the treatment program?
		9b. What would you attempt to do to motivate them after release?
		9c. How would your plan differ for women with singular SUD or no mental health issues?
	IQ10: What do you find the most challenging for DDFOs in completing treatment, both in the current programming at your prison and in your own ideal design? How do you anticipate your design will alleviate the issues you see currently experienced?	
	IQ11: Any other closing comments you'd like to make as you conclude the interview?	

Appendix B: Informed Consent

You are invited to take part in a research study exploring the motivational facilitators, barriers, and suggested strategies as seen by direct care providers of dual-diagnosed adult female offenders in substance disorder treatment. The researcher is inviting substance treatment program directors, counselors, and clinicians to be in the study who have experience working with forensic females specifically with major clinical disorders enrolled in substance disorder treatment in The State of Delaware. This form is part of a process called "informed consent" to allow you to understand the nature of this study before deciding whether or not to take part.

This study is being conducted by a researcher named **Cara R. Tilbury**, a doctoral student at Walden University, under the supervision of Dr. David Rentler.

Background Information:
The purpose of this study is to explore motivational facilitators, barriers to treatment, and suggested strategies of effective treatment for dual-diagnosed female offenders through the eyes of direct care providers.

Procedures:
If you agree to be in this study, you will be asked to:

- Participate in an interview with the researcher; the interview will take 60-90 minutes and will be audiotaped to ensure the data are captured accurately.
- Participate in a final meeting to review the researcher's interpretation of your responses, and provide feedback to confirm the interpretations, correct misinterpretations, and/or clarify any of the interview data. (estimated time: 30-45 minutes)

Here are some sample questions:

- Can you tell me about some difficulties you see when working with dual-diagnosed female offenders?

: If you were able to develop a treatment program designed solely to address the complex needs of DDFOs that include both prison-based and after-care components, what would you do? (Money is no object)

Voluntary Nature of the Study:
This study is voluntary. I will respect your decision whether or not you choose to be in the study. No one will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:
Being in this study would not pose a risk to your safety or well-being.

The benefit to you for participating in this study is the opportunity to add to the literature regarding the complexities of effective treatment of dual-diagnosed female offenders by bettering the understanding of the effective motivational facilitators, and the barriers that may be experienced by these offenders. .

Payment:
There will be no payment for participating in this research.

Privacy:
Any information you provide will be kept confidential. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept secure by using pseudonyms rather than your name in the transcribed and published work. Data will be stored in a locked cabinet in the researcher's office. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:
You may ask any questions you have now. Or if you have questions later, you may contact the researcher via [redacted] or [redacted].

The researcher will give you a copy of this form to keep.

Statement of Consent:
I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By signing below, I understand that I am agreeing to the terms described above.

Printed Name of Participant

Date of consent

Participant 's Signature

Researcher's Signature