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Authenticity in Multiracial Well-Being

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There is conflicting empirical evidence regarding the well-being of multiracial people. While authenticity plays an important role in counseling, its relationship to multiracial well-being has not been studied. The present study surveyed 191 multiracial adults to explore how authenticity relates to well-being, defined as perceived stress and life satisfaction. Findings suggest that self-alienation, a measure of authenticity, has a significant role in multiracial well-being. Implications are discussed concerning counseling with multiracial individuals.

Keywords: multiracial, mixed-race, well-being, authenticity

A growing body of research looking into the experiences of multiracial individuals has produced varied outcomes when it comes to mental health. Though some quantitative studies suggest negative outcomes for multiracial individuals (Gaither, 2015; Shih & Sanchez, 2005), such as decreased self-esteem (Sanchez & Bonam, 2009), other studies reveal how multiracial people navigate multiple self-aspects and experience shifts in their identity expression (Franco et al., 2016; Norman & Chen, 2019). In this regard, it is important to understand how multiracial individuals experience authenticity within their identities. Not only has research shown the importance of authenticity for psychological health, but many counseling theories (i.e., Person-Centered, Object Relations, Existential) have also posited that authenticity is the foundation of well-being (Rogers, 1961; Winnicott, 1965; Yalom, 1980). Because findings about the mental health outcomes for multiracial individuals are mixed, exploring the role of authenticity will help illuminate how multiracial individuals feel more-or-less true to themselves and its relation to psychological well-being.

In addition to the varied outcomes in multiracial well-being research, as multiracial individuals encompass an increasing proportion of the U.S. population, the need for additional quantitative research becomes clearer. According to the U.S. Census Bureau (2020), between 2000 and 2010 the number of respondents who identified with multiple races grew from 6.8 million to 9.0 million individuals (Jones & Bullock, 2013), and – between the 2010 and 2020 U.S. Census Bureau the number grew by 276% to 33.8 million (Jones et al., 2021). A 2015 Pew Research Center study, however, found that the increase in the 2010 U.S. Census Bureau findings may not represent the full picture. Rather than simply asking respondents how they self-identified, Parker et al. (2015) asked respondents to also identify the races of their parents and grandparents. It was found that while the 2010 Census Bureau reported that 2.1% of adults in the U.S. identified as multiracial, 6.9% of adults in the U.S. may be considered multiracial based on parentage. Additionally, despite the marked increase, the results from the 2020 U.S. Census Bureau may under-account for multiracial individuals: COVID-19 has driven response rates down in ways that critics say disproportionately undercount people of color (Wines, 2020). Regardless of how surveys tally the number of multiracial individuals in the U.S., the population growth is stark. With inconsistent mental health findings about multiracial individuals and given the growing population and recognition of racial and ethnic complexity, researchers need to explore factors involved in multiracial mental health. Moreover, research highlighting how multiracial individuals experience authenticity and how this relates to their well-being should be considered relevant for working counselors as the multiracial population continues to increase. As an attempt to address this need, this study investigates the role of authenticity in the psychological well-being of multiracial individuals.

Psychological Well-Being

Studies with multiracial individuals define psychological well-being as increased life satisfaction, positive affect, decreased stress, overall self-esteem, and decreased scores on measures of depressive

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symptoms (Binning et al., 2009; Sanchez et al., 2009). However, findings from extant literature of multiracial individuals' mental health have been equivocal (Gaither, 2015; Shih & Sanchez, 2005). For example, studies have shown that multiracial individuals have higher self-esteem (Bracey et al., 2004; Cauce et al., 1992), other studies show lower self-esteem (Field, 1996; Milan & Keiley, 2000), as well as studies with evidence of no differences in self-esteem (Herman, 2004) in comparison to individuals who identified with a singular group identity. A study from Albuja et al. (2019) indicates that having one's identity denied or questioned, an experience common amongst multiracial individuals, is related to higher depressive symptoms, stress, and conflict between identities. However, in their review of existing literature, Shih and colleagues (2019) theorized that multiracial individuals maintain psychological strength and resilience by developing behavioral strategies to navigate multiple identities.

Research on the psychological well-being of multiracial individuals has also suffered given the dearth of applicable, quantifiable, and empirically valid measures (Rockquemore et al., 2009, Salahuddin & O'Brian, 2011). Namely, scholars have raised concern about using individual self-esteem as a measure to examine psychological well-being for people of color because of the restriction of range in self-reporting high self-esteem (Verkuyten, 2005). The following study attempts to contribute to empirical research of multiracial people by evaluating psychological well-being using measures of life satisfaction and perceived stress. Adding to the literature on multiracial mental health is critical as well as affirming the racial complexity for these individuals and potential role of authenticity.

Complex Multiple Racial Heritages

Identity and self-concept literature provide potential frameworks for understanding the complex multiple racial realities of mixed-race people. Early identity models suggest a linear resolution to identity development of multiracial people, but ecological frameworks are inclusive of the multiple environmental factors that may contribute to identity development (Renn, 2003) and self-concept literature acknowledges the importance of complexity in well-being (Rafaeli & Hiller, 2010). Qualitative studies with multiracial individuals highlight the flexibility and complexity of choices in the lived experience of racial identification (Brown, et al., 2006). Research describes identity as an "internalized and evolving narrative of self" thus asserting one's racial identity in a specific situation may be informed by context (Terry & Winston, 2010, p. 437).

Given the racial complexity of multiracial individuals, self-complexity research provides insight into how multiracial individuals may integrate their multiple racial realities. Multiracial individuals, especially, navigate through social contexts with multiple race-based self-aspects and must often integrate divergent experiences into their understanding of self and identity. In multiracial research, the ability to integrate one's identity and perceive less racial distance and conflict between identities has been linked with multiracial pride and has implications for cognitive complexity and overall well-being (Cheng & Lee, 2009; Jackson et al., 2012). Overall, having identities that are more complex – or a wider array of self-aspects – might serve as a buffer against depression and stress (Rafaeli & Hiller, 2010).

For multiracial individuals, the shifting social realities and contexts where an individual's various aspects of self are more or less salient, one's identity might be malleable in certain situations where the individual is receiving information about the self (Sanchez et al., 2009). A common experience for multiracial people is having their identity questioned when declaring a Black-White identity and receiving the response, "but you don't look Black." Such social denials may lead to flexibility, yet incongruence may arise after receiving contradictory perceptions from others. However, it is not clear how the multiracial individual feels authentic in their expression of their identity nor whether authenticity has a role in multiracial well-being. Thus, this study explored the construct of authenticity – whether individuals feel or view themselves to be authentic to whom they believe themselves to be.

Authenticity

Historically, multiracial people were assumed to be "confused" as a result of multiple racial heritages (Shih & Sanchez, 2009), it is important to acknowledge that assumption is rooted in racism in the United States

context. While recent research has moved away from this deficit approach, there is still emphasis on congruence in many counseling modalities and in relation to well-being (Hill, 2020). Qualitative studies with multiracial individuals have noted that mixed race people feel authentic in their varying expressions of race (Jackson et al., 2012), therefore, this study aimed to add empirical evidence to the relationship between authenticity and well-being for multiracial people. Ryan et al. (2005) found authenticity to be the missing factor in the relationship between self-complexity and well-being; in mental representations of self during stressful events, an individual's authentic self-aspects helped buffer the stress of the event. Findings from this study showed that authentic self-complexity was associated with better mental health and lower perceived stress. Additionally, a meta-analysis of the effect of self-complexity on buffering stress-related illness found mixed results for the impact of self-complexity and other findings suggest that it was either unrelated or mildly negatively related adjustment (Rafaeli-Mor & Steinberg, 2002). A recent study by Borawski (2021) provides evidence that authenticity mediates the relationship between loneliness and well-being.

Authenticity can be defined as being true to oneself regarding congruent thoughts and behaviors as well as self-expression (Sheldon et al., 1997). Scholars indicate that authenticity plays an important role in healthy psychological functioning (Boyraz et al., 2014; Rogers, 1961; Sheldon et al., 1997; Thomaes et al., 2017). Though, for example, Rivera et al. (2019) point to the subjective nature of authenticity, questioning whether this construct of "true self" could ever really be measured, they nonetheless conclude that feeling authentic plays a role in well-being.

Wood et al. (2008) developed a framework for authenticity that is rooted in person-centered theory that puts forth measurable dispositions of authenticity: self-alienation, authentic living, and accepting external influences. Within this framework, self-alienation is defined as the "[misalignment of] conscious awareness and actual experience (the true self)," authentic living as "behaving and expressing emotions in such a way that is consistent with the conscious awareness of physiological states, emotions, beliefs, and cognitions," accepting external influence as "the extent to which one accepts the influence of other people and the belief that one has to conform to the expectations of others" (p. 386). This framework and corresponding scale are cited in over 1300 studies yet have not been explored in the multiracial population despite qualitative multiracial research making the connection between fluid racial expression and authenticity (Romo, 2011). This study seeks to fill this gap with an empirical study of the relationship between aspects of authenticity and psychological well-being of multiracial people.

The Present Study

The current literature published on multiracial mental health has been ambiguous and incomplete. Counseling theories posit those feelings of authenticity – being "true" to oneself– are important for an individual's mental health, and though research has discussed how multiracial identity is complex, context-dependent, and involves other people's perceptions, studies have yet to delve into the role that authenticity plays in the psychological health of these individuals. Therefore, to expand the literature, this study aimed to understand the relationship between aspects of authenticity and psychological well-being. Psychological well-being, defined as one's overall sense of positive psychological characteristics and the absence of negative characteristics, was assessed with life satisfaction and perceived stress measures. The aim of this study was exploratory to examine whether authenticity is related to psychological well-being for individuals who self-identified as multiracial.

Method

Participants

Based on inclusionary criteria, 191 self-identifying multiracial individuals completed a web-based survey over 4 months via social media. A power analysis was conducted a priori. To be included in this study, individuals had to self-identify as multiracial and be at least 18 years old. Individuals ranged from 18 to 70 years old ($M = 30.74$, $SD = 9.86$). Most of the sample identified as female (n = 149, 76.8%). One individual declined to report their gender; the remaining sample reported that they were male (n = 42, 21.6%) or transgender (n = 2, 1%). The sample varied regarding relationship status with many individuals reporting that they were single/never married (n = 113, 58.2%), married (n = 44, 22.7%), divorced (n = 16, 8.2%) or cohabitating (n =15, 7.7%). Regarding educational attainment, much of the

sample reported having completed a bachelor's degree (n = 74, 38.1%), a graduate degree (n = 53, 27.3%), or not having completed a 4-year degree (n = 67, 34.5%).

Racial Demographic Information

Anyone who self-identified as multiracial was included in this study. Participants were asked to describe their racial heritage utilizing multiple-choice questions with *check all that apply* directions, as well as open-ended questions. Respondents described their racial heritage in 52 distinct ways: some used the checkboxes, some wrote in "biracial," "multiracial," or "mixed-race" and other individuals responded with specific ethnic heritages. The most common response was Black-White (n = 61, 31.4%).

Procedures

Recruitment

The IRB-approved survey was web-based. Given increased use and access to social media, multiracial individuals were able to connect across communities and it served as a resource with its vast number of message boards and social groups dedicated to multiracial identity (Sanchez et al., 2009). The study recruitment email was distributed through multiracial listservs and was posted on multiracial, mixed-race, or biracial social media groups. Specifically, multiracial organizations such as Swirl, Inc., the MAVIN Foundation, and multiracial groups on Twitter, Facebook, Google Groups, LinkedIn, as well as websites that highlighted mixed-race studies research were asked to post the study or send the study link to potential participants. Recruitment emails described the study's inclusion criteria and indicated that the purpose of the study was to understand more about the multiracial experience. Recruitment followed a snowball sample procedure, such that the recruitment email or posting asked those who received the email to share the study link with anyone who meets the inclusion criteria.

Upon entering the web-based survey, participants encountered a form asking them to confirm their eligibility; they needed to confirm that they were over the age of 18 and respond to how they racially identified. Participants were able to enter the survey regardless of the number of boxes they checked because some individuals checked *other* and specified that they identified with multiple racial groups or as biracial. Since recruitment materials specified that one must self-identify as multiracial to participate, all individuals who completed the study were included. Participants who are 18 years of age or older and who identify with multiple races were then directed to view the informed consent page, which included the purpose and design of the study, a brief description of how to complete a web-based survey, as well as the potential benefits and risks associated with participating in the study.

Measures

Demographic Questionnaire

Participant demographics were assessed with inquiries regarding the age, gender, racial heritage, and socioeconomic statuses (e.g., highest educational level attained, current income) of participants. Other questions in the demographic measure also allowed participants to indicate the racial composition of their school, work, and/or neighborhood. This measure incorporated recommendations from Binning et al. (2009) for the quantitative assessment of racial identity. Individuals were able to report multiple racial heritages with a *check all that apply* directive based on the U.S. Census Bureau's racial and ethnic identity options.

Authenticity

The *Authenticity Scale* was utilized to assess the participants' sense of authenticity (Wood et al., 2008). There are a total of 12-items with a Likert-type response scale ranging from 1 (*does not describe me at all*) to 7 (*describes me very well*). Items on this measure reflect individuals' incorporation of others' perceptions (*I am strongly influenced by the opinions of others*), beliefs (*I always stand by what I believe in*), and sense of self (*I feel as if I don't know myself very well*). Exploratory and confirmatory factor analyses demonstrated evidence for a three-factor structure of authenticity with an ethnically and racially diverse sample, including acceptance of external influence (α = .78), authentic living (α = .69), and self-alienation (α = .78). For the current study, internal consistency was demonstrated for the three subscales as follows: acceptance of external influence (α = .83), authentic living (α = .70), and self-alienation (α = .90). Wood et al. (2008) demonstrated convergent and discriminant validity for the *Authenticity Scale*. Further, there is evidence for discriminant validity with measures of social desirability, which suggests that responses to the *Authenticity Scale* are not influenced by social

desirability. In this sample, scores ranged from 4 to 28 (M = 10.94, SD = 4.99) for acceptance of external influence, from 10 to 28 (M = 24.19, SD = 3.23) for authentic living, and from 4 to 28 (M = 8.77, SD = 5.84) for self-alienation. Scores on this measure are like other diverse samples utilizing this measure.

Psychological Well-Being

Psychological well-being has been measured using various psychological constructs that assess positive aspects of psychological characteristics as well as the absence of negative aspects of psychological characteristics (Suzuki-Crumly & Hyers, 2004). Therefore, this study utilized measures of global stress and life satisfaction that have been employed in previous studies on psychological well-being in multiracial individuals, including perceived stress, life satisfaction, and general life expectations.

The *Perceived Stress Scale* (PSS; Cohen et al., 1983) was used to measure participants' experience of general stress as a measure of psychological well-being. The PSS is a ten-item measure whereby respondents indicate their responses using a Likert-type scale ranging from 0 (*never*) to 4 (*very often*). Participants were asked to reflect on the last month when answering general questions about their experiences of stress (e.g., *In the last month, how often have you felt that you were unable to control the important things in your life?)*. The sample's scores ranged from 0 to 38 (M = 16.81 SD = 7.20). The sample's mean is slightly lower than other diverse community and student samples (Lavoie & Douglas, 2011) and therefore indicates a low level of perceived stress for this sample. For the current sample, internal consistency was demonstrated (α = .90).

Life satisfaction was measured using the *Satisfaction with Life Scale* (SWLS; Diener et al., 1985). The SWLS is a five-item measure with a Likert-type response scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). For the current sample, scores ranged from 6 to 35 (M = 23.33, SD = 6.79). This mean score suggests that this sample has an average level of life satisfaction. There is evidence for internal consistency of this measure with the current sample (α = .88). The SWLS measured positive characteristics of psychological well-being by assessing the agreement with statements (e.g., *The conditions of my life are excellent*).

General Life Experiences

To control for general life experiences that may be stressful and impact psychological well-being, the *Survey of Recent Life Experiences-Short Form* (SRLE; Kohn & Macdonald, 1992) was utilized. The SRLE consists of 41 items regarding daily experiences such as *being taken advantage of*, *a lot of responsibilities*, and *financial burdens*. Participants were instructed to indicate the intensity of the experience(s) over the past month ranging from 1 (*not at all part of my life*) to 4 (*very much part of my life*). Scores could range from 41 to 164. For the current sample, scores ranged from 42 to 127 (M = 75.64, SD = 17.90), which indicates an average degree of stressors in the last month. Internal consistency was demonstrated (α = .92).

Results

This study aimed to explore the role of authenticity and how it is related to psychological well-being for multiracial individuals. This aim was exploratory because there is no existing research exploring the role of authenticity in multiracial well-being. To explore the relationship between authenticity and psychological well-being, preliminary analyses were conducted.

Preliminary Analyses for Authenticity

Recent life experiences significantly correlated with the self-alienation subscale of the *Authenticity Scale* (r = .39, p = .000). Self-alienation significantly correlated with both perceived stress (r = .54, p = .000) and life satisfaction (r = -.33, p = .000). Specifically, these correlations suggest that the more self-alienated individuals reported feeling, the more they perceived stress and the less they reported feeling satisfied with life. The other two subscales of the *Authenticity Scale*, accepting external influences (r = .23, p = .003) and authentic living (r = -.22, p = .007) significantly correlated with perceived stress. This suggests that an increase in accepting external influences is related to reporting more perceived stress, while an increase in authentic living is related to reporting less perceived stress. Tests for multicollinearity indicated that a very low level of multicollinearity with perceived stress was present (VIF = 1.00 for accepting external influences, 1.00 for authentic living, and 1.18 for self-alienation). Regarding life satisfaction, tests indicated that a very low level of multicollinearity was present (VIF = 1.00 for

accepting external influences, 1.00 for authentic living, and 1.17 for self-alienation).

The Role of Authenticity

The relationships among variables were explored utilizing a hierarchical regression model to discern how much authenticity accounted for the variance in perceived stress and life satisfaction, after controlling for general life stressors. Steps were entered into the regression model as follows: (a) the covariate, recent life experiences; and (b) accepting external influences, authentic living, and self-alienation. These steps were completed for both perceived stress and life satisfaction.

Authenticity and Perceived Stress To test the exploratory question of how authenticity variables relate to perceived stress, a hierarchical linear regression analysis was performed. The results (See Table 1) suggest that a significant portion of total variation in perceived stress was predicted by recent life experiences (R^2 = .42, F(1, 142) = 103.53, p = .000). After controlling for recent life experiences, accepting external influences, authentic living, and self-alienation accounted for a significant amount of the variance in perceived stress (R^2 change = .10. F = 9.52, p = .000). Specifically, self-alienation accounted for a significant portion of the variance in perceived stress (β = .27, t = 3.60, r = .21, p = .000), while accepting external influence and authentic living were not significant predictors of perceived stress. Therefore, self-alienation appeared to have a significant role given the main effect on the variance in perceived stress. The significant direct effect of self-alienation on perceived stress suggests that the more one feels self-alienated and not sure of who they are, the more likely they are to perceive higher levels of stress.

Authenticity and Life Satisfaction To test the research question of how authenticity variables relate to life satisfaction, a hierarchical linear regression analysis was performed. Results of the regression analysis further clarify the research question regarding the relationship between authenticity and psychological well-being for multiracial individuals. The results of a hierarchical linear regression (See Table 1) suggest that a significant portion of total variation in life satisfaction was predicted by recent life experiences (R^2 = .21, F(1, 144) = 38.20, p = .000). After controlling for recent life experiences, accepting external influences, authentic living, and self-alienation accounted for a significant amount of the variance in life satisfaction (R^2 change = .07, F = 4.65, p = .004). Specifically, self-alienation significantly accounted for some of the variance in life satisfaction (β = -.31, t = -3.44, r = -.25, p = .001). Additionally, accepting external influences also accounted for some of the variance in life satisfaction (β= .21, t = 2.39, r = .17, p = .018). Thus, there is a main effect of self-alienation on life satisfaction and perceived stress; self-alienation plays a significant role as a factor of authenticity in multiracial well-being. While accepting external influences did not play a significant role in negative aspects of well-being, they did play a significant role in positive aspects of well-being.

Discussion

This study examined the relationship between authenticity and psychological well-being as defined by

Table 1
Hierarchical Linear Regression Analyses Predicting Psychological Well-Being from Authenticity

	Perceived Stress				Life Satisfaction			
	Est.	*SE*	*p*	R^2	Est.	*SE*	*p*	R^2
Model 1				.42				.21
Recent Life Experiences	.65	.03	.000		-.46	.03	.000	
Model 2				.52				.28
Recent Life Experiences	.54	.03	.000		-.35	.03	.000	
Accepting External Influences	-.003	.11	.967		.21	.12	.018	
Authentic Living	-.13	.17	.070		-.05	.18	.519	
Self-Alienation	.27	.09	.000		-.31	.10	.001	

Note. Estimates are standardized.

perceived stress and life satisfaction. Overall, this sample's mean scores indicated low levels of perceived stress compared to diverse community samples in other studies (Lavoie & Douglass, 2011), and average levels of life satisfaction based on normative data for the measure. This study aimed to explore how authenticity was related to psychological well-being. Findings suggest that self-alienation aspects of authenticity are related to psychological well-being–when individuals feel more disconnected from a sense of who they are, they perceive more stress and experience less life satisfaction. Further, multiracial individuals who report accepting external influence also seem to experience more life satisfaction.

Psychological Well-Being for Multiracial People

Overall, this sample reported positive psychological well-being, demonstrated by lower mean scores on negative aspects of well-being (i.e., perceived stress). Additionally, average scores on positive aspects of well-being (i.e., life satisfaction) when compared to diverse community samples (Lavoie & Douglas, 2011; Pavot & Diener, 1993). These findings help to extend the research on multiracial identity and psychological well-being through its use of a perceived stress measure to evaluate psychological well-being rather than a measure of depressive symptoms. Though Schlabach (2013) found that multiracial adolescents tend to have lower levels of emotional well-being compared to their monoracial peers based on scores from the *Center for Epidemiologic Studies Depression Scale* (CES-D), the CES-D has been demonstrated to be a problematic measure of psychological well-being in diverse samples (Kim et al., 2011). Meanwhile, akin to the present study, Binning et al. (2009) assessed multiracial psychological well-being using a measure of global stress and determined that individuals who identified with multiple racial groups reported significantly lower stress than multiracial people who identified as monoracial.

Furthermore, this study contributes in a novel way to research on the mental health of multiracial individuals. Previous research did not control for recent life experiences that may impact an individual's psychological well-being. In this study, recent life experiences accounted for significant variance in perceived stress and life satisfaction. Though this finding is consistent with research that explores how daily stressors are related to perceived stress and life satisfaction (Mayberry & Graham, 2001), previous multiracial research exploring psychological well-being neglected to include daily stressors as a control variable. This may account for some error in findings that support a relationship between multiracial identity and psychological well-being. By utilizing reliable and valid measures of well-being while controlling for general life stressors, this study helps clarify the equivocal research and elucidate multiracial well-being.

Authenticity and Psychological Well-Being

The present study explored the role of authenticity in multiracial psychological well-being. Findings suggest that the concept of self-alienation is an important factor in multiracial psychological well-being. For this multiracial sample, self-alienation–defined as "the subjective experience of not knowing oneself or feeling out of touch with the true self" (Wood et al., 2008, p. 386)–had a positive, significant relationship with perceived stress; the more self-alienation participants reported, the more perceived stress they reported. Participants also indicated a decrease in life satisfaction. Given the relationship between self-alienation and psychological well-being, it appears that feeling connected and knowing oneself may be a significant buffer for stress and impact life satisfaction for multiracial people. This is consistent with the literature on self-concept and the importance of authenticity in self-complexity (Ryan et al., 2005). Though researchers have qualitatively explored how multiracial individuals experience authenticity (Romo, 2011), the present study adds additional quantitative support for the role of authenticity, especially self-alienation, in multiracial well-being.

Interestingly, though accepting external influences was significantly correlated with perceived stress, it was not a significant predictor of perceived stress. However, it did significantly account for variance in life satisfaction. Authenticity involves accepting external influence (Wood et al, 2008), and this finding further supports existing research that cultural identity and self-understanding are influenced by one's social environment (English & Chen, 2007). More research on this relationship is needed to understand how multiracial individuals' accepting external influences is related to well-being in various contexts. For example, future

research could explore how social settings where one's identity is affirmed or denied impact the relationship between accepting external influences and well-being for multiracial people.

Additionally, authentic living–defined as the congruence between the way one feels internally and their behaviors–had a significant negative correlation with perceived stress. Therefore, the more congruence individuals feel between their internal sense of self and their behaviors, the less perceived stress they report. Though authentic living was not significant in the hierarchical linear regression model, the correlation indicates that authentic living may play a role in multiracial well-being. For example, authentic living may be context-specific and may not involve an overall sense of authenticity. Recent research has examined how feelings of authenticity can vary depending on whether an individual feels like their "true self" in a given setting (Ryan & Ryan, 2019).

Implications for the Mental Health Field

This study has implications for counselors who work with multiracial individuals. Firstly, the current sample did not indicate higher levels of stress compared to the general population; however, this sample did report average life satisfaction. Therefore, deficit models that characterize multiracial individuals as uniformly suffering from confusion, sadness, and lack of connection are outdated. Person-centered and other humanistic counseling theories not only see authenticity as crucial for psychological well-being but also posit that psychotherapy has the potential to increase one's authentic disposition (Rogers, 1961; Wood et al. 2008; Yalom, 1980). Counselors should acknowledge how a strong sense of self and racial socialization plays an important role in psychological well-being for multiracial clients (Villegas-Gold & Tran, 2018). The significant correlations found between self-alienation and perceived stress suggest that helping professionals may focus their work on assisting multiracial individuals to develop self-knowledge to increase life satisfaction and buffer against stress. Though social factors may influence how one expresses their identity in a given context (Franco et al., 2016; Norman & Chen, 2019), the processes by which individuals filter information from their social environment through their own self-knowledge should inform the development of counseling interventions for multiracial people.

Limitations and Next Steps

Though this study adds to the research on multiracial individuals, it is not without limitations. First, the cross-sectional design of this study does not allow for a context-specific exploration of these variables. It is important to note that quantitative methodology is limited in providing the context-specific logic of identifying differently in various situations. Additionally, this study used snowball-sampling methods, which resulted in varying sample sizes for different racial and ethnic heritages and reduced the ability to look for group differences. Further, a small portion of the sample was born outside of the U.S., but currently live in the U.S, while those who were born in the U.S. are currently living abroad. This study did not assess time residing in the U.S. or abroad and, given the small sample, could not assess differences in this regard. Finally, participants were recruited via multiracial-related social networking groups so multiracial identity may have been particularly central to their identity, which could limit the generalizability of this study to other multiracial samples.

Continued research exploring the relationship between multiracial identity and psychological well-being must use alternative ways of measuring well-being with multiracial individuals and control for general life stressors that impact well-being. Future studies may assess specific multiracial experiences, congruence between an internal sense of self and behaviors in that specific experience, and these factors' relation to psychological well-being. Giamo et al. (2012) point to how multiracial identification buffers the relationship between discrimination and psychological well-being, therefore, future research should examine the role of authenticity within that relationship. New research exploring the concept of subjective concealment of identity, which is the belief that an identity can be concealed from others, found no relationship with authenticity (LeForestier et al., 2022), this process could also be explored within the multiracial population given the findings of the present study and research on disclosure costs for multiracial people (Sanchez & Bonam, 2009).

The present study illuminated relationships between constructs that have not been previously studied with a multiracial sample. Remaining questions center on how aspects of authenticity influence psychological well-being in context-dependent ways. For example, a mixed-methods design may help contextualize authenticity with detailed qualitative accounts of lived experiences, thus allowing for an examination of the meaning-making processes that likely influence a variety of outcomes.

Conclusions

The findings of this study underscore the importance of authenticity in the well-being of multiracial people and gesture towards the ongoing importance of the continued study of how people experience authenticity. Moreover, the present study concludes that self-alienation plays a significant role in the psychological well-being of multiracial individuals. Additionally, suggests self-alienation as an area of focus for helping professionals who work with people with multiple racial heritages. For multiracial individuals, accepting external influences has an impact on positive aspects of psychological well-being. This research has implications for how mental health providers should consider counseling modalities such as humanistic modalities that emphasize authenticity when working with multiracial people, and ultimately, expands the body of work aimed at empirical study of the psychological outcomes of a growing portion of the population.

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A Review of Attachment Theory

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This article is an attempt to offer an overview of the original scholarships related to the history, development, trends, and implications of attachment theory. The theory's founders intended for its application to shift and evolve corresponding to the realities, norms, and needs of a changing world. However, the areas of concern for multicultural considerations remain in the theory's limited evaluation of how healthy attachment manifests in diverse populations, which is discussed in the current article.

***Keywords**:* attachment patterns; Bowlby; strange situation; parent-child relationship; attachment and culture

John Bowlby worked in conjunction with Mary Ainsworth to develop and advance attachment theory (Ainsworth & Bowlby, 1991). Bowlby incorporated and infused various concepts from different domains, such as ethology, information processing, developmental psychology, and psychoanalysis to construct the doctrine of the theory (Bretherton, 1992). He offered a new perspective of the bond between a child and the mother, and conceptualized how separation, deprivation, and bereavement contribute to its disruption. Ainsworth applied a novel methodology to empirically examine some of Bowlby's hypotheses and broaden the theory. She proposed an infant explores the world from a secure base, attachment figure (Bretherton, 1992). She also formulated the concept of maternal sensitivity, the mother's hyper attentiveness to nuances in their infant's behavior. She postulated maternal sensitivity to messages an infant communicates with their environment has a crucial role in the development of child-mother attachment patterns (Ainsworth et al., 1978). Although Bowlby directly, and Ainsworth indirectly, were influenced by similar pioneers of psychoanalysis, such as Sigmund Freud, and had similar research interests, they worked independently in their early careers (Bretherton, 1992). It is also imperative to note that the formation of the tenets of attachment theory was a prolonged journey that included several key research projects.

The Emergence of Attachment Theory

Edward John Mostyn Bowlby was a British psychologist, psychiatrist, and psychoanalyst who received intense scientific training in developmental psychology before graduating from the University of Cambridge in 1928 (Bretherton, 1992). His first clinical work with children took place at a school for maladjusted children, where he worked with an isolated and affectionless teenager with no stable mother figure who had been expelled from his previous school for larceny, and a seven-year-old anxious boy who would follow Bowlby around like his shadow (Brethrton, 1992). Interested in the effects of early family relationships on personality development, Bowlby pursued a career as a child psychiatrist studying medicine and psychiatry simultaneously. During postgraduate training at the British Psychoanalytic Institute, Bowlby found himself drawn to the etiology of children's emotional disturbances. He rejected the psychoanalytic notion that a child's emotional disturbances are solely created by internal conflict between aggressive and libidinal drives leading to fantasies, the conflict between the drives for survival and pleasure (Bowlby, 1969). Instead, he hypothesized that external factors such as family experiences play a critical role in causing emotional disturbances. Therefore, he found himself drawn to the object-relations approach which suggests that attachment to objects is more critical for emotional regulation and development of self in children. He focused on the concept of early relationships and the "pathogenic potential" of loss (Bowlby, 1969, p. xxxiii).

In Bowlby's first study, he examined 44 cases related to affectionless children inclined to steal, and concluded there is a connection between their symptoms and experience of maternal deprivation and separation (Bretherton, 1992). He expanded his theory by stating attachment relations are transmitted from one generation to another and therefore, helping parents can promote the well-being of children (Bretherton, 1992). In fact, Bowlby (1949), in the first published paper on family

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therapy, explained how interviewing parents about their childhood experiences led to clinical progress with children. To elaborate on the maternal role in child development, Bowlby posited, "if mental development is to proceed smoothly, it would appear to be necessary for the undifferentiated psyche to be exposed during certain critical periods to the influence of the psychic organizer-the mother" (Bowlby, 1952, p. 53). Bowlby's major conclusion was that to have healthy mental well-being, a child should experience a warm, intimate, and consistent relationship with the mother (Bowlby, 1952).

Although some feminist theorists have interpreted attachment theory as reinforcing the traditional perspective of women as primary caregivers (Bretherton, 1992; Chodorow, 1978; Johnson, 1988), it is noteworthy to point out that Bowlby believed this relationship could also be formed between the child and a "permanent mother substitute" and both the child and mother/the substitute mother should find "satisfaction" and "enjoyment" in the relationship (Bowlby, 1952, p. 13). Bowlby did not specify that caregiving must be done by mothers or a female figure. In fact, according to attachment theory, the most central element to healthy development is the need for a committed caregiving relationship with one or a few adult figures (Bretherton, 1992). Different studies showed that infants could be attached to a hierarchy of figures, including fathers, grandparents, and siblings, as well as to daycare providers (Flaherty & Sadler, 2011; Howes et al., 1988). However, these crucial components of the theory have been neglected in later studies that referenced Bowlby's attachment theory. Lastly, it is enlightening to know that Bowlby conducted his earlier studies in the 30s and 40s and therefore, the population he focused on were the people during the World War II era. He studied the separation of hospitalized children from their parents, which laid further groundwork for his later attachment research (Bretherton, 1992). Several years later, Ainsworth joined the research team centering her research on the observation of attachment styles of children in Uganda and Baltimore.

The Development of Attachment Theory

Bowlby presented the blueprint of attachment theory through five papers: "The Nature of the Child's Tie to His Mother" (1958), "Separation Anxiety" (1959), and "Grief and Mourning in Infancy and Early Childhood" (1960). He also completed two more studies pertinent to defensive processes related to mourning in 1962 but they were never published (Bretherton, 1992). Emanated from psychoanalytic theories, Bowlby in his first conceptualization of child-mother relationship propounded that a child's attachment behavior is built up of instinctual responses that facilitate the formation of a child-mother bond (Bowlby, 1958). These instinctual responses include sucking, clinging, following, and signaling behaviors such as smiling and crying. As the responses develop over the first year of life, they become integrated and concentrated on a mother figure. Bowlby also identified clinging and following as the most crucial innate behaviors for attachment. To reinforce his notion, he introduced ethological concepts such as social releasers that could activate, block, or terminate specific responses (Bowlby, 1958). A distinction between the view of Bowlby and some psychoanalysts is that he believed the stimuli could be both external and intrapsychic. He also elucidated the difference between the concept of dependency defined in the social learning theory and attachment, indicating that attachment is not emblematic of regression; rather, it is a natural, healthy function in life (Bretherton, 1992).

Examining the work of Harlow and Zimmermann (1958) on the effects of maternal deprivation in rhesus monkeys, Bowlby proposed there are three stages of separation response: protest, despair, and denial. Protest indicates that a child experiences separation anxiety when a situation or stimuli activates both escape and attachment behavior, but an attachment figure is not available (Bowlby, 1959). Bowlby believed adverse family experiences such as constant threats of abandonment or rejection by parents cause extreme separation anxiety. The illness or death of parents or siblings for which the child feels responsible are also contributing factors. On the other hand, excessive low separation anxiety or its absence indicates pseudo-independence, ascribed to defensive processes which is misconstrued as maturity (Bowlby, 1959). In addition, Bowlby viewed maternal over-gratification, which manifests as pseudo-affection or overprotection, as unhealthy since it suggests overcompensation for unconscious hostility in the mother figure (Bretherton, 1992). Bowlby concluded a child with a healthy bond with the mother is expected to protest separation from caregivers yet will foster self-reliance later in their life.

Bowlby further explained that if the attachment figure acknowledges and responds to the child's needs for comfort and protection and concurrently respects the child's need for independent exploration, it is expected for the child to develop an internal working model of the self as valued and reliable (Bowlby, 1959). Bowlby also noted that if the caregiver frequently rejects the child's asks for comfort or exploration, the child may form an internal working model of the self as unworthy or incompetent (Bretherton, 1992). Through these working models, a child can anticipate the attachment figure's behavior and plan their own responses accordingly. Bowlby also elaborated on the role of internal working models in the intergenerational transmission of attachment patterns. He postulated that individuals who grow up to become relatively stable and self-reliant usually have parents who are supportive yet allow and encourage autonomy. Consequently, Bowlby believed that the inheritance of mental health through family microculture outweighs the genetic inheritance (Bowlby, 1973).

Bowlby argued if a situation activates attachment behaviors and the attachment figure continues to be unavailable, the child's response to the situation escalates from protest to despair leading to grief and mourning. He also claimed frequently substituting attachment figures results in an inability to form deep relationships with others (Bretherton, 1992). Notably, Bowlby's work on mourning contributed to Colin Parkes' research on adult bereavement. Bowlby and Parkes (1970) jointly conducted research on a nonclinical group of widows and found out that the phases of separation response for children were described through four phases of grief during adult life: numbness, yearning and protest, disorganization and despair, and reorganization.

Shedding light on Ainsworth's contribution to the development of attachment theory, while already familiar with Bowlby's thinking derived from ethology, she conducted an observational study on the development of infant-mother attachment in Uganda in 1954 (Ainsworth & Bowlby, 1991). Soon she realized the relevance of Bowlby's notions. Hence, the first empirical study of attachment from an ethological perspective was launched several years prior to the publication of Bowlby's three prominent papers (Bowlby, 1958, 1959, 1960). Ainsworth studied the onset of proximity-promoting signals and behaviors and when they became preferentially directed toward the mother (Bretherton, 1992).

Ainsworth's second observational research was the Baltimore project, a longitudinal study beginning in 1963 (Ainsworth, 1985). The 26 participating Baltimore families were recruited before their child was born, with 18 home visits beginning in the infant's first month and ending at 54 weeks of age (Bretherton, 1992). Ainsworth and colleagues (1978) documented that mother-infant interaction patterns emerge during the first three months. The patterns included feeding situations, mother-infant face-to-face interaction, crying, infant greeting and following, attachment exploration balance, obedience, close bodily contact, approach behavior, and affectionate contact. Predominantly based on the infants' behavior, Ainsworth established a well-known laboratory procedure, the Strange Situation, to classify infant-parent relationships.

In the Strange Situation, the mother and infant are introduced to an experimental playroom, where an unfamiliar woman joins them later (Ainsworth et al., 1978). While the stranger plays with the child, the mother leaves momentarily and then returns. A second separation occurs when the child is completely alone. Finally, the stranger and then the mother return (Bretherton, 1992). Findings of Ainsworth and Bell (1981) revealed that infants explored the playroom and toys more vigorously while their mothers were present than in the presence of the stranger or when they were alone. Moreover, Ainsworth and her research team noticed unexpected patterns of infant reunion behaviors, which resonated with what had been documented and theorized about separation. They observed that a few numbers of the one-year-old participants were angry when the mother returned after a 3-minute separation (Ainsworth et al., 1978). They cried and wanted contact but would not simply cuddle or embrace warmly when picked up by their mother, instead they expressed ambivalence by kicking or swiping at her (Ainsworth et al., 1978). There was also another group of infants that even though they had searched for their mother while she was absent, they would snub or avoid the mother upon her return (Ainsworth et al., 1978). Notably, many of the infants sought proximity, interaction, or contact once they were reunited with their mothers (Bretherton, 1992).

Ainsworth and Bell (1981) concluded that those infants who were ambivalent or avoidant had experienced less harmony in their relationship with their mother at home compared to the majority group. They further explained that children whose mothers attentively responded to crying during the early months tended to cry less and relied for communication on facial expressions, gestures, and vocalizations. Likewise, children whose mothers provided warm and tender holding during the early months sought less contact during the later months; however, when the contact happened, they experienced more satisfaction and affection. These behaviors were aligned with the expectations the children had developed based on their prior satisfying or rejecting experiences with their mothers (Ainsworth et al., 1978).

Employing these findings, Ainsworth initially proposed three attachment classifications: secure, avoidant, anxious-ambivalent, and some infrequent reunion responses that were not fully explained by these three attachment styles, labeled as unclassified (Ainsworth et al., 1978). These infrequent responses included infants exhibiting odd, fearful, disjointed, and contradictory behavioral responses. In subsequent studies with maltreated and higher risk populations, Main and Solomon (1986, 1990) found that this outlier classification occurred enough to warrant a fourth classification, later labeled disorganized-disoriented attachment. Analyzing Ainsworth's findings, the secure category reflects parents who are usually available, responsive, and sensitive to their children's feelings (Belsky & Cassidy, 1994). The avoidant category represents parents who are often rejecting, detached, and uncomfortable with physical contact and are likely to withdraw support in times of distress. The anxious category also mirrors parents who are somewhat self-preoccupied, more sensitive to their own needs and anxiety than to their children's needs, and often intrusive and inconsistent. Lastly, the disorganized-disoriented group is related to parents who are more troubled, depressed, and abusive. This might be due to parents' unresolved attachment traumas or poor attachment styles which they have passed on to their children (Belsky & Cassidy, 1994).

Attachment Style in Adulthood

Incorporating Ainsworth's infant attachment typology, Hazan and Shaver (1988) studied adult attachment and developed a self-report measure to assess romantic attachment in adulthood. They began their study by describing the three attachment styles, secure, avoidant, and anxious-ambivalent, and inquiring adults to choose the description that matches all their significant romantic relationships. Their findings suggested attachment styles can significantly predict relationship outcomes (e.g., satisfaction, breakups, commitment), patterns of coping with stress, couple communication, and patterns of career development (Shaver & Clark, 1994). However, these three categories of attachment patterns were insufficient to accurately capture individual differences in adulthood. Building upon the work of his predecessors, Bartholomew (1990) posited adult attachment styles are conceptualized in four categories, suggesting the avoidance group is divided into two subcategories, dismissing and fearful. He further theorized that adults with the avoidant-dismissing attachment style are likely to be more defensive, denial oriented, and overtly unemotional. Conversely, adults with avoidant-fearful attachment styles tend to be more vulnerable, conscious of emotional pain, and fearful (Shaver & Hazan, 1988).

With this new perspective on adult attachment style, each of these four categories could be viewed two-dimensionally. One dimension reflects the model of self, and another represents the model of others; each can be considered positive or negative (Griffin & Bartholomew, 1994). Secure individuals possess positive models for both self and others. For preoccupied or anxious–ambivalent individuals, the model of others is positive (i.e., relationships are attractive), but the model of self is not. On the other hand, dismissing individuals have a positive model of self due to their relative defensiveness and a negative model of others (i.e., intimacy in relationships is regarded with caution or avoided). Finally, both models of self and others for fearful individuals are somewhat negative (Griffin & Bartholomew, 1994). Notably, view of self and view of others, positive or negative, strongly impact an individual's attachment style and social and relational

engagement and offer valuable content to identify patterns of relationships.

Attachment, Psychotherapy, and Assessment

In the last ten years of his life, Bowlby was preoccupied with how to incorporate attachment theory into psychotherapy (Bretherton, 1992). He proposed that the main goal in treatment based on attachment theory is to reappraise deficient and obsolete working models of self in relation to attachment figures. This objective could hardly be obtained if parents or substitute parents had proscribed their review (Bowlby, 1988). As highlighted by psychoanalysts, an individual with insufficient, fixed working models of attachment relations may redirect these models to interactions with others, including their therapist, which is called transference (Bowlby, 1988). During psychotherapy, the client and therapist work collaboratively to explore and analyze the roots of the dysfunctional internal working models of self and attachment figures. To facilitate the process, the therapist is expected to serve as a trustworthy and secure base with the help of which the client can embark on the taxing journey of understanding and refurbishing their internal working models (Bretherton, 1992). Bowlby believed that therapists could be a temporary attachment figure (Levy & Johnson, 2019) from which clients can explore their "affectional bond" with others (Bowlby, 1977, p. 421). Bowlby explained different ways that attachment and psychotherapy intersect and, accordingly, specified six chief treatment goals for psychotherapy: offering a secure base to provide a foundation from which clients explore the problematic aspects of their life in a supportive and safe environment; exploring past and current attachments and their expectations, feelings, and behaviors in those relationships; exploring the therapeutic relationship and examining how it may represent clients' other relationships or experiences; facilitating the process of finding nexus between past and current relationships and how past experiences manifest into present relationships; revising internal working models through encouraging clients to develop a new way of being including feeling, thinking, and acting. Although clients may express divergent working models, therapists can help them develop the most adaptive internal working models; and providing a safe space that can be internalized by the client and transcended to outside therapy spaces to help reduce distress (Bowlby, 1977; Levy & Johnson, 2019). Attachment theory and its principles have significantly contributed to the development of multiple interventions for psychological disorders and various forms of psychotherapy, a few of which will be discussed later.

Assessment

Empirical studies that explored the psychological, internal, and representational aspects of attachment theory corroborated the notion of intergenerational transmission of attachment patterns that had been at the center of Bowlby's interests since his beginning in psychiatry (Bretherton, 1992). In addition, the attempt to translate the work of Ainsworth on infant-mother attachment patterns into corresponding adult patterns led to the development of the Adult Attachment Interview (George et al., 1996), which deepened our understanding of how attachment patterns are passed on from one generation to another. The interview encompassed several open-ended questions, asking parents about their attachment relations in childhood and how those early relations influenced their development (George et al., 1996). The results revealed that there are three distinct patterns: autonomous-secure parents, who offered their either satisfying or dissatisfying accounts of early attachments clearly and coherently; preoccupied parents, who recalled many conflicted childhood memories in relation to attachment figures yet were not able to depict an organized and consistent picture; and dismissing parents, who demonstrated an inability to provide an account of their attachment relations in childhood or recalled episodes of rejection and subsequently, denied the influence of their early attachment experiences on later development (Bretherton, 1992). Further studies showed these classifications conceptually and empirically correspond to Ainsworth's secure, ambivalent, and avoidant infant patterns (Fonagy et al., 1991; Ward & Carlson, 1995).

After expanding attachment patterns from child-adult relationships to adult-adult relationships, which began with adult bereavement (Bowlby & Parkes, 1970), marital relationships, in particular marital separation, also found relevance in attachment theory (Bretherton, 1992; Weiss, 1991). Notably, adults who describe themselves as secure, avoidant, or ambivalent with respect to romantic relationships report their adult attachment style mimics patterns of parent-child

relationships in their families of origin (Bretherton, 1992). In examining attachment in the microsystem of family relationships, the Pennsylvania project revealed changes in marital satisfaction after the child's birth and parental satisfaction with social support predict a child's attachment quality at the end of the first year (Belsky et al., 1984a; Belsky et al., 1984b). Hence, the attachment patterns formed in childhood manifest in one's various relationships throughout life and influence their interpersonal interactions and intrapersonal communications.

Clinical Implications of Attachment Theory

Studies indicate that attachment theory is a generally efficacious clinical approach (Andriopoulou & Prowse, 2019; Bevington et al., 2015; Toth et al., 2002). Treatment modalities emanating from attachment theory are mainly designed for children due to the theory's strong emphasis on caregiver-child interactions. The implications of the theory could be broadened into treatments for adults as well, focusing predominantly on disorders with a strong relational component, such as borderline personality disorder (Levy et al., 2015). The attachment-based child interventions developed in the 1980s and 90s were mainly rooted in psychodynamic theory with additional components, such as direct modifications of the home environment or an emphasis on parent and child strengths (Levy & Johnson, 2019). The central tenets of these interventions include improving caregiver sensitivity, empathy, and responsiveness, fostering child self-efficacy and autonomy, and increasing the reciprocity and emotional engagement between child and caregiver. The more recent treatment modalities are focused on the real-life attachment behavior that manifests in the caregiver-child relationship and serves as the content of appraisal of dysfunctional patterns between caregiver and child (Levy & Johnson, 2019). Hence, observations, video recordings, psychoeducation regarding healthy parent-child interactions and effective parenting, and discussions of interactions could facilitate the modification process by reinforcing sensitive behavior and pointing out alternative ways of interactions (Marvin et al., 2002; Olds et al., 2007; Van Zeijl et al., 2006). A review of attachment intervention literature provides support for modalities that target behavioral patterns and include psychoeducation, such as home visits by trained professionals and specific short-term behavior-focused interventions (Bakermans-Kranenburg et al., 2003; Levy & Johnson, 2019; Olds et al., 2007).

One line of inquiry is the efficacy of attachment theory across various populations. In a 2021 study, researchers considered the quality of attachment between adolescents and their parents in military families (Farnsworth & O'Neal, 2021). The study examined how the quality of attachment to each parent, both civilian and active military, impacted the adolescent's adjustment to military stressors such as frequent moves and unpredictable family schedules. They found evidence for their hypothesis and concluded that improvement in the attachment between the adolescent and each parent helped the child with adjustment and other stressors (Farnsworth & O'Neal, 2021). Furthermore, a 2022 meta-analysis evaluated the efficacy of attachment-style interventions for parent-child attachment and psychosocial adjustment in foster and adoptive parents and children (Dalgaard et al., 2022). Of the participants (children, N = 1302; parents, N = 1344), 16 different populations were represented, including studies conducted in Belgium, Italy, the Netherlands, the United Kingdom, and the United States, all published between 1977 and 2020 (e.g., Barone et al., 2019; Dozier et al., 2009; Guerney, 1977). After a thorough analysis of all data available, the researchers concluded that "Parenting interventions based on attachment theory increase positive parent/child interactional behaviours, decrease parenting stress, and increase the overall psychosocial adjustment of children in foster and adoptive families postintervention" (Dalgaard et al. 2022, p. 3).

There are few treatments for adults that have explicitly originated from attachment theory. The most well-known one is interpersonal psychotherapy (IPT; Klerman et al., 1984). IPT, deriving from interpersonally oriented psychodynamic Neo-Freudian theory, underlines the importance of a secure base and safe space for cultivating attachment security. Consequently, the therapist is expected to convey warmth and compassion yet avoid promoting dependence (Levy & Johnson, 2019). Researchers revealed that IPT is effective in treating major depressive disorder, eating disorders, and addiction (Carroll et al., 1991; Levy & Johnson, 2019). A similar treatment to IPT is attachment-based family therapy (ABMT), which has been found effective in the case of depression, suicidality, hopelessness, anxiety,

internalizing and externalizing behaviors, and family conflict (Diamond et al., 2010).

Another treatment approach heavily based on attachment theory is emotion-focused therapy (EFT; Greenberg et al, 1993) for both individuals and couples. EFT focuses on how people interact with others based on their basic emotions and how those interactions with their attachment figures construct a sense of self. Makinen and Johnson (2006) postulated the notion of attachment injury (i.e., instances of a breach of trust or acts that impact relationship quality). They offered a trauma-informed resolution model to encourage communication and proximity among couples through exploring emotions within attachment frameworks and enhancing attachment security (Levy & Johnson, 2019). Another treatment modality explicitly rooted in attachment theory is mentalization-based treatment (MBT), developed by Bateman and Fonagy (1999). Mentalization refers to the capacity to think about mental states in self and others, such as wishes, desires, and intentions. This promotes prefrontal cortex–amygdala connectivity and could be activated along with the attachment system in affectively stimulated interpersonal events (Fonagy & Bateman, 2006; Siegel, 2006). The mechanism of change in MBT reflects the social, cognitive, and affective capacity for mentalization and encourages the client to engage in metacognition from a secure base or connection with a trusted other person (Fonagy & Bateman, 2006). Researchers demonstrated that MBT effectively improves borderline personality disorder, depressive symptoms, social and interpersonal functioning, and suicidal behaviors (Bateman & Fonagy, 1999, 2009, 2012). Particularly, clients with disorganized attachment and borderline personality disorder tend to have remarkably sensitive arousal, which is generally incompatible with the 'slow thinking' required for successful mentalizing. Therefore, nurturing the development of mentalizing skills is a critical contribution of psychotherapy to therapeutic practice (Holmes & Slade, 2019). In addition to these treatments, attachment theory has implicitly been incorporated into various therapeutic techniques based on attachment constructs, such as fostering a therapeutic alliance or the exploration of past and present relational experiences to revise maladaptive views of self and others (Levy & Johnson, 2019).

Looking at attachment as a factor of psychotherapy efficacy, studies have found that specific aspects of attachment may moderate treatment responses (Levy et al., 2018). For instance, in comparison with preoccupied or anxious attachment, a secure attachment style is likely to predict better outcomes (Fonagy et al., 1996). Mikulincer and Shaver (2007) reported that clients with a secure attachment style are more cooperative with treatment recommendations. On the other hand, in an avoidant attachment style, clients' high dependency needs may confound the objectives of therapy (e.g., increasing agency, self-reliance, and individuation), leading to poorer outcomes (Levy & Johnson, 2019). It is noteworthy that clients with preoccupied, anxious, or avoidant attachment styles are not precluded from experiencing healing and restorative benefits of therapy. Rather, understanding various attachment styles can help clinicians offer a more accurate prognosis and appropriate referrals for clients needing long-term care (Levy & Johnson, 2019). Furthermore, the therapist's attachment style may play a role in treatment effectiveness. Diamond and colleagues (2003) stated that insecure therapists are more likely to mirror their clients' styles of interaction, while securely attached therapists tend to challenge clients' established interpersonal strategies, which could ultimately contribute to clients' improvement. Attachment could also be considered a mechanism of change in psychotherapy. For instance, exploring the fear of abandonment, a prominent facet of anxious attachment style, within the attachment framework could itself bring significant improvements in relationship quality (Burgess Moser et al., 2017). Shifting from an insecure to a secure style of attachment or bringing changes in the dimensions of attachment could also be a primary target in psychotherapy (Buchheim et al., 2017; Levy & Johnson, 2019).

Multicultural Considerations of Attachment Theory

An area of Bowlby's attachment theory that has been neglected is his emphasis on the fact that fostering a well-functioning mother-child relationship depends on their social networks and economic and health factors (Bretherton, 1992). Despite his effort to draw the attention of society to provide support for parents decades ago, this is still an area of struggle in different communities. Bowlby believed "if a community values its children, it must cherish their parents" (Bowlby,

1952, p. 84). In particular, he emphasized the financial arrangement that society should offer parents, especially the female parent (Bretherton, 1992). Cultural differences should also be taken into consideration as the value that diverse communities place on attachment relations varies. According to Marris (1991), a society should attempt to lessen or eliminate disruptive events, protect each child's experience of attachment from harm, and support family coping. However, individuals and families might be convinced to obtain certainty at the expense of others by imposing a substantial burden of uncertainty on them or by providing fewer social resources. Therefore, there is a difference between the needs and influences of each force which could create tension: a tendency to construct a secure and predictable social order and the urge to amplify one's own opportunities at the expense of others. When dominant groups in communities advance their own control over life circumstances by marginalizing others, they create hindrances for marginalized populations to render and experience security in their own families (Bretherton, 1992). Hence, attachment relations suggest not only psychological implications but also offer public policy and moral implications for society.

Critics of attachment theory note that it has primarily been evaluated in Western countries with predominantly White populations (Breuer, 1999; Dalgaard et al., 2022; Upadhyaya et al., 2019). Even though Ainsworth spent a considerable portion of her research focused on attachment in Uganda, and other studies have focused on some tribal communities (Tronick et al., 1987) and Asian communities (Rothbaum et al., 2000), there have been scant empirical studies conducted on non-White and non-Western populations. Further, there has been limited work toward broadening the understanding and definition of healthy attachment, considering multicultural differences. Examining how attachment relationships reverberate in the social constellation of non-Western cultures could contribute to exploring cultural variations in attachment behaviors. Therefore, it is essential to design ecologically reliable measures customized to specific cultures. These assessment measures should be developed based on a profound understanding of family relationships and culture-specific parenting practices (Bretherton, 1992). The risk in adhering rigidly to one definition of healthy attachment validated in White, Western populations is to further pathologize people from non-dominant groups. Hence, for attachment theory to remain relevant and effective, clinicians and researchers must re-evaluate how healthy attachments are defined to capture its variability and ensure that attachment theory is used efficiently for the benefit of diverse clients in need of healing.

Future Directions

Bowlby wrote one of the first family therapy papers (1949), noting the importance of positive, functional parent-infant attachment that provides a secure base for the child. However, he did not consider family relationships beyond the parent-child dyad. From a family system perspective, family is more than the sum of its members. Children are influenced by the emotional communications that take place in the family, which can contribute to the formation of attachment style (Stevenson-Hinde, 2007). Further, adult attachment classifications were developed based on early Strange Situation classifications to mother or a substitute mother figure. Therefore, these classifications do not capture the early attachment to different individuals within the family such as siblings and grandparents. It is noteworthy that Bowlby was supportive of the extensions of attachment theory (Stevenson-Hinde, 2007), and in his own words, he stated, "The tasks for those who use attachment theory to guide their research or their clinical work are to see where the ideas already formulated can aid understanding, to recognize where they need supplementing from elsewhere, and to accept that there are probably many fields on which they shed no light" (Bowlby, 1982, p. 313). Honoring that sentiment, we offer suggestions for future research to continue the development of a robust attachment theory applicable for diverse client populations.

Research with the entire family is essential to identify a child's attachment style and apply modifications to internal working models more accurately. Though early attachment works were explicitly focused on one caregiver (mostly the mother) and the child, appraising attachment-related emotional communication among all family members could provide substantial materials for the therapist to identify recurrent dysfunctional patterns and, eventually, develop an effective treatment plan through which family members can serve as a secure base for one another. Attachment theory neglects the idea that children can influence their peers'

development. Hence, exploring and assessing child-child relationships can serve as a rich source of information for therapists and a context to intervene and apply modifications.

Attachment theory has become a leading agenda in various domains related to the development and well-being of children, including family counseling, custody decisions, and child placement. It can inform family court decisions regarding custody issues and children's residence (Keller, 2021). However, due to the lack of cultural considerations, solely following attachment theory to evaluate parental competence and the capacity to care adequately and responsibly for children may result in undesirable outcomes. For instance, it is a common practice in some cultures to receive assistance from relatives to care for their child. Accordingly, an emigrant family from such cultures may find themselves without their familiar support system in their host Western country and, therefore, struggle to manage their various responsibilities, including parenting. However, instead of providing the family with resources and relevant education, State agencies may deem parents as incompetent and remove the child (Keller, 2021).

Attachment theory was incorporated into policy across international organizations such as UNICEF and WHO to support destitute children and families in areas of crisis (Keller, 2021). However, this approach appears based on the fallacious assumption that attachment theory and its implications are universal and valid across cultures and reinforced the misconception that families in poverty have poor parenting. Examining and revising the application of attachment theory in different cultures is crucial and ensures that experts who work with children and families consider multicultural differences when providing recommendations.

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Historical and Contemporary Use of Distance Counseling Service: A Brief Summary

Michael B. Sickels

Although distance counseling practices saw greater normalization in the wake of the COVID-19 pandemic, such practices have operated at some level shortly after the invention of the telephone itself. As technology continued to evolve, so too did its incorporation in counseling sessions. Following the safety precautions precipitated by the COVID-19 pandemic, telehealth interventions have been used with greater acceptance, reimbursement, and regularity.

Keywords: distance counseling, remote counseling, telehealth, COVID-19

In response to the COVID-19 pandemic, distance counseling (i.e., videoconferencing and telephonic counseling) quickly shifted from a niche preference to a widespread necessity. Such a shift allowed for the practice of social distancing as a means of reducing potential infectious exposures (CDC, 2021), precipitating a 4,347% national increase in telehealth claim lines from March 2019 to March 2020 (Gelburd, 2020). Although infrequent at the time in comparison to face-to-face sessions, the incorporation of remote counseling interventions has been in place long before the COVID-19 pandemic launched the modality to a state of normalcy. Given this observation, the purpose of this article is to illuminate historical and contemporary use of telehealth services as a means of providing context to telehealth interventions prior to their unexpected proliferation in response to the COVID-19 pandemic.

Historical Context of Distance Counseling

When acknowledging the historical beginnings of distance counseling, one must first observe the origin of its predecessor, telemedicine. Three years after Alexander Graham Bell's invention of the telephone in 1876, the first report of telemedicine was published in a major medical journal, exploring the use of the telephone in the diagnosis of a child's cough ("The Telephone as a Medium of Consultation and Medical Diagnosis," 1879). Following this publication, the telephone quickly became a widely used tool in the practice of primary care medicine (Mohr et al., 2008). The incorporation of the telephone into counseling was a comparatively slower process, evidenced by the first study on the topic being published by Berger and Glueck (1949), 70 years after the initial telemedicine report.

Suicide prevention was the first movement toward telephone use in mental health intervention, initiated by the opening of the first suicide prevention center in Los Angeles in the 1950s (Lester, 1977). This inception was followed by the instantiation of other telephone-delivered services, such as crisis intervention, teen hotlines, drug hotlines, and poison centers (Lester, 1977). An example of such a service can be observed in the 24-hour telephone counseling and referral service at the University of Texas that began operations in July 1967 and received 62,000 telephone calls by July 1970 (Iscoe, 1971). Based on the nature of these services, one might observe that the use of telephone-administered counseling was largely rooted in the treatment of depressive symptoms, which occur with common frequency and are a significant cause of disability (Murray & Lopez, 1997).

In 1959, videoconferencing was being practiced in its infancy at the Nebraska Psychiatric Institute to provide group counseling, long-term counseling, consultation-liaison psychiatry, and medical student training (Von Hafften, 2020). Ten years later, in 1969, Massachusetts General Hospital provided psychiatric consultations at a Logan International Airport clinic via videoconferencing, a practice that expanded into most diagnostic and therapeutic interactions in the 1970s and 1980s (Von Hafften, 2020). It was during this period, at

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the 1972 International Conference on Computers, when Stanford and the University of California, Los Angeles (UCLA) staff used linked computers to provide the first demonstration of text-based counseling (Rauch, 2017).

In the 1990s, distance counseling became more commonly incorporated in outpatient counseling with the rise of internet and videophone technology (Mozer et al., 2008). As technology continued to advance, counselors appropriated technological advancements into their offices such as cell phones and computers on an ongoing basis (Vincent et al., 2017). In 1995, telemedicine programs were active in at least 40 states (Perednia & Allen, 1995), and approximately 100 telehealth networks were in operation by 1999 (Winerman, 2006). Perednia and Allen (1995) note that the growth of telemedicine during this time was driven primarily by the political and economic factors of a managed care approach to health services, in addition to the national effort to develop the electronic information highway. Telemedicine also afforded providers a reduction in economic and medical risks regarding caring for patients in rural areas (Allen et al., 1992; Perednia & Allen, 1995).

Text-based counseling saw a departure from its history of public mental health advice columns in the 1990s when Dr. David Sommers created the first text-based counseling service that provided a one-on-one therapeutic relationship that resembled traditional outpatient counseling (Rauch, 2017). Research on the practice of telehealth intervention also increased in the 1990s, providing a platform for practice guidelines developed in the 2000s, such as those listed by the American Telemedicine Association (2020) and the American Counseling Association (ACA; 2014). The 2000s also saw the expansion of text-based counseling services, which became more accessible to clients as smartphones became more sophisticated in the 2010s (Rauch, 2017). A further exploration into more contemporary use of telehealth services will be explored below.

Contemporary Use of Telehealth Services

Prior to the widespread necessitation of telehealth services precipitated by COVID-19, such distance-based services were conducted on a comparatively infrequent basis. The small percentage of telehealth usage prior to COVID-19 can be observed in Wilson et al.'s (2017) analysis of the largest private claims database in the United States, the Health Care Cost Institute database. The authors looked at 3,986,159 claims from the years 2009-2013 and found that 13,480 of these claims were submitted for telehealth, constituting 3% of total claims. Of these claims, 9,868 were submitted for psychiatry, 1,950 for clinical psychologists, 1,416 by mental health professionals, and 246 by social workers. This small ratio of telehealth to face-to-face services can be explained by a variety of barriers observed in the literature. For example, although leaders of healthcare reform have judged telehealth as a viable option for curtailing the growth of healthcare costs (Simon, 2017; Wicklund, 2017), the economic cost of installing and operating telehealth systems, in addition to training staff on telehealth use, were considered a significant barrier to widespread adoption of telehealth services prior to its necessitation brought about by COVID-19 (Wilson et al., 2017).

In addition to systemic barriers to the incorporation of telehealth services, individual concerns regarding security and professional competence further presented a hindrance to the widespread use of telehealth services prior to COVID-19. A recent study conducted by Glueckauf et al. (2018) on clinicians' (N = 164) use of telehealth technologies found that respondents reported concerns pertaining to confidentiality guidelines (79%), response to crisis situations (52%), and relevant professional association guidelines (55%). Another study conducted by Antoniotti et al. (2014) found that barriers to submitting telehealth claims such as coding issues, higher rates of denial for service, and lack of reimbursement from payers have been cited as reasons that clinicians have been historically hesitant to adopt telehealth practices. Another barrier that may have deterred the adoption of telehealth may have been hesitance regarding the general applicability of the medium, as 75% of respondents in Glueckauf et al.'s (2018) study were "slightly or not at all confident" they could provide telehealth services without an initial in-person assessment. The study also found that only 3% of respondents reported providing telehealth services to children, and 9% reported providing such services to elderly clients, suggesting that counselors may have historically seen the medium as applicable to only adult clients who were considered neither children nor elderly.

Although an increasing number of states steadily eased restrictions and clarified policies on reimbursements for telehealth services prior to COVID-19, Wilson et al. (2017) found that telehealth policies nonetheless varied widely between states regarding types of services, types of providers, location of patients, and acceptable technologies. This variance in policy likely resonates with Glueckauf et al.'s (2018) finding that most clinicians in their study reported little or no awareness of laws regulating telehealth services. Wilson et al. (2017) also found that only seven states (Arkansas, Delaware, Hawaii, Minnesota, Mississippi, Tennessee, and Virginia) required telehealth services at the same billable rate as non-telehealth services as of January 2016. Data found by Wilson et al. (2017) indicate that telehealth-related services were reimbursed at lower rates on average than non-telehealth services for no clear reason, which likely acted as a further deterrent to counselors incorporating telehealth services.

Glueckauf et al. (2018) found that the lack of training and education in telehealth services likely acted as yet another deterrent to counselors' use of such services prior to COVID-19. In their study, the authors found that 96% of clinician respondents indicated that "mental health practitioners should undergo training about the clinical, legal, and/or ethical issues related to telehealth" (p. 210), and that 90% of respondents indicated that practitioners should receive training on technical issues surrounding the delivery of telehealth services. These findings align with those of other researchers in the literature (Callan et al., 2017; McMinn et al., 2011) who have advocated for telehealth services training in graduate programs and continuing education after completing terminal degrees.

Regarding telehealth services implemented by clinicians prior to COVID-19, Glueckauf et al. (2018) found that 63% of respondents reported using telephone, 26% reported using videoconferencing, and 6% reported using text-based intervention. The more frequent use of telephonic interventions than other methods of implementation may further warrant exploration into telephonic counseling, as most of the recent studies place emphasis on the medium of videoconferencing (Poletti et al., 2020). Also, Glueckauf et al.'s (2018) findings regarding greater use of telephonic and videoconference than text-based interventions align with prior research (Mora et al., 2008; Perle et al., 2013) reporting that synchronous applications (e.g., telephone, videoconferencing) of telehealth intervention are used substantially more often than asynchronous interventions (e.g., text-based counseling).

COVID-19: From Preference to Necessity

An obvious discrepancy between the incorporation of telehealth prior to and during COVID-19 is that what was once available as a preference was now presented as a necessity. While having to follow *sheltering in place* (i.e., when large segments of the population are asked to stay at home) protocols precipitated by COVID-19, telehealth allowed both counselors and clients to continue treatment despite having to quarantine in their respective homes (Rosen et al., 2020). This rapid necessitation of remote services brought about a widespread transition to telehealth in the provision of mental health services (Gelburd, 2020). Clinicians were forced to rapidly adapt despite the historically seldom incorporation of telehealth evidenced above. In a survey administered by the American Psychological Association (APA) in 2020 to its member clinicians, 76% of respondents reported providing solely remote services to clients. Despite the necessitation of telehealth services by COVID-19, the literature suggests that clinicians should routinely ask their patients about their comfort level with receiving virtual care and address concerns about the modality (Rosen et al., 2020).

Long-Term Implications for Telehealth

Following the widespread and prolonged use of telehealth practices in the counseling profession, such remote interventions will likely be incorporated with greater commonality than they were prior to the pandemic. During the pandemic, counselors, practices, and insurance companies were forced to increase their level of comfort regarding the provision of telehealth services. Speaking further to this point, Rosen et al. (2020) observe in the literature that the greatest barrier to the adoption of telehealth practices prior to COVID-19 was clinician knowledge and comfort. The author writes, "Now that clinicians have been forced to adapt and change, and the greatest barrier to the expansion of telepsychotherapy has been eliminated, [telehealth] may become a permanent part of the mental health landscape" (p. 183). This claim by Rosen et al. (2020) suggests that clients were comparatively more receptive to telehealth than counselors. This claim has empirical grounding, as

many patients were highly receptive to receiving medical and psychiatric services via telehealth prior to COVID-19 (Grubaugh et al., 2008).

In addition to amassing greater acceptance from individual providers and recipients of care, telehealth appears to be gathering greater recognition and acceptance on an organizational level. A recent example can be observed in the creation of the Board Certified-TeleMental Health Provider (BC-TMH) credential by the National Board for Certified Counselors (NBCC; 2020), requiring counselors to complete a curriculum involving presentation skills, confidentiality, best practices, crisis protocols, choice of technology, and telehealth care coordination to receive the credential. The increased credentialing (NBCC, 2020) and greater normalization (APA, 2020) of telehealth services suggests that this modality is likely to remain in practice following the conclusion of the COVID-19 crisis.

Another long-term implication to telehealth pertains to the Counseling Compact, an interstate compact developed and championed by the American Counseling Association that allows professional counselors to practice in other compact member states without the need for multiple licenses (National Center for Interstate Compacts [NCIC], 2020). Section 7.A of the Counseling Compact Model Legislation discusses the right for professional counselors to "practice Professional Counseling in any Member State via Telehealth" (NCIC, 2020, p. 11). Such legislation speaks not only to the permanence of telehealth in the counseling field, but also to the increased accessibility to counseling that the Counseling Compact and telehealth modality might afford in conjunction.

Conclusion

Although telehealth practices were launched into normalcy in the wake of the COVID-19 pandemic, telehealth practices have operated at some level since only a few years after the invention of the telephone itself. As technology continued to evolve, clinicians found ways to incorporate the given technologies into the field of counseling in terms of crisis intervention, advice columns, and outpatient counseling. These technologies were not as widely incorporated in the field as face-to-face counseling due to lack of familiarity, training, and insurance reimbursement. Following the safety precautions precipitated by the COVID-19 pandemic, telehealth interventions rose astronomically in use out of necessity. In the present day, telehealth interventions continue to be widely incorporated, and see far greater acceptance than in the days preceding the pandemic. Due to the widespread and prolonged use of telehealth services in the counseling field, it is likely that telehealth interventions will continue to exist in the realm of normalcy, continuing to provide accommodation for clients who benefit from their use.

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Personal Experiences with Long Term Recovery: A Qualitative Exploration of Catalysts for Change

Brittany Sager-Heinrichs & Brittany L. Pollard-Kosidowski

Addiction to alcohol and other drugs continues to ravage the United States, and efforts at decreasing use/abuse have historically been minimally effective. This transcendental phenomenological study explored the lived experiences of individuals in long-term recovery (LTR), with findings highlighting the catalysts that motivated their entry into and maintenance of LTR status. Implications for trauma-informed addiction counseling are provided, along with suggestions for future research focused on the LTR experiences of diverse populations.

Keywords: addiction, trauma, connection, Stages of Change, recovery

Since 1999, more than 932,000 individuals have died from drug overdoses within the United States (Centers for Disease Control and Prevention [CDC], 2021). In 2021, 162.5 million people reported having used substances within the past month and of those individuals, more than 40.3 million had been diagnosed with a substance use disorder (SUD; Substance Abuse and Mental Health Services Administration [SAMHSA], 2021). Given the pervasiveness of substance abuse in America, addiction issues present in nearly all mental health treatment settings and consistently challenge what clinicians know about therapeutic best practices (Nissen, 2014), especially professional counselors most likely to work with clients experiencing addiction. (Young, 2015). This makes knowledge related to treatment success, relapse rates, and long-term change mechanisms especially relevant to the practice of counselor training.

Relapse and recovery are two processes that can occur after an individual disengages from problematic alcohol or drug (AOD) use (Uğurlu et al., 2020). Relapse refers to an individual's return to previous behaviors, psychological states, or practices after obtaining sobriety, whereas recovery describes a person's maintenance of changed patterns of behavior and the effective management of one's addiction (Menon & Kandasamy, 2018; Steckler et al., 2013). Universal relapse rates continue to be high, despite consistent evolution within the field of addiction treatment, with Chandrakar et al. (2020) identifying a relapse rate of nearly 52 percent. This leads to the question of what types and degrees of change and/or motivators for change best support a client's entry into and maintenance of long-term recovery (LTR). LTR is defined as a period characterized by stability, a decreased risk of relapse, and increase quality of life after a person discontinued the use of substance abuse (Flores, 2001; Hser, 2007; Martinelli et al, 2020).

The transtheoretical model (TTM; Prochaska, 1979), which posits that people engage in stage-based change processes, is based on four defining factors: preconditions for therapy, processes of change, content to be changed, and the therapeutic relationship. TTM identifies five processes central to change (Prochaska, 1979), as well as the five Stages of Change commonly seen in addiction literature: pre-contemplative, contemplative, preparation, action, and maintenance. The pre-contemplative stage is when there is little to no consideration, whereas the contemplative stage is when the individual begins to consider and examine the problematic behavior (DiClemente, 2018). The next stage, preparation, is when the individual commits to take action which leads to the action stage where the individual implements the plan to change the problematic behavior (DiClemente, 2018). The maintenance stage occurs after the behavior has been changed and the individual is sustaining the change pattern (DiClemente, 2018). The relapse and recycling stage represents a return to pre-contemplation when an individual experiences a return to the pattern of problematic behavior (DiClemente, 2018). This study primarily focuses on the maintenance stage of change.

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Method

Participants

Study participants included individuals over age 18 who self-identified as being in LTR. Inclusion criteria required that participants were not presently: a) using AOD, b) engaging in prescription medication abuse, c) engaged in a medication-assisted treatment (MAT) program, d) incarcerated, e) enrolled in any form of substance abuse treatment, f) had obtained and maintained at least six months of self-reported sobriety, and g) were living in the community. In total, eight participants were recruited for this study and data saturation was reached. Each participant selected a pseudonym to protect their confidentiality. Participants ranged in age from 27-63, with five identifying as female and three as male. All participants were White. Recovery time ranged from five to 35 years.

Procedures

Upon obtaining IRB approval, letters of invitation were mailed to addiction treatment centers throughout the state in which the researchers resided, and single county authorities (SCA) were identified using the Department of Drug and Alcohol Program (DDAP) online directory. In addition to all 46 SCA, 104 treatment sites were randomly selected to receive the study invitation. Facility directors were encouraged to distribute the invitation to potentially eligible colleagues, former clients, friends, and/or family members. Invitations consisted of a brief study summary, inclusion criteria, and instructions for providing informed consent and contacting the lead researcher. Individuals deemed eligible were contacted by the lead researcher to confirm their inclusion in the study and schedule their virtual interview. Participants then engaged in individual recorded interviews via Zoom. Interviews were designed to further explore participants' personal processes of change and recovery using a semi-structured interview protocol. Once all interviews had been conducted, recordings were transcribed and emailed independently to each participant for review and the opportunity to make corrections. Only one minor revision was made.

Data Analysis

Throughout data analysis, the researchers maintained ongoing memos that later served as the foundation for coding, which entailed organizing the data by thematic units (Creswell & Creswell, 2018), noting similarities or differences in collected data (Ravitch & Carl, 2021) and collapsing codes into thematic categories based on their commonalities. Identified themes were then integrated into a narrative of what the phenomena of both change and LTR meant collectively to participants (textural description) and later used to develop the *how* associated with participants' experiences (structural description; Moustakas, 1994).

Findings

Five main themes emerged during data analysis. Two of the themes highlight participants' experiences of entering recovery, including change catalysts related to trauma, desperation, and the avoidance of external consequences. The third theme illustrates participants' motivations for maintaining their recovery long-term, while the fourth theme accounts for one aspect of the LTR experience, connection, that nearly all participants identified as a key contributor to their success. The final theme represents the individual nuances of the recovery that highlights the idiosyncrasies of personal experiences with both addiction and recovery, these findings represent important outlier data.

Theme 1: Experiences of Trauma and Desperation Motivate Recovery

The first emergent theme was that experiencing trauma during active addiction motivated participants' entrance into recovery. Trauma is defined as "… a subjective human experience, colored by an individual's perspective, life experience, and healing style" (Marich, 2014, p. 5). Five of the eight participants identified encountering traumatic experiences near the endpoint of active addiction significantly motivated their ultimate decision to enter recovery. While the relationship between trauma and addiction has been well-documented in existing literature (Najavitas, 2022; Wiechelt & Straussner, 2015), research on the relationship between trauma and recovery is less extensive. For these participants, trauma came in many forms.

For example, while disclosing a suicide attempt that she described as leading her to recovery, Taylor shared, "It's a tough spot to be in when you feel like you don't want to be here anymore… and that's how I felt. I was just done." Another participant, Bob, supported Taylor's sentiment, reporting, "I just got to the point where every time I shot up, I was trying to kill myself." The multiple suicide attempts described by these participants

represent traumatic experiences that led them to feelings of hopelessness and a sense that they had no option other than to stop using and try a different method of finding relief.

Aside from suicidality, participants described other traumatic experiences that motivated their decision to seek recovery. Bill recalled a sense of hopelessness related to the trauma of loss, stating, "It was kind of all at once - my wife left, I didn't know where my kids were, my job was on the line, and my father was through with me… I was through with myself." The trauma of losing everything and everyone, including, as he reported, himself, left Bill willing to attend an Alcoholics Anonymous (AA) meeting for the first time. The experience of loss trauma also resonated with Jack, who shared, "I didn't have anywhere else to go and I've overdosed eight times. I mean, I was going to die... a homeless shelter was kicking me out." Sally referred to trauma directly upon disclosing a situation where the Federal Bureau of Investigation (FBI) raided her house for addiction-related activities, sharing, "It was a nightmare... The whole situation was PTSD within itself... Not something I ever wanted to experience again." Sally reported knowing that the only way to prevent that from happening was to seek recovery.

Five participants described experiencing hopelessness toward the end of their active addictions, a feeling that motivated what many termed "desperate" attempts at entering what would become LTR. Taylor described "hitting my bottom, feeling empty, feeling like I was alone, losing everyone and burning every bridge I had," while Elizabeth stated, "I was… wanted for identity theft and I was scared and we ran for three weeks and I was like, I cannot do this anymore." Bob shared, "I was in hell... just dope sick... always broke, switching between being on the street... and having a home... not eating." Bill described desperation as hopelessness that resulted in passive death wishes and reported, "I wanted to die." Finally, Suzanne reflected on her own experiences of trauma both before and during addiction and identified wanting to simply escape feelings and behaviors she encountered along the way. She stated, "I was so desperate to be someone other than that hurt little girl." Suzanne explained that an experience of incarceration during her final recovery attempt offered her the opportunity to work on herself and on healing from the traumas she had experienced. During this process of engaging in intrapersonal work, she recalled experiencing what she described as a desperate desire to remain in recovery.

Theme 2: Avoiding Consequences Motivates Entry into Recovery

The second emergent theme continued to answer the question of what catalysts specifically motivated participants to enter AOD recovery. Several participants directly identified wanting to avoid the consequences of continued addiction, particularly those involving legal issues, while others inadvertently avoided further consequences by seeking recovery. Three participants focused primarily on using recovery as a means of avoiding the criminal justice system.

Elizabeth reported that after she was arrested for identity theft, she was offered the opportunity to participate in drug court. Her desire to avoid consequences were identified when she disclosed "I didn't want to go to state prison." Similarly, Samantha noted, "I was tired of going to jail," when reflecting on her many experiences with being incarcerated and relocating frequently to decrease her chances of being apprehended on active warrants. Suzanne stated, "I did not like jail, so that was a huge motivator... I was also afraid that I would go upstate [to prison] if my judge saw me again, and I didn't want to go there." A commonality among the themes, was the experience of being out of other choices. Aside from incarceration, other participants also described external motivators that came in the form of consequences they wished to avoid. Bob, for example, recalled his experience of being in a counseling session with his individual AOD counselor and their ultimatum to go to AA or rehab and failure to do either would result in discharge from counseling. Faced with the consequence of losing this support, Bob made the choice to commit himself to the change process.

Theme 3: Shifts in Self-Perception Motivate LTR Maintenance

In addition to describing the catalysts that prompted their recovery entrance, participants also described the catalysts that help them to maintain LTR status. Shifting self-perceptions represents a theme related to participants' motivations for maintaining recovery, with seven of eight identifying changes in how they viewed themselves as their recovery progressed. Taylor noted, "I kept progressing as a person… being a good mom, a

good student, and a good employee." Sally seconded this notion, asserting, "I feel like I make a difference now. I feel like I have a purpose. I'm just a better person. I am a good person and I like who I am, so that's what keeps me motivated." Sally reported that these feelings of pride in herself only developed after entering recovery and would be lost if she returned to active addiction.

In addition to changes in self-perception, several participants mentioned other aspects of personhood, self-concept, and motivation that contribute to their ongoing recovery success. Elizabeth reflected on aspirations and goals that have emerged as she has evolved throughout recovery, sharing, "I have goals… big career goals... I want to take care of my son." Several participants observed that addiction did not offer them the opportunity to exist as productive and successful members of society. Jack reported that since entering recovery he has recognized his ability to both "make good decisions [and] make mistakes without relapsing" and reflected on his own growth as a member of society. "I'm a licensed professional, I have three kids, I own a home... I am respected in the community." For him, these personal experiences further motivate his continued recovery, as the benefits have been both internally and externally gratifying. Bob shared, "I'm learning how to live differently," while reflecting on his experience of making different decisions, attending required appointments, having people rely on him, and being a responsible member of his community during recovery.

Two participants reflected specifically on how their views of themselves as parents and experiences of parenting have changed following their time in active addiction. After describing damage to his relationships with his children during active addiction, Bill shared that in recovery, "I was my son's best man when he got married and I walked the halls with my daughter when my granddaughter was born." For Bill, these experiences represent the depth and significance of the changes he has made in his life, and they motivate him to continue the LTR path. Suzanne similarly disclosed about her own LTR experience, noting, "It is learning how to be a woman and learning how to be a mother... learning how to give emotion," as she lost custody of her daughter and the opportunity to be an active mother during her addiction.

Three participants specifically focused on how their experiences with recovery are further motivated by their ability to engage responsibly and take pride in activities of adulthood and experience a sense of accomplishment as a result. Jack described paying bills on time in early recovery as providing a bigger rush than getting high and went on to say that he, "learned how to… be responsible for myself," which was also identified by Samantha stating "Going to work every day and paying bills. I didn't know how to pay bills; I was in so much debt," when reflecting on the pride she experiences in assuming age-appropriate responsibilities. For many participants, the ability to maintain responsibility for themselves as adults was a new concept that only crystallized once they had entered recovery. Bob shared his pride in maintaining a living space that supports his recovery, noting, "My apartment is actually clean!" with a sense of satisfaction. When the participants experienced intrapersonal changes that resulted in new self-perspectives, they reported an accompanying sense of hope and encouragement, feelings further compounded by the realization that those struggling with addiction can and do recover**.**

Theme 4: Connection is a Thread Throughout Recovery

The final collective theme that presented for six of the eight participants was the importance of interpersonal connection throughout the recovery experience. For these participants, connection was prevalent in all stages of recovery. During the beginning of the recovery process, participants reported that connection served as establishing a sense of belonging. In LTR, the participants described connection as a cornerstone in and benefit of maintaining their recovery status and preventing relapse. Though researchers have long espoused all humans' natural desire to connect with others, participants highlighted how integral personal connection truly is to AOD recovery success.

Bill identified obtaining and maintaining a sense of belonging through his connections to others as motivating his desire to continue with recovery, despite some initial personal hesitancy and suspicion about his ability to be successful. He described how helpful making connections through AA meetings was for him and stated that "…just to hear someone talk about the feelings that I could not put into words" was critical to his own success. Similarly, Samantha reported using her connection with a work acquaintance to make a step toward seeking initial recovery, stating, "I was…

disgusted with myself; I picked up the phone and… was like, I really need to go to meeting." Similarly, Elizabeth reflected on an early recovery experience and what was needed for her to maintain her recovery at the time, noting, "Staying connected, that was a big thing for me at the beginning." According to Elizabeth, being in contact with people who were also seeking recovery, who were abstinent from using AOD, and who were specifically working a 12-step program like her, helped her to find success in her pursuit of LTR.

Taylor spoke of the importance of connecting as well, sharing, "I reach out to [other] people in recovery." She spoke at length about using connection as a strategy for maintaining her recovery, which Bob also described. He specifically focused on personal accountability, noting, "I've learn[ed] [that] to prevent relapse, you got to pick up the phone." Sally shared about being on the other side of the experience at this point, disclosing with pride that, "People reach out to me… and ask me questions" about recovery. She described this connection with others as being an experience isolated to her recovery and one that motivates her LTR success.

Suzanne processed the benefits of recovery and highlighted connection as a personal motivator. She stated, "Recovery is the ability to have relationships again without thinking people have an ulterior motive." Suzanne explained that in addiction, she was hurt by others and that it was hard for her to make personal connections. She shared that her experience in a 12-step program offered the opportunity to build trust and connection with people that did not hurt her, which allowed her for the first time in many years to experience the positive benefits of feeling like she belonged. She noted that these experiences with connection are now generalized throughout her life in recovery.

Theme 5: Idiosyncratic Experiences

The final emergent theme, though it represents differing disclosures from each participant, is that the experience of recovery is idiosyncratic to every individual. Each person who experiences addiction identifies catalysts for change and pursues recovery differently; it is important to note the nuance associated with understanding diverse personal experiences. While this theme is prevalent in every participant's story, three participants explicitly noted individual nuances as a unifying characteristic. Elizabeth asserted, "Everybody's recovery is different," while Jack asserted, "I think multiple things can exist for recovery. There is no clear answer, and we should support anything that works."

The other five participants all disclosed outlier experiences that further emphasized the individual nature of AOD addiction and recovery. One participant, Bob, explained that he was no longer able to get high in a manner that he enjoyed, which contributed to his desire to enter recovery. Samantha explained that her age was a contributing factor in her desire to discontinue drug use and begin the recovery process. She recalled noting to herself, "I am too old for this," when seeing younger females around her in prison which motivated her to discontinue certain behaviors and become a productive member of society. Two participants identified that additional support assisted in their success of LTR. Sally described MAT as her initial method of obtaining recovery and noted that it assisted in resolving some of her mental health concerns and avoiding the physical symptoms of detoxification. In a similar vein, Taylor identified continued counseling support as a significant part of her ability to remain in recovery. She shared about experiencing significant trauma both prior to and during active addiction, and how the counseling process has offered her an opportunity to break related cycles and take accountability for changing her own behaviors.

Discussion

Trauma and Desperation as Entry Points into Recovery

The connection between trauma and addiction is not a new concept; there are many studies focused on how experiences of trauma may be likened to cycles of addiction and how they may, in fact, perpetuate active addiction (Boppre & Boyer, 2012; Langman & Chung, 2013). Keyser-Marcus et al. (2015) found that individuals who struggle with addiction often also struggle with psychiatric comorbidities and experience some sort of trauma both before and during active addiction. While trauma was identified by the participants in this study as a common experience of addiction, many also offered new insight into the ways in which trauma may motivate recovery. Of the eight participants who engaged in this study, six disclosed some sort of traumatic experience that ultimately resulted in their LTR experience.

Current literature highlights a specific link between adverse childhood experiences (ACES) of trauma and substance abuse (Boppre & Boyer, 2021; Hunter, 2016) and specifically Langman and Chung (2013) found that 54% of AOD-addicted participants also fit the criteria for PTSD. Read et al. (2004) highlighted a higher risk of relapse among individuals who struggle with co-morbid PTSD. Despite ample research exploring the compounded challenges associated with dual diagnosis, research highlighting how traumatic events may motivate recovery is lacking. Additionally, while there exists a fair amount of research exploring the use of trauma-informed care (TIC) in AOD addiction treatment (Amaro et al., 2007), there exists little to no research on treating AOD addiction and related experiences as traumatic in and of themselves. Therefore, the concept of how trauma may motivate individuals to enter and progress through the action and maintenances stages of change within the TTM represents a novel finding in the field of AOD treatment.

Morjaria-Keval (2006) found that significant personal events such as deteriorating physical health and compromised relationships provided participants exhibiting problem drinking behaviors a catalyst for initiating the change process. It is possible that individuals were already in the preparation or action stage of change prior to experiencing these significant events; further research should explore how stages of change may be related to catalysts for change. This study aimed to begin that investigation by examining participants' experiences through the TTM lens.

Relatedly, Matzger (2005) found that having experienced a negative personal event during active addiction more than doubled an individual's odds of experiencing sustained remission from problematic drinking. Tuchfeld (1981) discovered that for study participants who were addicted to alcohol, experiencing events described as "humiliating" frequently resulted in moving toward behavioral change. Klingemann (1991) conducted a mixed methods study exploring motivation for change among individuals with problem alcohol and heroin use and found that hitting their personal rock bottom was a common factor for individuals entering the change process. Snook and authors (2023) described rock bottom as a severe difficulty that turns the world upside down, which then causes individuals to question their beliefs and in turn their identity.

These collective findings directly coincide with findings from the present study and highlight the need for continued research on the phenomenon of recovery both entered and sustained. While the concepts of hitting rock bottom and experiencing negative personal events have been previously explored as motivators for change, there exists a gap in specifically understanding definitive *trauma* as a precedent for change. The findings from this study lay a solid foundation on which to continue engaging in relevant exploratory research.

In correlation with the traumatic experiences reported by this study's participants, desperation was identified by five of the eight as another catalyst for change in their experiences of initiating LTR. This finding also aligns with existing literature, which often uses other phrases or words to describe participants' collective sense of desperation; Cunningham et al. (2004) identified the experience as "hitting rock bottom" (p. 365), while Morjaria-Kevel (2006) characterized it simply as encountering a "significant event" (p. 96). Strobbe and Kurtz (2012) noted that for their participants, hitting rock bottom was represented by experiences ranging from alienation to moral and spiritual bankruptcy. The concept of desperation leading to AOD recovery is deeply connected to the concept of trauma leading to recovery. It is important to note that someone may experience feelings of desperation without experiencing trauma and that these concepts require further research to better understand their potential relation to LTR entry and maintenance.

Motivators for Entering and Maintaining Recovery

The second key finding that emerged from collected data combines themes two and three and highlights participants' motivators for engaging successfully in LTR. The link between experiencing consequences and exiting active addiction is not a new concept and is rampant throughout the research on the Behavioral and Moral Models of addiction etiology (Carroll & Onken, 2005; Lassiter & Spivey, 2018). Consequences commonly experienced by individuals in active addiction are often stigmatized and viewed negatively by society, which could be internalized into self-stigma and shame (Israel et al., 2022; Matthews et al., 2017). However, the participants in this study described the ways in which consequences and/or the threat of consequences resulted in positive personal change that

prompted their movement into the action and maintenance stages of the TTM. For example, for several participants, the potential consequence of incarceration served as one primary motivator for their entry into LTR, although other consequences such as losing friends and family members and experiencing homelessness, also factored into their ultimate decisions to quit using.

Three of the four participants who specifically identified experiencing consequences as a significant catalyst for LTR entrance identified the threat of criminal prosecution as the consequence that ultimately motivated their decision to change. Through the lens of the TTM, the participants were externally motivated by the criminal justice system to enter the action stage of change. However, literature identifies that the criminal justice system can incentivize change but is not generally correlated with an individual's *readiness* to change (Alley et al., 2014; Henninger & Hung-En, 2014). For this study's participants who focused on their experiences specifically within the action and maintenance stages, there did exist a correlation between external consequences and their readiness to commit to LTR. This constitutes another novel finding that should be further explored. Gregoire and Burke's (2004) finding that individuals engaged in the criminal justice system during addiction treatment sometimes demonstrate higher levels of motivation directly aligns with the experiences reported by these participants.

While prior research has focused primarily on how individuals in AOD recovery become productive members of society, the findings of this study also highlight the *internal* motivation associated with shifting perceptions of self and assuming increased personal accountability. Existing research indicates that shame about one's addiction can perpetuate the addiction cycle and increase rates of relapse (Flanagan 2013; Matthews et al., 2017). This aligns with present findings and supports the notion that a shift in one's self-perspective and thoughts about the addiction experience can contribute to the maintenance of LTR, representing the final stage described by the TTM.

O'Sullivan et al. (2017) identified self-stigma and abstinence self-efficacy as integral aspects of recovery capital correlated with participants' quality of life in recovery. Recovery capital emphasizes both the resources and barriers that an individual might encounter while seeking LTR (Hanauer et al., 2019). Rotărescu (2017) also found self-stigma and rejection to be associated with active substance abuse, further supporting the concept that individuals' own self-perceptions can help or hinder their recovery efforts. In this study, participants' motivations to remain in LTR, or the maintenance stage, stemmed primarily from their newfound sense of personal identity, and the improved capabilities they recognized within themselves.

Individuals in active addiction rarely live their lives in total alignment with their personal beliefs and values system, and one common goal of treatment is to help them live lives that are congruent and purposeful (McConnell & Snoek, 2018). Koski-Jännes (2002) identified that profound changes in a person's self-concept, values, and personal orientations in life must occur for addiction recovery to be successful. This insinuates that to begin or maintain the maintenance stage of change, a change in self-perspective must occur, as seen within this study. Biernacki (1986) explained that this change in self-perception occurs when one discontinues abuse of AOD and their identities suddenly conflict with what feels acceptable to them in recovery. Participants in this study captured this sentiment in their own descriptions of increased personal accountability and shifting views of self as they navigated the maintenance stage of change.

Connection as a Cornerstone of Long-Term Recovery

Connection was identified thematically for seven out of the eight participants as a catalyst that impacted their recovery at some point along the way. Connection relates to Maslow's (1948) basic need of belonging, which exists as a necessity for many in the early stages of recovery. Contemporary literature defines this as "social capital," illustrating the support that individuals require as they transition from active addiction to the action stage of change (Neale et al., 2018; Wen, 2017). Social capital supports may include family members, friends, neighbors, colleagues, professional contacts, and other allies (O'Sullivan et al., 2017). Developing and maintaining new connections could be viewed as sustained behavioral changes that align closely with processes that characterize the action and maintenance stages of the TTM. McGaffin et al. (2018) found that while support in early abstinence does not necessarily guarantee positive LTR outcomes, consistent

encouragement from a person's social network does result in positive outcomes for mental health. Multiple individuals in this study identified healing from mental health issues as a part of their overall recovery experience and noted the fundamental role that connection played in that process. This signifies the overlaps that exist between addiction, mental health, connection, and recovery as part of the successful LTR experience.

Prior research also supports the notion that connection in early recovery can sometimes be predictive of both treatment outcomes and the quality of one's life following this major personal transition (Best et al., 2011). Rotărescu (2017) found that rebuilding relationships with estranged family members and developing social/communication skills is an essential part of the recovery process. The participants in this study also asserted that calling their 12-step sponsors, talking to others in recovery, and helping others to navigate the transition assists them in maintaining their own LTR status.

It is important to note that personal connections encouraging LTR could be beneficial in any stage of change. For example, Bill disclosed that when his uncle initially offered him a direct connection to a 12-step program, he did not enter recovery, as he was in the pre-contemplative stage of change. He later made use of that connection to help further solidify his recovery in the maintenance stage. Similarly, Samantha was offered a 12-step program connection while in the pre-contemplative stage of change but did not make use of it until post-rehabilitation.

Idiosyncratic Experiences

It is no surprise that a singular experience shared by multiple individuals can affect each person very differently. While collective themes emerged from the present data, it is important to note that the individual differences characterizing addiction and recovery for these participants represent the final key finding. More specifically, three of the participants in this study directly asserted that the process of recovery is inherently different for each individual person, and that what may work for one does not always work for others. The recovery process is one that is multidimensional and, according to Costello (2020), one that consists of seven intertwining subthemes: psychological, spiritual, social relations, physical health, occupational, daily life functioning, and life satisfaction. Given the complexity of recovery and its nuances, it makes sense that individual differences surfaced throughout the exploration of the lived experiences of these eight participants and their motivations for entering and maintaining LTR status. The participants in this study noted repeatedly that recovery is an individual journey, which felt particularly important for them to emphasize. Although there were several identified ties that bound these eight participants together in their experiences of recovery, there were just as many individual nuances that rendered their accounts personal and unique.

Implications

Considering the ever-increasing rates of substance use, abuse, and overdose in the United States, this study's findings are critical to the continued evolution of addiction treatment. With increasingly high rates of relapse and minimal progress in establishing new treatment paradigms, these findings provide useful information for addiction treatment professionals and those who train them. They could additionally inform both AOD treatment planning, advocacy, and reform.

In terms of implications specific to addiction counseling professionals, the findings detailed here denote the importance of not only providing TIC to those in active addiction, but also of considering the ways in which trauma may have prompted clients to seek, enter, and maintain recovery. The experiences shared by these participants could support AOD counselors in reframing their perspectives on clients' recovery needs and challenging their potential biases about how both addiction and recovery manifest. Being aware that trauma may precipitate not only addiction, but also potentially recovery, could change perspectives on how addiction treatment is both designed and implemented.

The American Counseling Association's (ACA; 2014) *Code of Ethics* suggests that advocacy and social justice are integral aspects of a counselor's job. Continuing to explore and publicize the notion that recovery could be prompted by traumatic experiences could encourage treatment providers and managed care organizations to support lengthier treatment with a focus on treating underlying traumas and helping clients to transform them into motivators for LTR. The AOD treatment system continues to experience high rates of

recidivism, which indicates a high need of reformed treatment approaches.

Findings could help counselor educators to better assist trainees in understanding the compounded effects of stigma, marginalization, and discrimination on the AOD recovery process. More specifically, it could be beneficial for counselor educators to develop and maintain access to an instructional manual that highlights the power of language and de-stigmatizes the change process in addiction treatment. Such a manual could enhance counselor training and lead to opportunities for trainees to explore their self-efficacy around providing AOD treatment. For example, the manual could include exercises designed to promote self-reflection as it pertains to the use of representative language and personal biases regarding the process of change, while simultaneously providing content that helps the user to make their practice more inclusive and equitable.

There is a potential implication for exploring the development of substages within the action and/or maintenance stages of change within the TTM. The participants in this study reported several shared nuances in their experiences of entering and sustaining recovery, many of which could be explored as commonalities of both early and long-term recovery. Identifying substages that may exist within the overarching Stages of Change model could provide increased knowledge to counselors and counselor educators about the change process and help them to implement new, substage-specific treatment strategies that may reduce clients' overall risk of relapse.

Lastly, it is possible that clients seeking recovery from AOD addictions could benefit directly from these findings, as experiences of trauma and desperation are further normalized, destigmatized, and acknowledged for their complex impact. Clients may benefit from entering treatment systems in which trauma recovery is emphasized and prior personal experiences are appropriately incorporated into strategies for leveraging motivation. Additionally, highlighting the need to support clients' intentional development of personal connections and supports prior to exiting treatment programs could promote success for LTR.

As educators and treatment providers continue to advance their knowledge and understanding of both addiction and recovery experiences, clients will increasingly benefit from new findings and evolving treatment practices designed to support their success in LTR. Clients and providers may also benefit specifically from the use of client-focused treatment and mindfulness of current stage of change. This finding helps to further awareness that individual nuances may significantly contribute to one's success in obtaining and maintaining LTR.

Recommendations for Future Research

Due to the qualitative nature of this study, the findings described above cannot be further generalized to those beyond this sample. While these findings indicate a potential link between traumatic experiences and one's entry into LTR, further qualitative and quantitative exploration would provide a richer sense of this phenomenon. Also, to best understand any potential correlation, it would be beneficial to include specific demographic populations, including those who presently engaged in treatment modalities such as MAT.

Limitations

There are several limitations to this study that are worth noting. First, all participants engaged in this study disclosed a maximum of two attempts at recovery, which pales in comparison to research that suggests a range of 0 to 100 recovery attempts made by any given individual, with five being average (Depue et al., 2012; Kelly et al., 2019). Second, transferability is limited in this study due to the homogeneity of its participants. All participants identified as being White/Caucasian and resided in the same continental state. Findings of this study do not speak to the specific barriers encountered by and the unique needs of Black, Indigenous, and People of Color (BIPOC), as well as those characterizing other marginalized populations in active addiction and LTR. The third limitation involves the reading level at which the questions were written. Many of the participants disclosed difficulty in understanding the questions and requested their repetition. These challenges in comprehension could have impacted the disclosures provided. Finally, six of the eight participants shared that they are currently working in AOD treatment in some capacity, which may have resulted in biased perspectives on recovery and its antecedents.

Conclusion

The present study explored personal catalysts for change among eight participants currently engaged in LTR from AOD addiction. The findings from their collective interviews indicated a potential connection between experiencing trauma and entering LTR, as well as participants' shared experiences of being motivated into LTR by the threat of various consequences, noting shifts in self-perception that have helped sustain their maintenance of LTR, and observing connection as an instrumental part of the recovery experience. Findings indicated that one's motivators for entering recovery may be influential in their ability to both achieve and maintain LTR. This research highlights both the value and necessity of further exploring catalysts for change among expanded participant samples and provides information that could be beneficial for counselors, counselor educators, and clients alike.

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JPCA Test to Earn CE Credit

Note: Earn 2.0 Free Continuing Education Credits by reading selected articles in this issue. Read the articles identified below and answer 8 of the 10 questions correctly to earn 2 CE credit.

Authenticity in Multiracial Well-Being (pp. 3-14)

1. How many distinct ways did participants identify their racial heritages?
- ☐ a. 52
- ☐ b. 365
- ☐ c. 30
- ☐ d. 5

2. Which factor of authenticity was significantly related to perceived stress for this sample?
- ☐ a. accepting external influences
- ☐ b. authentic living
- ☐ c. self-alienation
- ☐ d. none

3. By what percentage did the multiracial population in the US grow between 2010 and 2020?
- ☐ a. 50%
- ☐ b. 0%
- ☐ c. 300%
- ☐ d. 276%

A Review of Attachment Theory (pp. 15-28)

4. Which of the following is true?
- ☐ a. Attachment styles are universally applicable across culture.
- ☐ b. Attachment styles must be understood and evaluated within cultural context in order to avoid inappropriate pathologizing.
- ☐ c. Attachment styles are always the same regardless of social context.
- ☐ d. Parents who value independence for their children are neglectful and the children develop maladaptive attachment styles.

1. 5. Which of the following attachment styles correspond to infants who exhibit odd, fearful, disjointed, and contradictory behavioral reunion responses?
- ☐ a. Secure
- ☐ b. Avoidant
- ☐ c. Disorganized-disoriented
- ☐ d. Anxious-ambivalent

6. According to Bowlby, what would be the child's response if a situation activates attachment behaviors, and the attachment figure *continues* to be unavailable?
- ☐ a. Protest
- ☐ b. Despair
- ☐ c. Denial
- ☐ d. Resilience

Historical and Contemporary Use of Distance Counseling Services: A Brief Summary (pp. 29-34)

7. What was the first movement toward telephone use in mental health intervention?
- ☐ a. Homelessness prevention
- ☐ b. Suicide prevention
- ☐ c. Domestic violence prevention
- ☐ d. Substance use prevention

3. 8. Wilson et al. (2017) found in their analysis of the Health Care Cost Institute database that what percentage of claims were submitted for telehealth between 2009 and 2013?
- ☐ a. 3%
- ☐ b. 26%
- ☐ c. 47%
- ☐ d. 0%

Personal Experiences with Long Term Recovery:
A Qualitative Exploration of Catalysts for Change
(pp. 35-47)

9. Relapse is a(n)____ occurrence in the AOD recovery process.
- ☐ a. Common
- ☐ b. Unlikely
- ☐ c. Uncommon
- ☐ d. Guaranteed

10. Long-term recovery is characterized by which of the following?
- ☐ a. Inconsistency
- ☐ b. Increased risk of relapse
- ☐ c. AOD use
- ☐ d. Stability

☐ I certify that I have completed this test without receiving any help choosing the answers.

Feedback

Please rate the following items according to the following scale:

5 – Superior 4 – Above Average 3- Average 2 – Below Average 1 – Poor

	Superior	Above Average	Average	Below Average	Poor
The authors were knowledgeable on the subject matter	☐5	☐4	☐3	☐2	☐1
The material that I received was beneficial	☐5	☐4	☐3	☐2	☐1
The content was relevant to my practice	☐5	☐4	☐3	☐2	☐1
This journal edition met my expectations as a mental health professional	☐5	☐4	☐3	☐2	☐1
How would you rate the overall quality of the test?	☐5	☐4	☐3	☐2	☐1

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