2018

EXPLORING THE TREATMENT EXPERIENCES OF AFRICAN AMERICAN SUBSTANCE USING WOMEN AND PERCEPTIONS OF CULTURALLY COMPETENT CARE

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EXPLORING THE TREATMENT EXPERIENCES OF AFRICAN AMERICAN SUBSTANCE USING WOMEN AND PERCEPTIONS OF CULTURALLY COMPETENT CARE

BY

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A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

IN

PSYCHOLOGY

UNIVERSITY OF RHODE ISLAND

2018

DOCTOR OF PHILOSOPHY DISSERTATION

OF

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2018

ABSTRACT

Research continues to suggest that substance use treatment retention and completion presents an ongoing problem, especially among marginalized groups. In particular, African American women have the lowest rates of treatment retention and completion across all substance using groups. While gender and ethnoracial identities continue to be examined in their relation to substance use treatment, these identities are often studied in isolation offering limited information about how intersecting identities impact substance use treatment for African American women. Researchers have commented on the immediate need for research aimed at describing, understanding, and improving treatment for this population. Research using the voices of African American women to better understand treatment experiences is critically necessary to understand how their intersecting identities interact with treatment retention and completion. Understanding their perceptions of culturally competent care could also be used to address their unique treatment needs. The purpose of this study is to describe and examine the substance use treatment experiences of African American women, and qualitatively explore the treatment process for this sample with special attention to the role of cultural competency. This study will address the following research questions: 1) How do African American women describe their experiences in substance use treatment? 2) What is the nature of the relationship African American women have had with their substance use treatment provider(s)? 3) What are the perceptions of a culturally competent provider and to what extent is this valued by African American women receiving substance use treatment?

Participants included six African American adult women ages 30-63 years old, who were currently engaged in formal substance use treatment or have been engaged in treatment within the last year. Participants were recruited from community-based treatment settings including residential, intensive outpatient, and outpatient. Due to the descriptive nature of this study, one to two semi-structured, open-ended interviews were conducted, lasting approximately 60 to 90 minutes each. Data analysis utilized a combined and layered approach that was divided into three steps: observational notes, theoretical notes, and methodological notes. Data analysis focused on developing common descriptions across participants' stories in relation to the above-mentioned research questions. Results and implications are further discussed regarding efforts to improve substance use treatment for African American women.

ACKNOWLEDGMENTS

First and foremost, I would like to thank God for his continued blessings, grace, and provisions throughout this process. I also want to extend a warm thank you to the research participants of this study for their willingness, vulnerability, and kindness in sharing their powerful stories. I am also grateful to my major professor, Dr. Nichea Spillane for her mentorship as I continue to foster and enhance my program of research. I greatly appreciate her efforts in assisting me in completing this project. I would also like to express my thanks to the committee members Dr. Colleen Redding and Dr. Donna Schwartz Barcott for their expertise, enthusiasm, and input. Lastly, I would like to acknowledge Dr. Jasmine Mena for being an amazing mentor throughout my graduate career. You are beyond a great example in scholarship and practice, you are someone I deeply admire and look up to. Thank you for being the representation I needed to see.

I must also acknowledge my family whom have been incredibly supportive throughout this journey. I am forever grateful for their encouragement and love. A special thank you to my parents and siblings. You all taught me to be curious, courageous, and to remain committed to my goals despite adversity. To my network of friends and colleagues- thank you for the motivation and cheerleading that you have provided along the way, it has made all the difference in this process. An extra thanks to Dr. Daphne Cole, Dr. Shayna Bassett, Dr. April Trotman, and Dr. Tasha Brown-your friendship and sisterhood is beyond valuable and I wouldn't have made it through graduate school without you. Thank you all very much for believing in me and my work!

DEDICATION

I dedicate this work to my nephews Jordan Wyatt and Malik Harrison, and to my nieces A'Nya Harrison and D'Airra Wyatt. I am incredibly proud of the young people you are becoming. May you continue to courageously chase your dreams, live in your truth, and demonstrate excellence in all that you do. A new bar has been set for our family, and now I lovingly challenge you to go farther and reach new heights!

I would also like to dedicate this work to my mother, Karen Wyatt. Thank you for teaching me about faith, and not so by lecture but by lifestyle. I am filled with enormous gratitude to have completed the doctoral journey with you by my side claiming victory. Thank you for fostering my love of reading and writing as a young child. My hope is that you too will be able to go forth and accomplish more of your dreams with the same great determination that you have instilled in all your children.

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CHAPTER 1

INTRODUCTION

Substance use remains a costly public health concern affecting individuals, families, and communities. In 2017, the National Institute of Drug Abuse (NIDA) estimated that the nation spends more than $740 billion annually in costs related to substance use treatment, health care, lost work productivity, and crime, making substance use treatment a high priority concern (NIDA, 2017). In 2016, the Center for Disease Control (CDC) reported that 10.6% of persons twelve years and older reported illicit drug use in the last month, which is an increase from the 8.7% reported rate in 2009 (CDC, 2014). Results of the 2014 National Survey on Drug Use and Health indicated that 21.2 million individuals twelve years of age and older needed substance use treatment, however approximately only 12% received treatment (Substance Abuse and Mental Health Service Administration, 2014). For those in substance use treatment, the research continues to show that treatment retention and completion presents an ongoing problem, especially among marginalized groups (Jacobson et al., 2007; King & Canada, 2004; McCaul et al., 2001). For example, women are more likely to terminate substance use treatment early (Arfken et al., 2001; King & Canada, 2004; McCaul et al., 2001) and show more harmful effects of substance use (Curtis-Boles & Jenkins-Monroe, 2000; McCaul, Svikis, & Moore, 2001) compared to men. A growing concern centers on the decreasing numbers of non-Hispanic Black men and women receiving substance use treatment despite no decrease in the rates of those needing treatment (SAMHSA, 2014). While at the same time, treatment rates for non-Hispanic Whites and Hispanics/Latinos

have remained steady or increased (SAMHSA, 2015). Black women in particular have the lowest rates of treatment retention across all substance using groups (McCaul, Svikis, & Moore, 2001; Mertens & Weisner, 2000), underscoring the importance of studying treatment experiences of this vulnerable and underserved population.

One under-developed area of research that could provide insight into improving treatment utilization among marginalized communities is examining the role of intersecting social identities. For example, gender and ethnoracial identities are often examined independently in their relation to substance use treatment (Greenfield et al., 2007). An important factor in improving treatment for individuals with marginalized, and often intersecting identities is implementing culturally competent care practices. SAMHSA has defined cultural competence as an interactive practice that allows clinicians to effectively serve clients of different cultural backgrounds, including but not limited to, race/ethnicity, gender, age, religion, or education (SAMHSA, 2016). The use of cross-cultural counseling skills, combined with providers' cultural knowledge and cultural self-awareness is often included in the concept of cultural competency (Arredondo et al., 1996). Assessing the value and utility of cultural competency in substance use treatment has grown increasingly important in recent years (Burlew, Copeland, Ahuama-Jones, and Calsyn, 2013; Castro and Alarcon, 2002). In a recent meta-analytic review, it was found that providing culturally adapted interventions improved treatment effectiveness across racial groups (Griner and Smith, 2006). Furthermore, research demonstrates that cultural competency promotes the therapeutic relationship and increases treatment satisfaction among African American clients (Constatine, 2007). The therapeutic alliance is of great importance as it consistently

predicts treatment retention and satisfaction among both racial/ethnic groups and substance users (Cournoyer, Brochu, Landry, & Bergeron, 2007; Coonor et al., 1997; Constatine, 2002). The therapeutic alliance has also been shown to impact a woman's decision to stay engaged in substance use treatment (Lewis, 2004; Marsh, Shin, & Cao, 2010). While this is an important area, there has only been one study that specifically focused on cultural competency and the therapeutic alliance in African American substance using women. Davis, Ancis, and Ashby (2015) found that a therapist's demonstration of cultural competence explained additional and significant variance in the therapeutic alliance among African American substance using women. These findings highlight that even after controlling for general therapist characteristics (e.g., empathy, regard, and genuineness), cultural competence (e.g., cultural self-awareness, cultural knowledge, and cross-cultural counseling skills) is an important therapeutic factor in substance use treatment for this population. As noted above, Black women have the lowest rates of treatment retention across all substance using groups (McCaul, Svikis, & Moore, 2001; Mertens & Weisner, 2000), therefore continued research efforts are necessary to improve the clinical experiences, including treatment engagement and retention among this population, and to further explore the role of cultural competence in treatment.

The use of highly addictive substances (Stahler, Kirby, & Kerwin, 2007), and higher rates of traumatic events related to substance use (Curtis-Boles & Jenkins-Monroe, 2000; CDC, 2008), combined with higher rates of treatment attrition in comparison to other groups (McCaul et al., 2001; Mertens & Weisner, 2000, Scott-Lenox, Rose, Bhling, and Lennox, 2000), underscore the importance of efforts to better understand and

improve treatment for African American women. The intersection of race/ethnicity, gender, and clinical presentation may indicate how combined social identities demonstrate unique treatment needs and influence treatment experiences. Current research identifies factors that influence substance use treatment initiation, retention and engagement among African American women, however more is needed to better understand the actual treatment process for this population. Gaps in the current research literature highlight the need to describe treatment experiences, and to do so using the voices of African American substance using women. Centering the voices of this population provides a platform to incorporate their input on what is best for their treatment. Additionally, research is needed to explore their perceptions of culturally competent care and its impact on substance use treatment. The purpose of this study is to qualitatively address these identified literature gaps. This study will address the following research questions: 1) How do African American women describe their experiences in substance use treatment? 2) What is the nature of the relationship African American women have had with their substance use treatment provider? 3) What are the conceptions of a culturally competent provider and to what extent is this valued by African American women receiving substance use treatment?

CHAPTER 2

REVIEW OF LITERATURE

Risk Factors for Substance Use Among African American/Black Women

Substances that are most prevalent among African American/Black women include crack cocaine, heroin, alcohol, and marijuana (Keen, Whitehead, Clifford, Rose, & Latimer, 2014; Curtis-Boles & Jenkins-Monroe 2000; Stahler, Kirby, & Kerwin, 2007; Roberts & Nishimoto, 2006). Of note, the subsequent discussion of research findings will use the original language of the authors in describing ethnoracial/racial identities (i.e. African American or Black). In some studies ethnic identities are specified, while in others the terms African American and Black are used interchangeably. One study comparing substance using and non-substance using low-income Black women, suggested several risk factors for substance use, including: lack of consistent support, absence of spiritual foundation, early drug use onset, and absence of supportive family relationships (Curtis-Boles & Jenkins-Monroe 2000). Other risk factors among Black women include parental substance use, and childhood physical and sexual abuse (Boyd, 1993). In fact, lifetime trauma has been identified as a critical risk factor for this population. A qualitative study of substance using Black women found that participants reported histories of sexual and physical abuse, as well as childhood neglect (Davis, 1997). This finding is consistent with Ross-Durow and Boyd's (2000) research which identified that 61% of the substance using Black women in their study reported histories of sexual abuse. Overall stress, stressful life events, and coping with difficult life

circumstances are other factors that have been associated with substance use and relapse among African American/Black women (Taylor & Jackson, 1990; Allen, 1995, Grary & Littlefield, 2002). Current research suggests that substance use among Black women often include substances that are highly addictive and have a high risk for overdose (Stahler, Kirby, & Kerwin, 2007). Previous research has also documented that Black women experience a greater occurrence of substance use risk factors (Curtis-Boles & Jenkins-Monroe, 2000), as well as lower substance use treatment retention (McCaul et al., 2001; Mertens & Weisner, 2000). This combination of factors suggests that African American/Black women may have different or unique treatment needs that need to be addressed.

Consequences for Substance Use Among African American/Black Women

Substance use in this population has also been associated with serious medical/health and social consequences (Boyd, Mackey, Phillips, & Ravakoli, 2006). One of the most devastating health consequences of substance use is HIV acquisition through injection drug use. The Center for Disease Control (CDC) reported that 8% of new HIV infections were attributed to injection drug use (CDC, 2015). Data from the same CDC report indicate that African American women represent 46% of these new cases. Injection drug use that leads to HIV infection compromises the health of these women and further contributes to HIV being the leading cause of death for young Black women (CDC, 2008). Relatedly, research has shown associations between risky sexual behavior and history of sexually transmitted infections (STI) among substance using African Americans (Pacek, Malcolm, & Martins, 2012). Seeing how substance use alters cognition and functioning while under the influence, women are at a heightened risk for

STI infection, while engaging in substance use. Additionally, substance using African American women are at an increased risk for developing alcohol-related disorders and cardiovascular disease (D'Avanzo, Dunn, Murdock, & Naegle, 2001) as a result of their substance use.

Other consequences are often seen in more social context, for example substance using African American women are more likely to have interactions with child and family services resulting in their children being removed from their care, when compared to other groups (Wallace, 1990). This type of potential legal involvement could prevent women from connecting with prenatal care services or substance use treatment. In fact, researchers found that African American substance using women often delay prenatal treatment (Barroso & Sandelowski, 2004) having critical impacts for both the mother and the child. Barroso and Sandelowski (2004) also found that active engagement in substance use compromises the quality of the mother-child relationship among African American women, putting mothers at increased risk of losing custodial and parental rights due to the severity of their substance use. Furthermore, research has shown that homelessness and prostitution are observed consequences among African American women substance users (Carroll & Trull, 2002). This is of particular interest seeing that engaging in prostitution could serve as financial or relational access to substances; however, such activity likely impacts negative sexual health outcomes as discussed above. The consequences outlined above are worth consideration when working with this population given their complex presentation, as well as highlighting the need for improved substance use treatment for African American women given the severity of these associated consequences.

Racial Differences in Substance Use Treatment

The treatment process is comprised of elements that impact initiation, engagement, and completion. The current literature base has noted racial and ethnic trends regarding each of these elements in substance use treatment. Treatment initiation is perhaps one of the most important markers of the treatment process as it demonstrates awareness for treatment need, however disparities in rates of initiation highlight concerning ethnoracial differences have been found (Acevedo et al., 2012). For example, in a study assessing racial and ethnic differences in substance use treatment initiation and engagement patterns, African American men and women were least likely to initiate substance use treatment compared to White and Native American participants (Acevedo et al., 2012). There are also noted racial differences in types of treatments that individuals choose to engage in. For example, Perron and colleagues (2009) found that those identified as non-Hispanic Black, as compared to White, were more likely to engage in more informal service types such as, 12-step meetings/programs and seeking help from their clergy. Whereas those who identified as non-Hispanic White were more likely to use professional evidence-based treatment services for substance use (Perron et al., 2009). This suggests that Black clients may be more likely to engage with non-professional providers or providers who may better understand their cultural identity.

Other important elements in the treatment process are retention and completion. Treatment retention is defined as the duration of time in treatment from initiation to completion (Roberts & Nishimoto, 2006). Treatment retention and completion are associated with positive outcomes (Henskens et al., 2005), and improved family relations (Hser, Evans, & Huang, 2005), however completing substance use treatment is often

difficult to accomplish (Dobkin, De Civita, Paraherakis, & Gill, 2002). More specifically, rates of treatment completion are especially low among Black substance users (Jacobson, Robinson, & Bluthenal, 2006). Furthermore, results from two clinical trials identified that African American participants completed fewer days of substance use treatment compared to those who identified as White, despite similar treatment expectations (Milligan, Nich, & Carroll, 2004). Some factors which may help explain the lower treatment completion rates include that African Americans in this study were more likely to use highly addictive substances, as well as more likely to experience employment problems. These observed racial differences at various stages in the treatment process, combined with research on barriers for completion among marginalized groups, supports the need to improve substance use treatment in efforts to eliminate current treatment disparities. The present study aims to better understand the treatment process for substance using African America women, and the multifaceted challenges that it presents.

Gender Differences in Substance Use Treatment

Historically, the substance use literature has primarily focused on treatment trends and outcomes among men, with little attention to gender differences. Recent shifts in research to include women have allowed researchers to identify gender differences in substance use and treatment outcomes. Research has found that women are at an increased susceptibility for adverse medical, social, and psychiatric consequences related to substance use (Chatham et al., 1999; Gentilello et al., 2000; Heskens et al., 2005). Research has also found that women progress more rapidly in their severity and quantity of use (Hernandez-Avila et al., 2004, Smith & Weisner, 2000), and are less likely to enter treatment over their lifetime (Greenfield et al., 2007) compared to men. When women do

decide to enter treatment, it is likely to be for mental health difficulties and not substance use (Greenfield et al., 2007). Reasons for lower substance use treatment entry among women include perceived social stigma, lower social support, economic inequalities, and educational disparities (Greenfield et al., 2007). Among women, Black women in particular appear to have the lowest treatment retention rates when compared to women from other racial/ethnic groups (McCaul et al., 2001; Scott-Lennox, Rose, Bohlig, & Lennox, 2000; Mertens &Weisner,2000). However, the reasons for why these differences exist are not yet clear, suggesting that more research is needed to better understand the cumulative risks, progression, and characteristics of substance use among this population, in efforts to avoid negative outcomes.

Substance Use Treatment Barriers Among African American/Black Women

Guerrero and colleagues (2014) found that Black women, in comparison to Black men, were less likely to engage in outpatient substance use services, received fewer counseling sessions, and reported greater substance use after treatment. This suggests that there may be important barriers that Black women face in comparison to Black men. Identifying treatment barriers is critical so that they can be addressed in efforts to make treatment more accessible. In a community-based sample of illicit drug using African American men and women, researchers found that women were more likely to report intrapersonal barriers to treatment such as “can handle it alone”, “don’t have a problem”, “and no need to stop” (Keen, Whitehead, Clifford, Rose, & Latimer, 2014). A treatment barrier that is recurrent in the literature among African American/Black women is their parental role or concerns about childcare. This is of particular interest for African American women considering the historical meaning of family for this community and

the high sociocultural value placed on women as mothers, and the stigma associated with substance using mothers (Curtis-Boles & Jenkins-Monroe, 2000). Furthermore, motherhood is highly valued in African American communities, may provide a source of resilience, and often represents a symbol of "hope" for Black women (Collins, 2000). Given this historical meaning and importance of Black women to their families, substance use places an additional burden on an already disenfranchised community that relies heavily on collectivism. While substance use may be one way to cope with the stressors associated with being primary providers, these cultural factors may also compete with the need for or interfere with Black women's engagement in substance use treatment due to the increased importance of and responsibility to the family.

While some women in this population were motivated by their parental role to seek services (MacMaster, 2005), other women refused treatment due to fear of forfeiting parental duties. In a sample of African American women cocaine users, treatment facilities were deemed "inaccessible" if facilities did not offer childcare (Brown, Hill, & Giroux, 2004). Similarly, Roberts and Nishimoto (2006) found that lack of childcare was a frequently reported treatment program barrier among post-partum African American women seeking substance use treatment. Social support is an integral factor in the substance use treatment process and the lack of support has been identified as a treatment barrier. Supportive networks often provide women with opportunities to engage in communities of recovery, providing a healthy alternative to their previous communities of using and addiction (Harris, Fallot, & Berley, 2005). Cooper et al. (2014) found that Black women were reluctant to initiate or complete treatment due to concerns about their romantic partners. Some women expressed concern about their partners engagement in

drug related or criminal activities while they were in treatment, while other women expressed concerns about their own treatment and recovery success if they had partners who were unsupportive and/or still active in addiction. Without such social support, initiating or completing substance use treatment can be more difficult (Guzman et al., 2006).

Black women have identified shame and fear as a major barrier for initiating and engaging in substance use treatment (MacMaster, 2005; Allen, 1995). Among Black women, shame about engaging in substance use has the potential to manifest and be projected as denial for needing treatment (Keen, Whitehead, Clifford, Rose, & Latimer, 2014). Black women seeking treatment may fear judgment by others upon treatment initiation, or throughout the treatment process. Additionally, there may be fears of the negative perception of re-engaging in treatment after resumed substance use (MacMaster, 2005). In a qualitative study exploring Black women's treatment experiences, perceived stigma was described as a barrier to treatment, especially in interactions with treatment providers (Guzman et al., 2006). Perceived stigma from providers resulted from the intersection of marginalized identities of being Black, a woman, and a substance user. Perceived stigma likely contributes to the quality of the therapeutic alliance as it interferes with the ability of the client and clinician to create an effective bond and collaboratively address treatment goals (Bordin, 1979; Meier et al., 2005, Constatine, 2007). Previous research has highlighted the importance of the therapeutic relationship with substance using Black women in treatment (Davis, Ancis, & Ashby, 2015). In fact feeling connected to a treatment provider has been identified as a predictor of treatment satisfaction for substance using African American women (Lewis, 2004). Researchers

have stressed the importance of further identifying therapist characteristics, such as cultural competency, that are significant in developing a positive alliance with substance using African American women in hopes to improve treatment retention and efficacy rates among this underserved population (Norcross & Lambert, 2011; Davis &Ancis, 2012; Davis, Ancis & Ashby, 2015). The treatment experiences of substance using Black women are layered and complex in nature, and a greater understanding of these experiences, especially as they relate to cultural identities, is imperative in improving treatment engagement, retention, and efficacy.

Substance Use Treatment Efficacy

Approaches to intervention are limited for substance using African American women and are in need of continued research efforts to improve outcomes for this population. Early efforts to improve treatment access and outcomes looked to both feminism and Afrocentric theory for guidelines. Rhode and Johnson (1997) discuss the need for using the feminist model of therapy to treat African American women struggling with substance use, highlighting their social and environmental contexts. They further suggest that the medical model for treatment decontextualizes the lives of African American women, offering a limited understanding of factors that cause and support their addiction. Roberts, Jackson, and Carlton-Laney (2000) also call for the need to integrate Black feminist theory and Afrocentric theory into treatment for substance abusing African American women. Researchers suggest that the use of these theoretical perspectives in the treatment help to create and utilize culturally sensitive interventions for this group. To date there are only a few treatment approaches that have been designed and show promising results for African American women. For example, 'Bridges to the

Community' (Stahler et al. 2005) is a community-based intervention for homeless, cocaine-using African American women that integrates peer support/mentor services provided by local church members into a residential substance use treatment program. When compared to a standard treatment program, the Bridges Program demonstrated greater treatment retention, reduced substance use at follow-up, higher rates of treatment satisfaction, decreased depressive symptoms, and decreases sexual risk-taking behaviors (Stahler, Kirby, & Kerwin, 2007). Other programs designed for African American substance using women such as The Treatment Access Project also utilized community-based approaches to boost treatment effects (Opaku, MacMaster, Dennie, & Tolliver, 2008). This project incorporated African American women currently in recovery to engage in community outreach services and assist women in initiating treatment, which has been reported to be helpful, however treatment outcomes have yet to be published. While this model for treatment access and treatment initiation does show some promising results, empirical research is needed to assess its efficacy in improving treatment retention and completion. For substance using African American women, treatment approaches that go beyond the general use of gender-responsive treatment, and include culturally congruent skills and strategies need to be created, implemented, and further examined in efforts to improve the treatment experiences of this population.

Purpose of the Study

The current research on racial/ethnic and gender disparities to better understand the experiences of substance using African American women is limited (McCaul, Svikis, & Moore, 2001). Research aimed at better understanding treatment retention is desperately needed for African American women given that their treatment completion

rates are lower than those of any other group (Mertens & Weisner, 2000). Specifically, qualitative research offers a method to further examine the treatment process for substance using African American women in efforts to improve treatment engagement and retention. Given that social and cultural variables influence substance use among African American women (Grary & Littlefield, 2002), effective substance use treatment for this population must be culturally relevant and appropriate. However, the current literature does not offer enough perspective on how cultural competence may influence the substance use treatment process among African American women. Previous research has provided limited insight into the lived experiences of substance use treatment for African American women, specifically as it relates to their relationship with the treatment providers, and the impact, if any, that cultural competency has on this relationship.

The purpose of this study is to describe and examine the treatment experiences of African American women who have a history of substance use and are currently engaged in professional substance use treatment, or have been engaged in the last year. While there are many persons of African descent in the United States that racially identify as Black, not all identify as African American due to ethnic or cultural differences. Such groups include those who identify as Caribbean, West Indian, Afro-Latina, or persons from continental Africa. While the term Black has often been used interchangeably with African American in previous research, this does not acknowledge the unique and vast intra-group variations and instead views/treats Black people as a monolithic group. For the purposes of this study, the term African American, rather than Black, is used to specify the ethnic, racial, and cultural group similarities of the participants. The study aims to describe the treatment process for this sample while specifically exploring the

role of cultural competence in their substance use treatment experiences. Collectively these research goals seek to better understand efforts needed to increase both engagement and retention among African American women in substance use treatment. The present study is informed by the aforementioned literature review and seeks to answer the following research questions:

1. **How do African American women describe their experiences in substance use treatment?**

2. What is the nature of the relationship African American women have had with their treatment provider?

3. What are the conceptions of a culturally competent provider and to what extent is this valued by African American women receiving substance use treatment?

CHAPTER 3

METHODOLOGY

Research Design

The present study was conducted by implementing a qualitative approach to explore experiences and descriptions of substance use treatment among African American women. Given the dearth of current literature regarding African American women in substance use treatment, qualitative research methods can best illuminate the experiences of this population in efforts to inform future research seeking to improve treatment effectiveness. This study was designed to be exploratory and descriptive in nature utilizing qualitative methods to guide both data collection and analysis. In-person interviews were used to explore the lived experiences of participants related to their substance use treatment, clinical relationships, and perceptions of culturally competent care. Fontana and Frey (2000) describe the interview method as an interactional encounter that is both dynamic and interpersonal in nature. Interviews were audio taped and transcribed for data analysis. The interview data were analyzed to identify common descriptions and patterns across participants' accounts and experiences, as they aligned with the three research questions.

The qualitative approach utilized in the present study sought to describe the substance use treatment experiences of African American women, allowing both the researcher and participant to engage in an active process of exploration and constructing knowledge. Although qualitative methods have been viewed as having less scientific rigor than quantitative methods in psychological research, there are distinct advantages of

utilizing a qualitative approach to answer the research questions for the present study. First, exploring the lived accounts of African American women in substance use treatment is largely absent from the current literature. As outlined above, this population continues to demonstrate higher rates of substance use treatment drop-out, and qualitative methods can assist in better understanding this pattern. Secondly, the use of qualitative methods can assist in exploring the concept of cultural competence by utilizing the voices of research participants, shifting the power dynamic from the researcher to the consumer. This shift allows for a potentially more comprehensive understanding of cultural competence as it relates to African American women in treatment. Lastly, qualitative methods provide an opportunity to explore the intersections of gender, ethnicity, and cultural identifications for this group, as well as to identify novel constructs that may surface during the research process by participants. This is of particular importance because the use of qualitative methods in the present study can be used to inform future quantitative research, such as measure development.

Participants and Setting

The participants for this study consisted of those who self-identify as a woman and as African American. All participants were eighteen years of age or older, with a self-reported current or past history of substance use. Specifically, the target population for this study were women who are currently engaged in professional substance use treatment or have engaged in treatment within the last year. Additional inclusion criteria required that participants were able to understand, read, and speak the English language. Women were excluded from participating in the research study if they were pregnant. Women were also excluded if they self-identified as Black Hispanic or Multiethnic.

A convenience sampling approach was used to enroll participants in the study based on specified inclusion criteria. Participants were recruited from community-based substance use and mental health treatment centers in a Northeastern city. Recruitment materials were circulated by the researcher in these settings (See Appendix A). Recruitment materials provided information about the study, eligibility criteria, participation requirements, and researcher contact information. Clinical staff and treatment providers at the community clinics were provided with information about the study, researcher contact information, and recruitment materials to distribute, per their discretion. Potential participants were able to contact the researcher via phone or email to schedule the phone screening to assess for eligibility. In addition to circulating recruitment materials at community-based clinics, the researcher also actively recruited participants in the waiting areas/rooms of community-based treatment centers and conducted in-person eligibility screenings.

Participants responded to a set of demographic questions during recruitment to determine eligibility. Demographic questions captured participants' age, race, ethnicity, and current treatment status. Once participants were deemed eligible, information about the purpose and design of the study, participant expectations, and information about compensation was provided. The researcher also described the risks and benefits related to participation in the study. Once eligible and individuals expressed interest in participating in the study, interview dates and times were arranged between the primary investigator and participants. Interviews were conducted at a mutually agreed upon location that allowed for both convenience and confidentiality. Participant recruitment

continued until saturation was reached, the point at which no new information was learned or added.

Interview

Participants engaged in an in-person, semi-structured, in-depth interview. Fontana and Frey (2000) describe the interview method as an interactional encounter that is both dynamic and interpersonal in nature. This qualitative approach allowed both the researcher and participant to engage in an active process of exploring and constructing knowledge. Conducting in-person interviews, compared to phone interviews, allow the researcher and participant to establish rapport and trust, providing the participant more ease and comfort throughout the interview process. Additionally, an in-person interview gives the researcher access to visual cues and behavioral observations, such as body language, that are displayed throughout the interview process. Attention to such cues and observations can complement participant verbal responses during the interview process and are utilized during data analysis (Sturges & Hanrahan, 2004). Utilizing a semi-structured interview approach allowed for openness and flexibility (Kvale, 1996) throughout the interview process for both the researcher and participant to explore meaningful experiences related to the research questions. Utilizing a descriptive qualitative approach assisted in creating a comprehensive summary of descriptions and experiences from the voices of the participants (Sandelowski, 2009). Lastly, this semi-structured, open-ended qualitative approach also allows the researcher to capture and better understand the behaviors or processes of the interviewee.

The purpose of the semi-structured, in-depth interview was to obtain information about participants substance use treatment experiences, and information about the

meaning they attached to their experiences (Siedman, 2006). The semi-structured approach ensured all participants received a set of predetermined interview questions, in addition to follow up and clarifying questions that were needed for some participants. The interview guide (see Appendix C) included questions prepared in advance focused on treatment experiences as well as additional prompts to elicit more information from participants to increase understanding of their experiences (Polit & Beck, 2008).

The interview guide utilized in the current study was created and implemented to provide a general focus for the interview process and assist the researcher in gathering information related to the research questions. The use of follow- up and clarifying questions were critical in best capturing participant experiences and descriptions, however the researcher was careful to avoid imposing personal interests on the experiences of participants. In an effort to balance the inherent power dynamic present in research, and to center the voices of participants, the researcher was cognizant to allow participants to give their accounts in full detail, with little interruptions from the researcher, essentially taking a more observant stance of intent listening (Raheim et al., 2016; Kvale & Brinkham, 2009; Lincoln & Guba, 1985). Moreover, the researcher made best attempts to adhere to qualitative interviewing techniques such as, the use of follow-up questions, asking participants for specific details, eliciting concrete examples, utilizing open-ended questions, and avoiding leading questions (Seidman, 1998). Lastly, the researcher concluded each interview with the question, "Is there something that I have not asked you, that would be important in best understanding your substance use treatment experiences?" to allow participants the opportunity to share additional information that the researcher had not yet obtained.

Data Collection

Prior to the execution of the present research study, the University of Rhode Island Institutional Review Board (IRB) approved the following procedures for human subjects protections. Written informed consent (see Appendix B) was obtained from each participant prior to engaging in the interview process. During the consent process, participants were made aware that their participation was voluntary and that they may withdraw their participation in the study at any time without penalty. Since the present study involved the use of audiotape recording during the interview process, participants were made aware of this feature and provided additional consent for the use of audio recording during the interview process. Participants were informed of the procedures and measures that were being taken to maintain their confidentiality in the study, especially as they related to the audio recording and transcriptions. Once participants confirmed their interest in participating, written informed consent was obtained. Before the interview process, each participant received a signed copy of the consent form. After the consent procedure participants were required to choose a pseudonym that was used for the remainder of the study and for data analysis.

Due to the descriptive nature of this study, each participant engaged in one or two in-person interviews that lasted 60-90 minutes in length. Since the current study aimed to encourage women to describe their substance use treatment experiences in narrative form, a second interview provided the opportunity to share multiple experiences. A second interview was also scheduled if there was not enough time allotted in the first interview to address all the questions on the interview guide or if clarification was needed. During the interview process, participants were prompted to respond to questions aimed at

exploring experiences of substance use treatment episodes, nature or quality of the relationship the participant has with her treatment provider, and the participant's conception and value of culturally competent substance use treatment. An interview guide was used to provide the researcher with guidance throughout the interview while also allowing flexibility that does not interfere with the flow of the interview. See Appendix C for the complete interview guide. The interview guide consisted of both grand tour and mini tour questions (Spradley, 1979) to further guide the interviewing process. Grand tour questions aimed to encourage participants to describe extensively and openly about their experiences. Mini tour questions were more probe-like in nature, aimed to encourage participants to describe more detailed experiences such as thoughts, feelings, and the meaning they made of their experiences. Prior to the interviews, the primary researcher shared the interview guide with committee members who have experience working with substance use and multicultural populations to ensure culturally sensitive and non-judgmental language was used. In efforts to validate participant responses, the researcher utilized member checking throughout the interview process. Member checking is a qualitative research technique used in data collection to validate participant responses and improve the credibility of the study. Member checking allows the researcher to clarify participant responses to obtain the most accurate description of the participant's account. Field notes and participant observation notes were also taken by the researcher for each participant to make note of behavioral observations during the interview. Observation notes were used in efforts to log key words/phrases participants used for the researcher to obtain a clearer understanding of the language used when

describing treatment experiences. Lastly, observation notes informed subsequent interviews to assess for similar experiences across participants.

At the completion of the interview process, additional participant demographic and personal background information was collected (see Appendix D). Additional demographic questions captured participants' current relationship status, parental status, highest level of education, and employment status. Participants also responded to personal background and treatment questions at the end of the interview process. These questions gathered information regarding participants' age of first time illicit substance use, current tobacco use, current substance use treatment status and setting, primary substance of choice, and longest period of maintained abstinence. For participants not currently in treatment, they were asked about their time last treatment episode and how long they were engaged in treatment. This structure of data collection was chosen purposefully to establish rapport and comfort with participants prior to gathering personal background information. This structure also assisted in avoiding the use of close-ended questions early in the interview process. The risk of beginning data collection with close-ended questions is that it can quickly establish a response pattern of one-word answers or short descriptions, which may hinder later conversations between the researcher and participant (Kvale, 1996). After all the data was collected, each participant was compensated with ten dollars for their time and participation in the study.

After each interview all interview data was transcribed by the primary researcher, with assistance from an undergraduate research student. Each transcript was checked for accuracy and prepared for analysis by the primary researcher prior to conducting the subsequent participant interview. This was done to ensure that each participant fully

addressed the research and interview questions and no further clarification was needed. For every hour of interviewing, three to five hours was needed for transcription and editing. This approach to data collection allowed the researcher to learn of specific terms and/or experiences that could be used to inform the following interview. The interviewing, transcription, and initial date review procedures lasted two to three weeks for each participant. To further protect participant privacy and confidentiality, all written transcripts, interview notes, and audiotapes tapes were kept in a locked file with access only by the primary researcher. All electronic data was password protected and encrypted and could only be accessed by the primary researcher and members of the research team.

Data Analysis

Quantitative data were analyzed descriptively to understand the demographic and personal background characteristics of the sample. A qualitative, descriptive analytical approach was utilized in the current study to analyze the interview data. Qualitative data preparation included the verbatim transcription from the audio taped interviews. Following transcription, data were cleaned to eliminate all possible participant identifiers and using the chosen pseudonyms to ensure participant confidentiality. After transcription and editing were complete, the primary researcher conducted several readings of each transcript with the use of the audio recording to ensure accuracy of the transcript.

This study utilized a combined and layered analytical approach for the qualitative data that is divided into three steps: observational note, theoretical note, and methodological note. As previously stated during the interview, the primary researcher took field notes and written observations throughout the interview process for each

participant (observational note). When a second interview was conducted, transcription of the first interview was completed (observational note) and checked for accuracy. Upon the completion of each interview the researcher logged reactions and impressions about the interview, the participant, and the research interaction that was conducted (observational note). Theoretical notes also included original languages and phrases, experiences, and questions that would inform subsequent interviews. An interview summary was created for each participant that was informed by field observations, the audio recording, and transcript (theoretical note). Summaries reflected participant actions, thinking processes, and emotional experiences as captured in the interview. Summaries also included the researchers' general impressions of the participant and the interview (theoretical note). In preparation for upcoming interviews the researcher adjusted the current interview guide adding mini tour questions that were repeatedly mentioned in previous interviews (methodological note). Upon completion of all interviews, the primary researcher reviewed each transcript individually, and in full detail to reflect upon what was learned about the research questions and how the described experiences compare to the current research literature (theoretical note).

Given the layered data collection and analysis approach, each participant required approximately three weeks of individual time for analysis. During the individual analysis of each transcript, the primary researcher became familiar with the data by engaging in repetitive review and readings of the transcriptions. In combination with the layered analytical approach outlined above, content analysis was employed to further analyze the data based on the three identified research questions. Graneheim and Lundman (2004) define content analysis as a systematic and dynamic approach for analyzing interview

data. Content analysis also allows for flexibility as an analytical approach to interview data (Cavanagh, 1997). When using content analysis, data is broken down into smaller units, coded, and grouped together under shared concepts (Graneheim & Lundman, 2004). Prior to coding, each interview was read through numerous times to obtain a sense of the participant and the whole interview. Through the continuous reading and listening of participant experiences, the primary researcher identified and coded recurrent descriptions and patterns within the data about the accounted treatment experiences. Phrases and units of sentences were identified and labeled to capture key concepts, creating the initial coding scheme (Graneheim & Lundman, 2003; Hsieh & Shannon, 2005). Meaningful text was given a code to summarize the description of the text. These meaningful units and codes were directly applied to one of the research questions, given the context of the topic area. A member of the committee with expertise in qualitative data assisted in coding, comparing codes with the primary researcher and discussed until agreement was met. Manifest content analysis was used which relied on the visible and obvious text and meaning (Graneheim & Lundman, 2004). This approach avoids deeper interpretations of the text that goes beyond what the participant directly described. Therefore, the researcher is only pulling meaning from the emerged data that is obvious and clear in description. Codes that were created from emerged patterns allowed for constant comparison between and across participants, as well as across experiences (Charmaz, 2000). This approach to analysis also allowed for identification of contradictory codes across participants and experiences. Coded descriptions and experiences were categorized by research questions and used to draw conclusions about treatment experiences across the entire sample (Graneheim & Lundman, 2004). When

fresh insights were no longer experienced, theoretical saturation was reached and concluded the data analysis phase. To ensure that theoretical saturation had been achieved, the primary researcher re-examined all interview transcripts, field notes, and interview summaries to confirm that participant experiences and descriptions were accurately reflected in the analysis (Bowleg, Lucas, & Taschann, 2004). Throughout the analysis, all ethical considerations were taken to maintain the privacy of participants and the validity of their interviews. Qualitative findings are presented organized by research question, providing descriptions and responses and utilizing participant quotations to augment the results (White & March, 2006).

Trustworthiness

Research is often measured and evaluated by the quality of the methods, procedures, and product. Trustworthiness is a critical component in conducting and reporting qualitative research. Establishing trustworthiness in qualitative research is related to research quality and rigor. Lincoln and Guba (1985) identified four criteria to be used for qualitative research in efforts to establish trustworthiness of the data: credibility, transferability, dependability, and confirmability. The criterion used for evaluating research findings increases the probability that trustworthiness of the data will be established. Credibility is described as the focus of the research and how well the research question, data, and analysis attends to the intended focus (Graneheim & Lundman, 2004). Credibility refers to the complexity of the research findings and the ability to accurately represent the experiences of participants from a variety of perspectives. Transferability is described as the ability of the findings to be transferred or generalized to other similar groups. To ensure transferability, clear and distinct

descriptions of the culture, context, selection, and characteristics of the participants is critical. Similar to transferability, dependability is related to the consistent execution of the research methods and consistency in findings over time. Lastly, confirmability relates to the neutrality and objectivity of the data (Beck, 1993). To demonstrate trustworthiness was established in the present study, participants were carefully screened for eligibility to guarantee their experiences were aligned with the research questions. During the data collection phase, an interview guide and schedule was used with each participant to ensure consistent execution of methods. Additionally, the primary researcher established credibility through the use of member checks throughout the data collection phase to gain clarity of participant responses. During data analysis, consultation with an experienced qualitative researcher was used to enhance trustworthiness of the findings. Through consultation the primary researcher was able to both debrief about processes as well as seek agreement in interpretations of participant responses. Also, in efforts to increase trustworthiness specifically related to credibility and transferability, participant quotations are identified and presented in the findings to illustrate representation in the data. To decrease bias and interference with analyses, the primary researcher documented personal reactions and reflective notes after each interview. Lastly, trustworthiness of the data was established with the use of an audit trail, having an additional researcher observe and monitor research procedures throughout the duration of the study.

Ethical Concerns in the Current Study

Prior to presenting the research findings of the current study, the use of qualitative research and the responsibility of representation should be discussed. Fine, Weis, Wessen, and Wong (2003) have suggested that qualitative researchers have a

responsibility to reflect on their personal positioning in relation to the research they conduct. This is rooted in the belief that research is both personal and political, carrying value for researchers, participants, and consumers. Moreover, researchers approach their work with working assumptions, beliefs, and ideals that have been informed by lived experiences and value systems. Given that qualitative research is an interactive process in which the researcher is tasked with interpreting text and participants experiences (Sword, 1999), it is deemed critical for the researcher to identify his or her values and identities. In fact, researchers have referred to this process as an "ethical injunction" considering that such positioning can influence data interpretation (Fine, Weis, Wessen, & Wong, 2003). Therefore, before presenting the results, certain ethical concerns are addressed. As suggested by Sword (1999) and Fine, Weis, Wessen, and Wong (2003) the primary researcher has reflected on personal experiences, perceptions, and identities as they relate to the data analysis of the present study. Additionally, the primary researcher identified steps taken during the analysis phase to address these ethical concerns. Both processes are to provide context to the readers which can assist in a deeper and full understanding of the researcher's interpretation of the data.

As an African American woman pursuing a career in scientific research and clinical practice aimed at improving the conditions of marginalized groups, I often think about the implications of my work for the populations I am looking to serve. I am deeply invested in understanding how intersecting marginalized identities influence the experiences of individuals, and how these experiences may differ across social positions. Secondly, I strongly believe that psychology can be used as a tool for social justice. These values encouraged me to reflect on my ethnoracial identity, social positions, and

privileges as I met with participants throughout the interview process. I was aware of both the contrast and similarities between myself and the participants and how this may influence my credibility and the gathering of data. Prior to conducting the interview, I emphasized that I was interested in understanding the women's experiences and perspectives, positioning myself as the learner (Sword, 1999). Throughout the interview process, the aim was to maintain a position of neutrality in attitude and reactions (Patton, 1990) as women disclosed their personal experiences of addiction and treatment. Through note taking after the interviews, I was able to reflect on emerging feelings and reactions. This was done in efforts to decrease the interference of my affect during the analysis phase. Upon further reflecting on my role as a researcher, I am aware that this position gives me control over the interpretative process and my intent was not to impose my values onto participant experiences. Lastly, I am aware and acknowledge that my personal experiences as a African American women, coupled with my knowledge about the historical and sociocultural experiences of both women and African Americans in the United States informs my approach to interpreting the data.

Using criteria set forth by Fine, Weis, Wessen, and Wong (2003) about the ethics of social responsibility in qualitative research, I engaged in specific processes during data analysis to best present the findings. Such processes included a) portraying the "mundane" experiences of participants in addition to what is considered noteworthy, b) involving participants in member checking to clarify responses and enhance interpretations, c) avoiding the use of a passive voice, and d) recognizing my contributions to the interpretative process. I was cognizant to implement these processes at multiple time points during analysis. Furthermore, consultation with experts in

qualitative research was critical to both reduce bias and to capture the personal meanings that participants attached to their experiences.

CHAPTER 4

FINDINGS

Demographic and Contextual Data

The participants in the present study included six, self-identified African American women. Participants' ages ranged from 30-63 years old; four of the women were 56-63 years old, one participant was 45 years old, and the youngest participant was 30 years old. Participants represented a wide range of additional demographic factors. Three of the women reported being single, never married, two participants reported being married, and one reported being widowed. Five of the women were unemployed and one reported having part-time employment. Four participants stated that they had received their high school diploma, and the remaining two reported obtaining some college education (e.g. one year, associate degree). All participants reported being a mother of one or more children, and four of the women further identified being a grandmother. Half of the participants disclosed a history of involvement with the Department of Child and Family Services (DCYF) and previously having their children removed from their care due to their substance use. Only one participant reported not having current custody of her children due to her substance use.

The participants also varied in their clinical presentations. Four of the women experienced having comorbid substance use and mental health difficulties, including depression and anxiety. Two of the women with comorbid mental health conditions further disclosed a history of experiencing psychotic symptoms. Three participants

reported having a medical health condition including diabetes and human immunodeficiency virus. Participants also disclosed a range of ages in which they began using alcohol and illicit substances, (15-30 years old). While many of the women disclosed a history of use including a variety of substances, all were able to identify their primary substance(s) of choice including crack cocaine (n=3), heroin (n=2), and alcohol (n=2). Of note, one participant reported having two substances of choice, including both crack cocaine and alcohol. Three of the participants were currently engaged in professional substance use treatment at the time of the study, and the other half had been engaged in formal substance use treatment within the last year. For those currently in treatment, one was engaged in Intensive Outpatient care, another was in residential, and one was engaged in outpatient treatment in combination with Medication-Assisted Treatment (MAT). Of the participants not currently engaged in treatment, two reported sustained abstinence since their last treatment episode. Additional demographic and substance use information for the sample is presented in Table 1. Of the six participants, four of the women engaged in one 90 minute interview, and two of the women engaged in two 60 minute interviews.

Findings

The findings of the interview are organized by the three aforementioned research questions. For each research question major themes, sub-themes, and concepts were identified and described. Participant quotes are utilized to both illustrate examples as well as to give power to the voices of the women in this study as they describe their experiences. Individual participants will be referred to using pseudonyms to protect their

privacy and confidentiality. See Tables 2-5 for an illustration of themes and subthemes related to the research questions.

Research Question #1: How do African American women describe their experiences in substance use treatment?

The first research question sought to comprehensively explore and understand how women describe their substance use treatment experiences. Four major themes characterized the nature of participants' treatment experiences as: a) a cyclical and ongoing process over the lifetime, b) effecting recovery efforts, c) an opportunity to get help and learn, and d) a process requiring personal investment, commitment, and agency. The following describes each theme in detail coupled with participant examples.

Treatment as a cyclical and ongoing process

When participants were asked to describe their treatment experiences, all six of the women expressed that they have participated in multiple (three or more) treatment programs and described their histories as cyclical and reoccurring, demonstrating both the ongoing process of treatment as well as the cycle and severity of their addiction. These cycles included periods of active substance use resulting in treatment initiation, followed by treatment completion or termination. All participants described experiences of resumed use after a treatment episode, and/or a significant time of maintained abstinence. When participants spoke about their cyclical treatment processes, it became clear that for most of the women recovery is something they have worked hard to maintain over the course of many years. For example, one participant noted that her first treatment experience was thirty- nine years ago, another stated hers was thirty years ago, and two participants disclosed that they first initiated treatment eighteen years ago. The remaining

two participants described that their experiences with treatment was initiated within the last six years, and also reflected a cyclical process. April, a participant currently in residential treatment, described how the severity of her substance use led her to initiate treatment, as well as the multiple episodes of care she has engaged in since. She said,

> I never looked for help. I never wanted help, I was just living my life that way. I started looking for help because I was running out of money and I was sick. I was like sick in my head, like I was just using cocaine everyday and that's sick! And then when I started losing, losing my apartments and my kids. This is the second time I lost my kids, and I said wait a minute. That's when I started going to detoxes and stuff like that. What I do is I go to detox, they clinically stabilize me, and after I get out of detox I go to further treatment. That is the process every time. This is my third time in a residential program.

When asked about the time between her last treatment episode and her current episode of care, April disclosed that she resumed substance use which led to initiating her current treatment episode.

> Eventually I started doing drugs again and I started drinking, right after that program (previous residential). So I finally got into detox again. I did the whole thing again, detox, transitional housing, and then residential.

Melanie, a participant not currently in treatment, described a similar experience of engaging in multiple treatment programs over her lifetime, highlighting how treatment has been an ongoing process for her.

> I wasn't ready to quit smoking, but I had pressure on me to go into the program. I completed it but when I came back out I picked back up again and it was really hard. I just started running, meaning that I would use and then go to inpatient rehabs. I was here for three months, there for six months, I did outpatient. I've done a lot. I was an addict. I am a recovering crack addict so yeah, I went into like five different rehabs.

Another participant not currently in treatment shares her process of initiating substance use treatment, also stating that she has had various episodes of care. Denise said:

> When I got old enough to take care of me, I went and got help, for me cuz I knew something was going on. I been to different programs. I been to good country club treatment centers and programs. I been to state programs, sixty-day programs, ninety-day programs. I went to good ones and bad ones. I been to quite a few you know.

When reflecting on previous episodes of care, participants spoke to the cyclical nature of their treatment, and for some, providing additional treatment details became challenging. Half of the women became overwhelmed when asked to describe their experiences of treatment in detail, expressing that there had been so many treatment episodes and not knowing where to begin. For example, when asked to reflect on the beginning of her treatment history Melanie sated:

> I don't know, it was just so long ago, I know that DCYF was involved. I think I went to (residential treatment center) first, I been there about three times. I stayed there umh three months, and then I went again after I think I had 6 months clean. Then I went a third time.

Other participants were able to easily describe each episode in chronological order. For example, Ramona gave a detailed history of her episodes of care, starting with the first time she initiated treatment over thirty years ago.

> Ok the first time I went into treatment it was in 1979, one of my supervisors they noticed my tardiness and one day I came in tipsy. She told me she wasn't going to fire me but would like for me to go into a detox. So my first was then, at the hospital and then I went into a thirty day treatment center. So then I stayed sober for a while and then I went back to treatment in 2001. I went to detox and then I did another thirty-day program. Then my last relapse was in 2016, almost 2 years ago now. I mean I lost my apartment because of my drinking, the drinking was just more important. I found myself doing things I thought I would never do. I started doing like standing on the street corner, begging for money, standing in the store. Then I got tired, I just got sick and tired. I went into the hospital to detox then I went into the holding program until I got into a residential treatment program.

When asked about their most memorable treatment experiences, all of the women spoke of both positive and negative episodes of care. For example, Denise reflects on her overall experiences and said,

> You know I remember some of the real good ones, some of the bullshit ones, the ones I bullshitted my way through, and the ones I took serious. All of them have the same concept of getting better, wanting you to get better, to do better you know.

Another participant, Susan, described a highly positive treatment experience:

> The first time was (local state hospital) the (program name). That was a great program. That was the best inpatient program I ever went to, it helped me a great deal. That was back in 1999, and they wanted me to become an assertive person so they put me on patient government. I started speaking up for myself after that! {participant begins laughing} Yea they showed me leadership and everything.

While women were sharing their treatment experiences, it became clear to the researcher that the cyclical nature of treatment episodes was often driven by experiences of relapse or resumed substance use. Participants openly shared success after treatment completion as well as moments of difficulty.

Cycles of relapse. Within the theme of treatment as cyclical, a subtheme that emerged in participants' descriptions was: cycles of relapse. It became very clear early in the interview process that all of the women struggled greatly with maintaining post-treatment success and abstaining from substance use. These challenges eventually led participants to re-engage in formal treatment, even after completing a previous episode of care. Melanie described her experiences of relapses that facilitated ongoing treatment cycles and said,

> I went to about five (treatment programs) so I been to mostly of all over (New England city) you know. DCYF wanted me to umh go inpatient and so yeah I

> went inpatient and but then I picked up right after and then I, the cycle just went on and on. Another program, get out, picked up again, another program, get out, then I pick up again.

Resumed substance use was a pattern even for participants that were able to abstain from substances for a significant period on time. For example, Ramona said,

> Well this is not my first go around. I been in and out of treatment uhm and the last I stayed sober was eight and half years and then uhm I was doing everything, the steps, I had a sponsor, going to meetings and then I slacked on meetings and then I relapsed in 2016, that's when I lost everything.

Another participant also described having multiple episodes of care, making a distinction between her current treatment episode and past treatment attempts. Susan said,

> That's (treatment) been a big help, well now this trip around. This time around I'm really into now, then I was the first time around. The first time around I was really into it then too, but my son was staying with me and I was having problems with him and he was drinking and it was affecting me so I started back getting high.

Kathy also shared similar difficulties with resumed use after treatment completion. When asked about the time frame in which she was able to abstain from substance use after completing a previous treatment program she responded:

> Actually it was two weeks because I remember when I got home I started back using and my daughter said to me, “mom you’re back at it again?”. And I was like ok, ok, I’m going back (to treatment) because once I go (using), I go hard and them two weeks I was all in, I didn’t care about nothing. Then I went to (residential treatment center) and I never turned back and it’s been almost four years.

Descriptions of resumed use were often expressed with intense emotions. For example, Susan expressed both sadness and disappointment upon reflecting on her substance use and experiences of resumed use.

> I get angry at myself because I relapsed. And it's, it's dumb because the drug, I mean like really you, what is it doing for me, nothing, not nothing! It's just tearing me down, it's all negativity! Nothing is good about it. And every time I use, the, the after effect, ahh, oh God, it's, it's just so stupid. It just takes away so much from you, it just, it just bankrupts you. Yea it bankrupts you. It's a total loss, you as a person, as a human being, gone.

Engagement in multiple treatment episodes was an experience that all of the women shared, highlighting the cyclical nature of treatment, the chronicity of their addiction, as well as the difficulties with abstaining from substance use.

Treatment as effecting recovery

All of the women identified treatment as helpful in their recovery process. Although the women conceptualized treatment efficacy in different ways, they all spoke about a general focus of maintained abstinence. For example, Ramona described that her participation in a previous residential program gave her long term success in maintaining abstinence. She stated,

> The best treatment I had was my second one because I stayed sober for 8 years cuz I did the participation, I did the groups, I done everything that was laid out for me.

When asked about treatment effectiveness with previous episodes of care, Denise also expressed that treatment has helped her in maintaining long-term sobriety. She said,

> Yea I remember the ones that meant something to me, that helped me when I did get out and stay clean for a period of time.

Similarly, Susan described how treatment has been effective for her, both currently and in the past. She identified that treatment offered her something tangible to successfully

maintain her recovery, such as skills that assist with both emotion regulation and interpersonal effectiveness, both of which are personal difficulties that threaten her sobriety. Additionally, Susan placed great emphasis on the necessity of these skills that she learns in treatment. She said,

> And in IOP, they had the DBT (dialectical behavior therapy) skills, they would give you skills that you can use when you get out of there. I will look at those as time goes on cuz I look at them as tools, when you get into a jam. Just take those tools and just go through it as you would go through any problem that you might encounter. I'm going to need those tools to deal with life, with early recovery because early recovery you going, you going to need those tools in order to stay clean.

Another participant, Kathy, describes that treatment has been effective for her as well, especially in avoiding the consequences of being active in addiction. Kathy also expressed how grateful she is for the opportunity to engage in a variety of treatments, all of which she describes as successful episodes of care. Kathy stated,

> Oh that (treatment) means a lot! What if we didn't have these substance abuse programs, where would we be? If I didn't have the outpatient, the IOP, the methadone program? If I didn't have none of those, to tell you the truth I don't think I would have my daughter right now. I don't think that, I wouldn't be sitting here with you. I wouldn't have nothing. You know, I thank God for substance abuse programs.

Approaches to treatment. In regard to the theme of treatment effecting recovery, a subtheme that emerged in participants' descriptions was: diversified treatment approaches. All of the women describe participating in a variety of treatment settings over their course of recovery including residential, inpatient, intensive outpatient, outpatient, individual psychotherapy, and group psychotherapy. Of note, only one participant described utilizing medication-assisted treatment (MAT), following her completion of residential treatment. Additionally, nearly all participants described

engaging in an informal treatment process aimed at maintaining successful recovery. In fact, participants stressed the importance of attending self-help meetings after completing formal treatment or while actively involved in a treatment episode. For example, Susan said,

> I was almost 6 months clean and he (her brother) told me the reason why I, I went back out using is because I wasn't in the rooms, like AA meetings and NA meetings and I had picked up because I didn't go to NA meetings, AA meetings and I didn't find a sponsor. So now I'm going to AA meetings and NA meetings cuz you, you have to do that in order to stay clean.

April also described the importance of follow up care to maintaining her sobriety.

> Nobody knew though that was I getting like back to my ways. I didn't even know it was a problem at that time, it was so early in my recovery I didn't know after you get out a halfway house you should go to meetings. I didn't do none of that stuff. So I started using again.

Through her recovery history April was able to recognize that by not engaging in an informal treatment process, such self-help groups or meetings after completing a treatment episode, her post-treatment success would be at risk. During the interview April further described the importance and meaning of attending self-help groups and how it is critical in helping her avoid resumed substance use.

Treatment as an opportunity to get help and learn

The third theme that emerged from the data in response to the first research question is treatment as an opportunity to get help and learn, with a specific focus on preventing resumed substance use. Participants expressed that substance use treatment gave them opportunities to learn about themselves, their addiction, as well as an opportunity to learn from others during their treatment episodes. For example, Denise

described how treatment has been a learning experience for her and what elements of the experience were helpful in facilitating her increased knowledge. She said,

> You know I have learned a lot over the, over different programs. I got a lot out of them. I took something from every one that I went to. The literature was really important too, it was powerful you know, and the instructors that they had knew what they was talking about. You know the instructors, they knew their business and that's what made it so much better to enhance the part of learning about recovery.

When reflecting on a past treatment experience that was meaningful to her, Susan spoke to the specific process related to learning about her emotions as a part of her recovery. Susan said,

> It (treatment) showed me a lot, it, its uhm, it showed me how to deal with my feelings, my emotions, it showed me how to look inside myself. How to take those emotions and break them down and sort each one of them out, and to know what each one of those emotions was, how they were making me feel, and to be able to identify each emotion and why they were making me feel this way. Whether I'm on drugs or not on drugs. It was a good learning experience.

Susan also described what she is looking forward to learning from her current treatment and said,

> I want to be able to, be able to stay clean and sober once I get out of here. I want to learn everything I possibly can while I'm in IOP, and be able to use what I learn in IOP to, to utilize it after I leave. I told her (the clinician) I got to do this, I got to do this, cuz I don't want to die. I'm tired of going to the emergency room. I'm tired of this, I'm just really tired of this. I don't think I have uh another go round of going out and getting high, I don't have it in me, I'm tired. So please help me.

Another participant described that she learned most from others in addiction, specifically at Narcotics Anonymous (NA) meetings. She expressed that she holds a lot of value for learning about recovery and abstinence from those with similar lived experiences, more than she has learned in formal treatment settings. Melanie said,

> I like to hear their stories and I can learn something by when they speak or whatever they went through or you know. I pick up things by listening to them and see how they got it and made it through and stayed clean, and to live clean.

Treatment as a personal investment and commitment

The fourth theme that emerged from the data in relation to the first research question is, treatment as a personal investment requiring commitment and agency. Participants' accounts of treatment experiences often included descriptions of being invested and committed to the treatment process. Participants spoke frankly about times they were not invested in treatment for various reasons, and the consequences such as continued substance use and treatment re-engagement. Upon reflecting on previous treatment episodes Susan described how her commitment to treatment and recovery has changed over time. She said,

> I think the other times that I was in treatment programs I really didn't see the seriousness in it. I really didn't but, I really do now and I'm taking this opportunity now to take it more seriously cuz like I say, I may not have another chance to take it. You have to do it that way, if not you're going to fail, you're going to fail and then you going to be back out there, doing the same dumb things that you was doing before and like they said, jail, institutions and death that's all you going to have and I'm not going to. I'm not going to, I refuse.

Susan is not only more invested in her current treatment episode, but she also expressed her concern if she doesn't take her recovery seriously and what that would mean for her. Similarly, Ramona described her lack of personal investment in treatment during her first episode of care. She said,

> The worst (treatment) was only when I didn't put the effort into it. I just went through the motions so maybe I really wasn't ready to get sober. That was the first time. I just did it because I was pressured to do it.

However, when expressing her current investment, Ramona said,

> You have to really be determined, you got to really want it cuz I mean, we can make excuses to not to stay sober, what it is, I don't know. I have no more excuses. I just want to live now.

Other participants also stressed the importance of being invested in treatment and committed to recovery. Participants described this commitment as a mindset that translated to behavior changes demonstrating their dedication to recovery. For example, Denise explained,

> It's what you want, it's what you take from it, you know I took what I needed, what I wanted, you know I took what I needed. I knew I was going there (treatment) for a purpose you know what I mean. I wasn't going there to bullshit. I was really trying to get help cuz I got sick and tired of being sick and tired of what I was doing, so I said let me work this to my advantage. I don't want to be an addict all my life. I don't want that for my life or the rest of my life. I want to live you know, I don't want to die. I don't want to OD (overdose). I don't want to die. It's what you put into it. I put a lot into it (treatment), cuz I wanted to get clean.

Similarly, when describing her current experiences in residential treatment, April expressed her determination and commitment to change. She said,

> Then I went to detox again and uhm I was pretty strong and I kind of like was ok I seen this, did that, I know how I'm going to do it this time. I could have went back with my family but you can't do that in treatment, you can't skip levels or think you can go back home cuz the same thing is going to happen again. And then I called here (current residential program) and they told me I could come. I was so excited, and all that stuff changed me. I just want to do the next right thing.

April's investment in her current treatment was demonstrated in a variety of ways. She was better able to recognize what puts her recovery at risk if she doesn't engage in treatment after detox, as well as the risks posed in her family/community environment. April illustrated her agency by not only deciding to go to treatment after detox, but also by making the call herself to a residential program. This was particularly meaningful for

her considering that her previous treatment attempts were heavily influenced by familial pressure.

Participants also spoke about the importance of their families and how they often served as a motivation for sustained recovery. Personal investment in treatment was often connected to participants' identities as a mother, grandmother, and even daughter. When expressing the personal importance of treatment, Susan described the potential consequences of not being invested.

> I can lose the respect of my sons. They can give up on me and God knows they have been there for me, but they are getting sick and tired of me, of me using. And my grandchildren, they are not dumb, they can, they know when I'm using, they are not stupid. And my mom, well she has dementia and if I'm using that means I'm not going to visit her. I can't do that, I can't you know hurt her like that.

Similarly, Melanie described why being invested in treatment is important to her and spoke about her struggles with commitment to recovery.

> Being a mother for my kids to look up to, and my granddaughter. I want to be a good example. I'm learning that when I say something that means I got to not just speak it, I got to own it because my kids say I say things and then I don't follow through. It's important for me to be reliable and dependable and being there for them when they need me, and not getting into drug and alcohol again.

For all participants maternal and familial identities appeared to be a motivating factor for treatment engagement and success. Treatment invested was important to all participants and this theme highlights not only their commitment to recovery and wellness but also their change processes over the course of their treatment experiences.

Research question number one provided rich context, data, and descriptions that illustrated participants' substance use treatment experiences. The four themes that emerged from the data demonstrate how women view and experience treatment over their lifetime, what they value from the treatment experience, and what change processes take

place over the course of treatment. These descriptions also demonstrate the severity of their addiction journeys as well as how fragile recovery and abstinence can be for them. The clinical implications of these findings will be discussed later.

Research Question #2 What is the nature of the relationship African American women have had with their treatment provider?

The second research question sought to explore the ways in which participants describe and experience their relationship with their treatment provider. What became clear as a result of the first research question is that the participants have worked with a number of clinical treatment providers over time, given their numerous treatment episodes. For clarity and flow these results will focus on participants reflections about their most memorable providers over time, as well as the most recent or current provider. Of note, rarely did participants need to be probed specifically about their treatment provider relationship. These descriptions were often organically introduced throughout the interview as participants described their treatment experiences. Follow up questions were asked about these clinical relationships, to gather more data and to ensure clarity. Overall, participants described their treatment provider relationships within two frameworks, positive and negative experiences. These frameworks were used to organize the themes that emerged and are outlined below.

Positive Provider Relationships

All participants, described having one or more positive treatment provider relationship(s) over the course of their treatment history. The three participants that were currently in substance use treatment described having a positive relationship with their current provider, as well as having positive relationships with past providers. Participants

currently not in treatment also described having positive relationships and experiences with past treatment providers. The following four themes emerged as participants described positive provider relationships and experiences: a) providers as supportive, b) providers are valuable to the treatment episode and to participants' recovery, c) provider relationships that are long-lasting, and d) providers of matched racial and gender identities.

Providers as supportive

All participants described experiencing the majority of their treatment providers as helpful, encouraging, and caring. These interpersonal qualities were important to participants as they assisted in the facilitation of rapport and connection. Participants also expressed that these qualities facilitated their comfort in the treatment relationships, allowing them to be more open and willing to disclose. For example, Ramona describes what was most helpful about her relationship with her provider and said,

> Just his personality, so warm and comfortable and open minded. Willing to just sit down and listen to you. Help you in any shape or form ... uhm he, he's pretty good. He listens and he asks me questions and I just be straight up with him. He helps me in that way, makes sure I'm on track.

Another participant, Kathy, shared what has been helpful about her current treatment provider and what specifically made their relationship positive. She said,

> She's just awesome! She has good feedback. Like she don't sugar coat nothing, that's what I like. Don't tell me what I want to hear, don't try to make me feel good you know just tell me what it is. She don't rush me at all, she will sit there all day and listen... she's a good listener. I love (treatment provider name)!

Kathy both describes the positive qualities of her provider, as well as the meaning she attributed to these qualities. Her description demonstrates the type of connection she has with her provider and how she experiences the relationship as helpful.

Providers as valuable to treatment

As participants described the helpful nature of treatment providers, they often did so with great positive affect. This demonstrates that above and beyond helpfulness, participants experience treatment providers being highly valuable to them personally, to their treatment, and to their recovery. These descriptions emerged as a second theme of providers being valuable to the treatment episode, to participants treatment engagement, and to participants recovery process. When asked what made this treatment experience better than previous ones, April immediately identified her provider as an important factor for her current treatment and future recovery.

> Yea my counselor! I really feel like I could like just like talk to her and get everything out and you know really tell her how I feel. At first it was like I can't take it in this house, now it's like I'm more focused on my recovery and why I am here. Like with my counselor it's like ok she's my counselor but at the end of the day I can cry in front of her. This is the person that is going to get me through this journey being here. So I lucked out big time! I want help. That's why I need counselors, I need help.

April's response highlights the emphasis she puts on her relationship with her treatment provider as a supportive and positive factor in her treatment process. She also highlighted her appreciation for her provider, further demonstrating the importance that she places on this relationship and how critical this relationship is to her recovery. Other participants shared a similar sentiment about their treatment provider. For example, Susan expressed strong positive emotions about her current treatment provider in an intensive outpatient program.

> I love that woman cuz she know I'm serious about it (recovery) this time. Because she makes me feel that what I say to her, she knows I mean it. She gets it. She's a good clinician, she does her job very well and she knows that I'm serious about this IOP this time around.

The value of this provider relationship is also placed on the connection to treatment and recovery. This provider relationship is especially important for Susan because as she described her current treatment episode as another attempt to recovery, having a provider that supported her commitment is important to her. Other participants described having close relationships with their providers and how this relationship influenced them personally. When reflecting on her previous treatment providers, Denise described a positive clinical relationship and the meaning it holds for her. She said,

> I had good therapists, I had bad therapists, I had good clinicians, I had bad clinicians, some crazier than me. Then God blessed me with a wonderful woman, a good clinician. She always made me feel important. She made me feel that I was worthy. She cared about me and that made me realize that someone cares about me and that made me feel good and made me open up to her because she seemed to be truly genuine.

This quote demonstrates that the provider relationship is not only important for the purposes of treatment but there is also an emotional connection that participants develop to their provider. Furthermore, treatment provider relationships also influenced how participants perceived themselves as a result of having a positive clinical relationship. The value that participants hold in relation to their treatment providers can be further demonstrated by the longevity of the clinical relationships that participants described.

Meaningful long- lasting provider relationships

The third theme that emerged as participants described relational experiences with treatment providers was the length of the relationship. For example, Melanie described

the relationship she had with a previous provider and the importance it held for her. She said,

> I had a very good counselor for 7 years at SATU, she retired. I'll never forget her, umh she stayed with, me for 7 years. At first I kinda pulled back, I wasn't comfortable, I didn't keep up with my appointments but she stayed with me, she would reschedule. I was still, mmm just getting clean and she was patient, she was nice, she was understanding. It was just, it was very personal relationship.

This participant was able to develop and maintain a long lasting clinical relationship with her provider and attributed some of the relationship success to her providers ability to demonstrate patience as the participant struggles with both building rapport and working through early recovery. Building this personal relationship left an impression on the participant that she continues to appreciate. Denise described a similar long-term relationship she had with her previous provider and said,

> She was my clinician for (five) years and me and her got along really well and she helped me though a lot of trials and tribulations... because she allowed me to be me. I never felt that judgmental feeling. She always made me feel important. She cared about me. She would call me. You know, call me on my cell phone, if I missed an appointment...yeah and she really paid attention to who you were.

Susan, a participant currently in treatment described her relationship with a provider that she has worked on and off with for the last three years. She explained that the ongoing nature of their treatment relationship is due to her cyclical relapses followed by re-engaging in treatment. When asked what about this relationship and what makes it positive she responded,

> Because we get deep, we get deep. I told her I got to do this, cuz I don't want to die. I'm just really tired of this. I don't think I have another go round of going out and getting high. She's just down to earth, she's a down to earth person. Just her personality, her interest in her job. You know when somebody loves their job, the client can feel it, and I grabbed hold to her loving her job. And she asked me, she said, "Susan" what do you really want out of this time, out of IOP, out of me? And I told her. I said just, just relapse prevention period, just whatever, anything just something, just something so I don't pick up again.

Participants greatly valued the long-term relationships they were able to develop and maintain with their providers. Despite the challenges with treatment and early recovery, participants were invested in and greatly valued the therapeutic relationship. It also became clear that a facilitating factor in maintaining a positive treatment relationship was a clinicians' demonstration of their own investment in the client and the treatment episode.

Matched racial and gender identities

The last theme in regard to the second research question that emerged from the interviews is the value of clinician and client matched social identity. Many participants described their treatment experiences with providers who also identified as African American/ Black women. Having a matched racial and gender identity was highly valued by participants as they expressed feeling more connected and relatable to their providers. When asked about the relationship with her current treatment provider April immediately spoke to her providers identity and why that was meaningful for her.

> Its good! Like she's (whispers) African American, (returns to normal tone) and that's a plus! Because we come from the same background so I could really like be myself and she gets it.

A similar excitement was expressed when Susan described a relationship she had with a treatment provider of the same gender and racial identity. She said,

> (Clinicians name) now that's my girl, she alright! She Black, she, me and her got a connection. There is something different with (clinician), I can talk to her about, about anything.

When probed further about the identity of the clinician, and what made this meaningful for Susan, she responded,

> Hmm, It's a black thing, it's just a Black thing, a Black woman's thing.

While Susan was not able to further express the meaning of having a Black woman as a treatment provider, it was clear to the researcher that her tone and body language that these were valuable factors to the relationship. Denise shared a similar meaningful sentiment when describing the relationship with her previous provider. She said,

> I think what drew me to her was that a woman to another woman, one on one, and...you know she is a Afro American woman. And I think she knew some of the struggles that Afro Americans have in the city, that played a big role too.

Negative Provider Relationships

While all participants described having positive relationships with treatment providers, negative provider experiences were identified as well. In fact, all but one participant described having at least one negative provider relationship experience over the course of their treatment. The most salient theme that emerged through participant descriptions was: early treatment termination as a result of negative treatment provider relationships. Participants gave various examples of negative provider experiences, such as perceived stigma and/or discrimination, feeling as though the provider was not invested in building therapeutic rapport, experiencing the provider's personal recovery status as a relational barrier, and feeling invalidated by the provider. The following quotes provide examples of how participants responded to having negative encounters with treatment providers, ultimately affecting their treatment engagement and retention.

Early treatment termination

One participant, Melanie, described a negative provider experience she had very early on in her treatment history, expressing frustration and disappointment about the lack of interest the provider expressed in helping her. She said,

> I went to (name of treatment program) about 30 years ago, yeah and she (clinician) was no help and I stopped going. When I look back at the moment, she was in the office with me and I'm sharing you know how I'm feeling and umh she could of cared less. We just didn't click. She just didn't care, she didn't speak much at all, didn't say anything encouraging... I just walked out.

The perceived lack of interest and empathy experienced by the participant quickly shaped her opinion about the provider. Ultimately this perception informed her decision to terminate treatment and not return after this encounter. The inability to "click" with a treatment provider was shared by other participants, also resulting in early termination. For example, Denise said,

> The lady that I had as a clinician... me and her didn't click at all you know, she was you know, she was always worried about a urine and uhm she, she really didn't ask me about me. It was all about do this, do that, and that didn't work for me. All she was worried about was me having clean urine and umh being on time, she wasn't for me. She didn't talk to me, and me and her we didn't click so I, I didn't, I left there.

Denise's decision to discontinue treatment was due to the difficulty in establishing a desired connection wither her provider. Having a provider that is only focused on her urine toxicology screens created a barrier in the relationship, leaving the participant feeling unattended to as a client. Moreover, these descriptions illustrate participants expectations about the provider relationship that were unmet during their encounters. Similarly, Ramona described having a poor provider relationship that led to her decision to end treatment prematurely. She specifically described the source of the relational disconnect and said,

> I mean she was just there. She hardly ever talked, I just didn't talk to her. I felt like she would have been judgmental yea so I never tried. I don't know, I never gave her a chance.

Experiencing a sense of judgment from providers was commonly described by participants and for some, it influenced how willing they were to invest in the therapeutic relationship. Participants also described unexpected negative experiences with providers who were also in recovery themselves. For example, April described an experience in a residential program and a provider relationship that was difficult for her to manage. She said,

> She was just like you know, trying to bust our chops all the time, searching through our shit like and I just didn't know why. Like I get it, this is your job but it's like she's the type where ok, she was in recovery before now she's working and got her life together and now you forgot where you came from and now you don't know how to treat an addict but you're an addict, and I didn't like that.

Participants anticipated that having a treatment provider who was also in recovery would allow them to have a more meaningful connection, however some of their experiences often left them feeling judged and/or misunderstood. Participants described how they came to make decisions about not returning to treatment because of these negative encounters with providers. The negative provider experiences that influenced participants to terminate treatment early ultimately resulted in lack of care, leaving their substance use untreated. This result highlights the important role of treatment providers and their influence on the treatment episode.

Research Question #3 What are the conceptions of a culturally competent provider and to what extent is this valued by African American women receiving substance use treatment?

The third research question set out to comprehensively explore participants' ideas and perspectives about culturally competent providers and understand the value participants attribute to this in their substance use treatment. As a result of exploring this topic during the interviews, the following three themes emerged: a) culture as a treatment factor is unfamiliar, yet perceived as a valued concept, b) matched marginalized identities increased perceptions of competency, and c) identified preferred provider characteristics.

Culture as a valued treatment factor

During the interview process it became clear that for nearly all the women the concept of culture and cultural competency as a substance use treatment factor was novel. Being unfamiliar with this concept facilitated participant interviews responses that were more process oriented, instead of descriptive in nature, as compared to the first two research questions. When participants were asked if treatment providers directly asked them about their cultural backgrounds and identities, half of them said no. Despite the fact that some participants reported not being asked, all but one deemed this as an important concept to discuss in treatment. For example, when the researcher asked Susan about her experiences in discussing her cultural identity in a treatment setting and the value of doing so she responded,

> No, this is the first(time). That's very important, that should be asked. We do more struggling than any other race, I know, we got it bad.

When further probed about why she should be asked about her cultural background in treatment, she said,

> To know how us Black females, how we feel, struggling with our addiction and being a Black woman. The things we had to go through, emotionally and physically in this society.

Ramona shared a similar experience and sentiment when asked about her experience and perception. She said,

> Yea I don't think anyone has asked me. No, because they (providers) look at all, Black and White is basically the same, but its different experiences. Black people have a wide range of problems and situations than a white person, for their addiction and stuff you know. It would be important because I mean, I think it would be important I guess so they know where we coming from.

While some participants reported having experiences of discussing their cultural backgrounds and identities with a provider in a treatment setting, only one participant was able to clearly describe her experience in rich detail. When asked about her experiences Denise responded,

> We use to talk about it, we talked about being Black, and raised in the city where the odds are against you because inner city, low income housing and people already stigmatize you. We talked about it and how I felt about it.

In fact, Denise was familiar with the phrase 'cultural competency' and when asked what it meant to her she responded,

> It's just a word you know, cultural competency. It's about who you are as a person. You know but it's how you come at a person and culture does play a big role and people come from different backgrounds. But people are people first... get to know somebody first, you gotta be open minded.

While the term 'cultural competency' held no personal meaning or importance to this participant, she expressed that culture is a critical component of a person's identity. Furthermore, she stated that the interpersonal dynamic between patient and provider and being able to relate as "people" is important in the treatment relationship.

Only one participant stated she would not want to be asked about her racial and/or cultural identity in treatment. Kathy said,

> I don't think those questions should be asked. I think that's, I think it's racist. Coming from (whispers) a White woman to a Black woman, (returns to normal tone) I think that's racist. You don't ask no Black woman that, especially if you're White, no.

When the researcher asked Kathy if questions about cultural identity would be different if asked by a non-white provider, she responded,

> Very different! You're (points to the researcher) just like me, you're my race and I know you're not saying it as a racist, it could be for other reasons. But for another nationality to ask me that, it's just totally different, it's just different, definitely. Coming from a Black woman, it's not offensive at all.

Kathy disclosed that she has never discussed her cultural identity or background in a treatment setting. Furthermore, she would find it offensive and perhaps prejudiced if a non-Black provider asked her about her cultural identity in the context of substance use treatment. However, she appears she might be willing to discuss this with a Black treatment provider if questioned. This highlights the need for both sensitivity and respect when providers are asking about a client's racial or cultural identity, in efforts to not offend the client especially in cross-racial dyads.

Matched identity and perceived competency

The second theme that emerged from the data is: matched marginal identity increases perceptions of providers' cultural competency. Participant descriptions and experiences of having treatment providers with matched social identities of various types continuously surfaced during the interviews. All but one of the participants expressed that having a treatment provider with a similar identity or background helped them feel more comfortable, connected and understood. Feelings of connectedness were often related to

perceived similarity in experiences contingent upon identity. For example, April described a conversation she had with her current treatment provider about their matched racial identity.

> Being Black did come up in it because I was just so glad that I got a Black counselor cuz like... I really want to just do this. I don't want to come back here (treatment) again and maybe she will like understand like why I am the way I am. And it's nice to always have that person like that can relate to me, not in active addiction, but just growing up a Black girl.

Being able to relate to and being understood by her provider is important for April and she perceives that their matched racial identity can assist in a providers' deeper understanding of her as a client. She further expressed that perhaps this deeper understanding can assist in her treatment and recovery success. Denise also expressed that having a treatment provider with similar identities is helpful for her therapeutic relationship. She said,

> It helps, they have a better understanding, a better understanding of being a Black woman in America or a Black woman in an inner city.

Denise described similarities beyond racial identities that include both gender and references to socioeconomic status. For Denise, having a treatment provider who can understand the social experiences most often accompanied by these identities has helped her in the treatment relationship. Another participant, Melanie, referred to similar racialized experiences when asked about the differences between having a therapeutic relationship with a provider of a different racial identity. She said,

> It would be different! It would yeah, because the White woman is not Black and she never went through the struggles and everything that we had went through. So a White woman, you know I mean, they got their struggles too but they are not

> Black. I don't know just being a woman of color you know and our upbringing and umh the way we were raised, it's different.

Only one participant, Kathy, expressed that matched social identities were not important for her regarding her provider, and further stated that her only concern is the quality of treatment she is receiving. She said,

> Yea I don't care about that, I don't care about the race. Because if you have to care about that then you're not there for recovery because that shouldn't even be on your mind. Who cares of that person is not Black? You didn't come here for that, you came here to get help. I don't care if my counselor is not in recovery. I don't care if my counselor is not Black. I came for help. I didn't come to see if my counselor is going to be Black. No that don't matter to me.

Preferred provider characteristics

The last theme related to the third research question that emerged was descriptions of preferred treatment provider characteristics. These character descriptions were based on both personal treatment experiences and participants' desires for the qualities they would want from a provider. All participants provided character descriptions that were further divided into two subthemes: general positive characteristics and characteristics related to cultural awareness.

General positive characteristics. General positive characteristics that were identified by all participants were: understanding, respect, equality, validation, and acceptance. Participants referred to these treatment provider qualities as highly valuable and desired. Participants described their appreciation for these qualities based upon personal experiences, as well as described characteristics that would be particularly meaningful for them as they engage in substance use treatment. When asked about provider characteristics that were important to participants specifically as African

American women in substance use treatment, participants gave a variety of responses highlighting these general positive characteristics. For example Melanie said,

> When you're in treatment you just hope that the person is caring or understanding or you can rely on them because at that point in early recovery you kinda hoping you get a clinician that can hang in there with you. You probably got so many clients but it makes a difference when a person cares.

Additionally, Kathy identified characteristics that are important to her and said,

> To be a perfect counselor is having respect, being fair don't like, don't treat this person different because especially when you're in treatment, other clients will see that. As long as I get help and I get treated with respect, that's all that matters.

Denise also identified respect as a positive provider characteristic as well as acceptance. When describing what she desires from providers she said,

> Just know that people are people and respect goes a long way, and don't judge. Meeting people where they at. That's a good thing and if you gotta take a couple more steps to get to the person, so be it.

Susan also referred to respect and equality, specifically related to her racial and gender identity. She said,

> Just respect the fact that I am a person, a Black woman. Treat me the same as you would your, your own race, you know what I am saying.

Characteristics of cultural awareness. Characteristics related to cultural awareness also emerged as a subtheme as participants described their perceptions of a culturally competent provider. In addition to cultural awareness related to racial identity, all participants (n=6) spoke about the importance of providers being aware of the culture of addiction, and the importance this held for them in treatment. For example, Susan suggested that treatment providers ask specific questions to improve their understanding of a client's cultural background, as well as the stigma that is associated with addiction. She said,

> Like ask us about our background, what have we been through, though our life, with the drug, and our emotions. Know about how we feel and how others look at us as, as addicts cuz that can have a lot for uhm addicts, to have to deal with, how people look at us as, as a person.

Another participant, Kathy, explicitly described how important it is for her to have a clinician that understands addiction. Specifically, the culture and lifestyle that accompanies addiction, as well as the consequences of addiction.

> A person that ain't been in recovery can't really tell me shit. That's how I see it, you ain't been down the road, you can't tell me nothing. If you ain't did what I did, if you ain't had that struggle with drugs and know what I went through and witnessed and know what it's like to take from their child knowing that's it's not really you, it's that drug doing it, you can't tell me shit. That's why I say, the best counselors are addicts cuz they know. You got to know for yourself to really know what it's like.

Ramona had a similar opinion regarding the importance of providers having awareness about and/or personal experiences with addiction. She further explained that her experiences of connectedness with previous treatment providers have been with those that have personal addiction histories. She said,

> Especially the ones I would connect with, its ones that been there, have been through addiction, you know. They went through the addiction and then they went to school and got educated, and now they are teaching and reaching out to others. I think I connect more with those kind of counselors.

Participants' conceptions and value for culturally competent providers was mixed. These results highlight the important meaning of culture for these participants, as well as the layered perceptions of culture and identity in the context of substance use treatment. Overall the findings from each research questions have important clinical implications for treatment providers engaging African American women in substance use treatment. These findings also have future research implications aimed at improving substance use treatment outcomes for this population. These implications are discussed below.

CHAPTER 5

DISCUSSION

The current study aimed to explore the ways in which African American women describe their treatment experiences, and perceptions of their treatment providers' cultural competence. This is an area for which there is very little research with African American women. The present study builds upon and contributes to the substance use literature for African American women, a group with low treatment engagement and completion, (McCaul et al., 2001; Mertens & Weisner, 2000) and high treatment needs (Curtis-Boles & Jenkins-Monroe, 2000; SAMHSA, 2013; Boyd, Mackey, Phillips, & Ravakoli, 2006). With the use of qualitative methods for data collection and analysis yielding rich participant descriptions, the results provide insightful reflections about substance use treatment and recovery processes, which offers promising steps towards improving clinical care among this population.

Substance use treatment experiences among African American women

Study participants described a wide range of substance use treatment experiences over their lifetime. Notably all women described the cyclical nature and process of treatment, further demonstrating the severity, acuity, and chronicity of their addiction. Consistent with previous research (Keen, Whitehead, Clifford, Rose, & Latimer, 2014; Stahler, Kirby, & Kerwin, 2007; Roberts& Nishimoto, 2006), participants described heavy use with highly addictive illicit substances (i.e. crack cocaine and heroin). In addition, consistent with other studies, participants described a worsening of their substance use problems over time resulting in significant consequences (Hernandez-Avila

et al., 2004, Smith & Weisner, 2000). Participants correlated the severity of their substance use with the need for multiple treatment episodes due to the chronic cycling of active addiction and periods of abstinence. The current study encouraged women to share their treatment experiences in depth which allowed the researcher to capture a detailed and elaborate history. This finding is of importance because it illustrates a more longitudinal and historical perspective of substance use and treatment engagement, instead of solely focusing on current or most recent treatment episodes, an approach that is commonly used in substance use research. These qualitative methods also encouraged women to give voice to their own unique perspectives about their nuanced treatment and recovery experiences. Capturing a full history of treatment experiences contextualized treatment processes, and further depicted the severity of substance use in this sample.

Similar to other studies of substance using African American women, the women in this study expressed barriers to their post-treatment recovery (Jones, Hopson, Warner, Hardiman, & James,2015). All participants identified a variety of obstacles that place their post-treatment recovery status at risk such as interpersonal stress, lack of social support, and lack of relapse prevention or drug refusal skills. Similar to the findings from Kurk and Sandberg (2013), women in this study described that such obstacles led to unsuccessful recovery attempts. This highlights the need for ongoing social support during treatment and post-treatment to maintain treatment success and avoid resumed substance use. Results from the current study also demonstrate that participants describe their substance use treatment as experiences requiring personal investment, agency and commitment. Participants identified these factors as important for both treatment engagement and success. They further described that the absence of these factors either

resulted in premature treatment termination, or not experiencing the full benefits of treatment. For example, women reflected on the times they were not committed or invested in treatment and how this became a barrier in maintaining post treatment recovery success. These results are consistent with previous qualitative studies of women across racial and ethnic backgrounds, in which personal agency was noted as an intrapersonal characteristic that facilitated and assisted in maintaining substance use treatment success (Sword et al., 2009).

Parenting and maternal identity are well documented influential factors in the substance use literature for women of all backgrounds, (Sword et al., 2009; Greenfield et al., 2007; Kurk & Sandberg, 2013). The results of the present study are consistent with the previous findings that have highlighted the importance of maternal identity as a motivating factor to the treatment and recovery processes (Jones, Hopson, Warner, Hardiman, & James, 2015; McMasrter, 2005; Guerro, Marsh, Cao, Hee-Choon, & Andrews, 2017). However, in the current study participants did not identify children or their maternal identity as a barrier in their treatment engagement, which has been previously documented as a barrier among African American women (Brown, Hill, & Giroux, 2004; Roberts & Nishomoto, 2006). On the surface this may seem inconsistent with previous research, however it could be related to the support participants described having in relation to the care taking of their children while in treatment. Another possibility is that some participants described being involved with the Department of Youth and Families (DCYF) resulting in children being removed from their care, which allowed for and promoted treatment engagement. The results of the current study expand the literature base by also identifying participants' role as a grandmother as a significant

motivating factor for treatment engagement and recovery success. This finding is consistent with values of matriarchy within African American culture (Taylor, 1999; Collins, 2000), and the historical significance of women in their communities (Curtis-Boles & Jenkins-Monroe, 2000).

Relationship with treatment providers

Findings from Davis and Ancis (2012) have highlighted the need for research on the treatment provider relationship between African American women and their substance use treatment providers. Previous research has continuously noted the importance of the client-provider relationship across all clinical areas (Ackerman et al., 2001), including substance using populations (Meier, Donmall, Barrowclougj, McElduff, & Heller, 2005). In the present study, women discussed how feeling connected to their treatment providers facilitated positive therapeutic rapport and increased treatment engagement. This finding is consistent with research suggesting that feelings of connection to treatment providers is a strong predictor of treatment engagement, completion, and satisfaction for African American substance using women (Brown, Hill, & Giroux, 2004; Guzman et al., 2006; Lewis, 2004). Notably, participants described having long lasting therapeutic relationships with providers, with most identifying provider relationships lasting for two or more years. To date, this finding of long-lasting provider relationships among substance using African American women has not been noted in the literature. Their descriptions also highlight that the client-provider relationship in substance use treatment has effects beyond the formal treatment episode and is also a critical component in the recovery process. These results suggest that when

the therapeutic alliance is helpful, positive, and supportive, African American women remain engaged in substance use treatment.

Matched gender and racial identities between provider and participants was another prominent finding in the current study. Specifically, participants described appreciation and value for providers that identified as Black women which appeared to offer an added degree of safety and feeling understood during treatment. Participants reported that when working with providers of a matched racial and gender identity, they felt more comfortable and connected to the provider, over all facilitating greater treatment engagement. Similar to previous studies of substance using African American women, most of the participants in this study reported higher treatment satisfaction when the provider was of a matched identity (Jones, Hopson, Warner, Hardiman, & James, 2014; Lewis, 2004; Brown, Hill, & Giroux, 2004). In fact, previous research has found that a lack of racial diversity among providers was a barrier to initiating substance use treatment in this population (Lewis, 2004). What became clear in the current study was that most participants perceived that having a provider with a matched racial and gender identity would translate into a clearer understanding of them and their experiences. Specifically, participants described that when working with Black female treatment providers, they believed that the provider would be better able to relate to their experiences of embodying intersecting marginalized social identities. Essentially participants perceived that providers of matched identities would be able to validate their experiences as women of color, and more fully understand how those experiences influenced their substance use and treatment needs. This finding is of particular importance given the current literature on the ethnic/racial matching of client-therapist

dyads. A recent meta-analytic review found that clients have a strong preference for and perceive providers more positively when they are of the same racial/ethnic identity (Cabral & Smith, 2011). However, they also found that ethnic/racial matching had no significant effect on treatment outcomes across racial and ethnic groups (Cabral & Smith, 2011). In contrast, research has found that a counselor's understanding of the client's culture improves substance use treatment outcomes (Suarez-Morales et al., 2010). These findings, in combination with the results of the present study suggest that while a racial/ethnic match is preferred, clients find it most meaningful when providers can understand their worldviews from a cultural lens. These findings further strengthen the need for future research efforts focused on improving treatment outcomes for this group. Future research is also needed to assess the implementation and efficacy of culturally competent substance use treatment for African American women (Jones, Hopson, Warner, Hardiman, & James, 2014; Durant, 2005; Brown, Hill, & Giroux, 2004; Ehrmin, 2005).

Most participants described having at least one negative provider relationship in their history of substance use treatment. A major finding of the present study demonstrated that when substance using African American women experience negative treatment provider relationships, they disengage in treatment and prematurely terminate. Premature discontinuation in treatment is a finding that has been routinely documented in research across clinical groups, including addictions (Swift & Greenberg, 2012). However, premature termination is of major concern for substance using groups (Dutra, et al., 2008), and of heightened concern for substance using African American women (McCaul, Svikis, and Moore, 2001; Mertens and Weisner, 2000). Furthermore, premature

termination leaves clients with severe and chronic addictions untreated, and as the dose-effect literature documents, clients do not have the opportunity to experience clinically significant changes (Lambert, 2007). In the present study participants described a variety of negative provider experiences that ultimately influenced their decision to disengage from treatment, such as perceived discrimination. Unfortunately, perceived discrimination from treatment providers has been previously documented in the substance use literature regarding African American women (Constatine, 2007). Relatedly, perceived stigma was also described by participants in the present study, also influencing participants' decision to terminate treatment. This finding is also consistent with findings from a qualitative study reporting that African American women in substance use treatment experienced stigma specifically as it related to their social identities including being a woman of color and substance user (Guzman et al., 2006). Overall, findings from the current study suggest that the clinical provider relationship is a critical component in substance use treatment influencing both engagement and retention for this population.

Conceptions of cultural competent substance use treatment providers

For many participants in the current study the concept of culturally competent care was unfamiliar at first. Participants described that they hadn't specifically thought about how their cultural identity would influence their treatment experiences or provider relationships. However, while it was a novel concept, nearly all participants stated that it would be important to consider cultural identity in the context of their treatment. Only three participants reported being asked about or discussing their racial cultural identity in a treatment setting. Furthermore, these participants described that this discussion was only held when the provider and participant shared a similar racial identity/background.

Given that previous research has demonstrated that Black women are more likely to engage in treatment as well as more willing to self-disclose when their treatment provider addresses cultural factors, including racial identity (Tompson, Wothington, & Atkinson, 1994), the results of the current study are concerning since half of the participants reported never being asked about their cultural identity in treatment. Consistent with findings from Wade and Bernstein (1991), women in this study also reported greater treatment engagement and retention when providers either demonstrated cultural competency and/or when the provider was a similar racial identity. Participants in this study had a similar experience to those in the Jones and colleagues (2015) study who found that substance using Black women reported that issues related to race and racial identity were often "ignored" in their treatment experiences by non-Black providers. Together, these results suggest the need to assess client's views of their racial identity in the context of treatment or the client-provider relationship. It appears that the underlying assumption that facilitates increased treatment engagement among African American/Black women is that providers of a matched racial identity are better able to understand and empathize with the client, based on similar social experiences (Tompson, Wothington, Atkinson, 1994; Wade and Bernstein, 1991; Marsh, Shin, and Cao, 2010; Jones, Hopson, Warner, Hadriman, and James, 2015).

While the scope of the current study aimed to better understand the conception and value of cultural competence in relation to racial/ethnic and gender identities, results highlighted additional cultural factors influential to the treatment process. In addition to feeling more connected to providers of matched racial identities and integrating their racial identity in treatment, participants also identified that culturally competent providers

need to understand the cultures of addiction and recovery. Many participants of the study discussed the meaning of having a provider understand the culture of addiction and recovery. The Substance Use and Mental Health Services Administration (SAMHSA) defines 'drug culture' as an evolving culture that includes individuals engaging in alcohol and illicit substance use (SAMHSA, 2014). While the research literature provides a limited understanding of drug/addiction culture, it is assumed that this culture likely influences substance use, treatment, and recovery (SAMHSA, 2015). These results suggest a broader definition of culture than simply race and ethnicity is warranted. However, problems associated with drug/addiction culture affiliation is that it often supports and reinforces substance use, increases chances for relapses, and provides a risky model for social interactions. Women in the current study reported that it is important for them to work with a treatment provider that is familiar with cultures of addiction, and/or have personal experiences of substance use. Previous research has found that the importance of drug culture affiliation strengthens as individuals spend more time engaged in this culture (Moshier et al., 2012). Given the length of the addiction histories for the current participants, engagements in and connections to cultures of addiction is likely strong. Participants' preferences of treatment providers that have an understanding of drug/addiction culture suggest that they desire a clinician that can fully understand them, the culture they are immersed in, and their treatment needs. Working with a provider that is unfamiliar with the drug/addiction culture might create a barrier in substance use treatment engagement for this population. However, if clients are able to express the salient cultural factors that are important to them, it could strengthen the client-provider relationship, as well as the treatment effect.

Similarly, results of the present study revealed that participants desire to work with treatment providers that are familiar with cultures of recovery. Recovery culture has been defined as social networks in which group norms, attitudes, and behaviors reinforce long-term recovery from drug addiction (White, 1996). In a recent qualitative study, Black women expressed the importance of engaging in a culture of recovery and connecting support systems that promote wellness (Jones, Hopson, Warner, Hadriman, &James, 2015). While in substance use treatment, women are making attempts to abstain from use and prevent relapse, and being able to engage in a culture that counteracts their engagement in drug cultures, likely facilities treatment success. These results expand upon conceptions of providing culturally competent care for African American women in substance use treatment. The findings suggest that providers should have a familiar understanding of drug culture and client affiliation, as well as assist women in engaging in cultures of recovery to bolster treatment success.

Participants of the current study reported that culturally congruent provider characteristics are: respect, understanding, equality, validation, and acceptance. Two of the described characteristics, understanding and acceptance, map onto characteristics from previous research, such as empathy and positive regard, which have been found to facilitate the development of positive patient-provider relationships among general counseling populations (Ackerman and Hilsenroth, 2003). The findings of the current study contribute to the literature by confirming the value of the above-mentioned provider characteristics by African American women. Results from Davis and Ancis (2012) and Davis, Ancis, and Ashby (2015) further suggest provider characteristics that can facilitate positive therapeutic relationships among African American substance using

women, including multicultural competency, egalitarianism, and empowerment. However, multicultural provider characteristics for this population have not been well defined in the literature. To date there are only two studies that specifically examine the therapeutic relationship among substance using African American women in treatment, and the role of cultural competency (Davis & Ancis, 2012; Davis, Ancis, & Ashby, 2015). Results of the current study contribute to the literature with participants identifying specific provider characteristics that were conceptualized as culturally competent and preferred in treatment. These characteristics include: respect, equality, and validation. These characteristics facilitate a therapeutic relationship among African American women in substance use treatment and should be further examined.

Overall the findings of the present research have contributed to the scientific knowledge base of substance use treatment among African American women in a significant and meaningful way. By implementing qualitative methods and analyses, the researcher was able to utilize the voices and experiences of African American women to better understand their treatment experiences and perceptions of culturally competent care. Results from this study have corroborated previous research findings, as well as addressed gaps in the literature related to the value of culturally competent treatment provider relationships among African American women in substance use treatment. These results have also highlighted the need for future development in the areas of both scientific research and clinical practice that are aimed at increasing treatment engagement, retention, completion, and success among this population.

Limitations

While the current study adds to the extant literature on the substance use treatment of African American women and their perceptions of cultural competency, it is not without limitations. Clinical measures of substance use severity, or diagnostic measures were not included in this study. Therefore, this study relies on self-reported data, which reflects the participants' current recall of their substance use and treatment histories. Interview responses and information obtained from participants solely relied on memory of events that for some occurred several years prior to the interview, thus making it more difficult to recall for some participants. However, the interview guide used in the present study allowed for further probing during the data collection phase so that the researcher was able to gather histories on the most memorable treatment experiences. Additionally, most participants in this study grew up in a generation that likely endured very overt systemic and individual acts of racism, discrimination, and oppression. Given the sociocultural and historical context of African Americans in the United States, it is possible that different age groups of African American women might produce different findings related treatment histories, and to the role of culture and cultural competency in substance use treatment.

Another limitation, due to legal and ethical considerations, was the exclusion of pregnant women in this study. However, pregnant, drug-using women of all racial and ethnic backgrounds are a growing population that faces significant consequences due their substance use and is in great need of treatment. While the present research findings may not extend to pregnant African American women, this group likely experiences additional stressors, especially if they are members of multiple stigmatized groups.

Additionally, most of the participants in this study were of a lower educational and socioeconomic status, and while results may not extend to all African American women, one would anticipate that they are higher risk of substance use and need for treatment, in comparison to those of a higher socioeconomic status. Lastly, the primary researcher who conducted the interviews for this study was an African American woman which may have influenced participant responses, perhaps limiting the ability to replicate these findings in future research with interviewers of a non-matched identity. However, it is likely that the researchers' racial and gender identity allowed participants to openly share their unique experiences and perspectives, which therefore is also a major strength in this study. Although not intended to be generalizable, the results of the present study do have important clinical and research implications.

Clinical Implications

Consistent with previous research, the present study draws attention to the need for improved treatment efforts for African American women, highlighting important clinical and practical implications. Results of this study suggest that substance use treatment providers that are working with African American women might take into account the severity and chronicity with which this population often presents. Given that this population is more likely to use substances that are highly addictive in nature and are prone to relapses, it may be particularly important for treatment providers to engage in comprehensive assessment and treatment planning specifically around maintaining therapeutic gains and avoiding resumed substance use. During the assessment phase it could be helpful to gather a detailed history including clients' current substance use, past use, and past treatment experiences and recovery histories, to gain a comprehensive

understanding of the client's treatment needs. In addition, providers could make use of the American Psychiatric Association (APA) Cultural Formulation Interview (CFI) as a tool to gather culturally relevant information from clients (Diagnostic and Statistical Manual of Mental Disorders, 2013). While not a diagnostic measure, the CFI in addition to a standard clinical interview can be used to enhance the understanding of an individual's clinical presentation through a cultural lens which can inform their treatment plan. Results of this study also demonstrate that the participants had histories of multiple cycles of active addiction and recovery with cyclical relapses over time. This highlights the critical need for relapse prevention teaching, coaching, implementation, and practice as a primary treatment goal. Such skills have the potential to improve therapeutic gains and maintain treatment success, further decreasing relapses and treatment re-engagement.

Study results also highlight the need of integrated care models and approaches to meet the complex needs of substance using African American women. Given the complexity in clinical presentations of the participants in the present study that included comorbid substance use and mental health needs, and compromised medical/physical health, integrated treatment is needed to promote overall recovery and wellness. Assessing and addressing the mental health needs of clients such as mood and trauma related disorders can complement their substance use treatment and bolster treatment effects, potentially resulting in improved functioning and recovery success. Participants in this study also presented with a variety of social needs such as housing, employment, and histories/current criminal legal involvement. These findings highlight that women may be facing multiple stressors in addition to maintaining recovery that influence their treatment and post-treatment experiences. Working with additional care providers such as

medical or primary care in addition to other agencies such as parole/probation, Department of Children and Families, and community-based employment specialists could assist the substance use treatment provider in coordinating care that can potentially improve treatment engagement and completion.

Lastly in addition to implementing culturally congruent treatment interventions, clinicians working with this population should also be mindful of the ways in which cultural competence can be demonstrated in their client-provider relationships. Results of this study suggest that clients value provider characteristics such as respect, understanding, validation, equality, and acceptance. While some of these are understood as general therapist characteristics, other characteristics, such as equality, are aligned with concepts reflective of cultural competency (Davis, Ancis, and Ashby, 2015). Clinicians working with this population may want to consider how they demonstrate these characteristics, and routinely assess feeling of connectedness between the patient and the provider. This is of importance for matched and non-matched providers alike, especially as it relates to addressing culture respectfully within the treatment relationship. This could be especially important for training institutions to be mindful of in their cultural competence curriculum and supervision of trainees as treatment populations continue to grow in diversity. Additionally, the results of this study, as well as previous research has demonstrated the importance of family and familial identities in substance use treatment. Clinicians could utilize the Community Reinforcement and Family Training Approach (CRAFT) to integrate family and community members that are supportive of the client's recovery in their treatment planning. In a 2010 meta-analytic review, researchers found that CRAFT increases treatment engagement, decreases

familial conflict, and improves interpersonal effectiveness for a variety of substance using individuals (Roozen, Wart, & Van der Kroft, 2010). Family members can assist clients in their recovery by providing healthy social networks, when possible, emotional support, and encouragement for treatment retention. Family members can also serve as a source of motivation for clients in their recovery process. While future research is needed to demonstrate efficacy for this population, the results of this study suggest that CRAFT has potential to be helpful in improving treatment for African American women.

Future Directions

Given the current study's results, limitations, and practical implications, future research aimed at further understanding the treatment needs and experiences, as well as improving the treatment efforts and success for African American women are necessary. Future efforts should include a wider range of educational and socio-economic backgrounds, to see if the present results hold true for other groups. Other demographic factors such as gender identity and gender expression, as well as sexual orientation are important to examine among African American women substance users and has gone overlooked in the extant literature. Such identities and group membership, may influence their substance use and treatment experiences. Furthermore, while this study focuses on African-American women, further research is needed to identify intra-group variations in substance use etiology, treatment engagement, and treatment effectiveness. Future research is also needed to extend the recent work of Stevens-Watkins et al., (2016) that examines the role of John Henryism Active Coping, a cultural construct defined for African Americans related to coping styles, and the relationship this has with substance use treatment engagement among African American women.

Future qualitative research efforts may benefit from utilizing an ethnographic interviewing technique in addition to the stand-alone interview to further improve the current body of literature. Ethnographic research would result in more in-depth, noteworthy findings about treatment experiences, specifically facilitators of treatment engagement and post treatment success. Future research efforts might also benefit from the use of longitudinal studies in to better understand and further inform substance use treatment for this population. To date, only two studies have examined the role of cultural competent treatment providers in substance use treatment for this population, and more research is needed to better understand the direct links to treatment engagement and retention. Lastly, the results of the present study revealed that there is a serious need for research efforts aimed at improving post-treatment success and maintaining therapeutic gains to reduce relapses. Research aimed at examining the continuity of care that is needed for substance using African American women is key for recovery efforts to bolster treatment gains, decrease addiction chronicity, and maintain success over time.

Conclusion

The present study was conducted to gain a comprehensive and deep understanding of African American women's substance use treatment experiences. Descriptions of treatment, clinical provider relationships, and perceptions of culturally competent care produced rich findings in this understudied area. The findings of the current study supported previous research findings and produced new insights that are beneficial to both clinical practice, clinical supervision, and future clinical research. Continued research aimed at improving access to treatment, treatment engagement and retention, and treatment success for African American women is greatly needed.

Moreover, clinical research designed to understand the role of culture and the implementation of culturally competent skills and strategies for this population is of great importance to progress the field of substance use treatment research. The current research study provided a platform and gave voice to a difficult-to-engage and traditionally underserved populations in order to inform access and quality of substance use treatment.

TABLES

Table 1

Demographic Information of Participants

Age M(SD)	52(12.41)
Relationship Status (N)	
Single	3
Married	1
Widowed	2
Children (N)	
Yes	6
No	0
Education (N)	
Some High School	2
High School Diploma/GED	2
Some College	2
Current Employment (N)	
Unemployed	5
Part-Time	1
Full-Time	0
Tobacco Smoker (N)	
Yes	6
No	0
Initial Age of Substance Use M(SD)	22(6.60)
Drug of Choice (N)[1]	
Alcohol	2
Crack Cocaine/Cocaine	3
Heroin	2
Engagement in Current Substance Use Treatment	
Yes	3
No	3
Treatment Modality for Those Currently in Treatment	
Intensive Outpatient	
Outpatient	1
Residential	1
MAT	1
	1
Last Treatment Modality for Those Not Currently in Treatment	
Outpatient	2
Residential	1
MAT	1
Longest Length of Sobriety (years) M(SD)	4.45(3.71)
Currently Using Substances	
Yes	1
No	5

[1]One participant endorsed polysubstance use (alcohol and cocaine)

Table 2
Research Question 1: Substance use treatment experiences

Major Theme	Subtheme	Example
Treatments as a cyclical and ongoing repetitive process over the lifetime	Cycles of Relapse	I went inpatient and but then I picked up right after and then I, the cycle just went on and on. Another program, get out, picked up again, another program, get out, then I pick up again.
Treatment Effecting recovery	Approaches to Treatment	Yea I remember the ones that meant something to me, that helped me when I did get out and stay clean for a period of time.
Treatment as an opportunity to get help and learn		
Treatment requires personal investment, commitment, and agency		I want to be able to, be able to stay clean and sober once I get out of here. I want to learn everything I possibly can while I'm in IOP.

Table 3
Research Question 2: Relationship with provider

Major Theme	Subtheme	Example
Providers as supportive and helpful[1]		She always made me feel important. She made me feel that I was worthy. She cared about me and that made me realize that someone cares about me and that made me feel good and made me open up to her because she seemed to be truly genuine.
Providers are valuable to the treatment episode[1]		
Meaningful long lasting provider relationships[1]		
Appreciation for matched racial and gender identities with treatment provider[1]		I think what drew me to her was that a woman to another woman, and she is a Afro American woman... she knew some of the struggles that Afro Americans have in the city, that played a big role too.
Early treatment termination[2]		
	Perceived stigma and/or discrimination	I just didn't talk to her. I felt like she would have been judgmental yea so I never tried.
	Feeling as though the provider not interested in building rapport	
	Experiencing the providers personal recovery status as a relational barrier	
	Feeling invalidated by the provider	

[1] Positive relationships
[2] Negative relationship

Table 4
Research Question 3: Conceptions of cultural competency

Major Theme	Subtheme	Example
Culture as a treatment factor is unfamiliar, yet perceived as a valued concept		To know how us Black females, how we feel, struggling with our addiction and being a Black woman. The things we had to go through, emotionally and physically in this society.
Matched marginalized identities increased perceptions of competency		Being Black did come up in it because I was just so glad that I got a Black counselor. I don't want to come back here again and maybe she will understand why I am the way I am
Preferred provider characteristics	General positive characteristics	
	Characteristics of cultural awareness	Especially the ones I would connect with, its ones that been there, have been through addiction, you know. They went through the addiction

APPENDIES

Appendix A

Recruitment Advertisement

Substance use **E**xperiences among **A**frican American women in **T**reatmen

You are invited to participate in **Project SEAT**, a project designed to explore the substance use treatment experiences of African American women. Participating gives yo the opportunity to share your treatment experiences in efforts to improve treatment for other women! **Your voice matters, so we invite you to take a seat at the table!**

Purpose:
•To better understand the substance use treatment experiences of African American women and their perceptions of care

Eligibility Criteria:
•African American/Black women
•Must be 18 years and older
•Currently engaged in substance use treatment or engaged in the last year
•Currently not pregnant

What To Expect:
•Complete 1-2 individual, in-person interviews with a Project SEAT researcher
•Interviews will take place at a mutually agreed upon location
•Each interview is expected to take 60-90 minutes
•Interviews will be audio-recorded
•Project participation is confidential and private
•You can be reimbursed up to $20 for your time.

Contact Information:
If you are interested in participating or would like more information about the project, please contact (401) 680-0823 or ProjectSEATURI@gmail.com

This is University of Rhode Island research conducted by Nichea Spillane, Ph.D.
This research has been approved by the University of Rhode Island Institutional Review Board

Appendix B
Informed Consent

The University of Rhode Island
CPRC, Social Science Research Center
Kingston, RI 02881

Project SEAT
CONSENT FORM FOR RESEARCH

You have been invited to take part in a research project described below. The researcher will explain the project to you in detail. You should feel free to ask questions. If you have any questions or concerns later on, please feel free to contact Janan Wyatt at ProjectSEATURI@gmail.com, 401-680-0823 or Dr. Nichea Spillane, who is supervising this project, at nspillane@uri.edu, 401-874-4252. You must be at least 18 years old to be in this research project, identify as an African American/non-Hispanic Black woman, endorsed current or recent engagement (i.e., treatment within a year) in substance use treatment, and currently not pregnant.

1. Project Description:
This is a qualitative study aimed at exploring the substance use treatment experiences of African American/Black women and their perceptions of culturally competent and quality care.

2. What will be done:
If you decide to take part in this study here is what will happen: You will be asked to meet with the researcher, Janan Wyatt, at a mutually agreed upon location and participate in up to two interviews. Each interview will take 60-90 minutes to complete and will be audio recorded. Audio-recorded interviews are a requirement to participate in this study. Interviews are audio-recorded to maintain session quality; your name is not associated with the recordings. At the end of the first interview, you will complete a demographic questionnaire that asks questions about your education, employment, substance use behaviors, and substance use treatment history. Your name is not associated with any answers to these questions and your participation in this study will remain confidential. The total time required for participation for both interviews is 2-3 hours. You will be paid $10 upon completing each interview for a total up to $20.

3. Risks or discomfort:
The risks in this project are considered minimal. The questions asked and procedures in the project are commonly used in research. You may feel a little uncomfortable in discussing personal topics, such as substance use treatment history. You do not have to answer any questions that you do not want to answer.

4. Benefits of this study:
Your participation in this project will assist in evaluating methods to assist girls in learning more about birth control options and prevention of STIs. You may find the

questions and interviews interesting, informative, and useful. However, we cannot guarantee that you will receive any direct benefit resulting from your participation in this project.

5. Confidentiality:
Your participation in this project is confidential and private. All data you provide is confidential and will only be shared among the study investigators. None of the information will identify you by name. All records will be kept in a locked filing cabinet at The University of Rhode Island. All audio recordings will be stored on password-protected computers. Only project staff will have access to the information you provide. No information will be shared with others such without your written approval. The results of this project will probably be published, but your name and your participation in the project will not be mentioned in these reports.

6. Decision to quit at any time:
The decision to take part in this study is up to you. You do not have to participate. If you decide to take part in the study, you may quit at any time. Whatever you decide will in no way change your access to care. If you wish to quit, simply inform the researcher of your decision.

7. Rights and Complaints:
If you are not satisfied with the way this study is performed, you may discuss your complaints with Janan Wyatt at (401) 680-0823 or with Nichea Spillane (nspillane@uri.edu), confidentially, if you choose. In addition, if you have questions about your rights as a research participant, you may contact the office of the Vice President for Research and Economic Development, 70 Lower College Road, Suite 2, University of Rhode Island, Kingston, Rhode Island, telephone: (401) 874-4328.

Your signature on this form means that you understand the information, your questions have been answered and that you agree to participate in this study.

_____	_____
Signature of Participant	Signature of Researcher
_____	_____
Date	Date
_____	_____
Name of Participant	Name of Researcher

Your signature on this form means that you understand that all interviews will be audio recorded and will only be used for the purposes of this study.

_____	_____
Signature of Participant	Signature of Researcher

Date	Date
Name of Participant	Name of Researcher

Appendix C
Interview Guide

[Begin with introduction]

Thank you for agreeing to do this interview. As you know, my name is Janan Wyatt and I am completing my Doctoral Degree from the University of Rhode Island. I am very interested in helping women with substance use difficulties in treatment. My hope is that you can help me better understand these treatment experiences.

[Provide information about the interview process and review informed consent.]

1. **Maybe the best way to start our interview is for you to tell me how you would describe or identify yourself?**

2. **What are the most important aspects of your background or identity?** By background/identity I mean the communities you belong to, your racial or ethnic background, your gender, your faith/religion/spirituality, sexual orientation.

3. **Are there aspects of your identity that you believe influence or make a difference to your substance use experiences?**

Possible Probes:
Racial/Ethnic identity
Gender identity
Substance user
Motherhood

4. Often people look for help for their substance use from many different sources including different kinds of doctors, helpers, or healers. In the past, what type of treatment, help, advice or healing have you sought for your substance use?

5. Can you tell me in detail about the most positive/helpful substance use treatment experience you have had?

6. Can you tell me about what it was like the other times you were in treatment for substance use? (negative/least helpful)

7. Can you think of your most helpful counselor and tell me about your relationship with him/her?

Possible Probes:
negative/unhelpful/least helpful
Tx you remember the most; why
Treatment Process
Thinking, Feeling, Doing
Cultural competence

8. Has anything ever prevented you from getting the help you need for your substance use (money, work or family commitments, stigma, discrimination, lack of services)?

9. Sometimes clinicians and clients misunderstand each other because they come from different backgrounds or cultural identities. Have you ever had this experience? Have you ever been concerned about this in your treatment?

10. How important is it to you for your clinicians to understand your cultural identity when you are in treatment?

a. How do you know they understand? (thinking, feeling, doing)

b.Can you tell me what that understanding feels like to you?

c. Are there aspects of your background or identity that you would like to be incorporated in your treatment? Do you value this in treatment?

Possible Probes:
Provider connection/understanding
Most unhelpful counselor
Treatment involvement
Positive characteristics
Negative characteristics/experiences
Cultural comp. importance-how/why
Cultural values and practices

11. Is there anything we, as clinicians can do to better provide you with the care you need given your cultural identity?

Thank you so much for taking the time to talk to me about your experiences and how to help other women in treatment. Do you have any questions for me?

Appendix D

Demographic Information Questionnaire

Demographic Sheet Participant Pseudonym: Date:

Please provide your answers below by checking the box or filling in the blank.

1. Age: _____
2. What is your nationality (country of origin): _____
3. What is your current relationship status? (check one)
   - ☐ Single
   - ☐ Married/Partnered
   - ☐ Divorced/Separated
   - ☐ Widowed

4. Do you have children? (check one)
   - ☐ Yes
   - ☐ No

5. What is the highest level of education you have achieved? (check one)
   - ☐ 8th grade or less
   - ☐ Some high school but did not graduate
   - ☐ High School Diploma/GED
   - ☐ Trade/technical/vocational training
   - ☐ Some college (e.g. one year, associate degree)
   - ☐ College degree (e.g. Bachelor's Degree)
   - ☐ Graduate degree and/or Professional degree (e.g. MA, MS, and PhD)

6. Are you currently employed? (check one)
   - ☐ Yes, Full-time
   - ☐ Yes, Part-time
   - ☐ Student
   - ☐ No

6. Are you a current smoker?
   - ☐ Yes
   - ☐ No

7. What age did you begin using substances? _____

8. Of the times you have been in substance use treatment, what substances were/are you in treatment for? _____

9. Are you currently in treatment?

☐ Yes

☐ No

10. If you are not currently in treatment, when were you last in treatment? And for how long were you in treatment?

_____

11. For your current treatment or treatment in the last year, what types of treatment have you been in? (check all that apply)

☐ Residential

☐ Intensive Outpatient Program (IOP)

☐ Outpatient, individual

☐ Outpatient, group

12. Longest period of abstinence? _____

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