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Removing a Barrier to Widen the Door to Recovery: Working Alliance Development with African American Women Substance Abusers

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ACCEPTANCE

This dissertation, REMOVING A BARRIER TO WIDEN THE DOOR TO RECOVERY: WORKING ALLIANCE DEVELOPMENT WITH AFRICAN AMERICAN WOMEN SUBSTANCE ABUSERS, by TELSIE A. DAVIS, was prepared under the direction of the candidate's Dissertation Advisory Committee. It is accepted by the committee members in partial fulfillment of the requirements for the degree Doctor of Philosophy in the College of Education, Georgia State University.

The Dissertation Advisory Committee and the student's Department Chair, as representatives of the faculty, certify that this dissertation has met all standards of excellence and scholarship as determined by the faculty. The Dean of the College of Education concurs.

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ABSTRACT

REMOVING A BARRIER TO WIDEN THE DOOR TO RECOVERY:
WORKING ALLIANCE DEVELOPMENT WITH AFRICAN
AMERICAN WOMEN SUBSTANCE ABUSERS
by
Telsie A. Davis

Empirical investigation of the intersection of ethnicity and gender reveal that African American (AfA) women with substance use disorders experience the lowest rates of treatment retention among substance abusers (McCaul et al., 2001; Mertens &Weisner, 2000). This is problematic given that substance abuse treatment is effective largely to the extent clients are retained in treatment (National Institute on Drug Abuse [NIDA], 2009). A review of the literature demonstrates that a weak working alliance (WA) resulting from a negative perception of the therapist, is a central barrier to treatment retention for this population (Constantine, 2007; Lewis, 2004; Palmer et al., 2009; Terrell & Terrell, 1984). Given that WA is a significant predictor of treatment retention (Sharf et al., 2010), identifying therapist characteristics that facilitate positive WA specifically among AfA women substance abusers stands as a promising step towards reducing disparities in treatment retention for this group. Thus, the aim of this study is to identify the process by which therapist characteristics are predictive of a positive WA with the target population. Two groups of therapist characteristics were explored as predictors of working alliance (WA) with AfA women substance abusers (n = 102). This study tested the hypotheses that Population Sensitive Therapist Characteristics (PSTCs; i.e. multicultural competence [MC], egalitarianism [EG], and empowerment [EM]) would explain an additional and significant amount of the variance in WA beyond that explained by general therapist characteristics (GTCs; i.e. empathy, unconditional positive regard, and genuineness); and

that GTCs mediate the effect of each individual PSTC on WA. Hierarchical multiple regression revealed that PSTCs explained an additional 12% of the variance in WA, after controlling for GTCs. Bootstrapping analyses demonstrated that GTCs fully mediated the effect of MC and EM on WA, and partially mediated the effect of EG on WA. These findings suggest that therapists can cultivate stronger WA with the target population through demonstration of PSTCs in addition to GTCs, and that PSTCs are facilitative in whole or in part, because they increase the likelihood the therapist is perceived as empathic, unconditionally accepting and respectful, and genuine.

REMOVING A BARRIER TO WIDEN THE DOOR TO RECOVERY: WORKING ALLIANCE DEVELOPMENT WITH AFRICAN AMERICAN WOMEN SUBSTANCE ABUSERS

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TABLE OF CONTENTS

ABBREVIATIONS

EG	Egalitarianism
EM	Empowerment
GTCs	General Therapist Characteristics
MC	Multicultural Competence
PSTCs	Population-Sensitive Therapist Characteristics
UPR	Unconditional Positive Regard
WA	Working Alliance

Chapter I

AFRICAN AMERICAN WOMEN SUBSTANCE ABUSERS, POOR TREATMENT RETENTION AND WORKING ALLIANCE

Substance abuse is arguably the foremost public health concern in the United States (Ehrmin, 2005; National Institute on Drug Abuse [NIDA, 2008]). It causes "more deaths, illnesses, and disabilities than any other preventable health condition" (Ericson, 2001, p.1) in America, and costs our society an estimated 350 billion dollars annually (NIDA, 2008). It is directly linked to cancer, heart disease, sexually transmitted diseases, and HIV/AIDS (NIDA, 2003; NIDA 2008), and implicated in societal problems such as homelessness, violence against women (Blumenthal, 2002; Office of National Drug Control Policy [ONDCP], 2001), a strained health care system, overcrowded jails, and millions of preventable deaths annually (Ericson, 2001; Ehrmin, 2005; ONDCP, 2001). Due to pregnancy and women shouldering the majority of parenting responsibilities in the US (Nelson-Zlupko, Dore, Kauffman, & Kaltenbach, 1996), female substance abuse is additionally associated with poor social, physical, and mental health indicators for children (Roberts & Nishimoto, 2006; Scott-Lennox, Rose, Bohlig, & Lennox, 2000).

For African American (AfA) women, substance abuse is associated with still more devastating problems. Research has shown that when abusing substances, AfA women are more likely to use the most severely addictive drugs and incur the highest rate of drug-related emergencies and alcohol-related mortalities (Curtis-Boles & Jenkins-

Monroe, 2000). They have been found to have a higher prevalence of untreated medical disorders (e.g. anemia and sexually transmitted diseases) and dental diseases associated with their substance-abusing lifestyle (McCaul, Svikis, & Moore, 2001). Moreover, for African American women, AIDS is the leading cause of death for those aged 25-34 years, the third leading cause for those aged 35-44 years, and the fourth leading cause for those aged 45-54 years; and 24% of these documented transmissions are drug-related (Centers for Disease Control and Prevention [CDC], 2008). Given AfA women's traditional position as primary nurturer within the Black family, their substance abuse is an additional encumbrance weighing on a community already shouldering a disproportionate amount of community-debilitating factors such as poverty and oppression (Curtis-Boles & Jenkins-Monroe, 2000).

Fortunately, substance abuse treatment has proven effective in mitigating the deleterious consequences of substance abuse. Treatment is associated with decreased levels of substance use, criminal activity, jail time, and HIV infection; increased employability, post-natal birth weights, and family functioning; as well as improved medical and psychiatric conditions (Greenfield et al., 2007; NIDA, 1997; NIDA 2008; NIDA, 2009; Office of National Drug Control Policy [ONDCP], 2008). Successful substance abuse outcomes are largely associated with treatment retention, such that there is a positive correlation between length of stay in treatment and constructive change (Greenfield et al., 2007; NIDA, 1997; NIDA, 2009). Additionally, data has shown that short treatment stays increase client risk of multiple treatment episodes (Mertens & Weisner, 2000) which is linked to continued substance abuse, increased criminal activity, lower employment, and risky behavior such as sex work (Anglin, Hser, & Grella, 1997;

Palmer, Murphy, Piselli, & Ball, 2009), further underscoring the importance of treatment retention.

Empirical findings suggest that AfA women have the lowest rates of treatment retention in comparison to other ethnic and gender groups in substance abuse treatment (McCaul et al., 2001; Mertens & Weisner, 2000). Such data validates the need for immediate research aimed at increasing the retention rates of this population. Thus, the purpose of this chapter is two-fold. The first aim is to review existing literature pertaining to disparities in treatment retention and highlight a significant barrier to treatment retention for this population. The second is to present support for an empirical focus on culturally responsive working alliance development as a means to address this barrier and enact a promising first step towards increasing the treatment retention rates of AfA women with substance use disorders. Therapist characteristics believed to be culturally responsive and facilitative of a strong working alliance with this population will be outlined.

Treatment Retention and African American Women with Substance Use Disorders

Treatment retention is operationalized as the number of days spent in treatment from the date of admittance to the last date of service (Roberts & Nishimoto, 2006). Research has repeatedly demonstrated retention to be a major challenge in substance abuse treatment (Dobkin, De Civita, Paraherakis & Gill, 2002; Meier, Donmall, Barrowclough, McElduff & Heller, 2005), with dropout rates in outpatient programs averaging 55% (Agosti, Nunes, & Ocepeck-welikson, 1996). Data from the 2009 SAMHSA Treatment Episode Data Set (TEDS) showed that of the 1.37 million client discharges in 2005, only 44% completed treatment (Substance Abuse Mental Health

Services Administration [SAMHSA], 2009). As stated previously, treatment retention is positively correlated with successful treatment outcomes (Fiorentine, Nakashima, & Anglin, 1999; Greenfield et al., 2007; NIDA, 2007; NIDA, 2009) such as decreased or cessation of substance use, decreased criminality and risky behavior, increased employment (Anglin et al., 1997; Palmer et al., 2009), and improved psychological functioning (Roberts & Nishimoto, 1996). Such findings highlight the necessity of an empirical focus on improving substance abuse treatment retention rates.

African American ethnicity (Agosti et al., 1996; Campbell, Weisner, & Sterling, 2006; Jacobson, Robinson & Bluthenthal; 2007; King & Canada, 2004; McCaul et al., 2001; Milligan, Nich, & Carroll, 2004; Siqueland et al., 2002a; Wolf, Sowards, & Wolf, 2003) and female gender (Arfken, Klein, di Menza & Schuster, 2001; King & Canada, 2004; McCaul, Svikis & Moore, 2001; Petry & Bickel, 2000) have been shown to be independent and consistent predictors of low treatment retention. The following is a brief review of the robust findings concerning individual investigations of both these variables, followed by a review of the literature pertaining to the intersection of the two.

African American Ethnicity and Treatment Retention

Several studies identified significantly lower treatment retention rates among African American participants compared to their European American counterparts (Campbell et al., 2006; Jacobson et al., 2007; King & Canada, 2004; Longshore & Teruya, 2006; McCaul et al., 2001; Milligan et al., 2004; Siqueland et al., 2002a: Wolf et al., 2003). Jacobson et al.'s (2007) review of 10,591 study participants' intake and discharge records from every publicly funded outpatient and residential alcohol treatment programs in Los Angeles County during 1998–2000, revealed significantly lower

retention rates for African Americans in both outpatient and residential programs in comparison to European Americans. Campbell et al. (2006) investigated substance abuse treatment initiation and retention rates of 419 African American, European American, Native American, Latino, and Asian American adolescents. Results indicated that even after controlling for severity of substance use, African Americans had the lowest rates of retention among all groups.

While there exists convergent evidence that African American ethnicity is a predictor of low treatment retention, other studies have found no differences (e.g. Niv, Pham, & Hser, 2009). It has also been suggested that the predictive role of ethnicity may be mediated by educational attainment (Sayre, Schmitz, Stotts, Averill, Rhoades, & Grabowski, 2002). Though studies have shown that higher education levels are associated with longer stays in substance abuse treatment (Mertens & Weisner, 2000; Van Ness, Davis, & Johnson, 2004), no nationally representative studies with detailed adjustment for educational attainment among ethnic groups are available in the health care literature (Wiltshire, Person, Kiefe, & Allison, 2009).

Female Gender and Treatment Retention

Studies examining whether gender is an independent predictor of treatment retention are inconsistent. Several clinical trials that examined gender differences in substance abuse treatment retention revealed women to have poorer retention rates than their male counterparts (Arfken et al., 2001; King & Canada, 2004; McCaul, Svikis & Moore, 2001; Petry & Bickel, 2000). However, a convergence of results from several large, population-based studies suggest that gender is not a significant predictor of substance abuse treatment retention (Greenfield et al., 2007).

In response to these divergent results, Humphreys and Weisner (2000) caution that common exclusion criteria used in large-scale, substance abuse research often show a pattern of producing population samples that are largely European American and higher functioning than individuals seen in actual practice. They argue that the exclusion criteria disproportionately exclude African Americans and individuals with lower income and more severe substance use and psychiatric problems (Humphreys & Weisner, 2000). This has direct implications for the generalizability of large-scale studies to substance-abusing African American women since this group typically presents with more severe symptomatology than other groups of substance abusers (Beatty, Jones, & Doctor, 2005; Boyd, Phillips, & Dorsey, 2003).

The Intersections of African American Ethnicity, Female Gender, and Treatment Retention

The author found only two studies that explored the intersection of ethnicity and gender concerning treatment retention among substance abusers. McCaul et al. (2001) investigated a combined ethnicity/gender variable, and the results showed that treatment retention rates for AfA women were lower than any other ethnic and gender group studied. In a women-only sample of 317 participants in an outpatient substance abuse treatment program, Mertens and Weisner (2000) found that longer treatment retention was predicted by ethnicities other than African American. Despite a dearth of findings specific to the treatment retention of the target population, the aforementioned emergent data, along with robust data on separate and independent analyses of AfA ethnicity and female gender provides compelling evidence that retention for this population is among the lowest of substance abusers and of great concern (Bride & Humble, 2008).

The finding of only two studies concerning the treatment retention of AfA women is likely related to the fact that historically, gender and ethnicity have been treated as independent variables in substance abuse research (Greenfield et al., 2007). Such treatment of these variables reflects in part, the poor acknowledgement of the saliency of ethnicity and gender as dimensions that transform the meaning and experience of the other (Jackson & Greene, 2000). Such treatment also highlights the necessity of an urgent and increased empirical focus on the intersection of these cultural characteristics as it relates to the clinical experience of AfA women.

In fact, AfA women with substance use disorders are overrepresented in public substance abuse treatment programs relative to their numbers in the general population (NIDA, 2003; Roberts & Nishimoto, 2006; Weisner & Schmidt, 1994 as cited in Schmidt & Mulia, 2009). The author posits that this groups' overrepresentation does not necessarily negate the need for a focus on treatment retention, but may highlight a serious service delivery problem wherein AfA women often present to treatment, but prematurely drop out in numbers significantly higher than many other groups (Lewis, 2004; Mertens & Weisner, 2000; Roberts, 1999).

Barriers to Treatment Retention for African American Women with Substance Use Disorders

Barriers to treatment retention are conceptualized as program or client factors (Amaro, Chernoff, Brown, Arévalo & Gatz, 2007) that influence premature dropout unrelated to mutual client–therapist agreement to terminate or treatment ending for reasons such as incarceration or relocation (Cournoyer, Brochu1, Landry & Bergeron, 2007). A commonly cited programmatic barrier to treatment retention for AfA women is

"negative client perception of the therapist" (see Bass & Jackson, 1997; Dalton, 2001; Lewis, 2004; Palmer et al., 2009; Roberts & Nishimoto, 2006; Sanchez-Hucles, 2001, Terrell & Terrell, 1984), which is a generic expression for several independent, but related findings in the literature concerning negative client views of the therapist associated with treatment drop out. These findings include client perceptions that therapists are insensitive and untrustworthy (Terrell & Terrell, 1984), unable or unwilling to connect with clients (Palmer et al., 2009), and lack relevant cultural knowledge about the clients with whom they work (Lewis, 2004). The barrier of "negative client perception of the therapist" also highlights the issue of weak therapeutic relationships between clients and therapists, and the subsequent influence on treatment retention.

The Importance of the Therapist and the Therapeutic Relationship to Treatment Retention

Research highlights the importance of the therapist, and the therapeutic relationship to treatment. In fact, the therapist is one of the most significant factors in effective substance abuse treatment (Najavits & Weiss, 1994). Other than client factors, the therapeutic relationship accounts for more of the explained variance in treatment outcomes than any other variable (Ackerman et al., 2001), and a positive relationship with a therapist is a significant factor in a woman's decision to remain in substance abuse treatment (Dalton, 2001; Lewis, 2004; Nelson-Zlupko et al., 1996; Sanchez-Hucles, 2001). Fiorentine et al.'s (1999) data concerning client engagement in drug treatment also underscores the relevance of the therapist to treatment retention. Their findings showed that treatment experiences, inclusive of a perceived favorable therapeutic relationship with a therapist, influenced client's active engagement in treatment

(Fiorentine et al., 1999). Thus, the author posits that identification of therapist characteristics facilitative of a positive therapeutic relationship is a promising step towards increasing treatment retention for this population.

Therapist Characteristics, Working Alliance, and Treatment Retention

A popular measurement of the therapeutic relationship is the working alliance (Lambert & Barley, 2002), and it has been demonstrated to be a consistent predictor of treatment retention among substance abusing populations (Barber et al., 2001). The working alliance is broadly defined as the emotional attachment between the client and therapist (Martin et al., 2000; Luborsky et al., 1997). A well-accepted operational definition of the working alliance is that proposed by Bordin (1979). He defined working alliance as comprised of three dimensions: (1) the affective bond between the therapist and the client, (2) therapist and client agreement on treatment goals, and (3) therapist and client agreement on treatment tasks to achieve the goals (Bordin, 1979; Martin et al., 2000; Horvath & Symonds, 1991).

The literature has consistently recognized the significant and independent contribution the working alliance makes to positive treatment outcomes such as treatment retention (Barber et al., 2001; Palmer et al., 2009) across modalities and client groups (Barber et al., 2001; Conners, Carroll, DiClemente, Longabaugh, & Donovan, 1997; Horvath & Symonds, 1991; Martin et al., 2000; Meier et al., 2005; Ackerman et al., 2001; Wintersteen, Mesinger & Diamond, 2005). Working alliance has been documented to account for 36% to 57% of the variance in treatment outcomes (Horvath & Luborsky, 1993), and the most recent meta-analytic review concerning the relationship between working alliance and outcome that spanned 79 studies, cited a moderate effect size of .22

(Martin et al., 2000). Empirical study of this relationship has proven it to be stable and consistent, and not the result of suspected confounds such as clinical diagnosis, type of intervention, type of rater (i.e. patient, therapist, and observer), or time of rating (Martin et al., 2000). In fact, the working alliance is so directly linked to positive treatment outcomes (Fiorentine & Hillhouse, 1999; Lambert & Barley, 2002; Luborsky) that many theorists refer to it as the "quintessential integrative variable" (Wolfe & Goldfried, 1988, p.449) and an effective intervention in and of itself (Martin et al., 2000; Horvath & Symonds, 1991).

The Therapist's Contribution to the Working Alliance

Both the therapist and client contribute to the development of the working alliance; but it has been the client's contribution that has garnered the greatest amount of empirical scrutiny (Ackerman & Hilsenroth, 2003; Horvath & Luborsky, 1993; Meier et al., 2005; Ritter, Bowden, Murray, Ross, Greeley, & Pead, 2002). The APA Division 29 Task Force on Empirically Supported Therapy Relationships asserts that therapist characteristics are just as central to working alliance development and significant enough to warrant investigations that explicitly identify therapist characteristics facilitative of a positive therapeutic relationship (Ackerman et al., 2001). Norcross and Lambert (2011) and The US Department of Health and Human Services (USDHHS) (2001) extend this argument and call for an understanding of therapist characteristics that promote working alliance development with diverse and disorder-specific groups of clients.

An argument for the study of therapist characteristics predictive of working alliance development concerns the reality that client characteristics (i.e. interpersonal skills, intrapersonal dynamics, and diagnostic features) can only be manipulated, if at all,

once a client presents to treatment. Thus, an inequitable focus on client factors that contribute to working alliance development is a handicap to treatment; for a robust understanding of only client factors necessitates that initial and valuable treatment time be spent preparing the client for services. In contrast, a more equitable focus on therapist characteristics that are facilitative of the working alliance allows treatment to be client-responsive at the point of entry, when the client is likely to be the most motivated for treatment, and where dropout often occurs (Chawdhary et al., 2007).

A significant relationship between working alliance and treatment retention has been found for clients in substance abuse treatment (Barber et al., 2001). Moreover, negative therapist attitudes have been identified as a significant programmatic barrier to treatment retention with AfA women with substance use disorders (Lewis, 2004; Rhodes & Johnson, 1997; Roberts & Nishimoto, 2006). Consequently, the identification of therapist characteristics facilitative of a positive working alliance with the target population could ultimately lead to the mitigation of a significant barrier to retention and improved treatment retention rates for this vulnerable group.

Therapist Characteristics and Working Alliance Development

"General Therapist Characteristics." Ackerman and Hilsenroth's (2003) meta-analysis of therapist characteristics influencing the working alliance identified nine therapist attributes as facilitative of working alliance development in the general counseling population: empathy, positive regard, genuineness, trustworthiness, expertness, self-efficacy, flexibility, interest, and alertness. Three of these characteristics (empathy, positive regard, and genuineness) are also known as Carl Rogers' necessary and sufficient conditions of therapeutic change (Ritter et al., 2002). Findings of the APA

Division 29 Task Force on Empirically Supported Therapy Relationships provide support for these three therapist characteristics as well. The Task Force classified empathy as "demonstrably effective" (Ackerman et al., 2001, p. 495), and positive regard and genuineness as "promising and probably effective" (Ackerman et al., 2001, p. 495). In the substance abuse literature, these characteristics also received empirical support as therapist characteristics associated with positive working alliance development (Najavits & Weiss, 1994; Ritter et al., 2002). Given the robust empirical findings that empathy, positive regard, and genuineness are therapist characteristics associated with positive relationship development across client type and treatment modality (Ackerman & Hilsenroth, 2003), they will be referred to as General Therapist Characteristics (GTCs).

Of important note, data concerning GTCs is based largely on European American male clients. As such, despite the robustness of the findings, they may not significantly predict alliance development for African American women with substance use disorders. Additionally, research has demonstrated the existence of gender and cultural differences in personal characteristics; etiology, patterns, and progression of substance use; and treatment needs among substance abusers (Brady & Ashley, 2005). Aggregate analyses may have masked the influence of these important differences. Thus, the author cautions against generalizing results based on a European male population as has been routinely done in the past (Blumenthal, 2002; Copeland & Hall, 1992; Kropp & Banhal-Baugus, 1996; Roberts, Jackson, & Carlton-LaNey, 2000; Sterk, Elifson & Theall, 2000; Swift et al., 1996; Wallen, 2002), and calls for an empirical study of whether empathy, positive regard, and genuineness are in fact, predictive of positive working alliance development with this population in particular.

Consideration of therapist characteristics responsive to the unique cultural characteristics of client groups is justified by findings of Griner and Smith's 2006 meta-analysis of culturally responsive mental health interventions. Interventions adapted for a specific cultural group were four times as effective as those that were not culturally specific. Other research demonstrates that culturally responsive treatment is positively correlated with improved working alliance (Chung & Bemak, 2002; Comas-Diaz & Greene, 1994). Thus, an investigation of culturally responsive therapist characteristics appears promising for the study of effective working alliance development with AfA women substance abusers.

"Population-Sensitive Therapist Characteristics." African American women enter substance abuse treatment facing significant barriers to treatment retention. One barrier appears with great frequency in the small, but emergent body of literature on African American women with substance use disorders: the experience of culturally insensitive attitudes (Bass & Jackson, 1997; Ehrmin, 2002; Greene, 1994; Lewis, 2004; Rhodes; Roberts et al., 2000). A review of the literature on the working alliance concerning women, women substance abusers, and African American women substance abusers in particular, have highlighted therapist characteristics posited to be responsive to the cultural insensitivity this population often faces. These characteristics, referred to as Population-Sensitive Therapist Characteristics (PSTCs), include multicultural competency, egalitarianism, and empowerment.

Multicultural competency. The empirical focus on multicultural competency has steadily increased in the mental health field over the last three decades in light of the demographic changes in the U.S. population (Dyche & Zayas, 2001; Fuertes et al., 2006).

Multicultural competency refers to the ability of a therapist to: (1) be actively mindful of their cultural conditioning and how it influences their psychological practice; (2) actively attempt to understand, respect, and appreciate the worldview of the client; and (3) therapeutically intervene with skills and strategies that are responsive to the needs, experiences, and values of the client (Sue, Arredondo, & McDavis, 1992). Researchers suggest that a failure to consider and address relevant cultural factors (e.g. sexism, racism, race-specific gender effects, and gender-specific race effects) will compromise therapeutic relationships with AfA women (Constantine, 2007; Greene, 1994) and those with substance use disorders (Bass & Jackson, 1997; Comas-Diaz & Greene, 1994; Ehrmin, 2001; Ehrmin, 2002; Ferguson & Candib, 2002; Lewis, 2004; Roberts et al., 2000). Regression analyses in Fuertes and Brobst's (2002) examination of client ratings of therapist multicultural competence showed that multicultural competency explained an additional and significant amount of variance in client ratings of satisfaction only for ethnic minority clients, validating the assumption that multicultural competency is important for that demographic.

Research has demonstrated that the absence of therapist multicultural competence results in clinical misses including misunderstanding, misinterpretation, and misdiagnosing of clients' attitudes, values, beliefs, opinions, and behaviors (Ancis, 2004; Chung & Bemack, 2002; Sue et al., 1992); as well as premature termination of treatment (Castro & Garfinkle, 2003). Specific to African American clients in therapy with European American therapists, Constantine (2007) found that clients' perception of microaggressions predicted a weak working alliance and was associated with low ratings of therapist multicultural competence. In sum, findings support the theory that therapist

multicultural competence is likely facilitative of strong working alliances with African American women.

Egalitarianism. Egalitarianism as a therapist characteristic is defined as the therapist's capacity to share power with the client and create a therapeutic relationship based on a recognition of the equally valuable expertise of both parties: the therapist as a clinical expert and the client as an expert on themselves (Worell & Johnson, 2001). The resulting egalitarian relationship includes self-disclosure by the therapist (Remer & Rostosky, 2002; Remer & Oakley, 2005) and is absent of the imbalanced power hierarchies that often relegate African American women substance abusers to the bottom of socially constructed power differentials. The provision of an egalitarian therapist could aid members of this population in defining themselves as capable contributors to the well-being of self and others. Such self-definition is believed to initiate the lessening of poor self-esteem (Ehrmin, 2001; Lewis, 2004), and internalized racism (Amaro et al., 2005; Curtis-Boles & Jenkins-Monroe, 2000; Lewis, 2004) exhibited by many Black women substance abusers (Ehrmin, 2001; Lewis, 2004; Roberts et al., 2000). A participant quote from Davis and Ancis (unpublished manuscript) illustrates the utility of and client preference for therapist egalitarianism, "That's what I'm asking for, help you know. I'm not asking you to drive the car, I'm asking you to be in the passenger seat while I drive, alright (p.16)."

Chin (1994) offers a favorable perspective on the role of hierarchies in the lives of women and advises of the importance of hierarchical relationships to many women of color. She argues that unequal power structures are not inherently detrimental to the therapeutic process, but that the therapist's inappropriate use of power is what can be

hindering in therapy. Contrary to Chin (1994), feminist and womanist scholars (Comas-Diaz & Greene, 1994; hooks, 2005; Rader & Gilbert, 2005) advise that given women's subordinate positions in most cultures, relationships based on more equal power structures are essential in cultivating space for women to see themselves as valuable and their experiences as non-pathological responses to oppressive socio-political factors. The present author posits that both perspectives are valid, and that taken together, do not diminish the usefulness of egalitarianism, but highlight the importance of therapists considering individual dynamics when negotiating power in therapy with women of color.

Empowerment. Therapist empowerment concerns the ability of the therapist to increase the client's self-efficacy to effectively cope with current and future stressors (Worell & Johnson, 2001). Feminist conceptualizations of empowerment focus on facilitating the client's understanding of both internal and external contributions to their distress and well-being (Worell & Remer, 2003). Facilitating the client's understanding of both causes of pain and sources of resilience is posited to imbue clients with a sense of power to positively address and/or cope with their problems (Worell & Remer, 2003). In an investigation of female substance abusers' therapist preferences, Davis and Ancis (unpublished manuscript) found that women substance abusers expressed a preference for a therapist who focused on their strengths as well as their problems. One participant indicated, "I needed someone to see me, see, you know, that I could make it. I needed somebody to tell me that they thought I had what it takes to make it" (Davis & Ancis, unpublished manuscript, p.16).

Researchers (Greene, 1994; Roberts et al., 2000) assert there is a therapeutic

imperative for therapists to understand the rich, but often antagonistic social milieu African American women must navigate, that at any given time, may facilitate, or undermine her adaptive functioning. In addition to two marginalized identities, African American women substance abusers, have the added stigmatized identity of a substance abuser that serves to amplify oppression and social rejection (Comas-Diaz & Greene, 1994; Ehrmin, 2005; Lewis, 2004). Thus, it is conceivable that this triple marginalization intensifies feelings of powerlessness. As such, a therapist who facilitates clients' empowerment could be successful in helping them positively address and cope with the many factors that undermine or make their recovery challenging. (Ehrmin, 2005; Lewis, 2004; Roberts & Nishimoto, 2006; Stahler, Kirby & Kerwin, 2007).

The argument that multicultural competency, egalitarianism, and empowerment are therapist characteristics that are culturally responsive to the target population begs the research question, "Are these PSTCs facilitative of a positive working alliance with AfA women with substance use disorders?" Another question to be investigated simultaneously is, "How much of the variance in this population's working alliance ratings do these characteristics account for over and above GTCs (i.e. empathy, positive regard, and genuineness), if any?" Whatever combination of therapist characteristics proves to be significantly facilitative of a positive working alliance with the target population, the research will be successful in identifying for therapists a culturally responsive model of working alliance development that could ultimately lead to increased treatment retention for AfA women with substance use disorders.

Conclusion

Substance abuse is a complex problem that has proven treatable with appropriate

therapeutic interventions (NIDA, 2009). However, the consensus is that treatment is largely successful to the extent that clients are retained in treatment (Greenfield et al., 2007; NIDA, 2007; NIDA, 2009). Given the documented vulnerabilities of AfA women substance abusers and mounting evidence of their low treatment retention rates, there is an urgent need for an empirical focus on increasing retention rates for this population (Bride & Humble, 2008).

This paper proposes that a promising first step towards increasing treatment retention for the target group is to focus on strengthening the working alliance between AfA women substance abusers and their therapists. Research indicates that the working alliance is a consistent predictor of treatment completion among substance abusers (Luborsky et al., 1995; Barber et al., 2001). Unfortunately, findings that these clients often perceive negative and prejudicial attitudes on the part of their therapists and treatment staff (Bass & Jackson, 1997; Cournoyer et al., 2007; Dalton, 2001; Lewis, 2004; Roberts & Nishimoto, 2006; Rhodes & Johnson, 1997; Sanchez-Hucles, 2001) suggests there exist significant barriers for professionals in developing strong working alliances with this group.

Empathy, positive regard, and genuineness are identified as GTCs that are facilitative of working alliance development across client type and treatment modality (Ackerman & Hilsenroth, 2003; Najavits & Weiss, 1994; Ackerman et al., 2001; Ritter et al., 2002). Multicultural competence (Bass & Jackson, 1997; Comas-Diaz & Greene, 1994; Constantine, 2007; Greene, 1994; Ehrmin, 2001; Ehrmin, 2002; Ferguson & Candib, 2002; Lewis, 2004; Nelson-Zlupko et al., 1995; Roberts et al., 2000), empowerment (Davis & Ancis, unpublished manuscript; Ehrmin, 2005; Lewis, 2004;

Roberts & Nishimoto, 2006; Stahler, Kirby & Kerwin, 2007), and egalitarianism (Davis & Ancis, unpublished manuscript; Rader & Gilbert, 2005) are identified as PSTCs facilitative of working alliance development specifically with AfA women substance users. The author hypothesizes that while a positive working alliance may be established with the target population utilizing GTCs, concurrent use of PSTCs that are sensitive to the reality of being an AfA woman substance abuser may result in a stronger working alliance. Identification of therapist characteristics that are facilitative of working alliance development specifically for this population can increase the likelihood that therapists will be more effective at relationship building, likely allowing them to successfully attend to relevant cultural issues and counteract ethnic, gender, and disability prejudice among other biases emanating from thought and behavior.

In sum, the author advocates for research that will identify therapist characteristics that are empirically demonstrated to be facilitative of positive working alliance development with AfA women who have substance use disorders. In addition to allowing for more effective relationship building with this population, identifying such characteristics could lead to the development of a culturally responsive model of working alliance development that allows for a greater understanding of how the therapist can create and sustain a therapeutic relationship with this population. Such knowledge concerning the creation of more effective working alliances could also ultimately lead to increased levels of treatment retention for this group.

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CHAPTER II

REMOVING A BARRIER TO WIDEN THE DOOR TO RECOVERY: WORKING ALLIANCE DEVELOPMENT WITH AFRICAN AMERICAN WOMEN SUBSTANCE ABUSERS

Substantial evidence exists that substance abuse is the most significant and preventable public health problem facing America (National Institute on Drug Abuse [NIDA], 2008). Its consequences are associated with the overcrowding of jails and emergency rooms, homelessness, violence against women, sexually transmitted diseases, HIV/AIDS, sick days off work (NIDA, 2003a; NIDA 2008), premature birth rates (Roberts & Nishimoto, 2006; Scott-Lennox, Rose, Bohlig, & Lennox, 2000), and millions of preventable deaths (Blumenthal, 2002; Office of National Drug Control Policy [ONDCP], 2001). It has a price tag of an estimated 350 billion dollars annually (NIDA, 2008), which is trending on the rise.

Substance abuse is particularly impactful on the lives of African American (AfA) women. In comparison to other demographic groups, their substance use is marked by usage of the most severely addictive substances (Stahler, Kirby & Kerwin, 2007), the highest rates of substance-related medical emergencies and mortalities (Curtis-Boles & Jenkins-Monroe, 2000), and the highest rates of untreated medical disorders and dental disease (McCaul, Svikis, & Moore, 2001). HIV/AIDS is the leading, third, and fourth cause of death among AfA women ages 25-34, 35-44, and 45-54, respectively; and 24% of AfA women contract the life-threatening HIV infection through substance use, largely

drug injections (Centers for Disease Control and Prevention [CDC], 2008).

Positive news is found in the robust data showing that substance abuse treatment works, yielding successful treatment outcomes inclusive of reduced substance use, jail time, criminal activity, HIV infection, and accidental deaths (Greenfield et al., 2007; NIDA, 1997; NIDA 2008; NIDA, 2009; ONDCP, 2008). There is vast consensus that these successful outcomes are predicated on clients staying in treatment (Greenfield et al., 2007; NIDA, 1997; NIDA, 2009). Yet, unfortunately, high dropout rates are more the norm among substance abusers (Dobkin, De Civita, Paraherakis & Gill, 2002; Meier, Donmall, Barrowclough, McElduff & Heller, 2005; Substance Abuse and Mental Health Services Administration [SAMSHA], 2009) and AfA women in particular (McCaul et al., 2001; Mertens & Weisner, 2000).

A small body of literature has focused on the individual characteristics of AfA women substance abusers in an effort to understand their poor treatment retention rates (e.g., Allen, 1995; Roberts & Nishimoto, 2006). Efforts to increase the target population's length of stay in treatment has included the offering of clinical interventions responsive to such characteristics as religiosity (e.g., Stahler et al., 2007), low socioeconomic status (e.g., Bride & Humble, 2008), and lack of transportation (Dakof et al., 2003). The results have been promising; however, the focus of such interventions has often been on client characteristics that are seldom modifiable and can only be responded to through interventions that are often costly and labor intensive (Bride & Humble, 2008). As such, this investigation seeks to expand the dialogue to include a potentially more adaptable, laborsaving, and sustainable focus that is demonstrated to significantly impact the treatment experience of the client – the therapist.

After the client, the therapist accounts for the most significant amount of variance in treatment outcomes (Lambert, 1994; Wampold, 2001). Particularly for clients with substance use issues, research has demonstrated that the therapist is either equally or more significant to the effectiveness of treatment relative to the client or treatment intervention (Luborsky et al., 1986; Najavits, Crits-Christoph, & Dierberger, 2000). So impactful is the therapist for substance abusing clients, that many intervention researchers assert that the therapist is the therapy (Najavits, 2002). Najavits (2002) illustrates this through her question, "Who can separate the dancer from the dance" (p. viii)? Moreover, the therapist in relationship with the client (i.e., the therapeutic relationship) is significantly and consistently associated with increased treatment retention rates (Barber et al., 2001; Norcross & Lambert, 2011; Palmer, Murphy, Piselli, & Ball, 2009; Roberts & Nishimoto, 2006).

African American Women and Treatment Retention

Some of the lowest rates of retention in substance abuse treatment are found among AfA women. An emergent body of literature has identified AfA ethnicity and female gender as predictors of low treatment retention in comparison to both European Americans (Campbell et al., 2006; Jacobson et al., 2007; King & Canada, 2004; Longshore & Teruya, 2006; McCaul et al., 2001; Mertens & Weisner, 2000; Milligan et al., 2004; Siqueland et al., 2002a: Wolf et al., 2003) and men (Arfken et al., 2001; King & Canada, 2004; McCaul, Svikis & Moore, 2001; Petry & Bickel, 2000). Though the evidence is compelling, divergent findings do exist. Some studies have found no ethnic differences in retention (e.g., Niv, Pham, & Hser, 2009). In addition, the predictive role of ethnicity has been suggested to be mediated by educational attainment (see Mertens &

Weisner, 2000; Sayre et al., 2002; Van Ness, Davis, & Johnson, 2004). However, no nationally representative study investigating the influence of educational attainment on treatment retention among diverse ethnic groups has been published in the literature (Wiltshire, Person, Kiefe, & Allison, 2009).

Similarly, findings for gender have varied. Several population-based studies have found that gender is not a significant predictor of retention and suggested that the advent of gender-sensitive treatment services in the mid-nineties have resulted in women's retention rates matching, and at times exceeding, that of men (Greenfield et al., 2007). A cautionary note is that exclusionary criteria used by large-scale studies disproportionately exclude African Americans and individuals with severe substance use (Humphreys & Weisner, 2000). This limits generalizability of results to AfA women given their ethnicity, and their tendency to present to treatment more severely addicted and with more addiction-related medical problems than other client groups (Beatty, Jones, & Doctor, 2005; Boyd, Phillips, & Dorsey, 2003; Nelson-Zlupko et al., 1996).

Despite the inconsistencies concerning the influence of ethnicity and gender on treatment retention, emergent findings based specifically on investigations of a combined ethnicity and gender variable have shown that AfA women with substance use disorders have significantly lower retention rates in comparison to other cultural groups (see McCaul et al., 2001; Mertens & Weisner, 2000; Scott-Lennox et al., 2000). Though preliminary, this data, in tandem with robust data from separate and independent analyses of ethnicity and female gender, provides convincing support that retention for this population is significantly lower than other groups.

Empirical studies exist concerning increasing the retention of AfA women in

substance abuse treatment. However, this body of literature is small and limited in focus. A comprehensive search of the PsycINFO, PsycEXTRA, PsycARTICLES, Psychology and Behavioral Sciences Collection, and MEDLINE databases yielded only three studies that empirically investigated interventions aimed at increasing treatment retention rates for this population (see Bride & Humble, 2008; Dakof et al., 2003; Stahler et al., 2007), and all focused on examining the efficacy of clinical services. Bride and Humble (2008) investigated the efficacy of a contingency management program for a sample of urban, AfA substance abusing women on welfare. Findings provided evidence that the intervention increased both treatment attendance and completion rates among the sample (Bride & Humble, 2008). Dakof et al. (2003) conducted a randomized investigation of an in-home enrollment and retention program that was an independent adjunct to substance abuse treatment, in a sample of Black mothers with substance-exposed infants. Results revealed the intervention condition was a significant predictor of treatment retention at four weeks (Dakof et al., 2003). Last, Stahler et al. (2007) randomly assigned participants to either a faith-based treatment adjunct to residential treatment or residential treatment with an Attention Control. The experimental condition resulted in significantly better treatment retention than standard residential treatment alone (Stahler et al., 2007).

The results of studies focused on increasing treatment retention rates of AfA women substance abusers are promising, yet, as mentioned earlier, adjusting clinical services is often costly and/or labor intensive (Bride & Humble, 2008). Moreover, a promising area of intervention has been ignored. Each study examined the efficacy of clinical services, but none examined the effectiveness of the therapist. While clinical services represent a significant barrier to treatment retention for substance abusers (Dakof

et al., 2003, Roberts & Nishimoto, 2006), it is only one programmatic barrier. Another significant programmatic barrier to treatment retention cited in the literature is that of the therapist.

The Role of the Therapist

"Negative client perception of the therapist" is a commonly cited programmatic barrier to treatment retention among African Americans in general (Closser & Blow, 1993 as cited by Bass & Jackson, 1997; Palmer et al., 2009; Terrell & Terrell, 1984; Wade & Bernstein, 1991), and AfA women substance abusers specifically (Lewis, 2004; Roberts & Nishimoto, 2006). Negative client perception of the therapist is an umbrella construct used by this author to typify empirical findings regarding clients' perceptions about clinician characteristics considered to be obstacles to staying in treatment. Such findings include client perceptions that therapists are untrustworthy (Terrell & Terrell, 1984), lack relevant cultural knowledge (Lewis, 2004), and are unable or unwilling to connect (Palmer et al., 2009).

Several authors (Bass & Jackson, 1997; Comas-Diaz & Greene, 1994; Constantine, 2007; Sanchez-Hucles, 2001) have argued that a client's negative perception of the therapist weakens the therapeutic relationship. For example, Constantine (2007) found that perceived racial microaggressions by AfA clients were predictive of a weaker working alliance with therapists. Such findings, along with evidence that: (1) therapist characteristics account for between 6% to 9% of the variance in treatment outcomes, with a strong effect size ranging from .50 to .60. (Wampold, 2001); (2) the therapist is one of the most significant factors in effective substance abuse treatment (Najavits & Weiss, 1994); and (3) a perceived favorable therapeutic relationship by the client is positively

associated with treatment retention (Dalton, 2001; Fiorentine et al., 1999; Lewis, 2004; Nelson-Zlupko et al., 1996; Sanchez-Hucles, 2001) validates a focus on the therapist as the target of intervention in order to ultimately improve treatment retention rates for AfA women substance abusers. The author posits that an investigation concerning the therapist's contribution to the establishment of a positive therapeutic relationship will close a gap in the retention literature by addressing a significant barrier to treatment retention for this population.

The Therapeutic Relationship

For clients with substance use issues, the therapist is extremely vital to the effectiveness of treatment and achievement of successful outcomes (Ackerman et al., 2001; Lambert, 1994; Najavits, Crits-Christoph, & Dierberger, 2000; Wampold, 2001). Robust data demonstrates that a perceived favorable therapeutic relationship by the client is significantly associated with increased treatment retention (e.g., Fiorentine et al., 1999; Hawke, Hennen, Gallione, 2005; Martin, 2000; Palmer et al., 2009). Even still, relatively little is known about how to create positive therapeutic relationships for diverse clinical populations (Ackerman et al., 2001) or disorder-specific groups (Norcross & Lambert, 2011) such as AfA women substance abusers. The APA Division 29 Task Force on empirically supported therapy relationships asserts that clinical and training guidelines should explicitly outline therapist attributes that promote a successful therapeutic relationship in order to enhance the effectiveness of treatment for client populations (Ackerman et al., 2001). Relatedly, there exists a call to further study therapist factors that are facilitative of a productive therapeutic relationship (Ackerman et al., 2001; Conners et al., 1997; Norcross & Lambert, 2011).

The Working Alliance

The working alliance (WA) is a well-accepted construct that characterizes the therapeutic relationship (Lambert & Barley, 2002). WA is a consistent predictor of treatment outcomes, inclusive of treatment retention, in both general clinical (Ackerman et al., 2001; Horvath & Symonds, 1991; Wintersteen et al., 2005) and substance abusing populations (Barber et al., 2001; Conners et al., 1997; Martin et al., 2000; Meier et al., 2005). It accounts for 36% to 57% of the variance in general treatment outcomes (Horvath & Luborsky, 1993), and the most recent meta-analysis on the alliance and outcome cited a moderate, but highly reliable effect size of .28 (Horvath, Del Re, Flückieger, & Symonds, 2011). Specific to the problem of low treatment retention, the most recent meta-analysis on the alliance and dropout rates cites a strong effect size of .55 (Sharf, Primavera, & Diener, 2010). The significant statistical relationship between alliance and outcome, as well as alliance and dropout, has proven robust irrespective of patient diagnosis, type of clinical intervention, time of rating, or type of rater (i.e., patient, therapist, or observer) (Horvath et al., 2011; Martin et al., 2000; Sharf et al., 2010).

Therapist Characteristics Likely Facilitative of WA Development with AfA Women Substance Abusers

"General Therapist Characteristics." Empathy, unconditional positive regard, and genuineness were identified by Rogers (1957) as necessary and sufficient conditions for therapeutic change. Since then, they have been empirically validated as facilitative of WA across client type and treatment modality (Ackerman et al., 2001; Ackerman & Hilsenroth, 2003; Kirschenbaum & Jourdan, 2005; Ritter et al., 2002) and associated with

general therapist effectiveness (Najavits & Weiss, 1994). These therapist characteristics have robust data to support their facilitativeness of a positive WA with the general population, so it is likely they will be equally facilitative with AfA women substance abusers. However, this has not been empirically validated in the literature. The individual therapist characteristics are explored in the following paragraph, and collectively, they will be referred to as General Therapist Characteristics (GTCs).

Empathy is generally described as both an affective and cognitive process by which the therapist comes to understand the client's world as if it were his or her own (Rogers, 1957). It is operationally defined as the therapist's ability to gain an accurate emotional understanding of the client's perspective (Chung & Bemak, 2002). Unconditional positive regard is often conceptualized as the degree to which the therapist experiences acceptance of the client without stipulation (Rogers, 1957), and is operationalized as the therapist's capacity to respect and accept clients for who they are without judgment (Walker & Little, 1969). Last, genuineness, also known as congruence, refers to how freely the therapist allows himself or herself to be in the therapeutic relationship (Rogers, 1957). It is the opposite of presenting a façade (Rogers, 1957) and is operationalized as the congruence between what therapists think and feel and what they express within the context of the therapeutic relationship (Impett, Sorsoli, Schooler, Henson, & Tolman, 2008; Patterson, 1985).

"Population-Sensitive Therapist Characteristics." A review of gender-sensitive substance abuse (e.g., Ehrmin, 2002; Roberts & Nishimoto, 2006), multicultural (e.g., Ancis, 2004; Chung & Bemack, 2002; Constantine, 2007), and feminist (e.g., Comas-Diaz & Greene, 1994; Rader & Gilbert, 2005) literatures revealed three therapist

characteristics facilitative of positive client perceptions of the therapist, directly addressing the commonly cited barrier to treatment retention for this population (i.e., negative client perception of the therapist). As such, it is believed that these characteristics will be facilitative of WA development with this group. The characteristics are multicultural competence, egalitarianism, and empowerment. Given the hypothesized specificity of these characteristics to the target population, they will be collectively referred to in this study as Population-Sensitive Therapist Characteristics (PSTCs). The characteristics are often interrelated, such that they are often responsive to the same client issues. The definition and particular relevance of each therapist characteristic to WA development with the target group is discussed in the paragraphs to follow.

Multicultural competence. Multicultural competence (MC) is generally defined as a tridimensional construct that is composed of the therapist's ability to actively: (1) consider their personal cultural conditioning and how it influences their psychological practice; (2) understand and respect the worldview of the client; and (3) intervene with skills and strategies that are culturally responsive to the client (Sue, Arredondo, & McDavis, 1992). It is operationalized as the extent to which a therapist possesses cultural self-awareness, cultural knowledge, and cross-cultural counseling skills (Arredondo et al., 1996; LaFromboise, Coleman, & Hernandez, 1991).

The multicultural and feminist literatures emphasize the importance of therapist MC for responding appropriately to the unique stressors endured by AfA women that are often attributable to their marginalized and intersecting ethnic and gender identities. Unique stressors for this population of substance abusers include racism and

discrimination (Constantine, 2007), sexism and objectification (Rader & Gilbert, 2005), stigmatization and powerlessness (Najavits, 2002), and guilt and shame (Johnson et al., 2005). Given that these stressors frequently impact the client's clinical presentation (Bass & Jackson, 1997; Comas-Diaz & Greene, 1994; Jackson & Greene, 2000) and that therapist attributes that communicate understanding of the client's experience positively influence WA development, therapist MC is extensively recommended (see Ehrmin, 2001; Ehrmin, 2002; Ferguson & Candib, 2002; Lewis, 2004; Roberts et al., 2000).

Egalitarianism. Egalitarianism (EG) refers to the therapist's capacity to create a therapeutic relationship that is absent of hierarchy and replete with an acknowledgment of and capitalization on the expertise of both the therapist and the client (Rader & Gilbert, 2005; Worell & Johnson, 2001). It is operationalized as power-sharing (Worell, Chandler, & Robinson, 1996).

A robust body of literature (e.g., Comas-Diaz & Greene, 1994; Davis & Ancis, unpublished manuscript; hooks, 2005; Rader & Gilbert, 2005) suggests a strong relationship between EG and WA among the target population**.** Women often occupy a subordinate position in American culture (Comas-Diaz & Greene, 1994; hooks, 2005; Rader & Gilbert, 2005), and this is particularly the case for women of color. Specific to the target group, the addition of a substance abuser label further "relegates them to the bottom of socially constructed power differentials" (Davis, unpublished manuscript, p. 17). An egalitarian relationship is believed to be able to aid members of this population in defining themselves as valuable and capable (Davis, 2010), and likely initiate a therapeutic bond between the therapist and client in the process. A participant quote from Davis and Ancis' (unpublished manuscript) empirical investigation illustrates client

preferences for EG and alludes to its impact on WA, "That's what I'm asking for, help you know. I'm not asking you to drive the car, I'm asking you to be in the passenger seat while I drive, alright (p.16)."

Empowerment. Empowerment (EM) is conceptualized as enabling the client to cope more effectively with current and future stressors (Johnson, Worell, & Chandler, 2005). It is operationalized as the therapist's proficiency in facilitating the client's embodiment of Worell's (1993) ten "Components of Personal Empowerment": (1) positive self-evaluation/self-esteem, (2) a favorable comfort-distress ratio, (3) gender and cultural awareness, (4) personal control/self-efficacy, (5) self-nurturance, (6) effective problem-solving skills, (7) competent use of assertiveness skills, (8) effective access to multiple resources, (9) gender and cultural flexibility, and (10) social activism (as cited by Worell, 2001, p.340).

The relevance of EM to WA development with the target population was deduced from substance abuse, multicultural, and feminist literatures. Gender-sensitive addiction models highlight that abusive relationships and trauma experiences that often engender powerlessness in the lives of women are frequently interwoven in the etiology of women's substance use (Covington, 2002; Najavits, 2002). The added stigma of substance use results in triple marginalization for the target population (Ehrmin, 2005; Lewis, 2004), likely serving to increase feelings of helplessness. Feminist psychologists (e.g., Worell & Remer, 2003) argue that facilitating the client's understanding of internal and external contributions to their distress imbues them with strength to positively address their problems and thwarts continued feelings of powerlessness. Building on these findings, Davis & Chang's (under review) qualitative investigation of gender-

sensitive substance abuse treatment explicitly identifies that EM aids in WA development with women substance abusers. The following participant quote was used to illustrate the significance of therapist EM in their article, but it also highlighted the client's connection to her therapist,

> "I talk to her and she just knows how to say things that may get, that make me… not to make me feel bad, but just to feel good about myself, where I don't have to stay down, she keeps me happy" (Davis & Chang, under review, p.13).

Collectively, PSTCs (i.e., MC, EG, and EM) have strong support as therapist characteristics facilitative of WA with AfA women substance abusers. These characteristics engender therapist responsiveness to both internal and external factors that influence the experiences of this population; experiences that if ignored could pose barriers to WA development (Ackerman & Hilsenroth, 2003). Moreover, it is believed these characteristics can mitigate this population's negative perception of the therapist, a commonly cited and significant barrier to treatment retention for this population (Lewis, 2004; Palmer et al., 2009; Roberts & Nishimoto, 2006); further facilitating the development of a positive working alliance with AfA women substance abusers.

Based on the robust empirical literature that indicates GTCs are facilitative of working alliance development with clients irrespective of client type and treatment modality (Ackerman et al., 2001; Ackerman & Hilsenroth, 2003; Ritter et al., 2002), it is likely that a therapist who demonstrates GTCs (i.e., empathy, positive regard, and genuineness) will establish a positive working alliance with African American women substance abusers. However, the literature suggests that concurrent demonstration of PSTCs will elicit an even stronger working alliance. Moreover, the literature suggests

that the impact of PSTCs on WA ratings by the target group may be influenced by GTCs. That is, each PSTCs' ability to facilitate WA development with this population may be due to their capacity to increase the likelihood AfA women substance abusers experience the therapist as empathic, unconditionally accepting and respectful, and genuine (i.e., demonstrating GTCs).

Multicultural Competence (MC), Working Alliance (WA), and General Therapist Characteristics (GTCs). To date, a number of studies exist that substantiate significant associations between MC and WA, GTCs and WA, and MC and GTCs. Concerning MC and WA, findings from Fuertes et al.'s (2006) investigation of therapy dyads demonstrate that ratings of therapist MC predicted client ratings of WA. Constantine's (2007) examination of the therapeutic relationship between AfA clients and cross-racial therapists revealed that clients' perception of therapist insensitivity was negatively associated with WA. Path analyses in Inman's (2006) investigation of supervisory process and outcome found supervisory multicultural competency to be positively associated with supervisory WA. A primary limitation of the Constantine (2007) study was the use of a convenience sample of college students. For the Inman (2006) study, the 22.6% response bias is arguably a constraint on the validity of the results. Nevertheless, both studies lend burgeoning support to the link between MC and WA.

Concerning GTCs and WA, robust data exists that demonstrates GTCs are facilitative of WA development. As stated previously, GTCs have been empirically validated as facilitative of the WA irrespective of client characteristics or treatment modality (Ackerman et al., 2001; Ackerman & Hilsenroth, 2003; Ritter et al., 2002).

Moreover, a recent review by Kirschenbaum and Jourdan (2005) on the current status of Carl Rogers' core conditions in the empirical literature revealed that GTCs were facilitative of the WA in the latest generation of psychotherapy research.

Regarding the association between MC and GTCs, findings from Fuertes et al. (2006) also revealed multicultural competency was significantly associated with increased perceptions of therapist demonstration of GTCs. In their investigation of drug treatment effectiveness, Fiorentine and Hillhouse (1999) extrapolated from their results that providing culturally relevant substance user treatment services likely increases mutual empathy in the client-counselor relationship. In their study of the role of perceived therapist multicultural competency, Fuertes and Brobst (2002) found a positive correlation between client ratings of therapist multicultural competency and perceived therapist empathy. Though Fuertes and Brobst's (2002) results are based on a convenience sample of counseling graduate students, their findings speak strongly to the association between MC and empathy, one of the three GTCs.

Collectively, the aforementioned studies provide strong support for significant associations among the variables discussed. Strong associations between all three variables is illustrated in an empirical study concerning the patient-physician relationship where Fuertes, Boylan, & Fontanella (2008) found significant associations between perceived physician MC, perceived physician empathy, and client ratings of WA in their study of the alliance and other behavioral indices of outcome. However, which variables are causative and account for the effect on WA are unknown.

Egalitarianism (EG), Working Alliance (WA), and General Therapist Characteristics (GTCs). Specific to the associations between EG and WA and EG and

GTCs, there exists a dearth of empirical data to guide thinking concerning the nature of the relationship among these variables. However, several studies suggest theoretical relationships between EG-related constructs, WA, and GTCs. Terminology such as power-sharing, collaboration, and partnership have been used to described what is often considered EG. Though there are likely some differences among these constructs, each has a theoretical definition that includes a focus on the negotiation of power between the therapist and the client; and several researchers endorse this negotiation as facilitative of WA (see Brown, 2007; Fabri, 2001; Worell, 2001; Worell & Johnson, 2001). Parson (1993) holds that power-sharing is the "interpersonal glue that bonds therapist and client in a WA" (as cited by Dyche & Zoyas, 2001, p.247). Kim et al. (2008) assert that the WA is facilitated by client-therapist negotiation and partnership. Davis and Ancis (unpublished manuscript) found EG to be one of five characteristics clients used to describe an ideal therapist.

Regarding the relationship between EG and GTCs, in her description of feminist therapy, Brown (2007) reported that an egalitarian relationship requires deep respect (i.e., GTCs, specifically unconditional positive regard [UPR]) for the client. Rader and Gilbert's (2005) investigation of EG revealed that therapists viewed fostering an egalitarian relationship as a sign of respect and an acknowledgment of the value the client brings to treatment (i.e., GTCs, specifically UPR and genuineness). In an examination of therapeutic safety for trauma survivors, Fabri (2001) posited that therapist EG demonstrated regard for the cultural and social needs of the client. Woolhouse et al.'s (2004) qualitative examination of the physician-patient relationship documented that women who reported having egalitarian relationships with their physicians also reported

feeling understood, valued, and respected (i.e., GTCs, specifically empathy and UPR). In all, data concerning the association between EG and WA and EG and GTCs, suggests that the more the client perceives the therapist as egalitarian, the more the client will feel respected and valued, and that increased perception of therapist demonstration of GTCs will help facilitate a stronger WA.

Empowerment (EM), Working Alliance (WA), and General Therapist Characteristics (GTCs). As EM is an under-researched construct, there is a paucity of data on the relationship between EM and GTCs, and EM and WA. However, theoretical discourse suggests that therapist EM allows for sensitive responding to the target population's frequent experience of trauma and abuse that can facilitate clients' engagement in treatment. Najavits (2002) specifically notes that substance abuse clients' sensitivity to issues of power and control necessitates an empowerment approach for them to be successfully and positively engaged in treatment. Brown (2007) asserts that focusing on client strengths and resiliency (i.e., EM) can engender an empathic bond between the therapist and client, resulting in positive WA. Additionally, a case study of the University of New Mexico School of Medicine's alcohol and substance abuse prevention program communicates how an empowerment model facilitated participant engagement through a demonstrated desire to understand and communicate with targeted individuals (Wallerstein & Bernstein, 1988). The strength of this theoretical discourse, coupled with the dearth of empirical data on EM and WA, warrants an empirical investigation of whether EM facilitates WA, and whether GTCs help explain EM's influence on alliance development.

In sum, researchers have been charged with identifying therapist characteristics

facilitative of WA development, especially among culturally diverse clients (Ackerman et al., 2001; US Department of Health and Human Services [USDHHS], 2001) and disorder-specific groups (Norcross & Lambert, 2011). In light of this charge and findings that suggest a positive WA can increase substance abuse treatment retention (Barber et al., 2001; Conners et al., 1997; Martin et al., 2000; Meier et al., 2005), it seems especially vital to identify therapist characteristics that are facilitative of WA development with AfA women with substance use disorders. Additionally, empirical data that highlights the process whereby such characteristics are facilitative may help therapists create more effective therapy relationships. Thus, the specific aims of this study are to identify therapist characteristics that are predictive of a favorable therapeutic relationship, as measured by working alliance, with the target population, and to explain the underlying mechanisms that make the predictive therapist characteristics facilitative. Such research is a promising step towards increasing substance abuse treatment retention rates for AfA women.

Present Study

This investigation explores the therapist's contribution to the development of the WA with AfA women who are substance abusers. Therapist characteristics hypothesized as being predictive of WA development with this population were examined. Additionally, three hypothesized mediation models were tested in an effort to identify mechanisms through which predictive therapist characteristics influence WA development. To date, no published studies have explored this process in this population.

All therapist characteristics were evaluated from the client's perspective. Doing so was consistent with Grigg and Goldstein's (1957) assertion that, "Some appraisal of

the client's reaction to the counselor and to counseling should be obtained before we can say we have any comprehensive understanding of who makes a good counselor and what constitutes successful counseling techniques" (Grigg & Goldstein, 1957, p. 32 as cited by Ponterotto & Furlong, 1985, p.597). Such an investigation could result in an empirically supported working alliance development model for therapists, which may allow therapists to be responsive to clients at the point of entry where retention rates are the lowest (Siqueland et al., 2002).

The present study is based on the premise that a positive WA will be established with AfA women who are substance abusers through the use of GTCs, but that concurrent utilization of PSTC will enhance the ability of the therapist to elicit a stronger WA. The main hypotheses of this study are:

1. Hypothesis 1: MC, EG, and EM will explain an additional and significant amount of the variance in WA beyond that explained by GTCs.
2. Hypothesis 2: GTCs will mediate the relationship between MC and WA.
3. Hypothesis 3: GTCs will mediate the relationship between EG and WA.
4. Hypothesis 4: GTCs will mediate the relationship between EM and WA.

Hypotheses 2, 3, and 4 are pictorially depicted in Figure A1.

Methods

Procedure

Data was collected in an urban southeastern city from participants enrolled across eight outpatient mental health and substance abuse treatment settings that granted approval to this study. Through in-person or telephone contact by the student principal investigator, eligible individuals were informed of the purpose of the study, content of the study (informed consent, demographic questionnaire, and self-report inventories), expected length of participation, and amount of compensation. Participants completed a demographic questionnaire and a battery of five self-report inventories. Participants were instructed to base their responses to the self-report inventories on the counselor "you spend the most time with." All data collection was conducted at the participants' treatment location. Although therapists at participating treatment sites were aware of the study, none were told the purpose of the research.

Participants

Participants were recruited via convenience sampling from eight outpatient mental health and substance abuse treatment settings located in a southeastern urban area. Inclusion criteria for participation were: self-identification as ethnically or racially African American/Black, 18 years of age or older, self-reported substance use disorder during lifetime, actively enrolled in outpatient treatment, attended three or more sessions with the identified therapist, and a demonstrated ability to read a brief text description of the study written at a 7th grade reading level as measured by the Flesh-Kincaid Grade Level readability statistic. Of the 103 participants that met criteria for participation and provided informed consent, 102 participants (N = 102) returned completed survey packets

and were included in the final sample. A $10.00 payment was given for participation.

Characteristics of final participant sample. All participants were female, 99% self-identified as African American/Black, 1% self-identified as African American/Black and multiracial. Ages ranged from 23 to 65 years, with a mean of 41.7 years (*SD* = 10.27). The majority of participants reported having at least completed high school: high school diploma (27.5%), some college (14.7%), and vocational training (13.7%). Almost half reported being single, never married (46.1%); just under a quarter of participants were divorced (20.6%); 10.8% were separated; 10.8% identified as being partnered, living together but not married; and 8.8% were married. Most participants endorsed having a yearly income of less than $10,000 (70.6%) and having government issued health insurance (54.9%). Concerning specific substances abused, abuse of multiple substances was most often reported (54.9%), followed by alcohol only (21.6%), and marijuana only (9.8%). Roughly sixty-four percent (63.7%) of participants endorsed having a co-morbid mental health disorder and three-quarters (75.2%) acknowledged having a history of physical, sexual, psychological, and/or emotional abuse. Participants reported being in treatment an average of 2.7 times during their lifetime.

Characteristics of participants' therapists. As reported by the participants, the majority of therapists were female (91.2%). Most were African American/Black (58.8%), followed by European American/White (32.4%). The mean number of sessions participants had attended with their therapists was 19.1. The greatest number of participants reported seeing their therapist once per week (36.3%), followed by once per month (26.5%), twice per week (19.6%), and twice per month (9.8%).

Measures

Working alliance (WA) was assessed using participant ratings on the *Working Alliance Inventory – Short Form* (WAI-S; Tracey & Kokotovic, 1989). The WAI-S is composed of 12 items rated on a 7-point Likert-type scale (1 = never, 7 = always). Participants were instructed to base their responses on their general impression of their therapist in an effort to capture overall impressions of the alliance versus a critique of the relationship at one point in time. The WAI-S total score was used as an indicator of working alliance with higher scores indicating a stronger alliance. Internal consistency estimates for WAI-S total score range from .80 to .92 (Busseri & Tyler, 2003). Consistent with the literature, a Cronbach's alpha of .92 was found in this study.

General therapist characteristics (GTCs; i.e., empathy, regard, and genuineness) were assessed using one measure, the *Barrett-Lennard Relationship Inventory* (BLRI; Barrett-Lennard, 1962). The BLRI was specifically developed to measure those conditions Carl Rogers (1957) identified as necessary and sufficient for therapeutic change to occur for the client. It is a 64-item measure rated on a 6-point Likert-type scale (+3 = Yes, I strongly feel that it is true, -3 = No, I strongly feel that it is not true). The BLRI total score was used as an indicator of therapist demonstration of Rogerian characteristics, with higher scores indicating higher levels of therapist facilitativeness. Cramer (1990) reported an alpha reliability of .90 for the BLRI total score. A Cronbach's alpha of .84 was found in this study.

Each of the population-sensitive therapist characteristics (PSTCs; i.e., multicultural competency [MC], egalitarianism [EG], and empowerment [EM]) were independently assessed. MC was assessed using the *Cross-Cultural Competence Inventory - Revised* (CCCI-R; LaFromboise, et al., 1991). The CCCI-R is based on the

11 cross-cultural counseling competencies outlined by Sue et al. (1992). It is a 20-item scale and uses a 6-point Likert scale. Participants rate the extent to which the CCCI-R items describe the therapist (1 = strongly disagree, 6 = strongly agree), with higher scores indicating greater therapist multicultural competency. The authors of the CCCI-R reported the measure to have an internal consistency of .95 (LaFromboise et al., 1991). Consistent with this finding, a Cronbach's alpha of .96 was found in this study.

EG was assessed using the *Client Therapy with Women Scale* (CTWS; Worell, Chandler, & Robinson, 1996). The CTWS is a 28-item self-report measure that assesses perceptions of therapist power sharing (i.e., egalitarianism). Items are rated on a 5-point Likert scale (1=not at all true, 5=frequently true), with higher scores indicating greater therapist egalitarianism. Internal consistency estimates are reported at .86 (Rader & Gilbert, 2005). A Cronbach's alpha of .87 was found in this study.

EM was assessed using the *Personal Progress Scale-Revised* (PPS-R; Worell & Chandler, 1998). The PPS-R is a 28-item self-report measure designed to assess an individual's sense of empowerment. Given the purpose of this study is to assess participants' perspective of therapist characteristics, therapist empowerment was measured by slightly modifying the instructions to direct participants to use the following prompt to answer each item, "Since working with my counselor…" In the original measure, no prompt is given. The decision was made to modify the intent of this instrument because no other measure of empowerment could be located in the literature. Items on the PPS-R are rated on a 7-point Likert scale (1=almost never, 7=almost always), with higher scores denoting higher therapist empowerment behaviors. Internal consistency is reported at .73 (Worell et al., 2004). A Cronbach's alpha of .83 was found

in this study.

Data Analysis

Prior to running the analyses, descriptive statistics and distributional plots were obtained to assess for errors in the data file (e.g., missing data or outliers), and the normality, linearity, and homoscedasticity of the distribution of scores on the dependent and predictor variables. In preparation for hierarchical multiple regression and mediation analysis, correlational analyses were conducted to determine the magnitude of the relationships between each of the four hypothesized predictor variables (i.e., GTCs, MC, EG, and EM) and the dependent variable (i.e., WA). Next, Hypothesis 1 was tested using hierarchical multiple regression to determine significant predictors of working alliance after controlling for GTCs. Last, hypotheses 2, 3, and 4 were tested using the Preacher and Hayes (2004) mediation bootstrapping approach.

Results

All statistical procedures were performed using the Statistical Package for the Social Sciences (SPSS), Version 17.0. A priori power analysis indicated that to achieve a power of .80 with $p < .05$, an anticipated medium effect size of .15, and four predictor variables, a sample size of 87 would be required (Soper, 2004-10). Results of this investigation are based on 102 participants.

Preliminary Analyses

In advance of running hierarchical regression and meditation analyses, the dependent and predictor variables were examined and graphed to obtain descriptive statistics and ensure no violation of the assumptions of normality, linearity, and homoscedasticity. No variable violated any of these assumptions and all were continuous

in nature. Descriptive statistics for the dependent variable WA, and predictor variables GTCs, MC, EG, and EM, were calculated and are included in Table A1.

The relationship between WA and GTCs, MC, EG, and EM were investigated using Pearson product-moment correlation coefficients. There was a strong, positive correlation between WA (as measured by the WAI-S) and GTCs (as measured by the BLRI), $r = .682$, $n = 102$, $p < .000$; as well as between WA and EG (as measured by the CTWS), $r = .572$, $n = 102$, $p < .000$. There was a moderate, positive correlation between WA and MC (as measured by the CCCI-R), $r = .362$, $n = 102$, $p < .000$; as well as between WA and EM (as measured by the PPS-R), $r = .310$, $n = 102$, $p < .002$. Results of the correlations are presented in Table A2.

To reduce the likelihood of Type I errors in the subsequent regression and mediation analyses to follow, a potential confounding variable was examined. Partial correlation was used to explore the relationship between WA and each of the predictor variables, while controlling for length of time in treatment (as measured by the number of sessions the client had with their therapist). An inspection of the zero order correlations suggested that controlling for length of time in treatment had very little to no effect on the strength of the relationship between WA and each of the predictor variables.

Primary Analyses for Hypotheses Testing

Identifying Predictors of Working Alliance. In order to assess how well PSTCs (i.e., MC, EG, and EM) predict WA after the effect of GTCs are controlled for, hierarchical multiple regression was used. GTCs were entered at Step 1, explaining 46.5% of the variance in WA. After entry of the PSTCs at Step 2, the total variance explained by the model as a whole was 58.2%, $F (4, 97) = 33.77$, $p < .000$. The PSTCs

explained a significant and additional 12.0% of the variance in WA, after controlling for GTCs, R squared change = .12, F change (3, 97) = 9.07, $p < .000$, providing full support for Hypothesis 1. In the final model, GTCs and one of the PSTCs, EG, made statistically significant and unique contributions ($\beta = .52$ and $\beta = .350$, respectively). See Table A3 for hierarchical multiple regression results.

Determination of Mediation Effects. In order to test the hypotheses that GTCs partially mediate the relationship between each of the three population-sensitive therapist characteristics (i.e., MC, EG, and EM) and WA, the Preacher and Hayes (2004) bootstrapping methodology was used. Bootstrapping is a nonparametric approach used to estimate the extent and significance of indirect effects of mediator variables (Preacher, Rucker, & Hayes, 2007). This statistically rigorous approach (Frazier, Tix, & Barron, 2004) takes an extensive amount of samples from the original data set to create an empirical approximation of the distribution of the original sample for use in hypothesis testing (Preacher et al., 2007). Two key advantages of using bootstrapping methodology in psychological research are that the approach does not depend on an assumption of normality concerning the shape of the distributions of the variables and it can be applied with confidence to smaller samples (Preacher & Hayes, 2004).

Determining significant mediation effects using bootstrapping analysis involved taking five thousand random samples of size 102 (where 102 is the original sample size) from the data, replacing each value as it was sampled, and calculating the indirect effect of the independent variable on the dependent variable through the proposed mediator (i.e., the *c'* path) in each sample. Significant mediation is reported to have occurred if the indirect effect of the *c'* path is significantly different from zero at $p < .05$, where the

upper and lower bounds of the bias-corrected and accelerated (BCa) 95% confidence intervals do not include zero (Preacher & Hayes, 2004). The bootstrapping analysis was conducted three separate times to ascertain whether GTCs partially mediate the effect of each of the three PSTCs on WA. The result of each bootstrapping analysis is presented in Table A4.

Testing whether GTCs mediate the relationship between MC and WA. The four-step Barron and Kenny (1986) heuristic analysis to detect simple mediation was employed. Results revealed that MC was significantly related to GTCs (a path) (.95, $p <$ .000), GTCs was significantly related to WA (b path) (.15, $p < .000$), and MC was significantly related to WA (c path) (.23, $p < .000$). The direct effect of MC on WA did not significantly differ from zero when GTCs was included in the model (c' path) (.09, $p < .08$), suggesting full mediation. Bootstrapping analysis showed that MC had a significant indirect effect on WA through GTCs with a 95% BCa confidence interval of .062 to .269. Given zero was not within the confidence interval range, it was concluded that the relationship between MC and WA was significantly and fully mediated by GTCs (Preacher & Hayes, 2004). Full support was found for Hypothesis 2.

Testing whether GTCs mediate the relationship between EG and WA. The four-step Barron and Kenny (1986) heuristic analysis revealed that EG was significantly related to GTCs (a path) (1.11, $p < .000$), GTCs was significantly related to WA (b path) (.13, $p < .000$), and EG was significantly related to WA (c path) (.40, $p < .000$). The direct effect of EG on WA was reduced, but remained significant when GTCs was included in the model (c' path) (.25, $p < .000$), suggesting partial mediation. Results of the bootstrapping analysis showed that EG had a significant indirect effect on WA

through GTCs with a 95% BCa confidence interval of .065 to .261. Given zero was not within the confidence interval range, and the c' path remained significant, it was concluded that the relationship between EG and WA was significantly and partially mediated by GTCs (Preacher & Hayes, 2004). Thus, partial support was found for Hypothesis 3.

Testing whether GTCs mediate the relationship between EM and WA. The four-step Barron and Kenny (1986) heuristic analysis revealed that EM was significantly related to GTCs (a path) (.79, $p < .002$), GTCs was significantly related to WA (b path) (.16, $p < .000$), and EM was significantly related to WA (c path) (.19, $p < .002$). The direct effect of EM on WA did not significantly differ from zero when GTCs was included in the model (c' path) (.07, $p < .15$), suggesting full mediation. Bootstrapping analysis showed EM had a significant indirect effect on WA through GTCs with a 95% BCa confidence interval of .042 to .225. Given zero was not within the confidence interval range, it was concluded that the relationship between EM and WA was significantly and fully mediated by GTCs (Preacher & Hayes, 2004). Full support was found for Hypothesis 4.

Discussion

The results of this investigation answer a call from the literature to identify therapist factors empirically demonstrated to be facilitative of a productive therapeutic relationship (Ackerman et al., 2001; Conners et al., 1997). Findings revealed that the PSTCs, chosen because of their theoretical and emergent empirical relevance to the treatment needs of AfA women substance abusers, predicted a significant amount of the variance in working alliance ratings among this population, even after controlling for the

effect of GTCs. The effect of PSTCs on WA was moderate, yet statistically significant, accounting for 12% of the variance in WA ratings above and beyond GTC's. This finding is consistent with gender-sensitive substance abuse, multicultural, and feminist suppositions that the therapist can better facilitate WA by not only being responsive to universal client needs for relationship building, but also to needs that are unique to the target population (e.g., Ackerman & Hilsenroth, 2003; Constantine, 2007; Jackson & Green, 2000). Specifically, we can conclude that a stronger WA will be established with AfA women substance abusers when therapists are multiculturally competent, egalitarian, and empowering, in addition to empathic, unconditionally respectful and accepting, and genuine.

The intersection of AfA women substance abusers' ethnic, gender, and clinical identities foster distinctive life experiences that dictate special clinical needs. Unique experiences such as discrimination and marginalization due to their AfA and female identities (Jackson & Green, 2000), increased stigmatization attributable to being a female substance abuser (Rader & Gilbert, 2005; Davis & Chang, under review), and internalized feelings of powerlessness and shame (Johnson et al., 2005; Najavits, 2002) are reported among this population. Multicultural, feminist, and gender-sensitive substance abuse literatures suggest that therapist MC, EG, and EM (i.e., PSTCs) allow for appropriate therapist responding to these unique life experiences that are not effectively addressed by GTCs alone. While the results of this investigation do in fact demonstrate that PSTCs strengthen WA among this population above that of GTCs alone, it can now be argued that PSTCs do so by increasing therapist demonstration of GTCs; and in doing so, mitigate negative client perceptions of the therapist that arise largely due to client

perception of therapist insensitivity concerning their distinctive clinical issues.

Specifically, findings of this investigation revealed that GTCs fully mediate the effect of both MC and EM on WA, and partially mediate the relationship between EG and WA. Full mediation of the effect of MC and EM on WA by GTCs indicates that when the therapist's behavior conveys a sense that they are multiculturally competent and empowering in the therapeutic process, the therapist is then perceived to be empathic, respectful, and genuine (i.e., demonstrating GTCs), and that increased perception of the therapist as demonstrating GTCs is what completely accounts for positive client ratings of the WA. Partial mediation of the effect of EG on WA by GTCs indicates that when the therapist is egalitarian, the therapist is also then perceived to be empathic, respectful, and genuine (i.e., demonstrating GTCs), and that amplified perception of the therapist as demonstrating GTCs partially accounts for WA ratings in addition to other factors unique to EG.

The finding that MC's effect on WA is completely accounted for by GTCs has some support in the existing literature. Emergent empirical and theoretical findings demonstrate strong associations between MC and each of the GTCs. Quantitative results indicate that MC and empathy are strongly and positively correlated (Fiorentine and Hillhouse, 1999; Fuertes et al., 2006; Fuertes et al., 2008); and theoretical discourse suggests that though MC and Rogerian therapist conditions (i.e., GTCs) may have originated in separate fields for differing purposes, the core features are the same (Saha, Beach, & Cooper, 2008).

The finding that GTCs fully mediate the effect of EM on WA is a novel finding in the literature. It can also be considered an unexpected finding given many female

substance abusers require an empowerment approach to appropriately address their feelings of relative powerlessness resulting from the high rates of trauma and abuse they often experience (Covington, 2002; Najavits, 2002) that may not be appropriately addressed by GTCs alone. Though empowering behavior is believed to include the ability to develop an accurate and deep understanding of the client's issues and perspective (i.e., empathy) and acceptance of the client's abilities and challenges (i.e., unconditional positive regard), EM's relevance to WA development for this population does not intrinsically appear to be fully explained by these aspects. However, Ackerman & Hilsenroth (2003) identified therapist helping, an element of EM, as a key element of empathy. Given empathy is one of the three GTCs, it could be that therapist helping behaviors that are indicative of EM, are fully accounted for by GTCs, thereby supporting the finding of this study that GTCs fully mediate the relationship between EM and WA.

Partial mediation of EG's effect on WA by GTCs suggests that while GTCs explain a significant amount of EG's predictive power, they do not fully account for why EG is predictive of WA. In other words, EG influences WA through GTCs as well as through some other factor or factors. This result is consistent with findings from the only identified empirical study concerning therapist EG, Davis and Ancis (unpublished manuscript), which showed that women substance abusers identified EG as a characteristic of an effective therapist. Also in support of this finding are feminist and multicultural discourses that posit that since women typically occupy subordinate positions in most cultures, relationships based on power-sharing appropriately respond to women's need to feel valued and worthy (Comas-Diaz & Greene, 1994; hooks, 2005; Rader & Gilbert, 2005) which often contributes to positive WA.

This partial mediation finding also maps well onto Adult Attachment Theory (AAT), an extension of John Bowlby's (1969, 1988) attachment theory applied to adult functioning. Empirical studies regarding AAT suggest that clients with substance use disorders are more likely than non-substance abusing clients to have insecure attachment styles (Caspers, Yucuis, Troutman, & Spinks, 2006). AAT treatment implications for vulnerable women client populations, inclusive of substance abusers who often have insecure attachment styles, include therapists' use of Rogerian variables (i.e., GTCs), but also EG to effectively respond to frequent feelings of intense low self-worth and shame in order to establish a solid WA (Eells, 2001; Gormley, 2004). In response to the search for other mediating factors of the relationship between EG and WA, it could be that therapist EG effectively addresses problems inherent to insecure attachment styles, and thereby increases WA development. Future research may investigate an insecure attachment style as a mediator of EG's effect on WA among African American women with substance use disorders.

Clinical and Training Implications

The findings of this investigation provide the therapist with a prescriptive model of how to build positive alliances with AfA women substance abusers. To cultivate stronger working alliances with the target population, the therapist should take care to demonstrate multicultural competency, egalitarianism, and an empowerment approach in addition to empathy, unconditional positive regard, and genuineness. Building on the premise that mediation models are useful in identifying promising points of clinical intervention in applied psychological research (Shrout & Bolger, 2002), the mediation findings in this study have significant implications for psychological practice. These

findings suggest that if therapists are observing poor working alliances with members of this group, employing PSTCs may facilitate therapist demonstration of GTCs, behaviors empirically demonstrated to be facilitative of positive WA. As such, the client may experience the therapist as more empathic, demonstrative of unconditional positive regard, and genuine.

These findings also have significant implications for therapist education. Given that the influence of MC and EM on WA is fully mediated by GTCs, therapy trainees could be taught to demonstrate empathy, unconditional positive regard, and genuineness by learning how to be multiculturally competent and empowering. This is significant given that GTCs, particularly empathy and genuineness are often considered complex theoretical constructs that can be difficult to teach (Furman, 2005; Reynolds, Scott, & Jessiman, 1999; Shapiro, 2002), whereas PSTCs are skill-based attributes that are operationally defined by teachable components, making them more amenable to instruction. In sum, the specific understanding of the relationship between therapist attributes and WA development offered by this research could be integrated into therapist training paradigms to develop better-skilled clinicians equipped to develop and maintain the WA, which could ultimately have direct and positive implications for increased treatment retention for the target population (Greenfield et al., 2007; NIDA, 1997; NIDA, 2009).

Limitations and Future Directions

There were several limitations of this investigation. The study sample was composed of volunteers who were currently enrolled in treatment. Thus, a natural pre-selection may have occurred wherein only clients with positive working alliances were

represented in the sample since patients with poor alliances may have already exited treatment, rendering them unable to participate in the study. Additionally, measurements of all the variables were based only on client-ratings. This increased the chance of halo effects, possibly yielding confounds stemming from having the same person rating therapist characteristics and the WA (Ackerman & Hilsenroth, 2003). Findings may also have been impacted by participant's drug of choice which influences the severity and length of withdrawal, and possibly, participant's responses. This study should be replicated using multiple measurements of each variable of interest (e.g., use of client, therapist, and observer ratings of WA).

The mediation analyses in this study were based on a non-experimental, correlational design to establish causation. MacKinnon et al. (2007) warn that correlational analysis is open to direction of causation errors. For example, in this study, it could be that the client's feelings about the therapist are what influenced client ratings of WA versus the therapist's behavior as suggested. Despite this potential limitation, use of correlational analysis to imply causation is a common methodology used in psychological research, though experimental or longitudinal designs are preferred (Frazier et al., 2004; MacKinnon et al., 2007). While not all necessary conditions to establish causation were met in this study, it can be said that the suggested causal models were consistent with the data. Future research should use multiple raters of all variables of interest (e.g., client, therapist, and observer ratings), to rate variables at multiple points in time over the entire course of a client's treatment episode to help establish true causation and causal mediation relationships. Additionally, it would be effective to combine such an investigation with qualitative data from clients and therapists to further

clarify mediation relationships (MacKinnon, Fairchild, & Fritz, 2007).

Last, this study used single indicator variables instead of a model with latent variables. Measures for EG and EM had internal reliabilities of $\leq .9$ which calls for the use of multiple measures for a single variable (Holyle & Robinson, 2003). However, no other instruments to measure EG and EM could be located. For example, it could be that the findings that the effect of MC and EM on WA are fully mediated by GTCs reflect measurement error. Likewise, mediation results for both MC and EM when measuring the GTCs as one variable, instead of measuring them independently, could have simplified the results; such that, it is likely that one or more, but not all GTCs mediate the effect of MC and EM on WA. Statistics based on each independent GTC could clarify the meditational process and better explain the causal mechanisms concerning the effect of PSTCs on WA. Thus, before any solid conclusions are drawn based on these findings, it must be considered that these results could be due to measurement error from the use of single indicator variables (Holyle & Robinson, 2003). Future studies should replicate this investigation using latent variables that are based on multiple measures of each construct to be examined. Despite the possibility of measurement error and a lack of specificity concerning the mediating role of the GTCs, the regression and mediation models fit the data.

It is believed that the modest, but significant effect of PSTCs on WA ratings has implications for future directions. Given the positive correlation between strength of working alliance and treatment retention (Barber et al., 2001; Martin et al., 2000; Meier et al., 2005), any specific knowledge of how to increase the therapist's ability to strengthen the WA among the target group should increase the target group's rate of

treatment retention. Whether therapist demonstration of GTCs and PSTCs actually increase treatment retention rates for AfA women substance abusers should be investigated in future studies.

The fact that the results of this investigation appear to map on to two independent theoretical frameworks is also an implication for future directions. AAT, previously referred to when discussing the unique relevance of therapist EG to WA among this population, and Superwoman Schema (SWS; Woods-Giscombe`, 2010), yield themes that characterize and explain AfA women's interpersonal functioning in response to contextual factors. SWS highlights the role of historical and socio-historical factors that impinge on the interpersonal relating of women (Woods-Giscombe`& Black, 2010), while AAT, addresses the developmental, psychiatric, and trauma influences on their interpersonal functioning (Gormley, 2004). Given that AAT and SWS seemingly provide a cohesive framework for therapeutic relationship development with AfA women substance abusers who have often experienced discrimination and ruptures in early attachments, future research on WA development with the target population should incorporate empirical examination of these models.

Conclusions

This research is one of the first, if not the only investigation to identify specific therapeutic characteristics that predict working alliance development with an ethnic minority and female population through quantitative methodology. Insofar as the present study was the first to examine therapist characteristics as predictors of working alliance development among African American women substance abusers, these findings are in need of replication and should be interpreted accordingly. Even still, the findings build

upon studies that demonstrate that therapists' personal attributes significantly influence working alliance development (Ackerman & Hilsenroth, 2003) and adds to our knowledge about what specific therapist characteristics can facilitate a strong therapeutic relationship with AfA women substance abusers who cite negative relationships with therapists as a barrier to treatment retention.

The findings of this investigation lend credibility to the argument for bridging the gap between gender-sensitive substance abuse, multicultural, and feminist literatures, as well as the need to integrate them both into mainstream general psychological practice concerning clinical work with African American, female, psychiatric populations. The resultant gender-sensitive, multicultural, and feminist model of working alliance development for AfA women substance abusers identified in this research is helpful because it offers an expanded view on the solution to the problem of low treatment retention. Wherein the medical model of addiction bodes a singular and linear focus on the individual as the source of the problem, and thus the solution, the idea posed by this research proffers a multimodal intervention approach.

The impetus for this research was the premise that the problem of low treatment retention should not be conceptualized as indicative of client characteristics in isolation, but also that of contextual factors inclusive of the therapist who is responsible for service delivery. The findings of this research corroborate the results of other investigations that indicate that the therapist has a role in influencing positive WA. Specifically, findings show that demonstration of PSTCs in addition to GTCs will facilitate a stronger WA with the target group than GTCs alone; and that this is because therapist demonstration of PSTCs causes the therapist to be perceived by the client as more empathic, demonstrative

of unconditional positive regard, and genuine. Given the robust data substantiating the positive correlation between WA and treatment retention, the therapist's facilitation of an increased positive working alliance should aid in increasing treatment retention rates for AfA women substance abusers.

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APPENDIX

APPENDIX A

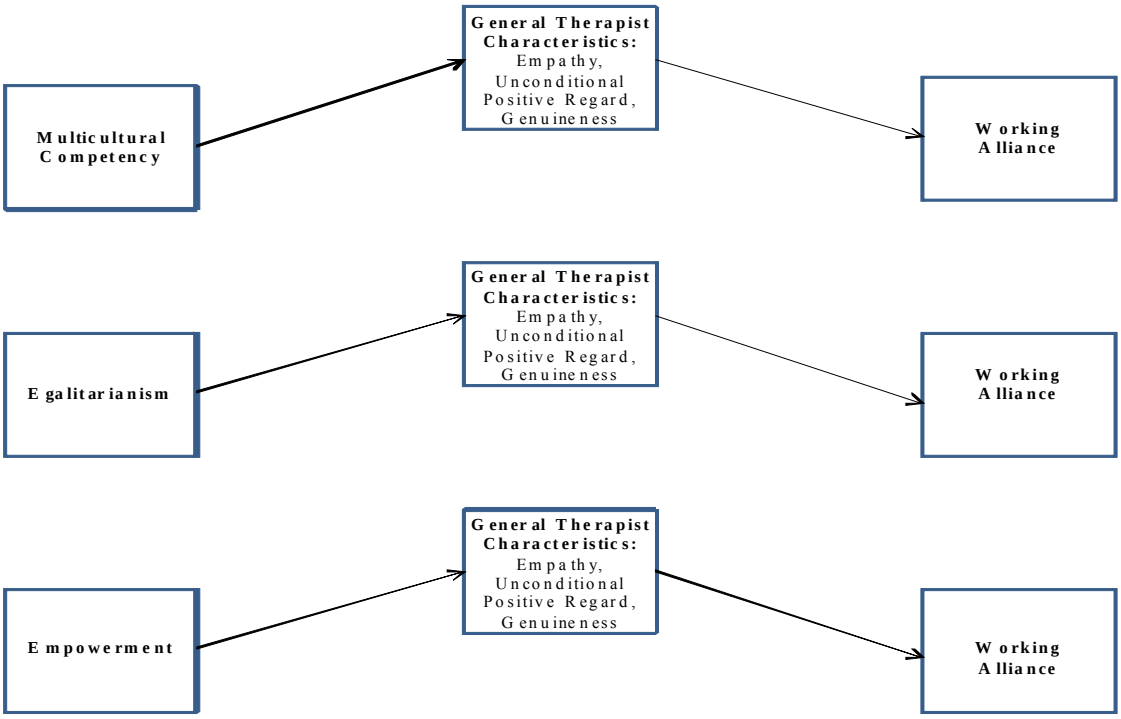

Figure A1. Hypothesized Mediated Models.

Table A1

Descriptive Statistics for Dependent and Predictor Variables with Total Sample (N = 102)

	N	*MIN*	*MAX*	*M*	*SD*	*Skewnesss*	*Kurtosis*
Working Alliance[a]	102	20.00	84.00	66.80	13.90	-1.13	1.10
General Therapist Characteristics[b] (Empathy, Unconditional Positive Regard, Genuineness)	102	-144.00	177.00	66.69	57.89	-.64	.94
Multicultural Competence[c]	102	21.00	120.00	97.94	21.64	-1.84	3.60
Egalitarianism[d]	102	37.00	140.00	103.46	20.16	-.59	.35
Empowerment[e]	102	87.00	186.00	135.31	22.29	.14	-.52

Note. [a]Working Alliance Inventory – Short Form (WAI-S; Tracey & Kokotovic, 1989); [b]Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1962); [c]Cross-Cultural Competence Inventory - Revised (CCCI-R; LaFromboise, et al., 1991); [d] Client Therapy with Women Scale (CTWS; Worell, Chandler, & Robinson, 1996); [e] Personal Progress Scale-Revised (PPS-R; Worell & Chandler, 1998)

Table A2

Intercorrelations of Variables of Interest

Variables	1	2	3	4	5
1. Working Alliance[a]	–				
2. General Therapist Characteristics[b] (Empathy, Unconditional Positive Regard, Genuineness)	.68**	–			
3. Multicultural Competence[c]	.36**	.36**	–		
4. Egalitarianism[d]	.57**	.39**	.38**	–	
5. Empowerment[e]	.31**	.31**	.40**	.22*	–

* *p*<.05, ***p*<.01

Note. [a]Working Alliance Inventory – Short Form (WAI-S; Tracey & Kokotovic, 1989); [b]Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1962); [c]Cross-Cultural Competence Inventory - Revised (CCCI-R; LaFromboise, et al., 1991); [d] Client Therapy with Women Scale (CTWS; Worell, Chandler, & Robinson, 1996); [e] Personal Progress Scale-Revised (PPS-R; Worell & Chandler, 1998)

Table A3

Summary of Hierarchical Regression Analysis for Variables Predicting Working Alliance

	Model 1			Model 2		
Variable	*B*	*SE*	*β*	*B*	*SE*	*β*
General Therapist Characteristics (Empathy, Unconditional Positive Regard, Genuineness)	55.88	1.55	.682			
Population-Sensitive Therapist Characteristics (Multicultural Competence, Egalitarianism, Empowerment)				26.69	7.08	.955
R^2		.47			.57	
R^2 Change		.465			.117	
F for change in R^2		86.87**			9.07**	

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

Table A4

Summary of Mediation Results for Working Alliance (DV) with Predictor Variables (IV) and General Therapist Characteristics (M)

	Predictor Variable (IV)	Effect of IV on *M* (*a*)	Effect of *M* on DV (*b*)	Total effects (*c*)	Direct effects (*c'*)	Indirect effect (*a* x *b*)	BCa 95 % CI		R-Square
						Point Estimate	Lower	Upper	
1.	Multicultural Competence	.95 (.25)**	.15 (.02)**	.23 (.06)**	.09 (.05)	.15 (.04)**	.06	.27	.48
2.	Egalitarianism	1.11 (.27)**	.13 (.02)**	.40 (.06)**	.25 (.05)**	.14 (.04)**	.07	.26	.58
3.	Empowerment	.79 (.25)**	.16 (.02)**	.19 (.10)**	.07 (.05)	.12 (.04)**	.04	.23	.48

* *p<.05, **p<.01*

Note. BCa = bias corrected and accelerated bootstrapping confidence intervals; 5,000 bootstrap samples.