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Lived Experiences of Women Receiving Substance Abuse Treatment from Male Counselors

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Walden University
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Abstract

Lived Experiences of Women Receiving Substance Abuse Treatment from Male Counselors

by

Robert C Bennett

MA, MHC Medaille College, 2010

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

[Counselor Education and Supervision: Crises and Supervision]

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Abstract

The cost of the misuse of drugs is significant. The impact is felt across multiple systems across America and is covered mostly by federal, state, and local governments. Women comprise a significant portion of the persons using illicit drugs. Treatment is an effective way of reducing substance misuse. However, research into the efficacy of treatment for women lag that of men. The Substance Abuse and Mental Health Services Administration reported that women receiving substance abuse treatment from a man had shorter stays in treatment and poorer outcomes than those who had a female counselor while in treatment. Phenomenological and relational-cultural theory (RCT) was used both as the design and conceptual lens to examine the experiences of 6 women, 18 and older, who had completed substance abuse treatment with a male as a primary counselor. Collection of data occurred through semistructured, in-depth, face-to-face interviews. Thematic analysis yielded five main ideas: (1) rapport-building skills, (2) genuineness, (3) empathy; (4) flexibility; and (5) acceptance. In addition to this, the women were questioned to whether they were offered a choice of a man or woman for a counselor. The result is that participants indicated that having a man as a counselor gave them an opportunity to interact with a positive role model, however, they suggested that women be offered a choice in the gender of counselor and accommodated whenever possible. The findings of this study will be made available to stakeholders of substance abuse treatment programs and in public health journals to serve as a basis for further research. The implication for social change is that the information contributes to sustaining women in treatment and improving treatment outcomes.

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Dedication

I dedicate this work to my God and to my family and friends who stood by me throughout this journey.

Acknowledgments

I would have not been able to accomplish this journey without the endless support and guidance of my supervisory committee chair, Dr. Geneva Gray. I would also like to thank my wonderful committee member, Dr. Katarzyna Peoples for all of her insightful recommendations throughout the dissertation process. I would also like to thank Dr. Joy Whitman for helping me in the beginning stages of this process.

Finally, I would like to appreciate the 6 research participants who were willing to express their lived experiences despite the sensitive nature of the study. I pray that you continue to experience recovery and success in all of your life adventures.

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Chapter 1: Introduction to the Study

Background of the Study

The cost for the misuse of drugs is significant. From a monetary standpoint alone, prescription opioid abuse has a substantial effect on the health care, criminal justice, and workplace costs in America (Birnbaum et al., 2011; Meyer, Patel, Rattana, Quock, & Mody, 2014). Between 2006 and 2010 the price of excessive drinking overtook the annual inflation rate (Sacks et al., 2015; Tai & Volkow, 2013). Recipients of Medicaid with substance use disorders used more medical services than individuals with other behavioral health disorders (Clark, Samnaliev, & McGovern, 2015). The cost of drug misuse is largely covered by federal, state, and local governments (Bouchery, et.al, 2011).

Women comprise a significant portion of the persons who use illicit drugs (National Institute on Drug Abuse, 2016). Nine million women used illegal substances in 2014, 3.7 million took prescription medications for nonmedical reasons, and 70% of women with (AIDS have drug-related issues (National Institute on Drug Abuse, 2016). Additionally, adult female substance abuse treatment admissions between 1992 and 2007 increased from 27.4% to 32.5% (Center for Behavioral Health Statistics and Quality, 2010). Women involved in illicit drug use made 300,000 visits per year to the emergency department from 2004 to 2009 (Center for Behavioral Health Statistics and Quality, 2011). Also, 4.8% of women entering substance abuse treatment between the years 2000 and 2010 were pregnant females ages 15 to 44 (Center for Behavioral Health Statistics

and Quality, 2013). These statistics suggest that substance abuse among women is becoming an issue of public concern.

Some of the additional challenges that women face in conjunction with their addiction are sexual trauma, mental health problems, social stigma, and childcare. (Korte, et al., 2011; Lal, Deb, & Kedia, 2015). For example, women with substance use disorders are more likely to have experience some form of sexual assault history, and more likely to have disorders such as post-traumatic stress disorder (PTSD), eating disorders, or depression and anxiety, than men. In addition to this, women are normally the primary caretakers of the children and fear losing them if their use becomes known and sometimes cannot participate in treatment due to lack or childcare, all of which leads to guilt and shame (Taylor, 2010).

Greenfield, Back, Lawson and Brady (2010) argued that women also face a phenomenon called the *telescoping effect*. The telescoping effect is the concept that even when using less of a substance and for a shorter duration of time women move from substance use toward addiction quicker than men (Harrop & Marlatt, 2010; Harvard Mental Health Letter, 2010).

For example, Brighton, Moxham, and Traynor (2016) found that when it relates to alcohol, women have smaller livers than men and metabolize alcohol slower, making them more susceptible to alcohol-related diseases. Women who consume dangerous amounts of alcohol were at a higher risk of developing depression, anxiety, familial conflict, and becoming victims of intimate partner violence than women who did not consume destructive levels of alcohol. In another study, Haas and Peters (2000)

examined a sample of women enrolled in drug court to discover whether women in this population displayed a telescoping effect. These women reported a quicker progression to problematic use than their male counterparts. They also reported more treatment episodes even though their use began later in life, confirming a telescoping effect for these women. In contrast, Hölscher et al. (2010) conducted a study regarding opiate dependence and the telescoping effects on gender and found no significant evidence of telescoping but did note that a higher intensity of emotional and social issues exists for women compared to men.

Taylor (2010) argued that regardless of the belief that a quicker progression toward dependence exists or not, the psychosocial challenges of comorbid mental health issues, childcare, stigma, sexual trauma, and a lack of family and financial support make it more difficult for women to seek and engage in treatment than men.

The significance of women attempting to recover from addiction while dealing with a mental health disorder presents unique challenges (Root et al., 2010). For example, gathering information from the National Institute on Drug Abuse (NIDA) analysis on women treated for substance use disorders and trauma, Resko and Mendoza (2012) discovered that women who possess a mental or emotional disturbance had a greater likelihood to end treatment before presenting for one single session. They argued that attrition from treatment and co-occurring disorders challenge clinicians and researchers to find strategies for improving treatment retention for women who abuse substances. Sarteschi and Vaughn (2010) examined how having a mental health and substance use disorder negatively influenced outcomes for women prisoners. The authors

argued that regardless of framework, studies that examine interventions to increase positive outcomes for women offenders who abuse substances and have a mental health disorder would enhance the delivery of services.

In yet another study, Brown, Jun, Min, and Tracy (2013) gathered information from a 3-year investigation of 369 women in receipt of substance abuse treatment in inner city programs and explored the influence of a dual disorder on the physical and psychosocial life quality. The result of the study was that psychosocial factors might play a bigger role in these women's success than mental health issues. Gaining an increased understanding of predictors of the post-treatment functioning of women with dual disorders will take longitudinal studies (Brown, Jun, Min, & Tracy, 2013).

Furthermore, approximately one-third of women who abuse substances are of child-bearing age (Milligan, Niccols, Sword, Thabane, Henderson, & Smith, 2011), thus compounding the challenges for those who are pregnant or parenting while simultaneously attempting to work on their recovery. According to Jones, Chisolm, Jansson, and Terplan (2013), pre-exposure to in-utero transmission of substances is a gender specific concern. The concern is heightened by the spike in opiate use and prompts additional emphasis for researchers and clinicians to discover various interventions for helping pregnant women who abuse drugs to decrease prenatal substance abuse (Terplan, Smith, & Glavin, 2010; Tzilos, Hess, Kao, & Zlotnick, 2013).

Another fundamental challenge for women who abuse substances who are parenting and trying to recover is associated with management of children's problematic behaviors (defiance, hyperactivity, disobedience), because they lack the resources and

supports to maintain their recovery efforts while simultaneously balancing their parenting responsibilities (Panchanadeswaran & Jayasundara, 2012). Jackson and Shannon (2012) examined a sample of pregnant women who abused substances residing in the rural areas in Kentucky and found these women reported fear of societal stigma as a primary barrier to treatment entry. Combine the fear of public scrutiny in a small community with the lack of accessibility to services, engaging in treatment may be very challenging to pregnant women living in rural areas. Pan and Yi (2013) expounded on the issue of women who abused substances during pregnancy to include the issue of neonatal withdrawal. The authors argued that due to the inability to treat an embryo or fetus experiencing in-utero withdrawal, it is very crucial to find interventions to assist women who are pregnant and abuse substances. Since the number of women becoming addicted to substances is growing and the challenges to helping them recover are multifaceted, it is critical to look at the interventions and strategies that can reduce negative outcomes when treating women receiving substance abuse treatment.

Problem Statement

Substance abuse among women remains a significant public health issue (Coleman-Cowger, 2012; Merritt, Jackson, Bunn, & Joyner, 2011). However, research into the efficacy of treatment for women with substance use disorders (SUD's) lag that of men (Tuchman, 2010). Several studies have shown the effectiveness of substance abuse treatment (Ashley, Marsden, & Brady, 2003; Ettner et al., 2006; Koenig et al., 1999; Thomas, Hodgkin, Levit, & Mark, 2016). However, according to the Substance Abuse and Mental Health Services Administration (Substance Abuse and Mental Health

Services Administration [SAMHSA], 2013), women receiving substance abuse treatment from a man had shorter stays in treatment and poorer outcomes than those who had a woman counselor while in treatment. If men matched with women receiving substance abuse treatment are inadvertently displaying some feature that is contributing to the premature dropout from services for this population, then these women will continue to engage in drug use and be at high-risk for life-long addiction issues (Taylor, 2010).

SAMHSA (2013) reported that women receiving substance abuse treatment matched with women counselors had better outcomes than those matched with men, but did not identify the factors that women attributed to influencing their outcomes when paired with a man. A comprehensive examination of the literature revealed that minimal studies examined how men counselors matched with women receiving substance abuse treatment affected treatment retention and outcomes. Understanding the factors women attributed to influencing their successful completion of treatment when matched with a man as a primary counselor can inform men's competencies about strategies that work with this population and help these women to remain engaged with treatment and improve their outcomes.

Ultimately, studying the lived experiences of women who completed substance abuse treatment, matched with a man, will inform counselors and counselor educators about the strategies that receiving substance abuse treatment attribute to delivering improved counseling services, promoting treatment retention, and enhancing treatment outcomes.

Purpose of Study

The purpose of this hermeneutic phenomenological study was to understand and describe the lived experiences of women who have completed substance abuse treatment who received primary individual counseling from a man. Insights gained from this study may bring increased understanding into how the client-counselor gender match (woman patient/man counselor) may affect treatment retention and outcomes for women receiving substance abuse treatment by illuminating the themes, counseling strategies, and interventions that this population attributes to affecting their treatment process and outcome. The information gained can also inform counselors and educators how to navigate better the issues that arise in the counseling relationship, especially with regards to women receiving substance abuse treatment matched with men. The information will also increase education of men counselors about strategies that contribute to sustaining women in treatment and improving outcomes when matched with a client of the opposite sex. The results of the study add to a gap in the literature identified by SAMSHA (2013) regarding the limitations of literature targeting the association between retention and outcomes amidst women with substance use disorders.

Research Question

Although the client-counselor gender match has received considerable attention from multiple disciplines, little information exists about how it works explicitly with women who have received substance abuse treatment from men counselors. The following question was central to this study:

Research Question 1 (RQ1): What are the lived experiences of women who received primary individual substance abuse counseling from a man and completed treatment?

Conceptual Framework Rationale

The primary concept under exploration was the lived experiences of women who received primary individual substance abuse counseling from a man and completed treatment. I used hermeneutic phenomenological methods, along with relational-cultural theory (RCT) as frameworks to examine their experiences. According to Lewis-Beck, Bryman, and Liao (2004), the foundation of phenomenology is the experiences of people and how they characterized their worlds. By paying close attention to how various cultures describe symbolic meanings, attitudes and shared realities are illuminated. Phenomenology allows researchers to describe the collective lived experiences of an individual or group of people (Patton, 2002).

The methodological framework for this study followed Heidegger's hermeneutic phenomenological concepts (Moustakas, 2009; Smith, Flowers, & Larkin, 2009). Heidegger's concept of phenomenology is that people do not live separate from their understanding or experience of their worlds (Gadamer, 1989). Humans understand and experience a phenomenon as a *Dasien* as they become aware of their existence within an event. The meaning of events may be concealed, and thus must be discovered and interpreted as it emerges. The new understanding is a circular process; to find the hidden meanings of a phenomenon one must be interpretative of a text or *hermeneutic*. Hidden meanings must be explicitly studied. (Smith, Flowers, & Larkin, 2009).

The phenomenon of this study was the experiences of six women ages 26 to 70, who completed substance abuse treatment in an urban area in New York State within the last 5 years, and had a male as a primary counselor. According to Smith, Flowers, and Larkin (2009) phenomenology invites participants to present rich, first person descriptions of their encounters. I utilized hermeneutic phenomenological analysis as an appropriate method to examine the participant's experiences, and how they interpreted those experiences.

According to Koehn (2010), a woman's addiction process frequently includes interpersonal associations; thus, addiction treatment necessitates a mutual interchange of processing the relational developments happening within and without the therapeutic relationship to produce positive treatment outcomes. Relational-cultural theory emerges out of feminist principles that focus on connecting to the experiences of women, human development, and the assumption that well-being is a product of people participating in growth-fostering relationships (Lenz, 2016; Miller, 1976). The relationships occurring between people is at the core of this theory and the concepts value the interconnectedness in which mutual empathy and empowerment foster development (West, 2005).

Adding a relational-cultural theoretical lens to a hermeneutic phenomenological approach provided an optimal framework for discovering and analyzing the lived experiences of women who received substance abuse counseling from a man and completed treatment. RCT encompasses multiculturalism, connection, and mental health (Duffey, & Trepal, 2016; Lenz, 2016). Using RCT allowed me to have an additional lens for case conceptualization and examining change processes.

Definition of Terms

This section includes definitions of key terms used throughout the study.

Clustering: The act of grouping similar objects. In this study, the term referred to grouping research data into core themes revealed by study participants (Moustakas, 2009).

Counseling: A combined endeavor between the counselor and client. Professional counselors assist a person in pinpointing goals and possible answers to difficulties that produce emotional turmoil (ACA, 2014).*Counselors/Therapist/Clinician:* For the purpose of this study these terms described professionals who work with clients on approaches to overcome problems and personal challenges that they are facing (ACA, 2014).

Lived experiences: In a qualitative phenomenological inquiry, the expression refers to the emotions and views relating to an incident or phenomenon experienced by the participant (Audet & Everall, 2010).

Phenomenology: attempts to gain a deeper comprehension of the nature or meaning of everyday experiences (Patton, 2002).

Purposive sampling: A data gathering system utilized when the researcher chooses participants centered on possession of one or more particular conditions (Miles, Huberman, & Saldana, 2014).

Qualitative research: Refers to a research approach that centers on observations and interviews to comprehend a human or social dilemma (Flemming, 2010).

Substance Use Disorder: Refers to a group of mental, behavioral and physiological symptoms demonstrating that the individual persists use of a substance regardless of substantial substance-related difficulties (American Psychiatric Association, 2013).

Therapeutic Alliance: This term referred to a client's and clinician's settlement on the objectives of treatment and the tasks to be accomplished to arrive at those objectives combined with a strong interactive connection (Tryon & Winograd, 2011).

Substance Abuse/Addiction Treatment: Intended to assist addicted individuals to stop compulsive drug seeking and use provided in various settings by specially trained individuals (SAMSHA, 2008).

Female/Woman/Women: These terms were used interchangeably to describe a client's or counselor's perceived gender.

Male/Man/Men: These terms were used interchangeably to describe a client's or counselor's perceived gender.

Assumptions

According to Moustakas (1994) hermeneutic phenomenological analysis is a valuable method for gaining information from participants about their experiences. From this framework, I made several assumptions about women receiving substance abuse treatment from a man: The lived experiences of the participants would direct and inform analysis, findings, and conclusions. Participants would comprehend the therapeutic alliance as significant enough to merit further research. Participants would comprehend the client-counselor match as significant enough to merit further research. I would be able to form enough of an alliance with the participants to obtain accurate

information. Finally, the contributors would respond to the questions truthfully and that their thoughts and perceptions would contribute to the foundation of the research.

Scope and Delimitations

This study described the lived experiences of women ages 18 and above who have completed substance abuse treatment within the last 5 years and received primary individual counseling from a man during any course of their treatment. I explored how each participant experienced the client-counselor gender match; identified the themes that emerged from those experiences, discovered what factors contributed to strong connections or alliance ruptures, and explored how the participants overcame breaks in the relationship to create positive treatment outcomes. A prerequisite to contributing to the study was participants had to complete treatment at either an inpatient, outpatient, or residential setting within the last 5 years and received individual counseling sessions from a man as a primary counselor while in treatment. There are three levels of care governed by the New York State Office of Alcoholism and Substance Abuse Services (OASAS) treatment providers. Part 818 inpatient rehabilitation lasts anywhere from 14 to 28 days; Part 820 residential treatment ranges from 3 to 6 months; and Part 822 outpatient treatment services can last from 3 months up to 1 year (OASAS, 2016).

I did not include all women who have received substance abuse treatment within the last 5 years, but restricted the study to a sample of those who have completed substance abuse treatment in an urban area in New York State within the last 5 years. I chose this geographical area as a result of living and working in this area, along with

having collaborated with many addiction treatment centers in this region, which created a stronger probability of recruiting participants in this area.

Limitations

One limitation was the sample population came from an urban area in New York State, which has its cultural norms regarding the exchanges that happen between men and women that may influence treatment results. Because I focused the research on women who completed substance abuse treatment in an urban area in New York State, the application of the results is limited to this area and the cultural and economic conditions of this geographic region. Finally, interviews could be subject to errors in memory, self-serving replies, participants' emotional conditions, and selective opinions that can distort the data (Patton, 2002). I further outlined researcher bias in Chapter 3.

Significance of Study

Because drug addiction for women is a public health problem (Center for Behavioral Health Statistics and Quality, 2011, December 8), increasing knowledge about strategies that support treatment retention and increase positive outcomes is critical to promoting positive social change for women with substance use disorders (SUDs). Bhati (2014) argued that to gain a better understanding about how gender differences in the client-therapist relationship influence treatment and outcomes, one must examine the narratives of the client and the therapist within the therapeutic environment.

Women who have received substance abuse treatment can best inform counselors about the interactions that increase or reduce treatment engagement when matched with a man (Greenfield et al., 2011). When counselor educators understand how to navigate the

intricacies challenging or promoting the therapeutic bond, they can train counselors with strategies for enhancing the treatment services for women receiving substance abuse treatment. The information gained from this study can ultimately inform men and treatment programs about strategies that strengthen competency in the area of building therapeutic alliances, increasing retention, and implementing positive interventions with women. The findings from this study can also inform men about how and when to address issues such as reproductive health, sexuality, relationships, and parenting.

Summary

In this study, I utilized a hermeneutic phenomenological analysis to try to discover and analyze data from six women ages 18 and above, who completed substance abuse treatment in an urban area in New York State, regarding their lived experiences receiving treatment from a man as a primary counselor. The research fills a gap in the literature proposed by SAMSHA (2013), asserting that the investigation of the client-counselor gender alignment for women receiving substance abuse treatment remains underexplored. Gaining information about this dynamic added to the existing literature about the influence of client-therapist gender matching with women receiving substance abuse treatment and contributed to increased education about providing services to this population. The following chapters contain a literature review (Chapter 2), a full account of the methodology (Chapter 3), the results of the research (Chapter 4), and interpretations and conclusions (Chapter 5).

Chapter 2: Literature Review

Introduction

In the 2020 strategic plan from the Office of Research on Women's Health the Honorable John Lewis, Congressman, Fifth District, Georgia stated:

> Do something about the health needs of women. That is a must. That is our mission and it is our goal….In the area of health, we must do what we can to bring about a revolution of values, a revolution of ideas….We must have the capacity to stand up, to speak up and out, to organize and mobilize (Regional Strategic Planning Meeting—Emory University, February 17, 2010, pg. 2).

The number of substance abuse treatment admissions for women between 1992 and 2007 increased from 27.4% to 32.5% (Center for Behavioral Health Statistics and Quality, 2013). NIDA reported that women ages 18 or above made up approximately 12% of the population who used illicit drugs in 2014 (NIDA, 2015) and growing medical and social consequences for this population continue to rise. Fewer women get admitted to treatment, and consequently, more effort is directed toward interventions designed to help men (Meyer, Patel, Rattana, Quock, & Mody, 2014). Terplan, Longinaker, and Appel (2015) utilized data from the National Survey of Substance Abuse Treatment Services (N-SSATS) to investigate trends in the availability of women-centered services while also assessing inequalities between service availability and treatment need and found that women-focused services are on the decline. Because the clinical focus of substance abuse treatment remains primarily man-centered, the authors argued for more

research to define which factors increase better outcomes for the female substance-abusing population.

Two features of treatment that are interrelated and may be central to successful retention and outcomes for women receiving substance abuse treatment are client-therapist gender alignment in concert with the therapeutic alliance. For example, Marsh, Angell, Andrews, and Curry (2012) conducted a systematic investigation of the connection of the client-provider relationship to treatment outcomes and the factors that augment the relationship's influence on treatment outcomes across several systems of care. The authors examined to define the factors, possible underlying interactions, central models and mediating processes between the therapeutic alliance and the results. They concluded that the client-provider relationship is an operational element of substance abuse treatment and therapeutic retention and outcomes. The authors argued for subsequent research to refine dimensions of the client-provider relationship.

SAMHSA (2013) reported that a high percentage of the woman receiving substance abuse treatment expressed a preference for a female counselor, and female clients receiving services from female counselors remained in treatment longer than those who had a male counselor. Even though knowledge exists that women matched with female therapists may produce enhanced treatment (SAMSHA, 2013), I could not locate any information that examined the treatment dynamics or outcomes of females receiving treatment for a substance use disorder who get paired with male clinicians. A gap in the literature exists specifically examining the lived experiences of women receiving

substance abuse treatment at inpatient, outpatient, or residential settings, matched with men as primary counselors.

In this literature review, I examined research focused on factors that may contribute to client-counselor gender match by exploring the lived experiences of women who completed drug addiction treatment and received primary individual counseling from a man at inpatient, outpatient, or residential settings. The contents of this chapter include the search strategy central to procuring articles. The items under review encompass how the therapeutic alliance influences treatment retention and outcomes; substance abuse and the therapeutic alliance; the therapeutic alliance and symptom change; and how a therapist' gender/sex relates to the therapeutic relationship, treatment retention, and outcomes.

Hermeneutic phenomenological (Moustakas, 2009) and RCT (Koehn, 2010) are conceptual frameworks suitable for examine the lived experience of people and relationships. I discuss these frameworks in literature review since these concepts are central to examining lived experiences and collaborative relationships. The basic notion of phenomenology centers on examining lived experiences (Creswell, 2012) and uses those experiences to describe what all participants of a group share in common. RCT focuses on the importance of people's relationships, asserting that safety and growth come from building healthy connections with others and mutual associations opposed to independence, ultimately creating a pathway for building a sense of self (Frey, 2013). According to Duffey and Somody (2011), RCT provides researchers with a theoretical

standpoint that includes gender as a foundational variable, along with a way to focus on the counselor-client relationship as central to the counseling process.

Literature Search Strategy

I attempted to explore as much of the existing peer-reviewed literature regarding the factors that relate to how the client-therapist gender alignment affects a woman's ability to remain in treatment and how these aspects influence outcomes for women who abuse substances. I conducted an extensive database search using the Walden University Library system. The majority of the articles I attained came from these EBSCO databases: Academic Search Complete, PsycARTICLES, PsycINFO, SocINDEX; ProQuest Central, Sage and Dissertation databases at Walden University. The list of search terms included but was not limited to: *substance use interventions and women, the therapeutic alliance, working alliance, therapeutic relationship, client preference, women and drugs, women and drug addiction,* and *client-therapist match.* I also used the following terms: *counseling outcome predictors, psychotherapy outcome predictors, therapist gender and outcome, counselor gender and outcome, psychiatrist gender and outcome, psychologist gender and outcome, boundary violations and counseling, sexual misconduct and counseling, hermeneutic phenomenology,* and *relational-cultural theory (RCT).*

For this study, the term "gender alignment or gender match" referred to the perceived gender of a client or counselor in the counseling relationship with someone of the opposite gender. I have structured the related research into a thorough review of the literature. Thus, the items I selected and incorporated came from my understanding of

the topics related to the client-therapist gender alignment. The search terms generated numerous articles varying in relevancy to the subject matter.

Brief Overview of Gender-Specific Treatment

The crack cocaine epidemic of the 1980s became a strategic time in history for the emergence of treatment services designed for women (Grella, & Greenwell, 2004). Maternal substance use became an issue of public concern, prompting the federal government to enact legislation and expand funding for the development of women-only treatment services, recognizing gender differences in substance abuse patterns and the implications for treatment (Carlson, 2006). Standard methods and diagnostic instruments were male-oriented and not alert to the issues facing women (Green, Polen, Dickinson, Lynch, & Bennett, 2002). Women who abused substances were more likely to have such problems as entering treatment younger than men, less income, children, less education, less employment, more sexual assault histories, and more likely to have experienced domestic violence (Bernstein et al., 2015; Greenfield et al., 2013). Women were also more likely to report poor health and emotional problems interfering with their normal activities. (Green et al., 2002). Thus, a push for research to examine factors affecting women with substance use disorders began to emerge, focusing not only for changes treatment modalities, but also in research and social policies (Claus et al., 2007; Cook, Epperson, & Gariti, 2005; Green, 2006; Grella, 2008).

This push for research to examine factors targeting women who abuse substances resulted in a plethora of studies examining the impact of gender on treatment or what is called gender-specific treatment. According Tang, Claus, Orwin, Kissin, and Arieira

(2012), gender-specific treatment is a series of comprehensive, family-focused interventions delivered with a strength-based, interpersonal, trauma-informed approach, inside of a protective and supportive setting. Greenfield, Brooks, Gordon, Green, Kropp, McHugh, and Miele (2007) conducted a critical review of literature that examined factors connected to treatment outcomes for women. The researchers examined engagement in treatment, retention, and post-treatment outcomes. The results were that gender alone did not necessarily connect to substance abuse treatment retention, completion, or outcome; however, men with drug addiction were more likely to enter treatment over their lifetime than women with substance use disorders.

For example, Simons (2008) examined the benefits of gender-specific interventions for pregnant and parenting women receiving substance abuse services at residential settings and confirmed the efficacy of gender-specific residential treatment as a method for helping women receiving substance abuse treatment and their children. In another study, Graff et al., (2009) investigated the connection between addiction treatment modality and retention and engagement in for women with alcohol problems, along with aspects of treatment that were predictors of retention and engagement. Graff et al. (2009) proposed that knowledge about treatment retention and engagement is founded on male samples or mixed gendered samples and highlight the implications of pinpointing predictors of retention and engagement among women and gender-specific treatment. Laux, Dupuy, Moe,

Cox, Lambert, Ventura, and Benjamin (2008) conducted a substance abuse needs assessment of women in the criminal justice system. These researchers proposed that

limitations in comprehending women's needs create a situation in which counselors risk delivering unproductive interventions. Laux et al. (2008) suggested that providers of treatment centers that do not already have gender-specific treatment should consider offering female-only groups that specifically address the needs of mothering and targeted women issues, or at minimum be aware of the potential adverse effect of addressing female-sensitive matters in a mixed-gendered group could have on women.

From a historical perspective, women were at higher risk of experiencing boundary violations and sexual misconduct from male counselors than female counselors. For example, drawing from a national survey of 323 mental health professionals 138 (43%) men and 185 (57%) women, Jackson and Nutall (2001) discovered the ratio of sexual misconduct among male therapists was 19 to 1 when compared to a female therapists. Stake and Oliver's (1991) exploration of the incidences of psychologists' attitudes toward sexually suggestive behaviors found male therapists reported higher percentages of sexual misconduct with their women clients than female therapists. Pope and Bajt's (1988) examination of ethical dilemmas encountered by members of the American Psychological Association (APA) found that out of 100 senior psychologists (state ethics committee members, APA's ethics committee members, or authors of ethical textbooks), 9% had engaged in an inappropriate sexual relationship. Counselor-client sexual contact is the highest form of boundary violation and is very destructive (Moleski & Kiselica, 2005).

In another study of all complaints alleged against psychologists to the New South Wales Psychologists Registration Board over a 4-year period, Grenyer and Lewis (2012)

found that out of a sample of 9,489 registered psychologists, misconduct complaints against men were 2.5 times more likely to occur than complaints made about a female psychologist. Capawana (2016) examined rates of sexual misconduct among mental health practitioners on the whole in the United States and discovered that the rates were 7–12% among general mental health practitioners; 2.5% women and 9.4% men. The offending therapists were overwhelmingly male, and victimized clients predominately female, contributing to increased amounts of distress and mental health symptomology directly connected to the inappropriate relationship. Thus, it is very crucial for male clinicians to learn strategies to prevent the misuse of power and boundary violations when paired with female clients.

Although gender-specific research about women has emerged, little has emerged examining the influence of male counselors matched with female clients as it relates to gender-specific substance abuse treatment. Greenfield et al., 2007 concluded that research examining different modalities and effectiveness of gender-specific therapeutic interventions is necessary. Understanding the lived experiences of women who have completed substance abuse treatment who received primary individual counseling from men, as primary counselors will add to the literature regarding gender-specific interventions.

How the Therapeutic Alliance Influences Treatment Retention and Outcomes

The therapeutic alliance is one factor consistently identified as central to assisting with retention and positive treatment outcomes across various populations (Gullo, Lo Coco, & Gelso, 2012; Tschacher, Junghan, & Pfammatter, 2014). No feature stands out

above the rest as a significant factor to cultivating treatment engagement as the therapeutic alliance (Horvath, Del Re, Flückiger, & Symonds, 2011; Kivlighan, Marmarosh, & Hilsenroth, 2014). Djurkov and Sertsou (2012) asserted that the therapeutic alliance is an intervention, whereby it is possible to build clinical skills in creating and maintaining partnerships, in addition to measuring how the alliance influences retention and treatment outcome. According to Krause, Horvath, and Altimir (2011), the therapeutic alliance is a canopy under which various researchers with different philosophical stances can operate in a unified manner about the universal influence of the therapeutic relationship and the multifaceted characteristics of all helping processes.

The concept of the therapeutic alliance emerges from exploratory work regarding aspects of transference in counseling approximately 60 years ago (Hausner, 2000). Ruglass, Miele, Hien, Campbell, Hu, Caldeira, and Nunes, (2012) defined the therapeutic alliance as the strength of the partnership between the client and therapist that blends the investment in the counseling process and bond with the therapist. This interaction that occurs between client and therapist may be at the core of therapeutic process and treatment success.

Sharf, Primavera, and Diener (2010) conducted a meta-analytic review to ascertain the strength of the therapeutic alliance's connection to treatment dropout in adult psychotherapy, expecting that a contrary alliance would relate to treatment dropout. The review contained 11 studies consisting of 1,301 participants, and an average of 118 participants per study. This investigation was the first to employ a meta-analytic strategy

to assess the client-therapist interaction as a predictor of treatment dropout. A calculation of effect sizes for the relationship between dropout rate and therapeutic alliance for each of the 11 studies and a weighted mean effect size occurred. The results were that clients who experienced a weaker therapeutic relationship were more apt to have early treatment attrition (weighted mean d = .55, 95% CI [.37, .73], Z = 5.92, p = .001, k = 11), supporting the therapist-client interaction as a significant predictor of psychotherapy dropout.

Tschacher, Junghan, and Pfammatter (2014) analyzed the association of common factors between techniques that affect client change in psychotherapy, with the purpose of reaching a grouping of factors. Experts in psychotherapy completed surveys regarding 22 common factors that they believed are significant to producing symptom change in psychotherapy. Out of the 22 factors examined the experts concluded that the therapeutic alliance is one of the most relevant factors significant to producing positive outcomes in psychotherapy regardless of the mode of intervention. In another example, Slone and Owen (2015) examined a sample of 247 clients receiving counseling at a university center (186 women, 57 men, and four who did not identify their gender) to explore the manner in which therapist alliance building activities influenced treatment outcomes. Part of the authors' hypothesis was that therapists rated higher in alliance building activities would experience better results. Clients completed surveys regarding their most current therapeutic encounter. Multilevel modeling was utilized to test the association between therapy outcomes; client ratings of the Alliance in Action (AiA), and Other-Interpersonal Subsystem Alliance (Other-Alliance). The results were that Therapists

accounted for 4.7% of the variance in Other-Alliance to 19.1% in AiA. Notably, therapists accounted for approximately 7% of the variance in therapy outcomes. The significant findings of their study were that those participants who perceived their therapist as engaging in alliance building activities (e.g., checking with the person about the partnership), promoted better client engagement, which ultimately resulted in more favorable treatment outcomes.

Horvath, Del Re, Flückiger, and Symonds (2011) conducted a synthesis of four meta-analytic reviews regarding the features that relate to the therapeutic alliance and psychotherapy dropout. The authors identified several significant factors regarding the therapeutic alliance: the quality of the therapeutic partnership affects treatment outcomes; it is an operational feature of therapy that is indispensable and inseparable from everything that occurs in therapy, and it is fundamental to creating collaboration for addressing the client's problems. Horvath et al. (2011) also noted that a negative alliance led to early dropout from psychotherapy treatment; patients who experienced weaker alliances had a greater tendency to dropout from therapy regardless of moderating factors such as length of stay and treatment setting. Thus, the authors conclude that the quality of the alliance is a critical factor influencing psychotherapy treatment outcome. Fluckiger, Del Re, Wampold, Symonds, and Horvath (2012) found similar results in their meta-analytic review of five possible mediators affecting the therapeutic alliance and psychotherapeutic treatment outcome. The moderators they evaluated were whether a study utilized relational-cultural theory, a disorder-specific manual, a cognitive behavioral intervention, researcher allegiance, or if an outcome was related to a targeted

disorder. The authors also examined how these features simultaneously influenced the alliance- association over the course of treatment. The result of their meta-analytic review proposed that regardless of the moderator, the therapeutic relationship is the most robust feature influencing treatment and outcome, supporting the significance of the alliance in accounting for treatment outcomes across modes of therapy.

McClintock, Anderson, and Petrarca (2015) conducted a study utilizing archival information gathered over a five-year period at a university psychology clinic to test a three path mediation model to see if the therapeutic alliance or a positive atmosphere in the therapy session act as moderators to client's expectations of treatment and outcome. The sample consisted of 116 clients seeking treatment for a variety of problems. The clients saw therapists enrolled in a clinical psychology Ph.D. program. Clients completed four research-supported instruments, the Expectations about counseling-brief form (EAC-B; Tinsley, Workman, & Kass, 1980), the working alliance inventory-short form revised (WAI-SR; Horvath & Greenberg, 1989; Hatcher & Gillaspy, 2006); the positivity subscale of the session evaluation questionnaire (SEQ-positivity; Stiles, 1980; Stiles & Snow, 1984; Stiles et al., 1994), and the outcome questionnaire -45 (OQ-45; Lambert et al., 2004). The results were that the therapeutic alliance and positive atmosphere in session act as mediators to client's expectation of treatment, ultimately influencing treatment outcome. McClintock, Anderson, and Petrarca (2015) argued that regardless of treatment modality client expectation and alliance are consistent features that assist with change and aid in the recovery of functioning. Consequently, it appears that the therapeutic alliance is consistent as one of the main factors influencing treatment

retention and outcome, and also functions as a buffer to a client's experience with treatment regardless of theoretical framework or model of intervention.

However, even though a good amount of information has linked the therapeutic alliance to clinical improvement and treatment outcome, contradictions to these findings exist. For example, Corso et al. (2012)) examined the therapeutic alliance and treatment outcomes in primary care behavioral health models. The study examined three factors; (a) the strength of patient-rating of the alliance after an initial 30-minute session, (b) patient-rated alliance in a primary care model compared to outpatient, and (c) treatment alliance connection to improvement in psychological symptoms in a primary care model. The sample consisted of 541 patients referred by the primary health care center for a behavioral health consultation. Patients completed a 20-item behavioral health measure after each appointment. The overall results suggested that clinical improvement did not connect to the therapeutic alliance. Corso et al. (2012) argued that interventions already introduced to the therapy sessions before measurement of the therapeutic partnership may account for the lack of association between these two variables. The alliance is not sufficient to determine an outcome by itself, but multiple factors may play a role such as a counselor's behavior or an intervention prescribed.

In another sample, Hendriksen, Peen, Van, Barber, and Dekker (2014) conducted a secondary analysis of a clinical trial performed by the Arkin Depression Research Group that compared the outcomes of psychodynamic treatment with combined therapy (psychodynamic and pharmacotherapy) for the treatment of major depression. The focus of this analysis was to investigate the predictive value of the therapeutic alliance on

symptom change, more specifically, does the working alliance predict changes in depressive symptoms or do changes in depressive symptoms affect the quality of the therapeutic partnership? The sample consisted of patients with depressive disorders seen over a three-year period at two outpatient clinics. Patients received 16 sessions of a manualized therapy. Hendriksen et al. (2014) failed to establish a significant predictive value of the therapeutic alliance affecting symptom change over the course of treatment. However, the authors continued to argue that no doubts should exist concerning the significance of the working alliance as the main factor influencing treatment outcome.

The inconclusiveness about the direct role the therapeutic alliance plays with treatment outcome may be related to other factors that mediate the healing process, such as a client's pre-therapy attachment tendencies, symptom improvement, or the therapist actions. For example, in their study examining the dynamic that occurs between the therapeutic alliance and symptom change in psychotherapy, Xu and Tracey (2015) hypothesized that a bi-directional relationship occurs. The therapeutic alliance linked to modification of symptomology and symptom change boost the intensity of the therapeutic alliance. The sample in this study consisted of 638 community clients seeking therapy for issues such as interpersonal difficulties, career decisions, anxiety, and depression. Clients completed The Working Alliance Inventory–Shortened Version WAI-Sh (Tracey & Kokotovic, 1989) and the Outcome Questionnaire–10.2 OQ-10.2 (Lambert et al., 1998) before each session, beginning with the third session, over the course of 14 treatment sessions. Xu and Tracey (2015) found both the alliance and symptom change have a reciprocal effect on each other; a good therapeutic alliance led to

symptom improvement, and symptom improvement strengthened the therapeutic relationship. The two interrelating progressions equally augment each other, ultimately affecting treatment outcome.

Mallinckrodt and Jeong (2015) conducted a meta-analysis of 14 studies published between 1995 and 2013 that examined the connection between a client's pre-therapy attachment patterns with their attachment to a therapist, to discover the connection between client pre-attachment tendencies and the therapeutic alliance. The review consisted of studies employing the Client Attachment to Therapist Scale only (Mallinckrodt, Gantt, & Coble, 1995). The studies either measured client pre-therapy attachment and the working partnership, the therapeutic alliance, but not pre-therapy attachment, or pre-therapy attachment, but not the working partnership. The results were that clients' pre-therapy attachment patterns did shape the ability for these patients to build a strong psychotherapeutic relationship. Thus pre-therapy attachment struggles correlated with weak psychotherapy attachment, affecting therapy outcome.

On the other hand, Elkin, Falconnier, Smith, Canada, Henderson, Brown and McKay (2014) tested the theory that a therapist' responsiveness in the first two sessions is critical to a client's continued engagement in therapy. The data came from the Treatment of Depression Collaborative Research Program TDCRP (Elkin, 1994; Elkin, Parloff, Hadley, & Autry 1985; Elkin et al., 1989), which consisted of a sample of 72 patients that received 16 weeks of either CBT or IPT treatment. Elkin et al. found that therapist responsiveness in the first two sessions was a significant predictor of both the patient's evaluation of the therapeutic alliance and retention in treatment beyond four meetings.

Additionally, Elkin et al. (2014) argued that a client's engagement in treatment might be more related to the therapist' responsiveness early in the relationship opposed to any other characteristic the therapist may possess.

Bedi and Duff (2014) argued that clients weigh the formation of the therapeutic bond primarily as the clinician's responsibility opposed to their efforts. In their study regarding clients' subjective experience of therapeutic alliance formation, Bedi and Duff (2014) utilized the Delphi method (Linstone & Turoff, 1975) to examine the therapeutic alliance (The Delphi method is a process by which researchers look for consensus about a topic). Thirty-six participants completed three questionnaires to classified alliance formation by categorizing "critical incidents" in alliance formation. Eighty-seven percent of the consensus placed a high significance on therapist's behaviors opposed to therapist's characteristics. Consequently, based on client's subjective experience the formation of the therapeutic relationship weighs heavily on the therapists' ability to build and maintain.

Beutler, Forrester, Gallagher-Thompson, Thompson, and Tomlins (2012) also noted in their study examining common variables that affect the quality of therapeutic alliance and treatment outcomes in psychotherapy that a natural tension exists between frameworks that assert the therapeutic alliance is more related to treatment outcomes opposed to targeted interventions or characteristics. In fact, the authors found that a reciprocal effect of clinical improvement might hinge on the patient and counselor's ability to form a collaborative connection, and as a result, the collaborative connection influences symptom change, and ultimately treatment engagement and outcomes.

Despite the differences of opinion regarding the role of the therapeutic alliance, counselors cannot dismiss the connection between the therapeutic relationship and symptom improvement, thus a proper functioning alliance is a prerequisite for maintaining symptom improvement throughout treatment (Falkenström, Granström, & Holmqvist, 2014). Since the therapeutic alliance appears to influence treatment and outcome in psychotherapy regardless of disorder, it is possible that it will have similar results on treatment outcomes in populations such as females receiving substance abuse treatment.

Substance Abuse Treatment and the Therapeutic Alliance

The therapeutic alliance is also one of the operational components affecting treatment retention and outcomes across several dimensions of substance abuse counseling. For example, Brorson, Arnevik, Rand-Hendriksen, and Duckert, (2013) conducted a systematic review of 122 studies involving a total of 199,331 participants to discover which common factors may predict substance abuse treatment drop-out and the reliability of these factors at successfully predicting drop-out. The common factors observed were patient's ages, sex, education level, and marital status, primary drug of choice, co-occurring disorder, and cognitive functioning. Also, treatment intervention, length of therapy, location, and patient/staff ratio, to see the role these factors play in treatment attrition. Finally, the authors reviewed treatment process factors, such as patient motivation, treatment satisfaction, and therapeutic alliance. A total of six (5%) of the studies investigated alliance, and all reported statistically significant associations, with lower alliance consistently relating to higher drop-out. These authors concluded that

measuring the alliance as a clinical intervention can act as warning factor allowing remediation efforts to occur to reduce premature dropout from treatment.

In another sample, Prince, Connors, Maisto, and Dearing (2016) examined the influence of the therapeutic alliance in predicting treatment outcomes between sessions for an alcohol use disorder in an outpatient setting. The authors argued that current approaches limit researchers because they assess alliance at targeted points compared to over the course of treatment resulting in only glimpses of the factors that influence the connection of alliance to outcomes. In addition, Prince, Connors, Maisto, and Dearing (2016) proposed that if the alliance is assessed after each treatment session, a greater grouping of factors related to the alliance will get revealed.

Participants included 65 clients seeking treatment for an alcohol use disorder. The participants completed the time follow-back assessment TLFB (an interviewer-administered evaluation of daily drinking Sobell & Sobell, 1992), and the working alliance inventory WAI-S (evaluates the client/therapist agreement regarding the goals of therapy, the tasks of treatment, and the client/therapist bond Horvath & Greenberg, 1986; Tracey & Kokotovic, 1989). In addition, the clients received 12 weeks of cognitive behavioral therapy. Participants provided alliance ratings after each session based on their view of the session that day. The results were if the alliance was rated as high, clients attended a greater number of meetings than if the clients rated the relationship as medium or low. Also, a strongly rated alliance by the client predicted a high amount of days of sobriety. However, the therapist rating of the alliance did not increase the number of sessions attended or percentage of days abstinent. The overall results of the

study confirmed that clients rate the quality of the therapeutic relationship as an essential dynamic within treatment, an important factor predicting treatment outcomes, and a predictor of the percentage of sober days following treatment.

Cook, Heather, and McCambridge (2015) found similar results regarding client's views about the therapeutic alliance. Cook et al. (2015) utilized data from The United Kingdom Alcohol Treatment Trial (UKATT; Research Team, 2005) in their longitudinal study to pinpoint whether the working alliance predicted drinking behavior, the motivation for post-treatment change, and outcome after nine months post-treatment. The evaluation of the working alliance took place after the first sessions of treatment; and an assessment of drinking behavior took place pretreatment, posttreatment, and nine months following treatment. Clients' ratings of the working alliance predicted outcomes and motivation to change, but therapist' rating of the alliance did not show any association. This inquiry was the first study that examined the influences of the working alliance on post-treatment motivation to change. The critical finding of this research was that no matter how the therapist rated the alliance, the client's assessment of the therapeutic relationship after the first session was more determinate of motivation to change and longer-term treatment results than the clinician's.

Knuuttila, Kuusisto, Saarnio, and Nummi (2012) took a naturalistic approach to examine the operational features of the therapeutic alliance on treatment retention and outcome in substance abuse outpatient treatment. The authors attempted to see if a therapist's inconsistencies affected the therapeutic partnership and treatment outcome, the manner by which an alliance created early in the relationship predicted the percentage of

days clean six months after treatment; the role of client versus patient rating in predicting treatment outcome, and how pretreatment abstinence predicted treatment results. Knuuttila et al. (2012) hypothesized that creating an alliance early in treatment would promote better results and client satisfaction in substance abuse outpatient treatment. The study included 327 patients and 33 therapists who completed a form to rate the therapeutic alliance at the conclusion of their first and third sessions. Only three of the therapists were men, and the study only examined the alliance rating after the ceiling of five meetings per client was met. According to the results, both parties rated alliances built early as increasing as treatment progressed. Client ratings after the first and third sessions predicted treatment satisfaction at the conclusion of therapy, but therapist's ratings of the therapeutic relationship were only relevant at the third session. An early therapeutic relationship did not predict the percentage of time in abstinence following treatment, but differences in a therapist's behavior connected to patient outcomes. The overall results imply that correlation does exist between the therapeutic alliance and treatment outcomes. However, the authors argued that the need to investigate which therapist behaviors created a better early working alliance to produce an effective treatment for patients continue to exist.

Urbanoski, Kelly, Hoeppner, and Slaymaker (2012) conducted a study to illuminate the function of the therapeutic alliance in the treatment of young adults who have a substance use disorder. The authors assessed to see if patient's pretreatment motivation, emotional and social supports, and attitudes toward treatment influenced a client's ability to form a good therapeutic relationship, and on the other hand, if the

therapeutic alliance regulated emotional distress, self-efficacy, and coping skills during the progression of treatment. The authors expected that the greater functional level and readiness to change, along with a strong quality alliance, would enrich client change during treatment. This naturalistic study consisted of 303 young adults receiving substance abuse services at a residential facility. After assessment of alliance and symptom modification, the results highlighted those patients who built stronger alliances earlier in treatment experienced more drops in emotional difficulty between admission and discharge. However, although a connection between the alliance and less psychological distress existed, it did not directly relate to changes in motivation for abstinence, self-efficacy, coping skills, or commitment to self-help programs. Urbanoski et al. (2012) still argued that a strong therapeutic alliance increases the likelihood that a reduction of emotional stress will occur, and reduction in stress supports recovery efforts for young adults receiving substance abuse treatment.

The functional role of the influence of the therapeutic alliance on treatment outcomes in psychotherapy and the substance abusing population is evident. If clients believe their clinician is knowledgeable, sincere, and encouraging, and if they experience their clinician as dedicated to therapy work, they will develop more collaborative and durable relationships, ultimately creating and maintaining the therapeutic relationship, resulting in better outcomes (Patterson, Anderson, & Wei, 2014). Braun (2013) related this connection to clients recalling the therapeutic relationship in their thought processes. Clients use their experiences with counselors as a coping mechanism for navigating stressful situations making the therapeutic alliance one of the primary catalysts of change

in addiction treatment and the most significant intervention affecting the posttreatment outcome (Braun, 2013).

The usefulness of building and maintaining a solid therapeutic relationship is evident. However, these studies offer limited information describing how the client-counselor gender-match influence the formation or maintenance of the partnership between male counselors and female clients receiving drug addiction treatment. Thus, it continues to remain relatively unclear about how the client-counselor gender alignment, in particular between male counselors and female clients receiving treatment for substance abuse influences retention and outcome for this population.

Counselor Gender

Multiple studies have investigated how a counselor's gender influences treatment retention and outcome across populations (Eastwood, Spielvogel, & Wile, 1990; Felton, 1986; Jome, & Murray, 2013; Jones, & Zoppel, 1982; Kuutmann, & Hilsenroth, 2012; Lukton, 1992; Ruderman, 1986). For instance, Landes, Burton, King, and Sullivan (2013) examined women's comfort in self-disclosure to a therapist of a different sex, along with their preference for a therapist of the same sex. One hundred and eighty-seven female students from a medium-sized Midwestern university participated in the study. Participants gave their disposition about disclosing about a hypothetical scenario to a therapist of the opposite sex. Next, they had the option to choose a therapist of the same sex, but same qualifications as the previous therapist. The results were that the participants would rather have a female therapist compared to a male because they believed that female counselors are more empathic, warmer, and similar to themselves.

Bowers and Bieschke (2005) examined a sample of psychologists to assess their attitudes concerning client's gender. The female psychologists had more positive viewpoints toward patients than male psychologists; they assigned less blame to their patients for the causes of their difficulties and anticipated greater improvement. Female psychologists articulated increased interest in working with clients. However, males reported greater comfort working with patients than a female therapist.

Sterling, Gottheil, Weinstein, and Serota (2001) examined a sample of clients receiving treatment for cocaine addiction to see if patients matched with the same sex and ethnic background as their therapists would remain in treatment longer and had better outcomes than those paired with the opposite sex. The results of the study revealed that gender match did not influence dropout rates, retention, or follow-up. However, the authors continue to infer that it is reasonable that a patients' comfort with the same sex therapists would result in their likeliness of returning and remaining in treatment.

In addition to this, Cottone, Drucker, and Javier (2002) investigated the influence of gender on treatment retention and change in psychological symptoms in psychotherapy dyads, after three months of therapy. One of the factors that Cottone et al. (2002) hypothesized is that female therapist's clients would experience a greater reduction of symptoms than clients assigned to male therapists. The sample involved 163 clients at the Center for Psychological Services and Clinical Studies, a community mental health clinic in Jamaica, New York. Before the initial therapy session, clients received the Beck Depression Inventory (BDI) (Beck & Steer, 1987), and the State–Trait Anxiety Inventory (STAI) (Spielberger, 1983). After three months of treatment, clients received

subsequent reassessment of the BDI and the STAI until termination of therapy. The results were that differences in therapist gender and client gender did not relate to change in psychological symptoms; in fact, female patients matched with male therapists were considerably more apt to advance past intake than male clients with male therapists. However, a patient's gender did account for time spent in therapy, implying that a patient's gender influences therapeutic alliance indirectly more so than the client-therapist match.

Evans, Li, Pierce, and Hser, (2013) conducted a longitudinal study of a cohort of mothers who received women's only treatment compared to mixed gendered treatment. The sample consisted of 789 mothers followed for ten years subsequent substance abuse treatment at women-only or mixed gendered facilities. The outcome showed that the odds of successful outcomes increase 44% for those who received treatment in women-only programs, and correlated with positive results and less arrest after a 10-year period.

Similar to the previous authors, Greenfield et al. (2013) conducted a qualitative analysis to compare women's lived experiences of satisfaction with a single-gendered substance abuse group treatment compared to a mixed-gendered group. The aim was to discover if the homogeneity of the women's group offered a greater sense of comfort, cohesiveness, and opportunity to talk freely about gender-specific triggers than a mixed-gendered group. A sample of 36 women in stage one treatment participated in the study. The results were that these women reported that being in a homogenous group enhanced their treatment experience and outcome, as the single-gendered group allowed opportunities for them to express all features of themselves (i.e., messed up one week and

strong in the next). These women extended the significance of being in a same-gendered group by insisting that having a female counselor lead the sessions is critical to engagement and outcome.

From a Marriage and Family Therapy perspective (MFT), Johnson and Cadwell (2011) explored the comparisons between therapists and clients' race and gender, along with therapists' confidence to see how these variables connect to patient satisfaction with the therapeutic relationship. Johnson and Cadwell (2011) hypothesized that significant differences would exist between client's and therapists' report of satisfaction if they were from a different race, a different viewpoint of the therapists' confidence or different gender. Most importantly, the authors hypothesized that when clients and therapist share gender, more satisfaction within the therapeutic relationship would occur. One hundred and eighty-two clinicians and 233 clients participated in the study; patients received individual, couple, or family therapy. Clients completed a basic demographic evaluation at the beginning of treatment and completed a brief survey analyzing the therapeutic relationship after session four of treatment. The clinicians in the study completed a similar survey at the end of the fourth session evaluating their satisfaction with the counseling relationship. The results were that when clients shared the same gender as their therapist (88.6% were female therapists paired with female clients, 11.4% male therapists paired with male clients), they reported increased satisfaction with the therapeutic relationship ($M = 8.86$, $p < .05$). However, the therapist did not report any significant satisfaction based on gender alignment. Even so, these results were only significant when gender match tested in isolation. However, when examined with other

variables the statistical significance of gender match no longer stood out. Johnson and Cadwell' (2011) argued that the gender alignment influence on the therapeutic alliance might come more from the client's preference and individual histories opposed to gender alone merely.

Williams et al. (2016) examined client preferences, analyzing data from the National Audit of Psychological Therapies for Anxiety and Depression. The audit was a large-scale assessment of the practice of psychological therapies in England and Wales to determine the prevalence of patient preferences, the extent to which these individuals believed these the agencies fulfilled their preferences, and if responding to these preferences had any impact on their treatment experiences. Patients completed surveys examining their treatment experiences and asked about whether their preferences for treatment were met, including the gender of the therapist they saw. Most of the participants felt they were offered sufficient choices for each variable examined. However, approximately sixty percent felt they were not offered enough choices when it came to a preference for the therapists' gender.

Whether the client-therapist match is a result of gender alone or a patient's preference also remains unclear. Bowman, Scogin, Floyd, and McKendree-Smith (2001) noted the uncertainty surrounding the effect of a clinician's gender on treatment outcome in their meta-analysis of psychotherapy length of stay and outcome. Bowman et al. question whether female clinicians produced better overall effects on treatment outcome than male clinicians and whether same-gender client-therapist match produced better results that mixed-gendered pairing. The analysis included sixty-four studies examining

effect size of client-therapist matching. The results indicated better results for clients treated by female therapists, but the results were not statistically significant enough that to make a clear distinction. Bowman et al. (2001) argued that a therapist's gender as a predictor of treatment outcome is not significant to psychotherapy planning alone. The inferences of the previous studies indicate that a therapists' gender may indeed influence a client's ability to form the therapeutic bond, ultimately affecting treatment outcomes, but the exact effect remains inconclusive.

In an editorial regarding implications for research and practice for substance abusing women, Sharma (2014) noted that a lack of research exists related to the effectiveness of intervention strategies for women receiving substance abuse treatment. The authors insist that additional studies must compare gender-specific interventions to mixed gender interventions.

Prendergast, Messina, Hall, and Warda (2011) evaluated the efficiency of women-only treatment compared to mixed-gendered treatment on outcomes. However, they examined this phenomenon specifically in an outpatient setting. Researchers hypothesized that women-only treatment programs would result in improved treatment outcomes for women. One hundred and thirty-five participants from the women-only program completed the 12-month follow-up interview, and 124 participants from the mixed group completed the follow-up interview. All hypotheses were tested at the .05 significance level using a two-tailed test. In the women-only group, 27.7% compared to 43.0% in the mixed –gender group had any substance use in past 30 days. 22.3% in the WO group compared to 39.7% in the MG group reported any criminal activities in past

30 days. 16.2% in the WO group compared to 23.1% in the MG reported any arrest in past year, and 22.3% in the WO compare to 40.5% in the MG group had been employed in past 30 days. The overall results were that the sample of women who participated in women-only services reported less substance use at the 12-month mark following treatment than those in mixed gendered programs, and better overall functioning. This study points to the concept that the creation of women-only treatment programs appears to have a positive influence on treatment outcomes. However, the authors argued that studies that explore treatment factors for women that are gender-responsive continue to be necessary.

Saarino (2010) investigated the differences in clinician's personality traits in substance abuse treatment through the lens of therapist's gender differences. One hundred and sixty-two therapist of inpatient treatment institutions participated in the study. The participants completed a background informational questionnaire and personality test. In addition to this, they completed a vignette task. The results revealed that women were friendlier, open to experiences, livelier; better at interpersonal functioning; and more enthusiastic about their work than men. Even though female therapist excelled in characteristics that help engage clients in treatment, Saarino (2010) argued that before reasonable conclusions about gender effects in this field can be made. Further research to answer whether male therapist possesses different attitudes toward patients than females and the differences between male and female therapist in the continuity and outcomes in substance abuse treatment must occur.

Wintersteen, Mensinger, and Diamond (2005) examined gender and racial matching effect on the therapeutic alliance and retention in treatment for substance abusing adolescents. Participants came from a sample of youth receiving substance abuse treatment at the Cannabis Youth Treatment project funded by the Center for Substance Abuse Treatment which assessed five outpatient models for adolescence substance abuse treatment. From the patient's perspectives, it was easier to build an alliance if matched with the same sex for a therapist, and those matched with the same gendered therapists were more apt to complete two-thirds of treatment than those matched with the opposite sex. One interesting finding emerged in the study with regards to male therapist's rating of the alliance. Male therapists rated the therapeutic relationship lower than the girls rated the relationship, indicating that male clinicians may have doubts about their ability to easily connect with teenage girls and may experience increased discomfort when treating female clients (Wintersteen, Mensinger, & Diamond, 2005).

When clinicians have doubts about their ability to connect to a client based on a mismatch of gender, it is understandable that this perception will affect the relationship and possibly treatment retention and outcome. Perception is critical as is seen in the study conducted by Nissen□Lie, Havik, Høglend, Rønnestad, and Monsen, (2015) who examined factors that contribute to the quality of alliance as viewed by the patients and therapists. The researchers examined alliance development over the course of a period, comparing patient ratings to therapist ratings (Nissen-Lie et al., 2015). The results were that a therapist's mental dispositions about the relationship was the significant factor to

the successful alliance; when therapists exhibit negativity, it was rated as more pronounced to patients and had more weight to influencing poorer treatment outcomes.

While investigating group composition Greenfield, Cummings, Kuper, Wigderson, and Koro-Ljungberg (2013) utilized semistructured interviews to compare women's self-reported encounters and satisfaction with single-gender versus mixed-gender substance abuse group therapies. The participants consisted of 36 women enrolled in a Stage I behavioral treatment development study. The women in the study emphasized that participation in a heterogeneous group provide an opportunity for them to be genuinely authentic. The women explained authenticity as having their needs met, having a common language, support from each other, and feelings of closeness. However, women participating in the mixed gendered group expressed perceptions of negativity, constraint in sharing, lack of empathy, and sexual tension. The women expressed that the different communication styles between women and men were often non-productive. Most significantly, the women expressed the importance of a female therapist leading the group; stating that having a female therapist enhanced their level of comfort with self-disclosure.

The discomfort of self-disclosure may be related to the personal experiences of women as was examined in one study by Salter and Breckenridge (2014). The researchers explored the personal experiences of a sample of females in women-only treatment with histories of child sexual abuse and substance abuse, along with the providers of those services to examine the subjective facets of the treatment encounter. They identified a strong preference for the same gender between clients and therapist.

According to the sample, many of the trauma experiences occurred at the hands of men, so the emotional safety that occurs within women-only treatment allows them to raise issues that they would very uncomfortable bringing up if men were present. According to one of the providers interviewed:

> There is definitely something to be said about the emotional energy that exists in a women – only service. Women are thinking of that same perspective – not that a man couldn't, but if a man was here it would trigger a whole bunch of new stuff that we'd have to cope with. That we don't want to, because there is an element of safety being around women (p.171).

According to Braun's (2013) analysis of narratives of a sample of therapists working with substance abusing patients; the connection between the client and therapist must be taken into context to examine what produces successful therapeutic outcomes. If men counselors are not aware of what role their perceived gender may play in creating barriers that prevent women from completing treatment, it is likely women may prematurely terminate counseling services. Braun (2013) noted that the complexity of the treatment process for substance abuse illuminates the need to embark on a multidimensional exploration of the interaction between intrapersonal and interpersonal components that occur between the client and clinician within the therapeutic relationship.

Again, in the Treatment Improvement Protocol (TIP) guidance for addressing the needs of women seeking substance abuse treatment, SAMHSA (2013) concluded that research about the influence of the client-counselor gender alignment is limited and needs

additional exploration. Examining how the client-therapist gender match affects the therapeutic alliance between women clients and men counselors will fill an unexplored gap in the literature by providing insight to how the therapeutic alliance pragmatically influences treatment retention and outcomes with women who have a men as a primary counselor.

Summary

Women who abuse substances and do not engage in addiction treatment will continue to be at high-risk for life-long addiction issues (Taylor, 2010) and society will continue to bear the cost. Bellamy, Gott, and Hinchliff (2011) argued that it will take collaboration between women and men to eradicate gender inequality and construct strong associations that improve egalitarian relationships. Jack et al. (2011) argued that agencies could benefit from the use of evidence-informed decision-making policies to create more efficient methods of translating knowledge gained from research to therapeutic practice for substance abusing women. Finfgeld-Connett and Johnson (2011); and Guerrero (2013) suggested that the investigation of program factors that enhance better treatment engagement, retention and outcomes should occur. However, a gap in the research exists concerning the phenomenon of gender match and the role it plays between women receiving substance abuse treatment from men counselors (SAMSHA, 2013).

Investigating the lived experiences of women who have completed substance abuse treatment who received primary individual counseling from a man has various potential benefits. For example, the information gained can assist counselors and

agencies with improving client-counselor matching and enhancing the understanding of the things that cause, or prevent, alliance ruptures in treatment with women receiving substance abuse treatment. In addition to this, gathering the direct experiences of women who have completed treatment and received primary individual counseling from a man can increase the understanding of the interventions that women say produce or hinder positive outcomes for them. Finally, the information gain from this inquiry can assist with the training and supervision of male counselors delivering substance abuse services to the females seeking treatment for drug addiction.

Counselors are at the forefront of implementing strategies that sustain women in drug treatment and reduce the impact of substance abuse and the transmission of mind and mood-altering substances to the next generation. When counselors and counselor educators have the adequate information, they are better prepared to affect social change by implementing interventions that promote engagement in treatment and healthy lifestyle changes. Creating strategies that sustain women in treatment may relate to the client-counselor gender match, thus understanding the dynamics of the client-counselor gender alignment by examining the lived experiences of women who have completed substance abuse treatment who received primary individual counseling from a man, are central to improving outcomes.

Chapter 3: Research Method

Introduction

To increase the knowledge and competencies surrounding successful engagement with women receiving substance abuse treatment paired with male counselors, I conducted a hermeneutic phenomenological study to answer the question "What are the lived experiences of women who received primary individual substance abuse counseling from a man and completed treatment?" In this chapter, I present the logic for the hermeneutic phenomenological approach, the role I played, and the credibility of the study.

Research Design and Rationale

Researchers in the social sciences endeavor to learn innovative or various approaches of comprehending social realities. Researchers utilize either quantitative or qualitative inquiries to investigate a phenomenon. The fundamental differences between types of research is in the method and methodology. The term method refers to the manner by which a researcher gathers information, and the term methodology refers to the use of the best tactics for attending to a problem.

The intent and purpose of qualitative research is the attempt to comprehend human beings' deeply engrafted experiences and thought process with regards the events that happen in their lives (Jackson, Drummond, & Camara, 2007). The characteristics of qualitative inquiry is the emergent design, the data is collected in the participant's setting, the researcher has face to face interactions with the participants, the researcher gathers the information themselves, the data analysis is inductive, and the focus of the research is

on the understanding the participant's meaning of a problem (Chesebro, & Borisoff, 2007; Creswell, 2009; Miles, Huberman, & Saldana, 2014).

There are five main approaches used in qualitative inquiry: ethnography, grounded theory, case studies, narrative, and phenomenological studies. Ethnography is best suited for examining cultural groups in their domestic environments. In a grounded theory approach the researcher draws theories from the participants to arrive at a concept, looking at the associations and interplay between the data. The main feature of this method is the process of examining two or more entities to discover similarities and differences between them while simultaneously examining budding categories to capitalize on understanding parallels amidst the categories (Creswell, 2009). A case study approach is much smaller in scope, but the researcher takes an in-depth look at an event or group of people. Narrative inquiry explores the lives of persons through their stories. The researcher arranges the story in the sequence in which events take place. At the end of the investigation, researcher combines views into a collaborative account (Creswell, 2013). A phenomenological inquiry is when a researcher attempts to discover the core of participant expressed experience. Phenomenological research seeks to comprehend the lived experiences of participants. The primary focus is on a small cluster of individuals with the objective of gaining awareness about the connection of meanings. The researcher often brackets his or her personal views within the study (Moustakas, 1994).

According to Howell (2013), the philosophy of phenomenology is study of the manner through which people make sense of their worlds through their lived experiences.

Understanding comes through individual's cultures, languages, and environments, which shape how people define their realities. People experience the world and events as they are and not as categorized or theorized. Therefore, using the phenomenological method is a valid strategy for describing experiences and interpreting the meanings of the lived experiences (Given, 2008). A phenomenological inquiry is when a researcher attempts to discover the core of participant expressed experience. Phenomenological research seeks to comprehend the lived experiences of participants. The primary focus is on a small cluster of individuals with the objective of gaining awareness about the connection of meanings. The researcher often brackets his or her personal views within the study (Moustakas, 1994).

Women who completed substance abuse treatment and received primary individual counseling from a man share a unique lived experience that could be best expressed by them. These women could best express how their experiences shaped how they defined their realities. Because using a phenomenology method provides a researcher with a method for examining a person's real world experience, the framework provided the best rationale for understanding the lived experiences of women who completed substance abuse treatment who received primary individual counseling from a man.

Role of the Researcher

In a qualitative phenomenological inquiry, the role of the researcher is to engage in a real encounter in which they gather information from the contributors to the research (Creswell, 2009). Between the years 2006 to 2012, I was the program director of a

women's substance abuse residential treatment center in the western New York region, which gave me experience with planning, implementing, and evaluating women's drug treatment. During that time, I was responsible for the clinical supervision of three counselors, instituting systematic objectives for all services, creating comprehensive programming for children of clients, and increasing follow-up procedures. The experience of working as a man responsible for examining clinical processes that promote good treatment outcomes for women was beneficial to building connections while performing interviews with the women who have completed substance abuse treatment who received primary individual counseling from a man.

To provide consistency with the data gathering and analysis process, I recruited participants, conducted taped recorded interviews, and transcribed and analyzed the data from the interviews. According to Howell (2013), a researcher utilizing hermeneutics is involved in a spiral interaction—or hermeneutic circle—moving between parts and the whole. I kept in mind my experience with the phenomenon as I engaged with the information, in an attempt to understand the context and meaning that the women gave to their experiences, understanding that new interpretations would occur in this circular interaction with the text. I revised my previous understandings of the information as I engaged in the hermeneutic circle.

Research Methodology

According to Moustakas (1994), engagement with phenomenology is to illuminate through a meticulous examination of accounts the core of human experience about an encounter in a personal and passionate way, in the fullest sense, rather than

examining a causal connection between ratings and scores. My research question was "what are the lived experiences of women who received primary individual substance abuse counseling from a man and completed treatment?" The word treatment referred to counseling services to assist addicted individuals to stop compulsive drug use delivered by a Credentialed Alcohol and Substance Abuse Counselor (CASAC; SAMSHA, 2008). The word experience pertained to my search for a full account from the research participants of how they expressed their lived experiences.

Employing in-depth interviews, I collected data from the narratives of the participants about how they experienced the working relationship between them and their counselor. I functioned as a mediator of the voices and experiences of the participants in an attempt to describe in detail those experiences to a broader community.

Hermeneutic Phenomenology

The methodological framework for this study followed Heidegger's phenomenological concepts (Moustakas, 2009; Smith, Flowers, & Larkin, 2009). The core of a phenomenological approach centers on examining the lived experiences of individuals and uses those experiences to describe what all participants of a group share in common (Creswell, 2012). The primary goal of phenomenological inquiry is to understand the deeply engrafted experiences of humans (Jackson, Drummond, & Camara, 2007; Patton, 2002). A strong point of utilizing a qualitative phenomenological approach as a methodology is its gives the researcher the capacity to discover great descriptions through the experience of the person who had the encounter (Davidsen, 2013).

Gee, Loewnthal, and Cayne (2013) expanded this concept to explain that phenomenology should not be considered a technique enacted upon participants, but an intersubjective encounter that emerges between a researcher and participants that include figurative thinking, contemplations, transitory insights, physical impressions, and deliberations.

Because phenomenology is inductive rather than deductive and the method of communication is subject driven (Chesebro, & Borisoff, 2007), this approach is ideal for exploring the lived experiences of women receiving substance abuse treatment working with men as their primary counselors. Researchers utilize a hermeneutic phenomenological approach to interpret the facts from the participant's view to comprehend the experience.

Hermeneutics comes from a Greek word that means "to interpret" or as Heidegger explained, as the sphere of understanding, illumination, and interpretation of an event (Howell, 2013). However, Heidegger did not believe that any interpretation or understanding of an event or text can occur without detailed consideration of the historical and societal circumstances encompassing those actions. Thus, to question or understand something, one must be involved in a hermeneutic circle. Heidegger believed that questions do not emanate out of thin air but already exist from some knowledge or pre-understanding of the questioned event; thus, answers to questions cause a reassessment of previously held perspectives, prompting further questioning (Gadamer, 1989).

From this perspective, comprehension is not a matter of information but fashioned out of *being* or how we experience the world. Thus, interpretation is rooted in the composition of social connections, and interpretation is a byproduct of expressing perceptions in language (Lewis-Beck, Bryman, & Liao, 2004). The process of engaging in the hermeneutic circle is an attempt to comprehend the undiscovered from the divided segments, and utilizing what is discovered to understand any part (Lewis-Beck, Bryman, & Liao, 2004). The researcher examines a homogeneous population to discover convergence or discrepancies; thus, sample size is relatively small (Smith, Flowers, & Larkin, 2009).

Relational-Cultural Theory

Relational-Cultural Theory (RCT) is derived from feminist principles. The theory centers on the premise that shared connections opposed to individualization lead to a healthy sense of self. Several concepts emerge from this theory: commitment and thoughtfulness, genuineness, and empowerment (Comstock, et al., 2008). Commitment and thoughtfulness refers to both parties having a readiness to be influenced by each other in the relationship. Genuineness implies that each person has the ability to freely express emotions, experiences, and thoughts with each other in the relationship and understanding how the ability to be authentic influences the authenticity of the other person in the relationship. The concept of empowerment relates to promoting personal strength, and the capacity to process diversity and conflict efficiently, which cultivates shared empowerment and understanding (Duffey & Haberstroh, 2012; Frey, 2013; Headley & Sangganjanavanich, 2014).

RCT has been utilized to transcend the conventional paradigms of human growth and clinical practice (Coghlan & Brydon-Miller, 2014). The fundamental tenet of RCT is the importance placed on peoples' relationships; safety and growth come from building healthy connections with others (West, 2005). Meaningful, mutual associations—opposed to independence—create a pathway for building a sense of self (Frey, 2013). RCT offers a theoretical standpoint that includes gender as a variable along with a foundation to examine the counselor-client relationship that is central to the counseling process (Duffey & Somody, 2011). For example, RCT theorists make the supposition that experiences of marginalization along with oppression, degradation, and microaggressions are relationally traumatic and the foundation for all human suffering (Comstock et al., 2008). Women who abuse substances face microaggressions and marginalization such as sexual trauma, oppression, and societal stigma (Lal, Deb, & Kedia, 2015). Strategies that boost mutual empathy and empowerment foster growth and development while simultaneously promoting social justice (Duffey & Haberstroh, 2012).

The key to the RCT is the focus on the collaborative relationship and RCT can combine with any approach, which makes it an ideal framework for exploring the relational process that happens in the therapeutic relationships of women with alcohol or other drugs of abuse problems (Koehn, 2010). Using a RCT framework to delineate further the healing mechanisms that occur within the counseling relationship can help women to be more prepared to identify and assemble collaborative structures that assist them with their recovery (Headley& Sangganjanavanich, 2014).

Purposive sampling

I used purposive sampling to gather a segment of women receiving substance abuse treatment to answer the research question. According to Lavrakas (2008), the primary goal of purposive sampling is to create a sample that is reasonably believed to represent the population studied. Expert knowledge of a population is utilized to select a cross-section that represents specified attributes of that population, in a non-random manner Lavrakas (2008). Purposive sampling is best suited for small sample selection, in a limited geographic area, or restricted population definition, when implications to the general population are not the primary concern (Given, 2008). The logic for using a purposive criterion sample in this study is that women from an urban area in New York State who completed treatment and had a man as a primary counselor will most likely share similar characteristics. According to Given (2008) snowball sampling is a functional way to accomplish purposive sampling by locating members that may know people who share the features that qualify for inclusion in the study. I incorporated snowball sampling to purposive sampling as a way to accomplish an adequate sample size.

Participants

The criteria for this study was that the women had to be ages 18 or above and had to have completed substance abuse treatment within the last 5 years at an agency certified by the New York State Office of Alcoholism and Substance Abuse Services (OASAS). During their treatment, they must have received individual counseling sessions from a man as a primary counselor, and had never have been on my caseload at any time during

any treatment episode (to reduce research bias). I selected this criterion because this specific group of people should be able to provide in-depth information about their experiences receiving treatment from a male as a primary counselor. Including only those who had completed treatment within the last 5 years helped to reduce recall bias or additional concerns with recalling what happened to them during treatment. I recruited participants by way of flyers posted at local community organizations and handed out at local area self-help meetings (See Appendix A). My contact information was on the flyer, along with the general description and criteria for participation in the study.

Sample Size

The sample size is determined by the research, the purpose of the research, and the manner in which the research results will be used (Patton, 2002). According to Daniel (2012), determination of sample size depends on the objectives of the study, size of the population, homogeneity/heterogeneity of the population, spatial distribution of the population; availability of resources; and ethical considerations. Also, a researcher needs to consider whether to utilize a fixed or sequential approach (Daniel, 2012). If a research study has an exploratory objective or a homogenous population, a small sample size is more appropriate. Since the researcher is not trying to make causative relationships, but rather inferences, a small sample size may suffice.

The typical sample size for phenomenological research is 6 to 10 participants (Creswell, 2013). Saturation occurs when redundancy in information or no new information emerges from the sample (Lewis-Beck, Bryman, & Futing, 2004). My goal for this study was to recruit 6 to 10 participants. The accomplishment of the correct

sample size occurred as soon as saturation or redundancy occurred in participant responses. Upon a participant's willingness to participate in the study, and at the point of the interview, I took participants through the process of informed consent, clarified the study in detail, and provided them with a list of research questions.

Data Collection

Upon IRB approval, I recruited participants by handing out and placing flyers at various community locations and local churches (see Appendix A). The flyer stated the criteria for the study, a general description of the research, and my contact information. Once contacted, I gave a general description of the purpose of the study and conducted a preliminary phone screen to evaluate if the person met the criteria for the study. If the person met the criteria, I personally explained the next steps involved in participating in the study. If not, I explained that they did not meet the criteria for participation and thanked them for responding.

For those respondents that meet the criteria, I explained the informed consent process, voluntary participation, and reminded the participants that they could withdraw from the study at any time. I asked the participants to be available one hour to conduct a face-to-face interview and one half hour to follow up at a time and location that was opportune to the participants. At the initiation of the interview, I reviewed the informed consent process and had the participants sign the informed consent (see Appendix B). I reminded them again that their participation was voluntary and included a statement on the informed consent that attested to this. The consent included a description of the procedures and gave participants the background information. Within the informed

consent process, I explained the potential risks and benefits that may occur as a result of the study, and included a confidentiality statement, along with my contact information.

The names of participants were kept confidential. I used aliases to identify them throughout the study. According to Maxwell (2013) participants should have the freedom to cancel or change what they said because of their right to have their own words reflected in a study. I explained to participants the incorporation of their words into the study and data collection. No other individual had access to the raw data. I stored the transcribed interviews under a password-protected personal computer. I also put backup copies of the transcribed files on a password protected USB flash drive. All the data collected and stored on the USB drive will be destroyed after 5 years. I will destroy any hard copies of transcriptions, participants' names, aliases, consent forms, and other associated records, and erase the data files on my personal computer.

I utilized a semistructured interview approach as this method offered me the most flexibility in pursuing information about a phenomenon. I used an interview guide to provide direction to exploring the subject matter. I utilized the interview guide (see Appendix B) to discuss with the participants their lived experiences receiving substance abuse counseling from a man. The guide contained descriptive, structural, open-ended questions to gain information about the phenomenon. I used background questions to start the interviews and to obtain standard information, such as participants' demographic information such as age, race education level, and marital status so that the participants could become comfortable during the interview session.

I utilized a high-quality digital voice recorder to record the face-to-face interviews. I made every attempt to remain open and attentive to the participants' expressions, along with verbal and non-verbal communication. After each interview session, I recorded my thoughts and reflections in my research journal. After this, I transcribed the interviews verbatim. I did not type names of participants in the transcription to maintain their anonymity. Opposed to names I used aliases.

Data Analysis

Data analysis started once the data was gathered and proceeded until completion of the process. I utilized a hermeneutic phenomenological analysis to provide the concepts and categories for understanding the lived experiences of women who received primary substance abuse counseling from a man and completed treatment. Hermeneutic data analysis was the organizing system to identify predominant themes through which to meaningfully organized, interpret, and present interviews of the participants (Lewis-Beck, Bryman, & Liao, 2004; Patterson & Williams, 2002).

Hermeneutic phenomenology data analysis began with an in-depth analysis of individual interviews. I transcribed interviews, then read them carefully, examining each interview transcription several times to gain a feel of the entire interview to reinforce engagement in the hermeneutic circle. To engage in a hermeneutic phenomenological analysis, the researcher must engage in the hermeneutic loop or the activity of comprehending the undiscovered whole from the divided segments and using this knowledge to understand any segment of the conversation. (Creswell, 2013; Lewis-Beck, Bryman, & Liao, 2004).

I read the transcripts several times thoroughly to get a general comprehension of the interviews, to aid with discovering the commonalities among the participants' experiences, and establishing the relevant text to my research topic. Next, I conducted follow-up interviews to clarify missing information or ambiguous statements given in the original transcript, and integrated this information into the original analysis to develop meaning units. According to Allen (2017) journaling is an efficient procedure of record keeping throughout various stages of research. I journaled and kept a research log in a notebook throughout the data analysis processes. I kept a record of the participants' names and aliases; times, dates, and duration of the interview sessions; and initial reactions and impressions regarding the participants in this notebook. After each interview, I journaled my observations, general tone of the discussions, and my thoughts regarding each interview session. I kept this notebook in a locked cabinet in my home office.

Next, I identified and marked *meaning units* within the transcript. An example of a preliminary unit is illustrated from Participant #3's description of her counselor's ability to be genuine.

> The one at the other facility (Note: crisis waiting center) was very caring and concerned so when I spoke about my past he had genuine care and concern in his emotions and I could tell he really cared about what I was talking about.

Patterson and Williams, (2002) and Roulston (2014) suggested reading the entire transcript, breaking down the elements of the transcripts into groups of sentences or meaning units, centering on those that offered perceptiveness to the phenomenon under

investigation. For example, a question that emerged from being engaged in the hermeneutic circle was "Did you get offered a choice of your preferred counselor's gender? Participant #2 replied "I don't think they asked." Participant #4 replied "No, I don't think I ever was." Participant #5 replied "They just assigned me."

According to Lewis-Beck, Bryman, and Liao (2004) engagement in the process of the hermeneutic loop will cause new questions to emerge. I occasionally returned to the entire manuscript again as the meaning units themselves came from actual statements or hard data from the interviews.

Subsequently, I developed thematic labels by grouping related subjects together. The thematic labels were interpretive, with the goal of exploring the underlying meanings and ideas concerning what the meaning units revealed regarding the phenomenon being studied (Creswell, 2009). These segments were the phrases, sentences, and paragraphs that are relevant to the research question regarding the lived experiences of women who received primary substance abuse counseling from a man and completed treatment. I used both the language of the participants and terms that they use to describe the thematic labels. I reviewed each segment with the same thematic label to ensure the consistency of the assignment of thematic labels to its description. I revisited the transcript writing the labels next to the applicable sections of text to see if new groupings and themes emerge.

Finally, I revisited the entire transcript to see if any new insights emerge, detailed any new concepts I discovered, and provided a unified summary of the experience. One example of this is when participants were asked "If you were training a male on

counseling women, what would be the most important things that you would want him to know?" Participant # 4 stated:

> First and foremost, every women is not the same. I been around a lot of women in my life and it doesn't matter how long they have been clean, there are still a lot of women that are stuck in the manipulation mode because we are great at it; so be careful with that. Also, I didn't have kids prior to five months ago, but I think helping to get the family back involved is important. I have a lot of friends that have been in halfway houses or rehabs and although you have to focus on yourself, give reminders that your families are still there, and there is a possibility to get them back. Whether it is to get custody of your kids back or build that relationship, like for me, with my parents and my siblings back.

According to Gadamer (1989), one must see outside current verbalization to the expressions that are not obvious, but present. One must explore everyday undertones of the language utilized and circumstances in which the dialogue transpires with the intention to listen beyond simple words. This loop causes a "fusion of horizons" or modification of the interpreter's perspective as an effect of the hermeneutical conversation. Language permits the mediation, the clarification, and conversion of past and present (Howell, 2013).

Trustworthiness

Trustworthiness is the process of ensuring that the conclusions of the research make sense, the procedures for gathering and analyzing the information is sound and authenticated. In other words, trustworthiness implies that confidence in the study's

findings exists (Miles, Huberman, & Saldana, 2014). According to Schwandt (2007), four characteristics drive trustworthiness: credibility, transferability, dependability, and confirmability. The best strategy for ensuring reliability is to use rigorous methods when collecting and analyzing the information (Patton, 2002). I gathered data in multiple formats, such as audio recording, transcription of interviews, note taking, and member checking once transcription had occurred.

Credibility

To ensure the credibility of this study, I employed procedures to make sure the information I collected is accurate. Kornbluh (2015) suggested utilizing specific strategies to assist with the credibility of the study. For example, member checking; following up with participants to confirm the interview content is correct. Finally, to bring credibility to the information gathered, researchers can also discuss important positions that the participants recollect during the data collection stage. I used audio recording along with notes to gain rich, thick descriptions of the interviews. I also used member checking to confirm that the conclusions showed the participant's meanings by conducting follow-up interviews of the final report to clarify whether the participants deem their stories as accurate.

Transferability

In qualitative inquiry, the researcher endeavors to create a study that has a high degree of transferability opposed to generalization. By providing readers with an adequate amount of information surrounding the cases studied, the readers authenticate the extent of likeness between the phenomenon examined and other circumstances where

results may transfer. The implication of transferability is that information gained from the results of a study can shift to a comparable situation (Maxwell & Chmiel, 2014). I used several strategies to ensure the transferability of this study: Used thick descriptions of the procedures, context, and participants; gave a full account for any changes in situations and documented any possible biases that arose. Bloor and Wood (2006) suggest leaving an audit trail as a method to assist with transferability. I left an audit trail for my dissertation committee to review about any interview and reflexive notes taken during the entire process.

Dependability

Dependability refers to establishing consistent findings by providing the details of the study that will permit a future researcher with the map to repeat the work (Shenton, 2004). Also, researchers utilizing a qualitative approach must acknowledge that the research circumstances may change and develop during the process of gathering data, and cannot be entirely comprehended in a clear instance in time, which could affect the dependability of the results of the study (Given, 2008). The researcher should give an account of all aspects of the research methods to establish dependability (Shenton, 2004). To establish dependability, I provided a detailed report of the plan, the data gathering process, and fieldwork. I provided full, substantial descriptions of the interviews, including nonverbal cues in addition to verbalized text, field notes, and reflective journaling, along with identifying any research biases. I utilized triangulation and audit trails to strengthen the dependability of the findings.

Confirmability

Confirmability in qualitative research establishes that the researcher's findings are derived from the participants' experiences and thought processes, opposed to the personality and inclinations of the researcher (Shenton, 2004). The researcher verifies confirmability by revealing that no distortion or manufacturing of the data occurred (Shenton, 2004). According to Thomas & Magilvy (2011), confirmability is the magnitude and thoroughness to which the researcher discloses his or her predisposition by describing to any observer, piece by piece decisions occurring throughout the progression of gathering and analyzing data.

To establish conformability, I used an audit trail; keeping all raw data, notes, documents, and recordings. According to Tobin and Begley (2004) journaling can assist a researcher with conformability. I used journaling to explore my views and concepts regarding the data. In the reflective journaling, I described the beliefs behind the choices I made regarding my logic for using one approach over another, and explained in detail the weakness in the techniques I employed during the process, in an ongoing reflective commentary.

Ethical Procedures

Ongoing ethical practice is associated with safeguarding participants who are directly impacted by the research, and others who could be influenced by the research. Ethical standards guide the accountability of the researcher and their interactions with participants. In other words, ethics guide the things that should occur or not with regards to the people being observed and written about (Marvasti, 2004). Because data collection

often happens in natural settings specific features of ethical responsibility have great significance, such as informed consent, privacy and anonymity of participants, avoidance of deception or the dishonest use of data, and confidentiality, except in the case of potential danger to vulnerable persons (Hammersley & Traianou, 2012).

Additionally, I took steps to safeguard the veracity, quality, and transparency regarding the intent, procedures and anticipated uses of the research. Taking into consideration, no one should participate in the research without understanding the dynamics mentioned above and the right to refuse at any time to take part or withdraw from the study. According to Shaw and Holland (2014) preservation of privacy and confidentiality should always be at the forefront of the researcher's mind. The chief determinant guiding the collection and interpretation of the information should be accurateness; meaning all information should be included to ensure that no omission or deceit occurred with the collection or analysis of data. Overall, thoughtfulness regarding the burden that takes place from participants taking part in the research should occur, prompting all efforts to protect the well-being of the participants (Flick, 2007).

To maintain the ethical standard of this proposed study, I requested permission to conduct the proposed research from the Walden International Review Board (IRB) before performing the research. The IRB is accountable for safeguarding and certifying that all Walden University studies conform to the U.S federal regulations and Walden ethical standards. No data gathering occurred before IRB approval. Once proposal approval occurred from IRB with the approval number **(06-21-18-0282779)**, I began participant

recruitment. I took each participant through the informed consent process, including providing informed consent forms to each participant before interviews.

During the informed consent process, I explained the reason for the study, which is to understand the lived experiences of the women who have completed substance abuse treatment and had a man as a primary counselor. During the informed consent process, I also described the procedures of the study. These procedures included a 45 to 60-minute scheduled interview about their lived experiences and a follow-up member checking session once transcription of data occurred.

Participants received reassurance about the confidentiality of their identities. Assurance of confidentiality occurred through the removal of identifiers in any documentation of interviews, transcriptions, or data analysis procedures. Included in the informed consent, was a contact number from the university, a statement regarding their voluntary participation, and a statement informing participants of their right to withdrawal from the study at any time without repercussions. Finally, although no conflicts of interests existed, if any arose, disclosure occurred in full detail. Storage of data occurred in compliance with Walden University standards.

Summary

The goal of chapter three was to offer the proposed methodology for this study. The chapter included the rationale for the proposed methodology, the researcher's role, participant selection, data analysis, and study credibility. Hermeneutic phenomenology along with RCT was the conceptual frameworks for obtaining descriptive data from women who have completed substance abuse treatment about their lived experiences

receiving primary individual counseling from a man. Understanding the lived experiences of this population adds to the existing literature about the influence of client-therapist gender matching, informs about strategies for helping women to remain in substance abuse treatment, and assists with the training and supervision of male counselors delivering substance abuse services to the females receiving treatment for drug addiction.

Chapter 4 includes the results of the interviews conducted to address the research question, a detailed description of how data was collected as well as the procedures used for tracking data, themes, and patterns. Additionally, the results of this study contain suggestions for future research relevant to this topic.

Chapter 4: Results

Introduction

In Chapter 4, I present the research findings and connect the findings of the study with hermeneutic phenomenological along with Relational-Cultural Theory (RCT) as conceptual frameworks to examine six participants' experiences who completed substance abuse treatment and had men as primary counselors. I discuss the process for data collection, procedures used for tracking data, themes and patterns, participant responses, data analysis, and a summary of the findings.

Data Collection

I conducted approximately 1-hour face-to-face interviews at the public library in a private study room in order to safeguard the participant's privacy as much as possible. This setting was chosen to provide a neutral setting that offered a sense of safety if the participants felt the need to end the interviews due to any triggering questioning. I met with the participants for an audio recorded interview on one occasion and met briefly with each participant to provide a copy of written transcripts for member checking. No unusual circumstances occurred during the data collection process.

Setting

Due to my previous knowledge of working with women receiving substance abuse treatment and understanding that many have trauma and domestic violence histories, it was important that the location of interviews occurred in a safe public setting that offered a quiet space to work. Interviews took place in a reserved room at the public

library, to minimize the possibility of an environment that may elicit a triggering and traumatic response. After determining that a participant met the general requirement for the study, I reserved a private study room in the library for a mutually agreed upon time to conduct the interview. Because the discussions were face-to-face, the participants were alone with me for a period of time. This location offered enough privacy for conversations to not be overheard by someone passing by, while also allowing the participants to be in a neutral public setting if at any time during the interview they felt emotionally or physically unsafe.

Participant Demographics

Six women ages 26 to 70, who completed substance abuse treatment in an urban area in New York State within the last 5 years and had a male as a primary counselor, participated in the study. Only African American and Caucasian women participated in the study. All of the participants received substance abuse treatment at an inpatient or outpatient center governed by the New York State Office of Alcoholism and Substance Abuse Services (OASAS), and their course of treatment ranged from 28 days (inpatient) to 3 months (outpatient). All of the women resided in the general community and received counseling at a treatment center in the area. Four women discussed their experiences receiving treatment at the inpatient level, one at the outpatient level, and one received treatment at both levels of care.

Participants' Demographics table

Participant	Age	Gender	Race	Drug of Choice	Type of Treatment
P1	70	Female	African American	Crack	Inpatient
P2	26	Female	Caucasian	Alcohol/Cocaine	Inpatient

P3	32	Female	Caucasian	Heroin	Outpatient/Inpatient
P4	35	Female	Caucasian	Crack	Outpatient
P5	44	Female	African American	Crack	Inpatient
P6	30	Female	African American	Opiates/Alcohol	Inpatient

Data Analysis

I conducted this study to discover the lived experiences of women who had a male counselor and completed substance abuse treatment. I asked participants a list of questions to answer the overarching research question: What are the lived experiences of women who have completed substance abuse treatment who received primary individual counseling from a man? Six women agreed to participate in the interviews; three black Americans and three Caucasian Americans. All participants completed treatment at an OASAS certified program and had a man as a primary counselor. P1, P2, P5 and P6 expressed their lived experiences regarding having a male counselor at the inpatient level of treatment. P3 described her experiences with male counselors at both the inpatient and outpatient levels. P4 described her experiences with a male counselor at the outpatient level.

The overarching research question asked in order to achieve the purpose of the study was: What are the lived experiences of women who received primary substance abuse counseling from a man and completed treatment? I used hermeneutic phenomenology as the method for data analysis. Relational-Cultural Theory (RCT) is the conceptual lens (Duffey & Haberstroh, 2012). The analysis process started with special attention on the general text that reflected the experiences of the participants and ended with reflections on the findings in light of the scientific literature.

Rubin and Rubin (2005) suggest beginning the transcription process by listening to each interview in its entirety immediately after interviews, then manually transcribing each interview into written form. I read the transcripts entirely multiple times to get an overall grasp of the interviews and to authenticate the critical text to the research topic. once I examined each participant's statement thoroughly, their perceptions about their lived experiences of having male counselors came to life. I engaged in manual coding by collapsing elements of the transcripts into meaning units that offered insight into the phenomenon under investigation.

Next, I organized statements by grouping data into themes. The themes came from the participant's statements (Creswell, 2009), viewed in light of the addiction core counseling competencies SAMHSA (2015), synthesized into textual descriptions of their lived experiences about receiving counseling from a male. I repeated this step for each lived experience. I read through each participant's transcript several times and selected specific statements regarding the phenomenon. For each core theme, I reflected on hermeneutic phenomenology, RCT, the literature review, and my personal experience of counseling women, which led to the engagement in the hermeneutic. Interpretive themes came from the responses by the participants to the questions. Each theme identified was grounded in the literature and supported by a textual description of the participant's experience in their own words. I revised my previous understandings of the information as I engaged in the hermeneutic circle. I reviewed each segment with the same thematic label to ensure the consistency of the assignment of thematic labels to its description. I revisited the transcript to ascertain whether new groupings and themes emerged.

Thematic analysis yielded five main themes. The first theme was rapport-building skills. The participant's counselor either possessed or did not exhibit a useful array of relational competencies that assisted them with building rapport, creating healthy relationships, and promoting trust. The second theme was genuineness. This theme referred to the counselor's capacity to be authentic. The third theme was empathy; the women expressed this theme as the counselor's ability to understand what it is like to walk in another person's shoes. The fourth theme was flexibility, which equated to the ability of the counselor to adjust the manner by which they responded to the women to meet the client's needs. The fifth them was acceptance, which referred to the counselor's ability to "meeting the client where they are at." In other words, connecting in an open, nonjudgmental manner, with acceptance. The women were also questioned about choice (whether she was given or offered a choice of a male or female counselor); this is not a core counseling competency but was central to examining an essential aspect of the study.

Table of Themes

	Participant response to category					
	Rapport-Building Skills	Genuineness	Empathy	Flexibility	Acceptance	Choice
P1	Yes	Yes	Yes	Yes	Yes	No
P2	Yes	Yes	Yes	Yes	Yes	No
P3	Yes	Yes	Yes	Yes	Yes	No
P4	Yes	Yes	Yes	Yes	Yes	Yes
P5	No	Yes	No	Yes	No	No
P6	Yes	Yes	Yes	Yes	Yes	No

Emergent Theme 1: Rapport Building Skills

The addiction counseling competency of rapport consists of a counselor's ability to be aware of the value and function of rapport building, approaches for rapport-building, and the scope of emotions (SAMSHA, 2015). This skill includes the readiness to create connections along with expressing good verbal and nonverbal exchanges, demonstrating empathy, respect, and genuineness. The ability to build rapport appears to be consistent with the interaction that occurs between a client and therapist expressed as the therapeutic alliance at the core of the therapeutic process (Hausner, 2000).

Five of the six participants described their counselor as having good rapport building skills. The women interpreted this skill as their counselor kept a "relaxed" or "light" atmosphere, joke around, and made them feel comfortable and optimistic.

P6 expressed this as:

> He picked me up from jail, and we had a nice long talk on the way back the facility. He made me feel comfortable and optimistic about going there because I had a rough run in the previous rehab. I built that kind of rapport before coming into the facility, and then he became my counselor. It worked in my favor.

P4 stated that the rapport built between her and her counselor allowed for more honesty to take place in the relationship.

> I dealt with my counselor (Note: outpatient) …let's say a six-month stint, so you build a different kind of rapport. The first time I ever had one (Note: male) was a little different, but I'm a fairly open person who is very receptive, so it was great.

> When you build rapport with somebody, I feel you become more honest with them.

One of the participants seemed to struggle building rapport with her male counselor, but this seemed to relate to her trauma history. P5 stated that when she initially found out that her counselor was male she felt:

> Very uncomfortable, for the simple fact I was coming into treatment not even knowing why I'm really there; and not even recognizing I am an addict and the damage I've done. The behaviors were still there, the manipulation. Sitting there talking to a male counselor, the first thing that came to my mind is that I can manipulate him.

Overall, most of the participants expressed their counselor's rapport-building skills and ability to connect to them as significant to them having a positive experience and creating a therapeutic bond (Ruglass, Miele, Hien, Campbell, Hu, Caldeira, & Nunes, 2012).

Emergent Theme 2: Counselor Genuineness

Five of the six participants described their counselor as displaying genuineness. This characteristic encompasses friendliness, showing consideration, and genuineness. Skills related to this competency include active listening, utilizing counseling authority in correct manners, respect for the client, and genuine care and concern (SAMSHA, 2015). The women described this characteristic as the counselor being "personable," i.e., "open" and someone they could "easily" talk too. Some of the participants stated that their

counselors shared parts of their lives with them, which made it easier for them to relate. Others talked about their counselor's ability to give them a different "perspective." Again, one of the participants verbalized struggling to connect to her first male counselor's ability to be genuine, but it appeared to be from an internal place. P2 expressed her experience with her counselor displaying genuineness as:

> He related to me when we were talking, but it was still counseling. He would share parts of his life with me, like "I went through this couple weeks ago with my wife." It related to me because I was going through issues with my son's dad. I rather my counselor male or female be straightforward with me, but I know many women might feel uncomfortable if a male is straightforward.

P3 explained that she could tell the difference between her counselors that were genuine and those who did not appear to express this competency in their interaction with her.

> As I said, he always kept the atmosphere light (inpatient counselor). He joked around a lot with me, but when we were talking about serious stuff; he knew that I was actually concerned and the topic was serious. His concern is genuine, and he really helped me a lot as far as going from one facility to another. I felt uncomfortable with my outpatient counselor. I do not think his concern was genuine. I feel like he was just there for a paycheck and not to help me. His demeanor was very rude, very short; he would interrupt while I was telling him something. The one at the other facility (Note: crisis waiting center) was very caring and concerned so when I spoke about my past he had genuine care and

> concern in his emotions, and I could tell he really cared about what I was talking about.

Emergent Theme 3: Counselor Use of Empathy

All of the participants verbalized that their male counselors were empathetic, and also described levels of empathy in manners that were helpful to their treatment process. From psychology, empathy is the capacity to emotionally understand where another person is coming from while simultaneously maintaining one's identity separate. The behaviors that are consistent with this characteristic are open-minded communication and unconditional acceptance of the client's experiences (Horvath & Bedi, 2002; Singer, Critchley, & Preuschoff, 2009). The women used terms such as "helpful," or "guiding her in the right way," and "relating" with her. P3 described her experience as:

> I was worried I was not going to get into the rehab because of the condition I was in. But, he guided me in the right way. I always talked about my experience, in my experience I have done everything in my addiction, but I did not feel uncomfortable sharing that at all. I just felt like males were able to lift my spirits up more, I don't know why I think it is because I have more in common with males.

P4 explained how her counselor would relate to her and show unconditional positive regard in a non-judgmental fashion about her past mistakes.

> As a father, he could speak to me. He would remind me that I am doing what I need to do to get better and as long as I continue to do what I need to do forgiveness is possible. I think that helped me have hope for the relationship with

> my father because my father has never given up on me. I have hurt him more than I hurt anybody, so my counselor was just good at taking what he knew in his life experience with his children and saying forgiveness is possible.

Emergent Theme 4: Counselor Flexibility

All of the participants described their counselors as displaying flexibility. The women stated that their counselors met with them more than the required sessions, was there for them any time they needed help, spent additional time with them, and went out of their way to help them. P1 described her experience with her counselor as spending more than the required time with her. When asked if she met with her counselor at least one time per week? She replied:

> More than that. There were times when he had to tell me "I am busy right now," and it was understandable because there were many residents there. You cannot get quality counseling at any point you choose; you have to wait your turn. But, if there were things that were important that I needed to know from him, I did not have a problem writing them down.

P2 described her counselor as always being there to help her:

> Anytime I needed help or anything; he was always there. He took the time out to talk to me if I needed, and he did the group counseling with the families and friends; that was good. He talked to me right before we did all of my paperwork to leave (Note: complete the program). We probably had an hour session and talked about everything.

Although P5 had a sexual trauma and domestic violence history that caused her to struggle with previous male counselors, she expressed her last counselor as displaying flexibility.

> Any male that I had in my life besides my father, even though the abuse was there, I still felt protected. A male counselor, to me, seems like he will go all out of his way (I do not know why) to help you get to where you need to be. For instance, my counselor came in on his day off and drove me six and one-half hours away because I did not have transportation to the next facility I was going to.

Emergent Theme 5: Counselor Acceptance

All of the participants described their counselors as exhibiting acceptance. From a relational-cultural lens, all of the women's counselors valued interconnectedness, mutual empathy, and empowerment (West, 2005). The women described these characteristics as their counselor's ability to talk to them, be helpful, treat them equally, reassuring; noncritical, genuinely understanding, non-judgmental, and encouraging. P4 described her experience with her counselor as:

> He was less judgmental than I thought he was going to be. From my point of view, I always had the impression that the things I did during my active addiction, that I am not proud of, telling a male or a female who never experienced it is almost more evasive. I was kind of hesitant, but there was no judgment.

P6 made comparisons between male and female counselor when expressing her experience with this theme, she stated:

> You guys will sit, listen, and apply; whereas the female counselors feel like they already know you…..they are not about to go for any of your bull because they know how females can be; manipulating and stuff like that. They already have this force field and shield up as if to say they are not going to be used by or misused by you.

Client Choice

Client choice was examined to assess if the participants had or were offered a choice of counselor gender. Tompkins, Swift, and Callahan (2013) asserted that incorporating client's preferences into the treatment decision-making process is significant to evidence-based psychology and connected to decreased dropout rates and better treatment outcomes. Only one of the participants who engaged in the study reported being offered a choice in the gender of the counselor. The women varied in their opinion about the significance of having a choice of a counselor. P3 stated:

> I did not get a choice with that (in outpatient). They just gave me to them; I did not feel as close to him as I did at inpatient. I believe they asked if I felt comfortable with a male counselor, and I did (at inpatient). For me, I felt respected because they asked me, but it does not bother me, but some women are not going to have the same mindset as me.

P5 described her experience and also did not get offered a choice of the counselor she preferred.

> No, I do not think I ever was. I believe that once you start with a counselor, in most places if you are not comfortable you can always switch, but I am a stubborn Irish girl, so I want to see what you got. I think I would choose a man.

P6 expounded the most on the issue of being offered a choice of counselor and how it may impact a woman's treatment and outcome.

> Moving forward in that whole rehab business I think they should give you a choice. I get they will change your counselor if there's a complaint that you may have after you have been with them during a session or so, but I feel when you come in, and you have your initial intake, they should ask you if you prefer a male or female counselor. I understand there is a shortage and you are limited, and it could be detrimental to the caseload for the counselor, but at the end of the day you are there to do a job, and we should have a say. I would still choose a male, but I know some women who preferred to have a female counselor. They did not want to shake or ruffle any feathers, so they did not say anything. They just dealt with it, and they ended up doing bad because they were resistant when it came to their counselors.

Other Significant Participant Responses

Participants of this study shared other responses that appeared to be critical to understanding their experiences. These aspects of their experiences affected them in profound manners but did not stop them from completing treatment. These responses where particular to the individual opposed to the whole. One participant responded that male counselors were more critical than female counselors without saying it. P2 stated:

> My male counselor was not critical or anything, but I think men are more critical without saying it. Not saying what they really want to say, because they do not want to say the wrong thing. Women feel like they can talk to a female about this (Note: sexual issues).

P3 described female counselors without a recovery background as less understanding and more judgmental than those with a recovery background. Women without recovery backgrounds were perceived as "textbook" counselors and did not know how to give positive reinforcement. P3 stated:

> The other ones, I feel that they did not really understand what I was going through. Their opinion was more like, I made bad choices because of my addiction, and they did not really know how to counsel me and give me positive reinforcement to use in my daily life. Whereas, the counselors that I had that lived in addiction understood what it is to be an addict. They understand that we make poor decisions when we are under the influence. The textbook counselor can say she understands, but deep down inside I know she does not, because she has never lived it."

P6 also described female counselors as more likely to stereotype and judge another woman compared to a man. She verbalized this as being so crucial to her treatment that her preference for counseling is male.

> Female staff stereotype you because that is just females. They judge you right off the back. They do not even want to know any details or really get to know about you. So, that separates the female counselors vs., the male counselors. Men will

> sit, listen, and apply; whereas the female counselors feel like they already know you they are not about to go for any of your bull because they know how females can be; manipulating and stuff like that. They already have this force field and shield up, as if to say they are not going to be used by or misused by you. You think that it would be the opposite because females are the same sex, but no, they actually couldn't care less. Quite frankly, they do not tolerate anything, they are not empathetic or sympathetic, and they are total "b..'s." It is just really different with women.

Finally, P4 expressed finding it difficult to get honest feedback about her image from her male counselor, even though talking about her physical image was a real concern for her. She believed that this aspect of her life is better expressed with a female, as the female would have better identification about the issue compared to a man.

> I think a time that I preferred a female counselor and felt they could relate more is when I put on weight since I have gotten clean. I used to be very, very heavy, then lost a bunch of weight, then lost even more weight while using. I probably put on about 50 pounds since I have been clean. To me, a female, your image is a lot, especially weight and body perception. Things like that, most men do not care about, at least in my experience, so he (Note: her counselor) looked at me as healthy and fine. A female kind of gets the weight issues a little more. I think today's society is changing, and nobody really wants to be overweight, but I do not think men have as much as an issue with it as women do. You can always talk about how you are feeling, what's going on blah, blah, blah…it would always

be great, but us women struggled with putting on weight, and it felt like nothing I did was helping. I do not think he tried to minimize it because he knew it was a stressor for me, but he tried to make me feel good and to let me know everything is fine. He never had to worry about a weight issue. He was not a slim man, but he was your average guy. He could not identify with why that (Note: weight) would be an issue.

General Summary of Phenomenon

Female substance abusers who experienced having a male as a primary counselor who is careful about their emotional needs, have excellent listening skills, non-judgmental, and genuine and authentic appear to be able to complete treatment and have positive outcomes. Even though many women receiving substance abuse have sexual trauma and domestic violence histories (Salter & Breckenridge, 2014), having a man as a counselor gives women an opportunity to be exposed to a positive male role model.

The lived experiences of the women in this study were that men counselors often took less critical approaches toward women substance abusers; and they were sensitive and compassionate, going above and beyond to help them to address their needs. These women believe that men may be overly cautious when it comes to discussing physical and sexual issues, but their overall experience did not cause them to believe women should only be assigned a counselor of the same gender, only offered a choice. Although SAMHSA (2013) reported that women clients that received substance abuse treatment matched with men counselors, had poorer outcomes than those matched with women,

these women's experiences suggest that being matched with a man as a primary counselor is a positive experience that they would embrace in the future.

Connecting to the Theoretical Framework

According to (Gadamer, 1989), it is impossible to dismiss one's *Dasien* or way of "being" when examining any phenomenon. During the data collection and analysis process, I was conscious of my experience as program director of a women's substance abuse residential treatment center in the Western, NY region, along with my current experience with women on my caseload. My experience gave me some foresight into the phenomenon under investigation. Because I had foreknowledge with regards to how my presence, voice tone, non-verbal communication, and experience working with women, I was confident in my ability to extract data and direct my questioning in a manner that was consistent with women's treatment. However, being in the experience, during the interview for specific responses, I was taken back in my memory to when I may not have been sensitive to certain aspects of women's treatment. For instance,

My *Dasien* was also reflected in my demeanor and engagement while conducting interviews, my assessment of answers to questions, and interpretation of the information leading to engaging in the hermeneutic circle. One example of this is when one of the participants discussed her physical image as an issue of recovery. P4 remarked:

> I put on probably about 50 pounds since I've been clean, so to me a female, your image is a lot, especially weight and body perception. Things like that, most men don't care about, at least in my experience, so he looked at me as healthy and fine. A female kind of gets the weight issues a little more.

She discussed how in an attempt to be non-offensive, men normalized these types of concerns. Not only did I become conscious and sensitive to a new perspective, but I also became aware of the instances in which I normalized physical image when counseling women in the past, and how this may have negatively influenced their counseling process. I incorporated this understanding to future interviews with the other participants. I now incorporate this new understanding into my current practice with clients, remembering to be sensitive, but not minimize a woman's concern about her physical image. Finally, I identified this dynamic as a significant finding of this research and a critical component for training men in strategies that assist women.

Another revelation that has affected my *Dasien*, as a result of the research and influenced my current practice as a counselor has to do with offering women a choice of their preferred counselor's gender. Participant 3 stated that: "Offering them (women) a choice of whether they want a woman or male counselor. For me, I felt respected because they asked me." I now ask women as a standard of practice about their preference for counselor gender. I gained a better understanding of the importance of being offered a choice (whether a choice is available or not) and how this displays to a client that the counselor is sensitive to the client's needs. The therapeutic relationship begins with a tone of respect because by giving the client a voice from the onset of therapy, the client equates this to respect for their views. I also addressed this revelation in the interpretation and recommendations in chapter 5.

From a hermeneutic perspective (Howell, 2013), the participants expressed their "being-in-the-world" or "lived experiences" regarding not being offered a choice of

counselor's gender, but having to navigate the situation, given their need for substance abuse treatment. The participant's real-world encounters shaped their treatment experience and how they viewed counseling when comparing their counselor's gender. The participants expressed how reflecting on their experiences shaped their current feelings about having a male counselor and their view about working with a male counselor in the future. When asked about how participating in the study affected their perceptions about their previous experiences, they expressed their *Dasien* as "It made me think about what an important part they (Note: the male counselors) played in my life and in my recovery; and I truly appreciate that." Another participant reflected "I am for male/female counseling relationships. I think I got more out of male counselors than female counselors; that's just my opinion." One woman said, "I think it has (having a male counselor) made me sit and appreciate it more." On the other hand, one participant was against opposite gender match in the initial stages of treatment "I believe when a person is coming into a facility, whatever the gender, I think they should be placed with the same gender."

P2 stated:

> It never crossed my mind to have a male counselor. I didn't think it was a big deal. I never had a male counselor (Note: before this treatment episode). I know it affects people differently; people don't want certain genders for their counselors, but it just didn't cross my mind. Now thinking about it, I believe I can have a male counselor in my future.

Finally, P6 stated:

> I didn't realize the difference between male and female counselors. I mean, I always thought about the difference between having a male or female counselor, but saying it out loud it makes me realize there is a significant difference.

These women had the opportunity to reflect on their participation in the study and how their experiences changed or strengthened their position and beliefs about being matched with a man as a counselor. Thus, their way of "being" or *Dasien* became influenced as a result of participating in the study.

Evidence of Trustworthiness

The participants validated the findings via the member checking process, and at the end were given a summary of the results. I use an interview guide to safeguard consistency and additional questions to clarify meaning when applicable. I let participants discuss issues using appropriate examples. The participants were genuine in conveying their lived experiences about receiving treatment from a male counselor. The women expressed their counselors as exhibiting the core counseling components of rapport-building skills, genuineness, empathy, flexibility, and acceptance. Precautions were taken to ensure that threat to trustworthiness was ruled out during the study. Participants were permitted to articulate their experiences to the fullest possible extent for the emergences of rich, thick descriptions of their experiences. During the interview, some of the statements of the participants were paraphrased for the participants to agree or disagree in order to achieve a greater understanding of the participants' experience.

Credibility

To assure that the research findings were credible, I utilized an interview protocol to guide the discussion and provide consistency across participants (see Appendix C). I used audio recording along with notes to gain rich, thick descriptions of the interviews. According to Kornbluh (2015) conducting member checking is a crucial step in the process of ensuring credibility. I conducted member checking by presenting the transcripts and interpretation to each participant for their confirmation of the reflection of their perceptions and experiences. Additionally, I provided participants with the opportunity to make changes where necessary.

Transferability

The lived experiences of these participants may offer similar insight as other populations with similar experiences. The themes and general summary about this phenomenon may offer insights for men receiving substance abuse treatment who have a female counselor, or women receiving psychotherapy or mental health treatment from male counselors in other treatment settings. One should consider the setting, participants, and their experiences before generalizing any findings.

Dependability

A thorough description and audit trail of the steps taken in the study was made available in Chapter 3 and I followed them in order to maintain the dependability of the study. Replicating the steps of this research into the same phenomenon within a similar context should yield comparable findings.

Confirmability

To guard against personal bias, I documented potential areas of bias in chapter 3 and utilized journaling to clarify my personal biases and to anticipate projections while trying to gain comprehension. I focused on the lived experiences of the participants throughout occurrences of distractions and biases. My objective was to exchange my perceptions with more appropriate ones through the process of thoughtful contemplation. Every revision of a pre-conception outlined a new meaning, and challenging projections appeared in conjunction with each other until the conformity of connotation was well-defined. Through journaling, I revised personal biases, and created the questions necessary for thoughtful revision (the hermeneutic circle).

Summary

In Chapter 4, I presented the research findings and connected the findings of the study with hermeneutic phenomenological along with Relational-Cultural Theory (RCT) as conceptual frameworks. I examined six participant's experiences who completed substance abuse treatment and had men as primary counselors. I discussed the process for data collection, procedures used for tracking data, themes and patterns; participant responses; data analysis; and a summary of the findings. Giving their experience, all of the participants expressed that they would embrace having a male counselor in the future and most would choose a man if they had an option to choose again. In Chapter 5, I will provide discussions of the final themes, conclusions, and recommendations for the study based on the findings in this chapter.

Chapter 5: Discussions, Conclusions, and Recommendations

Introduction

The primary research question under investigation was "what are the lived experiences of women who received primary individual substance abuse counseling from a man and completed treatment?" The significance of the study's results is that the information can help inform counselors, supervisors, and educators about the counseling competencies that women believe increase treatment engagement, treatment retention, and promote better outcomes when they get matched with a man as their primary counselor.

This chapter includes an interpretation of the findings of this phenomenological study, which was designed to discover and describe the lived experiences of women who have completed substance abuse treatment and received primary individual counseling from a man. I explored the lived experiences of six women through face-to-face interviews. The analyzed data indicated that these women experienced their counselors as having good rapport-building skills, genuineness, empathy, flexibility, and acceptance. Their counselors were very careful about their emotional needs, exposed them to a positive male role model, listened to them, were not judgmental, went above the call of duty, and protected them. The women's overall perspective regarding the impact of having a man as a primary counselor was positive, and all of them expressed that they would embrace or choose to have a man as a counselor in the future.

The study findings presented in the following sections are the review of the purpose of the study, interpretations of the findings compared to those reviewed in

Chapter 2, the interpretation of the findings in the context of phenomenology, and the limitations of the study. Finally, I will make recommendations for further research for women receiving substance abuse treatment and discuss implications of the information is study for positive social change. In this study I aimed to discover the lived experiences of women who have completed substance abuse treatment who received primary individual counseling from a man, gain their perspectives on the impact of having a male as a primary counselor, and uncover their perspectives on how it benefitted or hindered their treatment process.

The findings of the study generated themes and subthemes of the participants' lived experiences which are essential in understanding their lived experiences. The finding from this study may inform a future study or seminar. The participants expressed how they felt about receiving substance abuse counseling from a male.

Studies indicated that research into the efficacy of treatment for women with substance use disorders lags that of men (Tuchman, 2010). Female clients receiving substance abuse treatment from a male counselor had shorter stays in treatment and poorer outcomes than those who had a female counselor while in treatment (SAMHSA, 2013). However, SAMSHA (2013) did not identify the factors that women attributed to influencing their outcomes, and minimum studies explored the lived experiences of women receiving substance abuse counseling from men. There is a lack of information about women who completed treatment and get matched with a man as a primary counselor. The gap provided an opportunity to explore the lived experiences of women

who have completed substance abuse treatment and received primary individual counseling from a man.

The results of this study and current literature will illuminate the lived experiences of six participants who completed substance abuse treatment and received primary individual counseling from a man. Participants responded to questions centered on their individual views about their lived experiences. They also discussed their experience with being offered a choice of a counselor. The women's overall perspective regarding the impact of having a man as a primary counselor was positive. This experience exposed them to a positive male role model who played an essential role in their lives, listened to them, was not judgmental, went above the call of duty, and protected them.

They expressed that their counselors were very careful about their emotional needs. Only one expressed any concerns with having a man as a counselor, but her reactions appeared connected to her trauma history. That particular participant still connected to her last male counselor and expressed that she was able to build a trusting relationship with him. The one significant finding of their experience was that the women expressed having a choice of man or woman counselor as having some impact on their experience. Only one participant was adamant about being paired with the same gendered counselor upon admission to treatment, and one would have chosen a female as a default. This information can inform policy decisions for agencies in the area of improving client-counselor matching. Finally, the knowledge gained can inform training

and supervision of male and female counselors delivering substance abuse services to the women.

Interpretation of the Findings

The guiding question for this study was: What are the lived experiences of women who have completed substance abuse treatment who received primary individual counseling from a man? All study participants were open to describe their experiences despite the delicate make-up of the study.

Participants were all at least age 18 ranging up to age 70 and gave the impression that they were capable of comprehending the questions. The study started with the participants describing their lived experiences. The study developed gradually from their perception about those experiences. The most significant finding was that the women perceived the counselor's ability to create a therapeutic alliance or "bond" as being the primary reason for them creating a trusting relationship. P4 stated:

> I don't know if I truly knew how much appreciation I had for my male counselor until I verbalized it. I knew I appreciated him because I follow up and email him here and there. Whereas, I am thinking about someone from home, a female counselor I had; she was super sweet, but I was never honest. I feel as though I have been more honest with you (Note: Researcher). I feel like reflecting about my experience with my male counselor, I've been more honest with my male counselors than my female counselors, and I don't know why; can't tell you.

P3 stated:

> I just felt like males were able to lift my spirits up more, I don't know why I think it is because I have more in common with males. I also believe that because I was talking about toxic relationships with a male, because they're male they understand. They know how men act. So as far as my issue go, a lot of my issues in recovery have to do with codependency, so I felt like I got more out of a male counselor than I did the female counseling.

This narration was similar among all of the participants, even the one who revealed that she had a trauma history that caused her to be cautious about trusting anyone. They all considered their experiences with a male counselor as positive, nonjudgmental, protective, and caring about their emotional needs. These women's perspectives point toward the importance of the therapeutic alliance as a substantial contributing factor of treatment retention and outcome. This theme also confirms Duff and Bedi's (2010) assertion that validation acts as a significant function of the therapeutic alliance. According to the women, their counselor displayed behaviors essential to building the therapeutic alliance such as friendliness, compassion, helpfulness, and concern for others (Sweeney, Fahmy, Nolan, Morant, & Fox, et al., 2014).

Furthermore, this confirms what Bachelor (2013) stated about the significance of the therapeutic alliance: clients appear to be more involved with a therapist who exhibits a posture of real concern and empathy in accomplishing collaborative goals and who forms a conducive relational atmosphere. These narratives also confirmed what Brorson, Ajo Arnevik, Rand-Hendriksen, and Duckert (2013) stated regarding the therapeutic alliance as one of the most critical factors related to treatment retention and decreases in

treatment dropout. From a relational-cultural theoretical lens, the participants' counselors appeared to place their importance on the relationship in a manner that reflected genuineness and shared empowerment and understanding (Duffey & Haberstroh, 2012; Frey, 2013; Headley & Sangganjanavanich, 2014).

Another significant finding is that several participants perceived their female counselors as more prone to stereotype them, treat them from a negative frame of reference, and take a critical stance toward them, compared to a man. It may be that these women experienced a level of unacknowledged countertransference or over-identification from their female counselors. This countertransference turned into a tense interaction in the treatment because the issue presented by the client was similar to an issue that the female counselor had navigated with ease or overcome. According to de la Sierra (2012) when a counselor does not recognize their biases, in impacts their ability to properly address a client's needs. It could also be that these female counselors that these participants experienced did not recognize their subjective beliefs, judgments, and viewpoints, leading to a perceived or actual bias and non-receptiveness to addicts who are women, which inhibited their ability to realize the women's specific needs.

On the other hand, Markin, McCarthy and Barber (2013) asserts that negative transference as indicative of a rough session and positive countertransference behaviors as indicative of a smooth session can be non-therapeutic. These women could have misinterpreted "negativity" as non-therapeutic which could be misleading because a positive "only" interaction in a counseling session may be superficial and counterproductive to a deep therapeutic interaction whereby conflict exists.

Even though some of the participants believed that female counselors were averse to a degree in some aspects of their treatment, they also express an identification that only came with having a female counselor. Some of the participants viewed their male counselor a taking a dismissive and passive stance when it came to concerns such as body image and sexuality. The women explained this "passivity" as men being "careful" about violating boundaries. This stance is understandable as historically women experienced a higher rate of boundary violations and sexual misconduct from male counselors than female counselors (Jackson & Nutall, 2001; Stake & Oliver, 1991; Pope and Bajt; Moleski & Kiselica, 2005). P6 stated:

> Men are careful because they don't want you, especially a man in that type of profession, to feel like they're trying to come on to you as well. They will listen from a distance and try to help, but also make it where you know they are helping you on a professional level.

P2 stated:

> I feel they (Note: men) will just pass on it (Note: sexuality issues), not say what they really want to say. If I make a mistake and it's a promiscuous mistake, I feel a woman counselor is going to ask "why did you do that? Did you go to the doctor? Where a male counselor is going to be like, oh, ok, because they don't want to say the wrong thing. Women are more prone to freak out on a male than on a female. Women feel like they can talk to a female about this" (Note: sexual issues).

P5 stated:

> Talking about the molestation and my kids, my kids getting taken away and being raised by someone else. That comes from a place men don't have, that nurturing of a mother's instinct. To even identify with that piece that's empty, talking about that with a man was pointless because he could not identify with what I was going through. They only go to their opinion based on their other clients. The other help was good, pushing me in the right direction, but, sitting there and having a conversation about those topics and really getting a connection, it didn't work.

It appears as even though men exhibited a certain level of "carefulness" that caused the women to respond positively to therapy, this same "carefulness" seem to hinder some participants from being able to be as honest as they wanted to about sexuality and body image issues. Some of the participants discussed how female counselors better handle these female-specific issues. The participants expressed that female counselors share a different level of identification with these kinds of experiences because they are women.

One reason for male counselors being cautious about discussing sexuality issues may be related to their awareness of the high number of sexual boundary violations perpetrated against women who abuse substances (Jackson & Nutall, 2001). Because counselor-client sexual contact is the highest form of boundary violation (Moleski & Kiselica, 2005), and men perpetrate a higher number of these violations (Stake & Oliver, 1991), men may consider any conversation around sexuality as some form of subjective unwanted contact, leading them to shy away from engaging even in therapeutic

conversations of a sexual nature. P5 related being uncomfortable sharing sexual trauma issues with a man:

> Getting into molestations issues; the abuse, the domestic abuse, getting into those issues… it (Note: having a male counselor) held me back from talking about it. Because I didn't start touching on it (Note: the sexual trauma). That's something that could bring you back out, or take you to a place where you don't want to go. I just didn't feel comfortable talking to him about the molestation and all that; it did seem right, it didn't feel right.

This difference in perspectives confirms Gehart and Lyle's (2001) statements that male and female therapist's behavior often mimic stereotypes, which can either facilitate or impede therapy depending on the situation. This finding also confirms the client provider connection as a practical element of treatment associated with outcome (Marsh, Angell, Andrews, & Curry, 2012) and the therapists' position is advantageous to positive outcomes (Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012).

One final significant finding was that participants were not commonly offered choice of their preferred gender of a counselor. Five participants never received a choice, but all of the participants verbalized their belief about the inclusion of client choice as a significant concept in the treatment process.

This finding is consistent with Swift, Callahan, Ivanovic, and Kominiak (2013) who concluded that it is essential to the therapeutic process to consider and adapt therapy to client preferences. This finding also indicated the significance of merging client preference into treatment development as this is connected to lower dropout rates and

better-quality therapy outcomes (Tompkins, Swift, & Callahan, 2013). The findings also indicate what Lindhiem, Bennett, Trentacosta, and McLear (2014) confirmed that greater treatment satisfaction, completion rates, and clinical outcomes occurred when client choice and mutual decision making occurred, compared to clients where it did not occur. Although clients may struggle to convey their preferences when given a voice in their choices and beliefs concerning therapy, having a choice can improve the therapeutic connection and commitment while building openings for expression and understanding of collaborative choice-making (McLeod, 2012).

In their study regarding client preference for the sex of therapist Landes, Burton, King, & Sullivan (2013) indicated that women would rather have a female therapist, and presenting problem may influence preference for the sex of therapist. The findings of this study confirms that specific problems might be challenging for women to discuss with a male counselor, however, challenges whether women prefer female therapists. All of the participants of this study reported having positive experiences with a man as a primary counselor and when asked given a choice which would pick a man again, most of the participants stated they would.

Hermeneutic phenomenology was represented in the findings of this, which emphasizes the individual's experience (Davidsen, 2013). Phenomenology gives a framework for the person's perception about an event and comprehension about how people construct meaning (Howell, 2013). The participants of this study were able to express their experiences about having a man for a primary counselor and their perspectives toward their counselor's influence on their treatment outcome. I utilized

phenomenology as a method to examine the women's experiences, to obtain rich data from those experiences, and gain an in-depth understanding of how these individuals experienced counseling from a man.

Again, the most surprising finding during this process was that the female substance abusers viewed female counselors as more critical and judgmental than male counselors. One participant remarked how females responded to their needs "You think that it would be the opposite, because females are the same sex, but no, they actually couldn't care less. Quite frankly, they don't tolerate anything, they're not empathetic or sympathetic." Another participant reflected how her current interaction with me during the interview mirrored her experience with her male counselors:

> I feel just us talking, I have been more honest with you. I feel like reflecting about my experience with my male counselor, I've been more honest with my male counselors than my female counselors, and I don't know why; can't tell you.

These comments made me reflect on my experiences as a director of a women's residential treatment facility and some of the harsh responses that I occasionally heard coming from the women counselors. These women seemed to reflect on experiencing critical interactions from the women that were supposed to help them. I thought about how most female counselors are accomplished women; they may have experienced similar struggles as the women that succumbed to substance abuse but were able to use healthy coping skills to manage opposed to maladaptive behaviors. Women counselors who have the ability to navigate the issues of life without resorting to maladaptive coping

strategies may unconsciously display critical views without knowing it, and this comes out in their interactions with the women receiving substance abuse treatment.

Another significant revelation uncovered during the interviews was how often women were not given, or even, offered a choice of counselor gender. Because I have pre-knowledge about the impact of childhood sexual trauma, domestic violence, forced prostitution, and other activities to continue their addiction, that usually removes a woman's choice; it would seem that the counseling profession would offer a choice of counselor's gender to women whenever possible. Discovering that women were rarely offered a choice, affected my *Dasien* to the point that inwardly I felt apologetic to participants during interviews. Although I remained neutral during the interviews, I became conscious of the need for women to be offered a choice of counselor's gender in counseling.

Limitations of the Study

Several limitations exist in the study. First, the small sample size; the results can only be used to describe the lived experiences of six women in an urban city in New York State who received substance abuse treatment from a man. One of the contributing factors affecting sample size was that participants would commit to participating in an interview, then not show up or contact me to state they were no longer interested. Multiple factors related to substance use including relapse could have played a role in these women's ability to follow through. Awareness of this dynamic is essential for those who may want to research this population in the future as this could impact time constraints for completing specific time requirements. Proper planning is necessary to

gain a sufficient enough sample to accomplish saturation. Secondly, the study did not include women who had a male counselor and did not complete treatment, which also limits transferability.

Another limitation is the study did not include women who completed the residential level of care. Many residential facilities have a heterogeneous population, including staff, so women receiving treatment in these facilities may not experience a man as a counselor working in those facilities.

Also, several participants discussed having the ability to go to women counselors for specific request when their primary counselors were unavailable, or they felt uncomfortable going to a man, which may have mediated the impact of having to rely primarily on a man counselor to navigate issues of concern. Furthermore, the study did not include the perspectives of male counselor's experiences with female clients.

Another limitation of the study was my experience working with women. Because of my first-hand experience assisting substance-abusing women to work through their issues, I assumed that women had better experiences and outcomes with men than expressed in the research. I also had experience in utilizing non-threatening and authentic behaviors that elicit a certain level of comfort. Some of the participants knew about my history of working with women, and I knew to ask questions regarding choice of counselor, along with reflecting on comparisons. This foreknowledge shaped the analysis and interpretation of the findings. However, despite the possibility of researcher bias, I bracketed my expectations to record only the participant's experiences. Finally, as with all phenomenological approaches, the inability to generalize the findings to a larger

population is limited, because the information provided can only enhance further research on women who completed treatment and had a male as a primary counselor.

Recommendations

This study's results provide a glance into the therapy experiences of six clients of substance abuse treatment. Although broad generalizations should be avoided given the small number of participants and relative treatment histories, counselors have much to learn from these client's experiences. Perhaps the most striking pattern is that despite the inferences that women are better matched with women counselors, this study viewed that men could have a positive therapeutic relationship when matched with women.

Based on the findings of this study, supervisors of chemical dependency agencies must be aware of the impact that the sex of the therapist plays on treatment engagement and outcome for women receiving services. It is recommended that decisions around counselor-client matching, supervision, and program evaluation be made around this knowledge. Also, the therapeutic alliance should be assessed throughout the course of treatment especially when a woman is matched with a man to ensure that her needs are getting addressed, and to evaluate if steps are necessary to mediate premature dropout.

Furthermore, female counselors should take careful consideration to assess their internal motivations and attitudes when counseling female clients as to not counter-transfer their views on their clients; and to not assume that the therapeutic alliance is intact based on identification of a similar gender or gender-related experience (Asnaani, & Hofmann, 2012; Atzil-Slonim, et al., 2015; Messer, 2013).

Men should continue to be sensitive about issues surrounding sexuality, physical image, and trauma, but not shy away from those topics when they arise. Men should take confidence in their professional ability to address these sensitive topics competently. Training around trauma-informed care may assist them with better navigating issues of this nature. Also, men should be recruited and considered for positions in women-only treatment centers as they serve as role models of healthy male behavior. Another recommendation is that substance abuse providers offer a choice of gender to women as a standard practice of treatment and accommodate their preferences whenever possible.

One final recommendation is that training regarding client-counselor gender matching be incorporated into the counseling education curriculum. This data will inform new counselors about the importance of considering gender in assessment, counseling interventions, and treatment planning for their clients. Because of the small sample size, it is recommended for future studies to consider larger sample sizes. Also, because this study did not include women who had men as counselors and did not complete treatment, future studies should include those women who did not complete treatment. Finally, studies that include the perspectives of the men's experiences with women clients can provide additional information about strategies to assist this population.

Implications

Historically female clients receiving substance abuse treatment from a male counselor had shorter stays in treatment and poorer outcomes than those who had a female counselor while in treatment (SAMSHA, 2013). Through this research, I sought

to fill a gap in the literature by examining the lived experiences of women who have completed substance abuse treatment who received primary individual counseling from a man. I sought to gain their perspectives about their interactions with a male counselor, how that influenced their engagement in treatment, their care, and their perspectives on the role he played on their treatment outcomes. The findings of this study have several implications for positive social change.

First, the results of the study fills a gap in the literature identified by SAMSHA (2013) regarding the limitations of the literature regarding the association between retention and outcomes amidst women with substance use disorders. Next, the findings expand information about strategies that support treatment retention and increase positive outcomes for women receiving treatment for substance use disorders (SUDs). Another implication is the findings can inform counselors and educators about navigating better the issues that arise in the counseling relationship, especially men who counsel women. Another clinical implication of the study is the use of the information in the supervision of men counseling women, about strategies that contribute to sustaining women in treatment, and improving treatment outcomes.

The findings of the study can also be utilized in an oral presentation. In light of substance abuse among the female population being a significant public health issue (Coleman-Cowger, 2012; Merritt, Jackson, Bunn, & Joyner, 2011), there is the need to publish the findings of this study in a counseling journal for the benefits of the public health personnel. The information from the study suggests the need for increased awareness about the strategies that women who receive substance abuse treatment

attribute to delivering improved counseling services, promoting treatment retention, and enhancing treatment outcomes.

Conclusion

In conclusion, the aim of this phenomenological study was to explore the lived experiences of women who completed substance abuse treatment and had a male as a primary counselor. I use semistructured interview questions to answer the overarching research question "what are the lived experiences of women who completed substance abuse treatment and had a male as a primary counselor?" Data was obtained through the use of in-depth face-to-face interview sessions. These participants indicated that they had positive experiences that gave them an opportunity to interact with a positive man, however, they suggested that women be offered a choice in the gender of their counselor and accommodated whenever possible.

Their experiences confirmed that regardless of gender, effective therapist exhibit exemplary skills that build the therapeutic alliance, foster treatment engagement, and attend to the specific needs of the population they serve (Simon, 2012). The findings of this study creates a better understanding of the lived experiences of women receiving substance abuse treatment. It serves as a basis for training and supervision strategies that assist women matched with the opposite sex, and adds to filling the gap for research that helps to increase engagement, retention, and positive outcomes for women receiving substance abuse treatment.

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Appendix A: Data Collection Advertisement

Walden University

Lived Experiences of Women Receiving Substance Abuse Treatment from Male Counselors

[Volunteers] Wanted for a Research Study

The purpose of this research study will be to understand the lived experiences of women who have completed substance abuse treatment who received primary individual counseling from a man.

Participants will be asked to be available for 2 face-to-face interviews (one hour initial interview and ½ half hour follow up interview) at a time and location that is opportune to the participants.

Eligibility Criteria

- Women must be ages 18 or above
- Must have completed substance abuse treatment within the last five years at an agency certified by the New York State Office of Alcoholism and Substance Abuse Services (OASAS)
- Must have received individual counseling sessions from a man as a primary counselor

Contact Information

If you or someone you know is interested in participating: To learn more about this research, contact Rob Bennett at:

- 716-535-7637cell
- or email robert.bennett@waldenu.edu

This research is conducted under the direction of
Robert C Bennett
Counselor Education & Supervision Student
Walden University

Appendix B: Interview Protocol

Interview Script

Hello, my name is Robert C Bennett. I am a doctoral student at Walden University. I am conducting my dissertation study on the lived experiences of women who have completed substance abuse treatment who received primary individual counseling from a man. I want thank you again for agreeing to participate in the study and remind you that you can stop at any time during the process. The interview will last approximately 1 hour and I may contact you at another time for a follow up interview if I need to clarify any items. I want this to be a relaxed conversation about your experiences. However, I have some questions to help with the conversation. Do you have any questions before we begin? Remember, you have the right to stop this interview at any time. Shall we begin?

Interview Questions.

- Please explain your initial perceptions/thoughts when you first met your male counselor.
- Please describe the steps your counselor took to help development a counseling relationship with you?
- Describe a time during the counseling relationship when you preferred a female counselor. Explain the circumstances that led to this preference.
- Describe a time when you felt uncomfortable with your counselor? What happened in the episode you mentioned? Could you say something more about that?
- What subjects were difficult for you to discuss with your counselor? Can you explain why these topics were difficult to discuss?
- Please describe in as much detail as possible a situation in which you may have felt you had any physical or emotional attraction toward your counselor and how you handled it?
- Describe examples of situations that made you feel safe with your counselor?
- Describe examples of situations that made you feel unsafe with your counselor?
- If you were training a male on counseling women, what would be the most important things that you would want him to know?
- Please share any other information about your experiences with a male counselor.
- How has your participation in this study impacted your perceptions about your previous experiences of working with a male counselor?

Thank you again for sharing your experience with me.

Appendix C

Rapport-Building Skills **A useful array of relational competencies that assisted them with building rapport, creating healthy relationships, and promoting trust**	**Responses** • To the point • Relaxed atmosphere • Personal • Joking around • Making them feel comfortable and optimistic
Genuineness **The counselor's capacity to be authentic**	• Easy to talk to • Very helpful • "Even keel" • Sense of professionalism • Related when talking • Share parts of his life • Straight forward • Concerned • Put things in perspective • Want to understand women • Sit and listen and apply.
Empathetic **The counselor's ability to understand what it is like to walk in another person's shoes**	• Helpful • Conversational • Conversation and advice • Guided me in the right way • Able to lift my spirits up more • Positive male role model • Father figure • Taking what he knew in his life experience • Insightful • A little bit more empathy (than women) • Taking his time to talk to you even if he was not your counselor • Keeping his word • Felt safe • Straight forward • Teaching about consequences and stuff
Flexibility **The ability of the counselor to adjust the manner by which they responded to the women to meet the client's needs**	• Being available • Anytime I needed help, or anything, he was always there. • Took the time out to talk to me if I needed • Brought a female counselor in with him • Joke around to get my spirits up and then we would go on to the serious stuff • Available (if I come in there and we got a group and I need to talk to you afterwards, I need to talk to you [emphasis]). • Gave me the most hope I've ever had • Go all out of his way • Be solution focused • Kept eye contact me • He never got distracted • I knew he cared • He wanted to help me out • He believed that I would do well.

Acceptance **The counselor's ability to "meeting the client where they are at." In other words, connecting in an open, nonjudgmental manner, with acceptance**	• Could talk to any of them in the facility if I had any need to be met. • No problem going and asking at all and they were very helpful to me. • All the females were treated the same by my counselor • No difference **(Note: discrimination or favoritism)** was made with any females that attended our groups or meetings with him. • Giving alternatives

	• Giving assurance "I did feel it is a lot of my fault **(Note: the relationship issues)**, but he assured me "no, it is both of your fault." • Just treating women the same as you would treat a man. That is how I feel about it. • (My male counselor was not critical or anything, but I think men are more critical without saying it. • Women will ask, what did you do that for **(Note: ask straight forward)**? Women will be more vocal about it, where men don't want to offend the woman, put her in a bad spot, or make her feel uncomfortable. • They always put me in the right direction for the most part. • Always have their best interest at heart. • Be genuine with them. If they had questions or concerns about their children that would definitely be important. • Being knowledgeable about women issues: I feel women in recovery always have a past of abuse and not having self-worth, and a lot of times have problems with CPS and children, so I believe those would be the top three things. • Not soft spoken, but very gentle about certain topics. • Took everything I had to say with a grain of salt and was very optimistic. • No judgment. • Not aware of the importance of image • Making them (women) feel comfortable • Very caring • Could not identify with what I was going through. • Only go to their opinion based on their other clients. • A sensitive side • Not dominant • Not aggressive • work on behalf of the woman • Men are careful • Helping you on a professional level. • Guys will sit, listen, and apply
Choice **The offering of a choice in which gendered counselor she wanted**	• When you are my age and a female you are just grateful. It's like that dog that they throw the scraps at under the table in the bible. I would have taken those as long as they could help me, in which they did. I am truly grateful. • I don't think they asked. I remember them talking about it, but I don't think they asked, which really didn't bother me. • I probably would have picked a female just because I never had experience with male counselors; it is almost a default **(Note: to choose a woman)**. • I believe they asked if I felt comfortable with a male counselor, and I did. • I didn't get a choice with that. They just gave me to them….I didn't feel as close to him as I did at inpatient. • For me, I felt respected because they asked me. But it doesn't bother me, but some women aren't going to have the same mindset as me. • No, I don't think I ever was. • I think I would choose a man. I think men have the tendency to let you talk, and they listen better than women; not in relationships, but in these situations. • They just assigned me. If I had a choice at the beginning, it would have been a female. Being comfortable with a woman, and talking to a woman about female issues. • I believe when a person is coming into a facility, whatever the gender, I think they should be placed with the same gender. • Honestly it didn't bother me, but I know that is one thing I didn't have a choice in. Moving forward in that whole rehab business I think they should give you a choice. • I know my preferences, but it made me think back to other females or other people I met who had those same concerns and issues as well. I didn't know you can make suggestions…., if you **(Note: interviewer)** can suggest to someone that there be a change in how things are done I would recommend that.