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Social Support: A Mixed Blessing for Women in Substance Abuse Treatment

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Abstract

Using a personal social network framework, this qualitative study sought to understand how women in substance abuse treatment describe their network members' supportive and unsupportive behaviors related to recovery. Eighty-six women were interviewed from residential and outpatient substance abuse treatment programs. Positive and negative aspects of women's social networks were assessed via open-ended questions. Analysis was guided by grounded theory techniques using three coders. The findings extend classic social support concepts such as emotional, tangible, and informational support. Practice implications are presented in light of the potential roles network members may play in substance use and recovery.

Keywords

social support; social networks; substance use disorders; substance abuse; women

INTRODUCTION

Approximately 6.5 million adult women in the United States have a current substance abuse or dependence disorder (Office of Applied Studies, 2004). Research has identified gender differences in the course and pattern of substance use disorders (Becker & Gatz, 2005; DiNitto, Webb, & Rubin, 2002; Timko, Finney & Moos, 2005), including the vulnerability of women to negative consequences of substance use (Blume, 1992; Sun, 2009) and the likelihood that women with substance abuse problems have experienced prior sexual or physical abuse (Kang, Magura, Laudet, & Whitney, 1999; Najavits, Weiss & Shaw, 1997; Newmann & Sallmann, 2004) and continue to be exposed to violence (Velez et al., 2006). Women with substance use disorders (SUD) are more likely than their male counterparts to have co-occurring psychiatric disorders, including depression, anxiety and post-traumatic stress disorder (PTSD) (Dodge & Potocky, 2000). It is estimated that up to two thirds of women in treatment for substance abuse may have a co-occurring undiagnosed mental illness (McHugo et al., 2005; Newmann & Sallmann, 2004). This co-occurrence is clinically significant because, as compared to treatment

for adults with only one disorder, dual disorders pose special treatment challenges (Back, Brady, Jaanimagi, & Jackson, 2006; Chander, & McCaul, 2003; Compton, Cottler, Jacobs, Ben-Abdallah, & Spitznagel, 2003).

Research and clinical evidence document that chemically dependent women have limited social support networks (Curtis-Boles & Jenkins-Monroe, 2000; Davis & DiNitto, 1998; Kissin, Svikis, Morgan & Haug, 2001). In addition to small support networks (Savage & Russell, 2005), women with substance abuse problems may have inadequate support for sobriety from their networks (Majer, Jason, Ferrari, Venable, & Olson, 2002). Many male partners of these women offer inconsistent support for recovery (Laudet, Magura, Furst, Kumar, & Whitney, 1999). O'Dell, Turner, & Weaver (1998) found that drug misusing women received minimal support from partners (57%) and parents (37%) to abstain from drug use. However, Lam, Wechsberg, and Zule (2004) found that living with a partner could be a positive support for African American women who use drugs.

CONCEPTS OF SOCIAL SUPPORT AND SOCIAL NETWORKS

Using a *personal social network* conceptual framework (Marsella & Snyder, 1981), this study sought to understand how women in substance abuse treatment describe their network members' supportive and unsupportive behaviors and attitudes related to recovery. The term *social network* refers to a set of individuals and the ties among them (Wasserman & Faust, 1994). The study of personal social networks examines the relations surrounding a focal person, in this case a woman enrolled in a substance abuse treatment program (Scott, 2000). *Social support*, as defined in this study, follows the empirically derived definitions of Gottlieb (1983) and Barrera and Ainley (1983): verbal and/or non-verbal information or advice, tangible aid or action provided by social network members or inferred by their presence, which has beneficial emotional or behavioral effects on the recipient. Social support consists of a variety of types of helping behaviors and has typically been categorized into three primary types of support: informational support (advice and guidance), emotional support (including encouragement), and concrete support (tangible help and assistance). A *social support network* refers to a set of relationships that provides nurturance and reinforcement for efforts to cope with life on a daily basis such as sobriety support to maintain recovery and tangible help (e.g., child care while the mother is in treatment) (Whittaker & Garbarino, 1983). Not all social networks are social support networks, nor do all social networks reinforce pro-social behaviors. Our study aimed to further social support research by building understanding of how women in substance abuse treatment view the behaviors of network members as either supportive or unsupportive of recovery. Such specificity may help treatment programs to more precisely design and match social network interventions to sustain recovery.

PREVIOUS RESEARCH ON WOMEN, SUBSTANCE USE AND SOCIAL NETWORKS

Impact of Substance Using and Other Negative Network Members on Recovery

Substance using network members often maintain a presence in the networks of women in recovery, complicating efforts to maintain sobriety (Falkin & Strauss, 2003; Ellis, Bernichon, Roberts, & Herrell, 2004). Boyd and Mieczkowski (1990) reported that women in their study stated that their friends, mothers or sisters were the most likely people in their lives to help them become sober. Nearly 30% of the women, however, stated that they knew no one who would help them stop using drugs. In studies of women offenders mandated to substance abuse treatment, Falkin and Strauss (2003) and Strauss and Falkin (2001) reported an average of 9 supporters (about half of whom were family members), and 3 drug associates. Women in their sample had some support, some enablers and some network members who did both. Using

qualitative techniques, Trulsson and Hedin (2004) examined the social support of women in the process of giving up drugs and found that divisions occurred within their networks, between those people who supported recovery and those who primarily blamed and criticized the woman's previous substance using lifestyle. El-Bassel, Chen, and Cooper (1998) found that among women in methadone treatment, 10% of their network members had provided them with drugs and 18% had used drugs themselves. Focus group discussions with men and women with co-occurring schizophrenia and substance use disorder revealed that the most commonly cited extra-therapeutic factor that helped people stay substance-free was the emotional and practical support supplied by family members and/or friends (Maisto, Carey, Carey, Purnine, & Barnes, 1999). In fact, substance abusers with co-occurring mental disorders, as with substance users in general, frequently cite social reasons for using drugs (e.g., the desire to fit in and cope with peer pressure) (Drake, Brunette, & Mueser, 1998; Laudet, Magura, Vogel, Knight, 2004; Walton, Blow, Bindham & Chermack, 2003).

While social support has been recognized to have beneficial impacts on individuals' well-being and physical health, there are potential harmful/detrimental risks embedded in interpersonal relationships (Lincoln, 2000; Rook, 1984). The obligation to reciprocate (i.e., to return the favor) may be stressful and lead to reluctance to use social network resources, particularly for low income women with few resources to share. Ribisl and Luke (1993) found that the negative impact of substance users within the social network exerted a greater influence on recovery than positive family supports for treatment. Criticalness, hostility, and over-protectiveness of spouses/partners can reinforce continued substance using behavior and lead to increased relapse rates (Fals-Stewart & Birchler, 1994; O'Farrell, Hooley, Fals-Stewart, & Cutter, 1998). Sun (2007) reported that interpersonal conflicts with intimate partners, family members and service systems were perceived by women with substance use disorders as major triggers for relapse to occur. One contributing factor to interpersonal conflicts and negative emotions was found to be delayed or undiagnosed psychiatric disorders that interfered with interpersonal communications and relationships.

Social Networks and Treatment Outcomes

Social network members can either support or undermine participation in treatment and recovery from drug use. Both peer support within the treatment setting and social support outside of treatment appear to be significant factors in treatment progress and outcome (Joe, Broome, Rowan-Szal, & Simpson, 2002). Studies have examined the contribution of the characteristics of pre-treatment social networks to *extent of alcohol use* (Manuel, McCrady, Epstein, Cook, & Tonigan, 2007), *retention* in treatment (Dobkin, De Civita, Paraherakis, & Gill, 2002) and treatment *outcome* (Comfort, Sockloff, Loverro & Kaltenbach, 2003; Zywiak, Longabaugh, & Wirtz, 2002).

There is some evidence that interventions to build or mobilize supportive relationships in treatment and recovery are best matched to the nature and composition of clients' pre-treatment networks (Longabaugh, Wirtz, Beattie, Noel, & Stout, 1995). Other studies indicate that positive, abstinence-oriented social networks following treatment may be more predictive of treatment outcomes than are pre-treatment social networks (Broome, Simpson, & Joe, 2002). The importance of recovery-oriented social networks and non-using social network ties has been stressed in maintenance of sobriety (Gordon & Zrull, 1991; Walton et al., 2003; Weisner, Delucchi, Matzger, & Schmidt, 2003), treatment adherence (Galanter, 1993) and relapse (Bond, Kaskutas & Weisner, 2003; Dobkin et al., 2002; Zywiak et al., 2002).

Limitations of Previous Studies

In summary, research on social networks and substance abuse suggests a critical role for personal social networks and socially supportive relationships in one's participation in

treatment, treatment outcomes and maintaining outcomes following treatment. In fact, the National Institutes of Health (NIH) has set forth a research agenda regarding the process by which social networks link individuals to health providers and how network members influence patterns of health and risk (NIH, 2001). Yet, few studies have examined social network resources of women with substance use disorders, including what specific elements make up the experience of different types of social support and how women experience network members who are not supportive of recovery.

METHODS

Participants

As part of a larger NIDA funded study (Tracy & Johnson, 2007), 86 women, predominantly African American (81%), were recruited from residential (n=41) and outpatient (n=45) substance abuse treatment programs in Cleveland, Ohio. Those eligible for the study were 18 years or older, in treatment for 3 weeks or more, and with no known diagnosis of schizophrenia and no current use of any medication typically prescribed for a major thought disorder.

Of the women who were initially eligible for the study, 92.6% (101 of 109) were successfully contacted and asked to participate. Ninety-seven (96.2%) of these women agreed to participate. Ten women gave consent to be interviewed, but were not available to be scheduled for an interview before the end of the study. In addition, the case of a 75-year-old woman was deleted as an outlier, resulting in a final sample of 86 cases.

Using a cross-sectional survey design, data were collected by trained interviewers in face-to-face interviews lasting, on average, 1 hour 45 minutes. All measures were pretested prior to their use in this study. Respondents received \$45 payment plus transportation costs for participating in the interview. This study was approved by the Case Western Reserve University Human Research Protection Program (HRPP).

Measures

Psychiatric disorders were assessed using the Computerized Diagnostic Interview Schedule (C-DIS) (Robins et al., 1999). All of the women in the study completed the following mental disorder sections of the C-DIS: generalized anxiety disorder, depression, dysthymia, posttraumatic stress disorder (PTSD), and mania/hypomania. The C-DIS has demonstrated reliability and validity (Helzer et al., 1985; Robins, Helzer, Croughan, & Ratcliff, 1981) and is based on criteria from the Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition (DSM-IV) (American Psychiatric Association, 1994). This measure provides a DSM-IV compatible diagnosis and distinguishes current from lifetime disorders.

Substance use disorders (alcohol, drugs, or both) were determined from the results of a structured Computerized Intake Assessment Instrument (CIAIC-C) (University of Akron, 2001), a uniform assessment tool developed for the county in which this study took place. It is administered on intake and yields a DSM-IV-compatible diagnosis. Authorization to use this previously collected information was sought, so that study participants would not have to complete an additional substance abuse assessment.

Demographic information was collected from the demographic section of the C-DIS as follows: age, racial/ethnic identification, educational level, marital status, number of children, and employment history over the past 12 months. This information along with substance use and mental disorder status is reported in Table 1.

Qualitative Research Questions

Following the generation of a list of social network members, positive and negative aspects of women's social networks during treatment and recovery were assessed via the following open-ended questions: "Which of the people listed in your network have supported you the most in your current recovery efforts?" "What does each person do to support your recovery?" "Which of the people listed in your network make it hard for you to work on recovery?" "What does each person do to make it hard for you to work on your recovery?" "Thinking back to when you last used drugs or alcohol, which of the people listed in your network had something to do with your substance abuse?" "What did each person have to do with your using drugs?"

Analytic Strategy

The first three authors conducted the data analysis. Responses to open-ended questions were transcribed and entered into a word processing program, and later into Atlas.ti where data could be coded and merged. Analysis was an iterative process consisting of: (1) documenting initial impressions; (2) in-vivo coding; (3) merging and organizing codes; and (4) developing axial codes and themes. This process was guided by the constant comparison method (Glaser, 1965).

Analysts read participant responses independently. Guided by ideas from Taylor and Bogdan (1998), initial impressions were documented in the form of memos for later discussion. Based on these impressions and previous research on support networks, an initial codebook was developed by the first and second authors. Each analyst independently coded participant responses. The codebook was used as a guide, allowing flexibility for in-vivo coding. Several new codes emerged from this process.

Atlas.ti was used to merge and organize coded data. The first and third authors identified and discarded redundant codes. In cases where more than one code was used for a response, discrepant codes were discussed and only mutually-agreed upon codes were kept. In cases where agreement could not be reached, the second author served to help reach a consensus.

All three analysts met several times to discuss axial codes and themes. Each presented his/her ideas on the meaning of the data and relationships between codes. Reliability was established through these discussions and through a mutually agreed-upon presentation of the results. Themes and corresponding data elements are presented below.

RESULTS-PART 1: POSITIVE SUPPORT HELPFUL TO RECOVERY

The following are the resulting themes and corresponding data elements regarding positive support that was helpful to recovery: (See Appendix A for a visual depiction of themes and sub-themes.)

Emotional Support

Numerous data elements were coded as general emotional support, for example: "supports me," "she's been an all around support," "support mentally – talks to me," and "*he supports what I am going through.*" Also, seven more specific sub-codes emerged under the axial code of emotional support, namely encouragement, caring and concerned, communication, "being there," "making sure," praise and recognition of success for hard work, and positivity. These are discussed below:

Encouragement—One of the most frequently discussed forms of emotional support was encouragement. Women reported support in the form of general encouragement: "she encourages me to do my best and not give up," "tells me to keep up the good work," and

encouragement specifically related to treatment and recovery: “he told me I can do this; that I can stay sober and clean,” “she encourages me to stay in treatment no matter what,” and “encourages me to go to NA and AA meetings, encourages me to stay clean and talk with my sponsor.” Finally, women's reports of network member's encouraging comments suggested that they felt inspired: “*encourage me that I can overcome anything*” and assured: “*tells me I would be alright*” and “*...talked about my problems, that I'm not alone.*”

Caring and concern—Women in the present study spoke of network members as caring, which they perceived as supportive of recovery: “cared enough to get me into the program,” “is very caring,” “...they really care.” They also reported that network members were concerned about them: “*she is concerned about me.*” Further, caring extended to checking on women: “*checks on me,*” and “*calls to see if I'm ok.*” Women also commented that supporters provided comfort: “*he comforts me*” and “*hugs me.*” One woman expressed that network members cared by stating that they “*took care of me.*”

Communication—Talking and listening in person, through correspondence (e.g., letters) and telephone were highlighted by the majority of women in the study. Talking with women during treatment and the recovery process was a predominate form of emotional support for the many of the women in the present study. Comments revealed that having someone to talk to was important: “talked to me,” “she talks to me whenever I need it,” “long talks,” and “*talk on the phone.*” Also, women specifically reported that it was helpful to their recovery to talk with network members about their problems: “*she talks to me when I feel down*” and “he always talks to me about whatever I'm having a problem with.” Of particular interest, many women reported that they valued talk that was direct, honest, and held them accountable for their behaviors: “told me things I didn't want to hear about myself, honest w/me in my journals, gentle but direct,” “talks to me; telling me my attitude and behavior need to change,” “tells me what I need to hear, not what I want to hear,” “corrects me when I'm wrong, helps me stay focused,” and “lets me know when I'm slipping, he gives me that extra kick in the butt when I want some weed or something.” These comments suggest network members were valued for their willingness to talk directly to the women about their difficulties and the need for change in their lives. Listening was also an important aspect of emotional support for the women in the present study. Supportive network members were identified as good listeners: “*good listener when I'm upset,*” as someone that listens when women have problems: “*she listens when I have problems,*” and as individuals that will listen and give opinions and moral support: “she listens, gives her opinion,” “she listens and gives feedback,” and “*she listens and gives me moral support.*”

Being there—Women frequently commented that network members “being there” for them was viewed as supportive of sobriety: “is always there,” “she's always there no matter what,” “she is the reason I am still here, supported me when they were going to put me out,” “he's just there for me,” and “he's always there to talk to me and give me advice, he's always there to give money for personal things.” Consistency was also reported as supportive: “helped save my life, shoulder to cry on through good and bad times.”

Making sure—Responses revealed that network members who helped keep these women on the right track were viewed as supportive of treatment and recovery, for example: “kept asking ‘when are you going’ [to treatment] every day,” and “tells me off if I'm going to use, stays with me every day to make sure I'm not using” revealing a quality of consistent support that was initiated every day. Comments also revealed that network members often were perceived as making sure women have what they need: “*makes sure I have what I need,*” making sure they remain in treatment and keep appointments: “my counselor made me stay when I didn't want to be here, if it weren't for her I wouldn't be here,” “makes sure to get to my appointments and

meetings” and also maintain their recovery: “*makes sure I take care of my body and stay sober.*” Finally, “making sure” extended to important daily life activities, such as work: “*makes sure I stay on top of my jobs.*” “Making sure” and “being there” reveal that some network members provided consistent emotional support to women in recovery from addiction.

Praise and recognition of success for hard work—Another category of emotional support that emerged in the present study was women in recovery reporting that network members gave them praise for their hard work and told them that they were happy or proud. Comments such as: “happy that I am sober,” “she notices the changes,” “tells me she’s proud of me,” and “*stood up for me, told me how proud she is*” reveal that women valued the recognition that they received from network members for their efforts to get better in treatment. Also, women reported: “*tells me how glad they are,*” “*she’s happy I’m here*” and “*she’s happy that I am doing good,*” revealing that women found it supportive when network members revealed their happiness, gladness and joy to women in recovery.

Positivity—Finally, women found it helpful to their recovery when network members were simply positive. Comments such as: “was always positive,” “gave positive feedback,” “tells me I look good,” “tells me beautiful things,” and “*talks to me in a positive way*” support the importance of network members being positive to assist these women in the recovery process.

Tangible Help

Many forms of tangible help, including child care, a “place” to live, and money emerged as concrete support that impacted the experience of recovery from addiction. For example, women reported that network members taking care of their children supported their recovery: “she baby-sits when I go to AA meetings,” “keeps my child when I get stressed,” “given my kids food, going to buy them shoes and winter coats,” “she takes care of my kid, keeps them well and gives me information on how they are doing.” Shelter, or a place to live, was also reported as important to the process of recovery: “let me stay with her and got me off the street,” “put me in a hotel until I could get a place here,” “she provides me with a place to live” and “grateful that she didn’t put me out, if it weren’t for her I would be using today.” Each of these data elements reveals that women often were in need of housing while battling addiction and co-morbid mental illnesses. Money was also reported as critical to recovery. Money to help with recovery was utilized in many ways: “giving me money to pay rent,” “took me to dollar store and bought me personal items,” “helps me pay my bills, helps buy things for baby like diapers,” “buys stuff for the baby,” “pays for babysitting,” and “*bus fare.*” Finally, women reported that help finding employment was important to their recovery: “*tries to get me jobs*” and “*job search.*”

Bringing personal items—Another tangible support theme that emerged was the importance of bringing things to women while they were in treatment. Various items were mentioned by multiple women, for example, clothes, blankets, shoes, cigarettes, stamps, envelopes, a bible, and food, to name a few. While many of these items were necessary to keep up personal hygiene, bringing an item, in and of itself, was perceived as supportive. Many women simply stated: “*brings me things*” or “*brings me things I need.*” This suggested that the action of taking the time to bring things to them was an important aspect of support for the women in this study.

Keeping in touch throughout treatment—An additional tangible support code was the importance of maintaining contact during treatment. Women reported that network members supported their recovery in the following ways: “calls and checks on me,” “we call each other every day” “calls me daily” and “*always call me, every day.*” Also, visiting was repeatedly endorsed as a way to maintain contact with support network members: “*he comes to visit me*”

and “visits me at HC.” Contact through written correspondence was a tangible support women mentioned: “he writes me,” “sends cards,” “writes encouraging letters” and “he writes me letters (incarcerated).” “Seeing her face every day” is the way one woman described how a network member provided support for her recovery.

Doing for and doing with—Some data elements within tangible support were coded as “doing for” participants or “doing with” participants, as both processes were suggested in the data. “Doing for” included two codes, namely the frequently coded “does things for me” and “takes care of my personal business.” “Does things for me” included: “packed things for me when I was moving,” “tries to do as much as he can,” “does things for me,” “taken me to the store,” “took me to dollar store and bought me personal items,” “helps me with the household chores,” “goes to court with me,” “arranges activities that help to distract me,” and “*she did all of my Christmas shopping for me.*” Also, many women commented that network members took care of their personal business particularly when they were spending time in their treatment program: “check my mailbox, take care of my personal business for me,” “given my kids food, going to buy them shoes and winter coats and he's going to help out with my dad,” “helps me pay my bills, helps buy things for baby like diapers, helps watch baby, drives me to grocery store and back home,” and “*she handles my business.*”

“Doing with” included codes, such as “do things together” (positive) and “takes me to meetings.” Women reported that doing things with network members, such as “*watches movies with me about recovering people,*” and “*do fun things together*” was supportive to their recovery. Also, doing things with women that directly supported their recovery were often mentioned, such as “*go to AA meetings together*” and “*took me to meetings, introduced me to sober people.*” These data highlight that support network members played a key role in women's treatment process. These actions also provided women support as they felt an emotional connection to individuals that did things for and with them.

Helps me get into services—Data specifically illustrated that network members worked on behalf of and with respondents to help them get into services: “she's wonderful, she helped me get connected,” “cared enough to get me into the program, and they talked to a lady in their church and she told them about H C,” and “*directed me to different services.*”

Informational Support

Women's responses also focused on informational and cognitive support, including teaching, educating, advice giving and criticism. Teaching specific to the disease of addiction, teaching coping skills and sobriety support were part of informational support, described below.

Teaching specific to disease—Information about the disease of addiction and how to fight it was reported as supportive to women's recovery. Examples of women's responses were that network members: “makes me aware of what the disease does to you,” “taught me disease of addiction, how to live life without use of drugs,” “she gave me the knowledge about drugs and alcohol and taught me how not to use on a daily basis,” and “she teaches me how to stay clean every day, teaches about bad consequences.”

Teaching Coping Skills—Women in the present study perceived that network members also taught them how to cope with the emotions, thoughts and behaviors that surround recovering from addiction. Data elements suggest that social network members helped women identify, deal with and express emotions: “helping me identify my feelings, sharing about their recovery,” “teaching me to meet life on life's terms, deal with anger,” “...we have one-on-one talks, she teaches me to express my feelings,” and “help me get in touch with my feelings, okay to feel and talk...” Network members were also perceived as supporting women through

helping them cope with their thoughts: *“helps me with my thoughts.”* Being helped with identifying behaviors related to these difficult thoughts and emotions was important as well: *“sort things out, help me calm down when I’m stressed,”* and *“helps me avoid triggers.”*

Sobriety Support—Support specific to maintaining sobriety was commonly mentioned when discussing what helps women with their recovery. Women frequently endorsed this type of informational support when discussing supportive network members. Three codes were subsumed under sobriety support, “supports sobriety and doesn’t support use,” “does not use around me” and “helps me follow treatment program.”

Data suggests that network members communicated information that did not support substance use and endorsed the idea that staying sober would lead to a better life: *“told me to do the right thing; stay sober,”* *“tells me to stay away from drugs, don’t use,”* *“she tells me to leave those drugs alone, so you can get your baby back,”* and *“encourages me to stay sober, so that when he gets out we can be together.”* Sobriety support was also discussed as occurring through actions, such as helping women make new contacts with people who were also in recovery: *“introduced me to sober people”* and coming back into their lives when they were actively sober: *“she stayed away while I used, but she’s back now that I’m clean, she’s back in my life.”*

Women reported that substance using network members avoided use around them: *“she won’t drink or use weed around me anymore,”* *“not using around me,”* and *“doesn’t drink around me.”* This suggests that, for these women, having had network members that were sensitive to avoid use in their presence helped them fight their own addiction

Lastly, helping women follow their treatment program was an important dimension of sobriety support. Women perceived that network members helped them follow the 12 step program: *“helps me through my steps and keeps me sober,”* and *“she’s helping me through the 12 steps and pointing out to me where I need to change.”* More generally, network members provided support for treatment: *“helps me follow my case plan,”* *“read NA books,”* and *“counseled me.”* Counseling, reading, and working with women on their treatment plans were perceived as supportive to sobriety.

Advice—Informational support in the form of advice and lecturing was reported by many women: *“she gives me advice,”* *“he gives me lectures,”* and *“she gives feedback on issues.”* More specific advice was reported by women about staying away from people that use: *“stay away from her nephew,”* and, more generally: *“stay away from people who use.”* Finally, advice was given to women to: *“get myself together so I can take care of my kids.”*

Educating—Educating was also discussed as supportive to women: *“gives me a lot of education,”* *“lets me know what school is like,”* and *“shows me things, illustrates things.”*

RESULTS-PART 2: NEGATIVE SUPPORT HARMFUL TO RECOVERY

Nearly all women described networks that included relationships that were, in some ways, harmful to recovery. The following are the resulting themes and corresponding data elements regarding such negative support. (See Appendix A for a visual depiction of themes and sub-themes.)

Excessive Worry About Others

While women mentioned their children as important support network members, they also discussed that extensive worry about their children was not helpful when they were working on their recovery. One woman reported: *“just everything that you have to do with your kids, raising them and guiding them, makes it hard on your recovery because you have a full scale*

day, they also give support.” Another woman stated: “...harder to work on my recovery because I’m worried about my son.” Women experienced difficult emotions knowing that they were not with their children. In addition to their children, women reported worrying about others in their support network more generally and how much other people needed to do for them while they were in treatment: “she’s got so much responsibility, I worry about her.”

Tangible Supports Harmful to Recovery

Many of the tangible supports discussed above were also discussed as negative support that enabled women to continue using. For example, in regard to child care: “*she kept my kids,*” “*watched my daughter,*” and “*took care of my kids while I was using,*” and shelter: “*supplied the place to get high*” and “*gave me place to use.*” These situations were identified as harmful to recovery. Money and avenues to attain money, such as prostitution, were reported as harmful to recovery: “*tricks, money to use,*” “*men that I tricked with,*” and “*gave money to use,*” which was a phrase reported multiple times by the women in this study.

Unsupportive Messages/Information

Women reported that network members criticized them and sent messages experienced as unsupportive to their recovery. Some examples of critical remarks were: “makes me feel down and less than them,” “putting me down...makes me feel bad about myself,” and “negative, asking why I couldn’t just get a job, said I could quit without coming to this program.” Women perceived some network members’ actions as discouraging: “makes me feel I have no chance in staying sober,” “blames me for not staying clean,” and “not enough trust, afraid of relapse, afraid of my past.” Finally, one woman reported: “people in projects criticize you, don’t want you to have anything better than them...” which suggested that some participants heard criticism in the communities they returned to after leaving treatment.

Unsupportive Relationships

Women discussed dimensions of relationships with network members that made recovery from addiction more difficult. For example, male network members, some of whom were boyfriends, “come around” when they were not supposed to and invited others to use with them: “I’d be not thinking about getting high, he’d say ‘come on let’s go’ even though he knew I was trying to stay straight. He said ‘if you love me, you’ll do this,’ and ‘he tries to come around when he is not supposed to, he is not supportive, he has said he wishes I would relapse.’” Also, women discussed how female friends or partners also invited using and not staying in treatment: “she’s always calling me and asking where she can get some weed” and “*she wanted me to drop out of my drug rehab program.*” Support network members also engaged women in remembering their traumatic pasts, sometimes when they did not want to: “he wants me to live in the past, he keeps bringing up my past, my past relapses, he thinks I’m going to fall back into the same pattern,” and “not enough trust, he’s afraid I’m going to do the wrong thing, afraid of relapse, afraid of my past.” Thus, relationships with individuals that do not allow for future change may make recovery increasingly difficult for women to realize.

Women also spoke eloquently about how network member’s lack of understanding made recovery difficult: “she is just stuck in her ways...she is angry and doesn’t understand the disease:” “not understanding why I’m doing this, he’s selfish and thinks it’s about him when it’s not,” and “constantly come around when they know I am in recovery...they don’t understand so I have to shut them out.” Finally, women discussed how relationship conflict was difficult to manage while in recovery: “ex-boyfriend...he likes to argue and puts pressure on me,” “father of child, argues with me, makes me feel I am not doing my best,” and “*takes my focus, we argue too much.*”

Community of Use

Data from the present study revealed that women exist within a network of complex support relationships and a dense community of drug users. The data clearly illuminate the potential barriers to sustained recovery for low-income women. For example, comments such as: “we got high together,” “used with me,” “mother gave me my first drink, my first drug, my first hit of marijuana,” “cousin, she took me out and we went to bars,” “she be using bad, makes me feel funny, seeing someone else do it when I’m trying to recover,” “drug associate, introduced me to crack,” “person I got high with, they would drive me to get the drugs,” “ex-boyfriend would come around, do drugs, was a dealer,” “old boyfriends, they would buy drugs for me, and “*dad, smoke with him*,” highlight the complexity of attempting to maintain sobriety when close family and friends are engaged in substance abuse behaviors. For many of these women, family members and old friends in their social networks were still using.

Another difficulty of returning to a community of use was articulated by women through statements about easy access to drug dealers and exposure to drug users in the community. Women reported that drug dealers came around offering to sell drugs: “*come to my house, ask if I want to buy anything*,” and “*because they are close to where I live*.” Close proximity to dealers may make maintaining recovery all the more difficult. Women also reported that network members made it hard to work on their recovery because they allowed contact with individuals that were using: “*he lets his weed-smoking friends come over*,” and “the dope guys come onto the pizza shop and he won’t make them leave.” Drug dealers and people using in the community make it difficult for women in recovery.

Women also reported that network members gave them a place in the community to use: “*gave me place to use*,” and “*supplied the place to get high*.” This revealed that women had relationships with network members that could easily provide them with a place where they could use drugs together.

Finally, women reported that within their social network and the larger community, individuals were not helping them quit, but instead were urging them to use. For example, one woman stated about a network member: “talked to her about using when they got done with the treatment program, frequently urged me to use.” Others reported: “he let me use when I was pregnant,” “urged me to use, put ideas in my head even when I was trying to stop,” “he parties himself and so he doesn’t help me much, he doesn’t push me much to do what is right,” and “sister would urge me to ‘try one line’ and things like that.” Recovery from the physiological and psychological pull of addiction is difficult without these added layers of temptation, which were thrust upon the women in the present study by their identified social network members.

DISCUSSION

Results of the present study extend classic social support concepts, such as emotional, tangible and informational support, by contextualizing these types of support to the experiences of a group of women in treatment for substance use disorders. Further, additional themes emerged in this dataset that expand our thinking about personal social networks within the context of women who have struggled with addiction and within communities associated with their addiction. Consistent with previous literature on social support (Barrera & Ainley, 1983), the women in this study clearly described supportive actions of their network members that fall into the categories of emotional, informational and tangible support. Yet some elements of support as narrated by these women appear to be unique and best understood in the context of being embedded in a community of substance use. For example, while emotional support was reported as consisting of the expected supportive behaviors of encouragement, listening, caring, and consistency in relationships, “being there” and “making sure” (the women had what they needed to stay on track), were also viewed as emotionally supportive. In some ways, these

socially supportive behaviors can be thought of as combinations of types of support. Descriptions of “being there” and “making sure” combined elements of tangible, informational and emotional support (e.g., “*making sure I get to an appointment*” and “*always there to give me advice*”). “Talks to me” which was a frequently reported component of emotional support also involved giving direct advice and information (e.g., “telling me what I need to hear, not what I want to hear”). Further, some forms of informational support, such as teaching coping skills, combined the giving of advice and information with recognition and validation of emotions. Some forms of tangible support such as “*took me to meetings*” combined elements of information and advice.

Findings from this study are consistent with previous research documenting the positive and negative aspects of personal social networks of women in treatment and the potential roles network members may play in both use and recovery (Laudet et al, 1999; Savage & Russell, 2005). Some network members and specific forms of support they provided, such as “tangible support,” were described as simultaneously helpful and harmful to recovery. For example, network members both took care of children while mothers used and helped care for children while mothers attended treatment programs. Further, “*offering a place to stay*” was perceived as something that may help get someone “*off the streets*” or give them a “*place to use*.” Money was also a tangible type of support that was helpful to recovery, as was noted above, but also enabled women to use: “*the money to get high*” and “*she gave me money to get drugs*.” This dual role of some forms of network support highlights a potential reason it may be difficult for women, particularly low income women, to maintain their sobriety.

The data also reflect the negative impact of substance using network members and the difficulties created by conflictual relationships, as suggested by Lincoln (2000). For example, some supportive people also created emotional strain, such as excessive worry. Informational support in the form of criticism was described as harmful to women's recovery, resulting in difficult feelings. Women also discussed many dimensions of unsupportive relationships and messages that were harmful to recovery. Negative relationships with some network members could potentially add additional stress to the process of maintaining sobriety.

Overall, these findings highlight the fact that network members' actions can fulfill multiple functions and differing forms of support for women in treatment and that a variety of network behaviors are important to assess and evaluate. While research has typically focused on the potential for sobriety support (Warren, Stein, & Grella, 2007) or overall levels of support (Dobkin et al., 2002) that influence treatment outcomes, recent research has begun to examine the differential impact of types and sources of support. For example, Lewandowski and Hill's (2009) study of the impact of emotional and material support on women's drug treatment completion found that social support could have positive or negative effects, depending on the type and source. Perceived emotional support from family members was more predictive of treatment completion than material support from family members, partners, or government assistance programs. Women reporting higher levels of emotional support from friends were also more likely to complete treatment. More research examining the differential impact of various types and sources of support could be helpful in informing network interventions. The findings of this study suggest that we expand our thinking about the categories of social support and begin to gain a deeper understanding of the particular ways in which network members help.

In terms of practice implications that might be drawn from the above findings, social work practitioners, given their person-in-environment focus, may relate to the finding that substance abusing women are often embedded in networks that help and harm them at the same time. Reducing contact with network members who continue to use or who are not supportive of sobriety is viewed as difficult to achieve in the context of recovery, particularly when they may

be family members or partners who provide other essential types of support, such as child care and/or transportation. Tangible supports like a place to use, money to use and child care were discussed by women in this study as help that enabled them to continue their addiction. One approach may be to incorporate strategies for helping women cope with their inevitable return to a network and community of use. Practitioners could routinely ask women questions about their social networks to more clearly assess what network members do to either help or hinder the treatment process. Another strategy may be to integrate social network members into treatment program modules in order to build on positive aspects that are supportive of sobriety. While many substance abuse treatment programs find it difficult to engage family members in women's treatment, the women in this study suggested a number of simple tasks, such as "brings things" "doing for" and "doing with," that may contribute to feeling supported. Given the often important social functions of substance use, these findings are reflective of the fact that social functions served by substance using networks need to be replaced if women are to stop use and maintain sobriety (Alverson, Alverson, & Drake, 2001).

The women in this study also revealed how some network members facilitated their access to and use of helping services and encouraged them to remain in and complete their treatment program. This is consistent with the network-episode model and the crucial role of network and community ties in pathways to services (Pescosolido, 1992; Pescosolido, Gardner, & Lubell, 1998).

Talking and listening were important aspects of support for women in recovery in this study. Network members who were viewed as supportive of recovery were valued for their willingness to talk directly to the women about the latter's difficulties, and the need for change in their lives. Based on these findings, network members might benefit from interventions in order to enhance their ability to provide support for recovery. Kidorf et al. (2005) conducted an intervention to involve significant others in a methadone maintenance program and found that 78% of the clients who participated in the social support intervention achieved at least four weeks of abstinence. Women in this study responded more favorably to this intervention than did the men. Litt, Kadden, Kabela-Cormier, and Petry (2009) reported positive outcomes for a social network intervention in a randomized control trial. Their findings indicated that "network support treatment" (p.229) to change the network from one that supports drinking to one more supportive of sobriety could significantly contribute to improved outcomes over a two year period.

Tangible help was also valued as supportive of recovery. Help with child care, transportation to meetings, and taking care of personal business allowed women to focus on their treatment program. It may be beneficial for treatment programs to facilitate such help, either through incentives for family members to help in these ways or through volunteer services. In a similar vein, contact and keeping in touch during treatment were viewed as supportive of treatment. Visiting the women while in treatment was frequently mentioned as a way to stay connected with family members, as well as demonstrating endorsement of the women being in treatment. Treatment programs might consider how best to maintain open access for family members while a woman is in treatment.

The women in this study reported a number of barriers and constraints in their lives in regard to maintaining sobriety upon return to the community. Thus, a relapse prevention curriculum that considers the context of women's lives (e.g., lack of resources, need for child care, difficult housing situations, relatives and partners who continue to use, and neighborhoods of use) could be meaningful and relevant to their recovery. (See Sun, 2009, for a description of comprehensive women's treatment programs.)

Study Limitations

The practice implications suggested above are best viewed in the context of the study's limitations. These data were not analyzed to determine if dual disorder status influenced perceptions of support networks or the types of support exchanged. (See Tracy & Johnson, 2007, for a discussion of social networks and dual disorders). Nor were the data in this study analyzed in terms of which network members provided which types of support. Therefore, another limitation is not being able to parcel out or distinguish support provided by family and friends versus professional counselors or therapists. Additionally, the data were derived from a cross sectional study and therefore it was not possible to determine the ways in which support networks may change over time or the manner in which networks may contribute to treatment outcomes. Further, generalizability is limited to women enrolled in treatment programs from one Midwestern city.

CONCLUSION

Sarason and Sarason (2009) summarized the gaps in our knowledge of social support in stating that no one definition is clearly agreed upon and that the mechanisms by which social support exerts its influence and the factors that moderate its effectiveness are not fully understood. Future longitudinal research, therefore, should examine changes in social networks and social support over time in relation to a variety of outcomes. In addition, research should examine types of support, including multiple or blended forms of support provided by different network members, and be able to identify differences in support provided by informal and professional helpers. More intervention research is needed on the sequence and intensity of social network interventions, including the method and timing of delivery. Such research could identify and examine differential outcomes of various types and sources of support. We also need more information on whether network interventions need to be matched to the stage of treatment or stage of change. For example, perhaps certain types of support may be found more or less helpful depending on the stage of treatment or recovery. In spite of these needs, the nature of the qualitative data collected do offer us a more nuanced reflection of categories of social support and direct our attention to practice approaches that may lead to optimal community integration and a more enduring recovery for women with substance use disorders.

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Appendix A

1. .

Conceptualization of Data for Views of Social Support for Women in Recovery

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TABLE 1

Description of Sample (n=86)

	M(SD)	Range	N	%
Age	33.9 (8.39)	21–55		
Race				
African American			70	81.4
Of Latin Origin			2	2.3
White			14	16.3
Education				
Elementary/Junior High or less			42	48.8
High School/GED			39	45.3
Vocational Technical/Associate			5	5.9
Marital Status				
Married			4	4.7
Separated			4	4.7
Divorced			16	19
Never Married			62	72
Living with Someone			65	76
Number of Children				
0			8	9.3
1			15	17.4
2			14	16.3
3			15	17.4
4			14	16.3
5 or more			20	23.3
Months Employed Full-Time (past year)			26	30.2
Months Employed Part-Time (past year)			24	27.9
Substance Use Disorders				
Alcohol Dependence			44	52
Cocaine Dependence			49	58
Marijuana Dependence			24	28
Mental Disorder			48	56
Major Depressive Episode			35	41
PTSD			24	28
Manic Episode			18	21
Generalized Anxiety			12	14

Note: Numbers of disorders do not add to 100% because women may have had more than one disorder