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Social Adjustment of Women With and Without a Substance Abusing Partner

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Abstract

Little normative information is available about the psychosocial functioning of women who have a substance abusing intimate partner. This study examined whether the social adjustment of women who indicate that they have a substance abusing partner ($n=69$) is compromised relative to that of women who indicate that their partner does not abuse substances ($n=68$). Women with a substance abusing partner reported compromised social adjustment relative to a comparison sample both overall and in five of six life domains (work, social/leisure, primary relationship, parental, family). Results suggest the potential benefit of expanding the focus of research and treatment to include effects and outcomes for these women and to influence treatment-related policy.

Keywords

Concerned significant other; family members; women; social adjustment; substance abuse

INTRODUCTION

The negative impact of having a family member with a serious mental health issues or chronic illness is well documented. Literature reviews consistently point to the physical, emotional, financial, and interpersonal toll that people with serious mental health issues (Savage & Bailey 2004) and chronic illnesses (Petrie, Logan, & DeGrasse 2001) have on their loved ones who are often spouses or cohabitating adults. The stress that these

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individuals experience may be particularly acute in comparison to the stress experienced by other family members (e.g., siblings and parents), given that their role with the loved one is more likely to be that of both direct and indirect care provider (e.g., monitoring medication adherence; taking full responsibility for paying bills and childcare). Furthermore, the type of mental health or physical illness may affect various aspects of the spouse's life differently (Baanders & Heijmans 2007).

Substance abuse has been identified as a chronic illness (McLellan 2002; Saitz, Larson, LaBelle, Richardson, & Samet 2008) and research suggests that the behaviors exhibited by substance abusers negatively affect the lives of their family members and intimate partners. Family members with a substance abusing loved one report difficulties in life domains such as emotional and physical wellness, finances, and involvement with the legal system (Benishek, Kirby, & Dugosh 2011; Iwen, Bischof, Reinhardt, Grothues, Hapke, John, Freyer-Adam, & Rumpf 2010; Morita, Naruse, Yoskioka, Nishikawa, Okazaki, & Tsujimoto 2011; Ray, Mertens, & Weisner 2009). More specifically, spousal substance abuse has a detrimental impact on family functioning (Hussong, Huang, Curran, Chassin, & Zucker 2010; Johnson 2001; Orford et al. 2001) with the severity of that substance abuse differentially impacting the family unit according to the coping ability of the non-alcoholic partner, the extent of outside stressors, and the degree of the alcoholic family member's pathology (Moos & Moos 1984; Orford, Templeton, Velleman, & Copello 2005).

Irrespective of gender, it is widely documented that spousal/intimate partner substance abuse is associated with relationship difficulties for the non-substance abusing partner. These difficulties include relationship dissatisfaction (Fals-Stewart, Birchler, & O'Farrell 1999), enabling behaviors (Rotunda, West, & O'Farrell 2004), negative communication styles (Kelly, Halford, & Young 2002), and interpersonal violence (Foran & O'Leary 2009; Langenderfer 2013; Moore, Stuart, Meehan, Rhatigan, Hellmuth, & Keen 2008).

Research focusing on women with substance abusing partners has also identified a range of difficulties, including less emotional attachment and greater desire for intimacy with their partners (Carroll, Robinson, & Flowers 2002), increased risk to contract HIV (Fals-Stewart, Birchler, Hoebbel, Kashdan, Golden, & Parks 2003), a sense of insecurity, financial difficulties, psychological abuse, (Tiwari, Srivastava, & Kaushik 2010), and interpersonal violence (Moore et al. 2008). As a whole, this research indicates that substance abuse is associated with deterioration of family functioning in general and specifically in marital relationships.

There are three notable deficiencies associated with the extant literature on the impact of having a substance abusing partner has on wives. First, the majority of this research focuses on alcohol abusing partners and not those who abuse illicit drugs (e.g., Cranford, Floyd, Schulenberg, & Zuker 2011; Langenderfer 2013). This is relevant given that 3.9 million people in the United States are classified as abusing or dependent on illicit drugs but not alcohol (U.S. Department of Health & Human Services 2009).

Second, there is limited research examining the extent to which partners of both alcoholics and illicit drug users experience impaired social functioning relative to non-clinical

populations. For example, Dethier, Counerotte, & Blairy (2011) found lower levels of marital satisfaction and self-esteem among 15 wives of alcoholics in comparison to their 15 matched counterparts who did not have an alcohol abusing husband. Based on a larger sample size of 100 wives of alcohol dependent men and a comparison sample of 100 non-alcoholic spouses, Tiwani and colleagues (2010) found that the wives of alcohol dependent husbands reported higher levels of physical and sexual abuse, as well as emotional and financial problems. A large-scale U.S.-based epidemiological study of 11,683 women found that women whose intimate partners were alcohol abusers were three times more likely to report multiple victimizations (e.g., beatings, muggings, forced sex) and mood disorders, and two times more likely to report multiple physical injuries, anxiety disorders and fair to poor health in comparison to women who were not involved with a substance abusing partner (Dawson, Grant, Chou, & Stinson 2007).

Finally, the extensiveness and range of specific problems reported by these wives suggests that these difficulties will also impact their ability to function in a variety of broader life contexts. However, little is known about the degree to which their broader life functioning roles (such as in their work, social activities, parenting roles) is compromised in comparison to those who do not have a substance abusing partner. Moos and colleagues (1982) found that demographically matched community samples of husbands and wives of both recovered and relapsed alcoholics reported having a smaller number of informal social contacts in the past month in comparison to a community sample of spouses. Furthermore, data collected at a two-year follow-up indicated that there was less family cohesion, expressiveness, and involvement in recreational activities among the spouses of relapsed alcoholics in comparison to the spouses affiliated with the community control sample and the spouses whose partners were in recovery (Moos & Moos 1984).

More recently, Hudson and colleagues (2002) found that wives and mothers of illicit drug users had significant impairment in social functioning relative to two community comparison samples. This study was important given that it provided initial data identifying general functional impairment of female family members of both alcohol and illicit drug users that extends beyond their immediate familial relationships into areas such as work, social/leisure, and extended family. One limitation of this study, however, was its use of previously published data as the source of the comparison groups: data derived from a community mental health catchment area (Weissman, Prusoff, Thompson, Harding, & Myers 1978) and data from a study of women with bulimia nervosa (Rorty, Yager, Buckwalter, & Rossotto 1999). Data from these comparison samples were of limited utility because they either did not provide a contemporary comparison group or were geographically mismatched.

The purpose of the current study was to address these three limitations and examine whether female partners' social adjustment differs from that of a community comparison sample overall and in six specific life role domains. We hypothesized that the overall social adjustment, as well as the adjustment in six domains, would be poorer among a sample of women who had a substance using partner relative to the comparison sample of women who reported they did not have a partner with a substance use problem. This study expanded upon prior research examining social functioning of female partners of drug users by

comparing their functioning to that of a concurrently collected and geographically similar comparison sample. As with Hudson et al. (2002), it utilized a standardized and comprehensive measure that examined functioning not only within the immediate family, but also in a range of other life contexts and, importantly, it included the partners not only of alcoholics, but also of less frequently studied illicit substance users.

METHODS

Participants and Recruitment

Participants ($N = 137$) were comprised of two distinct groups of women: 69 spouses and partners of substance abusers (i.e., CSOs; concerned significant others) and 68 comparison participants recruited from the community who indicated that their spouse or partner did not have a substance abuse problem (i.e., CSs; community sample). To be eligible, all participants needed to be 18 years or older, have known their partner for a minimum of three months, have had contact with him on at least 12 of the past 30 days, and not have an alcohol or drug use problem themselves as measured by DSM-IV substance use disorder criteria.

The CSO sample consisted of women who reported on the screening questionnaire that they were concerned about a spouse or partner that had had a current drug use problem. CSO recruitment and data collection occurred in conjunction with a large study designed to develop an instrument to assess the life problems experienced by drug abusers' family members (Benishek, Dugosh, Faranda-Diedrich, & Kirby 2006). The CSO sample was recruited primarily through advertisements for participation in a study of the problems faced by family members of substance users. The advertisements, which clearly did not offer treatment, were placed in local newspapers and at other public areas (e.g., shopping areas). Several CSO participants (<10%) were recruited through family psychoeducational programs at drug and alcohol abuse treatment facilities where their spouse/partner was receiving treatment.

The CS sample of women reported on the screening questionnaire that they did not have a substance abusing spouse, partner or other immediate family member. This sample was recruited from public places (e.g., shopping areas, parks, subway stations) and employee pools associated with mental health treatment center workplaces. No data are available on the number of women approached and the percent who declined participation.

Procedures and Measures

Women in the CSO sample completed an initial telephone screening to confirm their eligibility to participate in the larger NIDA-funded study. If appropriate, they were scheduled to complete the consent process and a second screening to reconfirm study eligibility. These participants then completed a baseline assessment which included a descriptive information form, the Social Adjustment Scale-Self-Report (SAS-SR) questionnaire (Weissman & MHS Staff 1999), and the Significant Other Survey (SOS; Benishek et al. 2006). A subset of the participants also completed the drug and alcohol

section of the Addiction Severity Index (ASI; McLellan, Luborsky, O'Brien, & Woody 1980), reporting on their partner's drug use.

Women in the CS sample were approached by the lead author (CH) and invited to learn about the study. Interested participants provided informed consent, completed eligibility screening and, if eligible, completed the descriptive information form and the SAS-SR.

CSO participants received \$70 for completing the screening, consent, and assessment package which included several questionnaires in addition to the ASI and the semi-structured interview for the primary instrument development study (i.e., the SOS). CS participants received \$5 for completing a significantly briefer assessment package. All procedures were approved by the Treatment Research Institute, the Philadelphia Department of Public Health, and the Temple University institutional review boards.

Social Adjustment Scale-Self-Report (SAS-SR)—The SAS-SR (Weissman & MHS Staff 1999) is comprised of 54 items that yield an overall social adjustment score and six life-role scores based on life events that the person has experienced in the past two weeks. The content areas include: work (as a paid employee, 6 items, e.g., arguments at work; unpaid homemaker, 6 items, e.g., ability to complete housework; student, 6 items, e.g., ability to keep up with schoolwork), social and leisure (11 items; e.g., time spent on hobbies), extended family outside the home (8 items; e.g., letting relatives down), primary relationship (9 items; e.g., arguments with partner), parental role (4 items; e.g., arguments with child), and family unit (4 items; e.g., letting down partner child). It has been used with both clinical and non-clinical populations including significant others (Goldman, Skodol, & Lave 1992; Weissman & MHS Staff 1999). Participants did not complete items that were not applicable to their life situation (i.e., women with no children did not complete parenting items). Items are based on a five-point Likert-scale with higher values being indicative of poorer social adjustment. The overall adjustment and specific content areas are calculated by adding the scores associated with each item answered and then dividing by the total number of those items. Items that are not applicable are not included in the denominator. The SAS-SR has good internal consistency reliability (.71–.85) and test-retest reliability (.72–.82), as well as good concurrent, external, predictive and discriminant validity (see Weissman & MHS Staff 1999 and Weissman, Olfson, Gameroff, Feder, & Fuentes 2001 for a review).

Significant Other Survey (SOS)—The SOS (Benishek et al. 2006) is a semi-structured interview that asks significant others of substance abusing individuals about problems experienced in seven life areas (e.g., emotional, relationship, family, financial, physical violence, legal, health). The SOS demonstrates good internal reliability for six of the seven life areas, as well as good inter-rater agreement and test-re-test reliability (Benishek et al. 2006).

Addiction Severity Index (ASI) Drug and Alcohol Section—The ASI (McLellan et al. 1980) Drug and Alcohol Section assesses lifetime and recent use (past 30 days) of 10 drugs or drug categories, alcohol use, alcohol use to intoxication, and polysubstance use. Additional questions focus on past treatment for drug and/or alcohol problems, amount of money spent on substance use, and other questions that allow determination of the primary

substance of abuse and severity of problems. There is evidence of good convergent validity for the ASI recent drug and alcohol use indices (Alterman, Cacciola, Habling, & Lynch 2007) and high level of agreement with collateral reports (Weiss, Greenfield, Griffin, Najavits, & Fucito, 2000).

Study Design and Data Analysis

Given the difficulty obtaining uniform participant demographic characteristics in an observational study, propensity scores are often needed to reduce between-group bias caused by non-random treatment assignment. In the propensity score method, all covariates that are confounded with group membership and influence the outcome are reduced into a single score. This score represents the probability of group assignment conditional on observed demographic characteristics (Rosenbaum & Rubin 1983).

A propensity score is the conditional probability of participant membership in the CSO group, given the characteristics of that participant (e.g., age, years of education, income). Propensity scores ($\hat{p}$) are calculated with logistic regression, where p is the predicted probability of belonging to the CSO group. Essentially, the individual differences between both groups are eliminated so that the only remaining between-group difference is the identified variable of interest (i.e., whether or not the participant reported having a substance abusing partner). Assuming that no other confounders exist, matching on propensity scores mimics a randomized controlled assignment and allows for stronger conclusions to be drawn. Propensity scores have been used to analyze non-experimental data in both the social science and medical fields (Morgan & Harding 2006; Weitzen, Lapane, Toledano, Hume, & Mor 2004).

SAS 9.2 was used to conduct the analyses—The estimated propensity scores were used to construct weights in a weighted least squares (WLS) regression, with group affiliation (CSO/CS) as the independent variable. Participants in the CSO group were assigned a weight of $1/\hat{p}$, and the CS participants were assigned a weight of $1/(1 - \hat{p})$. Weighting each participant in this manner corrected for variable bias (Rosenbaum 1987; i.e., between group differences on the demographic characteristics). A non-parametric WLS regression based on the outcome ranks was then used for the seven social adjustment scores (i.e., overall score; work, social and leisure, extended family, primary relationship, parental, and family unit scores) since the social adjustment scores were positively skewed and efforts to normalize the data using various power transformations were not successful.

A Bonferroni correction was used to adjust for Type I error rates given that seven hypotheses were tested; $p < .007$ indicated statistical significance. Effect sizes are not reported since it is not appropriate to do so with nonparametric analyses (i.e., ranked scores in the WLS regressions), given that they are adversely affected by departures from the assumptions of regression, particularly deviations from normality or non-homogeneity of variance (Leech & Onwuegbuzie, 2002).

RESULTS

CSO and CS Characteristics

Table 1 indicates that, overall, the participants tended to be 39 years old (range = 18 – 85 years), educated beyond high school, employed, non-Hispanic or Latino, and living with their spouse or partner. Relative to the CSO sample, the CS participants were more likely to be more educated, higher in median income, white, currently married, and living with their spouse or partner.

Just over half (59%) of the CSOs reported that their spouse or partner was the only member of their immediate family who currently had an alcohol or drug problem, while the remainder reported having between one and five additional family members with such problems. Approximately half of the CSOs (52.2%) reported that their partner's primary drug of abuse was cocaine, 29% alcohol, 10.1% heroin, 5.8% other opiate/analgesics, and 2.9% marijuana. Data on the mean number of days of use in the past 30 days for primary substances of abuse for the substance users were collected from a sub-sample of CSO wives ($n = 29$). The mean number of days of use suggests problematic use: alcohol use to the point of intoxication ($Mn = 19.53$ days; $SD = 9.04$), heroin ($Mn = 15.75$; $SD = 5.06$), and cocaine ($Mn = 17.44$; $SD = 9.80$).

Social Adjustment Comparisons

After applying the Bonferroni correction, the WLS non-parametric regression found significant differences between the CSO and CS groups for six of the seven social adjustment scores. CSOs reported poorer overall social adjustment [$F(1, 123) = 15.25, p < .0002$], work [$F(1, 76) = 10.06, p < .002$], social and leisure [$F(1, 123) = 18.73, p < .0001$], primary relationship [$F(1, 116) = 17.47, p < .0001$], parental relationship [$F(1, 65) = 8.10, p < .005$], and family unit [$F(1, 122) = 9.83, p < .002$] scores. There were no statistically significant differences between CSO and CS participants on extended family scores. Table 2 contains the means, medians, and standard deviations associated with the overall social adjustment and subscale scores for the CSO and CS participants.

DISCUSSION

The results of this study supported our primary hypothesis that the overall social adjustment, would be poorer among a sample of women who had a substance using partner relative to a comparison sample of women who did not have a partner with a substance use problem. They also largely supported the secondary hypotheses in that CSOs reported compromised social adjustment relative to that of the CS participants in 5 of 6 domains: work, social/leisure, primary relationship, parental, and family. The between group differences noted in this study are similar in magnitude to differences reported in other studies comparing community and clinical samples (e.g., bipolar disorder, Cusi, MacQueen, McKinnon 2010; mood disorders, Pendse, Ojehagen, Engstrom, & Traskman-Bendz 2003; schizophrenia, Weissman & MHS Staff 1999) and the medium to large effect sizes we observed suggests the differences are also clinically meaningful.

This study's findings partially replicate the results of Hudson et al. (2002) that reported differences between CSOs and community samples with regard to overall social adjustment and in the work and social/leisure domains. However, the present study also found differences in three domains that were not analyzed in the earlier study: primary relationship, parental role, and family unit. The findings of both studies suggest that CSO impairment was present both within family roles and in more distal aspects of the women's lives (e.g., work, social/leisure activities); however, the data in the current study were collected at the same time and from the same geographical area, providing stronger evidence than Hudson et al. (2002). Interestingly, the current study did not replicate the 2002 finding that CSO functioning in the extended family domain was compromised relative to a community sample. One possible reason for this was that CSOs in the previous study were treatment-seeking (i.e., interested in receiving help in dealing with a treatment-resistant substance using loved one). In contrast, the CSOs enrolled in this study were not seeking treatment and their partner may or may not have been in treatment.

Limitations and Future Research

This study has several limitations. First, given the variability in the number of additional substance using immediate family members and multiple recruitment methods, skewed social adjustment scores, and small n's for some domains, it is possible that CSO participants were selected from more than one sampling frame and may not be representative of the broader population of partners of substance users. Limiting the sample to wives/female partners also restricts our ability to generalize from these results to husbands, male partners, or other family members. Second, the cross-sectional design does not permit casual inference. Finally, the CSO and comparison samples were similar in age, employment, and ethnicity, but they were different with respect to other demographic variables. Even though a propensity score analysis was used to reduce between-group bias (cf. Rosenbaum & Rubin 1983), this may not have completely corrected for these differences.

Future studies should include both male and female spouses and partners, as well as other family members (e.g., parents, siblings). Large randomly selected samples with standard recruitment procedures might reduce the likelihood of extraneous differences between the two groups and facilitate the identification of moderators between the social adjustment of partners and the loved one's substance use (e.g., legal versus illicit drugs; alcohol versus other substances) or severity of abuse.

Clinical and Policy Implications

Unfortunately, recognition of the problems faced by female partners of substance abusers has lagged behind our recognition of the problems of the substance-abusing individual. Our findings suggest that it is important to provide these women with therapeutic interventions; however, the extent to which the interventions need to directly focus on the woman's social adjustment is not clear. For example, Community Reinforcement and Family Training (CRAFT; Smith & Meyers 2004) is an approach that is designed for people who are concerned about a treatment-resistant loved one. The focus of CRAFT is on teaching CSOs ways of modifying their behavior toward the substance abuser, although some sessions

directly address the well-being and functioning of the CSO. Prior research has found that partners with compromised social functioning are able to engage meaningfully in the intervention (Kirby, Marlowe, Festinger, Garvey, & LaMonaca 1999), increase the likelihood that their spouse will engage in substance abuse treatment, and experience improvements in their own depression, anxiety, anger, and social functioning (e.g., Dutcher, Anderson, Moore, Luna-Anderson, Meyers, Delaney, & Smith 2009; Kirby et al. 1999; Meyers, Miller Smith, & Tonigan 2002). Similarly, Behavioral Couples Therapy and Family Behavior Therapy are two interventions that focus on improving the substance use outcomes of the substance-using spouse, but also result in better relationship and family functioning (Carroll & Onken 2005; Klostermann, Kelley, Mignone, Pusateri, & Wills 2011). However, the extent to which improvements in functioning in these two life areas may lead to improvements in other areas of social functioning for the spouse without the substance use problem is less clear. It has been noted that Behavioral Couples Therapy can be modified when either spouse has significant emotional difficulties (O'Farrell & Fals-Stewart 2006), suggesting that in some cases, focusing on the substance use and the relationship may not be sufficient. Individual or couples treatment focusing on the sober spouse's problems may be particularly important for wives who experience substantial social functioning impairments.

The current practice of substance abuse treatment has an almost exclusive focus upon the drug using individual, despite the existence of ample empirical support for marital and family treatment approaches to this problem (e.g., Copello, Velleman, & Templeton 2005). Furthermore, family members of substance abusers are often stigmatized and marginalized by the treatment community (Orford, Velleman, Natera, Templeton, & Copello 2013). Unfortunately, while most community-based treatment programs report that they offer family or couples counseling (Fals-Stewart & Birchler 2001), many of these interventions appear to involve a family disease or psycho-educational approach rather than actual family therapy. For example, in a survey of 1,709 patients from nine treatment programs, only 2% reported receiving family services even though 66% reported a need in this area (Pringle, Emptage, & Hubbard 2006). When 398 randomly selected community-based drug and alcohol treatment program administrators in the United States were asked why they did not use empirically-supported Behavioral Couples Therapy, reasons included the unwillingness of public funding agencies and managed care companies to support this intervention (Fals-Stewart & Birchler 2001). Only when the social and financial impact of substance use on family members is better understood and recognized can we develop appropriate policies regarding the provision and financing of interventions to benefit the entire family rather than just the substance abusing individual.

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Table 1

Participant Demographics

Characteristic	Total Sample	Statistic			
		CSO	CS	F/ χ^2	df p
Age (X)	39.3	40.8	37.6	3.06	1,134 .082
Years Education (X)	14.4	13.7	15.1	10.44	1,135 .002
Currently Employed	60.6	56.5	64.7	.96	1 .327
Household income (Mdn)	36K	29K	62K	22.12	1,125 .0001
Ethnicity (% Hispanic/Latino)	3.7	1.4	5.9	1.91	1 .167
Race (% white)	51.8	24.6	64.7	22.26	1 .0001
Currently married (%)	55.5	44.9	66.2	6.26	1 .012
Living with spouse/partner (%)	87.6	75.4	100	19.13	1 .000

Note. Concerned Significant Other Sample (CSO) $n = 69$, Comparison Sample (CS) $n = 68$. Bolded values indicate $p < .05$.

Table 2
Descriptive Statistics of SAS-SR scores for the Comparison and Concerned Significant Other Samples

SAS-SR Domain	Comparison Sample			Concerned Significant Other Sample		
	n	Mean (SD)	Median	n	Mean (SD)	Median
Overall Social Adjustment**	68	1.60 (.25)	1.60	69	2.06(.49)	2.00
Work*	43	1.29 (.29)	1.17	40	1.58(.68)	1.50
Social & Leisure**	68	1.78 (.43)	1.67	69	2.19(.52)	2.11
Extended Family	67	1.57 (.36)	1.50	67	1.88(.59)	1.75
Primary Relationship**	68	1.64 (.39)	1.56	60	2.40(.72)	2.33
Parental Relationship*	32	1.17 (.23)	1.00	43	1.56(.59)	1.50
Family Unit*	68	1.58 (.52)	1.50	68	2.32(.96)	2.00

Note.
* indicates $p \leq .005$,
** indicates $p \leq .0002$.