"IT'S JUST ME ON MY OWN.":

CONDITIONS AFFECTING SOCIAL SUPPORT AMONG WOMEN WHO USE DRUGS

by

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ABSTRACT OF THE DISSERTATION

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The concept of social support has played an important role in public health research. Past

research suggests that when individuals receive help, mental and physical stress is

lessened, health outcomes are improved and even the possibility of negative health is

warded off. However, research on social support among persons who use drugs at risk

for HIV is mixed in regards to the positive benefits of social support given that structural,

institutional and interpersonal factors may complicate whether and how support is sought

or received. To develop more effective interventions to decrease drug use and risk for

HIV, it is important to better understand the role of social support in women's lives. This

dissertation explores the conditions that affect support seeking, receiving, and providing

among women who use drugs. Using qualitative life-history interview data drawn from

25 drug-involved women in New York City, 15 of women are mothers, I investigate two

main areas of women's lives: recovery efforts – trying to become or stay drug-free and

relationships with their children. Using grounded theory, interview data were coded and

analyzed using Atlas.ti. Findings from this dissertation suggest that the social context in

which individuals invoke support transactions or avoid seeking support are critical to

understand. Social support may not be available for women who continue to use drugs,

particularly from family members, while in contrast, women may have no supportive

relationships separate from drug-involved relationships. Policy implications from this

dissertation suggest a holistic, family-based approach may be more successful to address

patterns of drug involvement and risk for HIV. This dissertation also highlights the

importance of qualitative research for the study of social support more broadly.

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Chapter One: Introduction

The use of crack cocaine, cocaine, heroin, and other illicit drugs continues to pose a significant public health problem. The myriad effects of drug use can include dependence and addiction, HIV/AIDS and other infectious diseases, homelessness, and the disruption of family ties. Research over the past thirty years has revealed many factors that influence drug-involved individuals' recovery efforts and quality of life. However, much of this work has been conducted solely on men, which may have resulted in insufficient knowledge about, and inadequate treatment for, drug-involved women. The present research fills this gap by qualitatively examining factors that affect recovery efforts and quality of life among women who use drugs.

Social support is a particularly important factor influencing drug-involved women's recovery efforts and quality of life. In general, social support plays an important role in shaping stress, health, and well-being. Over the past thirty years, social support researchers have made important contributions to our understanding of the interactions among social relationships, social behavior, and health and well-being (Caplan 1976; Cassel 1976; Cobb 1976; Cohen and Syme 1985; House 1981; Kahn and Antonucci 1980; Vaux 1990). Within drug use studies however, social support has received less attention than other social factors in explanations of women's drug use, risk behaviors, drug treatment, and role as mothers. Nevertheless, social support is an important concept that can shed light on women's drug involvement, dependence and addiction, drug treatment and recovery, risks for infectious diseases such as HIV/AIDS, and the competing demands of motherhood.

Prior research has demonstrated that social support has a positive effect during stressful situations, improving coping and health status (Caplan 1976; Cassel 1976; House 1981). Women tend to both seek out social support during periods of stress and to provide support to others, especially their children. This past research, however, did not consider the impact of women's drug use on the provision or acceptance of social support. Drug-involved women might be less able to provide such support given their drug use, barriers to treatment, and changes that often occur in custodial arrangements because of mother's drug use. However, the limited research on social support among women who use drugs is inconclusive; while some research indicates that social support leads to a positive reduction in risk behaviors and better treatment outcomes (Ellis et al. 2004; Knight et al. 2001; Marsh, D'Aunno and Smith 2000; Nyamathi et al. 1995; Falkin and Strauss 2000; Strauss and Falkin 2001), other research finds the opposite to be true (El-Bassel et al. 2001; Falkin and Strauss 2003; Gregoire and Snively 2001; Havassy, Hall and Wasserman 1991; Nelson-Zupko et al. 1995). Thus, Berkman and colleagues (2000) and Williams and colleagues (2004) argue that it is critical to examine the social contextual and structural factors in which social support operates to understand these contradictory findings.

While social support may be critical for improving women's opportunities for recovery and an improved quality of life, especially in their relations with their children, the factors that affect seeking, receiving, and providing social support are unclear. It is imperative to understand the conditions influencing support transactions (support seeking, receiving, providing) for women's recovery efforts and their life quality. This is

the overall goal of the present dissertation. I focus on exploring the conditions that affect support seeking, receiving and providing among women who use drugs. More specifically, I address conditions that encourage or deter social support in relation to the women's efforts to maintain drug-free status (i.e., to get and stay clean) and to improve their relationships with children.

I used qualitative data drawn from interviews with 25 drug-involved women to identify specific conditions, focusing on two areas of the women's lives: 1) their recovery efforts, that is, trying to become or stay drug-free, and 2) their relationships with their children. I found that three different types of conditions affected social support, which I categorized as structural conditions, institutional conditions, and interpersonal conditions. Structural conditions include neighborhood factors such as access to drugs in the community. Institutional-level conditions revolve around interactions with the criminal justice system, court system, and drug treatment programs. For instance, experiences with different types of treatment programs (mandatory and/or punitive, self-initiated and/or harm reduction oriented) affected the women's motivation to seeking assistance after completion of programs. Institutional conditions also included children's custodial arrangements, which influenced the women's ability to provide social support for their children. Interpersonal conditions referred to the quality of social relationships with friends, family members, and partners, as well as the individuals' assessments of these relationships. Interpersonal conditions that affected support included norms of reciprocity, past and current family histories, and patterns of self-reliance. For example, issues of trust and reliance on

friends and associates for resources, such as housing support, were salient determinants

of whether or not the women sought social support from others. Social support

includes the element of reciprocity, which can be understood as having both positive

and negative qualities. Social support is not necessarily freely provided but exchanged

with constraints and therefore may be refused by provider or receiver. In addition to

the women's own involvement with the drug economy, family histories of involvement

with drugs and crime affected the ability of women to seek resources and compromised

their ability to provide social support, especially for adolescent children. Interpersonal

conditions that led to limited social support resulted in the women relying on self-

support.

Overview of the chapters

In chapter two, I review conceptualizations of social support, tracing the

concept from its earliest use in the sociological and psychological literatures. This

chapter summarizes the social support literature, focusing on key ideas in the field,

including recent discussions on the apparent lack of definitional consensus in the field. I

also describe measurement issues concerning social support and conclude with a

discussion of the unique contributions of qualitative investigations of the conditions that

affect support transactions.

In chapter three, I review the small set of relevant empirical studies within the

field of drug use. In particular, I focus on the measurement and conceptualization of

social support in studies of women who use drugs. In addition, I discuss the importance

of qualitative research for drug-involved women in general, and for studies of social support more specifically.

In chapter four, I provide an overview of the research methods and characteristics of the sample and data analysis for this dissertation. I describe the larger study from which the interviews were drawn and discuss recruitment techniques for hard-to-reach populations. Next, I describe the sample and present specific demographic information. The advantages of qualitative analysis and the coding process are also highlighted.

In chapter five, I examine the conditions that affect how the women of the study sought, received and provided support in efforts to get or stay clean.   This chapter focuses on the women's descriptions of periods of time when they tried to get or stay clean and support transactions during these time periods.

Chapter six focuses on the sub-sample of women who are mothers (15 of the 28 women). In this chapter, I investigate the conditions that affect the women's ability to provide support to their children. In addition, I address the factors affecting the support these women received from others to help care for their children and for their own quality of life.

Finally, in chapter seven, I discuss the implications of the findings of this dissertation for social support and drug use literatures. I also evaluate how the findings presented here can enhance interventions and drug treatment programs and help improve women's relationships with their children.

Chapter Two: Conceptualizations of Social Support

Introduction

> Social support is a multi-faceted concept that has been difficult to conceptualize, define and measure. Although this concept has been extensively studied, there is little agreement among theoreticians and researchers as to its theoretical and operational definition.... The concept remains fuzzy and almost anything that infers a social interaction may be considered social support. Social support researchers have consistently ignored the complexity of the concept and measured the variable in a simplistic manner (Hupcey 1998).[1]

The social support literature is multidisciplinary, vast and ever growing. Over the past

thirty years, researchers have made important contributions to our understanding of

the interactions and connections among social relationships, social behavior and health

and well-being (Caplan 1974; Cassel 1976; Cobb 1976; Cohen and Syme 1985; House

1981; Kahn and Antonucci 1980; Vaux 1990). Early research focused on the positive

relationship that social support, defined as material, informational, or emotional

assistance, has on lessening stress or on the "alleviation of mental distress" (Tucker

1982). Yet, other researchers found that support is more complicated in terms of how it

is used, experienced by individuals, and affects health and well-being. Specifically,

researchers who measure support contend that it can lead to negative outcomes and

that it can even negatively affect health (Stevens et al. 1998; Kahn and Antonucci 1980;

Strauss and Falkin 2000).

Given the varieties of methods of conceptualizing and measuring social support,

the purpose of this chapter is to review central issues raised within the social support

literature and present the grounds for the current focus on the conditions affecting

social support in this dissertation. My focus stems directly from theoretical questions

within the social support literature regarding conceptual and measurement clarity of concepts, and the implications of this ambiguity for the inconsistent empirical findings of the effects of social support on health.

In this chapter, I begin with a brief review of the emergence of the concept of social support in studies on stress. This review draws attention to the main dimensions of social support used in the research. Next, I describe a series of critical appraisals of the concept of social support made over the past thirty years; despite numerous calls for conceptual clarity over the years, these successive appraisals find little increase in clarity.

Overall, this literature review is not exhaustive, but rather a review focused on the specific conceptual issues and questions relevant to my work. This includes taking a step back from studies that focus on quantitative measures of the effects of social support on health and shifting to an exploration of the conditions that affect how individual's perceive and interpret social support seeking, receiving, and providing.

Research on drug use illustrates how research on social support can find both positive and negative outcomes. Some studies, for example, have shown that the presence of social support is associated with lower rates of initiating drug use, lower use of illicit drugs, and lower relapse after dependence and recovery (Coughey et al. 1998; El-Bassel et al. 1998; Huselid et al. 1991; Moos 1984; Wills and Vaughan 1989). Yet other studies have shown that social support leads to an increased likelihood of relapse for drug and alcohol use (El-Bassel and Schilling 1994; Falkin and Strauss 2003; Havassy, Hall and Wasserman 1991). These seemingly incongruous findings have raised questions as

to the contrasting roles and definitions of support in the lives of individuals who use drugs and therefore raise measurement issues for the concept "social support." Thus, it is important to review the concept of social support in order to comprehend conflicting empirical findings and to situate this study within the larger literature on social support and health.

Social support and stress

Although he did not use the term "social support," sociologist Emile Durkheim is considered to be the first social scientist to examine the relationship between social support and health behavior through his study of the processes through which social integration affects health (Cohen, Gottlieb and Underwood 2000; House, Umberson and Landis 1988; Sarason, Sarason and Pierce 1990, Williams, Barclay and Schmied 2004). In his study, *Suicide* (1951) [originally published 1897]; he documented differences in suicide rates by countries and by social groups. He found that variations in the degree of social connections or degree of social integration between individuals and within groups mediated suicide rates (e.g., married versus divorced). Individuals with low levels of social integration were more likely to commit suicide than those with high levels of social integration within a group and less independence. While this finding showed that social ties are a necessary condition for social support, social integration and social support are separate concepts, although often conflated. Positive effects for stress and coping may not be dependent on the degree of integration (strength of ties) in a social network, but rather on the existence of types of social relationships that will provide requested or required assistance at certain times.

The concept of social support emerged in research on psychological well-being, notably research on the role of social support as a buffer from stress. In the 1970s, researchers began increasingly to investigate social support due to increased attention to mental health. A focus on the links among psychiatric illness, social disintegration, and marital status, led to attention to social support as a factor in alleviating stress (Cassel 1976; Cobb 1976; Cohen, Gottlieb and Underwood 2000; Gottlieb 1978). Researchers hypothesize that the absence of social support and social ties is an underlying cause of physical and mental health conditions. Researchers produced a "proliferation of definitions and theoretical discussions of the concept of social support" (Williams, Barclay and Schmied 2004: 943),

The work of three researchers served as the foundation for the burgeoning field. Cassel (1976) argued that individuals should be able to protect themselves from a stressful environment if provided with support from family, friends, or members of an individual's social network group. Caplan (1974; 1976) expanded the concept of the support system to include friends and institutions, as well as family. He also delineated social support as comprised of multiple types of assistance: emotional, material, and physical. Finally, Cobb (1976) described social support as information that led the recipient to feel cared for. He outlined three specific types of information that help individuals cope with stress: emotional, esteem, and belonging information.

These researchers emphasized social support as a set of resources to protect individuals from stressful situations and to increase the individual's coping skills. Although they did not offer a uniform theory of social support, they did propose models

of the relationships between individuals' social connections and health to understand

the relationship between social support and stress.

"Buffering Model" and "Main-Effect Model"

Based on this foundational research, later researchers developed the "buffering

model" and the "main-effect model" to explain how and why social support is

hypothesized to benefit health. The "buffering model" posits that "individuals with a

strong social support system should be better able to cope with major life changes;

those with little or no social support may be more vulnerable to life changes,

particularly undesirable ones" (Thoits 1982:145). The buffering model suggests that

social support provided after stressful life events mediates or lessens the negative

impact on health. Theorists argue that both the perception of available support and the

actual receipt of support during and after stressful situations may affect coping and

subsequent health (Cohen and Wills 1985; House 1981).

In contrast, the main-effect model suggests that social support positively affects

health even in the absence of a stressor (Cohen, Gottlieb and Underwood 2000; Cohen

and Willis 1985; House 1981). Under this model, social support is predicted to influence

health behaviors and offer protection to individuals in their everyday lives, regardless of

whether stressful situations occur. By providing assistance for health promotion such as

improved access to health care, for example, risks for disease are likely to be prevented.

Social support conferred through social relationships provides health benefits even

during periods of stability through health promoting behaviors (Cohen, Gottlieb and

Underwood 2000). Theorists posit that participation in a social network provides social

support, which confers information, affective support, and material support that in turn may reduce stress and increase access to a range of mental health and other types of services (Cassel 1976; Cohen et al. 2000; Thoits 1982).

The two models differ in terms of the timing of social support: the main-effect model suggests support's impact is more continuous and stable over time and the buffering model suggests social support's influence is in response to stressors (Williams et al. 2004).

Since this early work, several theorists have conceptualized social support into three main dimensions: emotional, informational, and material (House 1981). While these dimensions continue to be defined (or alluded to) and measured in varying ways, it is important to recognize that they grew out of an initial interest in examining how assistance through social relationships affects an individual's health and well-being.

Main conceptual dimensions of social support

Emotional support

Cobb (1976) was the first to conceptualize social support as including not only assistance for tangible resources but also emotional, intangible resources. His initial theorizing focused on whether an individual felt loved and cared for. Drawing from the main-effect model, Thoits (1982:147) defined emotional support as "information leading an individual to believe s/he is loved, cared for, esteemed and valued, and/or belongs to a network of communication and mutual obligation." Wills and Shinar (2000:88) define emotional support, from the buffering model, as "the availability of one or more persons who can listen sympathetically when an individual is having problems and can

provide indications of caring and acceptance." Evidence shows that emotional support enhances self-esteem and increases coping skills and creates feelings of comfort, leading an individual to feel loved, respected or admired (Jacobson 1986). Emotional support provides individuals with the opportunity to feel cared for and accepted, by having a person listen to them, share feelings, and express sympathy (Lin 1986; Thoits 1982). This type of support can lead to a decrease in symptoms of depression (Jacobson 1986). In addition, emotional support has been shown to decrease anxiety and depression and improve coping when dealing with illness (Lackner 1994).

Informational support

Informational support sometimes called appraisal support, is defined as the provision of information, advice, or guidance. It appears less often in research studies, including studies on drug use and drug treatment. Lazarus (1966) contended that informational support helps provide coping skills to an individual by presenting individuals with information to assess a situation and handle difficult situations (Cohen and Willis 1985; Larkins 1999). Wills and Shinar (2000:88) defined informational support as the provision of knowledge that is important for problem solving, such as providing information about resources and services or providing "alternative courses of action." Informational support is important for both the main-effect and buffer models. Informational support also can lead to an increase in the amount of help an individual has to obtain services, thereby increasing coping (Wills and Shinar 2000).

Whether an individual receives or accepts informational support may be influenced by the social norms of a group and the degree of a group's social integration.

For example, Larkins (1999) showed that information about safe injection practices provided to injection drug users (IDUs) at needle exchange programs that offered a place to receive other health services and emotional support, was more successful in reducing risk than harm reduction programs that did not offer additional services. This suggests that the social conditions in which informational support is provided and received are important to consider as well as the social norms around the dissemination of information. In addition, disentangling emotional and informational support may not always be possible since individuals can interpret advice giving as based on displays of trust or love.

Material support

Perhaps the most direct form of support, material or tangible support, encompasses the provision of a broad array of benefits including, but not limited to, money, a place to stay, childcare, transportation, and food. Most often, material support is conceptualized as providing practical help and tangible support when needed as well as solving problems (Cohen and Syme 1985; House 1981; Lin 1986; Vaux et al. 1986). Providing material assistance during illness or stressful situations, was part of the initial conception of material or instrumental support described by the early theorists (Caplan 1979; Cassel 1976; Cobb 1976; Cohen and Syme 1985).

Questions regarding the way individuals feel indebted to another when they receive material support have been raised in the literature. Both the individual's perception of support and the issue of reciprocity or exchange may be significant in understanding interactions and transactions of material assistance. While initially the

dimension of material assistance provided a straightforward description of tangible

assistance provided to an individual, more recently, some researchers have begun to

examine the role of reciprocity as part of the relationship between material support and

health. Social exchange theory suggests that support might not be based on a positive

receipt of assistance but an exchange with costs and benefits (Sahlins 1965). Norms of

reciprocity may affect whether material support is sought as social exchange theory

posits (Stewart 1993; Tilden and Galyen 1987). Perceptions of these costs and benefits

play a significant role in support seeking. This issue is raised within the dimension of

material support because it has been considered the most concrete dimension and

available to measure through social support scales.

Multiple definitions of social support

Since the 1970s, the idea of social support has gained greater currency among

researchers in a wide range of fields (Dobkin et al. 2002; El-Bassel et al. 1998; Falkin and

Strauss 2003; Koopman et al. 2000; Serovich et al. 2000; Stewart 1993). At the same

time, the concept of social support has become fuzzier, and it is inconsistently applied.

There is an undercurrent of continual criticism in the literature with many researchers

pointing out other's imprecise use of the concept. In 1982, Thoits remarked that there

were "conceptual, methodological and theoretical problems" with the literature. More

than fifteen years later, Hupcey (1998:1233) stated, "Analysis of the definitions and

variables used in social support research reveals that there is conceptual confusion and

various implicit assumptions regarding researchers' perceptions of what social support

is and the subsequent selection of measurement instruments." As recently as 2004,

Williams and colleagues (2004: 943) argued that:

> The academic literature revealed a fractured and confused concept. In particular,
> definitions of social support were many and varied. Their use seemed
> inconsistent, and definitional constructs bore little direct relevance to the
> contexts in which they were used for research and intervention studies.

Definitions of social support expanded after the emergence of the main concept and the

three main dimensions: Material, information and emotional. Although many empirical

studies measure the impact of emotional, informational or material support on

particular health behaviors for specific groups, often researchers do not delineate the

type of support being measured or provide a definition of the concept (Hupcey 1998a;

1998b; Stewart 1993; Thoits 1982; Vaux 1988; 1990; Williams et al. 2004). While

empirical studies using social support continue in a range of areas of health, some

scholars have begun to assess the range of social support studies through meta-

analyses. These and other critical appraisals of the literature offer recommendations for

future research to clarify the concept.

Critical reviews of social support literature

Several articles review the social support literature across disciplinary fields,

providing important information about how the multidimensional concept of social

support is conceptualized and measured (Hupcey 1998a, 1998b; Thoits 1982; 1986;

Stewart 1993; Vaux 1988, 1990; Williams et al. 2004). While published over several

decades, these reviews present similar criticisms of the conceptualization and

measurement of social support while offering differing frameworks for future studies.

They also suggest how to approach research questions in the area of social support without simply replicating or contributing to the problems they outline. These scholars emphasize the importance of studies on social support, acknowledging that much has been gained in terms of knowledge about the relationships among social support and health behaviors. However, their overall aims are to strengthen research on social support by, in some ways, asking researchers to reevaluate how they conceptualize and measure a multidimensional and dynamic concept.

Reviews of the social support literature point out that there is a plethora of definitions of social support. In their review, Williams and colleagues (2004) identified thirty definitions of social support across disciplines. Some definitions include a subjective appraisal (Jacobson 1986; Shumaker and Brownell 1985); others focus on the interaction between the provider and recipient (Antonucci 1985; Antonucci and Jackson 1990). While there has been a proliferation of empirical studies on the influence of social support on health, producing findings suggesting both positive and negative effects, several researchers' direct attention to the varied, inconsistent and "fuzzy" conceptual and operational definitions of social support found in studies (Hupcey 1998a, 1998b; Thoits 1982; Vaux 1990; Williams et al. 2004). Overall, it is clear that while social support continues to have great currency in health-related studies, it is important to address conceptual and measurement questions before beginning a new analysis on social support among women who use drugs.

Methodological and Measurement Issues

As this review illustrates, social support is a multidimensional construct that many researchers describe as comprised of three main dimensions of assistance: emotional, informational, and material. While these three dimensions have been established as theoretically separate, measuring these concepts is difficult because they are often interconnected in the interaction between the support provider and the recipient (Barker and Lemle 1984). In other words, a question arises as to whether individuals experience social support as distinguishable into discrete categories or whether researchers impose these categories . Social support scales allow for the measurement of individual's receipt of material assistance, such as financial support, childcare, or other resources and measurement, separately from informational and emotional social support. Conceptually distinguishing among these three dimensions of support might be important in order to maintain a typology of support that is specific for purposes of measurement and description. These distinctions allow researchers to investigate when forms of support might be most useful in different circumstances (Cohen and McKay 1984; House 1981; Rook 1985). In general, most quantitative research that relies on social support scales does separate out the three categories of support. Overall, strong arguments can be made for research that either delineates the dimensions of support or that focuses more on support as a concept that is experienced from the perspective of the individual. However, recognition of an individual's perception of assistance is a critical first step in determining how to identify social support as a transaction rather than a static feature of a relationship. Starting from the

individual's perspective may lead to distinguishing the dimensions of support or may lead to examining the interconnections among the dimensions.

Social support as a transaction

Some researchers conceptualize social support as an interaction or a transaction rather than a set of attributes that can be separated into the three dimensions of emotional, informational and material support. Veil and Bauman (1992) define social support as a characteristic of the individual (recipient) that has an interactional context and is influenced by the social environment. They consider it separate from social interactions but emphasize that it is influenced by interactions and the recipient and provider's perceptions of the particular situation. Social support is also defined as forms of assistance that are perceived by the recipient or by the provider to help either in everyday life or during difficult life situations (Sarason, Sarason and Pierce 1990; Stewart 1993). In labeling support a type of transaction, rather than interaction, it is possible to examine supportive processes within the context of other factors, including the specific social context or the larger environment since support may not be the only process involved in a particular social interaction between individuals.

In addition, a critical issue that is often overlooked in many empirical studies on support is that the concept of social support and the experience of support are dynamic, and not static in nature. As Vaux (1990:508) comments, "The person must actively develop and maintain network resources, employ them effectively to obtain supportive behavior by initiating and managing support incidents, and integrate relevant information through support appraisals." Cohen and Syme (1985) point out that over

the course of someone's life, the importance and the definition of social support

changes (cited in Williams et al. 2004: 957). This is a key point for both the idea of

support as an active process and the importance of investigating the conditions that

affect support transactions.

Further, there is a distinction between perceived and actual support in the

literature, suggesting that an individual's perceptions or own interpretations of

assistance and the context in which it is offered affects outcomes (Heller et al. 1986;

Sarason, Sarason and Pierce 1990; Vaux 1988). Appraisals of support may very well be

connected to an individual's social role and identity, social norms, and stigma, as well as

the social context.

In addition to viewing social support as a transaction between provider and

recipient, researchers emphasize the importance of the social context to the

understanding of social support (Berkman et al. 2000; Williams et al. 2004). Berkman

and colleagues (2000) explain that the emphasis on outcome measures of social support

has detracted from a focus on the social context and social structural factors that

influence social support. Sarason and colleagues (1985) point out that the situational

context must be accounted for to fully understand the role of social support in health,

both during stress and stability. This suggests that the emphasis on measuring the

number of individuals present to provide support or the types of relationships available

for support, as described earlier in the chapter, paints only a limited picture of support.

Instead, a detailed depiction of the social context that shapes support transactions is

important to understand such that the determinants or social factors that affect how

support is sought, received, and provided is illuminated. Rather than viewing social support as a set of independent variables, I consider social support as dynamic and potentially unstable transactions that are situated within social interactions and the larger social context.

In addition, initial theories of social support did not highlight the role of reciprocity or social support as a form of social exchange, but rather treated social support as a unidirectional concept. Social support as a transactional concept, however, implies a give and take—reciprocity. Reciprocity or norms of exchange can affect both the provider of support and the receiver of support. Social exchange theory suggests that social support can involve costs and benefits since recipients may not be able to return the social support provided (Sahlins 1965). Perceptions of benefits or costs can affect perceptions of support availability and help seeking (Cohen and Syme 1985; Shinn et al. 1984; Stewart 1993). Thus, social support as a transaction or form of interaction is not necessarily given or received without constraints or conditions that affect and are affected by the provider, recipient, and social context. Social exchange theory is important to the concept of social support when investigating reasons individuals give and receive support, both during stressful and non-stressful situations.

Theoretical importance of qualitative research

Qualitative research is well suited to examine the conditions that affect support transactions and situate social support within the broader context in which it occurs. As Williams and colleagues (2004) point out, only two of the thirty social support studies that they analyzed employed qualitative methods. They argue that future research on

social support would benefit greatly from qualitative inquiries because questions about

social support should focus on the individual's experiences of social support and be

based in the social context in which it occurs. (Williams et al. 2004).

> This change should be away from the deductive, hypothesis testing approach
> that has dominated research and discussion until now, to an inductive,
> hypothesis-forming approach. Rather than imposing a definition on a context in
> which it might not fit, we should derive from context to ensure fit (Williams et al.
> 2004: 957).

> Further, Lackner and colleagues (1994) argue that qualitative research is needed

to understand better the conditions in which social support relationships are configured

and reconfigured. Since there continues to be a lack of clarity of conceptual and

measurements issues in the social support literature, Lackner and colleagues (1994)

suggested a rethinking of both methods and research questions. They suggest a shift in

research on social support that would include empirical studies in the range of public

health topics under investigation.

Conclusion

This brief review of the social support literature reveals that there are many and

varied definitions of the concept of social support. In fact, conceptual clarity of social

support remains an issue in social support research. There is no consensus on a

coherent definition of social support and therefore no consensus on measurement

related issues. At the same time, theorists point out that researchers conducting

empirical studies within the field of public health, overlook these theoretical and

conceptual issues.

Nonetheless, the role of social support is an important area of investigation to understand better health and well-being. This study builds on both past and current research on social support through a qualitative analysis of social support among women who use drugs. There has been a consistent call for more nuanced studies of social support, with a shift to exploring the social context in which social support occurs. To this end, my work focuses on the conditions that affect social support transactions. Thus, I contribute to the ongoing theoretical conversations within the social support literature. At the same time, this research question is applied to the study of the lives of women who use drugs to better understand critical areas affecting health and well-being. In the next chapter, I review studies on drug use highlighting measurement and conceptualization issues related to how the construct of social support is employed in empirical studies on women and drug use. Specifically, the focus on conditions of social support emerges from the theoretical issues within the social support literature that I then examine as they relate to research on women and drug use.

Chapter Three: Literature Review of Social Support and Drug-Involved Women: Conceptualization and Measurement Issues

Introduction

Researchers have examined the role of social support in drug use and drug treatment. Yet there are significant limitations to the way this concept has been measured within the literature on women and drug use. Social support is a significant factor in improving the health and well-being of women who use drugs (including risk reduction and treatment). However, studies show that support does not always lead to positive outcomes, a fact that raises conceptual and measurement questions similar to as those I have discussed. In fact, the research on social support indicates that social support can lead to positive, negative, or even neutral outcomes (El-Bassel 1998; Goehl et al. 1993; Latkin et al. 1995; Neaigus et al. 1995; Tucker 1982). For example, a number of authors have reported that social support during and after treatment plays a meaningful role in recovery from drug addiction. In a study by Coughey and colleagues (1998), women with relationships, including friend and family relationships, remained in treatment longer and were more likely to continue case management services after treatment. Similarly, Kaskutas (1994) found that women reporting contact with friends and family were more likely to remain in recovery. On the other hand, research by Cosden and Cortez-Ison (1999) found that having supportive relationships with family and friends did not contribute to successful completion of treatment and recovery, mitigating the effect of support on treatment efficacy. Furthermore, Ellis and colleagues

(2004) found that drug use, criminal activity and family discord decreased recovery efforts by women who attended a long-term treatment program.

As a result of findings that do not offer consistent evidence of positive or negative outcomes and the questions that have emerged from the theoretical social support literature as reviewed in chapter two, it is important to examine how social support is conceptualized and measured. Often conceptualization and measurement issues are left unaddressed. In this chapter, I briefly review empirical studies focusing specifically on studies that examine social support among women who use drugs. These include studies from two main areas of research: 1) treatment seeking, retention and post-treatment abstinence and recovery among drug and alcohol treatment populations; and 2) epidemiological and social network studies of active drug users that focus on risk behaviors, such as the transmission of HIV/AIDS and other infectious diseases.

The majority of studies in the field of drug use and drug treatment employ quantitative methods of data collection (Alemi et al. 2003; Dobkin et al. 2002; Falkin and Strauss 2003; Havassy et al. 1995; Strauss and Falkin 2001; Zapka et al. 1993). Studies that examine social support in the area of drug treatment address questions such as, "Who provides support and what effect does support have on treatment efficacy and recovery?" Researchers have addressed these questions by focusing on 1) the number of individuals or "supporters" that comprise a support system or quantity of support, 2) the relationships among these supporters, including friends, sexual partners, family

members, and children, and 3) the dimensions of support: emotional, informational, or material.

Although the emphasis in epidemiological social network studies on drug use has been on risk behavior, some of this research investigates social support. A central area of research in the field of drug use has been to examine HIV-related risks of drug use, such as sharing needles and other drug paraphernalia, and engaging in unprotected sex. In the many studies that include social support measures, researchers have focused on the following questions related to social support: 1) what type of drug-related support (access to clean needles, information about needle exchanges, condoms) is shared among individuals and groups that use drugs, and what impact does this support have on risk reduction; 2) what types of relationships comprise individuals' support networks and how does that impact risk practices; and 3) how is the size of an individual's network related to risk (Boyd and Mieczkowski 1990; Gogineni et al. 2001; Latkin et al. 1999; Nyamathi et al. 1997; Schroeder et al. 2001; Suh et al. 1997)?

Most of the research on drug use and drug treatment does not begin with a clear conceptual definition of support. As noted earlier, social support is a multifaceted concept; however, many researchers do not explain the limitations of the measurement of support used in their research studies.

Measurement issues

Support measured as presence or absence

Researchers do examine the relationship between the presence and absence of support, and the impact on drug use and/or treatment and recovery issues. Gregorie

and colleagues (2001) examined the link between women's perceptions of social

support and substance use among females enrolled in a post-treatment, drug-free, long-

term residential program that focused on job skills and economic self-sufficiency. In this

study, the presence or absence of supporters who used drugs was identified as an

important factor in recovery efforts. Many women reported that they had family

members with drug and alcohol use problems. Most women lived with someone using

alcohol or drugs prior to treatment. The researchers found that women believed that

friends and family supported their recovery efforts. At the same time, however, the

researchers labeled living environments that included active users as "non-supportive

environments," due to the availability of drugs. Economic factors were hypothesized to

be one reason that women resided with individuals who used drugs or alcohol, despite

the risk these living arrangements posed for their recovery. Gregorie and colleagues

(2001) found that women who decreased their substance use were more likely to

increase their economic self-sufficiency. The results of this study highlight the positive

outcomes of drug-free living environments on women's recovery efforts and emphasize

the importance of residential treatment programs. Yet, limiting the definition of social

support to presence or absence of others who use drugs provides only a partial

understanding of the conditions that affect support. Women have to contend with

housing needs and other social relationship issues, in addition to considering whether

drugs may be available at the place they choose to stay. Social conditions that constrain

women's housing options are also important factors to consider when examining

support in relation to long-term treatment efficacy. In addition, the nuances of social

relationship factors may be overlooked in studies that label any drug-related or drug-involved individuals as "unsupportive" or providing "negative support" from the outset.

Nyamathi and colleagues (1997) examined social support variables among homeless women at risk of HIV/AIDS. Most used injection or non-injection drugs. Subjects identified their "closest source of social support" as friends (72%) and partners (23%). They found a lack of emotional support between subjects and their closest source of support, and also high rates of depression. The researchers conclude that women sought support from those who were unable to provide it, which exacerbated drug use. In addition, the researchers conclude that more specific information is needed on the relationships between social support and homeless and low-income women's behaviors. This suggests that a focus on the conditions that affect social support and relationships that confer support might shed light on these issues.

Support measured as degree of support provided—high vs. low

Many research studies focus on the degree of support, as measured by the number of relationships an individual reports. This research includes studies on men and women together, as well as woman-only samples. Researchers do not always find significant results when testing the relationship between support- and treatment-related issues, including quality of recovery, duration of recovery, and success of recovery. For example, Dobkin and colleagues (2002) tested the effects of the buffering model of social support (reviewed in chapter two) on substance use behavior among adults in an outpatient treatment program, and compared groups with high and low functional support (actual or perceived) at the beginning of treatment and six months

later. The authors were interested in examining whether individuals with high social support at the outset of treatment had lower rates of attrition than those with low social support. They measured support by degree and quantity using the Interpersonal Support Evaluation List (Cohen et al. 1985), which measures perceived availability of support. The results of the study suggest that individuals with greater social support at the beginning of treatment were more likely to remain in treatment and to reduce alcohol, but not drug, use. The authors concluded that further research is needed, as only a small proportion of the variance in treatment outcomes for drug and alcohol use is explained by social support. The authors offer several reasons for the non-significant findings between social support and substance use, including the suggestion that the buffering role of support may be impacted by an individual's investment in personal relationships, and that individuals may be influenced by their personal relationships (Dobkin et al. 2002).

Another study that tested the buffering model of support for individuals in recovery from substance use found no difference in substance use between patients with high and low support at a methadone treatment program (Goehl et al. 1993). Social support was defined as the quantity of relationships providing four dimensions of support (material, appraisal, emotional, and belonging). As they did not focus their research on the social environment in which support occurs, their study may not fully depict the role of support in efforts to stay clean.

Support measured as size of support system

Other studies of support report the size of the individual's support system. For example, O'Dell (1998) found that women who use drugs and alcohol reported an average of three support members and that these supporters provided "minimal support." Other studies examine both the number of supporters available and the type of support provided. An important study by El-Bassel and Schilling (1994) investigated a social network model of social support. They argue that this was the first study to examine the connections among social support, characteristics of the relationships, and social networks among women who use drugs. The study looked at the following types of issues: the profile of the social networks for women in methadone programs; relationships between types of support and sources of support; network properties and support; and relationships that provide "negative support." Social support was measured by questions that asked about financial, emotional, and drug-related assistance. Findings from the study, however, focused on the influence of the size of the social support system, as well as the type of relationships providing support. El-Bassel and Schilling argue that social networks, including attributes of network members, social tie characteristics, and the structure of social networks, affect the type of social support. This study presented a more sophisticated model of social support than prior research in this area. Findings include relationship between the density of a social network and assistance for housing. They found that women recruited from NYC methadone clinics reported an average of three individuals whom they could rely on for emotional, material, and instrumental support, both drug and non-drug related. In this study, respondents were more likely to report that family members were sources of potential

support than those in other relationships; this was particularly true with regards to emotional support. This was also consistent with findings for reciprocity, which was measured by whether others turned to them for assistance. Overall, the study emphasized the salience of the number of relationships, as well as the type of relationships available for social support for women on methadone. While findings from this study moved the discussions of support forward, the researchers did not address the conditions that affect support seeking, receiving, and providing.

In contrast, Falkin and Strauss (2003) found that women had an average of nine members, a much larger network than El-Bassel and Schilling (1994) or O'Dell (1998) found. Falkin and Strauss (2003) found that family and partners were the main supporters for women prior to treatment. The authors argue that the small number of individuals reported as social supporters in many drug use studies might be a result of the way the data are collected and may reflect different measures of social support. Specifically, they refer to studies that impose limits on the definition of support. This would influence the number of members an individual would include in a support system. They cite a study by El-Bassel (1998) on women methadone users as an example. While Falkin and Strauss (2003) point out measurement issues related to the number of supporters, this is only a first step to understanding the role of support in women's interactions when trying to stay clean. The current dissertation contributes to this work through a focus on conditions that affect social support without imposing limits on women's descriptions of their experiences.

Epidemiological studies—most often large-scale quantitative studies—on social networks of active drug users have examined the question of the size of an individual's social support network as it impacts HIV risk. One area of inquiry has been on the relationship between the size of a social support network, the provision of material support, and the impact on risk reduction. For example, as part of the ALIVE (AIDS linked to intravenous experiences) study, Latkin and colleagues (1995) found that injection drug users with small social support networks were less likely to inject at shooting galleries. Suh and colleagues (1997) noted that injection drug users receive support from other injection drug users, many of whom are family and intimate partners. They found that the presence of a support network was associated with sharing needles, but not injecting in shooting galleries. They argue for intervention methods that recognize the distinctions between drug networks and drug-related support networks. Risks from each type of network vary and interventions must be tailored to different types of relationships and social settings. While both studies point out how support networks affect risky practices (e.g., injecting at shooting galleries and sharing needles), support is quantitatively measured in these studies by the presence or absence of support networks. Shifting the focus to an analysis of the conditions that affect support, through qualitative methods, can shed additional light on how settings and specific interactions can promote or negate support transactions.

Conceptualization

The missing perspectives of women

Another key issue that quantitative studies on support do not usually address is the quality of support, particularly from the perspective of the women themselves. As many researchers point out, "[L]argely depending on the quality of support provided, the effect of social support provided by spouses, partners, and significant others also can have mixed effects" (Ellis et al. 2004:214). In addition to focusing on the number of individuals in a social network that provide support, studies have emphasized the types of relationships that provide support. The types of individuals most often focused on include: family, friends, sex partners, and drug-involved individuals. Empirical studies have produced mixed results when attempting to identify the type of relationship that is most important in providing support for cessation of drug use. For example, Tucker (1982) found that friends were more likely to provide material support than emotional support to women in treatment for heroin use. Material support included financial assistance, housework, and childcare. As women's perspectives on the meaning of social support were not included in the assessment of the relationship between support and treatment, it is not clear how women perceived or appraised the receipt of material support or the reasons why they reported more material than emotional support. This raises a question whether the separation of support into the three dimensions (emotional, informational, and material) led to these findings or whether women themselves interpreted these three types of support as distinct.

Ellis and colleagues (2004) found that women with supportive family relationships and social networks were less likely to relapse after treatment. However, the authors report that evidence indicates that substance use by social network

members leads to negative treatment outcomes. Findings from this study suggest that, to continue recovery efforts, women need to sever social ties with social supporters who are drug involved. In fact, many studies distinguish relationships in terms of drug use status as a means to identify whether positive or negative social support can even be offered. Some research defines the outcome of social support from drug-involved individuals as negative without distinguishing the quality of the relationship and focuses specifically on identifying the drug-use status of social support system members.

Yet, most drug-involved women's social relationships include others who use drugs. Studies have shown that most post-treatment women report that some of the people who provide social support in their lives—often partners—use drugs (Dunlap and Johnson 1992; El-Bassel and Schilling 1994; Strauss and Falkin 2001; Nyamathi et al. 1997; O'Dell et al. 1998; Strauss and Falkin 2000). Several studies document that women who use drugs name a partner as their most important supporter, and often these partners also use drugs (Marcenko and Spence 1995; O'Dell et al. 1998; Nyamathi et al. 1997; Robinson 1984; Woodhouse 1994). These relationships also may be violent and unhealthy (Gilbert et al. 2001; James, Johnson and Raghavan 2004; Nelson-Zlupko et al. 1996). In other cases, Falkin and Strauss (2003) found that partners who use drugs provided both emotional and material support. In a separate study, El-Bassel and Schilling (1994) found that 90% of women identified at least one supporter in their network who used drugs and 75% reported that a family member used drugs. While these studies offer evidence that women who use drugs rely on others who are drug involved for support, researchers often argue that recovery is possible only by severing

those ties. A limitation of many of these studies is that they do not assess the full

meaning of these types of relationships or the conditions that affect support

transactions.

Can active drug users provide support?

In an analysis of women mandated to treatment, Falkin and Strauss (2003:146)

asked respondents to list individuals "who had something to do with their drug use" and

how "their main drug associates had enabled their drug use." They found that 58% of

women's main drug associates also provided support and 24% of all social supporters

were reported to be involved in the women's drug use in some way. Nevertheless, 92%

of women who wanted to stop using drugs reported that at least one person

encouraged them to do so. Falkin and Strauss (2003) point out that their data show that

while all the women reported drug associates, many also reported friends who provided

support without drug use and about 20% had friends who provided them with

assistance to become drug-free. These findings differ from other studies that report that

women who use drugs report few friendships in general (Bourgois 1995, 1997; Maher

1996, 1997).

Stowe and colleagues (1993) examined the supportive resources of injection

drug users (men and women) and who they can turn to during periods of stress or crisis,

including changes in HIV status. They measured social support with the Interpersonal

Support Evaluation List (ISEL) modified for use with injection drug users. One measure of

support was "When you are having problems are you satisfied with the support you are

getting from your friends?" They found that 24% were satisfied, 30% were dissatisfied,

and 28% felt their level of support to be reasonable/okay. While the ISEL provides a

global measure of support for problems, it does not provide information about how

individuals contend with specific problems they encounter in their day-to-day lives. They

conclude friends are more important than family in providing support (Stowe et al.

1993). Yet, the authors point out important limitations to their study:

> [T]he meaning of the term "close friend" may have differed between
> respondents...some respondents tended to name almost everyone they
> knew...the interviewers noted that the concept of emotional support appeared
> alien to many respondents and there was a vagueness about needs and the
> concept of "going for help" in general in this population (Stowe et al. 1993:31).

Overall, Stowe and colleagues (1993) contend that research on social support among

injection drug users and HIV-infected injection drug users is an important area that

warrants further research. This provides further evidence that research is needed.

Rather than simply measuring the availability of support, it is important to examine the

determinants that affect support transactions (seeking, receiving, providing). This can

provide insight into the role of social support and the complex nature of issues related

to identity and behavior change in the lives of women who use drugs.

Another study examined the impact of social support on drug injection practices

and specifically how drug-involved individuals can provide support to others for risk

reduction purposes. Zapka and colleagues (1993) examined safe injection practices and

peer influence for individuals who completed a short-term residential detoxification

program. Individuals who learned about bleach cleaning their drug paraphernalia and

then shared the information with their drug partners were more likely to continue

cleaning their own drug paraphernalia, thus lowering their risk. This study suggests the

importance of informational support, particularly among peers for risk reduction

practices. Similarly Neaigus and colleagues (1994) indicated that injection drug users

who reported a social network of users who cleaned their drug paraphernalia were

more likely to engage in this behavior, thereby promoting risk reduction for HIV/AIDS

and other infectious diseases. Both studies demonstrate that for injection drug users

who are part of an integrated social network, informational support, as a form of a

shared knowledge, within a specific social context, can promote harm reduction

practices. This research is valuable in that it highlights the efficacy of peer support for

risk reduction behaviors. Teaching individuals to inject safely and pass the knowledge on

to those in their drug use networks can lead to risk reduction behavior throughout the

social network. As these researchers did not focus on how support may function in areas

of everyday life outside of the shooting gallery, their studies, while valuable, cannot

represent the full set of experiences of support among individuals who use drugs.

Support from mothers for drug-involved daughters with children

Although the emphasis in research on social support has been on the broad

range of social relationships, there has been some research that documents issues

related to relationships between mothers and their children. Interestingly, there is some

research that examines the role of women's own mothers. Specifically, this research

looks at whether women's mothers are "supporters" and the findings in several studies

are mixed (Boyd and Mieczkowski 1990; Strauss and Falkin 2001; Tucker 1982). Boyd

and Mieczkowski (1990) examined crack use, family relationships, and social support

among men and women recruited from a treatment program. 30% of women identified

their relationships with their mothers as their most important relationship. Similarly,

other studies have shown that family support is not always available to women,

including one by Rutherford and colleagues (1994) that found that 72% of women in

methadone maintenance did not report support from their mothers. When women have

children, the situation becomes more complicated. Low-income women with children,

including drug-involved women and drug-free women, often rely on their mothers for

childcare (Boyd and Mieczkowski 1990; Enos 2001; Hogan et al. 1990; Stack 1986;

Strauss and Falkin 2001). Some researchers argue that women may "exhaust support,"

particularly from family members (Boyd and Mieczkowski 1990). This finding results

from women's reports that "no one" would help them if they were attempting to cease

using drugs. Boyd (1993) argues that feelings of social isolation might precipitate this, or

it might be related to a lack of support. While perceptions of support are based on a

subjective perspective from the respondent, it conversely might suggest that women

might not actively ask for help in the future from family members, friends, or associates.

Further research in this area is needed to explore the multitude of reasons that women

believe support from family is unavailable and to learn about when family members cut

ties with women who use drugs.

Providing specific information in this area, Strauss and Falkin (2001) identified a

range of reasons that women identified their mothers as supportive or not supportive,

with a focus on the period of drug use cessation. They conducted a study of 100 women

mandated to community-based residential drug treatment programs to examine the

adult mother-daughter relationship for women who identified mothers as members of

their support system. Overall, women listed friends, family, and partners as supporters.

In this study, one in five of women's supporters were friends, and one in eight of their

support came from partners, parents, children, siblings, or other family members.

Thirty-five percent of respondents did not list mothers as supporters during

pretreatment. Women in the study identified several reasons that their mothers were

not supportive. The most salient reason was relationship issues between themselves

and their mothers. For example, some women reported that their mothers were absent

during their childhood. Other women reported that their mothers would not forgive

them for their drug use, while some explained that their mothers would not "help them

get clean." In addition, there were intergenerational patterns to drug use and some of

the women in the study reported that their mothers also used drugs, thus preventing

them from assisting their daughters with recovery related issues. The women who

identified mothers as supporters (65% of the sample), described frequent contact with

their mothers and consistency in their relationships—mothers served as resources for

all forms of support. Many women reported that even though their relationships with

their mothers were strained, they were perceived to be available for support. Although

this study did not focus on women with children specifically, the authors noted that

some women in the sample reported that their mothers cared for their children while

they used drugs and when they were in treatment. Also, participants reported that their

mothers encouraged them to stop drug use for the benefit of the children.

Despite the high number of women who use drugs and are mothers, few studies have explored conditions that affect support in the quality of women's lives as mothers both during periods of drug use and periods when women are drug-free.

Issues of support among drug-involved women with children

Barriers to drug treatment and the role of social support is one area where some research has been conducted on drug-involved women with children. An early study found that concern for children was a reason women gave to enter drug treatment, but lack of childcare was a barrier to entering (Rosenbaum 1981). Lack of childcare may limit the time women have available to attend a program. As a result, some women seek treatment only after they have lost custody (Corea 1992). Knight and colleagues (2003), in a study of child residency of women in drug treatment, found that families are more likely to remain together when women are able to have children with them at residential treatment programs. Additional factors also are important to success of treatment outcomes, including socioeconomic status, number of children and living arrangements after treatment. A study by Lundgren and colleagues (2003) in Massachusetts examined differences in parental status among women injection drug users who entered drug treatment between 1996 and 1999. Results showed that women who resided with their children were 75% more likely to enter methadone maintenance programs than women who did not reside with their children.

Other than a focus on barriers to treatment, little is known about the provision of support from mothers to children and family members caring for children (Campbell 1999; Stowe el al. 1993). Studies suggest that mothers who use drugs hold the same

normative ideas about what it means to be a good parent as mothers who do not use

drugs (Rosenbaum et al. 1990; Taylor 1993). Indeed, children are often central in the

lives of women who use drugs (Campbell 1999). Rosenbaum (1981) found that for

women who use heroin, their role as a mother is a primary source of self-esteem. A

qualitative study of HIV-positive women found that among the "disruptive life events"

women face, they described separation from children as even more stressful than HIV

diagnosis. Reasons included feelings of failure and guilt of not being able to provide for

their children and act as a "good mother" due to their drug use (Ciambrone 2001). In a

qualitative study of Puerto Rican mothers who use drugs, Hardesty and Black (1999:607)

explain that motherhood is central to these women's lives:

> Motherhood became their symbolic anchor. Even at the point of full-blown
> chaos, even when women lost custody of their children, children remained
> central in their lives—in fantasies, yearnings, and plans—which, as we will see,
> results in a numbing surrender to self-destruction or becomes the seeds for
> recovery. By controlling motherhood, the addict sustained an identity not
> completely defined by her life with drugs.

A woman's drug dependence and identity as a drug user competes with her

identity and role as a mother (Campbell 1999; Enos 2001; Hardesty and Black 1999;

Richter and Bammer 2000). While women often attempt to compartmentalize their drug

use from their role as a mother to provide support for their children, this is not always

successful. For example, Hardesty and Black (1999) found that providing social support

(e.g., material resources or caretaking responsibilities) might become secondary if the

women's income is affected by a change in drug acquisition patterns or a partner's

incarceration. This presents a more nuanced perspective of the experience of recovery

or drug cessation for women than often found in research on women who use drugs. Hardesty and Black (1999:617) explain:

> Mother work in the recovery state can set into motion a cycle of great expectations, failure to meet those expectations, and then drug relapse. The grand expectations of motherhood were repeatedly dashed in the actual practices of parenting after drug addiction; the failed mother identity resurfaced, and recovering addicts fell back into old drug habits in response to failure.

In order to contend with these competing roles, women engage in strategies to separate their drug use from their mothering (Boyd 1999; Hardesty and Black 1999; Richter and Bammer 2000; Theidon 1995). Women employ harm reduction strategies tailored to caring for children to separate their drug use from their families (Boyd 2000; Thiedon 1995).

Richter and Bammer (2000) conducted a qualitative study with a sample of low to moderate income Australian mothers who use heroin. Women were caring for at least one child under the age of ten and had custodial rights at least half of the time. The researchers found that women employed a hierarchy of strategies to reduce the impact of their drug use on their children such as "1. stop using completely; 2. go into treatment, especially methadone maintenance treatment for dependent heroin use; 3. maintain a stable, small habit…" (Richter and Bammer 2000: 404). Although there are differences between the environment in which women in Australia and women in the United States receive health care, as well as differences in laws governing drug use, this study sheds light on mothers' coping with drug use. It shows that women try to balance their role as a mother while contending with their drug dependence, and the

environment in which they are able to negotiate these strategies impacts greatly on both women and their children.

The small body of research on drug-involved mothers does not explore conditions that affect support seeking, receiving or providing. While traditional norms of motherhood dictate that mothers provide unconditional support for children, it is often the case that women who use drugs are not the primary caretakers for their children, and some have limited or no contact with these children. This creates situations where women may be more like "friends," visitors, or sometimes strangers to their children. Further, normative ideas about mothering are challenged as drug use and drug treatment alter their relationships with their children. Mothers who rely on others to care for their children may feel constrained by this support, or they may welcome the support provided by children's caretakers who are often family members.

Data collection issues

Limitations of quantitative research

Although the emphasis in research on support in the lives of women who use drugs has been on treatment and recovery, some research documents issues related to social support for quitting drug use without formal treatment. For example, Boyd and Mieczkowski (1990), in a study of crack cocaine users, found that 30% of women respondents recruited from a drug treatment program reported "no one" in response to the question "Do you know anyone who would help you get off drugs if you asked?" The researchers speculate as to the reasons underlying this "disconcerting" finding and state:

For example, it may indicate feelings of social isolation and low self-esteem within this subgroup of crack users, or it may truly indicate a lack of support within their family and social networks. This response might also be indicative of the kind of counseling these people are receiving, in which each patient is encouraged to become self-reliant and independent from social pressure. (Boyd and Mieczkowski 1990: 485)

Understanding the context in which support occurs or does not occur, as well as the meaning that women give to their social relationships, when women are trying to stay clean is particularly important. Further, El-Bassel and colleagues (1994), in their quantitative study of women recruited from methadone clinics speculate on the motivations that might illustrate who women do or do not turn to for social support:

We suggest that a woman may not turn to friends who know her well as a way to avoid disclosing a particularly strained situation. And some women may have exhausted the good will of close associates by behaving in ways that would alienate the most generous of individuals (El-Bassel et al. 1994: 395).

Research that relies on quantitative measures most often presents findings that portray social support as a static feature of relationships, and such research does not represent the conditions that impact support transactions. I argue that qualitative analysis can better illuminate the conditions that affect support transactions and shed light on the aspects of social support that may lead to the above findings.

Importance of qualitative research

Qualitative methods of research are especially suited to exploring phenomena that are difficult to quantify. Rhodes and More (2001) argue that qualitative analysis is particularly important for the field of drug use studies. Analysis of qualitative data allows for an exploration of social experiences and enables researchers to move beyond

or underneath statistics to analyze the complexity of such constructs as social support and social isolation (Rhodes and Moore 2001).

Although research on social support issues among women who use drugs has emphasized the degree and quantity of support, there has been some research that presents a more context-based perspective of support. For example, a study by El-Bassel and colleagues (1998) examined the social roles and social context of support for women recruited from methadone clinics. They noted that the closeness of social ties plays a role in support, as well as the type of social roles (kin or non-kin). They argue that "support within a woman's personal network is contingent on the types of support required under different circumstances, as well as the characteristics of the relationships and the structure of the social networks" (El-Bassel et al. 1998; 396). Network members who used drugs were more likely to provide financial aid, childcare, a place to stay, or assistance in acquiring drugs, and less likely to encourage women to stop using drugs.

In another qualitative study of injection drug users, Zule (1992) explored the injection drug users' drug use exchanges, the norms involved, and the impact of exchanges on HIV risk behaviors. He collected data about the interactions among injection drug users during buying, selling and using drugs and the roles they assumed during these interactions. To analyze these interactions, Zule (1992) employed the sociological concept of reciprocity (and did not focus specifically on social support). He presented a taxonomy of drug exchanges (purchase, barter, and gift) based on asymmetrical interactions when seeking drugs, finding that reciprocal exchanges of

drugs and injecting equipment, more often "occur in the context of asymmetrical social interactions, with a dominant and subordinate member" (Zule 1992: 243). Risky practices, therefore, can be a result of reciprocity that is an unequal exchange among drug users. He found that the social conditions underlying drug use behavior impacted the exchange relationships. Subsequently Zule (1992) identified these exchanges as symmetrical and asymmetrical depending on the type of reciprocity that occurred. This study provides important insight into the patterns of exchange among injection drugs users and HIV risk behaviors and can be applied to the study of social support in general as well as patterns around drug recovery efforts.

An additional study that provides a more nuanced representation of the role of peer support in risk reduction employed qualitative methods in a case study of needle exchange programs. Larkins' (1999) case study of two needle exchange programs in New Jersey found the presence of both former and current injection drug users at a needle exchange provided a trusted environment for the provision of informational social support for clients. For example, the author described how participants would visit the needle exchange programs even when they did not have needles to exchange. This finding stemmed directly from Larkins' participant observation at the needle exchange sites. She found that the workers believed that the clients gleaned emotional support from these visits and that the needle exchange provided more than services for harm reduction. According to a worker, participants "like to come to the exchange because it feels like someone cares whether he's healthy or not" (Larkins 1999: 165). Participants could then become engaged in the needle exchange program and receive opportunities

to volunteer at the program, reciprocating the support they received by providing

support for the workers who gave their time. Larkins (1999) described, based on the

experiences of both the participants and the workers themselves, how it was also a

source for supportive interactions because workers encouraged clients to change their

behavior but also to change other areas of their lives. Based on her case study, Larkins

(1999) argued that social support is a central feature of needle exchange programs and

a qualitative lens better enables researchers to recognize these nuances.

Conclusion

Measures that focus on the number of supportive relationships, types of

supportive relationships, and the dimensions of support (emotional, informational, and

material) may offer a limited picture of the role of support in the lives of drug-involved.

Such measures avert a focus on the interactions that take place when support is sought,

provided, or received, and the conditions that affect support transactions. Measuring

how many and what types of individuals provide support does not fully illuminate the

role of support in the lives of women who use drugs. It emphasizes structural features

of the support system, rather than the qualitative aspects of social support, such as

what features of the neighborhoods, institutional structures and relationships impact

support and how that affects quality of life and health-related concerns.

The relationship between social support and issues related to drug use may be

elucidated with research that examines social support though qualitative research and

focuses on conditions that affect support transactions. Recognizing the features that

affect support when women are trying to stay clean outside of a treatment environment

is particularly important to developing an understanding of how women who use drugs navigate the challenges they face.

Over the past several years, there has been greater attention to qualitative methods in drug use research (Rhodes and Moore 2001; Singer 1999). Qualitative research on women and drug use focuses on women's experiences from their own point of view, their social environment, and the context in which women use drugs, stop drug use, and negotiate their daily lives. This dissertation is an exploration of the conditions that affect drug-using women's support transactions (seeking, receiving, and providing) in two critical areas of their lives: the challenges of recovery and their roles as mothers. This is critical to assist in reducing risk and improve the health and well-being of women who use drugs.

Chapter Four: Methods and Description of the Sample

Data

This study is a secondary analysis of qualitative interviews with women who use drugs. Data are from a NIDA-funded multi-method study of women who use drugs in NYC, entitled "Networks, Resources, and Risks Among Women Drug Users."[2] The overall purpose of the project was to develop a "contextualized understanding of the linkages among structural/institutional factors, and network, relationship and behavioral risk for women who use drugs."[3] Specifically, the Principal Investigator (PI/interviewer) examined issues related to social networks, resource acquisition, drug use, and risk behaviors for women who use drugs, in order to examine risk on multiple causal levels: individual, dyadic, network, and structural. A main aim of the study was to assess the range of strategies that women used to acquire resources and the resulting costs and demands of such acquisitions (Miller and Neaigus 2002a). The PI interviewed women who used drugs and collected life-history information, focusing on the period from drug use initiation through the time of the interview. She collected information on all types of drug use experiences, as well as drug cessation and recovery experiences. As an exploratory study, the range of questions was broad and allowed for several different analyses, including the current analysis on social support, which the PI did not specifically address.

Participants were recruited from two low-income neighborhoods in New York City (NYC) with high proportions of drug use and well established drug markets: the East

Village/Lower East Side neighborhood, a white and Latino neighborhood in Manhattan, and Bedford-Stuyvesant, an African American neighborhood in Brooklyn. NYC is an important area in which to investigate women's drug use. It has a large drug-using population and high rates of HIV/AIDS attributed to drug-related risk factors. In addition, many areas of NYC are low-income and disproportionately affected by crime and violence related to the drug economy (Miller and Neaigus 2002a).

Sample Recruitment

The PI employed several different recruitment strategies to select interview participants. Strategies commonly employed to recruit hard-to-find or hidden populations were used in this investigation including ethnographically targeted outreach through snowball sampling, respondent driven sampling, distribution of printed material in both neighborhoods, and cooperation of staff from other research projects in the neighborhoods and from local community-based organizations (Heckathorn 1997; Watters and Biernacki 1989). Based on a previous study, "HIV Risk and Transitions from Non-Injecting Heroin Use,"[4] the PI aimed to recruit a sample of women who were racially diverse (25% White, 35% Black and 40% Hispanic), as well as poly-drug users and injection drug users (IDUs). Women were also recruited according to several additional characteristics, including age and types of drugs used. While not random nor representative of all women who use drugs in these neighborhoods or in NYC, the combination of sampling strategies allowed the PI to interview women with a range of experiences.[5]

Study Eligibility

To determine eligibility for the study, women were first screened for drug use (cocaine, crack, or heroin) in the past 12 months. If women reported drug use, they were found eligible. The project was described to them and they were asked to participate. Study participants were told that their participation was voluntary and that neither their true names nor any characteristics that would easily allow others to identify them would be used in any publications or presentations. They were also informed about the types of questions they would be asked and told that they could refuse to answer any question or stop the interview, which would be audio taped, at any time. In addition, study participants were informed of the types of precautions that would be taken to ensure the safety of the data, given the sensitive topic of the interviews. They study had a United States Federal Certificate of Confidentiality, this enables researchers to legally withhold participant identities and information from all persons not directly associated with the research project. The women who agreed to participate provided oral and written consent.

Interviews

The Principal Investigator conducted all interviews following a semi-structured interview guide. Interviews took place at a research study storefront and in community-based settings, (e.g., park, restaurant). Interview questions covered a range of topics including drug use, risk-related behavior, economic resources, characteristics of social networks, personal relationships, social support issues, family, children and motherhood, drug cessation, and issues related to their drug use. The PI referred participants to health care services and drug treatment services when such information

was requested. Participants were compensated $35 for their participation in the study. Interviews lasted between 60 and 90 minutes. Interviewing took place over a nine-month period, from March to November 2000. The audio-taped interviews were later transcribed verbatim. Field notes were written after each interview and were available for analysis along with the transcribed interview data. Participants' names were stripped from the transcripts and pseudonyms were assigned to all materials to ensure participant anonymity.

The Rutgers University Institutional Review Board approved this dissertation research. I signed a letter of confidentiality with the PI to gain access to the interview data. In addition, the PI provided a letter of approval for my use of these data. All information is on file with Rutgers University Institutional Review Board.

Interview Guide

The interview guide consisted of open-ended questions that provided opportunities for in-depth answers and probes by the interviewer. Questions focused mainly on reproductive history, drug use, access to resources, and social networks, and included issues related to neighborhood and relationships. Reproductive history questions focused on pregnancy, abortion and miscarriage, sexually transmitted disease, forced sex experiences, risk attitudes and behaviors, and sex work. Questions relating to drug use included patterns of drug use, arrest/incarceration, role of drug use in life, drug use history, initiation into drug use, and periods of getting and staying clean. Additional questions addressed access to resources for drug use. The interviewer asked questions about social norms relating to these issues and the women's attitudes towards their

behavior and relationships. As part of the focus on social networks, the interviewer created a diagram with all the individuals that the participant listed as "important people in your life" and continued to refer to this diagram throughout the interview. This map of social networks enabled the interviewer and the participants to distinguish between strong and weak ties and related to risks for transmission of HIV/AIDS and other infectious diseases. Questions about social support focused on who would help the participant in specific situations. However, other information related to social support was woven throughout the interviews. This provided unusually rich data on social support.

Demographic information was also collected. Self-reported race/ethnicity, age, and drug use were used to help determine eligibility for the study. Self-reported HIV, hepatitis B (HBV), and hepatitis C (HCV) testing and status information were also collected. Other relevant characteristics of the sample are presented in Table 4.1 below.

Dissertation Study Sample

The original sample size for the Principal Investigator's study was 28 participants. I had access to all 28 interviews, with field notes and began my initial exploration with all 28 interviews. I removed three participants from the sample, leaving 25, because of their questionable reliability and validity related to the topics relevant to this study. One participant, Kim, a 40-year-old black woman who injected heroin, did not want to discuss her drug use or staying clean experiences during the interview. She thought the interview would focus more on her HIV status and thus provided very little information on topics other than HIV. The second participant removed from the sample, Berta, is a

19-year-old, multiracial woman who injects heroin. The interviewer's notes commented

that she believed that Berta provided erroneous information during most of the

interview and had "scammed" her. For this reason, I removed her from the sample. The

final woman removed from the sample, Tywanna, is a 26-year-old black woman who

sniffs cocaine. She had one child living in foster care. She was also very difficult to

interview, according to the interviewer's notes, and provided little information on her

family, life history, sex partners, or drug use.

To examine the relationship between conditions affecting support and

experiences getting off drugs and trying to stay clean, I relied on the total sample of 25

women. All 25 women described at least one experience with drug cessation, although

experiences varied, as described in chapter five.

To examine the relationship between conditions affecting support and

experiences as a mother, only the 15 participants with children were selected. These

women account for 60% of the total sample size. Due to the focus on the women's

experiences as mothers, I chose not to include the entire sample of 25 women and not

to compare women with children and women without children in this chapter.

Characteristics of the study sample

In this section, I provide a brief description of the main demographic

characteristics of the study participants. Table 4.1 presents the participant's

pseudonyms, age at the time of the interview, race/ethnicity, number of children, and

self-reported drug use. The women's ages ranged from 20 to 41, with an average age of

31 at the time of the interview. The sample was racially diverse: 24% (6) of the women

were African American, 32% (8) were Latina, 8% (2) were self-reported mixed race/ethnicity and 36% (9) were white. Close to half, 44% (11) of the sample were high school graduates or had their GED,[6] none had higher level of education.

Heroin use was reported by 80% (20) of the women in the study; 40% (10) reported crack use; and 20% (5) reported cocaine use. Speedball, injecting a combination of heroin and cocaine, was also reported by 8% (2) women in the sample. Some 64% (16) reported they had injected drugs at least once in the course of their drug use. Some 44% (11) reported poly-drug use and 40% (10) reported heroin use alone.

Among the mothers, the number of children ranged from one to five. Three women had one child, seven women had two children, two women had three children, and three women had five children. At the time of the interview, three women were pregnant, although one of these believed she was pregnant but had not taken a pregnancy test or sought medical care. Ages of children at the time of the interview ranged from nine months to 25 years. At the time of the interview, seven of the 15 mothers and two children were HIV positive.

Table 4.1: Demographics

Name	Age	# of children	Race/Ethnicity	Drug Use*
Alex	24	0	White	Injects heroin
Anna	22	0	White	Injects heroin
Brigitte	20	0	White	Skin-pop heroin/cocaine
Danette	34	2	Biracial black/white	Smokes crack
Daniella	25	0	White	Injects heroin/cocaine
Ester	43	0	Latina	Smokes freebase cocaine
Fay	41	1	Black	Sniffs heroin
Glorice	41	1	Black	Sniffs heroin
Helen	26	2	Latina/white	Injects heroin
Jace	28	3	Latina	Smokes crack/injects heroin
Kitty	41	0	Black	Sniffs/injects heroin
Layla	31	0	White	Injects heroin/cocaine
Lorna	20	0	White	Snorts/injects heroin
Lorraine	31	0	White	Injects heroin
Mar	28	2	Latina	Smokes crack/sniffs heroin
Maria	27	2	Latina	Sniffs heroin
Martina	28	2	Latina	Injects heroin

Name	Age	# of children	Race/Ethnicity	Drug Use*
Mira	33	5	Latina	Smokes crack
Nana	36	5	White	Injects heroin
Princess	34	5	Black	Smokes crack
Renee	25	0	White	Injects heroin
Samantha	30	3	White	Smokes crack/sniffs heroin
Sandra	35	2	Black	Smokes crack
Trista	32	1	Latina	Sniffs heroin
Yolanda	33	2	Black	Smokes crack

* Drug use status (within past 12 months) on the basis of which the women participated in the study.

Participants were asked about whether they had been tested for HIV, HBV, or HCV (Table 4.2). Of the participants, 92% (23) reported that they had been tested at some point in their lives for HIV and 32% (8) reported being HIV positive at the time of the interview. The participants who reported HIV-positive status were Danette, Glorice, Jace, Princess, Renee, Sandra, Trista, and Yolanda. In addition, 52% (13) reported that they had had an HIV test within the past year. Nearly three quarters of the sample, 72% (18) had been tested for the HBV and 12% (3) stated they were positive (Layla, Mira, and Renee); 32% (8) had been tested in the past year. HCV testing was reported by 72% (18) of the sample, with 24% (6) reporting having tested positive (Alex, Daniella, Layla, Mira, and Nana); 36% (9) had been tested in the past year. It is possible that the percent

testing positive for HIV, HBV and HCV at the time of the interview was higher. A few

women commented that they were reluctant to be tested and two women were waiting

for test results at the time of the interview.

Table 4.2: HIV, HBV, and HCV Testing and Status

	%	N
HIV		
Ever Tested	92%	23
Reported Positive	32%	8
HBV		
Ever Tested	72%	18
Reported Positive	12%	3
HCV		
Ever Tested	72%	18
Reported Positive	24%	6

Table 4.3 summarizes select sample characteristics.. More than half of the

participants had been homeless at some point in their lives, 56% (14) reporting ever

being homeless and 16% homeless at the time of the interview. Their living

arrangements during periods of homelessness included shelters, living on the street,

and living with acquaintances. Living arrangements for women who did not experience

homelessness included living with family members, partners or associates, or living

independently in an apartment or in housing provided by government assistance

programs. Most participants (80%) indicated that they had been involved with the drug

business at some point in the past. Involvement in the drug economy or business

included selling or dealing drugs. Less (68%) reported that they had engaged in sex work

at some point. Some 12% (3) reported that they were engaged in sex work at the time of

the interview. Given the risks of involvement with the drug economy and illegal

activities, it is not surprising that 24 of the 25 women (96%) had a history of arrest

during the course of their drug use. The only participant who did not report ever being

arrested was Lorna, a 20-year-old white woman whose main drug use was cocaine.

Seventeen of the twenty-four (71%) women who had ever been arrested reported at

least one incarceration. Self-reported reasons for arrest included the possession of

drugs 48% (12), working in the drug business 56% (14), stealing 28% (7), sex work 8%

(2), assault 16% (4), and probation violation 16% (4).

Table 4.3: Select Sample Characteristics

	%	N
Homelessness		
Ever	56%	14
At time of interview	16%	4
Sex Work		
Ever	68%	17
At time of interview	12%	3
Arrest		
Ever	96%	24
Incarceration		
Ever	71%	17

Coding and analysis

Grounded theory

I coded and analyzed the interview data using a "grounded theory" approach

(Glaser and Strauss 1967; Strauss and Corbin 1998). As Corbin (1986:102) details in a

critical article on the process of coding, "Analyzing data by the grounded theory method

is an intricate process of reducing raw data into concepts that are designated to stand

for categories." Data reduction and coding, analysis, and theory are in reciprocal

relationships with each other (Strauss and Corbin 1998). By relying on a grounded

theory approach, this analysis uses theoretically informed coding categories and guided

research questions that I continued to revise through data analysis as unanticipated

themes arose. One of the key aspects of grounded theory is that it allows the researcher

to search for patterns in relationships among the data and inductively derive

conclusions, rather than force a structure onto the data (Marshall and Rossman 1995).

Atlas.ti

I coded the interview data using Atlas.ti (version 4.2), a qualitative software

package. The purpose of Atlas.ti is to provide a system of tools to work systematically

with qualitative data to code, reduce, extract, explore, compare, theorize, and interpret

findings. The benefits of the Atlas.ti software program are the organizational functions

that allowed me to manage a large volume of interview data easily. An additional

strength of using a software package to assist in qualitative data analysis is the ability to

reorganize codes and interview data for review, recoding, and further exploration of the

data. For each individual code, I followed the system in Atlas.ti of maintaining

information about a code that consisted of the code name, code description, code type,

links to other codes, and the frequency of the code's appearance within an interview

and across all interviews.

Coding

Atlas.ti allows the researcher to organize codes in several categories. This

provides greater ease for coding and analysis. I utilized several code categories,

including a preliminary code list, free codes, code families and a code structure. Prior to

the initial coding process, I entered a list of codes, which I refer to as a preliminary code

list. These codes were based on the dissertation literature review, proposal, and project

materials, and were created before I began coding the initial set of interviews. Atlas.ti

allows researchers to create codes throughout the coding process so that new codes,

called free codes, emerge from the data, rather than only from a prior code list, or in a

"top-down" method. I created free codes throughout the coding process, especially

during the initial phase of coding. Atlas.ti allowed me to create codes that were not yet

connected to any text or linked to any other codes. The coding process that I engaged in

merged a combination of prior theoretically and empirically informed knowledge about

the subject area and inductive exploration of the interview data. The process of coding

allowed patterns to emerge from the data itself, rather than from predetermined

expectations or deductive hypothesis testing.

First, I selected ten interviews to code and employed the types of codes

described above. Reading and coding this initial set of ten interviews allowed me to

become thoroughly immersed in the interview data. After closely reading the selected

ten interviews and working with the preliminary list of codes and new codes that I had

created, I added to the existing code list and created a new code list.[7] Each time I came

across a passage in the interview data that did not fit into one of the existing codes, I

created a new code category. I then defined the new code and continued to code the

ten interviews with the growing list as codes emerged from the data. Central to the

initial coding process was keeping detailed descriptions of codes and memos describing

how I defined a specific code.

Next, I focused on working with the new and much longer list of codes that I had

created while reviewing the first ten interviews. I refined the code list by first grouping

relevant codes into categories (code families). This let me compare and analyze the relationships among groups of codes. A code family allows you to link specific codes together and then explore relationships among those codes. For example, one code family was "future goals." This linked together all codes that had anything to do with women's discussion of the future, including drug-related goals, family- and child-related goals, and personal goals. This code family let me examine this group of code categories for similarities and differences. Second, I collapsed codes to reduce redundancy, as several codes described the same event or experience. For example, several codes related to women's relationships to family members. These involved very specific categories, such as, "attitudes about receiving money from parent," "attitudes about receiving bail from family," "attitudes about receiving rent money from family," and "attitudes about receiving money for food from family." Since these codes seemed to be closely related, I collapsed them into one code, "attitudes towards money from family." Third, I found that I had coded experiences and events that were not relevant to this analysis. I put these codes into one code family, in order to preserve the coding scheme for future analysis, but as not to distract from the current analysis. For example, based on codes emerging from the interview data, I initially coded passages related to "sexual risk reduction attitudes," then determined that this would not be included in the current analysis. I did not use these codes when I coded the additional 15 interviews.

At this point, I modified the code list and continued writing code memos to group codes together and to distinguish events and behaviors, attitudes and opinions, social context, and conceptual ideas. It was important to be able to distinguish

descriptive codes from theoretical codes. Theoretical codes emerged from preliminary interpretation of the data and led to initial analysis. Codes related to the concept of social support that focused on conditions of support, illustrate theoretically informed codes; I distinguished them from codes that illustrated exchange of resources.

In the next stage of the iterative process of coding, I coded the remaining 15 interviews using the refined code list. Once I was finished with this stage, I again examined the code list, collapsing codes that categorized the same data, regrouping codes, and removing extraneous codes. I determined this code list to be refined when there were sufficient codes to capture the topics of interest in the interview data. This decision was based on saturation of coding the data, elimination of redundant codes and a lack of further changes to the code list.

At this point, all the interviews had been initially coded. I read through each interview again using the initial codes and comparing them to the revised code list. I revised both the codes that had been assigned to the interviews and the code list following the method that Glaser and Strauss (1967) call "constant comparison." In constant comparison, Glaser and Strauss (1967) describe checking codes against the data and other codes in order to revise the code list so that codes are conceptually distinct and can be combined if they overlap. Often the beginning stages of coding results in very specific detailed codes that can be joined together into broader themes through the constant comparison method.

In the next stage of coding, I read through the coded interview data as attached to the code of interest and began to identify patterns in interview data grouped with the

particular code. I continued to revise codes when necessary, remove interview data that did not fit the patterns that were emerging from the data, and focusing on how the code categories were linked to the larger conceptual categories of interest. As an iterative process, coding continued throughout the analysis process. I determined themes and patterns that were relevant based on consistency across interviews and saturation of coding, and also identified experiences that would be considered outliers for the topics of interest in the study.

The main conceptual area of interest in this study is conditions affecting social support. The specific topic areas focus on women's experiences with stopping drug use and women's experiences as mothers. The salience of these two areas emerged from coding the interview data, rather than from deductive hypothesis testing. Initially, coding of qualitative interview data produces an overwhelming number of topic areas on which to focus. After preliminary coding and memo writing, I identified these two "central categories," as defined by Strauss and Corbin (1998). Many of the other issues coded in the interview data related to these two categories and they appeared frequently in the data. This practice of "selective coding," as described by Strauss and Corbin (1998), includes integrating codes and memos into the central categories for analysis and interpretation purposes.

The secondary categories that emerged through coding are linked to these main categories. Relationships that connect the different levels of codes are then examined. The secondary level of codes included norms about reciprocity, relationships, avoidance of negative interactions, and other contextual issues. The main conceptual issue of the

study, conditions affecting social support, was related to these issues, and connections

emerged from coding the data. Overall, the coding process provided an opportunity to

explore new and unanticipated areas for investigation leading to the research questions

presented in this study.

Chapter Five: Seeking Social Support When Trying to Stay Clean: The Role of Self-Reliance, Social Relationships, and the Neighborhood

Introduction

> Then I was staying with a friend of mine for a couple of months and right next door was a cocaine dealer and there was a heroin dealer in the building. I said, damn, I'm never going to get clean.

This was how Glorice described her experience seeking housing support from a friend. She was homeless and trying to stop her drug use but was also encountering easy availability of drugs. Her narrative illustrates some of the conditions affecting support when trying to seek assistance for housing and when trying to stay clean.

Most research on drug cessation and social support among women who use drugs focuses on treatment outcomes, as highlighted in chapter three. There is less attention, however, on the social conditions (structural, institutional and interpersonal) that affect social support transactions when women try to get and stay clean. The conditions that affect support seeking, receiving and providing are critical to examine because individuals do not receive social support simply due to the existence of social ties or social networks but rather engage in interactions that may result in assistance that increases or decreases risks for drug involvement as well as HIV/AIDS and other health issues. In addition, conditions affecting support for one type of assistance may create risks for other areas of health and well-being.

This chapter focuses on women's descriptions of periods when they try to get and stay clean. I explore the conditions that influence women's social support seeking, receiving, and providing when trying to change their drug use patterns. First, I describe

the main influences that women gave for changes in drug use patterns. Second, I

explore the conditions under which women stopped using drugs and the influence of

support transactions on these changes. Next, I discuss how the women in the study

navigated trying to stay clean and the conditions that affected whether or not they

sought or received assistance. I conclude with a discussion of the implications of these

findings.

Overview

The general perspective on successful treatment outcomes is that the existence

of positive social relationships increases the likelihood of continued recovery from drug

use (Bandura 1990; Falkin and Strauss 2003; Havassy et al. 1995; Strauss and Falkin

2000). In many studies, there is a distinction made between types of social relationships

– those who use drugs and those who do not – without exploring how and why women

contend with drug-involved social relationships in relation to harm reduction, treatment

seeking, and outcomes. For example, in a study of women mandated to a treatment

program, Falkin and Strauss (2003) delineated types of individuals that offer social

support into three main categories; individuals who provide helpful assistance

(traditional perspective on social support), drug-related assistance and individuals who

provide both. In another study, Nyamathi and colleagues (1996:37) argue that the

mechanisms by which social support enhances both risk avoidance and risk taking in

drug use behaviors and recovery are not clearly understood, "For drug users, it may be

that enhanced support and a resultant increase in problem-focused coping translates to

greater access to and use of drugs, rather than desired reductions in harmful

behaviors." However, a more nuanced exploration of the issues that women contend with when trying to stay clean might help explain reasons for and responses to relationships with individuals who use drugs as well as additional social conditions that influence social support.

Few studies have explored the underlying conditions that affect women's social support in relation to harm reduction and efforts to get and stay clean, especially efforts of self-regulation and self-reliance rather than treatment-based. Instead of simply dichotomizing social support as present or absent, it is important to understand why women who are trying to stay clean may seek social support from others who continue to use drugs. It is also important to investigate the specific conditions that affect support seeking and providing behaviors in order to develop effective treatment and intervention programs and policies that accurately reflect women's experiences. We know far less about an out of treatment sample in regards to these issues. The experiences of women who are not recruited through treatment programs provide a unique perspective through which to explore the conditions that affect support transactions.

Descriptions of influences on drug use: reasons to get clean

Throughout the interviews, women talked about many different influences that motivated them or led them to consider ways to change their drug use. Their experiences were categorized into two main themes; risk avoidance and self-improvement. Issues related to women with children are discussed in chapter six. Within the theme of risk avoidance, participants' descriptions focused on two main risk

areas; the risks encountered during sex work and the risks of arrest and incarceration. The second main theme that was salient in the interviews concerned self-improvement. Within this theme, feeling in control and improving health were important. These themes form a backdrop to the later discussion of the strategies women utilize to try to stay clean.

Risk avoidance: money and sex work and avoiding arrest

Daily life for women who use drugs is full of risks and dangers. Throughout the interviews, participants described some of their struggles just trying to get through the day. Struggles included trying to find drugs without being arrested and without encountering violence or other dangers within the street-based drug economy. For some women, the cumulative impact of everyday risks became a reason to want to get clean.

Money and sex work

The amount of money needed to meet basic daily living needs and access to money for drugs were constant concerns for most women. A common complaint that interviewees voiced was summed up as, "I'm getting sick of having to look for money for drugs…" When participants described wanting to get clean for a better life, some talked pragmatically about the costs of using. Ester, remarked, "So, I figure let me get, you know, on the program [detox]. And, ah and get off the dope… Because, not only was I doing dope, but I was starting to do the coke, so it was like two things at once. That's a lot of money that I didn't have." The cost of drugs and the social costs involved with procuring drugs were significant factors for several women to want to get straight.

Another motivating factor for many women in the study was to be able to end their involvement in sex work. More than half the women in the sample reported sex work (17 out of 25). Anna explained why she eventually stopped working on the street:

> Just because I couldn't stand it to begin with, and I don't know, I just, you know, I couldn't stand it and it just…and, I thought I'd better stop before I did end up getting something [HIV/AIDS, STD] and, you know that's about it… I think a friend asked me to go out there and watch her back one time, and I did and then just from there, I just, someone, this guy asked me to go out and I needed the money. So, I ended up starting to do it.

Ester, who had also engaged in sex work, commented, "And no way in hell am I going to go out in the street and sell myself, OK. Not for anything or anybody." When asked about her decision to enter a drug treatment program, Princess explained that one reason was that she was tired of sex work as her means of moneymaking for her drug habit. She explained:

> [A]hh, like just after a while you get sick and tired. You get sick and tired of using drugs and you know being with this one, being with that one, and your body gets tired. You know, because when you ask somebody for a favor, you gotta do a favor by using your body. Come on, you know? I got tired of it… Yeah, so. I just said, you know, no. I can't do it no more...

Avoiding arrest

As participants in an illegal economy, women who use drugs are under a constant threat of arrest for a range of illegal activities including simple possession, selling, possessing drug paraphernalia, sex work and even presence at locations where drugs are exchanged and used. As described by Layla, who was attempting to stay clean at the time of the interview, "I don't do anything illegal anymore to break the law, and I'm trying to get off the drugs and get clean so I don't have to go back [to jail]." Similarly, Mira remarked:

Some people do get tired of going back to prison and do change their lives you know. Some people don't. Some people end up living their lives, the rest of their lives, in prison. I didn't want to be one of those people... I started taking a couple of..., 'cause they have courses in there that you have to take, drug courses.

First-hand accounts of arrest (24 of 25 women) and incarceration (17 of 25 women) as well as stories from friends and family also impacted women's aspiration to get clean. Fear of arrest was a constant presence in women's lives, and Nana explained that she could not keep up with the debilitating course she faced. She commented, "Couldn't do it. I'm afraid to go to jail. Well, I mean, not afraid, you know, It's the habit. The dope habit. I don't want to be sick in the boot [jail]. You know. I think about that."

Self-improvement: feeling in control and improving health

Women also described wanting to actively change their lives and talked about this in terms of "feeling in control" and ideas about self-improvement. Participants explained that they felt as if their lives were being "controlled by drugs." Layla summarized this perspective saying, "[b]ecause I had to. I wanted to get off drugs. I hated it. I don't like being controlled..." For women who experienced homelessness, getting clean meant the potential to have more control over their living arrangements. As Layla remarked, "I didn't want to be strung out and go, be homeless anymore." Anna described her feelings about trying to get clean and her expectations for a future without drug use:

I'm just getting sick of the life style and getting sick of being broke and getting sick of not having anything and just, I'm always tired and like, I just look so awful. I don't take care of myself anymore that much. I, you know, I want to start having nice clothes and, hopefully, me and A [boyfriend] will end up being together like we want to, and that should make me happy and I want to find a normal job… just start doing stuff without drugs.

Improving health

Taking care of specific health needs was also a common theme. As Mira remarked, "I'm learning how to love myself… I go to the dentist now. I, I get regular check-ups, you know…" Focusing on self-care and improvement of health was an important consideration for motivations to reduce or cease drug use for some women. However, not all women were initially motivated by health problems as influences to try to get clean. For example, Kitty and Yolanda, both HIV positive, continued to use drugs, and explained that their initial HIV diagnosis was not a primary motivator for changing their drug involvement.

This brief section presents the two main themes that participants described as influences for wanting to change their drug use. While these are not necessarily exhaustive, they are the main reasons that participants talked about and highlight two different but interrelated areas of concerns. First, involvement in the drug economy creates a myriad of dangers that have been well-documented (Maher 1996; 1997; Miller and Neaigus 2001). While women engage in risk reduction and harm reduction practices, it may be difficult to avoid all forms of risk unless drug habits are completely altered. Second, descriptions of self-improvement are related to risk avoidance and risk reduction although often described in future goal-oriented ways. Both themes, while not exclusive of each other, provide some insight into women's attitudes towards their

drug use that may facilitate and constrain social support transactions when trying to get and stay clean. Next, I focus on the conditions of treatment experiences for getting clean that affect support transactions.

Conditions of treatment experiences: arrest- and non-arrest related programs

The reasons women offered to explain why they *wanted* to get clean were not always directly related to their ultimate experience of *trying* to get clean. Institutional level as well as interpersonal level conditions provide a framework through which to understand women's experiences. The findings are grouped into two main categories for presentation; programs related to arrest and incarceration and programs that are non-mandatory. As expected, many women experienced changes to their drug habits because of their involvement with the drug economy; there were also descriptions of changes in drug use that were described as self-motivated and program participation that was a result of family involvement. This section presents data on the different experiences with treatment programs, and whether women seek out social support or talk about feeling supported during these experiences. In addition, I describe how these experiences are part of the conditions that affect social support seeking, receiving or providing for trying to stay clean.

Conditions affecting changes to drug habits: arrest, incarceration, and mandatory drug treatment experiences

Women who use drugs face many challenges in trying to acquire drugs and other resources, as clearly documented in the literature on women, drug use, and risk (Maher 1996,1997; Miller and Neaguis 2002a, 2002b; Romero-Daza et al. 2003). Acquisition of

drugs, money and everyday resources puts women at risk of illness and disease,

violence, and punitive sanctions (Miller and Neaigus 2002a;). The women in this study

had all been active in the street-based drug economy in the Lower East Side or Bedford

Stuyvesant. Although they engaged in strategies to avoid arrest, they were not always

successful. Most (24) of the women interviewed had been arrested at least one time,

and 17 had spent some time in prison ranging from a few days to several years. Most of

the women were arrested due to charges related to drug use including drug dealing,

possession of drugs or paraphernalia, sex work, or stealing (see chapter four).

Non-program experiences during arrest and incarceration

Because of arrest, women faced prison sentences, and, at times, participation in

mandatory drug treatment programs. For some, arrest and punitive sanctions became

important factors related to changes in drug use, including a reduction in drug use,

changes in their drug habits, drug cessation, and withdrawal symptoms and illness. As a

result, this set of conditions mediated a certain type of drug treatment and was not

always perceived by the participants as supportive for recovery efforts. Negative health

effects and withdrawal symptoms were described as one aspect of the structural

conditions of arrest and incarceration. In addition, these experiences stood in contrast

to norms of self-reliance and attitudes when trying to make changes in their life.

However, it is important to point out that not all women cease drug use while

incarcerated; drug use in lock-up and prison is not uncommon (Maher 1996; Rosenbaum

1981).

Without the benefit of a drug treatment program, lock-up or prison do not

necessarily treat the physical symptoms of withdrawal of illicit drugs. Instead, the

women described painful withdrawal experiences. As Lorraine remarked about her

experience going without heroin after her arrest, "I was detoxing in jail, and … on the

floor…horribly, horribly, horribly. It was very degrading, it was very humiliating." Some

of the women interviewed described going "cold turkey" or "detoxing" but only

temporarily until they were released. Princess, who only remained clean while

incarcerated, described the difference between a voluntary detox program and her

experience of detoxing in jail, as follows: "It's not good, because when you're in there,

you're thinking about outside. But, you know you can't get out of there. You just can't

walk out like detox. You can't sign yourself out." She considered this a temporary

measure due to the constraints of her sentence. She differentiated this experience from

her experiences with voluntarily attending drug treatment programs in terms of her

ability to leave and be in control of changes in her drug habit. Martina, a heroin injector,

who spent almost a year in prison, reported that she that she was not put in detox.

Instead, she "kicked cold-turkey… Over five days. Beat the fuck down. Any little move

my shit'll come out. I was throwing up. Hot, cold sweat. I used to take a lot of hot

showers. Yo! Open the door! I gotta go shower!"

Incarceration-based treatment programs experiences

Another theme was the experience of treatment programs during incarceration

and the influence on social support for getting clean. This experience varied for

participants depending on their own situations. Getting clean through treatment

programs while incarcerated highlights women's experiences with a temporary receipt

of social support but was interpreted differently depending on women's circumstances.

A few women participated in prison-based drug treatment programs. Daniella

participated in a structured drug treatment program while at Rikers, describing it as

follows:

> It's just like a program, you know… They have four or five meetings a day, of an hour each… They have a rehab, like you have chores… your bed has to be made… By 7:30 you have to be up, you have to be clean, you have… it's not like the regular part of the jail where, you know, you can't even smoke on your bed… There's a room where you smoke…. It's a very structured thing.

Daniella commented that when she was released she immediately returned to using.

Thus, the program, despite offering a structured routine different from the general

prison population, had no long-term impact. Daniella's description raises the issue of

what types of prison-based treatment programs and follow-up after release would lead

women to continue a transition to recovery after release.

Past living conditions and risks involved in the drug economy as well as limited

opportunities for access to treatment programs led some women to seek support for

treatment during incarceration. Thus incarceration did provide a form of social support

that was not entirely undesirable. For homeless women, prison, while not actively

sought out, provided resources that were difficult to find on the streets, especially in the

winter months. Mira described the conditions of treatment programs during

incarceration as providing social support for getting clean. She described her periods of

incarceration as not entirely unintentional, but as:

Rest periods where I would stay away for a couple of weeks at a time, re-nourish my body and stuff. Put on some weight. And plus I got a, I spent a lot of time between '92 and up to January 2000 going back and forth to jail all the time. So when you spend time in prison and in jail, 'cause I violated parole a lot between '90….'99, yeah. And every time I went back I would, I would go back for periods of three to five months. So that automatically would give my body time to recoup. I'd come back out with all this extra weight and stuff and go right back into the drugs again. So I think that's what saved me most of the time, too, you know?

Mira explained that she did not use drugs, except prescribed anti-anxiety medications and sedatives, while in prison and as a means to try to become healthier, "…So those were rest periods that I took in there, come back out and go right back into the drugs again, violate parole, go right back in again." This cycle that Mira described was based on temporary drug cessation and a sort of structured social support for brief periods. Mira's experience illustrates how the conditions she faced day to day led her to seek out a somewhat drastic option of arrest and short-term incarceration, in order to have shelter and a limited form of health care.

Conditions affecting social support, even while incarcerated, included expectations of social relationships similar to sex work or "sugar daddy" relationships. One respondent described continuing her methadone at a higher dosage than customary while incarcerated at Rikers.

Helen explained:

I'm on the program on the outside and luckily the man who is in charge of the Methadone has a crush on me. He does… I'm on Methadone, he's in the Rikers Island. He's the keep….He likes me a lot and it was my first day there and I saw him. Everyone else that was on Methadone got 20, I got 70… Yeah, I got my 80… He said, you know, I did you a big favor, I put you on program, I filled out your paperwork without you even being here. I wasn't supposed to do that but he was like, you know, I like you. As I was getting released he came up to where you catch the bus to leave Rikers Island… and told me not to say anything but here's

my number, call me and we'll meet…I might call him and say thank you for the favor, you know, in case I ever go back. I don't want him to be mad.

Court-mandated treatment program experiences

Arrest also led to court mandated drug treatment programs without incarceration. In general, low-income women's experiences with drug treatment programs are more often the result of arrest and court-mandated sentencing rather than voluntary attendance at private or publicly funded treatment programs. A few participants stated that they knew the criminal justice and court system well enough to try to be sentenced to drug treatment rather than prison. Yolanda explained:

> When I went in front of the judge, I told the judge that I am a drug addict. I mean… No, I already know the system, because I've been through the system before. And instead of me getting a whole lot of jail time, it's better for me to tell them that I am a drug addict. This way they can help me…Because by having me sit in jail, for being a drug addict, it's not going to help me. Just let me go back, stay in jail, do my time, and then I have to do the same thing all over again, you know.

Since court-mandated programs are one pathway that the criminal justice system provides as an alternative to prison, women are sanctioned if they fail urine tests or violate program rules. They could be sentenced to prison. For some women, the programs became sources of risk of further sanctions rather than sites where they could seek or receive support for trying to get clean. The question of what would happen to them if they failed a drug test was always present and some women had difficulty navigating everyday obligations versus day program requirements.

Another participant preferred being sentenced to prison rather than a court-mandated drug treatment program, because of all of the rules of the program. Mar explained:

> So I told them, look, I'd rather stay the five months 'cause I want to deal with you all people. Because I could have came out in three months, you know… But I said no. But I would have to take that program. And I wasn't going to no program. That was like military style, you know. They say, when you're here… But the bullshit you got to through in there, you know.

Experiences with programs that sanctioned women for relapses were perceived as punitive rather than as supportive and the conditions created barriers rather than facilitating recovery efforts. As a formal source for social support, these types of programs were not necessarily sought by women for recovery efforts but for other purposes, as described above.

Further, the conditions of social relationships also influenced support seeking, receiving and providing, even within these programs. Mar described her experience with a court-mandated treatment program where she relapsed with another client from the program. Instead of mutual support for staying clean, they shared mutual support for drug use and then disagreed about what to do regarding the violation of the program's rules.

Mar described:

> She said… Let's go back to the program. I told her, yo, they're gonna punish me. They're gonna be hard because I was supposed to be taking care of you. I was supposed to be like responsible for you. And I said they were going to shoot me down, all of the way after I like starting all over. I don't 'want to feel that feeling. They are going to take all my passes. I'm going to be restricted to the house.… They're going to tell me all of those like yeah, I say it's an embarrassment, you know… I'm so embarrassed, you know. I said to her, I'm going to feel totally humiliated, you know. I felt like that. I'm not going back…

The rules of the program created a barrier for seeking and receiving social support for trying to get clean; Mar described her experience as a negative interaction with the program. These conditions led her to stay away from the program and impacted her continued drug use rather than shoring up support for her efforts to reduce her drug involvement.

Similar experiences of mutual support in social relationships for continued drug use during treatment programs was described by participants (Rhodes and Quirk 1996). Nana reported that she had been in detox two times and "…the same day I come out I go and buy dope." She also had been in a residential rehab program for 45 days and described, "…but I started getting high in the rehab. I met people that they had passes to go outside, so I used to give them, here, go buy me a bag, buy yourself a bag and take $20. So they used to do it. So, I came out of there with a habit." Others described going into programs where they got clean but spent their time thinking about when they would be able to leave and get high again. For example, Ester, remarked, "…I went to the hospital, and I stayed, it was…Um, six days and what you do there, is you think about drugs...Oh, when I get out of here, I'm going to get high…." These examples

suggest that drug treatment programs do not necessarily provide the type of social

support that women need to stop using drugs.

Overall, women's experiences with the different drug treatment programs

varied. Just as Mira described her stays in prison as respites, other women were more

likely to look at drug treatment as rests from the challenges and risks of their everyday

lives. Patterns emerged of seeing treatment as a respite and a means of risk reduction

rather than a means for drug cessation or recovery. Sometimes getting clean was a way

to seek social support that was used for a rest period or for risk reduction from drug

dealers, police, and sex work. Drug treatment also served as a temporary respite from

the conditions of the neighborhood, illegal economy, and challenges of everyday life.

Princess remarked:

> It's like you go out there and start all over again because like when people go to
> detox, that's just to get the rest, you know? And you get a meal and something
> like that. That's what a lot of people do. They just go there to hide out from a
> drug dealer that you took his stuff. So they figure they'll run to detox...

Women's decisions regarding drug treatment were based on more than their everyday

use of drugs; they were also based on different types of treatment programs, the

criminal justice system, avoidance of violence, and health care concerns. Thus, in terms

of social support seeking and receiving, the conditions of the neighborhoods, social

relationships and risks of involvement with the drug economy led women to participate

in treatment programs although not always for the express purpose of getting clean.

Non-mandated treatment experiences

Another salient theme concerns experiences with attendance at non-arrest or incarceration related treatment programs. Other types of drug treatment programs included private programs paid for by family members as well as publicly funded programs. Receipt of social support through private programs was often dependent on family participation and usually parents paid for the costs. Only a few women in the study had attended private drug treatment programs paid for by family members, usually parents. Women in private programs were no more likely to have better overall results for drug cessation or recovery efforts than other women in the study. There were some demographic differences that are notable, even with such a small sample size. Women who described their family members providing them material support for treatment programs were more likely to be white, to have families with financial resources, and to have families who resided outside of NYC. However, conditions of family support were not always constant. Availability of material support from family was described as unstable especially due to the inconsistent nature of family relationships. Multiple experiences with programs and relapses could lead family members to feel as if their support was "exhausted." Lorraine explained:

> I went to every treatment meeting you could go to. My father sent me to Hazelton twice… They found out I was using. They sent me out to Minnesota, Phoenix, all over the place, you know, the best places I can go to that you can afford and I wasn't ready and when they did finally cut me off ... I mean, my father paid my rent, I never had to work, he didn't know I was using all those years…

Lorraine would also go live with her grandparents in New Jersey to get away from the drug scene in NYC. Renee, a heroin injector, preferred publicly funded programs to the privately paid for program that her mother sent her to:

[M]other sent me to [New] Jersey, some old fancy place that never worked anyway… I'd rather go to a city hospital and see what they have to give me because that place, they were giving me, like, low blood pressure pills… or whatever….I was like, this is making me feel even shittier. I mean, it's not working. I need methadone. Knock it out… This was not for me. I did not like it at all.

Princess commented on a residential program that she attended:

When they talk to you, you have classes, you know, it's a great place. They have classes every day. You have a room. You shower. They give you back your respect and your humanity you know. They show you how to be yourself again, by being clean. You keep your room clean. You know, you got hot meals three times a day. You can't ask for nothing else….Once you got there, it's in your head and if you haven't got it, you're a hard head…

Underlying her description is the sense of respect and dignity she felt she received from the program. Another condition that impacted support was conditions of women's housing arrangements prior to treatment experiences. Participants who had been homeless or with unstable housing support were more likely to find the residential programs to be positive, even highly structured programs. These women described the non-drug treatment aspects of the program—shelter, food, and clean facilities—as the most attractive aspects. Drug-related treatment program services were in some ways described as secondary to what they gained from the housing support and health care services provided. Thus, getting clean at a residential treatment program for some homeless women belied a stronger motivation for stable living arrangements. Glorice explained the difference in her experience at two drug treatment programs:

I think so, yeah. I was getting tired. I was getting pretty tired. I woke her up and I told her, OK, I'm ready. She kept suggesting treatment programs and I just couldn't think of it. I'm a grown woman having somebody telling me what to do. It's the best move I made. I had started out in and to be honest, I tell my parents this all the time. For one, I don't think I would have had the desire to stay clean in D [treatment program]. I'm not even sure I would have had the desire to live in D [treatment program]. It's too hard a call for somebody that's really, I mean, I cannot even say I'm just HIV. I've got AIDS. Somebody in my condition, it's too strenuous. They start the morning off like 6:00 you're on the floor and you don't get off the floor until 10:00. I need naps now. Then, their food is just so un-nutritional. Any vegetable they cook it until all the vitamins go out. Just a lot of things. Not to mention, they start their day with what they call pull-ups… That's not my idea of starting my day. When I wake up I want to thank God for another day of life. I would sit there and say, this is not for real. Then I ended up in PSI. They start their morning off with this meeting called Good Feelings. You sing songs. You tell jokes. I remember sitting there in the morning meeting and I was laughing hysterically. When I came in there they had a bunch of comedians. I was laughing hysterically and I was like, oh shit, I'm sober. I can do this. I'm sober and look I'm laughing. I think they just gave me the desire to want it.

As Glorice described, qualities other than drug use and recovery were important in determining which program provided the type of social support desired to assist with her health. Assistance seeking when getting clean may be influenced by a multitude of issues, with drug use not always the priority. The conditions that affected support transactions included reasons for participation in treatment programs as well as the structure of treatment programs. In addition, concerns other than drug involvement were also salient influences on support seeking, receiving, and providing. This meant that, at times, women prioritized other health and basic needs over changing their drug involvement.

In the next section, findings related to experiences trying to stay clean are discussed. While the previous section focused on interviewees' experiences with different types of treatment programs and the effects of underlying conditions on social support seeking, receiving and providing, the next section looks more specifically at the support strategies for trying to stay clean. This shifts the focus to an exploration of the conditions that impact support seeking, receiving and providing during periods when women described that they had ceased drug use, even if during brief periods of time.

Conditions affecting support to stay clean

Interviewees described several different strategies to try to stay clean. Structural-level, institutional-level, and interpersonal conditions affect support transactions in this area. Trying to stay clean did not occur in neutral territory; instead, women navigated the social environment in order to avoid negative interactions while also contending with social relationships. In this section, I present findings on how women sought, accepted or provided social support to try to stay clean as mediated by specific conditions. First, institutional-level conditions are described through women's participation in voluntary groups. Second, interpersonal level conditions as relates to self-reliance and self-regulation are discussed. Next, the influence of social relationships, as an interpersonal level condition, on support transactions is described. Finally, findings of neighborhood conditions, which can be considered in the broad framework as structural level conditions, are described.

Voluntary recovery groups and meetings

In this first section, I describe voluntary treatment groups and meetings that can be thought of as institutional level conditions. As a strategy to try to stay clean, voluntary recovery groups such as Narcotics Anonymous (NA) offer opportunities to receive support and provide support for others through a group setting and formation of social relationships that are non-drug involved. The potential formation of new social relationships, removed from the social context of the street and drug use, may provide a sense of mutual support, based on a shared desire to stay clean. Voluntary groups and meetings are social settings where talking about recovery and a shared sense of purpose brings strangers together for a common goal. Thus, the expectation is that women's experiences at groups could lead to new relationships that provide support for recovery as well as expand participants' social networks. In fact, there is an assumption that recovery groups and meetings are, support groups; they provide members social support with little or no constraints. Findings here suggest that group rules and interpersonal relationships may affect support transactions in groups. Therefore, women's experiences are important to consider in evaluating support in this social context.

A relatively small number of women (10) in the study described experiences during periods trying to stay clean in which they attended voluntary treatment groups. It is unclear why more did not voluntarily attend these groups. Reasons might include a lack of meetings held in their neighborhoods, a lack of knowledge about this resource, negative feelings about treatment in general, and the social norm of avoiding former

users (discussed later in the chapter). Nevertheless, there was a range of opinions regarding the utility of the groups, and the role they played in women's everyday lives, including their perceived effectiveness for providing social support.

Overall, women had mixed experiences with groups. Groups were seen as settings for positive interactions with former drug-involved individuals who had been clean for a long time. Some members who were recovered from drug use served as role models, offering women a form of social support. Samantha described an overall positive experience with groups:

> Well see, that's why it's good with this place, because they got groups, and they got people that's been clean for like years, so I think it worked for them, so. And I already got a good idea, because this one, my cousin's girlfriend, you know, she's been clean for like a year and a half. So that's good. That's a good sign.

Samantha expressed some initial hesitation at attending this group because her cousin's girlfriend was a family member and someone who was already connected to her outside of the group. Her discussion of this time in her life reveals that asking for support to stay clean did not simply revolve around identifying people with resources but included issues of trust and disclosure. Samantha, like some of the other participants, did not necessarily identify family members who were available to provide social support. Instead, issues specific to family relationships (e.g., disclosure of drug use, prior family relationships) play a role in determining whether to seek support from family members or to rely on support from family members.

Unlike the women who described positive group interactions, some participants described groups as fraught with tension, particularly around issues of relapse and the

type of support they felt they needed to deal with the challenges of recovery after

relapses. While experiences of drug use and recovery are most often cyclical (Hser et al.

1997), some interviewees felt that the emphasis in voluntary groups was only on

recovery without acknowledgement that relapses occurred. Yolanda expressed a great

deal of frustration at the interactions she had with someone who was supposed to serve

as her "sponsor" or "friend" in the group she attended. She had been clean for several

months, relapsed, and then had stopped crack cocaine use for a month and was

attending groups to continue her recovery.

She explained:

> It's just like he has attitude, and sometimes he will bother and sometimes he
> don't, you know. Either you want to be my friend, and you want help me or you
> don't have to be my friend and just go on your way...And he's not trying to help
> me, you know. I explained my situation to him...Because if you're coming to me
> and you said that you needed help trying to stay clean, I'm going to do my job, as
> me being your friend, to help you trying to stay clean if I know that's what I can
> do.

Yolanda's frustration with her friend, who told her that he had been clean for 14 years,

suggests that she did not perceive the availability of support that she wanted. According

to Yolanda, the interactions with her friend were not sufficient for the challenges she

was facing after she relapsed. This suggests the importance of perceived availability of

support as well as norms of reciprocity in friendship (discussed later in the chapter) in

relation to the group setting. The conditions of the group as well as issues of friendship

did not automatically lead to receipt of support, based on Yolanda's experience. Instead,

her experience illustrates multiple factors influence support transactions even within

recovery groups.

A few women reported non-disclosure of information to the group as a coping

strategy to deal with the issue of relapse. Participants explained that they were more

likely to feel judged about their behavior than helped. As Samantha commented, "I can't

talk about myself, at meetings, I don't know. It's a lot of phony shit." A few participants

described concealing their relapses so that they would not be judged by others because

they felt that they would not be provided the type of assistance they wanted or needed.

Ester described her experiences with a NA group as negative as opposed to

supportive. She felt that rather than being supported for her efforts to stay off heroin,

she was labeled and stigmatized as a drug user because of her methadone use. For

Ester, this was very troubling because her participation in a methadone program was

successfully helping her stay off heroin and cocaine. The support from NA was

compromised by differing norms of what it means to be clean. She explained:

> They're very prejudiced….If you're in a methadone program you're using
> drugs….So, you're no longer, you're not NA, OK? You're not off drugs, you're still
> on a drug, and ah, you can't talk in the meeting….Yeah, if you're on a methadone
> program you have to tell them you're on a methadone program. Ah, if you um,
> well you know, like because this, if it's NA, you know, you're, you're there to be
> honest and open, you know? So, why lie? …Yeah. And, um because, that's what
> helped me off with the dope.

Overall experiences with groups were mixed in terms of the perceived

availability and receipt of support that women derived from their participation. In

general, having a place to go to interact with group members who were formerly drug-

involved was considered positive for women trying to stay clean; however, such

interactions were complicated by mistrusting others, feeling judged when relapses

occurred, and differing norms of support between group members and some of the

participants. While groups may provide some women new non-drug related social relationships, this was not the experience for all who attended groups. This suggests that positive support from interactions with non-drug involved individuals in recovery is not inevitable. The type of perceived assistance stemming from these groups was also affected by women's decisions regarding disclosure, particularly concerning relapse. Interestingly, few women discussed a feeling of mutual social support or reciprocity in the groups, contrary to commonplace assumptions about NA and other recovery groups. While groups are important sources for social support, it is important to consider the decisions that women make in relation to their involvement in such groups and not merely, whether or not they are involved.

Self-regulation and harm-reduction strategies

A second theme that was salient in the interviews was self-reliance and self-regulation, rather than reliance on treatment programs. In this regard, self-regulation of drug use and self-control in their drug habit was described as an important strategy to try to stay clean. While a drug treatment program would consider any continued cocaine, crack or heroin use as a relapse or failure, this behavior was interpreted differently by some participants in the study. Demonstrating self-control regarding the amount of drugs to use on a daily basis was both a pragmatic, economic decision, but also a sign of taking care of one's self. This also reflected the reasons for wanting to get clean. For example, Layla commented that both she and her boyfriend were recently thrown out of an in-patient detox program after three days. When asked whether she could attend an outpatient program and how she controlled her habit, Layla responded:

> Yeah, this one around the block, we could go to. I don't know if he's going to go or not…. I try not to, you know, do more than I need…Try to keep my habit low…. Will power. Common sense. You've got to control yourself, your mind, you know? You know how much need and what's too much and what's a waste of money, you know? I just don't throw a lot in the cooker, that's all….

For Layla, self-reliance was an important condition that drove her self-regulation as a first step to get clean and then try to stay clean. This contrasted with seeking support from treatment programs. It is also a reflection of Layla's perception of availability of support from other social relationships that might provide support. In addition, self-reliance and self-regulation could include harm reduction strategies although not necessarily risk reduction practices.

Religious faith was another form of self-reliance. Mira proudly admitted that she had not used hard drugs in two months prior to the interview and explained that she was relying on religious faith to help her stay clean:

> I just put down the drugs, I just stopped drugging. I'm still in the methadone program….Two months ago… I stopped. I was a crack smoker, I was an alcoholic… Well, I still am, because they say you still that, you continue being that all your life…So I, I put it down…By the grace of God my higher power, He's the one who's helping me stay strong…How did I stop? I just got tired. I mean, I remember saying one day, like, oh, God, give me the strength to finally put this down and give me the strength not to pick it back up again, to be able to say no and actually walk away from it.

Another woman, Yolanda, described attending Alcoholics Anonymous (AA) meetings at a church and when she was not using drugs, she stayed for the bible classes held each Sunday. She explained that she never attended church while using drugs but that she liked the bible classes and the church that she attended with her aunt, who had been in recovery for several years. While Yolanda described her relationship with her

aunt as positive, it was the bible class that she described as supporting her efforts to stop using. Rather than talk about the people in the bible class, she focused on the religious content of the class itself.

Overall, in both the discussions of informal groups and self-regulation and harm reduction methods of trying to stay clean, the emphasis for participants was on self-reliance more than on the strength of social relationships. The salient themes included conditions of trust, disclosure, norms about rules, and self-reliance that affected support seeking, receiving and providing. Variations in responses to groups and attitudes towards self-reliance illustrate how support for staying clean is contingent rather than fixed. In the next section, I describe women's social relationships and how they do or do not provide support for women who use drugs.

Interpersonal conditions that affect social support

In this section, I describe conditions on the interpersonal level focusing on participant's experiences with friendships, partners and family members. In terms of reducing drug use and trying to stay clean, women talked about a range of social relationships and the circumstances that led them to rely on particular types of relationships for social support. In this section, I describe three types of social relationships, friendships, family relationships, and partners. Specifically, I look at the issues that affected whether participants sought or provided social support from these types of relationships and how these relationships impacted women's efforts to reduce drug use and stay clean.

Friendship

For the interviewees, the very definition of friend and the meaning of friendship was multifaceted, and related to issues of trust, stigma, as well as social support. For the purposes of the dissertation, friends are non-family members and non-partner relationships. Descriptions of relationships that were non-familial centered on drug use and activities related to the drug economy. This is consistent with research on drug use, which has found that the social networks of drug users are often limited to other active drug users (Latkin et al. 1999; Miller and Neaigus 2002; Rhodes and Quirk 1998). Moreover, both during periods when women were using and when women were trying to stay clean, women described very few friendships in general. They mentioned few friends who were non-drug involved, and when they did mention acquaintances or associates, few women described being able to rely on them for help to stay clean.

An important theme that emerged from women's discussions of friends and associates was a strategy of mutual distancing rather than reliance on social interactions and active forms of social support. Therefore, there was a stress on self-reliance and social isolation rather than social interactions. Women separated themselves from friends and associates when trying to stay clean rather than seeking out social support. This suggests that social networks do not necessarily foster social support given the conditions in which women live and use drugs. This can be better understood by examining how women define friendship and how they describe differences between friends and associates, something that is not frequently done in studies of drug use.

"Drug users cannot be friends"

First, most women were reluctant to refer to the people they spent time with as friends. They were more likely to refer to them as "associates" or "acquaintances." Acquaintances that used drugs were often considered untrustworthy and unreliable. Renee commented, "I've just learned not to trust people…not even a friend. Just, I considered the people in the park [Tompkins Square Park] like, acquaintances." Renee's description of a person with whom she spent a lot of time during several years of drug use suggests that she viewed drug use and friendship as mutually exclusive:

> No, he was an acquaintance too, I mean, things would happen between us two that, I mean drug users cannot be friends. You know? I believe that. I just, you know, I mean I have a good heart and maybe I get taken advantage of a lot and that's why I don't consider any, I have any friends. You know? That's why I just, I'll say acquaintances first, you know?

Samantha considered one woman whom she met while incarcerated to be a friend but otherwise she did not trust anyone else with whom she spent time. She explained:

> Yeah, you know something, I'm telling, I don't keep, I don't have any friends, nobody. I only have, I do have one friend though, when I was in jail, she was a really good friend, Sherry. She was really a nice person. And we keep in contact a little bit, you know, I talk to her off and on, but…No. She's upstate [incarcerated]. She's…upstate. But I don't trust too many people though, because they usually, you know, they try to get your man, and they tell you lies and stuff like that… you know what I'm saying. …Yeah, really, they talk behind your back, you know, they talk in your face, and then, the next thing you know, they talk about you like a dog. Oh that bitch ain't shit. She's just trash, a whore, tramp, whatever else. And they steal from you and shit, you know. I just, I don't trust nobody at all.

Renee described a large social network of individuals who used drugs that she hung out with over the years including boyfriends, sugar daddies, and clients from sex work. She knew and interacted with many people through buying, selling, and using

drugs. When asked about whom she considered friends, she evaluated the different

types of people she knew and responded:

> I mean, I consider J. a friend because he's not a drug user. Me…uh W.[older male, non-user] and M. [older male, non-user], [I] would consider friends, because they would help me out, and I help them out and those three people I consider friends, but otherwise from there on, no…

This distinction between drug use and non-drug use as the basis for friendship did not

mean, however, that women did not spend the majority of their time with individuals

who used drugs. Moreover, women often had very few non-drug users involved in their

social networks.

Although many women considered others who with drug habits untrustworthy,

they did not always attribute this same quality to themselves. During the interviews,

they presented themselves as possessing the qualities of a friend, regardless of whether

or not they were using drugs. For example, Daniella explained that she would not

initiate her friends into injecting heroin and lead them from sniffing to injecting because

of the additional risks associated with it. Daniella commented:

> I was, you know, watching my friends, and I was like I, you know, I wanna go and everybody, everybody, my plans at that time, that was like two years ago, my friends at that time, they were all like, you know, nobody, well, I'm not gonna be the first one to shoot you up, you know. I'm not, I'm not gettin' anyone into that.

While many women seemed adamant about distinguishing between

acquaintances who were drug-involved and friends who were not, some described

friendships with others who use drugs and experiences where they were let down by

those they thought were friends. These experiences can be interpreted as examples, or

cautionary tales, for women to keep in mind for future interactions in their social

relationships. This suggests that the culture of drugs made it difficult to sustain

friendships.

In general, participants were more likely to describe friendships with other drug-

involved women. This may be because only a few women reported sexual relationships

with other women, and thus most relationships with men were either sex-based or

drug-use based. For example, Glorice explained that she had only one person she

considered a friend, another female drug user. She stated that she had known G. for

several years and that G. had her own house and would invite her over to use drugs

together and, "when G. felt lonely," to stay overnight. She felt positive about this

relationship because when she was involved with using crack cocaine, they used

together and did not seem to be in competition for drugs in any way. Thus, she believed

that if she did need a place to stay, she could rely on G. for assistance. For this reason,

and because they had never had any disagreements over drugs, she described this

relationship as a friendship rather than an acquaintanceship. Mutual social support and

lack of competition fostered a sense of friendship between the two women.

Other participants were more likely to recount stories where friends had let

them down and they had to rethink their perception of their relationships and their

reliability. Danette described having her wallet and ATM card stolen by someone she

thought was her friend, D. [male]. He had an apartment that was used as a crack house

and after a crack binge, she realized that her wallet was gone; she found out that her

bank account had been emptied and knew he had the ATM pin number. She was very

surprised that he would do this because she thought their relationship was different

than most of her relationships with other individuals who were drug involved. The

negative interaction led her to distrust him, and highlights the competition around

resources for drug use that is embedded in most relationships among those who use

drugs.

A few participants described experiences where they asked friends for assistance

and were denied help. Ester described a time when she and her husband became

homeless; she thought that she could count on a friend for a place to stay but the friend

did not help them. She explained:

> [W]e had nowhere to stay, nowhere to live, so we ended up living on the lot
> where he worked... And we had our dog. Unfortunately, you think you have
> friends when you have a problem, you don't have any friends. I didn't. I called a
> friend of mine, supposed to be my best friend, the only friend that I could say I
> had. 30 years, we were in the first grade together. We dipped and dabbed
> together, we went with the same man together, literally….And, but she said no
> to me, broke my heart.

Some women did report relationships with others in recovery; however, this

contact was limited and such relationships were not necessarily perceived as

friendships, or as actively supportive. For example, Daniella stated that she did not have

any friends at all. When discussing attempts to stay clean, she remarked, "I have a

couple of friends… I hang out with mostly guys…. From NA, actually. You know, because

my grandmother likes me to go to a lot of meetings when I'm home." She reported that

she spent time with them both when she was using drugs and when she stopped using

drugs. Yet her description of these relationships suggested that she relied on them to fill

time and placate her grandmother (who provided her with housing support and material resources) rather than relying on them to help her stay clean.

Given that participant's social relationships were often restricted to their immediate social environment, few women described friendships or relationships that were maintained other than in-person contact. Lorraine and Glorice described two exceptions. Lorraine described friendships with two women she only kept in contact with by telephone. One friend who she had she met at a methadone clinic 15 years earlier had remained clean. The other had never used drugs, according to Lorraine, an uncommon occurrence among the interviewees. A similar relationship existed for Glorice, who kept in contact with a friend only through telephone contact. One friend she had met in a drug treatment program and they talked often via telephone. The separate locations where the women and their friends lived created the barriers for their contact. Both women described these relationships as important. However, they were limited in the type of support that could be provided because the contact was mainly though the phone. This illustrates the problems of economic and geographic barriers often encountered by low-income women and their limited options for moving beyond the circumscribed neighborhoods in which they live.

Several of the participants described feeling as if they were alone in their attempts to stay clean and that they did not have friendships on which to draw social support. In fact, some expressed feelings of isolation both in terms of lack of support and in terms of interest in non-drug related activities. As Danette described, "I haven't been to the movies in a long time. People don't do that where I live at. They just want to

smoke and get high. They don't want to do shit…Yeah. 'Cause they strung out…."

Another participant, Yolanda, described trying to stay clean, relapsing, and starting

again, "And it's real hard, you know…And then my being alone, you know…Thinking I

had to do it, nobody's going to know about me, you know. Going inside, it's eating me

up more than anything you know…It's just me on my own…" Again, social isolation was

related to how women defined friendships and the limited opportunities to seek social

support.

Most of the women in the study reported few friends or associates in general

and more importantly, few who were non-drug users. Participants described feeling

frustrated by what appeared to be limited options about whom to spend time with

when trying to stay clean. When asked if they spent time with non-drug users, most

participants responded that, other than drug-involved individuals, they did not have any

one with whom to spend time. Responses from many participants included statements

such as, "I really don't have any friends;" "I don't trust anyone;" "I stay by myself;" "I

don't really hang out with many people."

Women's definition of friendship sheds light on the type of social support

available to them when they were trying to stay clean. The meaning imparted to

friendship, in contrast to associate or acquaintance status, presents insight into whether

and how drug-involved women might seek out support in this area of their lives. Issues

around trust and reciprocity are central to distinctions between friends and associates.

Not wanting to rely on others who use drugs is part of the interpersonal level conditions

that limit women's ability to seek social support and creates social distance and isolation when trying to get or stay clean.

Losing contact with associates or friends

Women reported knowing few other people who were also trying to stay clean. Many explained that they lost touch with friends and associates who had cleaned themselves up. In general, women's social networks were not necessarily stable for a variety of reasons related to the risks of the drug economy. Participants had varying degrees of knowledge of associates and friends who had been part of their social networks in the past but were no longer around. Participants described how some former friends had distanced themselves from their social networks because they were trying to get clean.

There was a range of knowledge about the whereabouts of these associates. Often participants described having an idea of where they might be but no direct interactions or contact. When talking about these associates, women were more likely to guess about the status of former associates or friends. In their descriptions, some participants mentioned that they might have a phone number or address but were uncertain as to whether this information was accurate or current. In descriptions of their friends and associates, participants explained that they often lost touch with them when they were getting clean and stated that this was not surprising to them.

Trista described not knowing the status of a particular friend. She used to live with this woman and use drugs with her as well. In response to being asked whether she maintained her friendship with this woman, Trista responded:

Well, I see her from time to time, but she is doing, I think it was, last year, she went to this place, to this program, and she tried to clean up her act. I don't know what she's doing right now, so...She was doing good like for a month or two. I don't know if she still is. She is trying to keep away like from everything. And that's really good, you know.

For women trying to stay clean, the lack of reliable information and contact information with which to maintain friendships with others who were also trying to avoid drug use created barriers to social support. Instead of actively seeking out former associates or friends for mutual support, participants described the loss of contact as the norm. In addition, stigma around differences in drug use status may also play a role in reasons why participants did not seek out support from former friends or associates who were thought to be clean.

For example, Anna commented on her relationship with a woman who was her sex work partner. They used to look out for each other while working the stroll (engaging in sex work on the street). Her partner had managed to clean herself up, and hold down a job at a clothing store. Anna described wanting to get in touch with her friend to renew their friendship; however, she did not want to reconnect with her friend until she was sure her recovery efforts were stable. Anna expressed concern that she would threaten her friend's recovery. The stigma of continuing to use drugs might be another reason that Anna did not contact her friend.

The lack of accurate information about associates or friends created risks for women in their own efforts to stay clean. Mira described a situation where she was trying to stay clean and thought that she would be able to rely on a friend. Mira moved

out of her boyfriend's house because he was still using and went to stay with this friend.

She explained:

> So I thought she was in recovery 'cause she was in recovery at one time back (this is quoted above), so she got into the methadone program because I helped her get into the program, right?... During the week I stood in her house… Then the friend's husband comes home and they start smoking crack – so I'm like, no this is not the place for me either. I said, I can't be over there 'cause they're going to do a drug raid. I, I just felt it, 'cause over there, there's heroin that I'm trying to get away from and this drug dealer that's hanging on the house and then, over here, now she's smoking crack… She's trying to make it look good by saying it's okay to do drugs once in a while.

The unreliability of social relationships with friends and associates while drug involved as well as stigma due to differences in drug use status may underlie the pattern of associates and friends distancing themselves from each other when trying to stay clean. This, of course, worked against mutual support for recovery efforts. Given this pattern, losing touch was not uncommon and served against seeking support for staying clean and increased patterns of social isolation.

Another example of losing contact with a friend due to differences in drug use status was reported by Anna. Anna had lost contact with a different friend when she was using and the friend got clean. She described an experience where someone claimed that this friend had started using again or was dead. She commented:

> Yeah. Well, I talked to her like a year ago because somebody had called me and said that she was dead, that she had got back on drugs and stuff and I was like WHAT?! I was like, no way! So then, I called this number that I had for her, and they called her. Then, she ended up calling me and it was like no, I'm not, I'm still clean.

Even after finding out about her friend, Anna described this experience in a manner that suggested that maintaining distance was a means of actively supporting her friend:

> Yeah, because I don't, I don't, I'd like to hear from her and stuff, but I'm still doing the same things. So, I don't want to be a bad influence. What am I going to say to her? Oh, I'm still doing drugs and the same stupid shit. So, I'm sure once I get clean that I'll look her up and be able to hang out again?

Glorice described her relationship with a woman who had an apartment that had served as a "crack house." Glorice considered this woman a friend, because she was able to rely on her for a place to stay. She described the relationship, though, as not necessarily supportive but reciprocal in terms of exchange of resources around drugs. This was the only person who Glorice referred to as a friend; she described the meaning she gave to friendship in terms of safety and stability in regard to housing issues. When asked if she was in touch with her friend, J., Glorice, who was trying to stay clean, explained:

> … I think housing wanted to put her out so she put her daughters on the lease so they actually have the apartment, but I think she's still staying there. The last time I saw her she was in recovery also. I don't know how good she's doing with it because she's right down in the heart of all of it. Sometimes geographically you really do have to make a change.

In addition, stigma may be an important influence on relationships with others who continue to use when the interviewees were trying to stay clean. For example, Princess came across an associate in the neighborhood who was still using during a period when Princess was clean.

She explained feelings of stigma that would also be involved in maintaining contact:

> Now that I got myself clean, so the knowledge that I have, I can offer to her, you know, and try to help her straighten up her life. But, see, some people don't think like that. They figure if they see you talking to a person that's using, crackhead… You know? And some people they figure if they see you talking with them, you make a reservation, or you're making plans to meet them, or if you pass them a dollar or something, you're giving them money to go and get you something to smoke. You know?

Trust, reliability, and drug use status are important components that women use to distinguish friends from associates in their social networks. These distinctions are not simply superficial but affect how participants describe their experiences seeking support when trying to stay clean. Many participants reported not knowing the drug use status of associates and friends whom they had lost contact with, especially those who had initiated recovery efforts. This meant that social relationships were not necessarily sources of support to stay clean.

Partner relationships

There were variations in women's descriptions of their relationships with partners, specifically in terms of support seeking, receiving and providing. Women explained that differences in drug use status often leading to the breakup of relationships; others described feeling responsible to try to provide support for their partner to get clean as well. Differences in drug use status in relationships varied in terms of whether women left relationships because they wanted to get clean or whether they believed they were hindering their partner's chances for recovery. Some participants expressed concern that their continued drug use might negatively affect

their partner's chances for staying clean, thus decisions to support their partners might

mean ending the relationship. Although providing support for partners might jeopardize

their own efforts to stay clean, providing support for partners might be more vital.

Norms of reciprocity around support for getting and staying clean is a salient condition

in relationships and varied from other types of relationships.

Relationships with boyfriends or husbands who were clean were described as

strained based on differences in drug use status. For example, Martina described

breaking up with her boyfriend of three years. He was in recovery and she had started

using again after a period of staying clean. She moved out of his apartment, explaining

that:

> [H]e tells me "I love you to live, I don't love you to die." You know and it's like I
> don't want to hurt him, so I stopped… Um-hm. A couple of weeks ago, last time
> we saw, we spoke and tried to make amends, tried to get together…I keep using.
> Who the fuck wants a woman that's using dope and shooting up and is never
> home because she's too busy running after that fucking bag?...

From her perspective, Martina's drug use jeopardized their relationship, and while she

described stopping in order to maintain the relationship, she eventually returned to

using.

Partner relationships were also expressed as motivators to stop using drugs.

Layla commented that she and her current boyfriend of six months, who were involved

in the drug economy, were going to quit drugs soon. She had known her boyfriend for

several years, but had only recently begun a relationship with him. Layla commented,

"And I don't want to lose him over drugs. He's gotta go to probation this week. So we

have to clean up. There is no we should, or maybe it's a good time to, we have to, and

we're gonna." Another woman, Anna, described stopping drug use to be with a boyfriend whom she loved, "…because I was pretty happy with him and plus I didn't want him to start doing it, and so I kicked and then…"

At another point in the interview, Daniella described several of her relationships with men. She reiterated norms of reciprocity and mutual support for staying clean that were important yet unstable in her relationships. However, one of her previous boyfriends died when they relapsed together after both having been clean together. She explained:

> I had a boyfriend die, and it like you know. It's funny, we were in NA, I was six and a half months clean. He had 18 and a half months clean. We decided to go to the city to get something to eat, he lives in Jersey. I guess in the back of my mind both of us knew what we were going to the city for, it was just not only to eat. You know, because we were going to the Lower East Side. So, I guess, you know, whatever we, got some drugs, you know copped some stuff and we came back to Jersey and you know we were, we were getting high. You know, shooting up, and…

For some women, the fact that a boyfriend got clean motivated them to end the relationship rather than necessarily motivate them to get clean. Daniella described her experience as, "Yeah, Jose was a boyfriend but…Just broke up with him, he doesn't get high, you know. You don't want a person that gets high, if they're trying to stay clean." Most of the women who expressed this sentiment focused on the needs of their partner and not their own needs. Renee explained:

I've told Mel too that I would love to be with Mel but I told him I'm not going to be with him because I'm on drugs…Until I'm off the drugs. I mean, I refuse to be in a relationship, something, I've never had that connection before, I've never felt like so attracted and so connected to somebody and just so free with somebody and I'm not going to mess that up over drugs. And it will get messed up. I mean, he doesn't, he says oh no, we, nothing will ever happen, pff, yeah, well. When you [need] $40 or $50 every day and you don't want me to work and I mean you know you don't you can't afford to give me money every day it'll be a problem. You know? Because I'm going to start lying… I'm going to start doing things that, you know behind your back and I just don't want to go through that, I know it won't work. So I told him when I get clean then I would think about being with him. Literally being with him, in his house or living together. But until now, I'm not going to, you know…

Mar described an experience when she had gotten out of prison, was clean and moved in with her girlfriend who had started injecting and engaging in sex work to support her habit. This strained her own attempts at staying clean; Mar started dealing so that her girlfriend would end the sex work. She commented:

She wasn't shooting up. She would smoke, you know, and sniff dope, you know. Her habit was always worse than mine. But you know, I had decided to take care of her. She didn't have to do that, you know. So then, when I came out of jail, I heard she was shooting up. I still tried to talk to her, why she don't need that shit, you know. So what happened, but she, I mean she gotten so bad that she would betray anybody, you know what I'm saying. It's like, I still care for her, but you know…

Mar's relationship depicts the difficulties of differences in drug use status between patterns and obligations that one partner may feel to take care of another. In contrast to friendship or associate relationships where losing contact when one person gets clean is the norm, Mar remained, supporting her girlfriend, which increased her risk of both arrest for selling drugs and relapse.

Another example of this theme was women's assistance with their partner's recovery efforts. Kitty, who was HIV positive and trying to stay clean, talked about her

common-law husband who was also HIV positive and sniffed heroin. Her experiences

illustrate the difficulties inherent in relationships where social support is not

reciprocated because one partner is using drugs while the other is in recovery. She had

met her husband at a Special Treatment Unit HIV/AIDS day program. They had been

together for three years and, according to Kitty:

> This is the longest relationship I've ever been in….Loving relationship. I don't
> usually be in a relationship like longer than like six months, eight months, nine
> months. Never a year, never. And it feels good to be in something that's steady
> like that. It feels good. So, the same way he's with me with my illness, my
> medication, I told you he's good for me help me take my medication. And so,
> he'll, he, OK, so it's like the way he helps me out with the pill, take my
> medication, I'm good for him in a way, too, up here because I like to see, I like to
> buy clothes. I like to dress him and I like to, you know, window shop and look for
> things, for him, not just for me. And I like to motivate him to look nice and to
> spend on himself…

However, Kitty also described the difficulties she had with his drug use:

> I just get tired of everything, drugs and stuff, because, you know, he's
> jeopardizing my, OK. Him just messing, you know, getting high and us being
> together is a jeopardy… He don't mean to…At times, I says, yes, has been clean. I
> have been able to keep him clean. Yes, I have, but it doesn't last long.

Indeed, she had relapsed several times and was nervous about doing so again. Yet Kitty

never mentioned ending the relationship during the interview. This was due, in part, to

the fact that she was concerned about her health, although both she and her husband

were HIV positive, she got sick more often than he did. Her husband did try to hide his

drug use, which Kitty took as a sign of support for her own recovery efforts, although it

was a limited show of support because she always knew when he was high. Yet, rather

than focus solely on his drug use like some of the other participants, she assessed the

importance of his support to counter his involvement with drugs.

In some cases, pretending to be clean was a strategy that each partner might attempt to provide a show of support for each other. Ester explained that both she and her husband pretended to be clean until they discovered that they each had started using again. Ester explained:

> It was very hard to hide it. You know, if I bought it outside and then I'd come in high. But I was checking up and he was more or less right, had the same kind of, you know, if I felt good, if I closed my eyes or whatever or nodded out, I kept looking at him saying well you know he looks like he's nodding out, too. Like what is he doing.. So finally we just know got, sat down and really talked. I said, listen, I'm doing this, so. He says, oh yeah, wow, well I didn't know, you should have told me cause I do it too. So I says OK. So then we started doing it together.

Overall, partner relationships did not provide much social support for recovery efforts. Instead, they reveal conditions that affect support seeking, receiving and providing. Norms of reciprocity to provide support for partners, either to help them stay clean or remain in relationships with drug-involved partners to provide support for other needs was a salient theme in the interviews. These narratives were similar and different from accounts described above for friendship and associates. For some women, providing support for partners meant remaining at risk of relapsing; other women whose partners were clean ended the relationships in order to support their partners' efforts. In this respect, there was an emphasis on the needs of the male partner, although this may also be tied to other issues related to access to resources.

Family relationships

Overall, women had minimal contact with family members (parents, grandparents, siblings) when they were trying to stay clean; when they did have contact, the interaction was often conflict-ridden. There were only a few instances when women

talked about receiving support from family for staying clean. Descriptions of their

relationships with family members around their struggles to stay clean varied based on

issues related to social class, degree of contact and the presence of children living with

family (issues related to children are discussed in detail in chapter six).

Participants whose family members were not low-income were more likely to be

white and live outside of NYC. They described experiences in which they were able to

change their living arrangements and receive housing support from family. These

families were also more likely to have sent the participants to private residential drug

treatment programs outside of NYC and paid their fees. Yet, not surprisingly, the pattern

of drug use, recovery through private drug treatment, and renewed drug use created

strains on family relationships, as described earlier in this chapter. Thus, the housing

support and support for drug treatment programs from their families was not

unconditional. Instead, a return to drug use could lead to a change in the support that

was offered by family members, particularly loss of living accommodations.

Daniella described living with her grandparents in New Jersey for part of the

year. Her grandmother encouraged her to go often to NA meetings. She described her

grandmother as the most important person in her life, even though she expressed

concern that she had done a lot of "terrible things to her" like "stealing money from

her." She commented that she was not sure she would be able to return to her

grandparent's home in New Jersey, "Um-hm. If, you know, if, if my grandmother has to

talk to my grandfather, I don't know if he actually wants me back." Daniella explained

that the last time she had relapsed; her grandfather stopped talking to her. Although

she was in recovery after the previous relapse, she was not sure whether the relationship had been irrevocably changed.

Lorraine also stayed with her grandparents when she was clean. She described her concern if her mother found out that her current boyfriend was on methadone and therefore a former drug user. She explained that she might be told to leave her grandparents' home if that fact were discovered. In the past, she and a boyfriend had stolen her grandfather's credit card and charged thousands of dollars. The history of negative interactions with her family led her to believe that she had perhaps exhausted their supply of social support.

Another participant, Layla, described visiting her grandmother in New Jersey about every two weeks. She relied on her grandmother for housing support during certain periods and used drugs at her grandmother's house although her grandmother assumed that she was not using. She reported that sometimes she would use the house as a safe place to inject cocaine since she was often homeless, squatting or staying at associates, and did not have safe places to inject. She used these visits as respites to take a shower, have access to food, and steal about $50. However, because her grandmother assumed she was in recovery, the support she offered was contingent upon Layla hiding her drug use from her grandmother.

Relationships with grandmothers who helped raise the interviewees were common, and described for the most part as loving, but not necessarily close or truthful. It is not surprising that women would not necessarily rely on their grandmothers for support to try to get or stay clean. Most participants described feeling ashamed that

their grandmothers knew they used drugs; thus, they hid their drug use and often

pretended to be in recovery.

There were some instances where women described positive experiences with

family members. Yolanda described how she improved her family relationship once she

stopped her drug use. She is also HIV positive and explained that she had a positive

relationship with her family at the time of the interview but that it took a long time to

rebuild. Yolanda seemed especially happy that she had been given a key to her parent's

home, and it seemed to signify a sign of trust in their relationship. In contrast, she

stated that her sister, who also was involved with drugs, did not have a key to her

parent's home. She explained:

> I know that I worried my family a lot when they didn't know where I was, if
> something happened to me. You know if I was dead or alive, you know. I know
> that I put them through a lot of changes, and it messed up, my drug and, you
> know. Now, I'm able to go in my house, stick the key and unlock the door. Go in
> and lock up behind me, and go in the kitchen and fix me something to eat. You
> know, I can get on the phone, say mom, I'm not feeling too good today, you
> know.

Glorice described when she decided to go into a treatment program and the role her

parents played in the initiation of this process. She explained:

It was basically one event. I had been out on a seven day run and I was just cold, tired and I had pneumonia. I had pneumonia. Anyway, I managed to stumble over my mother's house and when she opened the door I basically fell into her arms. I was so grungy and dirty that she literally took me into the bathroom, took all my clothes off and bathed me like a baby. I was coughing so bad she wanted to take me to emergency. Now, the way their apartment is situated, my mother and father's room is on one side of the apartment and the guest room is on the opposite side of the apartment. So, that night my mother bathed me, put pajamas on me and put me in the guest room and tucked me in. I was coughing so bad and she tried to get me to go to the hospital. I told her I just needed to rest, I just needed to rest. That morning when I woke up…and I saw her sleeping all cramped up on that couch because she was scared to go to her bedroom, she wouldn't hear me cough or cry out or whatever. I said, oh, I'm done. I'm done. Yeah, it was bad.

When asked if she had been considering going into a treatment program, especially because she had been diagnosed as HIV positive, Glorice commented, "I think so, yeah. I was getting tired. I was getting pretty tired. I woke her [mother] up and I told her, OK, I'm ready. She [mother] kept suggesting treatment programs and I just couldn't think of it…."

While there were some examples of receipt of support from family members, there are a number of reasons why so few women turned to family for support. These included stigma around drug use status and relapses and fear of losing housing support. Deceiving family members in order to maintain support illustrates the limited supply of support available to these women as well as concerns about past conflicts that might obstruct supportive transactions. Women may have exhausted their support from family while using drugs and thus judged that family members would not assist them when they were trying to stay clean. For example, Fay described her mother as her best friend. She did not, however, describe relying on her mother for support during periods

when she was clean and expressed regret over how she had treated her mother. She

explained:

> Yes, yeah, man, but she, my mom, man. Oh man. I've done so much shit that my mom, I said, man, when they say love unconditionally, she fucking loves me unconditionally because I have stole from her. I have lied to her. I went to the loan shark and said my mother said, gives her $300. I borrow money from her friend she worked with and didn't pay it back. I stole her wedding ring.

Even for participants who temporarily stayed with family members, some found this

arrangement to be stressful rather than supportive.

Most of the women's families were very unstable, living in low-income

neighborhoods with little resources. For example, Danette commented that staying with

her family would not be helpful because, "there were a lot of drugs and people doing,

shootin' up in the stairwells and everything." Alternatively, the conditions of family life,

which included other family members using drugs, led some women to decide to stay

away from family rather than seek out support. Intergenerational patterns of drug

involvement, criminal justice involvement and illness was a condition that affected

family relationships. Several women had family members who were also using drugs,

were HIV positive, or had died from drug-related causes, AIDS or gun-related violence.

In addition, several women described sexual and physical abuse by family members

during childhood and adolescence, providing additional reasons why they might not

seek out support from family.

In general, social relationships did not provide much in the way of social support

for efforts to stay clean. In sum, friendship and associate relationships, partners and

family relationships are not neutral relationships providing social support regardless of

circumstances. Interpersonal conditions including norms of reciprocity, trust, obligations for assistance and resources and the cumulative impact of prior interactions influence support transactions. In all three types of relationships, expectations and the meanings of relationships played a role in whether women received or provided support.

As the findings have shown thus far, participants in the study described experiences of self-reliance. In the final section of this chapter, neighborhood conditions and participants' responses in relation to support transactions are explored. Through their narratives, several themes emerged suggesting that women believed that an effective strategy to stay clean was to avoid social contact which meant not seeking support for a range of needs. Avoiding negative interactions combined with limited social contact fostered social isolation among participants.

Avoiding the neighborhood and "minding my own business"

Many participants' descriptions when talking about periods of time when they were trying to stay clean included discussions of the neighborhoods they lived in and where they used to hang out while using drugs. Their daily activities often revolved around the everyday demands of acquiring drugs and other resources. This often occurred in the neighborhoods where they lived, which had high rates of drug use, violence and crime. The social environment presented risks both during periods of drug use and cessation. The risks during periods of drug cessation included the availability of and access to drugs through locations for purchase and use of drugs as well as through social contacts. Not surprisingly, to avoid contact with potential sources to purchase or use crack, cocaine or heroin often meant avoiding these neighborhood areas. This was

not easily accomplished, particularly given women's constraints in social and economic mobility. As already discussed, participants in the sample were dependent on public housing, had periods of homelessness, moved from place to place and stayed with family. Very few women described housing stability and those with stable housing were located in areas that included access to drug use as well as risks of violence. It is important, therefore, to consider the role of the neighborhood, as described by participants, on support seeking, receiving and providing as it relates to strategies to stay clean.

One reason that some women avoided the areas where they used to spend time was to avoid the stigma of being labeled a drug user. Even when trying to stay clean, some women perceived that others viewed them as drug users; their central identity was as a user. Thus, women's interactions with others in the neighborhood were complicated by their status as drug user. Danette commented, "Yeah. If I wanna be somebody or do something, I mean I gotta do something [leave the neighborhood]."

Anna commented on how the neighborhood had changed [positively] and that it was more difficult to buy drugs out in the street anyway, so she felt that she would be fine staying there. One reason Anna perceived less concern about the neighborhood may be that most of the associates she used to hang out with in the streets were no longer there; many were dead, arrested or had gotten clean. Anna explained:

> I don't know. Years ago, I thought that, but I don't think so anymore because they've cleaned it up so much that it's actually really hard to get drugs anymore. It's like nowhere on the streets anymore…It's mostly all beepers and, in fact, I only know two people that I can call that are actual dealers. I don't really, well, now one because the other one got busted the other day…So, I don't, you know, so, I think it would actually be, I'll be OK now because before, you would just walk down the street and damn, it was right there. And a lot of the people I used to hang out with aren't around anymore. They either left or they're dead…

She believed that the "new crowd" in the neighborhood who would not identify her as someone who used drugs would assist in her recovery efforts. Anna commented:

> I don't really know anybody anymore. It's like a whole new crowd in the neighborhood now because I haven't really been hanging out to meet anybody. So, I'm hoping it would be, I think it will be easier… to stay off of it as long as I don't go and meet the wrong crowd. Like, if I get off of it, I think that I'll be OK because a lot of the people I know now don't even do drugs. And some of them know I do, but I like, I just, I don't like to let people know that I do it.

The stigma of being identified as someone who uses drugs should not be overlooked, particularly as this identity influences individuals who stay within the same neighborhood where they formerly used.

> Another participant, Princess, described an experience after detox:

> I had a friend; I walked through there one day, that's when I first came out of detox… you want to stop up by me for a few [drug use]? What does this mean? I didn't want to take a few minutes. No, no no. Now I know it's tough making it from down there, you know, because that means that you don't care [about yourself]…

The stigma of being identified by others as a drug user, even when trying to stay clean, was compounded due to constraints on where women lived and spent time. In addition, participants' inability to avoid the areas where they formerly used also made it difficult to develop new social relationships.

A central theme that was salient in many participants' comments was their struggle to avoid areas where they formerly bought or used drugs in order to avoid negative interactions. Some women commented that they felt at jeopardy by their surroundings in efforts to stay clean because the risks around them were too great. Staying away from certain neighborhood areas was combined with avoiding the people with whom they had associated. One participant, Mar, described her struggle with this situation. She explained:

> If you get involved at all, because I don't, once I stay home, and I don't do nothing, I'm back to square one, because I start getting bored. Then all the places where I know, I end up going back to there, you know. They're all right there, they want me, you know. And I'm getting tired, I really am, you know, getting tired of things, you know. I want to have my own things; you know what I'm saying.

Decisions about what neighborhood areas to frequent had an impact on whether women perceived opportunities for support that increased or decreased the likelihood of staying clean. Access to drugs was linked to relationships with individuals as well as the social environment where women spent time. Lorraine described this connection:

> I stayed clean for like four months, when I first came back to New York in August. She [associate] just happened to call, and I said, no, I been clean, I don't want to come into the neighborhood. Once I come into the neighborhood, I don't want to trigger.

Some participants actively avoided certain areas of the neighborhoods where they used to hang out and buy drugs. Several women recognized the easy access to drugs that the neighborhoods in which they lived afforded them. As one participant summed up her experience, "[I] came out [treatment program] and went back downtown [neighborhood] and fucked up again." Princess remarked, "And I avoid there. The only

time I pass there is when I got to go downtown, and I'm on the bus. And I just look. The

same people are still outside... When I see them, I just wave to them on the bus." Not all

women, however, had the option to deliberately avoid the areas where the used to use.

Princess described experiences where she left treatment and then encountered former

associates when she returned to the neighborhood where she lived:

> And then when you get out of there like as soon as you get on the block it's like
> oh Princess. I'm glad to see you. What happened? Here. You want a hit? You
> know, and then I'll be right back in the same predicament. And I got tired of it.

These comments illustrate an emphasis on decisions to avoid negative interactions as

opposed to actively seeking social support for staying clean. However, other than a few

women who were part of programs related to care for HIV, women did not describe

having alternative social environments that might provide opportunities for supportive

relationships.

The importance of the neighborhood context was not limited to avoiding social

relationships in areas associated with drug use. Women's living arrangements were

often tied to these neighborhoods, and, for some women, drugs and criminal activities

were present within their apartment buildings, on their block, or down the street. Thus,

it was impossible to detach from the effects of drugs on a neighborhood. For example,

Glorice had no stable housing and had stayed with different associates and friends over

time. During a time when she was not using crack, she was without a place to stay and

relied on others for housing. She described her frustration at her inability to steer clear

of a particular area of Bedford-Stuyvesant, Brooklyn. She commented, "Then I was

staying with a friend of mine for a couple of months and right next door was a cocaine

dealer and there was a heroin dealer in the building. I said, damn, I'm never going to get clean." For Glorice, it was not the support that her friend provided her that was in question; it was the location of the apartment that brought risks that seemed inescapable. Finding a place to stay was paramount for Glorice and while she was able to rely on a friend for social support, this decision brought with it risks due to the location of the housing and the conditions of the social environment.

Similarly, Yolanda, who had been clean for several months, described the conflict she felt in having stable housing in an unstable neighborhood. She explained:

> I got my own apartment out in Brooklyn… In Bed-Stuyvesant….And when I first moved in the neighborhood, it was really nice, you know. My apartment is great, because where I live at, in the building I live in, it's like all the people have lived there for a lot of years, you so… The building is beautiful. It's clean, you know. Everybody in the building helps each other. You know. It's just that the neighborhood is starting to be a little rough for me, you know….It's just, there's a lot of young kids in the neighborhood. They do a lot drugs there… Everything, you know. And then me trying to stay clean, that's the hardest part, you know. Because they sell my main drug of choice there, which was the crack the one I've done... And it's like I be subjected to it when I come out of the house and go and come back, you know. Because I have to come pass them in order to get to my block, and I have to go pass them to go out to where I have to take my business, you know. Sometimes it's like a real struggle for me, you know…

Yolanda's concern about the neighborhood and the availability of access to crack cocaine illustrates how decisions regarding living situations may affect chances to avoid negative interactions regarding the availability of drugs. This suggests that rather than participants seeking or accepting social support for recovery efforts, their focus may be on avoidance of drugs distinct from shoring up support for recovery. The norm of treatment and recovery, which is to avoid any exposure to drug use, is difficult for many

women to achieve. This structural condition of neighborhoods rife with drugs and crime is a significant underlying condition that affects women's ability to avoid negative interactions that involve access to drugs instead of social support for staying clean.

Another theme that was salient in the interviews was a strategy of self-reliance or self-support. Participants described avoiding places and people that might lead to using drugs again. These experiences varied depending on women's access to resources, relationships with family members and others, and access to housing. In order to avoid the risks of their surroundings, including drugs, drug associates and dealers, participants described staying home or inside for most of the day, and spending the day alone. It is important to note that participants were more likely to describe staying home alone than spending time with friends or family as measures to try to stay clean. Common among women trying to stay clean were descriptions of spending time alone, a form of social isolation. Like Daniella, many women commented about how they spend their time, "You know, I like to be home. I feel safe home..."

Women described not spending time with anyone, except if they were going to a day program or group, or if they had a partner (boyfriend, husband or girlfriend). Several women commented that they did not want to get together with anyone they could easily hang out with because almost all of their associates and acquaintances used drugs (as described earlier in the section on social relationships). Thus, the time they had spent on acquiring drugs or resources to get drugs was not necessarily replaced by other activities. Similar to other participants, Anna described her experiences when trying to get and stay clean:

> But lately, I haven't really been hanging out with anybody, like, since I've stopped working [sex work], you know, on the streets and doing, since I cut down all my drugs and stuff, I haven't, pretty much just stay home or I go out and, you know, to the restaurant and see A. [boyfriend]. That's about it, till I walk my dog.

For women who were attending treatment programs, their days were organized around that particular activity. These women had a specific reason to leave their apartment and neighborhood, depending on the location of the program. Women described going to their treatment programs as one of few activities that occupied their day, which was somewhat different from those who did not have this activity to fill part of their day. As Princess commented, "I stay home a lot…The only time I come out is when I have things to do like the clinic or to see a counselor…You know, that is the only time I come out…"

"Minding my own business"

Another salient theme that emerged in the interviews was for the women to stay away from people they knew who might offer them drugs. This strategy, however, was not always successful. While women were very deliberate in avoiding specific people, such as former dealers, and places, they could not control everyone they would meet in their daily lives. Even when avoiding actively seeking out drugs, some women felt that drugs found them. For example, some women would run into former associates, boyfriends, or sex partners, or people they had lost touch with, who would reintroduce drug use. This suggests that support for drug use was more readily available than support for staying clean. Women's identities as drug users, even when trying to stay clean, along with the environment they lived in, made it difficult for them to avoid

opportunities for renewed drug use. Several women described drug-related experiences

when they were trying to stay clean. As one participant put it, she was "minding my own

business," and ran into associates who were active, resulting in drug use. These

connections with the "once in a while pal" were infrequently discussed in the interviews

but almost always resulted in using drugs together, thus derailing their attempts to stay

clean. Fay described:

> But then I ran into somebody I hadn't seen in a while. They asked me could they
> come up to my house? I know that they get high, it's like I sabotaged myself…She
> had a couple of bags of dope. She smoked crack. She was sitting there and she
> said, do you want some?...I could say, well somebody helped me fuck it up? I
> didn't want to take the responsibility for myself. See, I've got a lot of shit with
> me, I know me. Instead of me doing it on my own, I'll run into somebody, come
> on so I can say they're the one that did that shit in front of me and that's why I
> wanted to do it. So, I sat with her and she gave me a bag and I sniffed the bag.

Jace described a similar experience when her boyfriend left and she had a temporary

relapse. Jace described sitting outside her apartment and an associate came by, offering

her crack cocaine:

> I was home alone and I got some money. So I went out in front of my building, sit
> down with the baby to play, and this girl I know, she popped the crack on my
> face. I'm like, OK. I can do it now. He's not here. I'm alone. I don't have to give
> urine this week. So I relapse again. But that time, I only relapsed on that day, No
> for three days.

Women perceived the social context of the neighborhood and the risks associated with

the people they would try to avoid as a challenge to staying clean. It is important to

point out, however, that participants did not seem to blame the associates as much as

themselves. This may be linked to the emphasis on self-reliance rather than seeking out

social support for trying to stay clean; thus, failed attempts were also framed in terms of an individual failing.

Conclusion

In this chapter, I explored the conditions that influenced support-seeking when women are trying to avoid drug use. These conditions included the women's appraisal of their risks involved in the drug economy, their social relationships, the social environment of their neighborhoods, and the emphasis they placed on self-regulation and self-reliance. Few explorations of social support among women who use drugs have examined the conditions that affect support transactions (seeking, receiving or providing) when trying to get or stay clean. Experiences trying to stop using drugs are often examined through treatment-based studies (Strauss and Falkin 2001) and less often through naturalistic descriptions stemming from interviews with women who are discussing their overall lives in the context of their drug use.

Women's experiences varied in terms of reasons to get clean, experiences with cessation of drugs, and strategies to get or maintain efforts to avoid drug use. The main reasons provided to stop drug use was to avoid risk behaviors and for self-improvement as well as to maintain sex partner relationships (relationships with children are discussed in chapter six). These findings are similar to other research on women who use drugs (Ashley et al. 2003; Jackson et al. 2003; Nyamathi et al. 1997). However, seeking out social support did not directly result from these motivations for several reasons. Experiences with court-mandated and non-mandated treatment programs suggest that women may not consider programs supportive. Instead, participants

emphasized strategies of self-reliance and self-regulation in contrast to, what they perceived as, the limitations of the availability of social support.

Interestingly, in a study of federal prison inmates entering a voluntary drug treatment program, Jackson and colleagues (2003) found that hope was negatively associated with entering treatment. The authors discuss how hope, as measured by a 12-point scale, may reflect a reliance on the individual self and a lack of recognition of the importance of formal treatment. While the individuals in Jackson's study were incarcerated at the time of the study, the issue of hope and self-reliance is also relevant to the findings of this study. In this analysis, the emphasis on self-reliance is a response to limitations of social relationships and the social environment. Self-reliance also is seen as a form of social isolation and therefore the opposite of social support. Yet the findings in this study present a more nuanced perspective on this relationship.

Many women described trying to stay away from others who use drugs, staying home alone, and avoiding certain neighborhood areas. Avoiding negative interactions often meant social isolation, and there were limited descriptions of participation in voluntary groups that were appraised positively. Women's appraisal of their social relationships and the social environment of their neighborhoods, as well as the emphasis they placed on self-regulation and self-reliance, fostered social isolation.

Another finding is related to prioritization of health needs and support. Decisions for housing support, for example, were a critical issue that often undermined opportunities to try to stay clean. While women described trying to avoid others who used drugs, it was not always possible to avoid such interactions. Decisions regarding

housing support as well as continuing partner relationships were two areas that were at times prioritized over decisions to try to avoid access to drugs. Specifically, in partner relationships, some women prioritized the needs of their partners over their own and remained at risk for continued drug use in order to maintain the relationship.

This dissertation indicates the significance of several broader conditions that contribute to our understanding of the role of social support in two areas in the lives of women who use drugs. The identification of these conditions is particularly important given that studies on women's drug use and treatment that include social support often focus specifically on the quantity of supporters and the types of supporters rather than women's role in interpreting availability and provision of social support. In addition, little research has examined reasons why women may report few social supporters in these studies. In fact, the findings in this dissertation present a more nuanced understanding of social support through the identification of conditions affecting women's support transactions. Neighborhood conditions, including access to drugs and unstable housing support, affect women's decisions to seek, receive, or provide social support. In a prior analysis of these data, Miller and Neaigus (2002) examined the resource acquisition strategies of participants and found that most women described strategies that were related to the drug economy and their male sex partners. This decreased risk reduction and increased women's risks for HIV/AIDS. Miller and Neaigus (2002) contend that the findings provide important evidence of the "costs and obligations," or a form of reciprocity that may be involved in receiving support from male sex partners. This dissertation broadened the analysis on social support and looked

at an even larger set of conditions that influence support. In addition, the findings

emphasize a way of looking at support that can be used to examine other health

problems.

Women who use drugs may not be at the point in which they are willing or able

to separate from all social ties that use drugs. Again, given the realities of their lives, this

may not be a realistic expectation of service providers and is not an expectation of harm

reduction programs that conflict with court-mandated and prison-based programs. This

pattern had a significant impact on women when seeking housing support, and

demonstrates that prioritization for assistance is not always based on avoiding drugs. In

other words, participants seek to meet their basic needs and may be unable to move

away from access to drugs. Harm reduction programs that include comprehensive

services as well as programs for eventual cessation of drug use may be able to foster

social ties among participants in a way that traditional treatment programs do not. The

social context beyond individual risk behavior, as the findings in this study suggest, must

be addressed or behavior change will not be sufficient to improve women and family's

lives (Weeks et al. 1999). Multifaceted programs that address other conditions are also

important. Programs that are located within neighborhoods, given the difficulties of

women moving, are also an important factor, particularly to foster new social

connections.

Participants' perceptions of their opportunities to seek out or provide support

have many implications for intervention-based studies and drug treatment studies. I

discuss these implications in chapter seven. The analysis above also suggests that we

rethink the way social support is measured in intervention studies to provide a better

understanding of the lives of women who use drugs.

Chapter Six: Conditions Affecting Social Support for Drug-Involved Women with Children

> Yeah, I gotta go to a program or something. But here it is, I can't just go and clean myself up, and then leave my son in the predicament he's in and let something happen to him. 'Cause then I ain't gonna want to get clean.

Danette, a 34-year-old woman with two children, expressed concern for her son and for the prospect of leaving him to attend a drug treatment program. Her narrative illustrates challenges drug-involved women face when trying to juggle providing support to their children and seeking support for recovery efforts in their role as mothers.

Many women who use drugs are mothers, children are often central in the lives of women who use drugs (Campbell 1999; Khoshnood and Stephens 1997; Metsch et al. 2001; Oliva et al. 1999; Walker and Rolland 1989). Most research on mothers who use drugs focuses on pregnant women, drug treatment, health care, custody issues, and children's development (Chavkin and Breibart 1997; Deren et al. 1990, Deren et al. 1995; Howell et al., 1999; Sterk et al. 2000).[8] Only a few studies focus on how women who use drugs participate in their children's lives, and evaluate their role as mothers, and on the conditions that affect social support transactions for children's care (Enos 2001; Hardesty and Black 1999; Richter and Bammer 2001). Studies that have focused on women, drug use, and motherhood have consistently found that, regardless of custodial arrangements, for most women, being a mother plays a significant role in both women's drug use and recovery process (Baker and Carson 1999; Boyd 1999; Enos 2001; Hardesty and Black 1999; Richter and Bammer 2000**).**

In this chapter, I focus on interviewees' strategies to provide and receive social support for their children and to bolster their role as mothers in the context of their drug use and efforts to cease drug use. Women's descriptions reveal conditions that color their assessment of the provision and receipt of social support in their role as mothers. A close examination of supportive transactions in mothers' relationships with their children reveals underlying conditions that influence 1) how women decide to provide, seek, or receive social support and 2) the limited capacity of women to provide social support, due to attempts to avoid negative interactions with children as related to drug use.

This chapter is focused on the 15 women with children in the study. I begin with data about the children's living arrangements. Next, I describe the women's responses to the different placement situations of their children. These sections provide information about who is providing basic, yet critical forms of assistance for children's care. Housing needs and everyday forms of social support (e.g., food, shelter, clothes, parental involvement) are integral to understanding if women are able to participate in their children's lives and if they provided or received support during this period. This information is based on the women's self-report at the time of the interview and it is important to note that it was not confirmed by other sources. In the central part of the chapter, I focus on how women endeavor to keep their drug use separate from their children in order to provide social support for their children, and examine the conditions that lead to positive and negative interactions with children. This also highlights how such conditions affect women's own support seeking or receiving transactions. Finally, I

conclude the chapter with a brief discussion of implications for future research and policy.

Children's living arrangements, at time of interview

This section provides important information regarding the living arrangements of children, as reported by the mothers in the study. Providing care for children can be identified as a form of social support, a form of assistance for the well-being of children that is ordinarily a mother's responsibility. However, among the 15 women, there was a range of custodial and living arrangements for children, ranging from women assuming the role of primary caretaker, to women visiting children who were living with family members, to women having no contact with children. In addition, many siblings lived with different caretakers. In general, participants had relatively fractured ties to their children and relationships were strained due to their drug use as well as to other factors that are discussed below.

Mothers as main caretakers

Overall, women were not likely to be the main caretakers of their children; only four women, Fay, Jace, Maria and Trista, reported that their children resided with them. These four women were able to be the primary caretakers of their children because they lived with a partner or received government assistance. However, only one of these women, Trista, reported less drug use or longer periods of cessation than the mothers who were not the primary caretakers of their children.

The living arrangements for these four mothers and their children varied. Jace, the mother of three children, was the caretaker for her youngest child while her two

older children lived with her sister. Maria was receiving housing for herself and her children through a program for low-income single mothers. In the past, however, she had experienced several years of unstable housing and had relied on family members to house her family. Fay's son was 25 years old at the time of the interview. He had been living with her but had been arrested for selling drugs and was incarcerated at Rikers at the time of the interview. Trista reported that her daughter, age eight at the time of the interview, resided with her and her husband and that she had maintained custody since birth.

Family members residing in NYC as main caretakers

Most of the mothers' children were residing with female family members: mothers, sisters and grandmothers. Frequently, family members had been awarded temporary or permanent custody of children by New York State through the involvement of the Bureau of Children's Welfare (BCW).[9] Most often, family members lived in the same neighborhoods as mothers or in other neighborhoods in NYC. Many of these family members had limited access to material resources other than limited government assistance. In general, the State identified placement with family members as the best choice for children and many, although not all women, expressed agreement or were satisfied with these arrangements. Mothers whose children resided with family members in NYC had different levels of contact with their children: some temporarily lived at the same residence; some visited their children regularly, and some had little or no contact with their children.

Family members residing outside of NYC as main caretakers

Helen, Princess, Samantha, and Sandra had children adopted by family members who resided outside of NYC. Helen lost permanent custody of her children to her parents in California before moving to NYC, while Samantha's children resided with her parents in Buffalo, New York. Samantha reported that she occasionally visited them and expressed a desire to bring them to NYC and to become a full-time parent.

Princess' and Sandra's children lived outside of New York with their biological fathers. These fathers were willing to take care of their children when most fathers were not. Other than the possibility of their children having a "better life," neither Princess nor Sandra provided reasons for these specific custodial arrangements. Sandra's older son was living in Germany with his father, who was in the military. Sandra had no contact with her son or his father after custody was awarded, which was years ago. In Princess's case, the father of three of her five children was awarded custody and he resided in Florida.

Foster care and adoption by non-family members

Only two women had children removed from their custody and placed with non-family members. These women, Sandra and Princess, had 2 and 5 children respectively; however, in each case, only one child was adopted by a non-family member. Sandra's youngest child resided in foster care since birth. Princess had lost her parental rights to the youngest of her five children who had been in foster care and was eventually adopted. For both women, the combination of drug use during pregnancy and unstable lives without reliable family members led to their children's placement in foster care and eventual adoption.

Responses to children's placement

Instead of assuming that drug-involved women do not care about their children, I focus on the conditions that affected support during decisions regarding their children's custodial and living arrangements. In addition to women's drug use, institutional level conditions (State involvement) and interpersonal level conditions (family involvement) affected women's ability to provide social support for their children. This occurred in many social contexts and a particularly important moment was the involvement of others to determine whether women could even be the primary caretaker for their child(ren). Given that a basic function of mothering is to support children and that involvement with drug use and the drug economy constrains this function, it is important to examine how support is altered during a change in children's living and custodial arrangements. Several themes emerged from women's descriptions of children's placement related to social support from their families and the State, as well as their own ability to provide social support for their children. Conditions included relationships with family who were raising children, women's drug use, access to resources and assistance from others as well as issues relating to reciprocity.

Social norms of motherhood dictate that mothers provide care for their children and are the main source of social support. In contrast, laws governing ingestion of drugs during pregnancy reflect an assumption that drug-involved women focus on their drug habit rather than caring for their children (Daniels 1993; Roberts 1997). In this study, women were reliant on family members for children's care, as well as for providing them with forms of social support to varying degrees. In this study women were

compelled both by court-mandated decisions, by family members and by their own

decisions to rely on family and strangers for children's care. Regardless of the reasons,

degree of contact varied after placement. Women became dependent on others,

particularly other family members, to care for their children, which introduced an

element of dependency into their relationships with other adults. Although most

women were not able to provide a home for their children, this did not mean that they

did not want to participate in their children's lives or even in the decisions around

children's placement. It is important to point out that some mothers with multiple

children described varying experiences depending on the child and the particular

conditions. This also suggests that decisions around providing and receiving assistance

are context-specific and can change over time.

Conflict-laden family relationships

Some women described feeling they were not involved in decisions regarding

their children's placement. While this would be expected for Princess and Sandra, the

two women who had children adopted by non-family members, it was also true for

several other women in the study. Participants including Helen, Jace, Mar, Martina, and

Sandra made comments that their children had been "taken," "stolen," or "snatched" by

family members or the State without their consent. Even women who had family

members take over caretaker responsibilities through temporary or permanent custody

of children did not always find these arrangements to be amenable. Some felt that they

had no control in decisions regarding their children's placement, even though children

were living nearby with family members. Women with conflict-laden family

relationships were more likely than those with amicable relationships to express

dissatisfaction with their children's custodial arrangements with family members. A few

women struggled with the loss of their children and blamed their parents who had

custody. They stated that parents had promised to return children to them once they

were in recovery but did not follow through with this promise.

Helen described how she felt she had been tricked into giving custody of her

children to her parents and how she regretted letting her mother have her children. She

further remarked that if she had been able to keep her children, she would have gotten

clean and not continued to use drugs. She described her mother as an abusive parent

who lied to her about returning her children after Helen got clean. In response to

believing the situation to be hopeless, Helen left California and traveled across the

country to NYC. In telling her story, Helen reported that her mother agreed to return

the two children to Helen after she got clean but later denied ever making that promise.

Helen claimed that she never consented to give up her children for adoption to her

parents:

> I let my kids get taken and put up for adoption, thinking my mom would still be,
> would surely let the kids come over, think I'm doing ok. 'Cause I would have
> stopped using the drugs… she said that I, I'll give them back to you, I thought she
> would. But then she said that she never said that she'd give them back… But
> after that, I just continued to use speed.

Helen's narrative suggests that her own mother did not lead her to feel as if she

could support her children and the adoption reinforced this perception. She described

the loss of custody of her children and perceived inability to provide support for them as

a reason to continue drug use, rather than a reason to cease using drugs. Finally, Helen

described the link she made between the relationship she had with her mother, her children's placement and living arrangements and her own coping skills regarding her drug use. While it is not clear that providing support for her children would have helped Helen in recovery efforts, her comments suggest that she identified this role as significant. Based on her self-report, Helen perceived her mother's dismissal of her ability to participate in her children's lives as evidence that she failed as a mother and that getting clean might not even provide a chance to alter this situation.

Another participant, Sandra, explained that she had a son with a married man who took custody of him and subsequently moved to Germany. She described wanting to be part of her son's life. Sandra said that she was prevented from even seeing her son because of the estranged relationship she had with the father of her child:

> But it was hard, you know. I struggled with it. I had nightmares about my son calling me in my sleep, you know. Mommy, mommy, take me, I want to come home… And I kept trying to get his mother to call him [father] and let me see my son. But she wouldn't call him or anything… just to see how he was doing…who he was, what he looked like…Let me see him.

After that point, she had no contact with her son. Sandra's other child, a daughter who was seven years old at the time of the interview, was in foster care and Sandra was able to visit with her.

Another participant, Mar, talked about decisions that her mother made concerning living arrangements. She explained that she did not want to "give" her child to her mother, but she felt that she was not given a choice in the decision-making process. She stated that her mother "had to get involved in this because the courts want to take them. As a matter of fact they didn't even give them to me when I had them in

the hospital… he came out [HIV] positive and everything…" Mar reported that her

mother was awarded temporary custody of the older child and adopted her younger

child. She stated that after all of this happened, "Now I'm smoking more and everything.

I started selling drugs, you know." Mar's response to her children's placement suggests

that she perceived a connection between her inability to provide support for her

children, as their mother, and her increased involvement with the drug economy.

Because of her drug involvement, Mar lost custody of her children, which shifted

responsibility to provide support to her own mother. Mar's response to this change, as

she commented, was a further distancing from her children.

Other mothers, including Helen and Princess, also described what they felt was a

marked increase in their drug use after they lost custody of their children. As Helen

described, "…things just went downhill after that." Another participant, Trista,

commented that her transition from sniffing to injecting heroin was a result of the

removal of her child. Princess, talked about a daughter removed from her care because

the child was born with crack cocaine in her system. Princess explained:

> No, no. So, after they took her, that really made me go out and use, because
> that's like a part of you that somebody's taken away from you, telling you, you
> can't see her no more. And you got to wait till these people are willing to bring
> her to the Center to see her. And, then, you and the father's fighting and
> everything, going through your ups and downs. After you have the baby, he's
> saying he don't want the baby. And I'm like, what? And that really tore me up.
> You know, if you would have told me, you know I would have got me an
> abortion. I wouldn't have had to walk around all these months with no big belly
> or whatever. You know what I'm saying? That really hurt me and everything,
> so I turned back to drugs again.

The strained relationships with family members as well as the perception that they had no role in their children's placement negatively impacted interviewees' drug use and attempts to get clean. Women's sense of involvement in their children's placement seemed to affect some of the decisions they made about whether to seek out help or assistance. This may have influenced their drug use or recovery efforts. Receiving social support from family members, in their role as a mother, even with limited contact with children, may influence women to seek out treatment options (providing that effective treatment options exist). Women's descriptions of being undermined in their role as mothers suggest that women who use drugs are concerned with their role as mothers, even when not maintaining custody. Women's responses, which focused on feeling as if decisions about children's placement were taken out of their hands, were affected by their family relationships and assessment of their drug use. Mothers identified decisions that led to increased drug use as resulting from a lack of support and not being able to provide support. In addition, strained family relationships were an important condition that affected their perception of issues related to arrangements of children and their role as mothers.

Accommodating family relationships

In contrast, other women described the placement of their children as a more active process. For some, it included asking family members to raise their children, assessing family members' ability to provide care for their children at the time, and finding satisfaction with the overall caretaking arrangements. Princess described:

No, I'm from here. They had moved down there [Florida] because I was going through my drug thing and he got tired of it so he took the kids and he left. 'Cause I gave him [children's father] custody, you know because I didn't have time, I didn't have the patience, you know? And he's a good man. He took the kids, he took care of them, and the kids grew up beautiful.

Another mother, Jace, stated that she was relieved that her sister took over the primary caretaking responsibilities for her children, "But thank God for my sister. My daughter now is fine, you know. She's a smarty. My oldest son, he's a smarty. But they're in a good care, now. She will take care of my kids so good…" In this case, self-assessment of drug use and abilities to provide for her children were part of the reason that Jace had a positive response towards her sister's role as caretaker. Similarly, Mira explained:

Yeah, if they weren't, if my mother didn't take them out the hospital, by the time they were two years old, they were living with my mother already because I couldn't deal with them myself. I couldn't, I mean I knew how to change Pampers and feed them and stuff, but I didn't have the patience because I was still in between, I was still, I would try to stop it cold turkey, doing drugs, just to take care of them, and it wouldn't work, 'cause, 'cause there's like a temper tantrum type of thing that we go through when we're kicking drugs, and there's this desperate period.

Some participants realized that their drug use made it difficult for them to manage their role as mothers and provide full-time support for their children and therefore relegated care to family members. Several women reported that their housing arrangements and daily lives were too unstable for them to act as primary caretakers for their children and thus turning custody over to family members was the best decision for their children.

Fay talked about the relationship she had with her mother, who had taken care of her son, even though Fay had continued to steal from her:

> He was living with me and my mom. My mom was on the top levels on the second floor. A lot of times he was with her most of time. And I was pacify him by buying him everything he want and send him to my mother 'cause he'd be in my way. My mom, man. Oh, man. I've done so much shit that my mom, I said, man, when they say love unconditionally, she fucking loves me unconditionally because I have stole from her. I have lied to her. I went to the loan shark and said my mother said, gives her $300. I borrow money from her friend she worked with and didn't pay it back. I stole her wedding ring.

Just as Fay's experience suggests that these relationships were not without strain, other mothers discussed a sense of ambivalence. Sandra represented herself as evaluating her inability to care for her child due to her drug use, feeling guilty over drug use during her pregnancy, but also experiencing undue pressure to place her child in foster care. She commented:

> Yeah, she is in foster care first. But then when I see that I couldn't take care of myself, that I wasn't able to stop using drugs, that I kept relapsing. I kept relapsing. And they kept pushing that, the adoption…So what we are going to do, they were going to put her up for adoption… I can't figure out, how could I do it to such a precious girl. My daughter…. I smoked crack while she was in my stomach.

In addition, a number of the participants commented that when the State/BCW became involved in their children's care, they became proactive and assessed the appropriate caretaker for their children. "The State wanted to take them…but I didn't want that to happen, so I signed them over to my mother…" Another participant felt confident that giving her child to her sister was the best option because, as she remarked about her sister, "I like the way she takes care of my kids." Women's responses to the institutional and interpersonal conditions through involvement of the

State and their families that affected their ability to support their children differed

significantly.

Jace explained that one sister wanted custody of her child in order to receive

government benefits; thus, Jace made sure it was a different sister who was awarded

custody. She felt strongly that her child be cared for properly and not be viewed as a

source of income. Jace explained:

> G. [son] turned a year and a half, and that's when I had to give custody to my
> sister, because I was doing drugs all over again. And they was going to call
> because my sister, one of my sisters, M., that's one we don't get along… And my
> son's father, they make a plan to call BCW on me. So, what I did was, I was
> thinking, give custody to M. [sister], right?… Temporary custody until I get myself
> situated. But, I was not realize she only want the baby, because the baby get SSI.
> She only want the money. Between my son's father and her, it was all about
> money. Then, I had to call [other sister] and she say, Jace, I'm going to take care
> of the baby. I'm going to give it a home. Thank God. Knock on wood. My son is
> six years old now, and he been living with my sister since then. He's got his own
> room. My daughter's got her own room. They got clothes that they can fit into
> closets. And I like the way she take care of my kids. When my kids called her
> mommy. In the beginning they was pissed off at me, but I got to realize that
> she's the one be there for them 24 hours. That's the mommy they know.

In this case, being able to rely on her sister both allowed Jace to preserve her

involvement in her children's lives but, at the same time, she relegated the primary role

of mothering to her sister due to her drug use. Specifically, some women acknowledged

that their drug use, at the time of the placement, compromised their ability to be the

best caretaker. Therefore, providing social support for their children (fulfilling

obligations as a mother) meant determining that a family member should care for their

children.

Overall, the issue of children's placement is a critical issue for women who use drugs, even in the determination that they cannot be primary caretakers for their children. Findings show that many women interpreted the decisions around children's placement in terms of their role as mothers and whether they felt involved. Women described wanting to be involved with decisions because they wanted to participate in their children's lives, even if they could not be the primary caretaker for their children. Although most children were placed with family members, mothers' experiences varied and not all women thought that family members were the best suited to care for their children.

Women's responses to the issue of children's placement are an important experience to examine because it sheds light on their sense of involvement or lack of involvement in this decision-making process. The dependence on others to be the primary caretaker for their children does not necessarily mean that women who use drugs separate themselves from their role as mothers. Instead, how women understand their ability to provide assistance or receive assistance in these decisions and the care for their children sheds light on the conditions that affect providing support for their children. In addition, whether an individual sees a particular interaction as helpful is, in part, dependent upon her subjective determination of the context in which it occurs and her appraisal of her participation in the interaction that has occurred.

In the next section, I first describe the role of fathers and then focus on current partners in women's lives, specifically in relation to providing support for children.

Fathers' role providing social support for mothers and children

Social support from biological fathers for children's care and for mothers themselves was very limited or entirely absent for women in this study. As described in chapter four, nearly all pregnancies were unplanned. Relationships with biological fathers were transformed by women's pregnancies; some continued during pregnancy, but ended while children were infants. Mothers' ability to rely on social support from men also tended to end when relationships ended. This also coincided with decisions about children's placement. In addition, many women described abusive relationships with boyfriends prior to, during, and after pregnancy; both Mar and Jace lived in shelters with their children at different points in time because of abusive boyfriends.

Not surprisingly, most of the fathers were involved with the drug economy as drug users and some sold drugs. Relationships with these men were unstable given the risks of arrest and incarceration. Several women reported that their relationships ended when fathers went to prison. As one participant commented, "…he dropped out of the picture when he went inside…" In only two cases did women bring children to visit their fathers when they first were incarcerated. Glorice and Yolanda both reported that they stopped those visits soon after. Given that this information is self-reported and not focused specifically on children's relationships with fathers, it is not clear why these visits ended. Another participant described that her child's father was "in and out of jail for dealing" and he was never present to visit his child or provide any resources or support. Some men were incarcerated for long periods, such as the father of one of Samantha's children who had been in jail for six years at the time of the interview.

Mothers' ability to rely on children's fathers to receive social support was limited, therefore, by the conditions in which they lived.

Some women described how they provided money, housing and other forms of social support to fathers, even after children were born. This support was often provided for a short period while children were infants. Several women reported engaging in sex work to provide resources for the entire household. One participant, Danette, described her boyfriend as a drug seller who sold the clothes, toys and furniture she had purchased for her infant while she was "out on the stroll." Another participant, Mar, reported that her boyfriend at the time stole the money she earned from sex work to buy drugs before she was able to buy food and other necessities for their child. Involvement with the drug economy as well as violence from men created instability in relationships, which often ended, and mothers did not have this social tie for a source of social support.

At the time of the interview, only two women were still living with boyfriends or husbands who were biological fathers of at least one of their children. As reported earlier in the chapter, two fathers had custody of children. In addition, only families of the women were raising children, no family members of biological fathers were caring for children. Almost all of the biological fathers were largely absent from their children's lives at the time of the interview. The most common pattern was for women to report not knowing the status of the fathers of their children at the time of the interview. As Samantha stated, referring to one of her children's fathers "Yeah, he's disappeared. I don't know where."

Some men were present on the periphery, living in the neighborhood, using and selling drugs, but not involved with the mothers of their children or with their children. As Fay commented, "They're all doing their own thing somewhere." Of the men who were still present in the neighborhood, few provided any form of social support or interacted with their children. Interestingly, one participant stated of the father of one of her sons,"…he's living in the next building you know, on and on, he's staying with some girl. He said, oh she pregnant from him or something…some older woman, but…I guess she got a house, you know, apartment…" Yet she reported that her son did not have a relationship with his father and that he did not provide any type of social support for their care or participate in their lives in any way. This was consistent with a few of the other mothers who reported that fathers had "other families, with other children" living in the neighborhood.

Only two women reported that fathers visited their children, even though they did not maintain any relationship with these men. Nana explained that while she does not have a relationship with the father of one of her children, he does visit his daughter every Sunday. The daughter lives with Nana's mother who cares for all five of Nana's children. Another mother, Mira reported that one father tries to stay in contact with his daughters. Her children lived with Mira's mother and she commented:

> [B]ut every time he comes around, the girls like really resent him coming around 'cause he doesn't know how to act like a normal person without hurting their feelings or something. Or saying something stupid, like he's going to try to take them away from my mother or something like that.

Social support for children by fathers, as reported by women in the study, was minimal and constrained by drug use, violence, incarceration and men's other families.

In descriptions of their relationships with current partners (boyfriends and husbands),

women reported more positive experiences receiving social support for children as well

as for their own current relationships. At the same time, the reliance on partners for

social support was contingent on men's own access to resources, which was often

constrained by their involvement with the drug economy. As a source of social support,

fathers often were not available. This created additional strain on women and women

turned to current partners for resources as well as for the expectation of future social

support for themselves and their children.

Current partners

Some of the women described their current boyfriends' relationships to their

children in very positive terms and expressed hope that these men would become

fathers to their children. They described their boyfriends as being concerned about their

children and providing resources for them. Women had expectations that current

boyfriends would play a significant role in children's care. They commented that their

boyfriends were interested in being with their children and described them as making

good fathers. Some women relied on them for resources for their children and for

drugs. For example, Jace described that she was having a difficult time providing for her

child because of a loss of resources from her boyfriend, who had been incarcerated for

several months. She stated, "I'm trying to hang in there. I'm doing the best I can. The

only one who was supporting me was my man. He's in jail. I can't do nothing. So, that's

reason I've got to struggle myself."

Descriptions of women's boyfriends at the time of the interview contrasted with descriptions of their children's biological fathers at the time of women's pregnancies. It was important to the mothers in this study that their boyfriends express interest in their children and a desire to participate in their care. Princess described her boyfriend, who was also in recovery, as intending to be her baby's father, even though he was not the biological father. The extent to which boyfriends, who were actively involved either with drugs or in recovery, could fulfill a role as supportive surrogate fathers is unclear.

In the next part of the chapter, I focus on the conditions that affect women's ability to provide support to their children and participate in their children's lives overall. In the interviews, women described many issues related to their role as mothers and issues related to their children. Participants described strategies to cope with their role as mothers and their drug use as well as their goals for improving their relationships with their children and their role as mothers. In this section, I focus on whether or not mothers were able to provide social support for their children, challenges they experienced related to their drug use, and efforts to bolster their role as mothers.

Conditions affecting mother's participation in children's lives

The women in this sample reported a range of contact with their children. Some women did not have any contact and, as described earlier, a few participants were the primary caretakers. The role of motherhood, involving contact and future goals for relationships with children, was salient for all women in the sample.

Limitations to provide resources for children

The most direct method by which mothers described providing social support for their children concerned decisions to offer money or other resources to family members caring for children. Mothers who had custody or were the primary caretakers of their children did not emphasize this form of social support in their discussions. This was most likely because they were already fulfilling what they perceived to be their main role caring for their children. Mothers who did not have primary custody explained that, at times they focused their efforts on providing resources for their children first before using money to purchase drugs. Women described feeling a sense of responsibility to demonstrate to their children and their children's caretakers that they were able to put the needs of their children before their own needs, particularly in regards to drug use. However, their ability to provide support, primarily material support, for their children was not without difficulties.

The ways in which women earned money for drugs and basic necessities and to provide for children were most often illegal activities related to the drug economy, including sex work, stealing, and selling drugs. A few women received money from government assistance or boyfriends, and some had relationships with men who were "sugar daddies" who provided them with additional funds. One participant, Danette, described sex work as a strategy for drugs but also for resources when her child was an infant, "So I wouldn't feel so bad that I was out on the street, 'cause you feel like shit after doing that [sex work]…I would buy the pampers, Similac, 'cause I wasn't getting no WIC or nothing. So I would buy pampers, Similac and stuff and then I would buy drugs."

Other mothers reported providing resources such as money, clothes, and food stamps

to family members raising their children. Mar described:

> [W]hen I do get my check, you know, and I get my food stamps, I give her all my food stamps, you know. So, and I try to help her out, but I'm saying, I know that's not enough for you, you know. She washes my clothes, she's taking care of my kids. She don't get any money from me [for herself], it's only for the kids.

Danette, who was not the primary caretaker of her sons commented, "So here it

is, I'd buy food and shit, even though I buy drugs too, but. First things first, I give my kids

money, and give my father money, or go to the supermarket and buy food at least $40,

$50 something, you know?" She had a sugar daddy who provided her with money on a

regular basis and even helped with the rent on the apartment, where she lived with her

children.

In addition to monetary resources, Princess described how she made sure that

their children had their health care provided for. She commented, "I have to take him to

an appointment [medical], you know. That's one thing…even when I was getting high, I

used to be real responsible with my appointments and my personal stuff that I had to

take care of myself and the baby."

The strategy of prioritizing children before drug use shored up women's role as

mothers. Some of the mothers expressed dissatisfaction that they did not have more

money to provide for their children. One participant, Nana, whose children lived with

her mother explained, "I try to help her out, but I'm saying, I know that's not enough,

you know…" Another participant, Mar, remarked, "I can't stay in [the] house, and don't

contribute. I mean not that they have asked me or nothing, but I would feel bad, me, personally."

Several conditions affected women's ability to provide for their children and family members caring for their children. Women attempted to prioritize their decisions around drug use and providing resources, although this varied considerably and was unstable. Family relationships and women's coping skills influenced the interplay of support transactions in this area. Social and environmental conditions also influenced how women perceived their options to provide support to their children.

This form of social support provision was not always successful and women occasionally stole or took money from family or children to use for drugs rather than to provide for children. For example, while sometimes Princess would provide resources for her child, other times she described how she used to "borrow" money from her adolescent daughter:

> I would go to my daughter from my other house and tell her I need money to go to the clinic, or something like that. I always make up an excuse. But, then, I will feel bad, because I know I'm lying. And I know once she gives me the money and I smoke it, I'm going to want more.

These actions reinforced and created conflicts in family relationships. One participant, Helen, blamed her mother for not being able to visit her children although she had stolen money from her, "Well, it's been two months that I don't see them because of my mother…I used to see them before. I used to stay over and everything…We broke up into an argument…Yeah. Some money disappeared… Yeah, I took $2,000 from her…"

These women recognized that these acts prevented them from providing social support for children.

Overall, however, women had little in the way of resources to provide for children. Given that this population of women is mostly low-income and reliant on resources often obtained illegally for drug use, it is not surprising that they were without a reservoir of access to resources to provide for their children. Thus, conditions of drug use and family relationships affected women's support providing to their children and, at times women described taking from their children rather than providing for children.

Stay away from children when high

Mothers described other situations where, rather than actively providing social support, they deliberately stayed away from their children. Deciding to avoid contact can be interpreted as attempting to limit negative interactions with their children. This results from the mothers' inability to provide social support prior to and during periods of time when they avoid their children due to their drug use. It was paramount to many women to shield children from drug use, even when the outcome resulted in limited contact and even worsening of relationships.

Mothers in this study attempted to avoid contact with their children when they were high, although the success of this strategy varied. Women were very concerned that they present themselves as respectable and caring, not stereotypical drug users. Deliberately avoiding visiting their children when they were high or sick from using drugs was a salient theme described in the interviews. For example, Glorice would only

go visit her daughter at her parents' home when "I was coming down and needed to rest…" Several participants explained that they never used drugs in front of their children. One participant, Helen, summed up the distinction she made in participating in her children's lives and using drugs, "I wouldn't have put the kids in that kind of environment [drugs]. But while they weren't with me I, I didn't give a fuck, you know? I would, I was still going out and getting high. I didn't care." While some might view these episodic periods of mothers' absences from their children's lives as neglect or symptomatic of preoccupation with drug use, the women in the study described a more deliberate decision to protect their children from their drug use. They described these decisions in relation to their role as mothers and as limited opportunities to shield their children from negative social interactions. However, this prevented women from providing support to their children. Instead of negative interactions, which might be interpreted as negative social support, women attempted to separate their drug use behavior from their caretaking responsibilities.

Not all mothers were successful at avoiding negative social interactions with their children, specifically related to their drug use. Distancing themselves from their children sometimes failed for several reasons. First, some mothers explained how their children witnessed their drug use or saw them when they were high. One participant, Mira, explained that she had on occasion visited her children while high. As a result, her children became afraid of her regardless of whether she was high or not. Subsequently she stayed away from her children for several years. She commented:

Well, before, even though they still loved me and everything, you know, they were really, they were afraid of me because I was on drugs, but they would prefer to have me around them than not around them 'cause they knew if I was around them, I wouldn't do drugs, you know.

Another participant believed that because of her drug use, her children "…they was pissed off at me…" One mother, Nana, described an experience where her teenage daughter had seen her in Tompkins Square Park hanging out with associates and Nana explained that she was embarrassed by the incident. They never discussed what had happened and Nana reported avoiding her child for a while as a result. Jace described an experience when she took her daughter with her to buy crack cocaine. Describing this incident she exclaimed, "It's a shame, it really is. But, at the time, I was not, what can I say? I was not in my mind, to be honest…" Most women tried to shield their children from drug use and its consequences but this strategy was not always successful and relationships with children were negatively affected as a result. In several cases, both the successes and the failures of this strategy resulted in very limited contact for some mothers and children.

Drug use and participation in the drug economy created ongoing risks for women. Mothers in the study attempted not only to shield children from their drug use but also from exposure to the criminal risks associated with drug use and other illegal activities. Several mothers in the study mentioned that it was important to them to try to shield children from knowledge of their activities and from witnessing illegal activities. This illustrates how the social conditions of women's involvement with the drug economy affected how women participated in their children's lives and whether

they could provide social support to their children. This is an extension of protecting

children from negative experiences related to drug use and criminal activities stemming

from involvement with the drug economy. Again, not being able to provide children

with assistance stemmed from criminal activities although there was also an interest to

protect children. Mar described a situation where she was attempting to avoid arrest;

she had been living at her mother's house where her children resided but she left there.

She knew that she had a warrant out for her arrest:

> I am in a program. I'm doing this, I'm doing that, you know. Everything is looking
> good for me. I said it's like, you know, at a one time, everything you know, just
> came back down on me, you know. I said damn, back to square one. I'm going to
> stay at mommy's house; they're going to come look for me. I don't know what to
> do. I got the kids there. I don't want to getting arrested in front of the kids and
> everything is going through my mind now. So then, so now I started staying at
> my friends' house, you know, again. Now I'm getting back selling again, you
> know.

Her children eventually learned that Mar was incarcerated; however, it was

important to her that they not witness her arrest. This example illustrates, again, that

protecting children was at times more likely to occur than the ability to provide

assistance to children. In addition, protecting children also affected women's own ability

to seek or receive support. This was particularly salient in regards to housing support as

Mar's experience illustrates. The options that women had to seek social support from

their social relationships were limited (as described in chapter five) and protecting

children might translate into seeking support from drug-involved individuals rather than

from drug-free family members caring from children.

Participants were not always successful at shielding children from criminal activities. In fact, almost all of the participants had been incarcerated; however, in the interviews most did not discuss what they thought the impact was on their children.[10] This might be because most women were often absent from their children's lives for varying lengths of time. Fay commented that her daughter had knowledge of her actions while growing up. She explained that she believed that this was both positive and negative for her daughter. Fay commented:

> And it's just certain and growing up right here in the Lower East Side, the awareness level of, you know, what happened. I don't think she [her daughter] wants that for herself. There was a time when I was into illegal stuff, getting a lot of fast money.

While she felt confident that this knowledge helped prevent her daughter from repeating her mistakes, Fay's inability to shield her daughter successfully from criminal activities was a source of concern. Strategies to shield children, particularly older children, from drug use and activities involved in the drug economy illustrate how the conditions of drug use, social ties and the social environment influence the ability to provide social support to children and opportunities for women to receive social support as well.

Do not bring others who use drugs around children

A related strategy described was to keep others who used drugs away from children. This was also to prevent negative social interactions with children, but at the same time, this did not provide social support for children. Most women reported that they would not buy drugs in their homes when children were present or where their children lived. Participants who sold drugs commented that that they would not sell

where their children lived. They also explained that they would keep their associates

away from their children. For example, Trista, who lived with her husband and daughter,

described keeping drug use behavior separate from home life:

> [W]e don't really bring people to the house, actually, you know…Um, because I don't really know what kind of habits they have and I have a little girl, so… he doesn't like that neither. We really don't like having people, like, in the house, staying over and doing whatever they want, you know. We usually don't do that.

The conditions in which mothers cared for children were dynamic and unstable.

Women could not always prevent associates from showing up at their homes and

offering them drugs. Jace described an experience where she relapsed and she

discussed several factors that seemed to be part of the event. She explained:

> That, my virus [HIV] came undetected that I was doing pretty good. One day, he [boyfriend who is a drug treatment counselor] chose to go to a retreat for people living with the virus…I was home alone, and I got some money. So I went in front of my building, sit down with the baby to play, and this girl that I know, she popped the crack on my face. I'm like, OK. I can do it now. He's not here. I'm alone. I don't have to give urine this week. So, I relapse again.

Jace described that she was feeling healthy, even though she was HIV positive; she had

recently passed a drug test; her main form of social support, her boyfriend, was away;

and she had easy access to drugs from a neighborhood associate. Although she was not

actively seeking out drugs, drugs became readily available for her use. While she was

caring for her child and trying to stay clean, Jace's experience illustrates some of the

underlying conditions that can impact the challenges to staying clean.

An exception to the strategy of keeping others who use drugs away from

children was women's boyfriends and other family members. Some of the mothers with

boyfriends, during periods of active drug use, did not always shield their children from

their boyfriends. In fact, some women described their boyfriends as playing an

important father-role to children, regardless of drug use status. In addition, several

women had family members, mainly siblings, who used drugs, and were present in

children's lives. This highlights how women's personal relationships may be an

important condition that may negate or alter decisions about children's care. This may

be due to women receiving other forms of social support from partners or family

members. Such multiple forms of social support transactions suggest that needs may be

prioritized in ways that are not always clear nor perhaps without additional risks.

Control habit or get clean

Not surprisingly, the strategy that women described as both most effective and

most rewarding in order for them to be more active in their children's lives and be able

to provide support was to control their drug habit or to try to get clean. Women

identified both their children as a reason to get clean and being off drugs as a significant

factor in the improvement in their relationship with children. While mothers described

this strategy as the most positive, how women sought support for getting clean, as

described in chapter five, highlights the challenges these women encounter.

Conditions that affected the ability of mothers to provide support for their

children by getting or staying clean included whether they had stable housing and

amicable relationships with family members and self-regulation of drug use. This

includes issues related to living arrangements and decisions regarding relying on sources

of support from family and other social ties. Trista, who was married with a stable living

arrangement, described how she deliberately changed her behavior to care for her daughter. She described the importance of staying drug-free, at least temporarily, in order to maintain custody of her daughter. "Ever since I had my daughter I think I have calmed down a lot…When she was born I had to stop [drug use], because then BCW [Bureau of Children's Services] got in, you know, and I had to stop or else I would lose her. I didn't want that, so I stopped. I didn't do nothing for a whole year…I'm not an injector no more." As a tactic, Trista explained that she self-monitored her drug use behavior, and that she transitioned from injecting heroin to sniffing heroin. She stated that she is careful to control her habit so she can continue to care for her daughter and maintain custody. Another participant, Glorice, described attending a methadone program to reduce her heroin use in order to become a more active parent for her son. However, she started leaving her son at her mother's house and subsequently her attendance at the methadone program became erratic. In this case, the support she received from her mother to care for her son prompted Glorice not to follow through on her participation at the methadone program.

For some women, periods of drug cessation influenced relationships with children, as well as, support received from family members. Given that recovery is critical in order to be able to care for children and play a more active role as a parent, relationships with family caring for children improved when mothers stopped using drugs. During periods when they were clean, mothers described their relationships with their children as closer. They reported visiting their children more frequently if possible, and they reported an accommodating relationship from family members caring for their

children. Mira explained, "You know, it's really nice because my kids and I and my mom, we're developing a better relationship between us now that I've been sober, working on my recovery." Another participant, Martina, explained that her children, who lived with her sister, only started calling her "mommy" when she was able to spend time with them after she had gotten clean. Several women had goals of getting clean so that they would be able to participate in their children's lives more fully. As Jace described, "I'm trying to better for me and my kids. But I'm trying to take care of myself like I can see my kids grow up and everything. I don't want to die getting high and nothing like that." Princess who was pregnant at the time of the interview, and had an 18-year-old daughter, who lived in her neighborhood with family members, commented:

> I don't want no more. I don't want no drugs, no alcohol. The only high I get is being around my daughter, and being around my family. 'Cause when I was out there using it, it was like I didn't have no family, you know my daughter don't wanna be bothered. But now… we're like sisters…

Women reported that they spent more time with children during periods when they were clean or in recovery. While women attempted to keep their drug use separate from their children, several mothers explained that, not surprisingly, the most effective method was to become drug-free. However, past relationships with family members as well as with children themselves affected degree and quality of contact with children and ability to provide social support as well as to receive social support.

While the strategy of getting clean was important to improve their relationships with their children, there were significant barriers for women. As described in chapter five, there were barriers to and negative experiences with drug treatment programs. In

fact, none of the mothers in the study who went to residential or day treatment programs reported that their children accompanied them. For participants who sought support for recovery efforts and support to improve their role as mothers, treatment options and family relationships were often insufficient. The conditions that affected support did not always facilitate positive outcomes.

Danette, whose younger adolescent son was living with her sister and had been in trouble with the juvenile justice system, had mixed feelings about attending a residential treatment program. She had not had success with day drug treatment programs in the past. It was troubling to her to consider leaving her son even though she believed she needed a residential treatment program, "Yeah, I gotta go to a program or something. But here it is, I can't just go and clean myself up, and then leave my son in the predicament he's in and let something happen to him. 'Cause then I ain't gonna want to get clean."

In another example, Helen, described not being able to get clean. This was a demand of her parents before she could care for her children. Instead, she moved out and eventually severed contact with her parents and her children. Helen explained:

> She [mother] says, I know this is hard on you. I know life, you know, this isn't working for you…. 'cause they wanted me to [go to]drug treatment. I went to parenting classes. I did do that, I completed that. They wanted me to drug test twice a week. They wanted me to go to these, um, psychologist and all this stuff. And I couldn't do that. I'm living on the street. I had another boyfriend. I'm starting injecting speed…

The history of family relationships, women's coping skills and their drug use interact as part of the conditions that affect women's ability to provide support for

children. Another participant, Princess, also expressed concern for her child when she

attended treatment. In her case, she described what she considered potential options

after she gave birth.

Princess summed up the choices she felt were available to her:

> But after I have the baby, I'm signing in for a outpatient program, because I could take the baby with me, you know, or my mother can watch it…No. I wouldn't leave my child in there [program]…Because a lot of people still using and going to the day program, because you have some programs that people are still using. And you don't know who has who, so I have to be careful…I don't want my child to catch nothing, you know. So, I have to be extra careful, especially when I have to go to the out-patient program…Yeah. It's not all that clean. So, if I could get my sister to baby sit while I go to out-patient, you know, a nine to four program, that would be fine. Or if I could find one with a day care, I would go, you know. Because I do plan to go to the outpatient program, after I have the baby.

In sum, while some mothers expressed the importance of recovery in order to improve

their ability to parent their children, experiences varied. Conditions that impacted social

support from family members and treatment programs interacted with women's drug

use and subsequently affected how mothers judged their ability to provide support to

their children. For some women, of course, there was no possibility to improve or even

establish a relationship with their children yet most discussed future goals around

motherhood (described later in the chapter).

Conditions affecting support for adolescent children

Women's relationships with adolescent children varied; however, a few

adolescent children were already involved with criminal activities. When women

discussed relationships with adolescent children, they were often concerned that their

children not repeat their mistakes and become involved with illicit drug use and, for

daughters, becoming pregnant at an early age. Several mothers commented that they were concerned about adolescent children's behavior and attitudes that seemed to mirror their own adolescence. This concern was exacerbated when children lived with family members with whom participants had strained relationships. These arrangements varied in terms of the degree and quality of contact that mothers had with adolescent children and the trust they felt with the care children received. In the interviews, women described several factors that impacted their relationships, and their ability to provide social support for their adolescent children including their drug use, efforts to stay clean, involvement with the criminal justice system, strained relationships with family members and a dearth of resources. Mira explained:

> My oldest daughter, I think she's in a gang. I believe strongly that she's in some kind of gang. Or a kind of school gang...Ah, I'm not saying that I got the greatest place for her to stay, but, uh, I sort of see my daughter going through the same patterns I went through and I don't want her to go out there and get lost. 'Cause I would, I think I would actually lose my mind somehow, so I -- Yeah. My mothers says that she, like, last week, I had, my mother says, oh, I can't stand her anymore. I want her out of my life. I want her away from me. And this is the same things my mother told me when I, this is the same things that came out of her mouth with my daughter came out of her mouth for me when I was about that age.

However, Mira reported that she had unstable living arrangements and was not able to take over the primary care for her daughter. Other than talking to her daughter, she had few resources to attempt to affect any change in her daughter's behavior.

While these are similar to the conditions described for all children, mothers described particular concern for their adolescent children because of the possibility of these children also using drugs. In general, providing support for younger children

revolved around material resources and not providing support for young children manifested in staying away from children when high. More specifically, mothers described wanting to prevent "wrong choices" for adolescent children.

Other women were more adamant that they protect their adolescent children from following in their footsteps. Danette was unable to contend with her 14-year-old son's juvenile criminal behavior due to her drug use. Although she reported that she lived at her father's apartment, where her son had been residing, she was not her son's primary caretaker because of her active crack cocaine use. Her son had been sentenced to a juvenile detention facility and later family court awarded temporary custody to Danette's sister. Danette was advised not to attend the family court hearing and to stay away from her son because of her own criminal record and her drug use. In Danette's description of this situation, she expressed a sense of relief that her son would be able to live with her sister. She also described the situation as frustrating because, although she was his mother, she was unable to provide support for him and instead had to avoid him.

Fay, who has one adolescent son, presented a slightly different perspective than some of the mothers. She explained that while she wanted to protect her son from selling drugs, she also believed that he was responsible for his own choices. Fay commented:

> [Y]ou know, it's a pretty decent project, but drugs is something that they do not allow, selling drugs in the vicinity, but they do. I lived down here, like, seven years, and my son, you know, he's at a age where he's easily influenced by others. He is on this thing about making this big money. He knows I do not allow it in my home. Matter of fact, he knows I prohibit that in my home but he'd never bring it in my house, but he does do it. I was aware that he was doing it, but the project directors and staff got a hold of it and they told me I had to move if I didn't put my son out. I would not put my son out. He has no where to go… [X] is the place that I took because I was originally from Harlem anyway. I was very familiar with the area. So, all I was doing was going back where I had left because of what was going on up there because I too, you know, am active somewhat in drugs. So, that's not really where I wanted to be, but I went back there. I told them that my son wouldn't be living with me, but of course I lied. A mother is not going to put her child on the street, especially her only child…So, I moved to the projects and again my son went up there with the same kind of mess. Right now he's incarcerated, he's in jail. I go and see him as often as I can. He's in Riker's Island… I go and see him as often as I can. I don't break my neck going there, because he knew the risk that he was taking when he went about doing this. You know? He dealt with that at his own risk. You can take him to the water but you can't make them drink.

At the same time, housing issues were salient factors in which women had to consider when caring for children, specifically the consequences of adolescent children's behavior.

Another participant also described dealing with concerns for her housing as part of the context in which she attempted to provided social support for her child. Yolanda, who was in recovery and living alone, described an experience with her 16-year-old daughter where she was trying to simultaneously protect her public housing and prevent her daughter from continuing to use drugs and repeat her own past. Her daughter, who had been living with Yolanda's grandmother, wanted to move in with Yolanda who agreed but with hesitation. She explained that her daughter and friends quickly started creating problems in the apartment building into which she had just moved and she did not want to jeopardize her housing because of her daughter's

behavior. Eventually, Yolanda had her daughter placed in a group home because her behavior was "out of control" and she was worried about what would happen to her. "I felt so guilty that I had to do that, you know. But I can't let her keep continue to run in the street, because the more I let her run in the street, the worse things are going to get, it's not going to get better." Yolanda felt so strongly that her daughter should not repeat her own past that she turned to the only form of help she felt was available to her, the juvenile justice system.

Women's ability to cope with their role as mothers in relation to their drug use colored the support available to them as well as the type of support they could provide to children and family members caring for children. Various incidents negatively affect both women's relationships to children's caretakers and their relationships with children. Women spent time in prison, at drug treatment programs, on the street and in other places that made them inaccessible to their children. Relationships with children's caretakers were sometimes strained by the involvement of female family members. Most often women's own mothers, sisters and grandmothers acted as gatekeepers in the participants' relationships to their children.

Future goals about motherhood

Finally, a salient theme was discussion of a hypothetical future in which women would improve their relationship with children and their role as mothers, overall. In some cases, women talked about adding new children to their lives, once the conditions of their current drug use and social relationships presented them the opportunity to support children. Another theme involved becoming closer to their children, suggesting

a reconfiguring of these social ties. Women described the future as an opportunity to improve their relationships with their children and to reevaluate the role they wanted to play in their children's lives. This can be seen as an extension of relationships that improve when women become clean; however, in this case mothers are describing goals and ideals rather than experiences. Interestingly, not all women believed that it was in their children's best interest for them to become the primary caretaker, even if women were in recovery.

Several themes emerged from women's descriptions of the future, building on the ways mothers interacted with children and decisions around social support in their role as mothers as described above. These themes included, improving their relationship with the children through recovery, becoming the primary caretaker of children, identifying as a friend rather than as children's mother, and thinking of a new child as a second chance. The themes also illustrate how the conditions that affect support may alter relationships with children even in regards to future goals. For many of the mothers, recovery was a goal linked to being able to parent their children and provide support in the future. Women described getting clean as a key factor to improve their relationship to their children in the future and this was described as long-term recovery. Several participants commented, similar to Nana, "I'd try to quit and fight to get my kids back." Several but not all of the mothers in this study had the goal of becoming their children's primary caretaker in the future. As one participant remarked about her goals for the future, which did not include primary custody but an improvement of her relationship, "…and sometimes I want to take them out. I want [it]

to be me and them, you know." A few participants were concerned that their mothers were getting older and would not be able to care for their children indefinitely. One participant described, "There's got to be a time when I step in cause my mother is getting older." Mira commented that she was concerned about taking "some of the burden off my mother's hands…" Social relationships with family members figured importantly in mother's descriptions of future goals to support children.

Some of the women described feeling as if they could play a friend role with their children but not fulfill a mother role. Glorice remarked, "I was going to say that I'm blessed that my daughter, she's forgiven me for all my drug abuse and all the madness I put her through. You know, we're really close, real close. And she loves when we go out together and stuff." She described their relationship similar to a strong friendship that would continue in the future and acknowledged that while her daughter was growing up, she "shirked [her] responsibilities…" Several participants described their frustration at how much they had missed in their children's lives. They recognized and identified the challenges of mothering their children after they had been absent in their children's lives for years. As one mother stated, "I'm not ready for it now, but they do communicate with me, so that's a start….I really don't know much about them." Another participant, Mira, described her relationship with her children and the dissimilarity she felt between herself and her mother, who was raising them:

 'Cause she [daughter] see me like a friend-type person. She does, cause she tells me she can't see me like a mother figure. Which I could understand that, 'cause even though I know I'm their Moms and they're my kids and stuff, I don't feel like a mother figure to them either, not like my mother is…or my mother is to me…I don't think I could ever fill that spot. But I could, but they know I'm their, their birth mother…And none of the kids could see me as, like, a Mommy…Like, once in a while they'll call me that…

When asked about the most significant event in their lives, not surprisingly women referred to their children. Even women with no connections to their children commented on a bond that existed between themselves and their children. For participants who were not involved in their children's care, having children was still the one positive thing they had done in their lives. Martina, whose children live with her mother, commented, "Having my children….It's a beautiful thing. It's my kids. No matter what, they love me. And no one can ever take that from me. That's mine; that's me. They care. It's an overwhelming experience. I can't explain. I will die for my kids."

Some women believed they had failed as mothers and still others held out the promise of having another child to redeem their role as mother. Three women reported being pregnant at the time of the interview. All three had children already. Of these women, only one woman, Maria, stated that she and her partner had talked about children because her partner did not have any children. She also explained that she was upset about the current pregnancy because she felt that children were too much responsibility. She already had three children and had unstable living situations. The other two women, however, believed that being pregnant was an opportunity to change their lives. Princess commented, "And then I found out I was pregnant, and I said

no…I'm not gonna go through this all over again. So I said better for me to get my life together and do what I have to do for this child."

When discussing future pregnancies and children, some mothers commented that their partners would provide resources, emotional support and help them raise the child. As one participant remarked, "This is what I always wanted, to be married, have my children, and be drug free and clear…" Yet prior pregnancies belie this image of pregnancy as an opportunity to change their lives. None of these women had custody of their other children and had only been clean for short time periods. Princess was adamant that she was going to use this event as a catalyst for change. Another participant, Samantha, had first described wanting to get her three children back from her parents, who lived in Buffalo, New York and later described wanting to have a child with her current boyfriend, "[W]e can take care of just one baby…" The focus on the future suggests a desire to protect children from their drug use and to present themselves in a positive light as mothers or friends. Women's description of the future in relation to motherhood and children also suggests expectations about their own ability to support children as well as partner's roles in caretaking responsibilities. Some women, however, assess their ability of the support available to them as well as to provide support for children in the future based on history of relationships and drug use. Women's expectations vary and these findings suggest it is due to their assessment of the role they can play in their children's lives as influenced by their drug use, social relationships and opportunities for change. Overall, future goals represent mothers' attitudes and suggest how women perceive opportunities to provide support in their

role as mothers, receive social support from others, as well as, for long-term cessation of drug use.

Conclusion

Little is known about the dynamics and everyday relationships of women who use drugs, their children and other family members (Stowe et al. 1994). The studies that have focused on women, drug use and motherhood have all found that, regardless of custodial arrangements, for most women, motherhood remained central in women's lives and plays a significant role in both women's drug use and recovery process (Baker and Carson 1999; Boyd 1999; Enos 2001; Hardesty and Black 1999; Richter and Bammer 2000). Metsch and colleagues (2001) argue that responsibility for children can be an important motivation for recovery and abstinence from substance abuse contrary to perspectives that it is an additional stressor.

In this study, I found that the conditions of support transactions for drug-involved women with children occur on multiple and interacting levels. The findings demonstrate that there are particular reasons why individuals may not always draw on potentially supportive social ties. For example, women's role as mothers includes a range of issues related to support seeking and providing. Conditions affecting support include women's limited access to resources, their attempts to shield children from their drug use, an interest in participating in their children's lives and their own needs for housing assistance. In addition, family members providing care for children may decide to protect children from women's drug use and prohibit mother's involvement in their children's lives as well as limit support provided to women thus affecting opportunities

to try to get and stay clean. Further, women may have "exhausted support" from family members, which then could limit receiving housing assistance from these family members. This might translate into different forms of housing instability and risks, including living with individuals who are actively drug involved, moving from place to place, or homelessness.

Chapter Seven: Conclusion

The receipt of various types of assistance (material, emotional and information) affects health during times of stress, and it can ward off strain yet this identification of the social contexts in which individuals invoke support transactions or avoid them is a critical contribution to the social support literature. In this dissertation, I have argued that to understand better the construct of social support in general and more specifically in the lives of women who use drugs, it is necessary to examine the conditions that affect social support seeking, receiving, and providing. The goal of this dissertation, then, is twofold, to contribute to the literature on social support and to contribute to research to improve the health outcomes of women who use drugs.

In this chapter, I review the main implications of my findings for the study of social support and research on the health of women who use drugs. I next describe the theoretical contributions for the study of the concept of social support. I also describe some of the limitations of the dissertation. Then I discuss the policy implications of my findings. Finally, I discuss the importance of future research in this area.

Research question revisited

I explored the conditions that affect support seeking, receiving, and providing among women who use drugs in two critical areas of their lives: trying to get and stay clean and improving relationships with their children. This main question emerged from two literatures: the social support and drug use literatures. A review of both highlighted the importance of integrating theoretical insights from the social support literature for the study of women and drug use. At the same time, this review underscored key issues

of concern regarding the health of women who use drugs and the often times overlooked issue of women's relationships to their children. These insights, in turn, suggest that a qualitative approach to the study of women who use drugs would yield important findings.

Summary of findings

Social support plays a crucial and diverse role in health and well-being. Reasons why assistance from others does not always lead to positive outcomes as well as reasons why some individuals report low levels of support or support seeking may have to do with the social context in which support transactions occur or do not occur. The findings from this dissertation are in line with other research, reviewed in chapter two, suggesting that the context in which social support occurs will alter the individual's response (Vaux 1990; Williams et al. 2004). For example, I found that not all women who participated in voluntary groups, such as Narcotics Anonymous (NA), determined that these groups provided sufficient support. Reasons for this determination included issues of trust and norms about relapses and the meanings of recovery. Another key finding relevant for the literature on social support is that individuals may prioritize needs and social support decisions and transactions in ways that seem to increase the stress or strain they are under.

Findings from this dissertation are also in line with other research that shows that social support is multidimensional (emotional, material and informational) (Sarason, Sarason and Pierce 1990; Thoits 1986; Williams et al. 2004). They also show that social support may not always lead to positive outcomes but may indeed lead to

outcomes that are deleterious to health. However, my findings go a step further. They

show how social support transactions may ultimately increase negative outcomes,

especially due to structural conditions. In this study, women who sought social support

when trying to stay clean were often seeking housing support. The social environments

of low-income neighborhoods, including access to drugs, and increased crime and

violence, often made it difficult for women to avoid drug use and others who were drug-

involved. Further, most of the participants' social relationships were with others who

continued to use drugs, making it difficult to find housing support, when needed, in a

drug-free environment. The influence of structural and interpersonal conditions, at

times, meant prioritizing seeking or accepting support in ways that might jeopardize the

overarching goal of trying to stay clean.

The findings from this study has the potential to reframe our understanding of

how to examine the construct of social support. Specifically, the results show that

support is affected by particular social conditions that occur on individual, interpersonal,

institutional, and structural levels. This perspective moves away from notions that social

support is a result of individual relationships only and limited to a unidirectional

relationship. The findings also contrast with notions that women either unknowingly or

without regard return to relationships that include individuals who use drugs when

trying to stay clean. Instead, the findings demonstrate that cessation of drug use is one

of many needs, some more immediate and basic. The idea that prioritizing needs plays a

role in seeking or receiving social support is in need of further study. Whether it is

specific to marginalized populations without access to many resources or is applicable to the study of other health issues is worth investigating.

Many women socially isolated themselves to avoid negative interactions with others, rather than failing to find social support. This finding is important because it goes beyond current theories that distinguish social support from social isolation and consider each in opposition. Participants lose contact with former associates and friends who break away from social ties to try to get or stay clean and this social isolation creates challenges for long-term opportunities for women's recovery and for service providers. This pattern and the socio-economic realities of the neighborhoods in which women live are difficult for treatment programs to counter.

Focusing on findings specific to the study of women who use drugs, this dissertation highlights the need to evaluate structural, institutional, and interpersonal conditions that influence support transactions. Interpersonal conditions that influence seeking social support when trying to get and stay clean include norms of reciprocity. These norms are salient within all three types of relationships investigated (partner, family, and friend/associate), yet operate differently within each type. Among the women in this study, prior relationships with family members influenced support transactions affecting both drug recovery efforts and relationships with children. In addition, as other research has demonstrated (Barreras, Drucker and Rosenthal 2005), intergenerational patterns of criminal involvement, HIV/AIDS and drug use were also conditions that affected support transactions. These patterns influenced whether women could rely on family members and whether reciprocity could even be invoked.

When family members were also involved with drug use, women's opportunities to seek

support from them were limited. Relying on family members to care for children

created a strong demand for reciprocity that was difficult for women to manage. For

friendship and associate relationships, how women defined and distinguished

friendships from other relationships and trust issues influenced their reliance on them

for social support. This differed from their relationships with family members and

partners. Women were more likely to remain with partners who used drugs than

friends who used drugs due to a desire to provide partners with emotional support and

potentially to receive material support. For some women their drug use meant that

they were unable to provide support to their partners, so they ended the relationship.

Findings here show that the patterns that affect support within relationships vary.

Future studies need to take into account these differences and move beyond just

measuring the type of relationships women have but also the quality of relationships

and the underlying conditions that affect the quality of these relationships. These are

nuances that quantitative measures of social support often do not capture.

The results of this study suggest that a further contextualized understanding of

these interactions is needed. Conditions during different periods of time for mothers,

children and children's caregivers are important. The interviews suggest that decision-

making regarding children's placement is a significant moment in terms of whether

mothers perceive their role as providing social support for their children and whether

mothers believe the decisions will provide for their children's well-being and allow

mothers to participate in their children's lives. At later times, women engage in

strategies to avoid exposing their children to their drug use and to shore up their role as "good mothers." This serves, however, to prevent the mothers from providing support to their children and forces them to rely on family members to do so. In addition, women may avoid seeking support from family members at key moments because they have already "exhausted support" from family members in the past, or family members may refuse to provide them with support. Overall, these patterns show that there is not a single path that mothers follow when it comes to providing support to children. Instead, efforts for caring for children and efforts for recovery vary depending on the situational context.

Implications for the study of social support

In my review of the social support literature, I found that the concept has been largely studied using quantitative methods. This shapes how researchers think about social support and the methods and measures that are employed within research studies. Most drug use studies have relied on quantitative measures of social support. Several researchers have pointed out that a broader theoretical understanding of the concept of social support is needed within research studies and that qualitative methods are an appropriate tool to undertake the study of the impact of social support on health and well-being (Bourgois et al. 1997; Rhodes and Moore 1998; Vaux 1990; Williams et al. 2004). This qualitative study identifies some of the benefits. Use of a qualitative method gave voice to the participants. They described social support transactions - receiving, providing, and seeking (Williams et al. 2004), and they described the myriad forms of assistance that may or may not be available.

Qualitative data allow us to see how women's experiences are situated within the social context in which they navigate their social relationships, neighborhood conditions and overall conditions of the drug economy. As researchers within the field of drug use have pointed out, qualitative research and analysis provide a method to examine questions emerging from social science theory that focus on processes and social meanings and interpretations of situations—not only individual behaviors (Bourgois et al. 1997; Maher 1997). Building on this perspective, I focused on shifting the study of social support from a static, uni-directional attribute to a transaction that is influenced by factors within the larger social context; social support can then be explored as a more active process in which individuals may seek, receive and provide assistance in numerous areas of their lives.

In addition, I highlighted context-specific experiences. This allowed for the discovery of how social support is or is not enacted by individuals or groups. The current analysis shows that rules and norms about relapse, abstinence, and social relationships all coalesce to influence individuals' perceptions of support in a particular interaction, including a group meeting. Qualitative research highlights the individual's interpretation, which is often unattainable in quantitative studies.

Finally, continuing to apply both qualitative methodology and a focus on the conditions affecting social support to the field of drug use studies remains critical. In order to provide effective services, research that supplements existing knowledge about harm reduction, drug recovery and cessation efforts as well as women's experiences as

mothers will assist both researchers and providers to improve services for women who use drugs.

Limitations and Future Research

There are several limitations of this investigation. First, the sample represents a small group of women who use drugs. The data are not intended to be representative of all women who use drugs and are not intended to be generalized. Further, it is important to note that it is not possible to determine if the patterns identified in this dissertation are relevant only to women in NYC or to women in the Lower East Side and Bedford Stuyvesant. Given the broad array of contextual factors operating in any environment, there are most certainly other undetected environmental conditions that might be specific to these urban environments. Future research could examine women's experiences in other parts of NYC as well as outside NYC.

Second, I conducted secondary analysis of data that had been previously collected. While I worked closely with the PI during the formative stages of the analysis, there are challenges with any type of secondary analysis. This includes the inability to probe on questions of interest, or to follow up with respondents later. Yet despite these limitations, this dissertation offers important insights into a group of drug-involved women and suggests areas for future research.

This research should focus on women with children, recruiting a larger sample than in this study. We need more detailed information about custodial arrangements, including first-person interviews with family caretakers (e.g., women's mothers, grandmothers and siblings). Further research is needed to identify how specific

conditions increase or undermine social support for drug recovery efforts and for participation in children's lives. In addition, such research would enable a more in-depth study on the conditions that affect social support among women with children and the family members caring for those children including measures to assess these conditions.

As stated earlier, future research could also focus on the issue of how women prioritize social support seeking needs. When do individuals prioritize needs that may lead to negative outcomes, what are the reasons for these decisions, and what are the conditions that affect how needs are prioritized? In addition, data on support provision may provide critical insight for treatment providers as it may shed light on how women prioritize their competing demands for their own health and family concerns. This would also provide information on how women define their role in social relationships and the impact it has on their own health seeking behaviors and drug involvement.

Future research is needed to examine social support and social isolation in relation to each other, moving towards an assessment of how support seeking, receiving, and providing may influence patterns of social isolation. Measuring how individuals assess assistance within the particular social context and within their social relationships will also provide a better understanding of social isolation as a multi-faceted construct. Future qualitative research could include exploration of the construct of social isolation in relation to social support and health and well-being. This research could be used to develop more nuanced measures of social support and social isolation, including measures that assess women's participation in children's lives.

Policy implications

The results of this dissertation have policy implications for harm reduction, drug treatment, and intervention programs. First, findings describe the social context (e.g., women's lives) in which to interpret quantitative research on social support and treatment for drug use, as well as studies on risk behaviors. Some of the existing research advocates that women, post-treatment, cease relationships with individuals who continue to use drugs. My research suggests that approaches that do not simply dictate to women that they sever ties or leave the neighborhoods in which they formerly used drugs are essential, especially given the social and economic realities of women's lives. Few women are able to leave the neighborhoods in which they used drugs. Instead, their social worlds become narrower when trying to stay clean. This may lead to additional forms of stress and negative health effects. The development of new non-drug involved social relationships was rarely mentioned in the interviews, suggesting that programs need to think of creative ways to develop new social ties. Providing emotional support or other forms of assistance for family members, children, and partners may supersede women's focus on their own health needs. Further, social relationships may confer other benefits that compete with removing oneself from drug involvement. In addition, treatment approaches that underscore the salience of women's identity as mothers, for those with children, are also critical, regardless of custodial arrangements.

The findings of the current study also indicate that providing assistance, including emotional support as well as material assistance, is important for interviewees' perception of self-worth. Children, family members caring for children, and partners were the three key recipients of women's support. But providing social support may conflict with women's attempts to try to stay clean. Treatment programs need to consider how to bolster women's opportunities to provide support while also staying clean.

Previous research has noted that women face many barriers to drug treatment (Ashley et al. 2003; Wobie et al. 1997). In this study, interviewees outlined additional barriers including their perception that they lacked support for their efforts to stay clean. Their focus on self-reliance and the high-risk conditions of their neighborhoods presented additional barriers to seeking support for drug recovery, efforts that policymakers need to consider when evaluating how to increase women's access to treatment.

My findings point to a need for a holistic and family-based approach to drug treatment. First, programs that provide treatment and interventions for partners may improve mutual support for continued recovery efforts. They may also enable women to end relationships that are detrimental to their health (El-Bassel et al. 2001). Second, given the high rate of drug use during pregnancy, programs that focus on women as well as children are important (Ashley et al., 2003; Howell et al. 1999). Findings in this study as well as in the broader literature suggest that women's perception that they are actively mothering their children enhances their chances of recovery. Treatment

programs that comprehensively care for women and children and involve family members who are caring for the children, may improve the types of support that the family members can provide to each other and improve treatment outcomes.

As others have pointed out, providing a holistic and family-based approach may also address some of the intergenerational patterns of drug involvement, HIV/AIDS, and criminal involvement (Barreras, Drucker and Rosenthal 2005; Falkin and Strauss 2003; Nyamathi et al. 1997). Social support availability from family members is constrained by individual's connection with the drug economy and subsequent risks. This study showed that mothers were concerned that their children not "repeat their mistakes." A family-based approach to treatment and intervention may address ongoing strains within the family as well as concerns about the potential for children's drug involvement. However, it is important to point out that programs alone cannot successfully address larger structural issues underlying intergenerational patterns within particular neighborhoods.

Another important finding for policymakers relates to the participants' reliance on self-regulation and their limited positive responses to treatment programs. One reason is that barriers to treatment programs for women and for women with children continue to exist, even with more recent improvements that target services directly to women (Ashley et al. 2003). Treatment models that are predicated on abstinence and are punitive when relapses occur may also be disincentives for participants, leading them to self-regulation and self-reliance. Programs and interventions that advocate the rejection of partners and family members who continue to use drugs after women

complete their treatment may push some women away from participating in treatment.

Future goals should include cessation and abstinence for individuals who use drugs;

however, this is not always realistic for individuals who are drug involved. For that

reason, a strict focus on abstinence and a focus on punitive sanctions can divert

attention from successful participation in programs. Harm reduction strategies have

been well documented to successfully decrease risk and improve health and well-being

(Des Jarlais and Friedman 1997; 1998; Larkins 1999). In addition, decisions to seek social

support from treatment programs may be increased if providers acknowledge the

competing priorities women face with regard to support. This includes relationships that

are drug involved. Further, a more nuanced understanding of social isolation is

important for providers to appreciate. The combination of social conditions and social

support transactions may lead to social isolation, which limits women's ability to

develop new social relationships, particularly non-drug involved social relationships.

Next, for women with children, the conditions affecting social support and

relationships with children reveal important implications. Participants may perceive

their decisions to stay away from their children as diminished opportunities to provide

support but at the same time, as a positive means to protect children from the stigma of

their drug involvement. Programs could capitalize on women's attitudes towards

mothering and shielding their children from drug use by making resources available to

women with children in a way that increases opportunities for women to provide

support for their children. Programs could also recognize how women employ

strategies to avoid negative interactions and when such experiences are unsuccessful.

Attention to women's identity and role as mothers warrants further consideration in treatment and intervention programs.

Another policy implication of the current research is that social support comprises seeking, receiving, and providing transactions, not simply receiving support. For example, staying in relationships with partners, although this may increase access to drugs, is a possible means of providing support and prioritizing others needs over their own. Treatment programs and interventions could include assessments of how women determine whether to provide support to others and their own interpretation of their health needs and drug use status. Avoiding negative social interactions may also lead to a rejection of certain types of social support that bring risks; programs could assist with these challenges positively.

Conclusion

This dissertation has made an important contribution in several areas of sociological and public health research. The findings presented here add to the dialogue within the theoretical literature on the construct of social support and suggest that social support transactions are embedded within social conditions that affect individuals' decision making. While there is a growing body of research on women who use drugs, this dissertation is distinctive in that it moves beyond a quantitative definition of social support to explore patterns from a qualitative perspective. In addition, it examined how women perceive their role in providing social support and avoiding negative interactions, particularly in their role as mothers. Policy implications include a family-based approach to treatment and intervention that may address

ongoing strains within the family as well as concerns about the potential for children's

drug involvement. Overall, more qualitative research is needed on micro-level

interpersonal relationships and macro-level structural conditions that impact social

support transactions. Finally, this approach can also be used to investigate other areas

of public health research.

Endnotes

[1] Hupcey, J.E. (1998a) Clarifying the Social Support Theory-Research Linkage. *Journal of Advanced Nursing,* 2, 1231-4121 (page 1232) as cited in Williams, Philippa, Barclay, Lelsey, Schmied, Virginia (2004). Defining Social Support in Context: A Necessary Step in Improving Research, Intervention and Practice. *Qualitative Health Research*. 14(7): 942-960.

[2] This project was funded through a grant from the National Institute on Drug Abuse (NIDA) and directed by Principal Investigator Maureen Miller, PhD.

[3] The PI's study was funded by the United States National Institutes of Health grants DA13135 and DA14523.

[4] This was a cohort study conducted in New York City's Lower East Side and East Village. Findings were used as a basis to determine categories of recruitment for this project.

[5] This, in turn, provided important information for the second stage of the investigator's project, the development of a network and social resource questionnaire.

[6] The racial/ethnic makeup for the total sample of 28 women recruited by the Principal Investigator included; 29% (8) were African American, 29% (8) were Latina, 10% (3) were mixed race/ethnicity, and 32% were white (9). This varies somewhat from the expected sample recruitment as stated in the study proposal with fewer Hispanic and African American women recruited. This may be due to the recruitment locations, particularly the Lower East Side, New York as well as snowball sampling techniques. Also, this sample included women who self-reported mixed race/ethnicity which was not included in the estimates from the initial proposal.

[7] The preliminary code list consisted of codes based on the literature review and dissertation proposal. As an exploratory study, the list of initial codes was focused mainly on women's active drug use, family relationships, including relationships with children. Social support was also a main areas but not the focus on perceptions of support. This emerged inductively from the data.

[8] Colliver and colleagues (1994) report that in 1991, an estimated 13 million US children lived with at least one parent who reported use of an illicit substance. This estimate would be higher if it included the number of children who live in foster care and the number of children who have been adopted as a result of drug-involved mothers.

[9] Systematic information on legal custody arrangements was not collected. Information on State removal of children by BCW was not verified.

[10] While the women in the sample did discuss periods of incarceration, it was not a main focus of the interview and systematic data were not collected on length of incarceration, specific charges, location of institutions, or other related issues.

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