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"I Don't Know What Fun Is": Examining the Intersection of Social Capital, Social Networks, and Social Recovery

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Abstract

Purpose—The purpose of this paper is to understand how people with problematic drug use access positive social capital. Social capital is defined as relations that provide valuable resources to individuals through participation in social networks. People with low socioeconomic status remain at a disadvantage for acquiring positive social capital, a component of recovery capital. The concept of social recovery emphasises the relational processes of recovery.

Design/methodology/approach—In-depth life history data were collected from 29 individuals who used heroin, cocaine, crack, or methamphetamine for at least five years, have less than a high school education, and unstable employment and housing. Qualitative data were coded for social networks accessed throughout the life course, distinguished by bonding, bridging and linking social capital.

Findings—Social networks included drug treatment programs; non-drug-using family and friends; religious/spiritual groups; workplace networks, and social clubs/activities. Bonding and/or bridging social capital were acquired through treatment, family and friends, religious/spiritual groups, workplaces, and social clubs. Linking social capital was not acquired through any social networks available, and many barriers to accessing mainstream social networks were found.

Limitations—This is a small study conducted in the US.

Social implications—A greater focus on social recovery is needed to achieve sustained recovery for individuals lacking access to and engagement in mainstream social networks.

Practical implications—Social recovery is proposed as an analytical tool as well as for developing prevention, intervention, and treatment strategies.

Keywords

social capital; recovery capital; social recovery; drug use; social networks; qualitative research

BACKGROUND

Recovery is a controversial concept with ambiguous definitions, but it refers to more than stopping drug use (Neale, Nettleton and Pickering, 2014). Social integration is vital for sustained recovery, and cycling through treatment, recovery and relapse is often stigmatizing

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for individuals marginalized by drug use and with few social resources (Boeri, 2013; Bourgois and Schonberg, 2009; Radcliffe and Stevens, 2008). Recovery capital, a concept based on social capital theory, focused recovery efforts on social resources (Cloud and Granfield, 2008).

Social capital is defined as relations that provide valuable resources to individuals through participation in social networks and has emerged as a tool to understand inequality of status achievement based on social ties (Bourdieu, 1984; Coleman, 1990; Portes, 1998; Putman, 2000). Access to new social networks is needed to increase social capital (Lockhart 2005; Wuthnow 2002). The literature distinguishes different types of social capital, which also act as mechanisms for accessing new social networks (Zschau et al., 2015). *Bonding* social capital refers to relations in networks made up of people with similar social identity; *bridging* social capital refers to relations in networks of people who are different in social identity but similar in status and power; and *linking* social capital refers to connections that cross social class divisions (Kawachi et al., 2004; Lockhart, 2005; Schuller, 2007; Szreter and Woolcock, 2004; Wuthnow, 2002). All types of social capital are needed. A very tight bonding mechanism within a social network may be detrimental if there is a lack of bridging or linking social capital, while high bridging and a lack of bonding produces alienated individuals and networks ready to disband (Schuller, 2007). Access to positive social capital is needed for recovery (Cloud and Granfield, 2008). While social capital is not positive or negative in itself, it can have positive or negative consequences (Wacquant, 1998). The purpose of this paper is to examine engagement in social networks throughout the lives of people with problematic drug use and low socioeconomic status to better understand how they access social networks to gain positive social capital.

Social Networks

Social capital is acquired through engagement and inclusion in social networks (Trulsson, 2004), and can be measured by the nature and extent of a person's involvement in informal and formal networks (Grootaert et al., 2003). A social capital analysis focuses on what a social network provides, how embedded it is, how it functions, and how the network interacts with other networks, also called "relational properties" (Schuller, 2007). Alejandro Portes (1998) cautions, "it is important to distinguish the resources themselves from the ability to obtain them by virtue of membership in different social structures" (p. 5). Embedded structural inequalities continue if people with drug use problems are not encouraged to seek a wide range of social activities provided through engagement in social networks (Neale, Nettleton and Pickering, 2014).

Recovery Capital

Social capital theory was used to conceptualize *recovery capital*, defined as the combined physical resources, skills, knowledge, and social capital available to a recovering person (Cloud and Granfield, 2008). While recovery capital is used to predict sustained recovery, its analytical lens remains focused primarily on the actions and behaviors of the individual. Moreover, while the bonding aspects of social capital are adequately measured by recovery capital, the bridging and linking mechanisms of social capital are less evident in recovery capital measures, which focus on 12-step support groups (Laudet, 2008).

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People in treatment are encouraged to avoid old social networks and environments (Farabee, Rawson and McCann, 2002). Introduction to new social networks is critical for sustained recovery; yet treatment programs often destroy drug-using networks without linking people to new social networks beyond recovery networks, resulting in recovering drug users returning to their communities with little diversity of social networks (Herbeck et al., 2014). For example, a recent study focused on network dynamics of recovery capital among drug treatment participants found that while the treatment program achieved severing ties to participants' old networks, it was not very adept at fostering ties to new positive social networks other than 12-step recovery groups (Zschau et al., 2015). Their findings show the need for more effort to be placed on linking participants to mainstream networks centered on meaningful activities outside the treatment environment.

Social Recovery

Similar to recovery capital, the concept of *social recovery* draws from social capital theory but with greater focus on social relations (Boeri, Gibson and Boshears, 2014). Social recovery directs attention to the *process* of acquiring the skills, resources, and networks that enhance people's ability to live a healthier lifestyle in mainstream society (Boeri, 2013). Whereas recovery capital was the "sum total of one's resources that can be brought to bear on the initiation and maintenance of substance misuse cessation" (Cloud and Granfield, 2008, p.1985), social recovery brings the focus back on the relational action of acquiring needed resources by placing less emphasis on individual resources and more on the social and relational processes of recovery (Boeri, Gibson and Boshears, 2014).

Individuals with low socioeconomic status have the greatest challenges to acquiring positive social capital (Bourdieu, 1984). In our study, we examined the process of acquiring positive social capital through contact with mainstream social networks throughout the life course of individuals with little social capital. The participants in this study were recovered, recovering, or trying to stop problematic drug use. While this study is based in the US, the concept of social recovery can be used to inform prevention, intervention and treatment efforts globally.

METHODS

The data used for this qualitative analysis were drawn from two studies on active and former users of heroin, cocaine, crack, or methamphetamine conducted in southeastern US between 2007 and 2011. Targeted and snowball sampling methods were used to recruit participants (Watters and Biernacki, 1989). The study was approved by an Institutional Review Board (IRB), and received a "certificate of confidentiality" from a federal agency. Oral consent was obtained before collecting any study data. No personal identifying material was collected.

A drug history survey and audio-recorded in-depth life history interview explored the themes of drug use, recovery, turning points, and social roles over the life course. The semi-structured, open-ended interviews were one to two hours long. Recordings were transcribed word-for-word and triangulated with the quantitative drug history data and field notes for verification purposes.

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Sample

Participants were included in this analysis if they had used crack, cocaine, methamphetamine, or heroin (hereafter collectively called hard drugs) for at least five consecutive years and identified as lower socioeconomic status, defined as having less than a high school diploma, low prestige or erratic employment history (e.g., dishwasher, temporary day worker), and insecure residential status (e.g., homeless, shelter, hotel) during the last five years. Having many consecutive years of drug use has shown to negatively impact mainstream social relations (Boeri, 2004). Five years of hard drug use and insecure employment and housing was selected to best capture the impact of extended drug history.

Of the 29 participants identified for inclusion in the analysis for this paper, five were currently not using any hard drugs for at least a year or more, and 24 were currently using at least one hard drug. Among the current users, eleven had stopped using hard drugs for at least a year or more at some time but relapsed. All participants tried to stop drug use multiple times throughout their lives. Their demographics are shown in Table 1.

Analysis

Coding of the qualitative data was conducted using modified grounded theory methods (Glaser and Strauss, 1967; Strauss and Corbin, 1998). A modified version of grounded theory allows an analytical framework to guide analysis of emerging concepts and the relations between them (see Charmaz, 2001, 2008). In our study, the analytical framework of social capital, social recovery, and social networks informed the coding and analysis. The qualitative data management program, QSR NVivo, was used to help organize the coding process. Transcripts were coded by at least two coders.

The first phase of coding provided an in-depth understanding of social networks where participants acquired positive social capital throughout their lives. These were organized by five social network categories found in the data: (1) drug treatment programs; (2) non-drug-using family and friends; (3) religious and spiritual groups; (4) workplace networks; and (5) social clubs and activities. No other social network providing positive social capital emerged from the study data. Participants were not directly asked to discuss social capital or networks. Instead they were asked to discuss their lives around the thematic areas mentioned above (drug use, recovery, turning points, and social roles) and encouraged to expand on the details, a common strategy in qualitative research (Malterud, 2001).

During the second phase of coding, analysis was guided by insights on bonding, bridging, and linking social capital. The category of *barriers* to social networks emerged from the data and was added to the analytical framework.

FINDINGS

To graphically depict how participants accessed social networks throughout their lives, Table 2 shows the intersections of bonding, bridging, and linking social capital by the social networks where participants acquired positive social capital. As mentioned, barriers were added when analysis showed significant challenges to accessing social networks. Each cell in Table 2 indicates a specific social network category by type of social capital (bonding,

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bridging, linking) that provided positive social capital, or a barrier to access. Whenever a participant mentioned acquiring positive social capital through a social network, or a barrier related to this network, the quote was coded by the network and social capital type, and the participant's number was added to the appropriate cell on the typology. Since this is a small sample using qualitative analysis, absolute numbers are not useful to show results (Neale, Nettleton and Pickering, 2014). Instead Table 2 shows the number of participants by low (1–2); moderate (3–5), and high (6 or more), representing those who mentioned access or barriers to social networks where positive social capital was acquired.

The quotes drawn from the participants' stories are organized by the five social network categories that emerged from the analysis. All names are pseudonyms. Brackets are used to show where names or places were replaced to protect confidentiality. Three periods indicate a pause made by the participants, and three periods in a bracket indicate a break in the quote.

Drug Treatment Programs

The primary social situation where participants in the study acquired positive social capital was while they were in drug treatment programs. Types of treatment included drug courts, 12-step, and various kinds of outpatient or inpatient programs. In the US, drug courts are an alternative to incarceration where the judicial court system oversees the treatment program. A 12-step program is a self-help recovery group and often referred to as "meetings" since participants meet for group sessions. Outpatient programs include any type of treatment attended only during the day. Inpatient programs include comprehensive residential treatment where participants stay overnight, typically for weeks or longer. While the type and quality of treatment varies widely, the choice of treatment in the US usually depends on insurance policies or the ability to pay. Comprehensive residential treatment is very expensive and rarely available to people with little economic means.

Some of the participants indicated that treatment provided high bonding social capital. For example, Lacey said that other members in her recovery network motivated her in a drug court treatment program:

> [I] got to know some of the clients like I was, and heard their story and what they… how they live. Like we sitting here talking about, how their life was when they grew up, and how they first got started on using drugs, and different type things. And then we had sponsors that was coming from the meeting—coming up there sharing about how long they had been on drugs 20, 30, and 40 years—how they changed their lives. That's what made me stay with it.

Lacey stayed in the program drug-free for almost three years but relapsed soon after she was released (called graduation) from the drug court program. At first Lacey said she did not have a sponsor and stopped going to meetings. Later in the interview she revealed boredom, family responsibilities, and a new boyfriend who used drugs were influential in her relapse:

> Well sometimes I was bored, and then I was just busy, cause like I said my momma was sick, then my daughter might need me to watch my grandbabies, so sometimes I would miss a few meetings, then I had a boyfriend I was dating.

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Recovery networks also provided some bridging social capital. Cody, who was looking for work in home construction, mentioned that other men in his treatment network would help his search. Like Lacey, he also indicated that he stayed in a residential program because of the camaraderie he found among participants, “Just all the love that’s in there, and the respect people have for each other…It’s real nice.”

Robin had been in every type of treatment program and always relapsed, but she had stopped using all drugs except tobacco for three years at the time of the interview. She attributed her success to a treatment program that offered subsidized housing and allowed her to take care of her children: “And they have women with their kids. We have [12-step] meetings here every Thursday and we go to outside meetings. And we have to do eight meetings a month and then community service.” The treatment program also helped her interact with people in the neighborhood through structured community service events, indicating bridging capital.

Non-Drug-Using Family and Friends

All of the participants reported drug use in their family while they were children as well as childhood years of physical, emotional, or sexual abuse. In adulthood, spouses, partners, and even children, were sources of both positive and negative social capital. Friends provided access to social capital through new social networks; however these were typically within the same drug-using community or with people from similar socioeconomic status. Social capital from drug-using family and friends (i.e., negative social capital) was excluded from this analysis.

Family and partners provided primarily bonding social capital. Some participants stopped drug use to protect their children from knowing they were using or to be better parents. Robin said she stopped using for her children:

> It came to the point after having kids that I told him [husband] that I had to raise my kids and this was not a good thing for both of us to be on drugs. And he wasn’t willing to give up drugs. So I knew somebody was going to have to, so I ended up leaving him because of that situation.

Not all women were able to stop drug use for their children. Sometimes, significant others played a role in their cessation. Olivia had stopped using drugs when her daughter was born. After four children, her husband deserted her, and she said she was alone and without resources. Drugs helped her cope with life for a few years. When Olivia met a non-drug-using man, he replaced her need for drugs: “And I think one reason I didn’t relapse right away was because I took all that energy for those pills and I put it toward him ‘cause I was just so amazed with him, ‘cause I never really met a real decent man.” During her relationship she remained drug-free for three years. She relapsed when he left her.

Tom, who started using hard drugs in his youth, stopped using when he married: “It took about the first five years of my marriage to stop, as far as the drinking went and everything. The drugs, I pretty much laid down because I’d used alcohol to lay off of it.” Tom’s relationship with his wife was influential in his recovery. Similar to many who relied on bonding social capital for their recovery, Tom went right back to using hard drugs after his divorce.

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Among people with very few resources, bridging social capital provided support from others in similar situations. For example, Violet, with a history of relapsing and incarceration, relied on reciprocity for legal help. She said she calls a friend who "owes me a favor" when lacking needed resources.

Zach mentioned a friend who motivated him to continue his education. Raised by a mother who used drugs, and sexually abused as a child, he lived in a trailer park where almost everyone used and sold drugs. A school friend offered a rare glimpse outside a life of drug use and violence: "I mean she's not anybody that has to do with drugs or anything like that. But she's a really good friend and she gets Pell grants [US government subsidized grants for higher education]." At the time of the interview, he was still using drugs but had started the process of earning his general education diploma (GED), an alternative US high school diploma required to attend college.

Religious and Spiritual Groups

Religious or spiritual involvement occurred at any time in life. Participants often mentioned engagement in a religious activity provided a sense of belonging and inspired them to be drug-free at some point in life. For example, Carl was exposed to religion in his youth and became engaged in religious activities as an altar boy. While he struggled with drug use his entire life, the Catholic Church was always something he felt he could turn to for emotional support. As an adult, he embraced a spiritual practice that helped him to stay drug-free after his release from prison, "Ancestral Healing. That was deep. Because, here I am, sitting in class, helping her [the spiritual leader] teach the class." At the time of the interview, Carl was teaching Ancestral Healing classes to others in drug treatment. The social nature of his spiritual involvement is an example of bridging social capital that helped sustain his recovery.

Rae also mentioned her earlier religious engagement provided her strength she needed for recovery: "I'm a Baptist. I read my Bible every day…that's what kept me clean for three years [and] praying. A lot of prayer." Although Rae had relapsed by the time she was interviewed, she still had hope that her faith would help her again. What she seemed to lack was a relationship with others of her faith.

Robin credited her spiritual foundation for giving her strength to remain drug-free for the last three years: "I like the way I'm living now. I have a spiritual foundation now. Joined a church, and I've turned my life around." However unlike Rae, who relied on prayer, Robin's religious engagement resulted in building relations with other church members who provided bridging social capital that helped sustain recovery.

Workplace Networks

The workplace can be fertile ground for engaging in new social networks and developing relations across social classes. However the data show little access to positive social capital for people whose work is often temporary, part-time, or sporadic. Many worked in jobs where drug use was rampant and relationships were developed around drugs. Their low-income work was stigmatizing and did not offer opportunities to engage in relations with employees at higher levels.

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Only Elena revealed a long-term position that provided positive bonding and bridging social capital for a short period in her life. Growing up in a poor and marginalized social environment, she recalled her employment in a grocery store as a time when she felt like she belonged:

> I started bagging groceries at [grocery store], and I was really being accepted at that store and I felt good about that. And I started moving up in the company. I went from that to customer service, then I ran my own department, then I was over three departments. I went from being this kid that was a dropout and on drugs and that had been violated, and I just said to myself. "Man, screw this. I'm gonna do something." So I started putting every ounce of energy I had in my work. That's an addiction as well. Every waking moment, I was at the store, working off the clock, doing my little displays at different departments, making arrangements for the floral shop, making announcements over the PA system.

Elena was particularly motivated by positive comments from her managers. Years later she remembered how she felt when she was praised for her work: "And I was like, 'What? Me? Do you know who I am? You know where I came from?' And my confidence wasn't that great but [the work] built my confidence." However, her description did not indicate a lasting relationship with anyone at work, and when Elena married she started using cocaine with her husband and stopped working.

Social Clubs and Activities

Participants were raised in poor neighborhoods with few opportunities to engage in social activities outside their neighborhood as children. Their sporadic work and unstable residence status as adults left little time for leisure activity. No one mentioned positive social capital acquired by engaging in social clubs or activities as an adult, and only one participant mentioned being involved in a social club during his youth. Carl described his engagement in a social activity as a child that he looked on with nostalgia: "That was my first love, swimming. I swam competitively from about 8 years old until I was 19. It was a public team. […] So, that was pretty much my routine." Carl thought it was impossible to engage in swimming or other leisure activities as an adult due to time and money constraints.

Recreational or social activities that could facilitate engagement in mainstream social networks were not accessible to participants in the study. Nevertheless, many were aware of what was missing in their lives compared to their wealthier neighbors. Their stories revealed multiple barriers throughout their lives.

Barriers to Positive Social Capital

While more barriers than opportunities were found, only a few are included here to illustrate challenges to acquiring positive social capital. Barriers started in childhood. Elle, a young woman who lived with her mother in a poor community, said she was ostracized at school, and positive recreational social activities were out-of-reach due to her lack of resources. She indicated that schools might provide more bridges to positive social networks:

> They just need more things in schools and stuff that they can do to get them away from the drug crowds. […] like do sports and things. And things should be cheaper.

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> Things should be like, you know, the government should pay it. Like the government pays for police and things like that. The government should pay for more things in the schools than rather the kids have to pay it themselves. Because it all starts with a lot of poor kids doing drugs in schools. That's the main group of kids that start doing drugs are the poor ones and the ones that don't fit in.

Betty confirmed the lack of available social clubs in poor neighborhoods today:

> It's just, there's nothing for them to do there. There's no YMCA, there's nothing to break the cycle.[…] It needs like a YMCA. Like baseball teams or something, extracurricular, but like structure. They need structure. They need…they need to be shown that there's other things to do because they really don't know.

Data show that recovery networks provided bonding and bridging capital but did not facilitate social interaction in mainstream networks outside of recovery groups. For example, Jude recalled: "You go to group meetings every morning, because you're strung out on heroin. You get up and go to a group meeting after breakfast every morning. Basically, that's about it." Emily explained what she thought was missing in the treatment programs she attended: "Structure like, you know, getting people to, you know, I mean to do more things and not letting them lay around on Saturdays and Sundays. […] I'd like to be able to enjoy life again." Their words suggest that lack of attention to other activities and little incentive to engage in social networks outside recovery groups presented barriers to positive social capital that might be available if treatment activities expanded beyond recovery networks.

The workplace was another setting where participants mentioned more barriers than opportunities for contact with new social networks. One challenge was the sporadic nature of their work; another was the presence of co-workers who used drugs. For example, Mark, who had many jobs throughout his 54 years, described his situation as a manual labor, "you might do a four-month job, and then you're off work for however how long, until another comes up." Toby started methamphetamine at his first job when a co-worker offered it: "I was scared you know. I was young." Toby continued using methamphetamine with co-workers to enhance his work performance. No one mentioned engaging in any social activities with people they met at work beyond using drugs together.

While drugs were also used as a recreational social activity at first, their life stories show that as they became adults drugs were used more for coping than for recreation. As Zach described:

> I would rather get high than like to than to deal with, like, what my reality is, the way I look at it. You know what I mean? Because I would much rather be like just stoned stupid, like so fucked up that you can't even walk than have to like worry about, like, what I'm going to do about electricity. What am I going to do about the rent?

Emily expressed an attitude felt by many: "[Drugs] are a rich man's high and a poor man's dream." Drugs were no longer fun, and most participants had lost any hope of engaging in leisure social activities. When asked what she does for fun now, Rae, who had relapsed a number of times, said without hesitation: "Nothing. I don't know what fun is."

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DISCUSSION

Loïc Wacquant (1998) proposed that social capital is "both *relational* (as opposed to substantial) and an *indexical* notion: capital exists as such, and its value is defined *only in relation* to a specific social space or arena of action" (p. 27 italics in original). Our social capital analysis focused on access to social network relations that provide positive social capital. People with little social capital have few opportunities to access or engage in new social networks outside their communities. A better understanding of how people in recovery access new social networks and the barriers to access can inform preventive measures aimed toward at-risk youth as well as intervention for adults with recurrent drug use problems.

Focusing on social recovery, the differences between bonding, bridging, and linking social capital helped reveal how people recovering from problematic drug use accessed new social networks that provided positive social capital. While some bonding and bridging capital was found—*linking* social capital was missing from their lives.

Most of the men and women in this sample were raised by drug users and had mainly drug-using friends. They experienced childhood trauma, such as sexual and physical abuse, and social marginalization. They were stigmatized at school. Poverty was the main barrier to acquiring more positive social capital and presented serious challenges to engagement in mainstream social networks.

The data revealed a high level of bonding social capital through family and friends who did not use drugs, which provided emotional support but no linking social capital. Only a moderate level of bonding and bridging capital was achieved through treatment networks, providing access to new social networks of individuals within recovery groups or with similar social status. Their life histories show that most relapsed after treatment, indicating more effort is needed to provide access to, as well as engagement in, social networks beyond recovery groups. The workplace can be a site for accessing new social networks and positive social capital, but only one participant mentioned bridging capital available through work.

Most evident was the lack of engagement in social clubs. Formerly free or low-cost social activities in the US (e.g., YMCA) have become unaffordable for the poor. In many US schools, physical education, art, and music classes, which facilitated social engagement across class boundaries, have dwindled as funding for these programs was eliminated. Many poor children could not engage in after-school activities due to a lack of transportation or rising costs of belonging to a sports club.

Social clubs engender social capital through building trust and reciprocity (Putnam, 2000) Only one participant mentioned any engagement in a social club throughout his life. Many lamented the lack of social activities available that social clubs typically provide.

The people in this study used drugs throughout their lives and experienced multiple episodes of treatment, recovery, and relapse. They blamed themselves for returning to drugs; yet, their life stories revealed few opportunities to access or engage in new social networks that can provide positive social capital. While some needed access to new social networks, others

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needed encouragement to continue engagement in new networks, and several needed help re-building mainstream networks outside recovery.

In the aforementioned formative study on network-based recovery capital (Zschau et al., 2015), the authors distinguished *natural networks*, which occur naturally by living in society, from *artificial networks*, which are created by recovery groups. Their finding that artificial networks “not only keep individuals stuck in a perpetual recovery microcosm but may also make it very difficult to establish ties to natural networks” (p.15), suggests that natural networks are needed for sustained recovery. Their work supports the importance of incorporating a social recovery focus on social network relations.

LIMITATIONS

The findings are limited to a small US sample and cannot be generalized to all populations of problematic drug users. The findings are also specific to individuals with low socioeconomic status, since the study intentionally focused on those with the least social capital. Middle- and upper-class individuals with higher levels of social capital have more resources to access and engage in new social networks, and more research is needed on these populations regarding engaging with new social networks during recovery. Lack of follow-up data collection to verify longer periods of sustained recovery is another limitation.

CONCLUSION

The findings of this study on people with reoccurring problematic drug use show that linking to more mainstream social networks is beneficial for sustained recovery. Social activities provide a conduit for purposeful relationships and social networking opportunities. While treatment programs are the most obvious space to facilitate access to new networks for recovery efforts, social institutions, such as religious organizations, schools, and workplaces, also can provide opportunities for social activities (Dutton and Ragins, 2007; Lockhart, 2005; Putnam and Campbell, 2010). Treatment programs might facilitate participation in social activities by providing transportation to social events outside recovery support groups and encourage engagement with natural networks.[1] Religious organizations can provide space for social clubs. Workplaces can promote social activities that encourage constructive relationships between employees at different levels. Schools can provide subsidies and transportation for children to participate in social clubs and sports teams.

There is growing interest in expanding the concept of recovery capital (Neale, Nettleton and Pickering, 2014; Zschau et al., 2015). Incorporating the concept of *social recovery* shifts the focus from individuals to the relations between individuals and social networks. Social recovery is an innovative conceptual tool that can be used in research and in practice to focus our lens on engagement in diverse social networks.

[1]For practical guidelines on social recovery implementation see Boeri, Lamonica and Harbry (2011)

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References

Boeri MW. "Hell, I'm an addict, but I ain't no junkie": An ethnographic analysis of aging heroin users. Human Organization. 2004; 63(2):236–245.

Boeri, MW. Women on Ice: Methamphetamine Use among Suburban Women. New Brunswick, NJ: Rutgers University Press; 2013.

Boeri M, Gibson D, Boshears P. Conceptualizing social recovery: Recovery routes of methamphetamine users. Journal of Qualitative Criminal Justice & Criminology. 2014; 2(1):5–38. [PubMed: 25574504]

Boeri M, Lamonica A, Harbry L. Social recovery, social capital, and drug courts. Practicing Anthropology. 2011; 33(1):8–13.

Boshears P, Boeri M, Harbry L. Addiction and sociality: Perspectives from methamphetamine users in suburban USA. Addiction Research & Theory. 2011; 19(4):289–301. [PubMed: 21887124]

Bourdieu, P. Distinction: A Social Critique of the Judgment of Taste. Cambridge, MA: Harvard University Press; 1984.

Bourgois, P.; Schonberg, J. Righteous Dopefiend. Los Angeles, CA: University of California Press; 2009.

Charmaz, K. Grounded theory. In: Emerson, RM., editor. Contemporary Field Research: Perspectives and Formulations. Prospect Heights, IL: Waveland Press; 2001. p. 335-352.

Charmaz, K. Constructing Grounded theory. A practical guide through qualitative analysis. London: Sage; 2008.

Cloud W, Granfield R. Conceptualizing recovery capital: Expansion of a theoretical construct. Substance Use and Misuse. 2008; 43(12–13):1971–1986. [PubMed: 19016174]

Coleman, JS. Foundations of Social Theory. Cambridge, MA: Harvard University Press; 1990.

Dutton, JE.; Ragins, BR. Exploring Positive Relationships at Work: Building and Theoretical and Research Foundation. Mawwah, New Jersey: Lawrence Erlbaum Associates; 2007.

Farabee D, Rawson R, McCann M. Adoption of drug avoidance activities among patient sub-contingency management and cognitive-behavioral treatments. Journal of Substance Abuse Treatment. 2002; 23(4):343–350. [PubMed: 12495796]

Glaser, BG.; Strauss, AL. Discovery of Grounded Theory: Strategies for Qualitative Research. New York, NY: Aldine Transaction; 1967.

Granfield R, Cloud W. The elephant that no one sees: Natural recovery among middle-class addicts. Journal of Drug Issues. 1996; 26(1):45–61.

Grootaert C, Narayan D, Jones VN, Woolcock M. Integrated questionnaire for the measurement of social capital. The World Bank Social Capital Thematic Group. 2003

Herbeck DM, Brecht ML, Christou D, Lovinger K. A qualitative study of methamphetamine users' perspectives on barriers and facilitators of drug abstinence. Journal of Psychoactive Drugs. 2014; 46(3):215–225. [PubMed: 25052880]

Kawachi I, Kim D, Coutts A, Subramanian SV. Commentary: Reconciling the three accounts of social capital. International Journal of Epidemiology. 2004; 33(4):682–690. [PubMed: 15282222]

Laudet AB. The road to recovery: Where are we going and how do we get there? Empirically driven conclusions and future directions for service development and research. Substance Use & Misuse. 2008; 43(12–13):2001–2020. [PubMed: 19016176]

Lockhart WH. Building bridges and bonds: Generating social capital in secular and faith-based poverty-to-work programs. Sociology of Religion. 2005; 66(1):45–60.

Malterud K. Qualitative research: standards, challenges, and guidelines. The Lancet. 2001; 358(9280): 483–488.

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Neale J, Nettleton S, Pickering L. Gender sameness and difference in recovery from heroin dependence: A qualitative exploration. International Journal of Drug Policy. 2014; 25:3–12. [PubMed: 24041800]

Portes A. Social capital: Its origins and applications in modern sociology. Annual Review of Sociology. 1998; 24:1–24.

Putnam, RD. Bowling alone: The Collapse and Revival of American Community. New York, NY: Simon and Schuster; 2000.

Putnam, RD.; Campbell, DE. American Grace: How Religion Divides and Unites Us. New York: Simon and Schuster; 2010.

Radcliffe P, Stevens A. Are drug treatment services only for 'thieving junkie scumbags'? Drug users and the management of stigmatised identities. Social Science & Medicine. 2008; 67(7):1065–1073. [PubMed: 18640760]

Schuller T. Reflections on the use of social capital. Review of Social Economy. 2007; 65(1):11–28.

Strauss, A.; Corbin, J. Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory. 2nd. Thousand Oaks, CA: Sage Publications, Inc; 1998.

Szreter S, Woolcock M. Health by association? Social capital, social theory and the political economy of public health. International Journal of Epidemiology. 2004; 33:650–667. [PubMed: 15282219]

Trulsson K, Hedin UC. The role of social support when giving up drug abuse: A female perspective. International Journal of Social Welfare. 2004; 13(2):145–157.

Wacquant LJ. Negative social capital: State breakdown and social destitution in America's urban core. Netherlands Journal of Housing and the Built Environment. 1998; 13(1):25–40.

Watters J, Biernacki P. Targeted sampling: Options for the study of hidden populations. Social Problems. 1989; 36(4):416–430.

Wuthnow R. Religious involvement and status- bridging social capital. Journal for the Scientific Study of Religion. 2002; 41(4):669–684.

Zschau T, Collins C, Lee H, Hatch DL. The hidden challenge: Limited recovery capital of drug court participants' support networks. Journal of Applied Social Science (Online). 2015:1–22.

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TABLE 1

Sample Demographics N=29

Demographic Characteristic	Inactive N=5	Active N=24 (*)
Gender		
Male	4	11 (3)
Female	1	13 (8)
Race/Ethnicity		
African American	1	8 (2)
Hispanic	1	
White	3	16 (9)
Age Group		
18–29	1	6 (3)
30 and older	4	18 (8)

*Number who relapsed after a being drug-free for year or more

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Table 2

Access and barriers to new social networks by type of social capital

	BONDING	**BRIDGING**	**LINKING**	***BARRIERS***
Drug treatment networks	moderate	moderate	none	*high*
Non-drug using family and friends	high	moderate	none	*high*
Religious and spiritual groups	moderate	low	none	*none*
Social clubs	none	low	none	*high*
Workplace networks	none	low	none	*moderate*

Legend: low indicates 1–2 participants; moderate indicates 3–5 participants; high indicate over 6 participants mentioned this type of access or barrier.