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A Study of Black Family Members' Perceptions of Substance Use Supports

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Abstract

Empirical literature shows the number of substance users has increased in the United States in the last 5 years. Support services are often limited to substance users only, leaving out families affected by addiction. Black individuals and families of substance users are underrepresented in the literature. The purpose of this study was to investigate the perceptions of substance use support services for Black family members of substance users. Data were collected using a qualitative interpretive phenomenological analysis, semi-structured, virtual interviews, and purposive sampling. The data from 10 participants in New York State was analyzed through the lens of Bronfenbrenner's ecological system theory. The themes that emerged were (a) health and wellness, (b) types of familymember supports, (c) challenges and obstacles, and (d) cultural influences across a person's lifetime. The results reveal Black family members' perceptions of intimate relationships, spiritual relationships, and community-based supports. The participants' beliefs derived from negative stigma and perceptions of self-image. Overall, the participants cultural events related to family cycle, trauma, and the code of silence have been reinforced over generations. It is recommended for policy makers and professionals to revise trainings and education in the behavioral health field to emphasize the influence of family members of substance users. Supportive health stages were developed in this study to detail the experience of affected families and to suggest a way professionals can better assist families. These initiatives can bring meaningful changes within the behavioral health field and can give a voice to Black families affected by substance use disorders.

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A Study of Black Family Members' Perceptions of Substance Use Supports

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Dedication

When I consider my loved ones who have inspired me during this process, I am forever grateful and overwhelmed by their unconditional love and support. This study is dedicated to those who have pushed me, encouraged me, and left me alone to write.

To my mother and my sister, thank you for your understanding and flexibility over the last 28 months. A special thanks to my brothers for believing in me and calling me the "smart one," even when I did not believe it. To all of my nieces and nephews, you are my inspiration and motivation. To my aunt, thank you for always helping me with my travels. To my Florida family, thank you for your support. It has been a privilege and an honor to present the family as a role model and to show we are not limited by our circumstances. Anything is possible when you want it badly enough.

To my team, Team E.L.I.C.I.T., I don't know how or why we were put together, but I am grateful to have you. Together we have truly given life to the meaning of Team E.L.I.C.I.T. We have shown effectiveness, leadership, innovation, communication, inspiration, and trust. Danny and Jason, there is no way I could have made it through this program without the two of you.

To my chair, Dr. VanDerLinden, my committee member, Dr. Quigley, and my advisor, Dr. Evans, thank you for believing in me and showing me kindness. Whether in the classroom, dissertation meetings, or by phone, your words have put me at ease and back on the right track. You all have made me into a leader, researcher, and now a scholar.

Someone once asked me about my why. "Why do you want a doctoral degree?" I explained it was important to be a role model to other Black girls. However, the more I thought about it, the more I realize this doctorate is for me. In my moments of self-doubt and defeatism, I remember how far I have come. I remember I have a purpose, and this degree is a vehicle to help me fulfill the purpose that was chosen for me and is greater than me. I was chosen to be a leader so that I could give voice to the voiceless.

I know my guardian angel, Grandma Sandra, is watching over me, guiding my steps to ensure I make it through this program whole. I'd like to believe she intentionally placed these kindred spirits in my workplace, cohort, and friendships to empower me and help me achieve my highest potential. Thank you for allowing me to be my authentic self and for accepting me, *flaws and all*.

Biographical Sketch

Tanya Henderson was born and raised on Long Island, NY. As the first person in her family to graduate college, Tanya relocated to upstate New York in pursuit of higher education and in commitment of a year of service to AmeriCorps VISTA. Believing education and servant leadership are the cornerstones for success, she forged forward aspiring to be a role model, mentor, and leader for her community. Tanya has demonstrated her competency in leading the community as a compassionate, tenacious, and transparent leader.

Tanya Henderson is a doctoral candidate at St. John Fisher College. She received a Bachelor of Science degree in Sociology and Child and Family Studies from SUNY Oneonta in 2010, and a Master of Science degree in Education in 2014 from The College of St. Rose. Throughout her 10 years in the field of behavioral health and human services, she has served as a Licensed Mental Health Counselor and is a Credentialed Alcoholism and Substance Abuse Counselor in the Capital Region of New York State. Additionally, Tanya has volunteered in the Capital Region with the Community Hospice Grief Services since 2013 and with the Domestic Violence Services since 2014. Currently, Tanya is the Founder and Chief Executive Officer of Our Village Services, LLC., a New York-based counseling practice whose primary mission is to break down barriers and generational traumas for families and individuals of color who are affected by mental health problems and substance use disorders.

Upon entering the Ed.D. program in Executive Leadership at St. John Fisher, she began

pursuing her qualitative research on knowledge, attitudes, and supports for families

affected by substance use disorder. Under the guidance of her dissertation chair, Dr. Kim

VanDerLinden, and committee member, Dr. Loretta Quigley, Tanya received her Ed.D.

degree in 2020.

Abstract

Empirical literature shows the number of substance users has increased in the United States in the last 5 years. Support services are often limited to substance users only, leaving out families affected by addiction. Black individuals and families of substance users are underrepresented in the literature. The purpose of this study was to investigate the perceptions of substance use support services for Black family members of substance users.

Data were collected using a qualitative interpretive phenomenological analysis, semi-structured, virtual interviews, and purposive sampling. The data from 10 participants in New York State was analyzed through the lens of Bronfenbrenner's ecological system theory.

The themes that emerged were (a) health and wellness, (b) types of family-member supports, (c) challenges and obstacles, and (d) cultural influences across a person's lifetime. The results reveal Black family members' perceptions of intimate relationships, spiritual relationships, and community-based supports. The participants' beliefs derived from negative stigma and perceptions of self-image. Overall, the participants cultural events related to family cycle, trauma, and the code of silence have been reinforced over generations.

It is recommended for policy makers and professionals to revise trainings and education in the behavioral health field to emphasize the influence of family members of substance users. Supportive health stages were developed in this study to detail the

experience of affected families and to suggest a way professionals can better assist

families. These initiatives can bring meaningful changes within the behavioral health

field and can give a voice to Black families affected by substance use disorders.

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Chapter 1: Introduction

In 2018, the Substance Abuse Mental Health Services Administration (SAMHSA) indicated that 164.8 million people in the United States reported using illicit substances, including alcohol, tobacco, cannabis, opioids, and other drugs, in the past month (SAMHSA, 2019a). More specifically, SAMHSA (2019b) reported that 20.3 million people have been diagnosed with a substance use disorder (SUD). The American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* defines SUDs as changes in the brain from patterns of repeated drug use, which include behaviors, such as relapse and increased craving, when exposed to stimuli. Drug users experience life impairment, risky behavior, and increased drug tolerance. The most used substances for people aged 12 years and older are cannabis, alcohol, and narcotic drugs, prescribed for pain, or opioids, as they are called colloquially (SAMHSA, 2019b). Opioids have become among the fastest-growing used substance in the United States. In fact, more than half of opioid users reported that these prescription drugs are available to them through family and friends (SAMHSA, 2019b).

The growing epidemic of substance use has accelerated throughout the world (Arlington & Miller, 2000). Researchers predicted that from 2015 to 2020, the number of diagnosed SUDs would double in the United States (Hodges & Copello, 2015). Unfortunately, substance use has rippling effects that disrupt the lives of the user's entire family and, by extension, the whole community. Studies have documented that the impact of SUDs include impaired attachments, economic hardship, legal involvement,

emotional distress, violence, academic underperformance, and work disruption (Gruber &

Taylor, 2006; Huebner, Hall, Smead, Willauer, & Posze, 2018; Lander, Howsare, &

Byrne, 2013; Orford, Templeton, Velleman, & Copello, 2005). Researchers continue to

examine the effects of SUDs within subgroups, cultures, and communities, such as low-

income groups where any kind of disruption could be severe.

Studies have shown that people living in low-income communities are more

susceptible to drug use (Oser et al., 2019). According to Chatters, Taylor, Lincoln,

Nguyen, and Joe (2011), Black individuals (those of African descendant) are more

vulnerable to developing SUDs due to their increased probability of having low

socioeconomic status (SES), living in impoverished housing conditions, and being

disadvantaged by the disparities of access to education and healthcare. Black populations

with lower SES are often exposed to the high-stress environments that commonly

accompany increased exposure to violence and crime (Eaton et al., 2013; Montgomery,

Stewart, Bryant, & Ounpraseuth, 2014). Black individuals living below the poverty line

are twice as likely to report psychological distress and drug-related issues than those

living above the poverty line (Office of Minority Health [OMH], 2019).

The 2018 National Survey on Drug Use and Health (SAMHSA, 2019a) reported

that 2,166,000 Black persons, aged 18 years or older, have an SUD. However, only 19%

received treatment during the calendar year of 2017-2018 (SAMHSA, 2019a). In

addition, and importantly, Black individuals are overrepresented in the homeless

population, given the proportion of Black people in the U.S. population. The Institute of

Global Homelessness (2018) showed that 51% of the homeless population are Black

families, and according to the U.S. Census Bureau (n.d.), the Black population makes up only 13% of the total U.S. population.

Despite their status as a racial minority in the overall U.S. population, Black people are associated with higher rates of drug-related issues compared to other ethnic groups (Gaston, Earl, Nisanci, & Glomb, 2016; Gilson et al., 2018; Oser et al., 2019). Black individuals are also predisposed to health-related issues and are at high risk of medical complications from drugs-related illnesses (Lewis, Lee, Kirk, & Redmond, 2011). Given the history of America, Black people's perceptions are influenced by historical trauma and events that were collectively experienced, shared, and conveyed to succeeding generations, shaping contemporary attitudes, values, and beliefs within Black communities and culture.

Black History in the United States

Black people have been, and continue to be, systemically oppressed throughout American history (Hardy & Qureshi, 2012). Black history in the United States is permeated by the prejudice that led to, and the horrors of, being captured and enslaved (White & Sanders, 2008). These sentiments and stereotypes about Black people have persisted and evolved into recurring instances of police brutality, racial profiling, and countless other covert strategies of subjugation (Jeffers, 2019). The literature indicates these traumatic historical events have influenced Black decision-making at the individual, family, community, and institutional levels (Booth & Anthony, 2015; Hanna, Boyce, & Yang, 2017). To date, the Black population and other people of color have suffered from disproportionate access to resources and rights, such as housing, school funding, and employment opportunities (Booth & Anthony, 2015; Chatters et al., 2011). In addition to

not having the same available resources as the majority White population has, Black communities regard the resources that are available to improve the conditions of underdeveloped Black communities with suspicion, given their negative historical experiences (Cooper, 2015). With such limited resources and opportunities in the community, drugs and other illicit activities serve as an outlet for financial gain and an escape from life stressors (Lacey et al., 2016). Maladaptive coping, not to mention overt despair, manifests itself in SUDs, mental illness, and criminal involvement (Cooper, 2015; Gaston et al., 2016; Hardy & Qureshi, 2012).

Following centuries of injustice, discrimination, and inequity, Black people have created novel ways to survive and endure oppression (White & Sanders, 2008). Hardy and Qureshi (2012) suggested that Black individuals use substances (a) for recreation or to socialize among peer groups, (b) for glorification, (c) because of family drug exposure, and (d) to medicate emotional and psychological stress. Drug use is a symptom of the conditions of many socioeconomically deprived communities (Cooper, 2015). Instead of receiving treatment, Black individuals are disproportionately incarcerated for drug offenses; they are more likely to receive punitive treatment than medical treatment for their drug use (Bell & McBride, 2012). Researchers have cited that Black communities fear disclosing the *family business* because of the belief that it will be weaponized against the family in a legal setting (Gaston et al., 2016). The Black family's fear of a legal setting includes family court, child protective services agencies, and state corrections facilities.

Blacks and Drug Policies

In 1973, President Richard Nixon initiated the War on Drugs policy in response to drug use in the United States. Many drug policies were derived from former slavery practices that were used to control slaves in areas where slaves outnumbered White people (Cooper, 2015). The 1973 Rockefeller drug laws, for instance, shifted the policies surrounding drug control from rehabilitation to punishment by establishing mandatory sentencing (Fortner, 2013). As such, drug-related arrests ballooned by 1,100% from 1980 to 2003, with severe and racially disproportionate racial consequences (King, 2008). This shift directly impacted Black people, particularly men, through a growing trend of mass incarceration.

Subsequent laws, such as the Second Offender Law of 1973 and the Violent Felony Offender Law of 1978, required second-time offenders to receive a felony conviction (Chronopoulos, 2010). This intensification resulted in longer sentences, similar to those of violent offenders. To the same end, the Handgun Possession Law of 1980 required a mandatory 1-year punishment for illegal gun possession (Chronopoulos, 2010). Furthermore, Black and Latino people were disproportionately affected by these policies when compared to the experiences of their White counterparts (King, 2008). By the 1980s, President Ronald Reagan reframed the War on Drugs as an issue of national security and dismantled the existing policies. The Fourth Amendment of the 1789 U.S. Constitution prohibited unreasonable searches and seizures of individuals (National Constitution Center, 2020). However, by the 1980s, police were permitted to conduct *stop and frisk* under the auspices of *probable suspicion* (Cooper, 2015). Probable cause

escalated to profiling, which targeted Black people and other minority ethnic groups (Alexander, 2010).

The premise of law enforcement was to take control of the underclass and evolved to *protect and serve* American citizens (Cooper, 2015). Historians have questioned if this mission included protecting Black Americans or if it were to protect Americans from Black Americans. As such, the War on Drugs amplified the racial discrepancy and disparity between Black people in America and law enforcement. The mission of the War on Drugs was ostensibly to rid the streets of criminals and their associated illicit drug activities. However, because funds were diverted from drug treatment services into law enforcement services, individuals, families, and communities languished due to neglect from the underfunded public services (King, 2008). The U.S. federal government reallocated drug treatment funds into local law enforcement that established a collaboration with military forces, specifically the purchase and use of military-grade gear and weapons (Cooper, 2015). These actions violated the 1878 federal statute, the Posse Comitatus Act, which prohibits the military from conducting domestic law enforcement without jurisdiction and requires authorization from Congress (Congressional Research Service, 2018). The political agenda to crack down on drugs crippled Black communities by dismantling families through separation and incarceration (Alexander, 2010; Cooper, 2015). Drug policies, today, continue the oppression and trauma woven into the fabric of America's history because they perpetuate feelings of distrust between the Black community and social services, government, and other public social systems.

Black Population's Distrust for Institutions

The Black community's attitude and beliefs about American systems and policies are not unfounded. The Tuskegee Syphilis Study, 1932 to 1972 (Centers for Disease Control and Prevention [CDC], 2020) is a hallmark example of the systematic racial abuse of Black males. During the study, Black males were injected with syphilis and were then withheld penicillin, which was then known to treat and cure the disease, because researchers wanted to study the natural course of the disease (Gaston et al., 2016). Researchers failed to obtain informed consent, nor did they explain the purpose of the study. For 40 years, the researchers led the Black community to believe they were being treated for *bad blood*, and the benefit of participating in the study would include a free medical exam, meals, and burial insurance (CDC, 2020). In this instance, the Black participants trusted a medical institution, but, instead, they were deceived, exploited, and harmed. This medical experimentation resulted in the suffering and unnecessary deaths of 600 Black men (CDC, 2020). Researchers reference *generational distrust* in terms of families passing down horror stories of medical maltreatment and malevolence from medical professionals (Williamson, Bigman, & Quick, 2019). These horrors and the consequent distrust fuel a cycle that hinders the acquisition of health care and other services, including education and government (Gaston et al., 2016). According to Pinkney (2016), the education system has disempowered the Black population by denying communities quality education. Historically, policies were changed after outcries from the community, demanding change, and the desegregation of schools. History illustrates that change only comes from the demand for improvement, but, unfortunately,

history also demonstrates that the government had disregarded Black people's fundamental rights.

The fallout after the U.S. Supreme Court decision of *Brown v. Board of Education* in 1954 to desegregate schools demonstrates the convoluted passage of history (Cooper, 2015). Specifically, the *Brown v. Board of Education* decision was noted as the driving force behind the Civil Rights movement (Ware & Diette, 2013). This landmark case declared the idea *separate but equal* unconstitutional. However, this decision was met with resistance and provoked tensions between the Black and White communities. The tensions persisted well into the Civil Rights movement and beyond. While the Civil Rights movement may have brought an end to the Jim Crow laws on paper, Smith and Barrett (2013) suggested it also correlated with the inception of mass incarceration. The disproportionate number of Black people who are incarcerated proves that society and its institutions found other ways to oppress and marginalize the Black community under the pretense of fighting crime and achieving justice against *perpetrators*. Because of this convoluted and insidious history, Black communities continue to endorse caution and trepidation toward the government and its institutions.

Well documented by researchers, the mass incarceration of the Black population has a direct impact on communities, families, and schools (Johnson & Young, 2002; Montgomery et al., 2014; Pinkney, 2016). In 2010, Alexander referenced *the school-to-prison pipeline* to illustrate how Black children were being prepared for prisons instead of career opportunities. Further, Black children have early exposure to law enforcement because they see their parents or relatives incarcerated, witness stop and frisk events, and

are present for other unwarranted harassment from officers (Alexander, 2010; Bell & McBride, 2012).

In 2017, there were 475,900 Black people incarcerated in the United States (Bronson & Carson, 2019). There were 436,500 White people incarcerated in the same year (Gramlich, 2019). Given that Black people only make up 12.5% of the U.S. population, it is clear that Blacks are being targeted by law enforcement and arrested at higher rates than other ethnic groups (Alexander, 2010). Blacks are targeted by law enforcement and arrested at higher rates than other ethnic groups (Alexander, 2010).

The disparate trends of the criminal justice system are most evident in drug-related arrests. The National Association for the Advancement of Colored People (NAACP) reported that the Black population only accounts for 12.5% of substance users, but Black individuals are arrested for 29% of drug-related offenses and represent 33% of inmates in state correctional facilities (NAACP, 2019). Bell and McBride (2012) suggested that the incarceration of the Black population is prioritized over preventative methods for substance use treatment. The racial inequality in sentencing prohibits Black individuals from improving their living conditions and from receiving treatment for a condition (i.e., SUD).

The marginalization of the Black population has been enveloped in a culture of colorblindness—a concept by which Black people and other minority groups of color are perceived as invisible or, rather, irrelevant. Colorblindness perpetuates inequality, injustice, and inequity in American society by diminishing the significance of ethnicity plays in the experience of people of color (Hanna et al., 2017). For example, the opioid epidemic illustrates the racial disparities in substance use treatment, and particularly in

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how the epidemic is described (Bebinger, 2019). According to Bebinger (2019), the opioid epidemic is perceived as a White epidemic, despite the rising rate of Black people dying from opioid overdoses. Netherland and Hansen (2017) described the opioid epidemic as a new war on drugs, a White drug, and a biomedical disease. Herzberg (2017) described the accessibility to pharmaceutical medication as a problematic *social entitlement* for privileged White people. This framing of the issue as a White problem obscures the real rates of addiction and death and the contemporary issues that pervasive drug problems in a community pose to the community at large. With the focus on White addicts and their supply chain, it is that much harder for Black addicts to seek and receive help. In addition to facing the idea that the opioid crisis is a White problem, Black addicts have the preexisting problem of the disproportionate rates of incarceration for illegal controlled substances.

The national surge in opioid overdoses has led to prescription drug monitoring programs, less punitive sentencing for drug-related crimes, decriminalization of the drug, and alternative treatment options—all primarily for White people (Allen, Harocopos, & Chernick, 2020; James & Jordan, 2018; Netherland & Hansen, 2017). Researchers have demonstrated that physicians have negative perceptions and biases toward Black substance users (Allen et al., 2020; Bebinger, 2019). Specifically, physicians lean toward not prescribing buprenorphine maintenance treatment (BMT), an opioid replacement drug that can help people overcome addiction, to Black users. In contrast, Whites are 35 times more likely to be prescribed BMT than Blacks (Bebinger, 2018). Further, regarding prescription disparities, Hatcher, Mendoza, and Hansen (2018) reported that physicians

clinically abandoned oppressed and low-income populations. Consequently, Black people are affected by physician clinical neglect.

A provider's attitude and beliefs toward Black people can impair the provider's ability to provide bias-free treatment. Hatcher et al. (2018) suggested that physicians and treatment providers should not only treat an individual's SUD but consider environmental and psychosocial factors as well. Not taking these factors into account further stigmatizes substance users and, more specifically, reinforces the Black community's distrust in medical practitioners and the social system.

Sarubbi, Kiyama, and Harper (2019) used the *ideology of invisibility* to describe the *misrecognition of diverse identity*, which ignores the adversity faced by ethnic groups. When communities of color experience the erasure of their diverse identity, they distrust government institutions and representatives and become alienated from the services, people, and systems that are designed to assist citizens in need. For example, the 1994 Multiethnic Placement Act and the 1996 Interethnic Adoptions Provision were implemented to eliminate the discrimination families of color face when adopting Black and Latino children (Hanna et al., 2017). The acts focused on changing the recruitment process because the existing recruitment efforts did not target families of color (Sarubbi et al., 2019). The changes addressed families' reports that the foster care system had poor communication and lacked knowledge of Black culture and their history of trauma (Hanna et al., 2017). Subsequently, Black families maintained a sense of distrust for government agencies until these practices were rectified (Sarubbi et al., 2019). Twenty years later, more than 50% of children awaiting adoption in the foster care system are Black and Latino (Hanna et al., 2017). The institutions have failed to validate and address

the experience of the Black population and other people of color, and that failure may further perpetuate the fear and distrust of institutions. Thus, researchers find Black families rely on each other instead of asking for help from people outside of their home, family, and community.

Black Families and Support

Black people have demonstrated strength and resilience over the years by coming together to support one another through hardship and adversity. The access and acquisition of support for Black community members are categorized into three channels: informal, semiformal, and formal (McDonagh, Connolly, & Devaney, 2018). Friends and relatives are among the informal support. However, these individuals may lack the knowledge and understanding of addiction, and they may not be able to relate to the concerns of those who have family members who use drugs (Edwards, Best, Irving, & Andersson, 2018). For Black communities, churches comprising family members, friends, parishioners, the clergy, and other church leaders, serve as both informal and semiformal support mechanisms. Both informal and semiformal support are crucial for Black resilience, and churches play a significant role in undergirding Black families (Bentelspacher, Ducan, Collins, Scandell, & Regulus, 2006).

Other semiformal avenues of support include support groups, physicians, work colleagues, and other professionals who offer care for families. However, these resources frequently lack the expert knowledge needed to provide substantial care. For example, while a colleague or support group member may recognize the needs of a family, they may not know where to send the affected individuals for support (Hutchinson & Allnock, 2014). Semiformal support also takes the form of grassroots organizations, such as Al-

Anon (2019) or Al-Ateen, which are created by the community to offer support for families of users. Much like the other forms of the semiformal support mentioned, community support groups generally lack professional expertise (Stenton, Best, & Roberts, 2014).

While formal support structures benefit from the expertise of medical practitioners and treatment providers, these institutions lack the knowledge of and empathy for the specific challenges faced by families and individuals with an SUD (Sell & Magor-Blatch, 2016). Social services and law-enforcement affiliates, such as drug court, family court, child family services, or child welfare services, count as formal support (Murphy, Harper, Griffiths, & Joffrion, 2017). However, these formal methods may be implemented or utilized as a condition of a court or legal intervention, thus having only an indirect influence on and benefit to the family members. Black communities are missing out on expert knowledge because of a cultural discrepancy between government institutions and the Black communities they seek to serve.

Problem Statement

While substance use is a worldwide issue, the American opioid epidemic catalyzed the investment in treatment options for substance users in the United States. The National Institute on Drug Abuse (2017) estimated that $740 billion were allocated to combatting the use of alcohol and other illicit drugs. Researchers have widely reported the use of family-based treatments to support the recovery efforts of substance users; however, less is known about support for family members. Despite the allocation of funds for drug treatment, few researchers have studied family members' perceptions of

substance-use services. Even less is known about this topic from the perspective of Black families.

In terms of an emphasis on Black communities, the literature on substance use has focused on prevention methods for adolescents (Hardy & Qureshi, 2012; Stewart, 2003), the criminal aspects of substance use (Cooper, 2015; Eaton et al., 2013), and the repercussions for family reunification (Murphy et al., 2017). The collective memory of traumatic historical events and policies affecting Black people persist in the generations of distrust in systems. The invisibility of Black perspectives in scholarly research further entrenches the feelings that bar Black access to support services. Recurring acts of oppression, discrimination, and isolation further trigger post-traumatic defenses against a system that has historically served as a threat rather than a help. Thus, the historical exclusion and exploitation of the Black population reinforce entrenched distrust in public systems and institutions. Where substance-use programs address the needs of substance users themselves, their family members' needs are often overlooked and disregarded (Huebner et al., 2018).

Furthermore, Black family members are particularly underrepresented in the academic literature regarding substance use. Additional research can shed light on the social issues and stressors experienced by Black families and their communities. It can also offer a call for more family-based supports for substance users (Sarubbi et al., 2019).

Despite the research being sparse, there is, nonetheless, a disproportionate lack of support services available within Black communities to help families cope with the strain of having substance-using relatives (Johnson & Young, 2002; Orford et al., 2005). Targeted support services for Black families would serve the particular constellation of

emotional and psychological needs that are embedded in the larger historical context, as described above, while also respecting the cultural identity and history of Black Americans (Brown, Parker-Dominguez, & Sorey, 2000). The most significant influences on a family member's willingness to engage in family-based treatment are the stigma and negative perceptions toward substance users. These barriers contribute to misinformation about available support services (Cohen-Filipic & Bentley, 2015). The lack of addiction education and limited availability of support programs are additional barriers to accessing support services and preventing family members from availing themselves of these resources (Edwards et al., 2018; Hutchinson & Allnock, 2014).

Even when family members are aware of support services, some encounter new barriers caused by alternative services, such as online support groups (Sell & Magor-Blatch, 2016). As a result of physical and geographic limitations, more support services are being offered online. While, theoretically, this allows for more support, family members may receive unreliable information from undertrained practitioners who lack cultural awareness of the areas they serve (Cohen-Filipic & Bentley, 2015; Wangensteen, Bramness, & Halsa, 2018). Thus, even when family members make efforts to obtain the help available to them, through no fault of their own, they are often unable to secure this support, and, therefore, cannot support their substance-using relatives (McCann, Lubman, Boardman, & Flood, 2017).

The specific needs and wants of Black families affected by substance use are primarily unaddressed by substance-use programs. Black people are systematically underserved and are, therefore, generally absent from family-based support programs (Clark et al., 2014; Usher, McShane, & Dwyer, 2015). Support is minimal for most, if not

all, Black families of substance users, with few programs that can tend to the specific cultural needs of Black families (Jeffers, 2019). This study aims to provide greater insight into the perspective of Black family members and substance-use support services.

Theoretical Rationale

Urie Bronfenbrenner is one of the most notable pioneers in the field of human development. For 60 years, Bronfenbrenner (2005) focused on the development of children, parenting, and human ecology. Development, as defined by Bronfenbrenner (1996), comprises the changes in a person over time through the influence of the world (environment), thus altering the trajectory of a person's life. All human development, according to Bronfenbrenner (1979), takes place within an ecological system. His theory regarding ecological systems posits that all social interactions occur within one of five environmental systems. These five systems include the microsystem, mesosystem, exosystem, macrosystem, and chronosystem (Bronfenbrenner, 2005).

Bronfenbrenner's (1989) ecological systems theory provides a multilayered lens through which to view the influences of a person's environment. The influence of the microsystem demonstrates the power of their closest systems: family, friends, home, and school. It illustrates the primary day-to-day interactions within these immediate environments. The mesosystem describes the relationship between one or more settings of the microsystem. For example, the mesosystem exemplifies the interaction between an individual's home and workplace or home and church. Bronfenbrenner (1979) implied that the mesosystem requires a closer examination of multiple entities in the microsystem. The exosystem affects a person's indirect environment, but it still influences a person's development (Bronfenbrenner, 2005). Addiction is a family disease

and can, therefore, affect others in the family (Usher et al., 2015). For example, a relative's use of drugs and alcohol is an indirect environmental factor in a person's exosystem. The macrosystem refers to cultural beliefs, society's values, and political and social events (Bronfenbrenner, 2005). The macrosystem is demonstrated in laws and policies established and enforced by government officials and law enforcement. Lastly, Bronfenbrenner's (2005) chronosystem encapsulates the historical events or experiences of an individual over time. As such, the development of the family is shaped by broader historical forces.

The ecological systems theory asserts that political, social, and cultural factors have an influence on families beyond an individual's awareness (Mason, 2004). Families influence their members through their own experiences and the interactions between the systems. For example, the exosystem illustrates that the relationship between families and law enforcement may be affected by the drug policies of the macrosystem. Clinicians are mandated to report perceived maltreatment, abuse, and neglect of children, and, consequently, legal interventions can result in family separation and possibly the incarceration of a relative (Murphy et al., 2017). Substance users' legal consequences are determined by a political climate that may elect to rehabilitate or punish drug offenders. After such an incident or encounter, children may return to school and adults back to work, but their microsystems are now altered by their exosystem; in this case, their relatives' decisions. However, the family's microsystem continues to be disrupted by substance users' decisions. As a result, children can experience behavioral issues in the school setting, and adults may miss work (Usher et al., 2015). The family bears the

financial burden of the legal fees and other associated costs after an arrest (McDonagh et al., 2018). These factors shift family members' relationships within each subsystem.

Bronfenbrenner's (1989) ecological systems theory captures how substance use inhibits families' development as microsystems, as well as their interactions within their community and society. This study examined the support services through the lens of the ecological systems theory and sought to understand the lived experiences of family members of substance users through Bronfenbrenner's (1989) ecological model, as demonstrated in Figure 1.1.
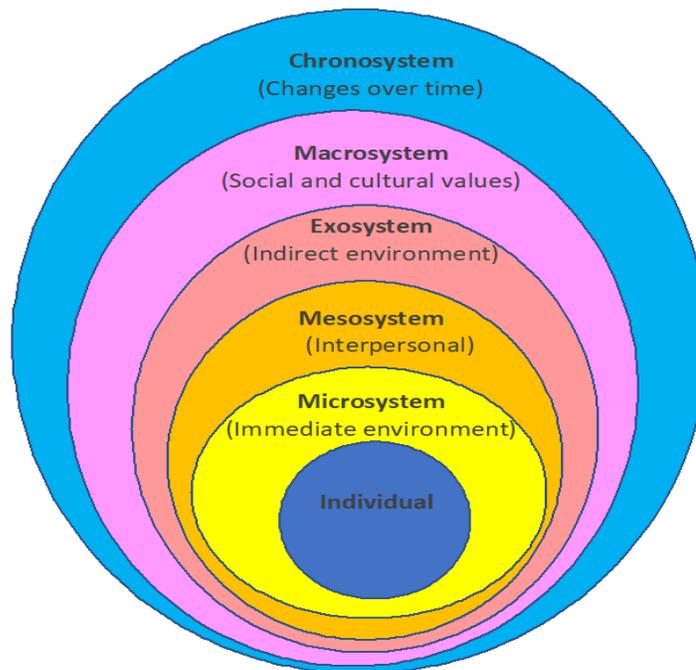
Figure 1.1. Bronfenbrenner's Ecological Systems Model. Adapted from "Ecological Systems Theory" by U. Bronfenbrenner, 1989. Copyright 1989 by Harvard University Press.

Statement of Purpose

As noted above, the perspectives of the Black community, specifically those of the non-substance using family members, are understudied (Jeffers, 2019; Johnson & Young, 2002). Therefore, the purpose of this study was to explore the perceptions of said Black family members and their utilization of support services. In this study, the researcher aimed to provide insight into support services through the theoretical frameworks of Bronfenbrenner's (1989) ecological system theory. This study explored the participants within the context of their immediate family, home, community, and institutions. This study contributes to the growing body of knowledge on support systems used by Black families.

Research Questions

The following research questions guided this study in determining the opinions regarding the support for Black families of substance users.

1. What types of informal, semiformal, and formal support do family members of substance users utilize?

2. From the perspective of family members of substance users, how, and in what ways, does support help the family?

3. From the perspective of family members of substance users, what obstacles exist in accessing and utilizing supports?

Potential Significance of the Study

Symptoms of distress may differ in the Black community from the society at large (Lewis et al., 2011). Currently, treatment providers and practitioners are unable to assess the needs of Black families and are undertrained in the area of SUD, (Galvani, Dance, & Hutchinson, 2013). Specialized training can improve practitioners' skills and confidence,

so they can then competently include families in a more holistic treatment plan. This study's findings can inform treatment practices, professional development, and the development of community programs. Training practitioners in cultural competency could inform diagnostic, treatment, and discharge planning (Hardy & Qureshi, 2012; Platter & Kelley, 2012).

Better knowledge and understanding of families affected by substance use can ultimately yield influence in the home, as well as influence in a community and at policy levels. Current drug policies are substantially more punitive than therapeutic. Drug laws and policies disproportionately impact Blacks and other communities of color more than Whites, as illustrated by the ethnic backgrounds of families fractured by arrests and convictions for drug-related offenses (Alexander, 2010; Chatters et al., 2011; King, 2018; Jeffers, 2019). In 2017, 96,400 children under the age of 18 were removed from their homes and placed in foster care for drug-related issues in their families in the United States (Sepulveda & Williams, 2019). Support for drug policy reform can strengthen families and communities by properly allocating funds for supportive resources (Alexander, 2010). The Drug Policy Alliance (2020) suggests child welfare agencies aim to keep families intact by reducing punitive consequences and prioritizing family preservation.

This study gave voice to Black families of substance users by identifying the support services they needed and how they should be offered to the targeted population. This study demonstrates the benefits of formal support systems for all affected family members, not just for the substance using family members. This study sought to gain insight specifically into how to integrate informal, semiformal, and formal supports into

Black families' homes, communities, and institutional settings. This study used

Bronfenbrenners's (1989) ecological system theory to explore interpersonal family

relationships, psychosocial factors, and cultural influences over time.

Definitions of Terms

Black – a person having origins in any of the Black racial groups, which are

people descended from African peoples. It includes people who identify their race as

Black, African American, Negro, or Person of Color (U.S. Census Bureau, 2020).

Ecological Systems Theory – a premise established by Bronfenbrenner in 1979 to

illustrate the developing person, their environment, and the interaction between the two

(Bronfenbrenner, 1979).

Family-Based Treatment – therapeutic services for families with SUDs designed

to improve knowledge of parenting, treatment, recovery, and the overall well-being of the

family unit (National Center on Substance Abuse and Child Welfare, n.d.).

Family Support – assistance provided to the family. Support is categorized in

terms of its nature: informal support, semiformal support, and formal supports

(McDonagh et al., 2018). Material, practical, informational, and emotional are

subcategories of informal support given to families (Arlington & Miller, 2000).

Institution – an established organization or corporation associated with a specific

location and devoted to the promotion of a particular cause or program ("institution,"

n.d.) and referred to here as *treatment programs* and/or *professional services*.

Self-Help Groups – gatherings affiliated with fellowship 12-step organizations,

such as Alcohol Anonymous (AA) and Narcotic Anonymous (NA) for family groups of

individuals affected by alcohol or drugs, including Adult Children of Alcoholics (ACA), Al-Anon, Al-Ateen, and Nar-Anon (ACA, 2018; Al-Anon, 2019; Nar-Anon, 2019).

Substance Use Disorder (SUD) – recurrent use of alcohol, tobacco, cannabis, cocaine, sedatives, opioids, hallucinogens, or other drugs, causing impairment in health, in daily functioning, and in home, work, or school tasks (SAMHSA, 2019b).

Support – a method to promote an interest; to provide with substantiation; to pay the cost; to provide a basis for the existence or subsistence; and to keep from fainting, yielding, or losing courage ("support," n.d.).

Treatment – a level of care for substance use services, including crisis, inpatient, outpatient, and opioid treatment, residential recovery support, and housing and prevention services (Office of Addiction Services and Supports [OASAS], 2010).

Chapter Summary

Chapter 1 provided an overview of SUDs and their effects on the Black community by highlighting the lack of research and resources to support family members. The plight of Black substance users is connected with deeply rooted distrust for institutions embedded in the fabric of American history and society. Black Americans have been systematically silenced and rendered invisible in the research. To date, few studies have detailed Black family members' experiences with substance-use support services. This phenomenon seems to align with historical patterns and events, leading to a culture of distrust for public services and institutions among Black families and communities in American society.

Chapter 2 presents a review of the literature relating to family-based supports. Chapter 3 focuses on the methodology that the researcher employed for this study.

Chapter 4 discusses the qualitative findings pertaining to the lived experience of Black

family members of substance users, and Chapter 5 provides the implications and

recommendations for this study.

Chapter 2: Review of the Literature

Introduction and Purpose

This chapter reviews the literature surrounding family-based, substance-use supports by targeting the effects of generational distrust and oppression in the Black community, which has led to an underrepresentation of Black families in said academic literature. The following studies illustrate how Black families, in general, cope with psychosocial stressors and describe the existing support services for families of substance users. Because no study has yet investigated the use of the social supports among the families of Black substance users, nor the Black families' perceptions of these supports, this literature review looks at various related studies and inquiries. Some studies investigate SUD support in general, and some explore families of substance users, but all of the studies focus on participants who are White. This review outlines categories of supports for families, stigma and institutional distrust, the impact of substance use on family relationships, and the protective factors for Black individuals and families. The concerns and issues that frame this study endeavor to make a novel contribution to the literature by focusing specifically on Black families of substance users and their perceptions of the support available to them.

Categories of Supports for Families

Family members of substance users may utilize various types of support, which can be categorized into levels. Researchers have suggested support is beneficial to family well-being. A quantitative study by Arlington and Miller (2000) described the support

provided to 53 parents of substance users. These participants identified various types of informal support—such as material, practical, informational, and emotional—that they received. Material support refers to monetary assistance, practical support refers to assistance with chores and household tasks, and informational support refers to the access to and provision of information and resources. Importantly, these kinds of support also fall into the categories of informal, semiformal, and formal support.

Arlington and Miller (2000) found that the quality of support is more significant than the quantity of support. Their findings demonstrate that family members perceive and appreciate the helpfulness of adequate practical, emotional, and informational support. Further, a participant described the support as integral to family stability. Specifically, parents of substance users reported that practical support improved communication in the family. In addition, such support minimized family conflict while encouraging greater family esteem and financial stability. Support contributed to the overall improvement of family functioning and communication (Arlington & Miller, 2000).

Moreover, emotional support contributed to the frequency of deep and meaningful family conversations (Arlington & Miller, 2000). Family members valued meaningful quality supports from one trusted source instead of multiple sources. They reported an invigorated sense of self-control and self-determination when they had access to a meaningful emotional support system (Arlington & Miller, 2000). Adequate emotional support improved upon the sense of community within the family. This finding suggests family members of substance users preferred a primary source of support.

Informal supports. A quantitative descriptive study of 73 Black women explored informal relationships and their perception of support in response to managing life stressors (Brown et al., 2000). The participants completed a survey assessing all social supports, which included parents, siblings, extended relatives, work colleagues, neighbors, and church members. Indicators of life stressors, as mentioned in the study, included five variables: finances, health, employment stress, relationship stress, and housing security. More specifically, quality-of-life indicators included depression, emotional health, physical health, and spiritual health. The study used a nonparametric test to rank the data in terms of the perceived helpfulness of social support among college-educated Black women. The findings reveal that Black females ranked female friends as their most important social support. Black women's sisters and mothers provided a secondary source of support. Secondary sources also included community-based support provided by churches and neighbors.

The Bentelspacher et al. (2006) grounded theory study of 16 Black family members provides insight into the experience of informal supports. Eight family members were interviewed about their role as caretakers to eight mentally ill relatives. The families discussed their reliance on an informal support network that included relatives, friends, neighbors, and church members. Black family members reported their social network of family and friends helped to reduce the emotional burden of having a mentally ill relative. Although the Black family members expressed feeling stressed and overwhelmed, these caretakers received additional support from other relatives in the form of material and emotional support. The exchange of assistance from the informal support network was indicated as a reciprocal relationship (Bentelspacher et al., 2006).

Blacks often draw upon close friends and family to build a community of support (Bentelspacher et al., 2006; Brown et al., 2000; Chatters et al., 2011; Stewart, 2003). These supports are considered informal, as they influence the family members' immediate environment, including friends, relatives, and church.

Semiformal support. Community-based supports are considered semiformal and provide additional support to families beyond their primary informal supports. Along those lines, Hartnett, Carr, Hamilton, and O'Reilly (2017) found evidence of semiformal supports for family members of substance users. In a meta-analysis of 14 studies, Hartnett et al. (2017) examined the effectiveness of functional family therapy (FFT). FFT is established in community-based programs that are dedicated to reducing the recidivism rate, easing behavioral and emotional difficulties, and mitigating the risk of reoffending. FFT was compared to a control group (CTL), a treatment as usual group (TAU), and an alternative treatment group (ALT). The CTL referenced the individuals in treatment or who were on a waiting list for treatment. TAU was the nonevidence-based treatment offered at shelter programs, including case management, anger management, skills training, and substance use education, which is also a form of semiformal support. Lastly, the ALT included group therapy, cognitive therapy, and family therapy. Harnett et al (2017) found that FFT was effective in reducing adolescent behavioral issues and drug use. In addition to FFT and TAU, it was indicated as an effective family-based treatment. The longer-term impact and outcomes of FFT included abstinence from alcohol and drugs and improved familial relationships. These outcomes were compared to nonfamily-based treatments in inpatient or outpatient settings (Hartnett et al., 2017). Furthermore,

Hartnett et al. (2107) emphasized the effectiveness of semiformal support services when families are involved.

In a related qualitative study of semiformal support, Platter and Kelley (2012) surveyed 32 predominately White family members and friends of substance users. The participants were recruited from a community-based support group, and were assessed for instances of enabling behaviors over 6 weeks. In this study, participants engaged in informal discussion groups and formal psycho-educational groups. Family members and friends were taught how to identify enabling behaviors and healthy coping techniques. Participants demonstrated their effectiveness at applying their newly acquired coping skills following the completion of the program. Platter and Kelley (2012) hypothesized that family members would feel less guilt and shame after engaging in this support program. The findings of this study reveal that family members reduced enabling behaviors and demonstrated an ability to apply learned coping skills. Furthermore, participants were more willing to get advice and seek professional support services upon the completion of community support groups. The family members reported the program was helpful, and that they would participate in similar programs in the future (Platter & Kelley, 2012). Semiformal support can include various forms of self-help groups, support groups, or therapeutic modalities, as described above.

Al-Anon. Al-Anon is a self-help support group for individuals affected by alcoholism (Al-Anon, 2019). Stenton et al. (2014) investigated self-help support groups from the perspective of participating family members affected by alcoholism. The study focused on the accessibility to self-help for the related family members and the alcoholic relative. This quantitative study collected data from 39 participants of the Al-Anon and

family support groups. The participant sample consisted of both predominantly White women and adult children of alcoholics. The findings of this study reveal that the participants were satisfied with Al-Anon, yet they expressed difficulty accessing information about the support groups. All the participants expressed the value of exchanging stories with people with similar life experiences. However, participants reported initial barriers in accessing the self-help meetings that prevented families from receiving much-needed support. The family members reported they could not find accurate information about family-based SUD support.

The Sell and Magor-Blatch (2016) quantitative study demonstrates another aspect of semiformal support through an assessment of the coping strategies used by 54 family members attending Al-Anon. Unlike the Platter and Kelley (2012) study, Sell and Magor-Blatch (2016) hypothesized that participants were impaired by certain behaviors they displayed when interacting with their substance-using family members. These included low levels of *engaged coping* and *tolerant inactive coping* behaviors, as well as high levels of *withdrawal coping* behaviors. The term engaged coping, in this example, referred to family members who attempted to control or influence the drinking habits of their loved ones. Tolerant inactive coping was demonstrated by family members who accepted or enabled their relative's alcohol use. Lastly, withdrawal coping was defined as family members setting extreme boundaries with their relatives and/or avoiding their relatives.

Sell and Magor-Blatch (2016) examined further the influence of participant Al-Anon engagement and membership, their relationship to an alcoholic relative, and the ability to cope with stressors relating to having an SUD relative. This study's findings

reveal that the participants of Al-Anon reported mostly positive experiences. Over 50%

of participants reported receiving benefits from listening to shared experiences, learning

the 12 steps, feeling emboldened to share because of the requisite of anonymity, and

appreciating the support of positive role models. The impact of Al-Anon, as reported by

participants, improved their self-esteem, self-worth, and self-efficacy. Family members

were able to verbalize their needs to relatives, set boundaries, be assertive, and to

prioritize their health and well-being (Sell & Magor-Blatch, 2016). However, according

to Sell and Magor-Blatch (2016), only 10% of Al-Anon participants are referred to

support services by professional service providers.

Clinicians have expressed frustration with the complexity of addiction, given the

overall lack of professional training regarding SUD (Galvani et al., 2013). Clinicians

have reported not knowing how to access or refer families to support services. These

findings of inadequate formal, professional support substantiate the literature regarding

service providers' lack of knowledge and limited resources (Hutchinson & Allnock,

2014).

Formal support. Professional services provided by physicians, practitioners, or

clinicians are characterized as formal support. According to McDonagh et al. (2018),

semiformal supports lack general knowledge of SUD that is needed to understand and

empathize with complicated family dynamics. In their qualitative study, McDonagh et al.

interviewed 10 family members of substance users who described the degrees of support

and satisfaction with the formal support they received. The participants reported

discontentment with the support they received from primary care physicians, teachers,

and work colleagues. Participants also reported being given inaccurate information in the

course of seeking professional help from within semiformal support systems (McDonagh et al., 2018). These findings suggest that among the three categories of support available to families of SUD individuals, it is arguable that formal support offers the least consistent and effective means of treatment, thus clinicians may benefit most from further training, research, and education.

   Training needs. A substantial body of research reveals many practitioners and physicians lack in-depth knowledge for treating SUD (Cohen-Filipic & Bentley, 2015; Cox, Ketner, & Blow, 2013; Galvani et al., 2013; Stenton et al., 2014). In a related study, Galvani et al. (2013) used a mixed methodology to survey and interview 597 family members and health care professionals. The researchers sought to assess the educational training that health care providers received and what training needs were not met. They examined the participants' perceptions of preparedness, previous experience, qualifications, and current training needs to work with adults and children with SUD. This study's findings support the existing literature, which demonstrates that often practitioners do not feel prepared because of their insufficient education and training regarding substance-use-related issues.

   Although physicians and practitioners know family members experience undue stress relating to substance-using relatives, families' needs are not addressed and resolved (Cohen-Filipic & Bentley, 2015). The current literature reveals that semiformal and formal supports primarily serve the substance users, while few address and support the struggles of their families (Cohen-Filipic & Bentley, 2015). In the Cohen-Filipic and Bentley (2015) study, 23 participants, consisting of clinicians and parents of adolescent substance users, described the therapeutic relationship. The thematic analysis revealed

two major themes: implications of guilt and feelings of blame. The parents expressed frustration in their attempts to navigate the support services. Parent participants also reported an overall lack of awareness of the different levels of treatment and differences in professional roles as well as a lack of education relating to the signs and symptoms of drug use, the ever-increasing cost of treatment, and the lack of diversity. The Cohen-Filipic and Bentley (2015) study revealed the need for better outreach and information for families of substance users, and it illustrated the areas in which clinicians can improve upon, namely treatment options and costs.

Professional services, clinicians, and SUD specialists are unable to address family members of substance user needs because they lack adequate resources and supports (Hutchinson & Allnock, 2014). Hutchinson and Allnock (2014) found similar results in their quantitative descriptive study of 200 prospective SUD practitioners who were surveyed while in clinical training. These participants revealed that the clinical workforce had insufficient resources for families, SUD training, and was without protocols to assist family members. Further, there was no plan to create a protocol to meet ongoing training needs (Hutchinson & Allnock, 2014). Clinicians felt ill-prepared with SUD families because it appeared that SUD was not prioritized in the training.

The Wangensteen et al. (2018) qualitative, phenomenological study explored the childhood experiences of 12 children growing up with substance-using parents. The study comprised three male and nine female participants who ranged from 13 to 26 years in age. Each participant recounted childhood experiences of growing up with a substance-using parent, and they described individual parent-child relationships in terms of communication. The findings reveal that the participants seldom sought out formal

supports. As such, these relationships suffered from a lack of professional help. When probed, these participants reported distrust when talking to professionals about their life stressors. These findings suggest a correlation between help-seeking and the representatives of formal sources of support, such as clinicians, teachers, and other people in positions of social and medical authority. A lack of trust in potential sources of support has implications in the outcomes of SUD individuals and their families—implications that can have intergeneration outcomes.

Stigmas and Institutional Distrust

Social stigma can be a barrier for individuals seeking SUD treatment. Individuals with a SUD experience high levels of public stigma and discrimination, which can contribute to distrust and isolation (Corrigan et al., 2017; Gaston et al., 2016). In a systematic review of 278 studies, Gaston et al. (2016) focused on the perception of mental health in the Black community. In detail, the studies examined Black culture from three perspectives: African Americans, Africans, and Caribbean Blacks. The study identified specific barriers against seeking out resources within the Black community relating to distrust, stigma, discrimination, cultural competence, and fear. The literature suggests the Black participants perceived service providers' lack of knowledge of Black society and culture as a form of disrespect and, as such, considered their providers untrustworthy (Gaston et al., 2016). The participants suggested service providers must be "emotionally and personally accessible" and "non-threatening and reassuring" (Gaston et al., 2016, p. 685). Failure to meet these needs was equated with a lack of engagement and concern, and they led to distrust. The Black women in the study who reported a lack of strong maternal role models linked their associated distrust of women and difficulty

establishing positive connections with others. The Black women in the study discussed adopting a *strong Black woman* persona, in which help-seeking is perceived as a weakness. The distrust of people and the fear of being perceived as weak deprived these Black women of seeking and receiving necessary support. As such, the Black women experienced unresolved trauma from historical events (Gaston et al., 2016). Thus, the burden of such trauma can be an insurmountable barrier to accessing necessary formal supports.

The impact of stigmas can be detrimental to substance-using families because it can deprive families of seeking and receiving appropriate support (Galvani, 2015; Mattoo et al., 2015; McDonagh et al., 2018). Witte, Wright, and Stinson (2019) conducted a quantitative study of 1,059 college students, predominantly White women, to assess public stigma toward substance use. The college students were assigned to two case studies to ascertain the influence of stigma surrounding, and discrimination against, substance users. The design of the study included variables relating to the levels of a substance user's behavior. The participants assessed the substance users' elevated levels of personal responsibility for initiating drug use.

Other factors Witte et al. (2019) assessed for stigma and discrimination included the onset of a controllable illness to explain drug-seeking behavior. They found elevated immoral behavior is associated with substance use, and low levels of willpower are linked to the attempt to control the SUD. Lastly, participants determined that substance users were accountable for severe consequences resulting from SUD, or that they were in denial when confronted about their SUD. The findings reveal higher levels of stigma toward substance users with low willpower to stop using, toward substance users who

experience severe consequences from continued use, and higher levels of stigma toward substance users who are in denial about problematic drug use. Indeed, the participants stigmatized substance users who could not discontinue use for reasons related to willpower, the severity of subsequent consequences, and levels of accountability with and denial about an SUD. The participants lacked knowledge about SUD and stigmatized substance users who experienced relapses. This study demonstrates typical, though incorrect, personally held beliefs relating to substance users (Witte et al., 2019). The college-educated participants' beliefs are shown to be shared by others who also lack accurate knowledge of SUD, suggesting that stigma is based, in part, on a lack of knowledge about the nature of addiction.

In another study related to stigma, Mattoo et al. (2015) sampled 50 substance users and 50 family members. Of these family members, more than 80% were married to alcoholics, and more than 50% were fathers of opioid users. The multivariable regression analysis revealed correlations between family members' perceptions of stigma, substance use, and employment. The findings reveal a relationship between marital status and perceived stigma, specifically that unmarried substance users are more often stigmatized. Overall, unmarried substance users are stigmatized by other substance users, as well as their family members, for being unemployed and single. The Mattoo et al. (2015) study provides evidence of the negative effects of SUDs on family members' relationships. It interrogated the correlations between stigma and marital status, and stigma and employment status among SUD individuals and their families.

Impact of Substance Use on Family Relationships

To understand the perceptions of Black family members of substance users, researchers examined the impact of SUDs. They supported seeking relationships between siblings, parents and children, and family members and friends. Researchers suggested individuals are first exposed to drugs and alcohol in their immediate environment, such as the family home (Johnson & Young, 2002; Smith-Genthôs, Logue, Low, & Hendrick, 2017). As such, the values that shape a typical societal attitude toward substance use can perpetuate stigmas because the individual is so attuned to the references of the substances (Mattoo et al., 2015). Hutchinson and Allnock (2014) provided evidence that stigma poses a barrier in accessing treatment for both substance users and their family members. Individuals with SUDs experience high levels of stigma and discrimination that limits their motivation to access services (Hardy & Qureshi, 2012).

Families are critical in the context of stigma for drug use because they can influence whether or not an SUD family member seeks treatment (Corrigan et al., 2017). Often, to resist the stigma against the family for being connected to an SUD, they may dissuade the person from seeking treatment (Mattoo et al., 2015). However, families may also be explored as the first line of support when an individual discovers the substance problem, and they can, therefore, serve as a positive influence and support for both their SUD relative and themselves. Some research describes the family relationship and their connection with SUD, but the literature is still sparse, and further research is necessary (Cohen-Filipic & Bentley, 2015).

Parent and child relationships. Stewart (2003) surveyed 233 low-income substance-using Black families to ascertain any relationship between family stability and adolescent substance use. The study aimed to gain insight into Black parents' perceptions

of risk behaviors and attitudes. The participants were asked about the following: (a) characteristics of parental monitoring, parental roles, and family rules; (b) perceptions of self, self-esteem, and degrees of trust for one another; (c) roles of significant relationships and peer influences outside the family; and (d) risk-taking behaviors, such as fighting, weapon use, and substance use. The data were collected over 4 years and revealed a negative correlation between what is understood to be the unique warmth of a mother's love and substance use support. Adolescents indicated that a warm relationship with their mother means the child can communicate their needs, and the mother can nourish those needs (Stewart, 2003).

On the other hand, adolescents reported that a warm relationship with their father meant an exchange of practical gestures, such as helping them complete a task, and their father's ability to comprehend severe problems the child may experience. Central to the Stewart (2003) study findings, the adolescents who reported warmer relationships with their mothers proved to be less likely to seek out and use alcohol and other drugs (AOD). Similarly, adolescents' warm relations with their father acted as a protective factor against alcohol and cocaine use. Within the context of the Black parent and child relationship, the quality of the parental relationship was correlated with adolescent AOD use. Understanding that Black parent-child relationships are significant in SUD can inform clinical practitioners' training and practice (Stewart, 2003).

In contrast, Tedgård, Råstam, and Wirtberg (2018) focused on the perspectives of adult children of substance users and the perceived inadequacies of the available social support. They interviewed 19 White adult children of alcoholics about their childhood experiences with substance-using parents. The participants provided insights into how the

parent-child relationship was affected by substance use. In this study, participants completed a self-administered questionnaire about the challenges they faced as adults regarding how they were raised, their current concerns for their parents, and their parenting. The findings focused on informal support provided by relatives, which, in this case, was minimal. Specifically, the participants of Tedgård et al. (2018) reported minimum contact with relatives, neighbors, and friends.

Furthermore, all the participants unanimously denied having anyone to confide in or receiving emotional support during their childhood. Many of the participants reported academic struggles, and the schools provided strictly curriculum-related support (Tedgård et al., 2018). The children of substance users were emotionally abandoned with no support to help them navigate life stressors. The participants' childhood experiences continued to impact their lives into adulthood and parenthood (Tedgård et al., 2018).

From a different perspective on parenthood, a quantitative cross-sectional study by Chou et al. (2018) surveyed the self-efficacy of 71 pregnant women as they entered SUD treatment. Specifically, the study aimed to determine whether the relationships between social support, substance use, and family empowerment are reliable and predictable. The analysis revealed positive correlations between social support and parenting self-efficacy, family empowerment and parenting self-efficacy, and family empowerment and social support. The Chou et al. (2018) participants indicated higher levels of self-efficacy with social support and empowerment from their families. However, the participants only reported high parenting self-efficacy when receiving social assistance, thus emphasizing social support as a protective factor for participants with SUD. The Chou et al. (2018) study reinforced the benefit of social support in the

form of interpersonal relationships among friends and family. The combined findings of the Stewart (2003), Tedgård et al. (2018), and Chou et al. (2018) studies strengthen the argument for informal protective factors, support resources, and the necessity of quality relationships to mitigate the harm of substance use in families.

Children of substance users. Children of substance users experience a multitude of substance-use related effects over their lifetime. Like Tedgård et al. (2018), Hodges and Copello (2015) focused on adult children of SUD parents but inquired into how the participants were impacted in their parenting. Hodges and Copello (2015) interpreted the experiences of six White female participants who grew up with alcoholic mothers.

The findings reveal emergent themes of normative expectation, emotional detachment, and functional or practical contact. The participants reported that memories, such as a wedding or childbirth, were negatively skewed by incidents involving an alcoholic parent. The experience of being a family member of a substance-using parent influenced these participants' decision-making. The participants questioned their decisions later in life as parents and decided to distance their children from their alcoholic parents.

This developing theme of emotional detachment enabled participants to set boundaries as a coping mechanism and as a way to limit disappointment and mitigate negative experiences. However, as a result of this pointed and deliberate emotional detachment, often serving as a survival mechanism, the participants maintained a negative perception of substance users. The family member's relationship with their substance-using relative ultimately influenced generational relationships. These negative

attitudes toward substance users stem from stigma and persist across a person's lifetime, notably arising in other significant relationships (Hodges & Copello, 2015).

Sibling relationships. Siblings have a direct influence on one another, serving as a potentially positive or negative role model. Smith-Genthôs et al. (2017) performed a quantitative study that surveyed 290 participants who demonstrated the influence of sibling relationships on substance use. A majority of the participants were White females. The researchers compared 64 participants with substance-using siblings to 226 participants with non-substance using siblings.

The questionnaire probed for information regarding depression, social support, and positive and negative reinforcements. Smith-Genthôs et al. (2017) hypothesized that participants with substance-using siblings would report the following behaviors: acceptance toward alcohol and drug use, depression, and less social support compared to participants with non-substance using siblings. The finding of this study confirmed that families of substance users tended to be more accepting of AOD use than non-substance using families. In terms of support, 80% of the participants with substance-using siblings indicated a loss of support once their sibling began using AODs. This loss of support suggested a void that the substance users created within the families. The Smith-Genthôs et al. (2017) study provides a voice for siblings, another underreported area of research for substance use supports.

Childhood trauma. Analyzing the effects of early exposure, Johnson and Young's (2002) qualitative study interviewed five Black incarcerated women about their childhood experiences relating to substance use and sexual abuse. The participants reported similar experiences with family histories of violence, child abuse, alcoholism,

drug addiction, and mental health problems. Although this study did not explicitly inquire about SUDs, so much as the overall constellation of addiction, violence, and incarceration, the study is meaningful to the inquiry of this study, because it demonstrates the gaps in support for vulnerable family members when substance use contributes to violence or imprisonment. The demographics of the participants align with the literature indicating that women with a history of childhood trauma are at higher risk of being sexually abused (Johnson & Young, 2002).

The participants reported incidents of rejection from professional service providers because they were not prepared to address the family's needs—only the user's needs. Therefore, the participants did not receive the appropriate help during childhood and adolescence. The Black women participants reported they experienced physical and sexual abuse when their parents were separated from the family (Johnson & Young, 2002). The participants also cited family disruption because of parental drug use, incarceration, or strained relationships. In the study, all of the women were sexually abused at some point during childhood. Two participants revealed the abuse occurred at a time when their mothers were incarcerated (Johnson & Young, 2002). In essence, vulnerability to sexual violence is increased during parental absence, such as incarceration (Johnson & Young, 2002). Early intervention to substance use-related crimes such as nonpunitive consequences could have been beneficial in restoring the familial system (Johnson & Young, 2002).

Protective Factors for Black Individuals and Families

Black people place value on relatives, kinship, church, social networks, and spirituality (Bentelspacher et al., 2006; Brown et al., 2000; Chatters et al., 2011; Stewart,

2003). These relationships and resources serve as protective factors for family members'
health and well-being. It follows that a consequence of underutilizing social support
concerning the quality-of-life indicators increases the effects of psychological distress
often associated with isolation and withdrawal (Bentelspacher et al., 2006). Evidence of
emotional and mental distress may result in a person isolating themselves from friends,
family, and other sources of community support (Huebner et al., 2018).

The literature has identified social support as a mitigator in reducing emotional
distress relating to substance use in the home, emotional turmoil, and psychological
distress, which are all pertinent to familial well-being (McCann et al., 2017; Soares,
Ferreira, and Graça, 2016; Stenton et al., 2014). Researchers have noted that emotional
and psychological distress, along with other relationship stressors commonly shared by
family members of substance users, inhibit the overall quality of family life (McCann et
al., 2017; Soares et al., 2016; Stenton et al., 2014).

Emotional and psychological distress. Soares et al. (2016) performed a
quantitative study in which they surveyed 120 family members of substance users. This
study examined the relationships between feelings of depression, distress, and burden,
and the rates in relying on all perceived social support. The participants were friends and
family of the substance users, predominately White, and they were recruited from self-
help support meetings. The participants completed a psychological test to assess their
feelings of depression, burden, and social support. The Soares et al. (2016) study also
emphasized social support by eliciting participant responses relating to accessing services
and a sense of satisfaction following the use of those services.

The findings reveal family members living with substance-using relatives suffered from mild to moderate depression. Many of the participants reported an absence of resources for coping with stressors. Family members without support and resources often withdrew from friends and family due to shame and guilt—social stigma. Lower social support was associated with higher levels of feeling like a burden. Family members with a social support network revealed a reduction in adverse psychological variables, such as depression, distress, and feeling like a burden. The Soares et al. (2016) study highlights the value of adequate support for families, but it is one of many studies that exemplifies the experiences of White substance users and their families. The lack of attention to the particular historical challenges and community concerns faced by Black families of substance users will continue to obscure the needs of those families and prevent an understanding of the best practices to meet those needs (Soares et al., 2016).

In terms of emotional distress, McCann et al. (2017) studied 31 White family members of substance users to discern the emotional toll of these participants' uniquely painful lived experiences. Many participants cited living in an environment of aggression and violence as it related to their relatives. Demographically, 81% of these participants were female spouses or parents affected by the substance use. Family members reported high levels of uneasiness resulting from the frequent mood changes and aggressive and violent behaviors displayed by their relatives (McCann et al., 2017). In these instances, the families needed support for their safety and overall wellness. Supports can enhance the quality of life for families in terms of emotional, mental, and physical health by improving coping strategies and listening to family member problems (McCann et al. 2017; Montgomery et al., 2014).

These family members recalled feeling emotional distress during interactions with law enforcement. As a last resort, the family members called the police to remove the substance-using relatives from the families' homes and to ensure the well-being and safety of their homes. Family members wanted more accessible resources before seeking legal involvement (McCann et al., 2017). Law enforcement intervenes when a substance user becomes abusive or unable to be managed by a family member, an option that Black people may be more hesitant to employ because of the ongoing problems with police brutality and race relations in the United States (Cooper, 2015). Therefore social supports could be put into place to be more accessible in the Black communities.

Marital satisfaction. Research indicates marital satisfaction as an essential factor in family well-being. A quantitative survey of 1,222 Black couples that examined marital satisfaction aimed to understand the impact of giving and receiving practical and emotional support amongst Black married couples (St. Vil, 2015). The author reported marital satisfaction as a key factor in family well-being. The results of the logistical regression analysis reveal that emotional support received from family was statistically significant in determining marital satisfaction. The frequency of emotional support received from family equated to marital satisfaction. The findings of the St. Vil (2015) study affirm that appropriate supports are protective factors to maintain the family system.

Church. Black churches provide spiritual support, but they also serve as a resource and outlet for managing psychological life stressors (Chatters et al., 2011). Chatters et al. studied 2,870 Black Americans and 1,256 Black Caribbean Americans to explore the relationship between church-based support and expressions of suicidal

tendencies using data from the National Survey of American Life (ICPSR, 2010). In examining the church-based support characteristics, Chatters et al. (2011) focused on the perceptions of emotional support compared to negative interactions. The negative interactions referred to unrealistic church-member demands, expectations, criticism, and the feeling that someone has taken advantage of him/her. The church provided participants with a sense of belonging and closeness from church members. The embedded nature of the church as a support group was found to diminish suicidal ideations (Chatter et al., 2011). The finding show that religious support serves as a protective factor to mitigate mental health symptoms. Furthermore, not only does the Chatter et al. (2011) research corroborate these findings, it lends further credence to the idea that the church functions as a protective factor for Black individuals. While geographic barriers limit access to resources and formal services, Black church members can rely on spiritual relationships for support with no hindrances.

Montgomery et al. (2014) attempted to improve the understanding of and expound upon the interconnectedness of religion, depression, and incidences of substance use among the Black population. The longitudinal study's respondent-driven sample method assessed 223 Black participants in the rural counties of the Arkansas-Mississippi Delta region. Participants completed the Patient Health Questionnaire to assess for depression, the Addiction Severity Index to assess for SUD, the Brief COPE assessment to determine coping responses, and the Religious Support Scale to assess religion. The participants represented poor neighborhoods with high-risk of drug exposure, violence, and crime, and the participants' communities were riddled with poor educational systems and higher risks of addiction and incarcerations rates. Additionally, the participants reported

financial barriers that limited healthcare and access to treatment (Montgomery et al., 2014).

The subsequent findings reinforce the role of spirituality. The results reveal a correlation between negative religious copings, such as feelings of shame, guilt, sadness, depression, and low self-worth, and incidences of depression and isolation (Montgomery et al., 2014). Negative religious coping was described as feelings of spiritual discontentment, God's punishment, and satanic reprisal. However, the Black people's perception of church support reduced alcohol use and depressive symptoms. Montgomery et al. (2014) found that the church is a resource for Black people to connect. Religious coping practices were described as church attendance, participation in Bible study, and engaging in the fellowship. These practices reinforced emotional coping techniques to alleviate life stressors. The absence of church or rejection from this support network can have a negative influence on a Black person's well-being (Montgomery et al., 2014).

Chapter Summary

Chapter 2 discussed the gap in the literature relating to clear, consistent information regarding the availability of support services for family members of those with SUD. The current literature exposes a range of vital elements in need of further research regarding social support available to families of substance users. These factors include implications of familial function and quality-of-life factors, identification of supports and barriers to access, and the effects of childhood experiences connected with substance use by family members (Arlington & Miller, 2000; Brown et al., 2000; Hodges & Copello, 2015; Wangensteen et al., 2018).

The few studies describing the lived experiences of relatives affected by a family member with a SUD were informed by adult participants recalling childhood memories. Most of the participants in these studies were White adult females. Therefore, little is known about the perspectives of Black family members of substance users. The limited literature about the Black community's experience with support services is not adequate in providing insight into how support services might best serve the Black community holistically. In terms of support, the literature suggests that Black families tend to rely on the informal support of relatives or friends and spirituality (Gaston et al., 2016). However, the vast majority of semiformal and formal supports available to study participants are not associated with or embedded in Black communities, culture, and history.

Consequently, the existing literature cannot provide insight into the Black experience. Surprisingly, there is limited evidence to indicate any unequal social support availability because few researchers have focused on the influence of ethnicity. Nevertheless, based on this literature review, additional research is needed to create a robust discussion of the impact of SUDs on Black families, specifically, and to identify various supports that will facilitate the participation of Black families suffering with a SUD family member.

Chapter 3 describes the research methodology for this study.

Chapter 3: Research Design Methodology

Introduction

The purpose of this study was to make meaning out of the various experiences of Black family members with substance use support through an analysis of their lived experiences. As rates of SUDs steadily increase, more support services are needed to meet the needs of all those affected (Hodges & Copello, 2015). However, currently, resources are primarily allocated to services that target the user. Therefore, the needs of the family are secondary, and treatment providers often ignore families completely (Hanna et al., 2017). The disruption to the family system is evidenced by emotional, physical, and psychological impairment (McDonagh et al., 2018; Spaniol & Nelson, 2015; St. Vil, 2015). The limitations in support services are exacerbated within Black communities, primarily owing to an historical distrust of service providers from outside of the individuals' homes and communities (Chatters et al., 2011). Family members of substance users also have identified having insufficient knowledge of the support services available to them as well as a lack of diversity and cultural competency in the support staff members (Brown et al., 2000; Hutchinson & Allnock, 2014; Lacey et al., 2016). Furthermore, little is known about these trends because of a gap in the literature investigating the particular lived experiences of Black families of substance users.

To better understand the perceptions of these Black family members regarding various forms of social support, data were gathered and analyzed through a qualitative research design approach (Creswell & Creswell, 2018). Husserl's (1998) contribution to

phenomenological research illustrates the importance of the *lived-world* (Moustakas, 1994) being an interaction between the environment and humans (Pietkiewicz & Smith, 2012). Such an approach is crucial for analyzing the complex dynamics that surround creating support services for the Black community. As such, this study adopted a qualitative, interpretive phenomenological analysis (IPA) as its methodological approach. This approach was used to better understand the perceptions of the lived experience of Black family members with existing support services for substance users (Pietkiewicz & Smith, 2012).

According to Creswell and Creswell (2018), the role of the researcher is to make known what is unknown. Previous studies reveal the benefits of family-based support services for substance users (Edwards et al., 2018; Galvani, 2015; Orford et al., 2005), yet, the subject of supports for families of substance users has received minimal attention. This study advances the understanding of support services for Black families with substance users. According to Smith (2018), IPA can make meaning and improve understanding of how human beings experience events and activities. IPA was used in this study to compare the lived experiences of all the participants while investigating the shared phenomenon of being a Black family member of a substance user (Creswell & Creswell, 2018). To date, few researchers have focused specifically on the struggles of Blacks families of substance users and the related supports they receive. This study aimed to use IPA for quality, not quantity, given the sensitivity and complexity of substance use.

This study's analysis was twofold. First, a personal account of support experiences was conducted by virtual interviews with the identified participants.

Following, the researcher interpreted the collected data through a coding process to obtain a detailed description of experiential themes (Jeong & Othman, 2016; Larkin, Watts, & Clifton, 2006). This IPA qualitative study examined the experiences of Black families with substance users, using an interview protocol guided by the research questions of this study:

1. What types of informal, semiformal, and formal support do family members of substance users utilize?

2. From the perspective of these family members of substance users, how, and in what ways, does support help the family?

3. From the perspective of family members of substance users, what obstacles exist in accessing and utilizing supports?

Research Context

There are no specific criteria for the context of an IPA study. However, Heidegger suggested the *emergent reality* in which the participant and the researcher encounter the nature of the participant's reality (Larkin et al., 2006). As such, the current study was initiated in the Capital Region of New York State (NYS), then modified as a result of the coronavirus stay-at-home orders. The researcher had greater access to participants statewide; therefore, the setting was modified to include all counties in NYS.

According to the National Survey on Drug Use and Health (SAMHSA, 2019a), 1,901,000 New Yorkers, aged 12 years and older, reported using substances within the last month. In terms of ethnicity, 2.2 million people, aged 18 or older, had a SUD in the United States (SAMHSA, 2020). The primary substance used by Black Americans is cannabis or marijuana, indicated in the data that in the past month, use was at 17.8%

compared to 15.9% of the U.S. population. However, in terms of other illicit drugs, the

Black population uses 5.6% alcohol, 1.8% cocaine, and 0.4% opioids (SAMHSA, 2020).

In terms of the opioid epidemic, New York City and Long Island, Mid-Hudson, and the

Capital Region have the top ranking in opioid overdoses in NYS (NYS Department of

Health, 2019). Conversely, NYS has the lowest drug overdose-related deaths compared to

the tristate area of New York City, New Jersey, and Connecticut (CDC, 2019). The

general trends are apparent in the prevalence of substance use in NYS.

It can be inferred from the literature, despite the lack of explicit data on the

subject, that family members bear the burden of supporting relatives, and they are

directly affected by the ailing health, AOD use, and death of loved ones from an

overdose. True to IPA research methodology constructs, this study focused on the

lifeworld of these Black SUD family members. The researcher used IPA to understand

how these participants experienced their world in terms of their perceptions of substance

use supports, as well as their feelings about being a family member to a substance user

(Tuohy, Cooney, Dowling, Murphy, & Sixsmith, 2013).

Research Participants

The primary strategy for establishing a viable sample of Black family members of

substance users, utilizing the IPA research method, is to select participants with similar

experiences concerning the phenomenon of the study (Smith, 2008). Therefore, certain

criteria were established to include specific participants. The participants of the study

were to be (a) over the age of 18 years old; (b) an immediate family member, parent,

guardian, or spouse of the substance user; (c) residing in the same household within the

last 5 years with the substance user; (d) identified as Black; and (e) the participant's

substance-using relative must have used alcohol or other drugs within the last 5 years. The exclusion criteria was the potential participant having a strained relationship or no interaction with the relative with the SUD within the last 5 years and sharing a household with another participant.

The IPA sample method is purposive, creating an intentional sampling with a relatively small sample size (Marshall & Rossman, 2016). Purposive sampling indicates the participants meet the criteria of being knowledgeable or experienced in the identified phenomenon (Creswell & Creswell, 2018). Methodology guidelines suggest a range of optimum sample sizes in the IPA methodology. For example, Jeong and Othman (2016) suggested eight participants, while Creswell and Creswell (2018) suggest a minimum of three and a maximum of 10 participants, and Pietkiwcz and Smith (2012) indicated a range of one to 15 participants. For this study, the target sample size was 10-15 participants. Given the smaller scale in sample size, Smith (2018) suggested conducting individual, semi-structured interviews with those participants who meet the inclusion criteria.

The researcher, at the time of the research, had 10 years of professional experience as a New York City Licensed Mental Health Counselor (LMHC) and had obtained an Alcoholism and Substance Abuse Counselor credential. There were no conflicts of interest with the potential participants as the researcher did not work directly with clientele and did not recruit participants with previous or current ties to their professional careers. For this study, the researcher accessed a professional network that included both public and private agencies in NYS to distribute electronic recruitment flyers to identify participants. Potential participants were recruited through clinical

contacts at local outpatient and residential substance-use programs. Additional recruitment for participants occurred within online social media groups for local churches and self-help support meetings, which included, but were not limited to, Friends of Recovery and a Nar-Anon (2019) family and friends support group.

After garnering the permission of the St. John Fisher College Institutional Review Board (SJFC IRB), interviews were conducted virtually using the Zoom platform. Interested potential participants were provided with an email address or telephone number to contact the researcher. During the initial contact with the participants, the purpose of the study was clarified, and the researcher verified the potential participants' inclusion criteria. Upon acquisition of oral consent from each participant, the researcher conducted semi-structured interviews, enlisting various instruments for collecting data, including an interview protocol and the use of field notes and audio recordings (Moustakas, 1994).

Instruments Used in Data Collection

Central to the IPA interview methodology, participants can tell their stories, speak freely and openly, and express a retrospective perspective (Pietkiwcz & Smith, 2012; Larkin et al., 2006; Smith, 2008). According to Moustakas (1994), the participant's experience regarding the phenomenon, interest in understanding the meaning of the study, and willingness to participate in potentially lengthy interviews is essential. This study gathered data by engaging in semi-structured, in-depth interviews to gain the perspective of Black family members' perceptions of substance-use supports and the participant's life experience with a substance user who was also a family member. The flexible nature of semi-structured interviews can prompt rapport between the participant

and researcher by following the participant's interest. The format also allows the researcher to change the order of the interview questions to probe further or ask less emotionally charged questions (Smith & Osborn, 2007). The nature of the phenomenological interview is its intentional focus on the participant's lived experience in conjunction with researcher's interpretation of the participant's experiences (Marshall & Rossman, 2016). In this methodological framework, the researcher served as the instrument for data collection. In addition to the researcher conducting the interviews, other tools used for gathering data included a demographic questionnaire, field notes, and research memos.

Creswell and Creswell's (2018) descriptions of interview strategies include asking questions and recording the answers throughout the interview process. This study used an online transcription service, Descript (descript.com, 2020), to transcribe the audio recordings of the interviews (Smith, 2008). According to IPA strategies, Smith, Flowers, and Larkin (2009) suggested the interview questions should be prepared in two-page lengths with spacing to allow for field notes, comments, or quotes in between the questions. However, Creswell and Creswell (2018) suggested using three interview protocol steps consisting of an introduction, probing question(s), and closing questions. Cottrell and McKenzie (2011) were more explicit, suggesting a specific protocol guide as an interview technique. This suggested that the interview protocol should begin with an introduction and should be followed by an opening question that is easy and quick to answer. They advised the use of a transition statement and a transition question to shift the direction of the interview toward key questions (Cottrell & McKenzie, 2011). Creswell & Creswell (2018) stated that the key questions should be followed by closing

questions for reflecting on the data collected. Lastly, the researchers suggested that the interview closes by summarizing thoughts and permitting time for the participant to make final comments (Creswell & Creswell, 2018).

The study instruments are foundational to the essence and purpose of the research. For this study, the researcher created an interview protocol to guide the semi-structured interview process, ensuring continuity of the interview questions (Appendix A) to collect sound data and conduct accurate data analysis. The interview questions were pilot tested before the formal commencement of the study to allow for revision suggestions.

Procedures for Data Collection and Analysis

Phenomenology is an iterative process aiming to gain a greater understanding of the meaning of human experiences in the world (Marshall & Rossman, 2016). To protect the rights and privacy of the participants, and to ensure the confidentiality of the participants, the researcher used pseudonyms. The researcher obtained verbal consent from the participants and electronically sent the informed consent form and explained their right to withdraw from the study at any time without penalty.

Smith et al. (2009) and Smith (2018) provided six stages for analyzing IPA data: (a) reading and rereading of the original data, (b) initial noting of the content and in vivo coding, (c) development of emergent themes and axial coding to link categories, (d) search for connections across emergent themes to categorize themes and grouping of subthemes, (e) repetition of the process on the next case, and (f) identification of patterns across all the information and the search for connections. According to Smith et al. (2009), line-by-line coding permits the researcher to interpret the accuracy of the interpretation. After the transcription and coding processes, the researcher organized and

summarized the completed work. Saldaña (2015) recommended the use of field notes, memos, and reflective notes as part of the data collection process, which, for this study, the researcher kept a work journal as a record of learning throughout the research process (Kvale & Brinkmann, 2015). The researcher secured all electronic documents in encrypted folders on a laptop computer. This process allowed for reflection and new learning. The information-collection process was followed by summarizing each interview and following up with the participants for clarification, if necessary (Hycner, 1985). This study implemented strategies to ensure the credibility of validity and reliability.

The validity and reliability of this study's research findings were credible, transferable, dependable, and confirmable. The participants were virtually interviewed in the comfort of their locations for an average of 60 minutes. Each interview allotted time for the researcher to spend on building trust and creating a relaxing environment by offering personal information before the interview. In addition, member checking was utilized by asking the participant to verify the accuracy of the interview transcript, and this established credibility. In terms of transferability, the lived experiences of the participants of this study are transferrable to other population with similar experiences. The finding and theme of this phenomenon may offer insight to other Black family members of substance users (Peoples, 2020).

This chapter details the process and steps to replicate this study to maintain dependability of the study. Repeating the steps with the same phenomenon and similar content should yield comparable findings. Lastly, to protect the research from the emergence of distraction, journaling and reflective memos were utilized. This practice of

confirmability addressed personal bias and anticipant projections. These strategies were used to create accountability and honesty of the research.

Summary

Chapter 3 discusses the research context, the research participants, the qualitative nature of this study, as well as the research design of this study, which was utilizing interpretive phenomenology research protocols and analysis. The primary aim of this study was to give voice to Black communities. The researcher identified the procedures for data collection, the identification of the research instrument as well as the corresponding analysis of coding best practices. Using IPA methods allowed the researcher to uncover meaning from the lived experiences of Black family members of substance users.

Chapter 4 details the results of the data collection and gives voice to the Black community. The findings add to the existing body of knowledge on the topic.

Chapter 4: Results

Introduction

SUD is a family disease that directly disrupts the lives of the immediate family members of the substance user (Usher et al., 2015). The literature shows that the insidious nature of SUD has life-altering impacts on individuals within the spheres of influence of the substance user. The purpose of IPA is to understand how individuals perceive the world and make sense of their experiences (Murray & Holms, 2014). This study focused on the phenomenon of the experience of Black family members of substance users to understand the efficacy of family-based supports.

This chapter describes the findings of this study, starting with the demographics of the 10 study participants. It also details the themes revealed by an interpretative analysis of each participant's interview. This chapter concludes with descriptions of themes and subthemes. The findings are synthesized to provide a greater understanding of the lived experiences of Black family members of substance users and the significance of family-based supports.

Research Questions

The following research questions guided this study:

1. What types of informal, semiformal, and formal support do family members of substance users utilize?

2. From the perspective of family members of substance users, how and in what ways does support help the family?

3. From the perspective of family members of substance users, what obstacles exist in accessing and utilizing supports?

Data Analysis and Findings

This section provides an overview of the demographic background, including the research context and the participants' demographics. The data were collected through semi-structured virtual interviews. A purposive sampling method was used to help identify the qualifying participants. The first round of coding included reading and rereading the transcript data. The second round of coding identified the initial codes using the participants' exact words. The third round of coding involved the development and connection of the themes. The fourth and final round of coding emphasized an in-depth interpretation of the themes and subthemes. This section details the results of the data categorized into four themes, followed by an interpretation of the participants' themes.

Demographic background. The 10 participants, at the time of this study, resided in counties throughout NYS. Half of the participants resided in the Capital Region, one participant lived in Western New York, and four participants were from the metropolitan New York City area. Six of the participants were adult children of substance users. Of those six participants, two had dual roles of being a daughter and a niece of substance users and being a daughter and a sibling of substance users. Two of the participants were grandmothers of substance users. Of the grandmothers, one was also the mother of a substance user. The remaining two participants were, respectively, a wife and a father of substance users. Most of the participants were female, with eight identifying as female and two identifying as male. Six of the 10 participants were over the age of 50 years. The predominant drug used by the participants' relatives was crack cocaine or cocaine, as

indicated by five crack cocaine users and two cocaine users. The other relatives included

two cannabis users, one alcohol user, and one user who used more than one substance

(polysubstance). Table 4.1 provides an overview of the study participants' demographic

information. To ensure anonymity, each participant received the pseudonym of

Participant and an assigned number of *1* through *10*.

Table 4.1

Participant Demographics

Pseudonym	Relation	Age	Relatives' Drugs of Choice
Participant 1	Daughter	38	Crack cocaine
Participant 2	Daughter	34	Alcohol
Participant 3	Wife	56	Crack cocaine
Participant 4	Sister & Daughter	55	Opiates and cannabis
Participant 5	Niece & Daughter	56	Crack cocaine
Participant 6	Grandmother	67	Cocaine
Participant 7	Grandmother & Mother	58	Cannabis, benzodiazepine, and cocaine
Participant 8	Daughter	38	Crack cocaine
Participant 9	Father	61	Polysubstance
Participant 10	Son	38	Crack cocaine

Themes and subthemes. During the coding process, the researcher searched for

connections across codes, which were then grouped into themes and subthemes.

Pietkiewicz and Smith (2012) suggested the coding of themes should be paired with the

researcher's interpretation of the themes. The goal of IPA is to provide an explanation of

themes, summarize them, and interpret the data. The findings are organized by the themes and subsequent subthemes relating to the responses to the interview questions.

This section describes the themes that were developed from analyzing the codes. Table 4.2 outlines the four themes identified across the collected data. The themes were (a) health and wellness, (b) types of family-member supports, (c) challenges and obstacles, and (d) cultural influences across a person's lifetime. The discussion of the themes revealed subthemes that emerged from the participants' shared experiences of being family members of substance users. This study focused on understanding the kinds of supports available to Black family members of substance users. During the interviews, the 10 participants described various ways they had used supports, found the supports helpful, and how they came across challenges relating to the supports.

Table 4.2

Description of Themes & Subthemes

Themes	Subtheme	Description
1. Health and wellness	Emotional distress, Psychological well-being	The stress and strain endured by family members contributed to their emotional, physical, psychological, and overall health and well-being.
2. Types of family-member supports	Intimate relationships, Spirituality, Community-based support	The supports relied on by family members used to cope with substance-using relatives. The prominent supports mentioned were intimate relationships, spirituality, and community-based supports.
3. Challenges and obstacles	Stigma, Institutional barriers, Distrust	The challenges experienced by family members that prevented access to supports and engagement in services.
4. Cultural influences across a person's lifetime	Code of silence, Family cycle	The exploration into the family's origin revealed culture norms relating to the family cycle of SUD, early exposures, generational trauma, and the code of silence.

Theme 1: Health and wellness. This section details the influence on the health and wellness that family members endured as a result of having a substance-using relative. All of the participants reiterated the emotional, physical, and mental toll they had experienced as family members of substance users. The participants discussed neglecting their own emotional well-being while trying to balance their roles as a spouse, parent, sibling, and caregiver. With minimal support and knowledge, the family members tried to navigate SUD on their own. As a result, they experienced emotional turmoil and competing emotions about their relatives.

Emotional distress. Participant 3 best articulated her fears and emotions relating to her substance-using husband. With no one to turn to, she was reluctant to let people help her. Still believing in his "potential," she was living with the pain of watching her husband's "lifestyle" and not being able to do anything about it. Participant 3 expressed the presence of negative emotions that she had developed from having a substance-using relative.

> To be in a marriage, to love the person, and to have to sit back and fantasize on which suit, which tie, which funeral home. And then to ask, "Is this the only purpose of our marriage—is for me to prepare for his funeral?" That's it. So, it is kind of fucked up. But I'm good. You know, we also gotta be good.

With raw emotion, she expressed being in constant fear of her husband's fate because of his SUD. Despite the excessive worry and fear for her substance-using relative, Participant 3 and her other family members present themselves to the world in a way that said "everyone is fine." As an unconscious coping mechanism or a self-

preservation tactic, many family members minimized their emotional distress and the disruption it caused to their daily functioning.

For example, Participant 2, the daughter of a substance user, shared how her substance-using relative had influenced her life and her perception of self. "I've got a reputation to uphold. I got an image. Because if not . . . to her, things in my life seem perfect. Seem like everything is okay." Concerned with the perception of others, Participant 2 devalued herself based on the opinions of what other people thought of her substance-using relative. However, through the help of her friends, she reclaimed her identity and self-esteem. Reflecting on the advice from a significant other, Participant 2 shared,

> Our father's actions are no reflection of us. . . . Even despite all that, you have to just give yourself credit, give your mom credit where it's due; for one, raising three kids as a single mother. And two, you being who you are. You are a woman who have been exposed once to an HBCU (historically Black college or university). You've gone to Africa. You're doing all of these things that people who's from our neighborhood don't—don't get to do, right? Despite the fact that this is your father. And so it's not an embarrassment.

Negativity from others can have a significant influence on family members' self-esteem and self-worth. Many of the participants felt responsible for their relatives' SUD and believed their relative's behavior reflected on their personal identity. Some of the participants were able to free themselves from feelings of guilt; while for others, the negative emotions manifested in, and eroded, the body physically, emotionally, and psychologically. At times, the family members were consumed by their role in caring for

their substance-using relatives; they stopped being in tune with their bodies and ignored physical and emotional cues.

In trying to care for her substance-using brother and father, Participant 4 reported she was "physically sick in my body." She ignored the physical cues, stating that "pressure could run high," and so she reduced her exercise routine. At times, she prioritized the needs of her substance-using relatives over her own because of the pressure from her family. Participant 4 recalled her mother's "subtle, kind of, nudging" to take care of her substance-using brother. In addition to helping her substance-using relative, Participant 4 had other roles in the family as a wife, a mother, and a school counselor. Throughout the interview, she offered numerous examples of trying to balance her roles and responsibilities.

> I mean, I guess I would say that it [relative's SUD] added to it [stress], but I can't say that it is the major cause of it because I did have other stressors in my life, but it definitely was stressful. When my parents are arguing, or my dad is, like, having, as we call [it] an "episode," and I then got [to] figure out how, on a weekend or an extra day or so, to get down to North Carolina and mediate for them or figure out how to get my dad up here or get my mom here. That's stressful, and I could tell just the stress level, just being stressed. My body was stressed. I'm anxious. I know that that's the case. When I was dealing with my brother, in his episodes that he's had, it takes a toll on you. We're running back and forth. I'm in the city. I'm in Long Island. 'I'm working. I gotta, afterward, meet up with my husband, drive into the city, go take care of him. Get back home about 9 o'clock, 9 or 10 o'clock at night. And I'm doing this.

For 2 months, Participant 4 juggled this intensive schedule and split herself between her other roles as an employee, a mother, a sister, a wife, and a daughter. The feeling of being overwhelmed with stress was inevitable. Many of the participants vacillated between when to step back and allow others to help and when to continue in silence. In this instance, Participant 4's body was physically forcing her to stop. The consequences and responsibilities of caring for a substance-using a relative can appear impossible. The stress is not only detrimental to family members' physical health but to their mental health as well.

Psychological well-being. Participant 6, the grandmother of a substance-using relative, elaborated on the influence stress had on her mental health and overall psychological well-being. She described experiencing hypervigilance while living with her substance-using grandson. She would walk around her home with a baseball bat, continually checking to see if her purse, checkbook, and electronics were secure because of past theft and fraud. Noteworthy was Participant 6's description of her declining mental health, influenced by the stressors relating to her grandson's SUD.

> I just was having such a hard time—believing that there was nothing there, that there was nowhere to go. So, I withdrew, and I withdrew into a deep depression to the point where there were days I could not leave my bedroom even to go downstairs. And then if I made it downstairs, but I didn't make it out . . . I realized I was going deeper and deeper, then I started to reach out to people that I thought could help me.

The psychological toll of being the grandmother of a substance user had severe consequences for her mental health. Family members do not realize the severity of their symptoms until their lives are completely unmanageable.

Similarly, another grandmother, Participant 7, experienced excessive worry and anxiety over her substance-using grandchildren. After overcoming her own SUD and with more than 30 years clean, Participant 7 felt helpless when it came to her grandchildren. Reflecting on her mental state, Participant 7 discussed the affects her grandchildren's SUDs had on her psychologically.

Well, I never had to be on an anxiety pill. I have anxiety from always worrying about them. More so from my grandchildren than my children, but both a little combined, but more so the grandchildren. Yeah. I'm always like afraid for something that's going to happen with them.

All of the participants wanted help to manage the emotions they felt when dealing with their substance-using relatives. With few skills to mitigate the emotional and psychological distress, family members suffer and attempt to adapt to living with worry, anxiety, and fear. Participant 7 decided to obtained help to cope with her anxiety. For her, like for many, the decision to get help was difficult. The challenge of wanting to help others and needing to find help for oneself can be debilitating.

Participant 9 reflected on being in limbo. He wanted to help his daughter, but he also felt complacent in his own life. Unable to help his daughter with all of his knowledge of SUD, and feeling a lack of control of his life, Participant 9 succumbed to a loss of motivation and became depressed. In describing his life, he recalled justifying his life decisions and indecisions.

I still haven't motivated myself enough . . . I could do a lot of things and I don't

do it. . . . I'll get to this point and say that I'm going to start tomorrow. And then

tomorrow still don't do anything. . . . I could rationalize it, and say that I don't

have to do anything because I'm waiting for the lawsuit to be over. But, instead,

I'm sitting in my house and 'I'm not doing anything constructive, you know what

I mean? Except just sitting here. . . . The virus is out there, and everything is

closed. . . . I could take that and rationalize that as another reason for me not to, to

start doing something because nothing is open.

The psychological toll on Participant 9 had overwhelmed his overall well-being, making

him feel hopeless and powerless. Once having found a sense of purpose from self-help

support meetings and the associated sponsorship and fellowship, he was, at the time of

his interview, engulfed with depression. Unable to help his substance-using daughter, he

did not know where to focus his emotions. He had to enforce boundaries to ensure his

own well-being. Participant 9 provided an example of his attempt to get his relative into

treatment.

I had to tell my daughter, "I would never get myself involved in your personal

life, but, if you need me, you come to say, 'I need help. I'm ready.' And I will do

everything I can. But I'm not going to try to tell you what to do. You need to stop

this, because I'm the one that ends up angry, and then that's not good for me."

Assessing his own limitations and being mindful of his emotional health, Participant 9

relinquished his will over his daughter. Reliving the distressing incidents with his

daughter, he resolved to accept her ambivalence. All the while, still making himself

available to her if she wants to change. Family members resist setting boundaries as if it is a sign of defeat.

Participant 10 also battled with setting boundaries for his substance-using mother. He discussed how he needed her to move out of his home to protect his mental well-being. When asked about his motivation for setting boundaries with his relative, he stated,

> To be honest with you, one is getting just tired of . . . the bullshit. Now, I'm speaking to somebody about it. And knowing that I don't have to . . . . I always thought . . . that's what I was "supposed to do," because that's my mother . . . . Everybody else probably been treating her bad and being disrespectful towards her and looking at her some type of way because of what she doing drugs. . . . . And I just didn't want to be one of them people. . . . It weighed me down.

The decision to choose self-preservation over defending a substance-using relative may seem like an inconceivable task, but it is the catalyst for healing and change. Family relationships are complicated and infused with emotions, loyalty, obedience, anguish, and compassion. Many of the participants, like Participant 10, believed they were impervious to the pain caused by their substance-using relatives and coped by trying to avoid their emotions. Family members are selectively vulnerable to maintain a sense of control because the perception of strength and psychological stability is essential.

Participant 3 was most concerned with not appearing weak or being a burden. One of her most significant stressors was the idea of her son learning her husband had a SUD. She feared he would "disassociate himself" because it was "antithetical" to the beliefs she instilled in her child and how she lived her life. Instead she acted as if there was no

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marital discord and privately awaited "for the strength to walk away," because she felt "obligated to stay." Upholding this dual identity weighed on her psychological and emotional health. With the uncertainty of her husband's SUD, she tried to take control of how others perceived her.

> I don't want to become . . . that girl, where "here she comes again." I don't want that. I want to have a perception of myself that I am constantly trying to project. And that perception of self certainly is about strength and it's about being self-empowered, being able [to be] self-sufficient.

Although guarded at times, Participant 3 exuded a sense of pride. Her ability to control her vulnerability contributed to her self-empowerment. Being in control of her decisions and her actions seemed to strengthen her psychological and emotional health. Elaborating on the experience of reclaiming her strength from her friends, she stated,

> I feel stronger when I don't share. I feel more like my life is more manageable when I don't share. . . . It seemed like before, when I would share with people, well, just certain select friend, three mainly, all of them had their input, and it seemed as if I didn't do or if I did not do it the way they wanted me to do it, there was a problem. It was always tension. So I just said, "well, you know what? I can't share my life. I can't share this part of my life with them and maintain friendship. . . ." One's going to have control over my life. And I just felt like they were trying to—they felt like they knew what was best for my life. And, yeah, that just didn't work for me, and it wasn't working for me. It was as if I was being reduced. At least I felt like I was being reduced in their eyes because I always, I guess if you had to ask my friends, "Give me one characteristic of her," they

probably would say, "she's strong." But I felt like because I was sharing my

struggle, that they felt like I was not that strong person anymore. And for me, I

have to be strong. It's just how it is for me.

Participant 3 emphasized the perception of "strength" and "control." These were

underlying concepts expressed by all of the participants. With all of the responsibility of

being a family member to a substance user, the participants believed they needed to be

strong and not to display any weakness. The emotional and psychological distress

endured was taxing and contributed to the family members' overall health and well-

being. The family members indicated a reduction in physical health and an increase in

anxiety and fear. In an attempt to manage stress, the family members turned to their

friends and relatives, as well as their spirituality and community programs, for support.

Theme 2: Types of family-member supports. This section examines the types of

supports available to family members of substance users as expressed by all of the

participants. The participants shared their perspectives on different kinds of supports they

had used. They experienced acceptance within either their intimate relationships, spiritual

relationships, or community relationships. It was because of their responses to formal

supports that the participants realized intimate relationships, community-based programs,

and spirituality were the best and most accessible supports. The following section further

explores these subthemes, starting with the support provided by intimate relationships:

relatives, friends, and significant others. The next subtheme, spirituality, relates to the

practice of faith, prayer, and belief in a higher power. Lastly, the subtheme of

community-based supports relates to self-help support groups and professional

counseling. While all of the participants were able to describe experience with at least one of these supports, the level of acceptance and helpfulness varied.

Intimate relationships. The subtheme of intimate relationships was identified as a result of the participants describing supports for family members of substance users in terms of their informal relationships with relatives, significant others, and close friends. These intimate relationships were the most meaningful and primary support for the Black family members of substance users. In their narratives, some participants described their relationships with family as "healthy" and "dependable," while other participants described their relationships as "dysfunctional" and "strained." However, the participants who expressed receiving minimal support from their immediate family and relatives often struggled to confide in friends as well. Generally, the participants perceived their relationships with significant others as helpful in coping with substance-using relatives.

Participant 4 is a daughter and sister to two substance-using relatives. When asked about the support she received from people in similar circumstances, she responded, "I don't have too many people that I can do that with other than my husband or my sister." Participant 4 described her family as "close-knit" and "loving" but encumbered with SUDs. She perceived the responsibility she felt for caring for her substance-using brother and father as less of a burden and more of a shared responsibility between her and her siblings. Participant 4 emphasized her siblings "showing up" for one another during times of need. In the context of addressing familial issues, she described "teaming up with family members and trying to deal with all of that stuff." The concept of a closed loop of support within the immediate family was consistent throughout the interview. It is

evident that in a healthy functional family, the members can articulate their needs and expectations, and have their support reciprocated.

On the other hand, Participant 8 described a strained relationship with her mother because of her active substance use. Consequently, Participant 8 relied on "unconditional love" from her father, aunts, cousins, and grandparents. She expressed feeling a constant void of affection from her mother and wanting a "normal" mother-daughter relationship. At times, Participant 8 appeared sad and bewildered by her mother's inability to provide her with the love and support she desired. Despite her close relationship with other relatives whom she called her "saviors," Participant 8 still struggled to disclose the challenges she was experiencing with her substance-using mother.

> I didn't feel the love in the house, but when I did go to my grandparents' house and my aunt's house, like, I felt the love emotionally all around. Like, unconditionally . . . I couldn't even share it with my family until I got grown. Well, they've just found out, like, everything that I was going through as a kid. The depth of it, like, they knew she did drugs or whatever, but [not] the depth of it.

The support from her family members was paramount to Participant 8's healing process. It is through these intimate relationships that she realized she no longer had to live with the pain caused by her substance-using relative. With the help of family, Participant 8 was ready to free herself from the trauma and address the emotional neglect she felt from her mother. Specifically, she wanted to express her grievances with her mother and "air it all out." Participant 8 believed that to heal she needed to confront her mother. Most of the participants experienced the cognitive dissonance of unresolved feelings of anger,

resentment, and disappointment mixed with feelings of love and affection. Family members of substance users often have similar experiences, and they feel most comfortable sharing with close relatives and friends.

Participant 10 developed a close bond with his aunt in the absence of his mother due to her SUD. He was able to rely on his aunt and to address any problems he had. However, the constant support from his aunt abruptly stopped. In response to being asked about having an outlet for emotional support, Participant 10 reflected on the loss of the profound relationship he had with his aunt.

> I used to [have support], but she's also now a drug addict. . . . And that was my aunt. . . . She was like my rock. She was definitely down to earth. Somebody you could talk to or whatever, but now . . . she's a full-blown alcoholic, and she smokes crackers herself. . . . And it's just hard to believe, because she definitely was my rock. Now, there's nobody I could talk to about that.

The loss of a primary source of support is devastating. It validates a person's fears of being helpless, hopeless, and lonely. The participants who were unable to seek refuge within their immediate family, turned to their close friends for support.

In the context of peer groups, close friendships resemble kinfolk relationships, and friends are often regarded as relatives in the Black community. Participant 2 best described the utility of close friends as she navigated her relationship with her substance-using father. When asked about the most helpful support, she replied, "My friend told me that me always attacking my dad could have been a trigger." Her friend validated Participant 2's experience with her father. She recalled a boyfriend telling her, "My dad is the same way." In opening up to friends and sharing her experiences, she learned she

was not alone. However, intimate relationships can reveal the limitations of family members' support. Participant 2 recalled, "We didn't know enough to say, 'Well, let's go to the counseling session. Let's seek out these people.'" When asked about her family dynamic, Participant 2 remembered that her grandfather "tried to step up" and provide support in the absence of her father. There was no discussion about SUD in the family and the impact her father's SUD has on the family.

> My grandfather—he didn't explicitly—when he was alive, he wouldn't explicitly have a conversation about that [father's substance use]. I think what he tried to do was do his actions. He tried to step up when my father lacked. So, like, he took us a lot. He gave my mom a break. We would stay at our grandparents' house a lot . . . because my mom naturally, being a single mom, they gave her some kind of relief . . . my grandfather, never really like said anything to us about [it], but you could tell that—now being [older], knowing what I know now, being older—his actions, I could definitely see that he was trying to make up for where my dad lacked.

Support from family members is mutually beneficial because close friends and relatives prove they can be trusted and relied on. The support received from intimate relationships may provide relief from the day-to-day stressors, but it cannot provide the support professional services can. Friends, relatives, and significant others' knowledge of SUD is predicated on their own lived experiences, and they may not know enough to suggest help outside of the family.

Participant 9, a self-identified recovering "crack survivor" with more than 30 years clean and sober, was trying to find the balance between supporting and rescuing his

substance-using daughter. As an expert in SUD from his own life experience, he expressed how he depended on his friendships of over 30 years for support.

> I'm not going to everybody, but I do have people that I could get my stress off with. I have people that, when I'm down and out, that I know I could talk to him . . . I definitely have four or five people in my inner circle that I could definitely talk to about anything almost.

For many in the Black community, lifelong friendships are an extension of family. This is especially true when familial relationships are strained. For Participant 9, his friends were his chosen family. He discussed confiding in his friends more often than his wife and siblings. An essential difference between Participant 9's friendships and the other participants' friendship is their origins. Participant 9 established his core network of friends from community self-help meetings during his early years of substance-use treatment. Thus, support can be provided by family made of blood relatives or by family made of friends and community members. In addition to the comfort provided by kinship relationships, the participants mentioned finding support in their spiritual relationships.

Spirituality. The subtheme of spirituality was mentioned by multiple participants using the terms "faith," "higher power," and "prayer." The meaning they assigned to family-member support was influenced by spirituality. It was faith and belief in a higher power that gave the family members the strength to endure the capricious relationship with their substance-using relative.

Participant 4 spoke the most in-depth about spirituality. For her, the influences of faith and family were woven into her everyday practice. She believed that her spirituality

fortified the family against challenges relating to health, mental illness, and internal strife.

> I honestly believe that if I didn't have that [faith], I probably wouldn't be sitting here talking to you. That has been the constant in my life . . . helping me deal with all of whatever obstacles that I have . . . whether it's health, whether it's with family, whether it's with finance, whether it's with the dynamics of the family, relationships with the people, whether it's their life, praying for them being faithful . . . . I want to say the family's faith has never wavered and [has] stayed intact. And that, I believe, is what has allowed us to kind of still be here.

Spirituality and prayer are the words Participant 4's family used to communicate and support one another. It was their belief that spirituality "teaches us that God is patient" and that families can be healed through prayer. Spirituality is the cornerstone of the Black community because there is unwavering, constant support, and there is no judgment cast.

Similarly, Participant 8 stated her faith and spirituality had brought her closer to her family. Although, she had a strained relationship with her substance-using mother, and COVID-19 social distancing ha, restricted access to her supports, the family remained close. When asked about an outlet for emotional support, Participant 8 responded,

> We [relatives] do Zoom meetings every Sunday to catch up. . . . We can't really touch each other right now. So, you still keep in touch, daily prayer. We have family Bible study [as] well, so, and they know everything now. Now that I'm old enough. I'm older, and now I want to talk about it.

The rituals of spirituality, such as prayer and fellowship, support family members and ease emotional distress. Most of the participants reflected on the practice of spirituality as opposed to churches or clergy members as supports. The participants were most concerned with their support being safe and private. Concerns of safety and confidentiality were frequently voiced in relation to community-based supports.

Community-based support. Community-based supports can be considered the second level of support for family members when compared to intimate relationships. This semiformal support is established outside of the home with nonrelatives. However, there must be a level comfort and familiarity that exists for a family member to seek out assistance. These subthemes emerged when talking about family-member support as the participants referenced self-help support meetings and professional counseling services. Some of the participants reflected on their experiences with therapy and their thoughts on being open to therapy in the near future.

Participant 6, a grandmother of a substance user, attempted to get help outside of the family. Unlike, many of the other participants, she primarily relied on her personal and professional network in the community for support. Participant 6 reflected on her help-seeking attempt with social workers, police officers, and attorneys. In describing these community-based supports, she shared,

> I spoke to my, my defense lawyer friend, and he really was, and he would listen. And maybe some things, basically, he could just affirm [what I already knew]. And so, [he said] how sorry he was, but he could not give me anything. I hadn't gotten any[thing]. He couldn't advance my knowledge base. And that was the part that I found really hard. Like, there's gotta be something else.

In this instance, Participant 6 intentionally reached out to her network, to people she believed would be beneficial. Instead, Participant 6 declared that her friends would listen but would yield with limited help, stating, "She couldn't hear me say I need help." The support from personal connections may provide comfort in the moment, but it may not be able to provide the guidance family members seek. As such, some of the participants reflected on their experiences with family-based, self-help support groups.

Participant 3, the wife of a substance user, was still trying to find the best support to meet her needs. With few friends and relatives to turn to, she sought out help from people in similar circumstances. When asked about her experience with community-based supports, Participant 3's opinions of self-help support meetings, such as Al-Anon and Nar-Anon, varied. As the only Black person in attendance, she stated that "the room wasn't comfortable," and she stopped attending. While she was receptive to hearing from people in similar circumstances, racial microaggressions were present in the Nar-Anon meeting. Participant 3 recalled,

> [At] Nar-Anon, it seems like there's this misunderstanding that all drugs originate from the Black neighborhood. And it seems as if they're upset that their kids hang out in that neighborhood. And I felt like I was a reminder.

This misconception of SUD and its connection to the Black community proved to be a significant barrier in finding judgment-free support. Participant 3 felt, like other the participants did, that family-members' supports needed to be safe spaces for family members to open up. Negative experiences such as these only reinforce feeling rejected, alone, and hopeless when trying to find the appropriate supports.

From a different perspective, Participant 6 described using community-based online support groups through a social network. She had a neutral response to self-help support meetings. Recalling her experience of using a social network to find supports she stated,

> Occasionally looking on Facebook like . . . . They're not really open to outsiders. I did find the one Al-Anon group . . . I did go for several sessions. I met some of the folks. Some nice people, some well-meaning people. Their situations were different in terms of what they were willing to put up with [substance-using relative] or how long they were willing to put up with stuff.

From the perspective of Participant 6, the family-based, self-help support groups were well intentioned, but they did not fully meet her expectations. Participant 6, like other participants who attended self-help support meetings, felt that the meetings catered to a specific group of people. It seemed the absence of diversity and cultural inclusivity in community-based support is more or less tolerated by Black family members because, at the time of this study, culturally specific space did not exist in the community.

Participant 9 is both a former substance user and a family member of a substance user. His life experience had given him expertise regarding how to help his daughter best. Participant 9 referenced principles he learned from attending narcotics anonymous (NA) meetings. He acknowledged, "I can't do nothing for her unless I'm able to do something for me." When asked about his knowledge of family-based, self-help support meetings, he replied:

> Al-Anon, no, I've never been to . . . you know what? I've never considered that. I knew about Al-Anon a long time . . . I wouldn't go to therapy now for [my

daughter], [but] I would go to therapy for [my granddaughter] . . . because I

honestly believe that [my daughter] has to go for herself. And if [my substance-

using daughter] ain't doing nothing, it don't make sense for me to do nothing.

Accepting that he could not make the necessary changes to his daughter's "lifestyle,"

Participant 9 chose to focus on himself. Also, in a recent self-help meeting, Participant 9

shared about how therapy saved his life and had informed his decision-making.

Affirming the life lessons he gained from therapy, he expressed,

Another thing I learned that is as long as I keep on talking about what's going on

inside of me, I know I'm dumping it out, and it ain't going to come out and

explode. . . . I know that if I give somebody up some of my garbage that is

lightening my load . . . all I gotta do is keep talking about how I feel, and then,

and I get a little ease out of that; I get a little comfort out of that . . . . For the last

20 years, I've never been afraid to talk about my feelings and what I'm going

through to anybody.

Therapy helped Participant 9 shed the generational trauma that haunted his life—

sometimes having a new perspective from someone unfamiliar with an individual's

experience brings out new insights and fosters breakthroughs. The few participants who

had tried therapy, as well as family-member support groups, agreed it benefited the

family members when the appropriate kind of support was selected.

Similarly, Participant 5, the daughter and niece of substance users, used therapy to

help cope with her relatives' SUD. In therapy, she began to unearth family secrets and

questioned family dynamics, stating she wished she had started counseling sooner. It was

through this counseling that she started to unpack family issues.

While I'm in counseling . . . these other issues are coming up, about my family, my mom, their drugs, the family dynamics, my dad, and my grandmother . . . all of these different relatives. So, it's helping me. 'Cause now I have somebody, besides my husband, to actually [help] get this out and [to] vent to.

These sentiments about therapy were consistent with the other participants. Family members often sought immediate support from their intimate relationships. In some instances, the family members had been apprehensive about opening up to their close friends, relatives, or significant others for support.

Participant 7, the mother and grandmother of substance users, could also attest to the benefit of formal treatment. After dismissing her preconceived beliefs about therapy, she allowed herself to be open to the experience. She recalled her earliest memory of therapy when she was in treatment for her own SUD.

When I first started with a therapist, it was very hard. Hard for me because I was always told, "You don't tell people things." So, it took a long time before I was able to open up. And I'm about to get a little emotional now and try not to. It took me a long time to open up. But when I finally did open up, it was the best thing that I did for myself. I really got a lot out of that. I was able to talk to my mother with things that I held in for a long time. I was able to pull down a lot of walls with therapy.

Participant 7's positive experience informed her decision to get her relative treatment and therapy. Therapy can support family members by delving into core beliefs that may be preventing them from growing and healing. In this instance, Participant 7 shed the misconceptions and beliefs she learned in childhood and that she continued to hold into

adulthood. The various types of family-member supports helped the families cope with substance-using relatives. However, there were limitations. The intimate relationships of relatives, friends, and significant others were perceived as trustworthy, but these relatives had limited knowledge. Spirituality provided a sense of security and comfort to the family members, but the reward was limited to the practice and not to fellowship. Concerning community-based support, family members had a variety of experiences, but most felt ostracized. Challenges and limitations are deeply rooted in cultural norms, family values, and societal beliefs about the Black community.

Theme 3: Challenges and obstacles. This section examines the challenges and obstacles the participants shared that prevented them from participating in community supports. Most of the participants indicated a lack of awareness of what supports were available, and they suggested increasing the visibility of said supports and programs.

Stigma. The subtheme of stigma focuses on the societal perception of substance users and their family members. The family members felt their substance-using relatives' behavior reflected on them, and they felt devalued because of their association with them. The misconceptions that family members are weak for maintaining relationships with their substance-using relatives, and they are perceived as codependent because they are trying to help the relative further, ostracize families. Family members then avoid seeking supports and services. Instead of placing blame externally on the stigma, family members internalize it and blame themselves.

Participant 2 provided her perspective on what contributed to the stigma. From her experience with her substance-using father, she recalled "feeling embarrassed because of the stigma that was attached to it." The stigma associated with SUD

contributes to unwarranted feelings of embarrassment and shame. Regarding the origins of stigma relating to SUD, she stated,

> I think the stigma just comes from us not sharing, not—and I don't even want to say being "supportive." Because, if you don't share, how can you be supportive with something you don't know? But it comes from us not sharing. It comes from us hoarding our experiences and information that we do know because of the embarrassment.

This stigma is a social construct developed from misinformation about and a lack of understanding of SUD. Therefore, individuals judge substance users and their family members based on false pretenses. Stigma should be perceived as an injustice to family members of substance users because it restricts their access to necessary supports.

For Participant 3, the wife of a substance user, being confronted with being stigmatized by friends was jarring. She learned of her husband's substance use within 3 months of them dating. She was not aware of the magnitude of his SUD, but she believed she would be able to change him. After 4 years of marriage, she realized she could not change her husband's SUD, and this was not what she expected. She was unable to share her experiences with friends and family because of her position in the community, and she was unable to hide his substance-using behavior from the community because of his lifestyle. Participant 3 was asked to define stigma as it related to her experience with her husband.

> Yes, and I've been trying to avoid that stigma, because my experience with their stigma is, people don't have the same respect for you. You're sort of deduced, your humanities sort of reduced. I think that they can handle you because they see

it as a type of weakness . . . . Because your husband is a junkie, that means you

aren't as good as, you don't deserve the best. "Ya'll are fucked up." Matter of

fact, his friend actually said to me—no, this is his best friend—actually said to

me, "something must be wrong with you, too." That opened my eyes right there. I

was like, "Whoa." That's what it means. I got a problem. That's what that stigma

means.

Stigma can be crippling, and it is especially damaging to the family members' self-

esteem. Participant 3 was being judged and mistreated because of her relationship with

the substance user. Stigma related to SUD is perceived to impact the substance user only,

but it is evident that the family members were impacted as well.

Institutional barriers. The subtheme of institutional barriers emphasizes

programmatic and systemic roadblocks impeding help-seeking efforts by family members

of substance users. All the participants mentioned barriers to the availability and visibility

of family-member support groups in the Black community.

Participant 1 was an active community member, and she was not aware of

resources for the families of substance users. In fact, outside of being informed by her

close friend who has a relative with a SUD, Participant 1 had no knowledge that such

services existed for family members of substance users. Participant 1 worked in the

behavioral health field, and at her previous workplaces, she helped get substance users

into treatment because of her experience with substance users. Despite her knowledge of

programs for substance users, she was not familiar with programs catering to family

members. When asked about her recommendations for community-based, substance-use

programs, she replied,

The goal is to reach more people like myself than perhaps there should be. If more

information [was] more visible . . . . So I guess, I was just trying to delve [into]

what's already available and what I don't see? . . . I don't see whether there is

support for individuals like me . . . I'm trying to figure out what . . . there was no

opportunity that I could see, nor that I felt something to be confidential in a way

for me to get what I needed without the stigma.

Perhaps if SUD were not stigmatized and if it were to be perceived as a medical

condition, similar to cancer, supports and services would be more readily available.

Improving the visibility of supports and making them available in communities of color

would also enhance inclusion and increase the number of diverse families in such

programs.

The participants indicated that they were concerned about programmatic barriers,

such as the challenge of finding a Black clinician who was professionally trained with

SUD experience and who had a sensitivity to family members' needs. Participant 3

described failed attempts at help-seeking in support groups and self-help support

meetings. Outlining various barriers, she described one incident with a hotline as

"absolutely horrific, almost traumatizing." In a second attempt with a community

program, Participant 3 stated, "The information that she provided me was not accurate, so

that wasn't helpful either." Neither the local authorities nor the church helped aid

Participant 3 with support or the ability to cope. When attempting to find a counselor,

Participant 3 expressed the challenges of finding a Black practitioner and a trained

addiction specialist. She stated, "It's like I have to teach them, and it's just too much for

me. . . . I should not have to pay you to teach you." The frustration from seeking

professionals delayed her future help-seeking attempts.

Participant 6 shared a unique experience of interacting with multiple institutional

and systematic barriers that exist in the government. At one point, Participant 6 recalled

encounters with the mental health system, a substance abuse program, criminal justice

programs, domestic violence services, and the family court. The mental health programs

were brief and focused on stabilization. They then referred her grandson to SUD

programs. Disenchanted by her experience, Participant 6 contentiously expressed her

experience of being left with her grandson's treatment and discharge plan.

> If I ever run into somebody who says they work there, then I have some serious
>
> conversations. But let's just say, I know that there are quality places if I had had
>
> the funds. Yeah. I would have sent him someplace for much longer than 30 days
>
> with programs that I could have gotten better information on any evaluation and
>
> that would have maintained contact. I can't imagine you're going to keep
>
> somebody for 30 days to say "they're discharged. Let them go."

Disillusioned by the SUD program's failure to engage with her and as the primary

caregiver to her grandson, Participant 6 hoped for a better outcome with the criminal

justice system. However, law enforcement had limited ability to assist unless she wanted

to press charges. She was redirected to multiple programs including drug court, family

court, and domestic violence services. Her voice remained unheard. This failure to render

the necessary support to a family member illuminates the fractures in the system and

shows that barriers prevent family members' access to services. With outcomes such as

this, it is not surprising that the family members did not trust the supports and services designed to help them.

Distrust. The subtheme of distrust is present when the foundation of established relationships for Black family members of substance users is undermined. In all of the above supports and services listed, the participants questioned their trust in others, specifically people who represented institutionalized power. Distrust was formulated during the years of heartache surrounding disappointment in their substance-using relative. At some point during their journey, many participants expressed needing to suspend their feelings of distrust to get the necessary help and support. In some instances, distrust served to protect the family members and to maneuver within particular settings.

Participant 1 reflected on how her substance using mother had impacted her life. She recalled feeling as if she needed to defend her mother to other people, stating that she felt like she could not disclose her mothers' SUD because they may judge her. With few people to talk and to seek comfort from, Participant 1 built a distrust of others, she explained.

> It impacted my resilience. It also impacted my trust. It impacted the fact that I feel like I have to navigate a lot of experiences by myself, because I've had to be very protective, even to this day, of my mother; it is important to me and always has been, to just honor her. Because I knew, ultimately, that what you [other people] saw was not the complete picture.

Participant 1, like many other family members of substance users, struggled with knowing who to trust. The challenge of finding people who are trustworthy has

implications in other areas of life. Often issues related to distrust can hinder establishing new relationships, current relationship, friendships, and occupation.

Participant 10 proclaimed that he was raised in the streets. His intuition of knowing who to trust and who not to trust protected him in harsh settings. The combination of his street lifestyle and his substance-using mother made it difficult for him to foster relationships based on trust. Often he would refer to "trust in women," "trust in the streets," "trust in jail," or "trustworthiness." Participant 10 was hesitant about disclosing his family dynamics and experiences to others. Concerning women, Participant 10 stated, "I don't trust women to save my life. If my mom is never there for me, how can another female be there for me?" As an adult, he reflected on how distrust had affected his relationships with significant others and with his children. Participant 10 prided himself on being a good parent to his children, and he wanted to ensure they maintained meaningful relationships. He reported seeing a therapist to restore the trust in himself and others. Distrust is an essential barrier to access services because of its subjectivity and resistance to change. These specific events and occurrences have interminable consequences of family members' lives.

Theme 4: Cultural influences across a person's lifetime. This section examines cultural influences across a person's lifetime. This theme was revealed during an exploration of the participants' family history. The family cycle was frequently mentioned in the context of family origin, early exposure to substances, and trauma. Most of the participants identified multiple relatives who had a SUD. Others referenced a normative culture of substance use, indicating the normality of seeing substance users in the community. All the participants mentioned using alcohol and drugs recreationally or

experimentally at some point during their lives. However, all of the participants at the time of their interviews, engaged in intentional practice, such as having open conversations about substance use to eradicate maladaptive believe in the family cycle.

Code of silence. The code of silence was an essential subtheme of the cultural influences across a person's lifetime. In various ways, most of the participants alluded to the saying "what goes on in the house, stays in the house." This belief underpinned the Black family members of substance users' use of supports and services. For some participants, silence was derived from that message in the home and in the community.

Participant 10, the son a substance user, admitted he periodically smoked cannabis but recently stopped. Throughout his interview, he mentioned growing up in the "streets" and the concept of "street culture." Elaborating on street culture, he stated his neighborhood was heavily influenced by substance use; people were soliciting drugs or distributing drugs. As such, there was a normalization of the SUD culture because of the frequency of use. When asked if he ever discussed his mother's SUD, Participant 10 replied,

> We didn't have to talk about it. Everybody knew what it was . . . I wouldn't say it's an unspoken rule or nothing. . . . It was just like you knew, and it wasn't so much talking about it. It was more or less like we were our support. . . . Just being around each other gave us comfort and gave us support; knowing that we weren't going to be like them.

In the streets, Participant 10 adapted to the culture where "you don't talk about stuff" because it was perceived as a weakness. However, assumptions of knowledge fortified the code of silence and hindered the possibility of meaningful conversation and

understanding of family members of substance users' experience. Unanimously, all of the participants confirmed the lack of communication about the SUD in their households growing up, ultimately implying there was an unspoken agreement of silence relating to the SUD in the family.

Participant 8, the daughter of a substance-using mother, was able to pinpoint a moment in her life when being silent was detrimental. She reflected on her first therapy experience at the age of 14, after running away from her mother's love to seek refuge at her grandparents' home.

The courts had to get involved, and I had to go to counseling. But when I went to counseling, I never spoke about anything, because she [my mother] told me when I went to counseling before . . . "What goes on in this house, stays in this house." I'm like, "All right, I can't tell." I can't even say what I'm going through or how I'm feeling. So, I would just go to therapy and just sit there. After 2, 3 weeks, they're like, "You're not saying anything to us. We can't help you." So I stopped.

The code of silence crippled the Black community and family members of the substance user. Family members deprived themselves of supports where they could be heard and had their experience validated. These falsehoods and beliefs are bestowed upon generation after generation until someone breaks the family cycle.

Family cycle. The subtheme of the family cycle focuses on the culture of families with substance users. The participants described vivid memories and occurrences that were impressionable upon their lives as children, and those memories were still influencing their lives as adults. The participants described the family cycle as a

repetition of maladaptive behaviors and unresolved generational trauma that continues within multigenerational families.

Echoing the desire to break the cycle of substance use in her family, Participant 4 emphasized being consciously aware of how her behaviors could influence her children. She reflected how her father relished in the idea of smoking with his children when they were of a certain age. As an adolescent, she would smoke and drink—the same as other children in the neighborhood. In her interview, as an adult caregiver to her substance-using brother and father, she was fully aware of the severity of SUD in her family. Not wanting to jeopardize her immediate family, she expressed the possible consequences of the family cycle and SUD.

> It's very hard, because, if you have those addictive tendencies, you might not have any control over becoming addicted quickly to some sort of substance, and then the negative effects and the chain reactions and the havoc that it can wreak on families.

Keenly aware of the family cycle of SUD, the participants who were parents were conscious of what they exposed to their children. When Participant 4 became a parent, she stopped smoking to ensure her children did not emulate this behavior, given that she had smoked cigarettes and cannabis with her father. Family members who are not conscious of maladaptive patterns are bound to repeat the family cycle throughout their lifetime.

Conversely, Participant 7 was not able to break the cycle of SUD for her children and grandchildren. Reflecting on how the early events of her childhood had influenced

her life, Participant 7 shared when she became consciously aware of the family cycle of SUD with her alcoholic father.

> I would always ask for a sip of beer. So, when I went into therapy, that was the first part that came up. "When did you start, start drinking?" And that's when I realized that's when I started my alcoholism—when I was 13- or 11-years old. When my father asked me to open up a can of beer for him . . . . Had he not allowed me to do that, maybe I wouldn't be that way.

With more than 30 years sober from substances, Participant 7 contemplated how life could have been different. Unable to change the past, she focused on improving the future of her substance-using sons and grandsons. As a living testament to the consequences of substance use, she hoped her life and story would deter her relatives. Knowing the possible outcomes could result in incarceration, death, and financial hardship, she was disheartened by their life choices.

> Seeing them tear their life down for drugs, when they have seen, generation after generation of using it and [wondering], "Why would you want to do this to yourself?". . . So [it's] very painful [and] very stressful to watch.

With firsthand knowledge of SUD, Participant 7 tried to disrupt the family cycle by being open about her troubles with substances. The intent was not just to break the family cycle, but to change the culture and the trajectory of future events.

> From the perspective of being the daughter and niece of substance user,

Participant 5 was conscious of how the family cycle of SUD had plagued her family. Growing up, seeing her grandfather, mother, aunts, and uncles suffer from SUD, she

developed a zero-tolerance attitude toward substance use. Reflecting on the influence the family cycle had on her life, Participant 5 recalled,

> It's made me just really focus more on my children as well. I talk to them more about drugs. So, it's made me almost have no nonsense [about] drugs and alcohol. My husband, at one point, I started looking at him that way. Like, "I'm seeing you drinking a little too much here," and, you know, I was taking the hammer to the head. Because I refuse to allow that into my circle.

Participant 5 was all too familiar with what happens when you tolerate certain behaviors. Thus, she would not accept excessive substance use in her home. She remembered growing up in her grandparents' house and normalizing her grandfather's use of heroin in the family room. She recalled a particular memory with her young brother of being accustomed to the culture of SUD in the family.

> My grandfather used to go in there [the living room] with his buddies, and they will close the door, and they would have like these little parties in there. They would shoot up, and they would . . . [be] drinking and drugging. And this one day, my little brother said, as he's peeking through the little hole that was there, he said, "When can I come in? When you finish taking your needle?"

Astounded by her brother's awareness, she realized SUD had been normalized in her family and, as an adult, vowed to break the cycle within her family and change the family culture to exclude SUD in the next generations.

> These life-altering events can have lasting effects across a person's lifetime and they can often inform intergenerational trauma. Participant 1 shared that she was molested as a teenager by an uncle, and then she learned another uncle had also molested

her mother. Unbeknownst to Participant 1, her mother was burdened by sexual trauma the same as her. Participant 1 recalled one of her final conversations with her mother, where she gained insight into her mother's suffering.

> She had explained to me she was molested by her uncle, too, but not the same one. And she never dealt with that, and then the same uncle turned her onto the drugs. And then when she actually said something, no one believed her . . . I knew it made sense how she was an outcast, essentially [the] black sheep for disclosing and made to feel that it was untrue or hurtful because she was on drugs. . . . She had never dealt with what happened to her.

With a new sense of clarity regarding her mother's pain, Participant 1 relinquished ill feelings toward her mother for not being able to do more than she was capable of doing. The mother-daughter connection was deepened by this shared experience within their family cycle. However, the culture of silence and shame of trauma prolonged the family from healing. The occurrence of traumatic experiences is ubiquitous within families with substance users. All too often, the trauma is not addressed, and issues arise across a person's lifetime.

For example, Participant 2 witnessed her substance-using father assault her mother on multiple occasions as a child. As she grew up, Participant 2 recalled experiencing "dreams and nightmares that my dad would come and try to kill us." She said, "And I was scared of him for a long time." To live in fear and uncertainty creates permanent scarring of the heart and mind. One particular memory that was unforgettable and traumatic involved her parents at her grandparents' home.

My mother came in the house. She came up the stairs and she [had] blood

everywhere [and], her face was busted open. My grandfather naturally asked what

[had] happened to her. And she said that my dad just showed up at my aunt's

house and just started beating her in the face. So, that was one instance that I

didn't actually see that, but I saw the result. The other one is when we were at my

aunt's house one time, my mother says something [or] my father asked my mother

something, and he didn't like her response and he was upstairs in the house, like

in the hallway, and he ran all the way down the stairs, and she was standing by the

car. He went all the way downstairs, and while she was in the car, he just started

punching her in the face.

Exposure to violence not only fosters helplessness but also fear. For Participant 2, she did

not instantly know how her father's SUD and behavior had influenced her life.

Recognizing the pattern of "constant issues" in her relationships, Participant 2

reevaluated her perception of her relationships. In referencing a past relationship with a

significant other, Participant 2 recalled,

It shouldn't make me feel as happy as it does when my boyfriend is telling me,

okay, that he's proud of me because I got an A on a paper, and he's showering me

with all of these accolades—that it shouldn't make me feel like a little girl that's

getting something that her dad didn't give her. I shouldn't be seeking them for

this emotional support. Where it's the support that I should be getting from my

dad.

Participant 2 was looking externally for the validation she did not get from her father and

other male figures in her life. Not wanting to be codependent on men and in relationships,

in general, she decided to make a lifestyle change. With the help of friends, Participant 2 acknowledged the problems in her relationships, then she decided the issue was worth changing. Committing to change one's lifestyle can improve primary relationships and can influence secondary relationships, such as in the workplace.

Regarding the workplace, Participant 1 discussed wanting to understand her mother and SUD better. Her interest evolved into a career in human services, working with people affected by mental illnesses and SUD. This new insight from her career started as a curiosity to better understand her family and evolved into helping other families break the family cycle and their generational barriers. Participant 1 shared how working with people with SUD gave her hope for her relationship with her mother.

> I'm wanting to know about things a bit more deeply because I was impacted so much. . . . Like, I never stopped trying to, not just [to] understand, but I always felt that there could be light at the end of the tunnel. I always felt that there was some hope there. So, I went into working in substance abuse, and, I had, actually, one of my jobs was to link people to treatment.

Participant 1 and other family members expressed a thirst for knowledge about how to engage with and understand SUD. Determined to gain an understanding of SUD, Participant 1 continued her career path in behavioral health. Small instances, such as career choices, are directly aligned with decisions made based on early life experiences.

The workplace is especially empowering for family members because it can grant them the tools to navigate conversations with their relatives. Participant 4 discussed how her work in counseling and education enabled her to address her substance-using father and brother.

My degrees in education and counseling and stuff, really, then started to make me

see things a little differently, and [I started] having some more understanding of

what was happening and what he's [substance using relative] going through and

the trauma that it had on our lives, on my life growing up as a child, or whatever.

Education and professional careers can advance knowledge of SUD, but they do not

reduce the emotional and psychological turmoil experienced by family members of

substance users. However, knowledge can be the antecedent for behavioral change that

influences multiple areas of a person's life, both in the moment and in the future. Most

noteworthy, actions and interactions impact future generations across the lifetime of the

family. This is especially true for the Black community, given its history and culture in

America.

Summary of Results

The four themes discussed in this chapter were health and wellness, family-

member supports, challenges and obstacles, and cultural influence across a person's

lifetime. All four themes were relevant to the experiences of the Black family members

who participated in this qualitative interpretative phenomenological study. This chapter

presented the results and data analysis from the study participants' lived experiences.

In the final chapter of this study, Chapter 5, a summary of the findings is provided

as well as a discussion of how these feelings connect with Bronfenbrenner's (1989)

ecological systems model. Implications of the study, recommendations for further

research, and the study's limitations are also discussed.

Chapter 5: Discussion

Introduction

Chapter 5 presents a discussion of this study's findings and the implications as guided by the research questions. The research questions are essential in understanding supports for family members of substance users and in recognizing the Black experience specifically. Throughout U.S. history, the Black community has been oppressed, discriminated against, and systematically ostracized from gaining access to SUD supports and services (Gaston et al., 2016; Hanna et al., 2017; Hardy & Qureshi, 2012). The literature defines supports as assistance provided to the family on the basis of informal, semiformal, and formal support services (McDonagh et al., 2018); the literature further includes the subcategories of material, practical, informational, and emotional support given to a family. For this study, the term supports was viewed primarily through the perspective of Black family members of substance users.

The first phase of the research process involved recruiting Black family members of substance users by accessing professional and personal networks within the researcher's community. The second phase of the research process included a series of virtual semi-structured interviews on the Zoom platform with 10 participants who met the qualifying criteria. Data analysis consisted of reading and rereading of the transcripts, the initial coding, the development of themes and subthemes, and the connection of patterns across the collected data. The following four themes emerged concerning family-based

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substance-use supports: (a) health and wellness, (b) types of family-member supports, (c) challenges and obstacles, and (d) cultural influences across a person's lifetime.

This chapter also addresses the study's limitations and offers recommendations to improve future clinical practice and academic research. Substance-use-related research often focuses heavily on the perspective of the substance users with limited inclusion of their family members. The documented barriers to treatment for family members of substance users are congruent with this study's findings and other scholarly literature. This research provides an overview and an analysis of the supports and services that are used (or not used) by the Black family members of substance users as well as how the services are regarded by Black family members. The purpose of the interpretative phenomenological analysis employed here was to provide greater insight into substance-use supports designed for the substance users' families from the perspectives of Black family members of substance users and assigning meaning and depth to the lived experiences of this population (Cottrell & McKenzie, 2011).

Implications of Findings

This present study explored the perspectives of Black family members of substance users. The findings of this research give meaning to use of or lack of supports by understanding and contextualizing aspects of the social, spiritual, and cultural issues faced by the Black community. Four themes emerged from the 10 participants' lived experiences as Black family members of substance users. These themes are the framework used to address the three research questions.

Research questions. This section presents the implications of the findings of the research, focusing on the following research questions:

1. What types of informal, semiformal, and formal support do family members of substance users utilize?

2. From the perspective of family members of substance users, how, and in what ways, does support help the family?

3. From the perspective of family members of substance users, what obstacles exist in accessing and utilizing supports?

This study set out with the aim of understanding and assessing the supports available to Black family members of substance users.

Research Question 1. What types of informal, semiformal, and formal support do family members of substance users utilize? All the participants were able to identify some types of family-member supports. They described intimate relationships, spirituality, and community-based supports, which fall into two of the three levels of support. Theme 2, types of family-member supports, emerged early on, and directly aligns with the first research question, which sought to understand what types of support family members used.

Informal support. Informal supports are intimate relationships consisting of close friends, relatives, and significant others. These relationships are considered reliable and can provide emotional support, although the people involved often have a limited knowledge of SUD. Consistent with the broader literature, this research found that participants relied on intimate relationships for support. This study found that the participants sought support from friends and relatives equally. However, the participants admitted they preferred to confide in close relatives as they were concerned with trustworthiness and considered close family to be more trustworthy than friends. Similar

to the research described in Chapter 2, where participants in the Bentelspacher et al. (2006) study indicated family members having a community of support from relatives and friends, the participants in this study also availed themselves of a range of support from relative and friends.

However, this study's findings were contrary to the Brown et al. (2000) study, which explored the influence of support in managing the life stressors of college-educated Black women. More specifically, the Brown et al. study focused on informal relationships and found Black women primarily preferred female friends over close relatives as a source of support. In contrast, the participants in this study believed they could not disclose to friends and were concerned with friends judging them. These participants considered close relatives and significant others more reliable sources of support. Family members without the support of relatives withdrew from other related supports and services because of their considerable distrust in, and fear of, judgment from friends regarding substance-use problems in their families.

Semiformal supports. Semiformal supports refer to spirituality, self-help support groups, and the workplace. The majority of participants said their spirituality, or the presence of a higher power, was a source of support and a protective factor in their lives. Nine of the 10 participants indicated prayer and faith as constant supports. This opinion differs slightly from prior research, such the Chatters et al. (2011) study, which focused on relationships with clergy, church leaders, and fellow churchgoers as a source of support for the Black community, although not in relation to families affected by SUD. While many participants in this study spoke of practices in the church they found supportive, such as prayer and fellowship, a few of the participants who attended church

did not feel comfortable disclosing their "family issues" there and simply used prayer as a support. These participants did not use their church community as a source of support for SUD problems in their families; instead, they focused on the practice of prayer and their spirituality.

This study affirms that spirituality, as a whole, is a protective factor for Black family members of substance users. For instance, for Participant 4, faith protected her family from succumbing to health issues and it brought her family closer together. This finding is consistent with Montgomery et al. (2014), who found that religious practices reinforced emotional coping techniques to manage life stressors. Also, the rationale for lack of religious engagement, such as poor church attendance, was associated with the family members' negative experiences with the fear of God's punishment or satanic reprisals. This unexpected finding revealed that the participants in this study subscribed to spirituality as opposed to church attendance because of their concern regarding the potential for negative experiences, such as violations of confidentiality and harmful judgment. Some of the participants worried their private business would not be kept secret and would be shared with people as gossip. Together, these results provide an emphasis on the concept of the spirituality rather than on the construct of the church. The participants in this study gave meaning to spirituality by expanding it to encompass the realm of the Divine and not just earthy relationships.

Previous researchers have focused on whether or not there are adequate supports and SUD resources and training in the workplace for professionals and practitioners working in the field of healthcare (Hutchinson & Allnock, 2014). Also, participants of the Hutchinson and Allnock (2014) study revealed work colleagues did not recognize the

need for supports for family members affected by SUD. However, three participants in this study reported their professions were a source of support to understand SUD and their own family dynamics better. In contrast to previous research, these participants focused on their field of work rather than on the perceived support from colleagues in workplaces. This unexpected finding explored career and occupationally related support, rather than support from colleagues in the workplace. In fact, the workplace was not seen as a source of support at all, partly because Black people exist as a misunderstood or isolated minority in a predominately White environment. The topic of SUD has already stigmatized the Black community and bringing it up in the workplace would further malign Black family members. However, the participants' professions were a source of support because they gave the participants specific knowledge and skills with which to understand SUD, both in a general context as well as within their own families where they were struggling with SUD-related issues. Therefore, the participants learned indirectly about SUD through their work and applied these skills within their own families.

From the perspective of community-based support, few participants were familiar with self-help meetings such as Al-Anon, Nar-Anon, and other family-member support meetings. The three participants who had attended self-help meetings, specifically Al-Anon and Nar-Anon, each spoke about being the only Black person present. Listening to other family members experiencing similar circumstances was said to be helpful. Yet, the participants emphasized feeling uncomfortable and out of place because of their race. A significant difference between this study and the previous literature is the cultural component. Although the participants in the Stenton et al. (2014) study were concerned

with the accessibility of self-help support groups, the sample was predominantly White. Although self-help support groups are open to the public and cannot discriminate by race, the previous studies suggest by the demographics of the participants that the self-help support groups did not meet the cultural needs of Black family members of substance users. Therefore, their research cannot corroborate the cultural experience of isolation as expressed by the participants of this study. The importance of cultural inclusion and diversity was reiterated by participants in this study when discussing professional services relating to and practitioners of SUD.

Formal supports. Formal supports are professional services provided by experts. For this study, formal supports pertain to counseling services and therapy. The majority of the participants in this study had experience with counseling services. The participants spoke of the benefit of having a safe outlet to discuss their concerns and address generational trauma. However, the participants expressed concerns about the accessibility to clinicians of color and their SUD knowledge. There are similarities between the attitudes expressed by the participants in this study and those described by Cohen-Filipic and Bentley (2014), who noted that family members complained about a lack of diversity in clinicians and the need for increased outreach to families. These findings corroborate those of this study, where participants noted the challenge of finding a Black clinician, or they described feeling unheard by often White professional service providers. The results relating to formal supports are emphasized further in the section on Research Question 3 about barriers and obstacles that prevent access to formal supports.

Research Question 2. From the perspective of family members of substance users, how, and in what ways, does support help families? The family members

perceived that the support they received from relatives, friends, and community programs or services did not meet their needs. Every participant expressed gratitude for their informal supports while expressing a need for more semiformal and formal supports. As described in the subtheme of intimate relationships, the way family members perceive supports is primarily through their relationships with close friends and relatives. In the past two decades, several researchers have sought to determine how supports help the families of substance users. In the Arlington and Miller (2000) study, different variables were attached to informal supports for families. They included material, practical, informational, and emotional support provided to family members of substance users. Concerning material support as it relates to the participants in this study, those who were children of substance users recalled receiving monetary support once or twice from other relatives during their early childhood years. In terms of practical support, the participants did not remember receiving help with daily tasks or chores from anyone other than a spouse or a relative with whom they shared a residence.

The concepts of informational and emotional support are central to understanding how support helps family members. Informational supports signify access to resources, written material, literature, media pages, web pages, or books for the affected families of substance-using individuals (Arlington & Miller, 2000). Perhaps the most striking finding of this study is that none of the participants in the study could attest to receiving or being recommended any informational support. Family members sought out these resources on their own by conducting independent research. The challenges of accessing informational support is elaborated on in Research Question 3; however, it is worth noting that Platter and Kelley's (2012) study of predominately White participants demonstrated how

informational supports could help family members because they allowed the family to engage in educational groups; to learn coping skills, tools, and techniques; and to access a broad range of other SUD-related resources. Further, the family members felt emotional support being amongst not only experts but people in similar circumstances to themselves, which suggests such support and educational groups can serve a dual purpose by providing information and skills and by offering the support and solidarity of people in similar circumstances. Building on Platter and Kelley's (2012) study, the participants in this study found the limited access to informational supports contributed to feelings of inadequacy, isolation, and emotional turmoil.

This study supports evidence from the clinical observations by Stewart (2003), who emphasized the influence of interpersonal relationships and emotional support. According to Stewart (2013), warm or close relationships were indicative of family stability and, therefore, contributed to a reduction in a relative's substance use. Given these findings, it was contrary to the researcher's expectations that this study found close ties with the substance-using relatives that did not have a bearing on their SUD. Instead, the close relationships were an indication of possible emotional healing. Although the participants wanted their relatives to stop using substances, the decision was beyond the participants' control. There were, however, moments in which the participants gained insight into the experience of SUD from conversations with their substance-using relatives. The discussions with participants' relatives permitted reconciliation and reinforced a sense of emotional support from the substance-using relative to family members. Therefore, if the family member had not had a close relationship with their substance-using relative, they would not have been able to engage in a conversation to

resolve the negative emotions. Therefore, it seems that family members are most empowered when they are given accurate information and the knowledge to make informed decisions regarding their substance-using relative.

 Research Question 3. From the perspective of family members of substance users, what obstacles exist in accessing and utilizing supports? The systemic oppression of Black people, both historically and today, has undoubtedly contributed to the strategies chosen for coping with the SUD dysfunction within the Black community. The prevalence of SUD in the Black population indirectly prevents family members from accessing supports because resources are generally allocated to the substance users. This study has demonstrated that there were both internal and external barriers. The internal barriers were cultural influences relating to the family cycle, distrust of others, and codes of silence. The external barriers were stigma, institutional obstacles, and programmatic constraints. Taken together, these are prominent barriers that prevented the participants from accessing much-needed support.

 Internal barriers. The issues relating to internal barriers are woven into the fabric of the Black identity. The cultural influence of SUD in the Black community places individuals at higher risk of exposure because of its prevalence in impoverished communities (Chatters et al., 2011), but it normalizes the severity of SUD. All of the participants in the study recalled being exposed to substance use at an early age, and yet, not once was there a family discussion about SUD. Similar to the findings of McCann et al. in 2017, instead of addressing familial issues, the families in this study adjusted to the substance user's absence, mood changes, and behaviors. This finding broadly supports the work of other studies in this area, linking perceptions of weakness to trust (Chatters et

al., 2011; Gaston et al., 2016; Stewart, 2003). Nearly all of the participants reported that the delay in help seeking was derived from the belief that asking for help makes one weak and that one should "Show no sign of weakness." The most significant finding was the code of silence within the Black community. All of the participants mentioned iterations of "What goes on in the house, stays in the house." A possible explanation for the code of silence is what other studies have called generational distrust (Gaston et al., 2016; Hatcher et al., 2018; Williamson et al., 2019). One surprising variable that was found to be significantly associated with the code of silence was the crack epidemic. Previous researchers have detailed how the crack epidemic ravished the Black community and disrupted the lives of Black families (Alexander, 2010; Cooper, 2015; King, 2008). However, this study found the shame associated with family members having a crack-using relative prevented them from accessing support. Overall, this study is a record of Black family members' accounts of substance users. The participants found previous generations had "hoarded" the information by remaining silent about family issues, while the newer generation was intent on breaking the cycle with open discussions to promote healing.

External barriers. The external barriers were expressed as indirect influences and factors that prevented family members from accessing support. The family members acknowledged institutional problems with systems, programmatic obstacles in the community, and stigma toward families of substance users. This is consistent with the literature that found challenges were related to misinformation (Cohen-Filipic & Bentley, 2015), awareness of supports (Sell & Major-Blacks, 2016), stigma (Hutchinson & Allnock, 2014), and professional training (Hardy & Qureshi, 2012; Johnson & Young,

2002; Platter & Kelley, 2012). The participants described incidents of getting inaccurate

information as to where and how to get support. Often the participants expressed

frustration about the lack of awareness of a program's very existence because of minimal

visibility and publicity.

While the findings of the Witte et al. (2019) study focused on the perception of

public stigma toward SUD, this study found that there was public stigma toward the

family members of substance users as well. The participants recalled incidents of public

shame and embarrassment from people in their neighborhood. Family members were

being judged and scrutinized for their relatives' SUD and for their continued relationships

with the substance-using relatives. These results suggest that families want to be seen and

understood without feeling shame. Recurrent obstacles that have prevented family

members from accessing supports are illustrated by the limitations with professional

services providers. In the broader literature, Black family members expressed a need for

clinicians who are culturally aware (Jeffers, 2019), educated and trained in SUD (Cohen-

Filipic & Bentley, 2015; Cox et al., 2013; Stenton et al., 2014), and sympathetic to family

members (Galvani et al., 2013). Overall, from the perspective of the family members of

the substance users, the desire to access support may be overshadowed by numerous

obstacles and challenges. The family members revealed such obstacles within supports in

their home, community, and society. Therefore, a theoretical framework was used as a

lens to understand the influence of supports in multiple environments.

Bronfenbrenner's (1979) Ecological Systems Theory

This study used Bronfenbrenner's (1979) ecological systems theory as a

theoretical framework to understand the implications of supports for family members in

the home, community, and society. The ecological system is a multilayered lens to demonstrate different influences in the world and changes over time (Bronfenbrenner, 2005). This systems approach focuses on the family rather than the individual, and it shows families are interdependent. The theoretical framework provides a useful account of family members' perceptions of supports as viewed through the microsystem, mesosystem, exosystem, macrosystem, and chronosystem.

The first sphere of the ecological system is the microsystem, demonstrated by relationships in a person's immediate environment. Within the scope of this study, the microsystem is the informal support comprising intimate relationships with friends, family, and significant others. The second sphere in the ecological system is the mesosystem, which comprehends the interactions of the microsystems. This study includes in the mesosystem the interpersonal family relationships between other relatives, fellow churchgoers, and the other members of support groups. The third sphere of the ecological system is the exosystem. The exosystem encompasses environments that have indirect influences on family members, which include the psychosocial and protective factors for families, such as spirituality, careers, law enforcement, and SUD training. For example, in this study, the family members gained insight into SUD by working in careers that served individuals with SUD or families affected by SUD. The fourth sphere of the ecological system is the macrosystem, which encompasses cultural values as well as structural systems like politics. The macrosystem, in the case of this study, refers to stigma, cultural influences, policies related to SUD, and psychological barriers, specifically shame and emotional distrust. The last sphere of the ecological system is the chronosystem, which refers to historical events and experiences that occur across a

person's lifetime. The participants reflected on vivid memories that held lasting influence on their lives and continued to impact the other spheres in the system.

No prior research has attempted to model the dynamics of support for family members affected by SUD using Bronfenbrenner's (1989) ecological systems model. The model contextualizes these dynamics by placing the family member in the center and distancing the supports around them based on the spheres in which they belong. The sphere closest to the family members is the informal support made primarily of friends and family. The informal supports are most accessible to family members, therefore, they are the most used. The farther away supports are from the center radius, the more challenges family members experience when trying to access them.

Bronfenbrenner's (1979) ecological system is aligned with both the research questions and the four identified themes. The microsystem and mesosystem are illustrated by Research Question 1 and Theme 2: types of family-member supports. The participants demonstrated the interactions in the microsystem and mesosystem by discussing the supports they used and how those supports related to different aspect of their lives. The intimate relationships of friends, relatives, and significant others are informal supports, spirituality is a semiformal support, and the community-based supports are both semiformal and formal supports.

The exosystem aligns with Research Question 2 and Theme 1, health and wellness, demonstrating the influence of the indirect environment. The emotional distress and psychological well-being endured by the participants was, in part, related to their substance-using relatives. In caring for their substance-using relative, family member neglected their own self-care needs.

The macrosystem aligns with Research Question 3 and Theme 3, challenges and obstacles demonstrated by the barriers, stigma, and societal values of distrust. The institutional barriers revealed issues relating to policies and governments that minimize the need for family engagement in SUD programs. At the same time, the stigma and the societal value of distrust present in the Black community undermine the experience of the Black community and prevent family members from seeking help.

Lastly, the chronosystem aligns with Research Question 3 and Theme 4, the cultural influences across a person's lifetime. Current generations unconsciously perpetuate historical events and occurrences when the issues surrounding SUD are left unaddressed by families. The maladaptive behavior of Black families will continue until the cycle is broken. The ecological systems theory is the fundamental framework in understanding the complex experiences of Black family members of substance users. Given the circumstances of the dearth of literature on Black experiences relating to SUD supports, future research can explore the implications of this theoretical framework further.

Limitations

The primary goal of this research was to gain insight into the experience of Black family members of substance users and to understand their perceptions of substance-use supports. This IPA study gives meaning to the lived experiences of the Black family members of these substance-using individuals. It also provides an opportunity to unpack and explore the meaning of these experiences regarding its relevance to the body of literature on SUD and families affected by SUD.

The main limitation of this study was that the data were collected from only three regions of NYS. The inclusion and exclusions criteria limits of family relationship required 5 years of a shared residence, and relatives' alcohol and/or drug use within 5 years. The narrow context and participant criteria could potentially limit the transferability of this study into other settings. In addition, the small sample size may not be generalizable compared to a larger sample. However, for the purpose phenomenological studies, small samples are recommended.

Lastly, the interviews were conducted virtually using the Zoom platform instead of in person. The limitations of virtual interviews were ensuring that the participants had a private and quiet location to complete the interview, reliable technology and a secure Internet connection, and a loss of nonverbal communication from body language.

Recommendations

There is abundant latitude for further progress in understanding Black family members of substance users and their sources of support. This is an important issue for future research because Black families have been understudied and invisible in the literature. Further studies that take these variables into account will need to be undertaken. The initial recommendations presented here will assist professionals working with affected families and they will be informed by the family members of substance-using relatives. The second set of recommendations will strengthen policy, practice, and future research.

Recommendations for policy, practice, and future research. A possible approach to helping family members of substance users is first to understand their lived experiences and then to provide the resources for them to recover and heal. The results of

this study have led to several recommendations for policy, future research, and improved practice. The recommendations include ways for supports and services to make changes and improve engagement.

  Recommendations for policy. The results of this study have led to recommendations for education and training changes in the behavioral health field. These are recommendation for educational leaders responsible for setting student learning standards and developing curricula. It is recommended that behavioral health-related certification and all collegiate programs be revised to require SUD courses. Currently, SUD courses are offered as an elective—if at all. The changes to the educational coursework, itself, can be to increase the knowledge of SUD for professionals entering the field.

  It is recommended for behavioral health organizations to require all practicing clinicians to participant in SUD trainings. For clinicians already in the field of SUD, training about the influence SUD on family dynamics is recommended. As a best practice, training should be provided on an ongoing basis and be easily accessible to professionals. In addition, SUD-related resources should be available in all behavioral health practices to increase the visibility of informational supports for families affected by SUD. Lastly, for leaders in behavioral health organizations, hiring practices should be examined. It is recommended to cultivate diverse clinicians to improve equity and inclusion of clinicians of color. In addition, the recommendation is to revise existing cultural competence training to ongoing cultural awareness workshops. These policy changes in the field of behavioral health can only improve practices for families with substance users.

Recommendations to improve practice. The findings of this study have helped to create a roadmap for understanding the lived experiences of Black family members of substance users, and the findings have suggested ways for them to heal. Table 5.1 demonstrates recommendations for improving practice specifically for professionals and family members of substance users to better support families' healing.

Table 5.1

Supportive Healing Stages and Recommendation

Stages	Description	Support Recommendation
1. State of uncertainty	A vague understanding of SUD and no knowledge of a relative's substance use	Early intervention in schools and after-school community programs
2. State of awareness	The development of knowledge, learning the signs, and changing behavior when a relative is under the influence	Support groups specializing in written material specific to families and self-care practices
3. State of confusion	More questions, bargaining, pleading, and self-blame	Outreach to family members for family counseling, education on the treatment process, and inquiry into well-being
4. State of reconciliation	Acceptance of powerlessness over a relative's SUD and reassessment of relationships with relatives	Self-help support meetings for families in similar circumstances
5. State of self-acceptance	Self-love and regained power for self-removal of external shame, acknowledgment of hurt	Individual counseling and therapy

Supportive healing stages and recommendations. The supportive healing stages in this section were informed by the sentiments expressed by the participants of this study to improve practices. The participants explicitly provided recommendations for families with SUD and SUD professionals. All five stages vary in the length of time a person would be in each stage and, overall, they are subject to family members' acceptance of the support. The stages suggest early intervention to destigmatize SUD and increase

visibility within the home, community, and society. Thus, improving visibility will first increase family members' awareness, availability, and comfort with SUD-related supports and services.

The first stage, the *state of uncertainty*, is the ground-level stage where all family members begin. In the state of uncertainty, family members may be unaware of their relative's substance use disorder or assume their relative is engaging in the recreational use of substances. Family members can experience happy oblivion to the SUD being present in their family. It is recommended to provide families with early-intervention information so they can learn about SUD.

In the second stage, the *state of awareness*, the family members know the relative has an SUD. In the state of awareness, family members begin to discover the depths of the relative's substance use. At this time, family members may question their relative's behavior and seek informal supports. For school-aged children, it is recommended that they participate in support groups for families affected by substance use. Children must have a safe space, guarded by policy, to minimize the risk of reprisal in terms of reports of abuse or neglect in their homes. This recommendation is supported by literature and this study that shows that the children did not have support in school to address their family dynamics. The recommendations for adults are similar, but they should be in community support groups or online support groups that vary by level of experience, so they are less intimidating for newcomers. Particularly, it is recommended to create a safe and private space just for Black family members.

The third stage, the *state of confusion*, refers to family members seeking a way to understand their experiences with their substance-using relative. In the state of confusion,

the family members may try to bargain and plead with their relative to stop using substances. Most significantly, family members may blame themselves and question their relative's affection toward them. At this stage, family members may use their power in the relationship to get the relative into treatment. It is recommended that an outreach effort to the family be provided as part of treatment and to maintain ongoing communication and education about the treatment process. It is vital at this time to assess the health and well-being of all the family members.

The fourth stage, the *state of reconciliation*, occurs both externally with the substance-using relative and internally within family members. The state of reconciliation includes agreements in which families decide how to engage with one another. Family members erect boundaries and accept they are powerless in making their relative change. Most critically, in this stage, family members reassess their relationships and decide how accessible they will be to the substance-using family member. It is recommended at this stage that family members participate in self-help support groups to develop a separate identity from the substance-using relative and their SUD. The comradery of people experiencing similar circumstances and social support of self-help systems is essential to improving a sense of self-efficacy and overall emotional well-being.

In the fifth and final stage, the *state of self-acceptance*, family members experience self-actualization and transformation. The state of self-acceptance allows the family members to shed the feelings of guilt, shame, and blame. In this stage, family members can begin to address unhealed wounds within the family and restore the power they lost. It is recommended that clinicians be adequately trained in SUD and be informed of cultural challenges experienced by Black families. Further research on Black

family members of substance users could elaborate, in culturally specific ways, on these supportive healing stages. There is also an opportunity for research to further explore the supportive healing stages and their application in family-based programs.

    Recommendations for future research. Research on family members of substance users often generalizes across populations, and future research should address cultural complexity. Acknowledging the Black experience is the key to understanding the Black community and the family dynamics within the Black community. In the future, it may be beneficial to (a) focus on a larger sample, (b) consider multigenerational families, and (c) sample participants nationally and internationally.

    Examining families generationally can provide insight to the family values and unearth beliefs validating the family cycle. The variation in family relationships can provide a unique perspective into the differences across Black families. In addition, given that females were overrepresented in this study, future research should consider recruiting more males. Lastly, a national and international phenomenological research on this topic would be useful in illuminating the experiences of all Black family members of substance users.

    Further research is needed to explore the findings that revealed SUD-related professional careers and occupations that contributed to family members' sense of support. This study could be replicated with a sample of professionals working in the behavioral health field and human services who have substance-using family members.

Conclusion

In today's social climate, social justice is needed more than ever. This study is designed to give a voice to Black family members of a substance user because their needs and wants are seemingly invisible. There are few services that provide support for families affected by SUD. The perceptions regarding SUD supports originate from the prevalence of substance use in the United States. With more than 20 million people reportedly diagnosed with SUD (SAMHSA, 2019b), less than 3 million of those people reported were Black (SAMHSA, 2020). However, the national perception is that people in the Black community are the predominant substance users. The literature suggests impoverished Black communities are predisposed to higher rates of poverty, criminal activity, lack of access to healthcare, and health-related issues (Gaston et al., 2016; Lewis et al., 2011; Oser et al., 2019). Resources and improvement programs are scarce, underfunded, and often inept in Black communities (Booth & Anthony, 2015; Chatters et al., 2011). Concerning SUD, funds are diverted to focus on the criminalization and imprisonment of substance users, which dismantles the family system (Alexander, 2010; St. Vil, 2015). Given the nature of the generations of trauma and lack of trust in others, Black communities are resistant to public services and institutions. The purpose of this study is to give a voice to the Black community, particularly the family members of substance users who have been invisible and neglected by SUD supports.

Supports for Black family members of substance users have not been adequately studied despite people suffering from SUD-related issues. The previous research focused on family members of substance users is from the perspective of predominately White populations. The studies relating to supports for Black people do not address the

influence of SUD issues. Therefore, the studies are missing vital elements needed to understand how SUD supports influence the social, spiritual, and cultural issues in Black families of substance users.

The IPA method unearthed the phenomenon of Black family members and gave meaning to SUD supports. The 10 participants provided rich accounts of their lived experiences through virtual interviews. After an iterative process of data collection and throughout the analysis of the data, codes were developed into patterns, then they were extrapolated into themes. The four themes that emerged were health and wellness, family-member supports, challenges and obstacles, and cultural influences across a person's lifetime.

Theme 1, health and wellness, emphasized the influence SUD has on family members. The family members' emotional, physical, and mental health can become compromised from excessive stress and worry about their substance-using relative. Theme 2, types of family-member supports, alluded to the supports used by the Black family members. The family members expressed categories in their use of supports, such as intimate relationships, spiritual relationships, and community-based supports. At the same time that the family members attested to some helpful supports, there were obstacles that prevented the Black families from accessing supports. Theme 3, challenges and obstacles faced by Black families members, subjugated family members to the same negative stigma as the substance users, and the attacks were fixated on how society perceived the value, self-worth, and self-image of their substance-using family members. The most common obstacles the participants faced concerned barriers relating to the visibility of supports, cultural inclusions, their knowledge of SUD, and the availability of

ethical professionals. Cultural identity, which is rooted in trust, was a precursor for the Black family members to engage in supports and services. Theme 4, the influence of culture across a person's lifetime, explained the generational issues, cultural values, and maladaptive behaviors metastasized within SUD-affected families. The family members alluded to the family cycle of early exposure, trauma, and codes of silence repeated over generations. Bronfenbrenner's (1979) ecological systems theory, first used as a lens to understand the influence of an individual's environments, was readapted to understand the influence of substance use on the user's family members. As such, the ecological systems theory was indirectly aligned with the four themes and three research questions. Through the narration of the lived experiences of the Black family members of substance users, recommendations were offered to improve future practices and research.

This study set out to gain a better understanding of the perception of SUD supports for Black family members of substance users. The supportive healing stages were developed from the contributions by the participants of this study. The recommendations for affected family, policymakers, and future researchers are grounded in research from previous scholars and the research from this study. Researchers have overlooked the experience of Black family members by focusing on predominately White participants who cannot address the influence of cultural identity in the Black community. The literature that does exist serves to obscure the needs of the Black community instead of addressing them. It is now possible to argue that Black family members of substance-using relatives rely on the intimate relationships of informal supports and that the most useful support for family members—the empowerment that comes from being given accurate information that can inform decision-making. Primary

obstacles preventing access to supports are both internal and external. However, Black

family members of substance users are not resistant to SUD supports when services are

attuned to their cultural needs.

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Appendix A

Semi-Structured Interview Questions

Purpose of the study: This study will explore the experience of Black family members of substance users, and if they received any support services, what were the experiences like? This study will add new insights into and perspectives on the current scholarly research on family-based substance use support, and it will help to discern deeper meaning and implications of the Black experience of substance abuse, as it is currently understudied and insufficiently addressed by the existing systems of support.

Participant rights: Participation in this study is completely voluntary, and participation can be withdrawn upon request of the participant at any time. Participants can choose to participate longer, and there are no repercussions for withdrawing from the study.

1. Can you tell me about your family?

    a. How does your family cope with difficult situations?

    b. Can you think of any people you feel closest to?

    c. Understanding support can be provided in various ways, such as monetary assistance with daily tasks, information, and emotional support. Can you describe your experience with various supports?

2. Can you please tell me about your relationship with your substance-using relative(s)?

   a. Can you think how your relationships changed?

   b. Can you describe any changes to your daily routine?

   c. Can you think of any events or moments that were altered because of your relative's substance use?

3. Can you think of when you first learned of your relative's SUD, and how your family handled it?

   a. Can you think of any challenges you may have experienced?

   b. Can you tell me how you have discussed your relative's substance use disorder?

   c. What do you do for self-care?

4. If you could, what advice would you give another family about being a family member of a substance user?

   a. What is the best advice that was given to you and from whom?

   b. Is there any information you wish you knew before you learned of your relative's substance use?

   c. Is there any suggestion you would give to professionals?