International Journal of Drug Policy 25 (2014) 3–12

Contents lists available at ScienceDirect

International Journal of Drug Policy

journal homepage: www.elsevier.com/locate/drugpo

Editors' Choice

Gender sameness and difference in recovery from heroin dependence: A qualitative exploration

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ARTICLE INFO

Article history:
Received 4 March 2013
Received in revised form 13 May 2013
Accepted 10 August 2013

Keywords:
Gender
Heroin use
Recovery
Recovery capital
Theory
Qualitative

ABSTRACT

Background: In recent years, 'recovery' has become a central, yet controversial, concept within the international drug and alcohol field. This paper explores gender sameness and difference in recovery from heroin dependence with reference to gender theory, the existing literature on women and drugs, and the concept of recovery capital.
Methods: Data were generated from 77 qualitative interviews conducted with 40 current or ex-heroin users (21 men and 19 women). Coded data were analysed using framework and key themes were mapped onto the four components of recovery capital: social capital, physical capital, human capital, and cultural capital. Differences between the views and experiences of male and female participants were then explored.
Results: Participants had limited social, physical and human capital but greater cultural resources. Although women reported more physical and sexual abuse than the men, they had better family and social relationships and more access to informal support, including material assistance and housing. Women also seemed to be better at managing money and more concerned with their physical appearance. Despite the salience of gender, individuals had diverse recovery resources that reflected a complex mix of intrapersonal, interpersonal and structural factors.
Conclusions: Findings are consistent with increasing feminist interest in intersectionality and contribute to a more gender-sensitive understanding of recovery. Gender was an important structure in shaping our participants' experiences, but there was no evidence of an 'essential' female recovery experience and women did not necessarily have less recovery resources than men. Whilst useful, the concept of recovery capital has a number of definitional and conceptual limitations that indicate a need for more empirical research to improve its utility in policy and practice.

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Introduction

Recovery and recovery capital

In recent years, 'recovery' has become a central concept within the international drug and alcohol field. Although there is a lack of consensus regarding what the term actually means (cf. Best, Groshkova, McCartney, Bamber, & Livingston, 2009; Betty Ford Institute, 2007; SAMHSA, 2011; Thom, 2010, chap. 4; UKDPC, 2008), it is generally recognised that recovery implies more than simply not taking drugs. Rather, it involves drug users achieving benefits in a wide range of life areas, including their relationships, housing, health, employment, and offending (HM Government, 2010; Scottish Government, 2008). In the UK, the shift towards recovery has been apparent in the policy field (as reflected in government strategies, publications by think tanks and speeches by politicians), substantial grassroots activity (encompassing both traditional mutual aid groups and new recovery communities), changes to service delivery (including less focus on keeping individuals in treatment and more emphasis on ensuring that they leave treatment drug-free), and altered funding structures (such as moves towards payment by results) (Duke, Herring, Thickett, & Thom, 2013).

Whilst advocates argue that recovery-focused treatment will prevent individuals from being 'parked' on substitution medication and provide a welcome opportunity to raise service users' goals and aspirations, concerns have been voiced across the sector. For example, the term 'recovery' has repeatedly been used interchangeably with the word 'abstinence', so undermining services operating within a harm reduction framework (Neale, Nettleton, & Pickering, 2011). Furthermore, recovery, and particularly abstinence-based

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http://dx.doi.org/10.1016/j.drugpo.2013.08.002

recovery, interface closely with traditional neoliberal values of decentralisation, voluntarism and a moral discourse of 'personal responsibility', that can then be deployed to scapegoat and blame individuals, as well as erode state-funded services (Duke et al., 2013). A focus on recovery-oriented treatment, particularly where payments are linked to abstinence-related outcomes, may also encourage service providers to cherry pick new clients who seem most likely to meet desired targets and neglect individuals with more complex needs (Dawson, 2012).

As the concept of recovery has spread across the drug and alcohol sector, the related construct of 'recovery capital' has also gained currency. Recovery capital refers to the sum of resources that an individual can draw upon to initiate and sustain recovery processes and has been introduced into the addictions field by two American social scientists, William Cloud and Robert Granfield (Cloud & Granfield, 2001, 2008; Granfield & Cloud, 1999). Drawing upon the earlier literature on social capital (e.g. Bourdieu & Wacquant, 1992; Bourdieu, 1986; Coleman, 1990; Putnam, 1993) and their own qualitative studies with individuals who had overcome their addictions (Cloud & Granfield, 1994; Granfield & Cloud, 1996), Cloud and Granfield have argued that recovery capital comprises four key components. These are: *social capital* (relationships, including family, friends, and broader social networks), *physical capital* (income, savings, investments property, and other tangible financial assets), *human capital* (education, knowledge, skills, hopes, aspirations, health, and heredity), and *cultural capital* (values, beliefs, and attitudes that link to social conformity and the ability to fit into dominant social behaviours) (Cloud & Granfield, 2008).

According to Cloud and Granfield (2008), people who have access to recovery capital are better placed to overcome their substance misuse-related problems than those who do not have such access. Nonetheless, an individual's personal circumstances, attributes, behaviours, values or relationships can impede their ability to cease drug taking; in which case their recovery capital might be described as negative. In discussing negative recovery capital, Cloud and Granfield have noted the specific challenges that women face when attempting to terminate substance misuse. These include higher rates of mental health problems than men, elevated levels of abuse and extreme violence, emotional scars accumulated through prostitution, and greater social stigma that creates barriers to help seeking (Cloud & Granfield, 2008). Additionally, Cloud and Granfield have suggested that shame and the threat of losing custody of children can paradoxically motivate women to eliminate substance misuse from their lives and thus be a source of positive recovery capital for them (ibid.).

In this paper, we utilise data from 77 qualitative interviews conducted with 40 current or ex-heroin users (21 men and 19 women) to explore gender sameness and difference in recovery from heroin dependence. Specifically, we investigate the extent to which women and men share experiences of recovery and recovery capital or have different experiences and resources. Our analyses evolve from our readings of gender theory and the existing literature on women and drugs, and contribute to a more nuanced understanding of recovery capital that might inform future research, policy and practice.

Gender theory

Prior to the 1980s, feminists argued that there were essential differences between women and men and all women shared common experiences resulting from their oppression by all men (Ramazanoglu, 1989). Reflecting this, feminist theorising frequently attempted to explain women's lives by reference to an essential 'we' of womanhood (e.g., Chodorow, 1978; Daly, 1978; Gilligan, 1982; Miller, 1973; Mitchell, 1974). This was contrasted to a male 'other', and commonly expressed via rudimentary binary oppositions, such as: male and female, public and private, work and home, production and reproduction, and subject and object.

Towards the end of the 1980s, the concept of sameness and shared oppression was challenged as many women began to argue that feminist generalisations had prioritised the experiences of white, middle-class, educated females and neglected their own lives (e.g., Davis, 1982; Hooks, 1982, 1984; Smith, 1983, chap. 1). In addition, the presumed consensus about what was, or was not, good for women was questioned and assumptions about the inherently exploitative nature of issues such as pornography and sex work were reconsidered (Gillis, Howie, & Munford, 2007). Responding to this, a new genre of feminists began to critique 'essentialist' definitions of femininity, emphasising that women had very diverse experiences based on their race, gender, age, class, nationality, sexual orientation, values, culture, politics, individual biography and so on. Moreover, these differences meant that some women held and exercised power over other women and some women shared political and economic interests with some men (Ramazanoglu, 1989).

Since then, feminists have adopted a range of political and theoretical positions, but often tended towards post-structuralism. This has involved questioning the power of social structures (such as patriarchy, class or race) to determine women's experiences (Holmes, 2007) and, instead, prioritising personal experience, individual agency, choice, fluidity and change. Post-structuralist feminism is largely 'deconstructive' in nature; that is, it denies the existence of single oppressive forces, overrides hierarchical binary oppositions, and rejects the notion of the essentialist 'woman'. Instead, difference and diversity are celebrated, the power of discourse to shape reality is emphasised, and language is prioritised over the material. Accordingly, the meaning of concepts – including 'woman' and 'female' – are deemed contingent, culturally constructed, and fundamentally unstable.

Post-structuralist feminism is now theoretically well developed, but there are concerns that it has become too 'academic' and undermined the capacity for collective activism by destroying the meaning of 'woman' (Connell, 2009; Moi, 1999). As Phillips (1992, chap. 2) has argued, the universalisms of gender and of woman may be suspect, but to rely on personal experience alone, and to leave women to define their own political priorities on the basis of the contradictory ways in which they are oppressed, leads to political fragmentation and divergence. Furthermore, post-structuralism's focus on difference, deconstruction, language and discourse denies the many experiences that women share and has deflected attention away from the ways in which women's lives are physically and materially constrained by both social and biological factors (Connell, 2009; Holmes, 2007).

In response to these concerns, feminists have continued to search for theoretical approaches that treat gender as an important structure, but simultaneously recognise that it is multidimensional, differs from one cultural context to another, and is interwoven with other social structures (Connell, 2009). One promising way forward has been offered by intersectionality: a paradigm that has often been used within the health field to illustrate how women's experiences are shaped by gender, in conjunction with other factors, including race, class, culture, income, education, age, ability, sexual orientation, immigration status, Indigeneity, geography, etc. (Crenshaw, 1991; Hankivsky & Cormier, 2009). An intersectional approach recognises the significance of gender, but does not assume that this is the most important axis of experience, power or oppression. Instead, the interactions between different aspects of social identity, the impact of systems and processes of oppression and domination, and the multiplicity of lived experiences are emphasised.

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