MEN ON METHADONE: FATHERHOOD, FAMILIES, AND PARTNERS

by

Megan S. Wright

A Dissertation Submitted to the Faculty of the

DEPARTMENT OF SOCIOLOGY

In Partial Fulfillment of the Requirements
For the Degree of

DOCTOR OF PHILOSOPHY

In the Graduate College

THE UNIVERSITY OF ARIZONA

2012

THE UNIVERSITY OF ARIZONA
GRADUATE COLLEGE

As members of the Dissertation Committee, we certify that we have read the dissertation
prepared by Megan S. Wright
entitled Men on Methadone: Fatherhood, Families, and Partners
and recommend that it be accepted as fulfilling the dissertation requirement for the Degree of Doctor of Philosophy

_____Date: 4/11/12
Celestino Fernandez

_____Date: 4/11/12
Ronald Breiger

_____Date: 4/11/12
Antonio Estrada

Final approval and acceptance of this dissertation is contingent upon the candidate's submission of the final copies of the dissertation to the Graduate College.

I hereby certify that I have read this dissertation prepared under my direction and recommend that it be accepted as fulfilling the dissertation requirement.

_____ Date: 4/11/12
Dissertation Director: Celestino Fernandez

STATEMENT BY AUTHOR

SIGNED: Megan S. Wright

ACKNOWLEDGEMENTS

I would like to thank my dissertation chair, Celestino Fernandez, for his invaluable assistance in obtaining access to my research field site and for supporting my research decisions, allowing the dissertation to unfold as it did. His feedback on and encouragement throughout the research process were indispensable to the completion of the dissertation. Additionally, I would like to thank my other committee members, Antonio Estrada and Ronald Breiger, for their support and service on the committee.

I would like to acknowledge the Social and Behavioral Science Research Institute for providing funding for this dissertation. The SBSRI dissertation research grant provided funds to compensate my research participants for their time.

I am thankful to the behavioral health organization that permitted me to study the methadone clinic, and I am thankful that I was welcomed at the methadone clinic. The clinic staff members were always willing to take the time to explain the everyday happenings in their work lives, and were instrumental in providing me a work place to conduct my interviews.

I am thankful to the research participants who were willing to answer my questions, which in any other setting, would be seen as intrusive.

I am appreciative of the members of my dissertation groups: Sondra Barringer, Cindy Cain, Daniel Duerr, David Melamed, and Eric Schoon. In addition to helpful feedback and encouragement, they also often provided a welcome distraction from the process of dissertating.

I am thankful for the research assistance of Benjamin Schutt, who transcribed several of the interviews and who provided feedback on several dissertation chapters.

My partner, Cindy Cain, deserves special acknowledgment. I relied heavily on her tireless support and encouragement at each stage of the dissertation. Additionally, her feedback on multiple drafts of the dissertation aided my argument formation and evidence presentation. I could have not have completed this research without her.

DEDICATION

For Cindy, Jaclyn, and men on methadone

TABLE OF CONTENTS

TABLE OF CONTENTS -- Continued

LIST OF TABLES

ABSTRACT

Women have been the focus of a great deal of research on opiate addiction and treatment because their gender is assumed to matter for their experiences in the drug world. Much of this has focused on women's experiences as mothers and caregivers. While men are often included as subjects in research on opiate addiction and treatment, their experiences as gendered beings are rarely analyzed. This research foregrounds men's gendered experiences as fathers, family members, and partners while in methadone maintenance treatment. Using data from addiction history interviews with 33 opiate-dependent men recruited from a single methadone clinic in Arizona, I find that men assign considerable significance to their family relationships. The men interviewed report that their experiences as fathers, grandfathers, sons, grandsons, brothers, husbands, and boyfriends both motivate them to seek methadone treatment for opiate addiction, and cause stress that sometimes pushes them to use or relapse on opiates. Given the importance of these men's family relationships, I argue that the marginalized masculinity of impoverished, drug-dependent men includes an ethic of care. Additionally, I argue that counselors in methadone clinics should consider men in the context of their family relationships in order to provide better treatment to men struggling to recover from opiate addiction.

CHAPTER ONE: INTRODUCTION AND LITERATURE REVIEW

In 2009, over 600,000 Americans age 12 and older abused heroin, and over 16 million Americans age 12 and older abused prescription medications, much of which are opiates (NIDA "Heroin" 2012). Given that an estimated 23% of opiate users will become dependent on opiates, and that injection of opiates is associated with the spread of HIV/AIDS and hepatitis as well as an increase in crime (NIDA "Prescription Medications" 2012), it is important to study opiate addiction and treatment as a social and public health problem.

Social scientists, however, have tended to focus more on drug addiction rather than drug treatment. In the few social scientific studies of treatment, researchers tend to neglect the perspective of the patients (Hunt and Baker 1999). This dissertation focuses on the perspectives of men in treatment for opiate addiction to address these two gaps. One common form of treatment for opiate addiction is methadone, which is a synthetic opiate that prevents an opiate addict from going into withdrawal and blocks cravings for opiates (NIDA "Heroin" 2012). Researchers have noted that from the opiate addict's perspective, using on the streets cannot be separated from being treated in clinics (Hunt and Baker 1999; Rosenbaum 1981). Given that treatment potentially reduces the social problems noted above, it is important to evaluate patients' experiences in treatment.

Many drug researchers have been cognizant of the potential for gender differences in drug addiction and treatment and have made women drug users the explicit object of analysis, assuming that women's gendered experiences and family relationships matter

for their treatment motivations and outcomes (e.g., Fraser 1997; Friedman and Alicea 2001; Rosenbaum 1981). While men are often research subjects in studies of opiate addiction and treatment, they are typically not studied as gendered beings embedded in family relationships. As Gerson (1993) notes: "Although we have grown accustomed to using gender as a category for analyzing women, we are less comfortable when the subject is men. Yet it is unquestionably true that men's outlooks reflect their experiences as *men* rather than as prototypical humans" (12, emphasis in original).

This dissertation will address the gaps in social science research by focusing on men's gendered experiences in methadone treatment with particular attention to the role of family relationships in using, abstaining, and taking treatment seriously. This dissertation uses interview data from 33 opiate-dependent men in methadone treatment at a public methadone clinic in the Southwest to explore how men report that their statuses as fathers, grandfathers, sons, grandsons, brothers, husbands, and boyfriends matter in their decisions to seek treatment and their outcomes in treatment. The dissertation explores the diversity of men's experiences and examines whether there are ethnic differences to any familial effects. Additionally, the dissertation speaks to the growing literature on masculinity by showing the ways that new definitions of masculinity may include forming and valuing relationships with others.

This chapter will review the literature on opiate use and gender, opiate use and ethnicity, drug use and family relationships, masculinity, fatherhood, and men's other family relationships in order to set up the remainder of the dissertation, which seeks to answer the following questions:

What is the state of fatherhood among men who are clients at Second Chances? How do men perceive that their status as fathers influences and is influenced by their participation in the opiate drug world? Are there ethnic variations in fatherhood ideals and practice? What do these men's narratives mean for fatherhood and masculinity more broadly? Has the "new father" ideal reached this marginalized and stigmatized population?

How do men on methadone talk about their families of origin? How do men perceive the quality of their family relationships? What role in men's opiate addiction and treatment do men ascribe to their family of origin? Are there racial and ethnic differences in family dynamics with these men? What do these findings mean for masculinity more generally?

How do these men talk about their partners and former partners? Are there any ethnic differences in men's relationships with their partners? How do men describe the impact their partners have on their opiate addiction and treatment? What might these men's relationships with their partners say about masculinity more broadly?

OPIATE ADDICTION AND TREATMENT

Opiates and Gender

Early studies of opiate addiction were interested in questions of opiate use (Lindesmith 1947), opiate addiction formation (Lindesmith 1968), and opiate addiction treatment (Dole and Nyswander 1965). Most of the individuals studied tended to be men, although published work contained the occasional case study of a female subject. Men

dominated the scholarly literature because they made up the great majority of heroin addicts (Courtwright 2001), but also because they were on the streets, and street addicts were easily accessible to researchers when denied access to institutions such as hospitals and prisons (Lindesmith 1968). General conclusions were drawn about opiate use, addiction, and treatment based on samples of mostly men. Ethnicity was also not a focus of this early research, despite the fact that minorities have constituted an increasing proportion of addicts since the 1950s (Courtwright 2001).

Researchers assumed their subjects represented universal truths about opiate use, addiction, and treatment. Not until the late 1970s were their conclusions challenged by others who argued that it should not be assumed that women experienced the opiate drug world in the same way as men. Rosenbaum (1981) did groundbreaking work on women heroin users, interviewing 100 women heroin addicts, evenly split between black and white subjects, the great majority of whom resided in San Francisco. Until Rosenbaum's research, women heroin users were assumed to be either nonexistent or to have the same experiences as men. Rosenbaum (1981) troubled this assumption by framing her research question simply as: What are the experiences of women heroin users?

Interestingly, Rosenbaum (1981) did not find many significant differences between men and women users in their pathway to initial heroin use. However, following from Lindesmith's (1968) conceptualization of addiction,[1] Rosenbaum (1981) found that women heroin users realized that they are addicted when their use impacted

[1] Lindesmith (1968) argues that addiction is not a natural response, but is socially and culturally constructed. Those who use heroin regularly will build up a physiological dependence on it, but it is not until they interpret the symptoms they experience when not taking it as "withdrawal," that they come to see themselves as drug addicts.

their family life—either through neglect of their children or male partner or by stealing from family to support their habit. From Rosenbaum's study, it appears that family relationships play a key role in the recognition, understanding, and interpretation of opiate addiction for women.

The women in Rosenbaum's (1981) sample who were mothers (70%) had all accepted the cultural ideals of motherhood, and so when they failed to live up to them because of their heroin addiction, they not only felt guilt, but saw themselves as having failed as women. Additionally, when their children were removed from their care, they fell deeper into addiction because they no longer had an incentive to try to remain drug-free and because they were attempting to deal with the pain that comes from believing they failed as women. Rosenbaum's (1981) sample also universally condemned pregnant addicts who gave birth to opiate-dependent babies who immediately began going through opiate withdrawal. Addicts who gave birth in hospitals also had to endure poor treatment from healthcare providers who judged the women for their addiction. Being able to adequately mother while maintaining their heroin addiction was a source of pride for these women, but often they neglected their children when they were "dopesick" or had to go out to find money for heroin. Some women chose to give their children to relatives, especially black women who had extended kin networks (see Stack 1974 for a discussion of African-American kin networks). Less frequently, the state removed children from the woman's care.

Rosenbaum (1981) also studied methadone treatment, which she argues has become part of the heroin scene, "a drug phenomenon of its own" (105) rather than a path

to a drug-free life like it was intended to be (Dole and Nyswander 1965). Methadone was initially considered an attractive form of drug treatment because it reduced crime and got the patients to a clinic to receive other services (e.g. psychological counseling).[2] Women have problems with this form of treatment, however, because of their family obligations and the lack of facilities for children (Fraser 1997; Rosenbaum 1981). Because neither Lindesmith (1968) nor Rosenbaum (1981) focused on men's family relationships as they relate to opiate use, addiction, and treatment, this question needs to be explored.

There have been many cultural and structural changes to men's lives, masculinity, and the family since Rosenbaum's study in the late 1970s, and it may be the case that addict-fathers are more involved with their children and have experiences similar to the women Rosenbaum interviewed. Rosenbaum (1981) claims that "[h]eroin becomes the focus of his [male addict's] life and takes precedence over all other endeavors" (104) compared to women who still have family concerns, but given the social shifts since her study, her conclusions become empirical questions.

Following 20 years later, Friedman and Alicea (2001) studied 37 women on methadone maintenance, and the goal of their research is to undo stereotypes of women addict. They use a Foucauldian theoretical perspective, and emphasize women's agency and resistance against race, class, and gender oppression. They conceptualize heroin use by these women as empowering in its resistance to gendered, raced, and classed expectations. Once addicted, women turn to methadone, which tries to discipline their

---

[2] Rosenbaum (1981) claims that individuals go on methadone to avoid jail, when they cannot obtain heroin, and when they want to decrease the size of their heroin habit, but that addicts do not go on methadone to get sober.

lives, but does not completely succeed. They argue that white women use heroin and reject femininity because they think feminine ideals are oppressive, and women of color use heroin and reject femininity because they think that feminine ideals are unattainable.

Friedman and Alicea (2001) do note some limits of resistance in that women cannot escape their internalization of feminine ideals (and classed and race ideals for the more privileged women in their study), and know that they are failing to live up to them. "Unfortunately, the women with whom we spoke find that wherever they go and whatever institutions they seek out or are processed through, they confront numerous forces, including their own voices, that remind them they have failed as women—daughters, girlfriends, wives, and mothers" (107). Like Rosenbaum (1981) found, Friedman and Alicea (2001) note that when women's children are taken away or when women give up their children, they hit rock bottom: "Women come to realize while on rock bottom that they fail in the one place that they are supposed to make a priority. Fathers, however, are often left unscathed as they are rarely scrutinized, judged, or condemned by the public for their inability or failure to assume caregiving or providing roles like mothers" (Friedman and Alicea 2001:109). Furstenberg (1995) studies African-American fathering, however, and would disagree with Friedman and Alicea's (2001) claim that men are not judged by their community for neglecting their children and that women who neglect their children are the parents who suffer. He writes: "Yet the men who stay involved with their children are esteemed by everyone I spoke to, and those who do not are the object of much opprobrium. Many fathers who disappear from their children's lives feel shame and a sense of loss" (Furstenberg 1995:127).

Mothering also motivates women heroin addicts' treatment decisions. Friedman and Alicea (2001) argue that women turn to methadone and the methadone clinic, which lack women-specific services like childcare, because they want to regain agency that they lost to heroin addiction, and once on methadone, women begin to monitor themselves according to gender, race, and class norms. They express a desire to take care of their children again, to stop abusing their children, to make sure that their children are not removed from their custody, and clean up before their children are old enough to realize that their mothers have a drug problem. If the women are pregnant, they may want to go on methadone because they think it is less harmful to their baby than heroin, and they will be treated better by healthcare providers than if they are on heroin. Friedman and Alicea (2001) assert that women heroin users' violation of gender norms means that healthcare and social service providers as well as the general public treat them poorly, which is what Rosenbaum (1981) found as well. White women are seen to be violating race and class norms, while women of color are seen to be reinforcing the racist stereotypes that exist about them.

Friedman and Alicea's (2001) research does not reveal anything about men's reasons for going on methadone maintenance and whether their family relationships motivate their treatment decisions. It also does not provide any evidence that addict-fathers do not also hit rock bottom when they lose their children. Although Rosenbaum (1981) and Friedman and Alicea (2001) made significant contributions to understanding women's experiences in the opiate drug world, correcting for the androcentric bias in science that either excludes women or represents women stereotypically (Leckenby

2007), much of the drug research has ignored men's uniquely gendered experiences (McMahon and Rounsaville 2002).

A research group in Connecticut led by Thomas McMahon notes that parenting has often been seen as a relevant issue in drug treatment for women, but that men's status as parents is typically ignored. McMahon and Rounsaville (2002) argue that "…the status of substance-abusing men as fathers is rarely acknowledged in the conceptualization of public policy, service delivery or research focusing on the adverse consequences of drug and alcohol abuse" (1109-1110). Furthermore, because of an absence of empirical data on substance-abusing men's family relationships, McMahon and Rounsaville (2002) assert that this group of men are not fully understood and are often negatively represented, which is similar to other marginalized groups of men such as African-American men who are also assumed to be neglectful or abusive (Allen and Connor 1997). In this paper, McMahon and Rounsaville (2002) set forth a research agenda that calls for determining whether it is the case that substance abuse leads to poor fathering, what mediates the relationship between substance abuse and poor fathering, how failing to adequately father according to cultural expectations may lead to increased substance abuse, and if there are ways to make positive family interventions.

In response to his own research call, McMahon and his colleagues designed several studies seeking to answer some of the questions posed in his 2002 article. McMahon, Winkel, Suchman, and Rounsaville (2007) argue that we do not really know much about the fathering of drug-abusing men, but instead have a lot of negative cultural stereotypes about them (e.g. have many children and abuse/neglect them). They studied

50 fathers in methadone treatment (mostly evenly split between black and white with six Hispanic men) about their historical fathering versus their current fathering. They found that men were involved in their children's lives when their children were young, but their involvement decreased as they continued using drugs, were unable to maintain positive relationships with their children's mothers, and they were unable to economically provide for their children. When the men were asked about their interest in becoming better parents, 96% said they would attend group counseling and 84% said they would attend individual counseling if offered. This is evidence that for men on methadone, fathering matters, but there are barriers to continued meaningful contact in their children's lives.

McMahon and his research group found that men on methadone maintenance cared about fathering and did take steps to be responsible fathers, which defies stereotypes of fathers who have abused drugs as irresponsible (McMahon, Winkel, and Rounsaville 2007). However, these men had much fewer economic resources to do so compared to non-opiate-dependent fathers, and their limited income came from welfare and disability benefits as well as from the underground economy. This meant that opiate-dependent men were less likely to be living with their children or financially supporting them. In sum, the opiate-dependent men tried to be responsible fathers, but were unable to sustain responsible fathering over time, which is similar to other disenfranchised, marginalized men (e.g., Furstenberg 1995). The recommendations stemming from this research for "family-oriented interventions" and discussions about parenting while in treatment are stated with an eye toward the effect that this group of fathers has on their

children rather than the ways that having children might matter for the men's treatment. This dissertation will address both directions of influence.

While their research agenda is ambitious, McMahon and colleagues fail to consider the ways that men's other family ties might also be impacted by treatment, and how men's family relationships may impact men's treatment. This dissertation will seek to answer some of McMahon's questions about fathers on methadone and will also address men's other intimate relationships. Additionally, given that McMahon's work has been entirely quantitative (structured interviews and self-report questionnaires), the voices of the men he studied are absent from his work. This qualitative dissertation will highlight the experiences of men on methadone in their own words. Finally, as McMahon notes, their sample is not representative, and because this dissertation focuses on men in the Southwest, home to a significant percentage of Mexican-Americans, rather than the Northeast, it will interesting to see if his findings can be replicated.

Opiates and Ethnicity

Hunter and Baker (1999) argue that in studies on drug addiction and treatment, most researchers treat all addicts and patients as though they are the same. "The structural characteristics of the client, whether in terms of race, class, or gender are either downplayed or completely ignored and a new homogenized identity, that of the addict, is erected" (129). However, a few researchers have examined linkages between injection drug use and treatment and other status characteristics such as ethnicity and gender. In a study of opiate users in the United Kingdom, researchers found that there are differences

in how Asian and white users choose to detox and their reasons for detoxing. One important reason for detoxing was family factors, and Asian opiate users reported that they had more contact with family members and detoxed to please family members more than white opiate users did (Day, Eggen, Ison, Copello, and Fazil 2006). Quintero and Estrada's (2000) ethnographic work on Latino men injection drug users also examines how culture and gender matter for drug use and treatment. Evidence of ethnic differences in family relationships and subsequent treatment decisions supports the idea that scholars should take seriously the intersection of ethnicity and family in drug treatment, something this dissertation aims to do.

Bourgois and Schonberg (2009) have done a recent study of heroin addiction, ethnicity, and gender. For twelve years they did a photo-ethnographic study of white, African-American, and Latino homeless heroin injectors (who were also polysubstance abusers) in San Francisco. There were about twenty people they studied at any given time, and these were mostly men in at least a 3:1 ratio; the final report focuses on about a dozen people. The authors focused on the suffering, abuse, and subjectivity of this marginalized population. The authors discuss racialized ways of using and viewing drugs. African-Americans did a lot of crack, and whites disparaged them for it, although they secretly indulged as well. Whites were more likely to drink vast quantities of alcohol in addition to their heroin use. There was also a contrast between the "black outlaw" and the "white bum." The authors write that:

> [T]he African-Americans in our social network strove more consistently to maintain the public appearance of being in control of their lives and having fun. In sustaining a sense of self-worth, they embraced an ecstatic commitment to getting high. Most of the whites, in contrast, considered

> themselves to be depressed and, indeed, most of the time looked and acted dejected (87).

Blacks were more likely to inject heroin even if it took a long time to find a vein and thus were more likely to overdose or have HIV or Hepatitis. Whites were more likely to inject into their skin and thus were more likely to have abscesses. All of the homeless research participants claimed to want to go clean, and most thought that methadone would positively impact their lives. No African-Americans went on it, although whites and Latinos did (usually 21 day detox programs). There is thus some evidence of ethnic differences in how individuals experience drug addiction and treatment.

Drug Use and Family Relationships

Much of the literature on substance abuse focuses on how marriage mediates substance abuse. Demographers have found that marriage has a positive effect on reducing some types of substance use for men, an effect separate from having children, although having children also reduces substance use (Duncan, Wilkerson, and England 2006). Duncan et al. (2006) found that binge drinking and marijuana use decrease upon marriage, although smoking cigarettes does not, and that both blacks and whites get this positive effect from marriage. In a more recent study, Kerr, Capaldi, Dowan, Wiesner, and Pears (2011) found that marriage was associated with a reduction in crime and alcohol and tobacco use, but not marijuana use. Neither of these studies examined illicit drugs other than marijuana, however, and so my dissertation can speak to how men on heroin and methadone benefit or do not benefit from being married or having children. It

may be the case that opiate users will not discontinue use upon marriage because they are so physically dependent on opiates.

Researchers have also been concerned with how family structures and relationships impact substance abuse. For example, some studies find that some groups of boys are at increased risk of using drugs if they do not live with their biological father (Mandara, Rogers, and Zinbarg 2011), and some studies find that parental warmth toward their children can reduce substance abuse for some types of adolescents (Broman, Reckase, and Freedman-Doan 2008). Other studies focus on the impact children have on their parent's substance abuse. One such study finds that drug-abusing parents who live with their children use drugs less frequently and have better living conditions than drug-abusing parents who do not live with their children (Meier, Donmall, and McElduff 2004). This dissertation will focus on how family relationships might matter for men on methadone.

In Bourgois and Schonberg's (2009) study discussed above, the authors spend a few chapters describing the relationships the homeless heroin injectors have with their families of origin. The majority of the white homeless addicts in this study did not have contact with their families of origin, but a few of them did contact family members when a life-threatening situation occurred. The white addicts often refused to talk about their families of origin because they felt ashamed and despondent at their family's rejection. African-American addicts in the study still had ongoing and extensive kin relationships even when their family life was unstable, and even though the addicts were homeless, they still attended family gatherings, for example. Two of the three Latino men studied

lived off and on with their mothers. This dissertation will examine family relationships of men in methadone treatment to determine whether the ethnic patterns noted by Bourgois and Schonberg (2009) are influenced by treatment.

The homeless heroin injectors in Bourgois and Schonberg's (2009) study were all parents (except for one man), but they all prioritized their addictions over relationships with their children. None of the addicts were in regular contact with their children, and many of the men admitted to beating their former wives and children, which they believed was an appropriate display of masculinity. The children of the white addicts tended to reject their parents, whereas the children of African-American addicts sought contact with their parents. Although the black addicts did not emotionally or financially support their children any more than white addicts did, they were very excited by contact with their children, and some of the black men spoke with joy about their grandchildren. As Rosenbaum (1981) and Friedman and Alicea (2001) discussed above, Bourgois and Schonberg (2009) argue that:

> Society condemns mothers more than fathers for using drugs and for abandoning children. All of the women on Edgewater Boulevard internalized this condemnation and had more prolonged and emotionally engaged relationships with their children, even though they, too, like the men, ultimately subordinated responsibility for children to drug consumption (199).

Because Bourgois and Schonberg (2009) study addicts who are not in treatment, it is not clear from their research how treatment would impact heroin addicts' family relationships.

Other scholars have also noted how drug treatment tends to focus on individuals and does not recognize that individuals are often part of couples. In an exploratory study

of injection drug using couples in Connecticut, Simmons (2006) finds that drug-abusing partners care about one another, although they often reinforce one another's addictions. Unfortunately, couples are often not permitted to enter treatment together at the same treatment center, and treatment providers often view relationships between addicts as unhealthy and dangerous. Simmons (2006) argues for providers to focus on "individuals within their actual social contexts" (2) and provide services such as counseling for couples. Given that other research has shown that one predictor of whether out-of-treatment injection drug users will enter treatment is being married (Corsi, Kwiatkowski, and Booth 2007; Schutz, Rapiti, Vlahob, and Anthony 1994), it is important for providers to focus on intimate relationships in treatment. This dissertation will address men as part of couples, but also address men as part of larger family units.

MASCULINITY AND MEN'S FAMILY RELATIONSHIPS

This dissertation will not only speak to the literature on opiate addiction and treatment, but will also extend to discussions of men's lives and relationships, and to masculinity more broadly. Opiate-dependent men, many of whom have not yet stabilized in treatment, who are poor and have been in and out of prison are arguably a marginalized group. As such, they provide an interesting vantage point from which to examine marginalized masculinities. This section will review the literature on masculinity, fatherhood, and men's family relationships.

Masculinity

Most studies of gender have focused on women. Some gender scholars have argued that theorists should make "men and masculinities *explicit objects* of theory and critique" (Hearn 2002:247, emphasis in original). One of the major masculinities theorists is Connell, who theorized four different types of masculinity: hegemonic, subordinate, complicit, and marginalized (2000, 2005). Hegemonic masculinity is whatever masculine attributes are held as ideal by the larger culture, which constantly changes to incorporate new valued attributes. Because not all men are equal, not all masculinities are equally valued. Men who are gay, for example, can never be hegemonically masculine because hegemonic masculinity is, by definition, heterosexual; gay men's masculinity is thus subordinated. Additionally, any heterosexual men who display effeminacy also have a subordinate masculinity (see also Pascoe 2007). Men of color and working-class men practice a marginalized masculinity because they are members of marginalized racial and ethnic groups and/or marginalized social classes (Connell 2005). Only a small group of powerful, wealthy, heterosexual, white men meet all the requirements of hegemonic masculinity, but men who share important characteristics with these men such as race, sexual orientation, and relative class-privilege practice a complicit masculinity, and are rewarded with the patriarchal dividend (Connell 2005).

Studies of masculinity have linked it to every aspect of men's lives. Important for this dissertation are studies of masculinity and crime. Messerschmidt (1993) argues that when boys and men lack access to more legitimate resources for doing masculinity, one

resource they still have is crime. He examined youth masculinity in school and found that there are "opposition" masculinities and "accommodating" masculinities, and that depending on whether white, middle-class boys were in school or out of school, they did a different version of this masculinity. White, working-class youth often see part-time work as a source for doing masculinity and leave school, thus perpetuating the class structure by getting lower status, lower paying jobs. Working-class, non-white boys who exist in the street scene use crime as a resource for doing masculinity because they are closed out from employment opportunities. Morris (2008) also notes that for Hispanic and black men, poor performance in school, leaving school, and being violent are resources for masculinity. Connell (2005), too, claims that when boys and men lack access to power, they will also turn to crime and violence. Because men's performance of masculinity differs according to social context (Connell 2005; Shows and Gerstel 2009), there may be an addict (public) masculinity that is different from an in-treatment (private) masculinity.

Raced and Classed Masculinities

Connell (2000, 2005) notes that gender is just one way of structuring social relations, and that others include race and class, so it is appropriate to look at the intersection of these different structures/variables (i.e. intersectionality). As noted above, there are multiple masculinities that depend on men's sexuality, social class, and race/ethnicity.

Many scholars have analyzed black masculinity (Clatterbaugh 1997; Segal 1990; Majors and Billson 1992). The paradox of black masculinity is that black men are simultaneously viewed as both too masculine and yet not masculine enough. Majors and Billson (1992) talk about how black men do "cool pose" or being tough and non-emotional as a response to the fact that "[o]utlets for achieving masculine pride and identity, especially in political, economic, and educational systems, are more fully available to white males than to black males. This in turn restricts the black man's ability to achieve in family systems, to take care of a wife and family, or to be a present and supportive father" (31) because of discrimination. Black men are set up to fail as far as masculinity is concerned because they are denied access to a key component of masculinity—a job. Majors and Billson (1992) argue that in light of these structural constraints, black men often turn to drugs and alcohol to cope.

More relevant for this dissertation is a discussion of Latino masculinity. Mirandé (1997) critiques Western scholars for ignoring Latino men in their theories of masculinity, and he conducted in-depth interviews with Latino men in order to determine what these men thought about manhood and to explore the concepts of "*macho*" and "*machismo*." Mirandé (1997) notes that when Anglos use the word "macho" to describe themselves, it is used positively, but when used to describe Latinos, it is used negatively (e.g., strength versus violence). Through his research, Mirandé (1997) found that there were both negative and positive aspects of *machismo*—it could be used to describe aggression, violence, selfishness, and patriarchy, or it could be used to describe an ethnical assertiveness, responsibility, and respect. The definitions of "*macho*" varied by

social class and whether the respondents were interviewed in the United States in English or in Spanish. Mirandé (1997) also determined that Western psychological gender inventories are not applicable to Latinos because Latino men "…may score high on traditional masculinity traits such as being independent, assertive, and having leadership abilities, while at the same time remaining sensitive to the needs of others. Conversely, Latino men may endorse traditional 'feminine' traits such as being warm, tender, loyal, and affectionate, and still remain self-reliant, self-sufficient, defend their beliefs, and be willing to take a stand" (85). Mirandé (1997) writes:

> The findings suggest that there is a distinct Latino cultural ethic surrounding masculinity and fatherhood that is radically different from dominant American conceptions. According to this ethic, whether a person is considered to be a successful man or a good father is determined not so much by such external qualities as success, fame, or wealth but by such internal qualities as responsibility, selflessness, and moral character. From this standpoint the worst or 'lowest' thing a man can do is to be irresponsible, to put his interests and welfare above those of his family, or not to take care of his family. The phrase 'not taking care of business'…is often used to describe a situation in which a man is criticized for failing to fulfill his responsibilities or duties as a man or a father (114).

Mirandé (1997) is careful to note that Latinos are a diverse group who display a multiplicity of masculinities, but that one of the worst things a man can do is use alcohol and drugs to the detriment of his family responsibilities. This dissertation will include Latino respondents' views on how their substance abuse has impacted their family lives and can potentially provide insight into this subset of Latino men and masculinity. Mirandé's (1997) findings also provide support for the idea that family relationships matter for addiction and subsequent treatment outcomes, which is something other scholars have explored.

In an ethnographic and interview study of Latino injection drug users in Nogales ("*tecatos*"), Quintero and Estrada (2000) highlight the ways in which this group of men displayed a "street" masculinity. Some boys in this area used drugs in order to appear tough and daring, and then escalated their use to cement their status as men. In order to pay for drugs, many turned to violence or drug dealing, which was a further display of "machismo" or manhood. The *tecatos* the authors interviewed recognized that these aspects of *machismo* had a negative impact on their ability to fulfill their obligations to family because all of their money went to drugs. Quintero and Estrada (2000) question how masculinity leads to the cessation of drug use, and this study will speak to this question as it focuses on Latino men in treatment for heroin addiction.[3] Similarly, Andrade and Estrada (2003) focus on how gender and culture intersect with substance abuse in their study of five Hispana (female) injection drug users, differentiating them from *tecatos* in that Hispanas still attempt to fulfill cultural gendered familial expectations. Bourgois and Schonberg (2009) also discuss how black and Latino homeless heroin addicts draw on hip-hop street culture to maintain a sense of masculinity despite lacking basic material resources.

In their discussion of culturally appropriate interventions for Latinos substance abusers, Gallardo and Curry (2009), too, emphasize the importance of family for Latino men, and they argue that substance abuse treatment counselor's can use this cultural

---

[3] The answer is that, once in treatment, the positive aspects of *machismo*—such as "care for the family or responsibility as a provider"—are possible and motivate staying clean (2000:62).

value to positively impact treatment outcomes. Gallardo and Curry (2009) also note that *machismo* is important, but misunderstood. They write:

> Machismo, a commonly misunderstood construct, originally embodied the masculine ideals of dignity, honor, hard work, and the ability to care for and protect one's family. Male Latino clients who value machismo may be reluctant to disclose personal issues to the counselor. When faced with a substance abuse issue, the counselor may feel that the client is defensive or resistant to change. In actuality, the male client may simply be trying to maintain the dignity central to his own and his family's honor. The counselor may approach the issue by reframing substance abuse from the Western conceptualization of "alcoholism" and "addiction" to the Latino conceptualization of machismo and the duty to care for one's family. By pointing out areas where substance abuse has compromised the duties associated with machismo, the client may more actively seek recovery (322).

So *machismo* can both explain Latino men's drug use and be helpful in designing treatment interventions.

Also relevant for this study is consideration of lower-classed masculinities. Based on her study of lower/working and middle/upper class marriages and remarriages, Pyke (1996) argues that when lower or working class men use drugs and alcohol, they are "constructing a compensatory form of masculinity," which is an "exaggerated masculinity [that] compensates for their subordinated status in the hierarchy of their everyday work worlds" (538). This is similar to the cool pose among African-Americans (Majors and Billson 1992). However, Pyke (1996) also found that a minority of the men in her study did have egalitarian ideas about division of childcare and were involved in family life, which "produce[d] an egalitarian masculinity involving expressiveness and high levels of family involvement" (542). "The pressures exerted by the structural conditions of working-class life may lead some men to juggle a Dr. Jekyll and Mr. Hyde

existence in which they produce hypermasculinity in male cliques and on the job and an egalitarian masculinity in their family relations" (542). In essence, she argues that one style of masculinity in one specific situation does not imply the same style of masculinity in a different situation. So while it may be the case that drug-using or drug-addicted men do hypermasculinity in their public/street life, in their family life, they may actually be egalitarian and committed to their families.

Fatherhood

Fathering has been the subject of much scholarly work for the past few decades because changing structural conditions such as women's greater labor force participation have greatly impacted family life (Coltrane 1995; Coltrane 1996; Gerson 1993; Gerson 1997). Coltrane (1995) has argued women's participation in the paid labor force has brought men into the home; he also argues that there have been cultural gender shifts as well that permit men to be more involved in family life. Because these structural shifts have largely impacted the working and middle classes, more marginalized groups, such as the impoverished or drug-addicted, need to be studied, something this dissertation will do.

The perspectives on contemporary fathering fall into two camps: "generative" (good fathering) and "deficit" (bad fathering). Generative fathering is "fathering that meets the needs of children by working to create and maintain a developing ethical relationship with them" (Dollahite, Hawkins, and Brotherson 1997:18). In the U.S., "[t]he good father is one who provides economic support for his children and who does

this as a consequence of his own efforts in the marketplace, without help from the state or charities" (Morgan 2002:280). May (1998) defines good fathering as occurring when men take "their relationships with mother or with child seriously" and when they are "in a caring relationship with [their] children through which one nurtures, supports, and educates them" (30). Deficit fathering is when fathers are absent, neglectful, or abusive—in other words, a "deadbeat" father (Marsiglio 1995a). Substance-abusing men are often assumed to be deadbeat fathers, but McMahon and Rounsaville (2002) argue that this may not be the case. Additionally, the ideal of generative or good fathering may not reflect what value marginalized men bring to their families or how they define good fathering.

There is debate in the literature on the role of fathers in the family, and scholars of the family have called for more research on the topic (Crosnoe and Cavanagh 2010). Some scholars have argued that there has been a cultural shift in fatherhood ideals (Coltrane 1996; Longwood 1996). Segal (1990) notes that men have become more involved as fathers and that one interpretation is that there is an emergence of a "new father," but another interpretation is that men are reasserting paternal rights exactly at the historical moment when their power in all other domains is diminishing. Also, in her review of the empirical literature, Segal (1990) finds evidence that while men's attitudes towards fathering and family have changed, their practices have not, which is similar to what Ranson (2001) finds in a more recent study of professional men who still prioritize breadwinning over their fatherhood responsibilities.

In their study of a "Family Matters" series in a Canadian newspaper, Wall and Arnold (2007) contend that although scholars have argued that there has been a shift in the culture of fatherhood toward men being portrayed as more nurturing and more involved in day-to-day parenting tasks, that neither the culture nor the actual practices of fathers have changed much at all. They assert that mothers are still the primary parents and that this is because parenting is caring, which is feminine and thus clashes with hegemonic masculinity. Whereas mothers who do not spend as much time with their children as they want feel worry and guilt about whether their children are okay, fathers tend to feel regret as it impacts them and not their children. Mothers are also addressed as the manager of family matters and relations and the parents most involved in early childhood care.[4] Fathers are assumed to be the breadwinners. Craig (2006) also argues that women spend more time parenting than men do and that when men do parent, they do the "fun" parenting tasks. This dissertation will explore whether and how marginalized men on methadone are involved with raising their children.

One important driver of whether a man is a generative father is access to a good job. Gerson (1993) studied 138 working and middle class men. She found that men wanted to be good, nurturing, "generative" fathers. Gerson (1997) writes:

> For men with limited work opportunities, the desire to nurture can be frustrated in the workplace. Blocked mobility can prompt men to look for other sources of meaning and fulfillment, and child rearing offers a rich alternative. These men look to parenting as a form of productive labor, and like the proverbial proud mother, they come to see children as their primary identity and even a source of vicarious identity (41).

---

[4] Coltrane (1989) also found that mothers are the managers and fathers are helpers in household labor.

This may also be the case for the marginalized men this dissertation examines. Parenting may be a resource for masculinity production for men excluded from the labor force.

Hobson and Morgan (2002), Hearn (2002), and Griswold (1993) note that fatherhood cannot be separated from masculinity. In exploring the links between contemporary fathering and hegemonic masculinity, Doucet (2006) interviewed a diverse group of 118 Canadian fathers who were primary caregivers to explore the question of whether men can mother, something that Coltrane (1989) asserts happens as men spend more time in domestic activities and Risman (2004) found was the case for single fathers. Doucet (2006) found that men and women can both be nurturing caregivers, but that there are distinct gendered parenting styles (men tend to emphasize fun and attempt to develop their children's independence, see also Craig 2006). Men do not mother and thus do not risk their masculinity, which eschews anything feminine such as caregiving, but when they nurture and provide primary care for their children, they create a new masculinity that includes both masculine and feminine characteristics and results in a "masculine conceptions of care" (238). While Doucet's (2006) work is interesting, it does not shed much light on how fathering matters for the masculinity of men who are not primary caregivers or for the men who are the most marginalized, such as substance-abusing, impoverished men.

Morgan (2002) notes that the dominant cultural image of fathers is one of fathers of young children, but that this representation ignores the complexity of relationships between fathers and their children. Fathers can have older children who may even have children themselves; fathers can be residential or absent; fathers can be nurturing or

violent, etc. Indeed, McMahon et al. (2007) found that 34% of the men in their sample were fathers of adult children. This dissertation will explore the variation among fathers as it focuses on men rather than on a particular fatherhood status.

The scholarly literature on fatherhood and masculinity seems to indicate that cultural ideals about fatherhood are in a state of flux (Gerson 1993 and Griswold 1993) and are changing to incorporate nurture, and that, in turn, masculinity has evolved to incorporate an ethic of care for children. But there is still a disconnect between fatherhood ideals and fathering practices, and there is also variation in fathering ideals and practices by race, ethnicity, and social class. This dissertation will address what fatherhood means to men on methadone and whether these meanings differ by ethnicity.

Fatherhood, Ethnicity, and Social Class

Morgan (2002) argues that scholars should "not [consider] fathers, or men, as an undifferentiated group, but rather of seeing gender and gender relationships as being shaped and modified by relations of class and ethnicity" (275). Although scholars on the family note that not much is known about ethnic or social class variation in parenting (Sassler 2010), some studies have indicated that there are differences in fathering by such social statuses. According to Majors and Billson (1992), fathering and economically supporting a child is a major part of masculinity for black men. However, when unable to financially support their children, black men can still display their masculinity by having a large number of children, particularly sons. This is not to say that black men do not want to be able to support their families or be involved in their children's lives; they

do. But because of their structural position in society, they are often unable to do so. Gavanas (2002) notes that low-income and minority men who are disadvantaged relative to white, middle-privileged men because they lack political and economic opportunities have "fragile families" (families that consist of an unmarried parent and their children).

Lorber (2005) notes that black men are more likely to be equal parenters than are white men because they are more likely to live in dual income households, where such parenting arrangements are a necessity; this reality contradicts the stereotypes of black men as deadbeats "who show little if any interest in their children" (Marsiglio 1995a:4). Furstenberg (1995) studied urban, low-income African-American fathering. Among the African-American parents he interviewed, there was no conflict in the definitions of being a good father, which was described as "doing for your children," which means not only economically supporting them but also emotionally supporting them. However, the men in his study noted that it was difficult for them to be good fathers, and the majority of the men did not meet their definition of good fathering and were disengaged from their children, which is similar to other marginalized populations. However, some were good fathers, but they needed help from family to make it work.

The meaning of fatherhood has also been explored for Latino men. When Mirandé (1997) asked what made Latino men good fathers, some men responded that it was because they provided financially for their children, others that they spent time with kids, and others that they nurtured and loved kids. Men born outside U.S. placed more emphasis on breadwinning while men born in U.S. talked about affection/love. The less educated and nonprofessional men also emphasized providing for their children.

There is debate about how fatherhood ideals and practices are classed. In Griswold's (1993) historical study of fatherhood, he argues that "new father" ideals and practices are found among middle-class men. He writes:

> The new fatherhood, then, can become a badge of class, a sign that one has the knowledge, time, and inclination to embrace more progressive visions of parenting…The new fatherhood thus becomes part of a middle-class strategy of survival in which men accommodate to the realities of their wives' careers and the decline of their breadwinning capabilities. For these men, pushing a pram becomes less a sign of a wimp than a public symbol of their commitment to a more refined, progressive set of values than those held by working-class men still imprisoned by outdated ideas of masculinity (254).

Marsiglio (1995b), however, suggests that expanding the definition of responsible fatherhood from a sole emphasis on providing for one's offspring to also include nurturing involvement may make it more likely that poor men will be more involved with their children. And Gerson (1997) asserts that: "In a world of diminishing economic opportunities, where most men do not earn enough to support a family alone, generative fathering offers men new opportunities for fulfillment" (48). Coltrane (1996) also predicts that low-income fathers will also be more involved in childcare. Recent empirical work indicates that working-class men are more involved in both the public and private aspects of fathering whereas professional men are "public" fathers who do not engage in fathering in the home (Shows and Gerstel 2009).

Given that the men in this study are low-income, substance-abusing men, this dissertation can speak to the type of fathering done by this group of men, which will answer a recent call for further research on "the nature and meaning of parenthood and

intergenerational relationships" for members of racial/ethnic minorities groups and disadvantaged social classes (Umberson, Pudrovska, and Reczek 2010:624).

Men's Other Family Relationships

Much of the literature on men's family relationships (other than fatherhood) examines household division of labor (e.g., Coltrane 1989; Gouch and Killewald 2011), domestic violence (e.g., Anderson 2010), the influence of family structure on child outcomes (e.g., Mandara et al. 2011), marital quality (e.g., Carlson, Pilkauskas, McLanahan, and Brooks-Gunn 2011; Hardie and Lucas 2010), and divorce (e.g., Amato 2010). It is rare for family scholars to focus on adult men's relationships with their families of origin (Knoester 2003) or how these relationships matter for men. This dissertation research will fill this gap in the literature by examining men's perceptions of how their family relationships affect their experiences with drug use and treatment.

Additionally, this dissertation will focus on men's relationships with their female partners. Because masculinity dictates that men are rational, unemotional, and independent from and superior to women (Connell 2005), Doucet (2006) was surprised at how emotionally invested men were in their relationships with women. She writes:

> [T]he relational losses felt by men when their marriage breaks down were stronger than I would have anticipated. It is as though hegemonic masculinity, with its emphasis on autonomy and self-reliance, collapses in those moments of crisis to reveal the hidden influences of more stereotypical feminine qualities of connection, relationships, and interdependence (217).

The men in this study are disproportionately without resources, so their partner relationships may be especially important for dealing with crisis, although scholars have

found that opiate-dependent men, even those in methadone treatment, are more likely to perpetrate violence and be victims of violence from their children's mother (Moore, Easton, and McMahon 2011).

Research has also shown that marriage provides physical and psychological health benefits to men (Fincham and Beach 2010), which benefits may also be found for married men on methadone. This dissertation will examine the importance (or lack thereof) of romantic partnership for men on methadone, using the men's voices to get at this importance. As Carr and Springer (2010) note, qualitative methods are necessary to "investigate the distinctive ways that families affect health in underrepresented populations" (755).

OUTLINE OF DISSERTATION CHAPTERS

This research aims to direct attention to opiate-dependent men's status and experiences as men and to explore men's perceptions of how their roles as fathers, grandfathers, sons, grandsons, brothers, husbands, and boyfriends influence and are influenced by the opiate drug world of addiction and treatment. Any ethnic differences will also be noted. Further, this research will speak to the work on masculinity, fatherhood, and men's other family relationships to see what the experiences and perspectives of this marginalized group of men can say about men more generally. Although part of a marginalized class, impoverished men on methadone are not immune from larger cultural trends or specific subcultural norms, and will likely prioritize their family relationships in some instances. Then again, not only are opiates powerful drugs

that tend to dominate an addict's life, but one aspect of masculinity is to not care about family, so it could also be the case that men do not prioritize or value their family relationships. I hypothesize that men on methadone will value and prioritize their family relationships, although they will still struggle with their addictions.

While there are differences between groups of men on the basis of race, ethnicity, social class, and sexuality, there is also unity in men's experiences, and sometimes men can be treated as a class (Hearn 2002). So, at times this dissertation will focus on gender, at other times on ethnicity, and finally at the intersection, following Risman's call to study categories of oppression both separately and as they intersect (Risman 2004).

The chapters will be organized as follows. The next chapter will describe the data that informs this dissertation, and how it was collected and analyzed. The third chapter will focus on fatherhood. The fourth chapter will focus on men's relationships with their families of origin. The fifth chapter will focus on men's relationships with their female partners. The concluding chapter will summarize the findings, discuss policy implications, and describe directions for future research.

CHAPTER TWO: DATA AND METHODS

In order to explore men's perceptions of how their family relationships matter for their opiate addiction and treatment and how addiction and treatment affect their family relationships, I interviewed 33 men from a single methadone clinic in the Southwest. This chapter will describe the methadone clinic and how I gained access to it in order to recruit participants into my study; it will also discuss the research participant recruitment process, the interview schedule, and how I analyzed the interview data.

Choosing a Research Site and Gaining Entry

The methadone clinic from which I recruited research participants is located in a metropolitan area in Arizona. The choice of location was both a matter of convenience (as I lived in Arizona at the beginning of this research) and because few studies of methadone have been conducted in the Southwest. Indeed, most have been done in the Northeast (McMahon et al. 2007), California (Anglin, Ryan, Booth, and Hser 1988; Binion 1982; Bourgois and Schonberg 2009; Rosenbaum 1981), the South and Southeast (Binion 1982; Clark, Capel, Goldsmith, and Stewart 1972; Friedman and Alicea 2001), and the Midwest (Binion 1982; Friedman and Alicea 2001). The Southwest is important to study because it is has been overlooked by previous studies and also because it is home to Mexican-Americans, an ethnic group that has been understudied.

It was a difficult and time-consuming process to gain entry to a methadone clinic. I began seeking access to methadone clinics in 2009 by conducting an internet search of

methadone clinics in Arizona. I then contacted the clinics by email or phone (whatever was listed on their website, if they even had a website). My email queries would often go unanswered and my voicemail messages unreturned. When I was able to get in contact with someone who was part of the organization, it was not uncommon for them to pass my query off to someone else, and the entire process of unreturned phone calls and emails began again.

At one point, one of the larger behavioral health organizations in the city in which I conducted my research allowed me to interview for a position as an intern/volunteer for a program for dual-diagnosis clients (those who have both a substance abuse issue and a psychiatric disorder). Some of the clients were addicted to heroin and were receiving methadone. This was not exactly what I was hoping for, but at this point I had been trying—unsuccessfully—to gain access a methadone clinic for about a year and I was willing to take any path afforded to me to get in contact with the population and type of treatment program I was interested in studying. Unfortunately, this option did not work out.

Finally, using the professional networks of my dissertation advisor who knew the head of a behavioral health organization in Arizona, I was able to get permission to study the methadone clinic associated with this behavioral health organization. Without this assistance, I likely would have been unable to gain overt, ethical entry to a methadone clinic. This is because these medical institutions treat a stigmatized population and, thus, they have legitimate privacy concerns, and outsiders are guarded against.

I officially entered the behavioral health organization as an unpaid intern with the methadone clinic. Entering as an official intern was an advantageous entry point because I had access to all parts of and populations in the clinic; additionally, workers made clinic policies, procedures, practices, and norms explicit in order to teach me. In order to be an intern, I had to fill out an employment application, go through various Human Resources trainings such as trainings on Sexual Harassment, attend a CPR training and be certified in CPR, and get a tuberculosis test. I also received an official identification card, which I used to enter the facilities. As an additional step, I also got Drug Enforcement Administration (DEA) approval to enter the actual nursing part of the methadone clinic where they dispense the methadone, though I never had a need to enter this part of the facilities. In addition to receiving IRB approval from the University of Arizona to conduct this research, I also had to do the same from the agency where I conducted my study. And finally, the methadone clinic where I conducted my research gave me an unused office in which to conduct my interviews. The use of this office was particularly helpful in that it allowed me to recruit interviewees on site and permitted observation of the daily activities of the clinic.

Description of Methadone Clinic

The clinic I studied, here referred to as Second Chances[5] has been in operation for over 40 years, and is one of several public, non-profit methadone clinics in Arizona. It is

[5] Although some scholars argue that disclosing the names and specific location of their research site "increases accountability," holds researchers to a "higher standard of evidence," and decreases the "likelihood of misrepresentation" (Duneier 1999:348), I am

part of a larger behavioral health organization that provides a variety of other services such as mental health services and housing assistance in several locations throughout the state of Arizona. In the city in which this methadone clinic is located, there are several private, for-profit methadone clinics and a few other public methadone clinics. Private clinics often charge more for methadone, allow clients to have more take home bottles,[6] allow clients to have higher doses of methadone, and begin immediate detoxification when a client misses payment. Second Chances receives about 78% of its funding from Medicaid, and the remainder of its funding from the Substance Abuse Treatment and Prevention federal block grant.

Second Chances is located centrally in the city, just around the block from another large methadone clinic, a liquor store, and a children's museum. It is also surrounded by local businesses, including gyms, restaurants, and coffee shops. The clinic itself has a fairly nondescript exterior that does not advertise its purpose. The only signs that it might be a drug treatment center are the clients[7] who enter and exit and sometimes congregate outside.

The interior of the clinic is divided into three parts. One entrance/exit leads to a lobby area where non-client visitors may come. The Clinical Supervisor's and the Intake

---

choosing to not disclose the name of the organization from which I recruited participants because I promised all participants confidentiality in order to make them feel safe in disclosing sensitive information to me. In order to make sure I fairly and accurately represented the organization and population I studied, I presented my findings from this research to the staff at one of their weekly team meetings, and my findings were largely unsurprising to the workers.

[6] Take home bottles are single doses of methadone that clients are permitted to take away from the clinic.

[7] People who use the clinic's services are referred to as "clients," and I likewise use this term when referring to this group.

Coordinator's offices are attached to this lobby, and the administrative assistant's desk is also located here. Behind the lobby and offices are the staff break room, a large room where staff have meetings and clients have group therapy, and the staff bathrooms. The middle of the clinic has another entrance/exit that current clients use. Right through the client entrance are vending machines and the hallway leading to the nurses' dosing station where clients come to receive their methadone doses. Because methadone is a highly controlled substance, it is only administered in the dosing area. In this area, there are several windows, and a nurse sits behind each one, dispensing methadone to clients one at a time. Just beyond the dosing area is a station where the lab tech sits to administer saliva drug tests. There is also a small waiting area in this section and bathrooms for clients. The final area of the clinic is where all the counselors have small, private offices, a restroom, and an exit they use for smoking breaks and to break up client loitering. My office was in this part of the clinic. There is also another large room used for acupuncture in this section of the clinic. In all parts of the clinic, the walls are filled with posters featuring inspirational quotes, pictures of Dr. Martin Luther King, Jr. and other notable historical figures, as well as Mexican and Native-American art.

The clinic employs about fifteen full-time employees at any given time. The staff who work at Second Chances include an administrative assistant; a lab technician responsible for both administrative tasks and for administering drug tests; an employee who does acupuncture, helps clients sign up for the state Medicaid program so that the cost of their methadone is covered, and does some research for the parent behavioral health organization; three or four nurses who provide methadone to the clients and help

with client medical intakes; counselors (between five and seven different counselors); the Intake Coordinator responsible for bringing clients onto the clinic (he is also a counselor); and the Clinical Supervisor. A nurse practitioner comes to the clinic a few days a week to do physical exams for new clients. The doctor for the parent organization also comes once a week to authorize methadone dose changes.

The workers at this clinic are quite ethnically and culturally diverse. There are three African-American employees, five Latino employees (all of whom are bilingual; English and Spanish), one Arab-American employee, and six white employees (some of whom speak Spanish). Four of the employees are men, and the rest are women. Some the staff members have been addicted to psychoactive substances and consider themselves to be in recovery while others have never used illicit substances or been addicted. This diversity in staff ethnicity and gender reflects the diversity of the city's population but more importantly of the clients served by the clinic. Indeed, the clinic's parent agency takes pride in the diversity of its staff and has been recognized nationally for its leadership in both the diversity of its staff and its success in working with highly diverse clients.

The client census of the clinic is constantly shifting as people exit treatment and new clients come on. The number of clients served at this clinic grew during my study, from approximately 300 to about 375. Two-thirds of the clinic's clients are men. 53% of the clients are white, and 43% are Hispanic. Almost all clients are on Arizona's Medicaid program, the Arizona Health Care Cost Containment System, for low-income individuals.

Interviews with Clients

For this dissertation, I interviewed 33 men clients at this methadone clinic during August and September 2010,[8] which was part of a larger research project that included interviews with members of the clinic's staff and observation of clinic worker's team meetings. I concluded the interview phase of this study when I had reached data saturation (Bailey 2007; Ragin 1994). Each client interviewed received a $20 Walmart gift card at the completion of the interview. Funding for interviews with men clients came from the Social and Behavioral Sciences Research Institute at the University of Arizona.[9] While this particular population has been surveyed and psychologically assessed in previous studies (e.g. McMahon et al. 2007), conducting qualitative interviews was the best way to discover what men's experiences with opiate addiction and treatment were. Interview data reveal participants' experiences *in their own words*, providing more description and depth and the ability to analyze meaning.

Criteria for inclusion in this study were that a participant had to be a male client at the clinic who was able to consent to an interview.[10] Clinic counselors were told about

---

[8] Bailey (2007) recommends that interviewers aim to interview at least 20 people and evaluate after that to see when saturated. Ragin (1994) defines saturation as the point where evidence collected is repetitious and nothing new is learned.

[9] I also interviewed 34 women clients at the request of the methadone clinic. While these interviews will not be part of the dissertation, the findings from these interviews have been reported to the clinic. When I informed the head of the clinic that I was not going to be interviewing women because I did not have additional funding, she requested that the Intake Coordinator use funds the clinic had saved from prescription drug companies (funds which were normally used to pay for office holiday parties) to fund interviews with women.

[10] I had to stop one interview after a few minutes when a client became unconscious (presumably because of the effects of either methadone or methadone in combination with some other psychoactive substance) during the consenting process.

the opportunities for their male clients to participate in the study, and they directed some of their clients to sign up for an interview time. The lab tech also put up signs on the walls announcing the opportunity for clients to participate in a survey and receive a gift card. I did not personally approach clients to invite them to participate, so the subjects selected into the study after seeing the announcement about the study or being asked by their counselor, the lab tech, or the Clinical Supervisor if they wanted to participate. However, on occasion, I did ask counselors to refer certain types of men to me (e.g. young men) when I felt like I had been interviewing the same type of person over and over again. The fact that I had established rapport with the Clinical Supervisor, the administrative assistants, and most of the counselors meant that I had a steady flow of interviews as they directed clinic clients to sign up for interviews with me.

Each week I left a sign-up sheet with available interview times at the desk in the waiting room where clients greeted the lab tech and did their saliva drug screens. I would typically have three to four time slots each morning of every day of the business week for clients to sign up. The interviews were designed to last no more than an hour, and so I would plan on doing three or four interviews each morning, one right after the other. It was not uncommon to have four people sign up for an interview, and then have only two show up for their interviews. The lab tech would try to help with the no show problem by adding reminders to the computer system, so that when clients came into dose, they would be reminded that they had an appointment with me, but this issue persisted throughout data collection.

My recruitment method influenced the composition of my final sample. I was more likely to recruit newer methadone patients who had to come to the clinic each day and did not yet have take home privileges; methadone clients who were not doing well in treatment and had to come to the clinic each day because they did not have take home privileges; clients who took advantage of the groups run at the clinic and were thus at the clinic often; clients who were unemployed and thus had time for the interview; and, clients who were desperate for any source of income. I was less likely to interview clients who came to the clinic less often; clients who did not take advantage of the groups and were thus not around the clinic for longer than the period of time it took them to dose; clients who had other commitments such as employment or family that prevented them from participating; and, clients who did not have a financial need for the $20 gift card offered to participants. While my sample is not representative of men in methadone treatment, my recruitment methods did give me access to some of the most marginalized men, which can be helpful for analyzing and rethinking drug treatment practices.

The interviews took place at the clinic in the small back office given to me as part of my internship. The first part of the interview involved the consenting process wherein I discussed the purpose of the research, what would happen during the study, the potential benefits and risks of the research, how their participation was voluntary, and how all information would be kept confidential. Because there was the potential during interviews for me to learn private or sensitive information (e.g. a client's positive HIV status) or have clients tell me about behavior that was illegal (e.g. that a client was selling drugs) or violated clinic policy and could impact their clinic treatment (e.g. that a client

was still using illicit substances), I promised confidentiality. I did not want research participants to be worse off than before they engaged in the research process with me (Madden 2010). After the consenting process, I began audio recording the interviews.

During the interviews, I asked clients about how they began using opiates, the consequences of using opiates, how and why they entered treatment at a methadone clinic, how their treatment was progressing, their evaluation of the clinic staff, whether they had tried other forms of treatment for opiate addiction, and what their family relationships were like.[11] I then concluded the interview with basic demographic questions. I call these interviews "addiction history interviews," which is a condensed form of a life history interview (Marshall and Rossman 2006) that focuses on the client's entry, duration, and possible exit from opiate addiction and treatment throughout their life course. Interviews ranged from just over 20 minutes to around 75 minutes in length, and the average interview was 43 minutes long. See Table 1.1 for a description of the sample.[12]

---

[11] The interview schedule resembles that used by Courtwright, Joseph, and Des Jarlais (1989) in their oral history of opiate addiction.

[12] I excluded a 59 year-old Native American and Latino man because he suffered from a brain injury that made much of the interview incoherent.

Table 1: Research Participants

Name	Age	Race/Ethnicity	Education	Employed	Father
Dan	31	White	Masters degree	SSI or SSDI	No
Ron	48	White	Missing	Yes	Missing
Carlos	53	Latino	High school	No, SSDI	Yes
John	49	White	Some college	No, SSDI	Yes
Mike	34	White	High school dropout	No	Yes
Steve	58	White	GED	No	Yes
Jake	23	White	Vocational degree	No	No
David	42	Latino	GED	No	No
Bryan	25	White	High School	No	Yes
Tom	56	Latino	GED	No	Yes
Matthew	28	Latino	High school dropout	No, student	Yes
Kevin	32	White	Some college	No	No
Nick	Missing	Missing	Missing	No, unemployment	Yes
Ethan	34	Native American and White	Some college	No, SSDI	No
Mario	44	Latino	GED	No, unemployment	Yes
Chris	24	White	High school dropout	No, SSDI	No
Xavier	39	Latino	Some college	Yes	Yes
Sam	39	White	Some college	No, unemployment	No
Jack	48	Hispanic	Some college	No, student	No
Paul	56	White	GED	No, SSDI	Yes
Jeremy	29	Latino	High school dropout	No	Yes
Will	49	Latino	High school dropout	No, SSDI	Yes
Victor	41	Native American and Latino	Some college	No, student	Yes
Ben	41	White	High school dropout	No	Yes
Roger	50	White	High school	No, unemployment	Yes
Robert	54	White	Some college	No, unemployment	Yes
George	51	White	GED	No	Yes
Frank	39	Latino	High school dropout	No, SSDI	Yes
Rick	32	White	Some college	No	Yes
Luis	57	Latino	GED	No, SSDI	Yes
Tim	37	White	College degree	No	No
Joe	54	Native American and White	GED	No, SSDI	No

The men interviewed ranged in age from 23 to 59, and the average age was 42 years. Five men (15%) were in their 20s, nine men (27%) were in their 30s, eight men (24%) were in their 40s, and 10 men (30%) were in their 50s. Seventeen (52%) participants were white, 12 (36%) were Hispanic, and three (9%) were biracial. Three participants (9%) reported having obtained at least a college degree, 10 (33%) had received some sort of technical training or had attended some college, 11 (33%) had a high school degree or high school equivalency degree, and seven (21%) were high school drop outs. Only two men (6%) were employed. Twelve (36%) were unemployed with no government support, 11 (33%) were on Social Security Insurance or Social Security Disability Insurance, five (15%) received unemployment benefits, and three (9%) were attending college. Of the men interviewed, 10 (30%) were not fathers, and 22 (67%) were fathers.[13]

Although the interviews were semi-structured and followed an interview schedule, I was open to new directions that the interview took, and I asked unplanned follow up questions when appropriate (Bailey 2007; Rubin and Rubin 2005). The mostly open-ended questions were also designed to allow the research participants to give their thoughts on a particular topic, to keep the conversation going long enough to get good information, and to not make the participants think there was a "right" answer (Madden 2010). So, for example, I asked both what participants "liked about methadone treatment" and what they "did not like about methadone treatment."

---

[13] McMahon, Winkel, Suchman, and Rounsaville (2007) studied men on methadone, and 30% of their sample was employed, which is a much higher rate than my sample consisted of. This can likely be explained by the fact that they recruited from fee-based, for-profit methadone clinics rather than public methadone clinics like Second Chances.

I transcribed 29 of the interviews with the men and an undergraduate research assistant transcribed four of them; at completion of the transcription, there were 526 pages of transcripts. The interviews were transcribed verbatim, but the interview quotations referenced in this dissertation were edited in order to be readable (e.g. stutters and filler words were removed, and accents were not documented) and to have the respondent's intended meaning come through, although doing so may come at a cost in that classed and ethnic ways of speaking are removed (Bourgois and Schonberg 2009; Kvale 1996).

Data Analysis

After the interviews with the men clients were transcribed, I read through the transcripts multiple times and identified patterns and themes common to the interviews (Marshall and Rossman 2006; Rubin and Rubin 2005). The focus of this dissertation is on the themes of family relationships, fatherhood, families or origin, and romantic relationships. These themes came up often during the interviews, many times unprompted, signaling that relationships were an important part of men's lives. In order to see if these findings were valid, I verified them in a discussion with the Clinical Supervisor and during a presentation to the counselors who found the findings interesting and largely unsurprising. The findings are also consistent with McMahon et al. (2007) quantitative findings about fathers on methadone, which supports the validity of my findings.

Reflexivity

My own status characteristics definitely influenced what type of knowledge I would have access to (Bailey 2007). As a non-opiate-dependent, never-addicted, educated, young, white woman doing sociological research, I contrasted sharply with many of my research participants. This had its advantages and disadvantages. On one hand, my differences meant that things that may have normally been taken for granted were made explicit and are thus part of the data. On the other hand, these differences may have meant that I was excluded from knowing or understanding certain information.

My research with the men clients, however, would not be classified as "insider research" (Baca Zinn 2001). It is also possible, however, that my differences may have made some parts of my data richer and given me access to perspectives that insiders to this population would not make explicit. Because my knowledge of heroin addiction and treatment is limited to what I have read in the scholarly literature and learned through fieldwork and conversations with research participants, I questioned much of what to the participants seems mundane. I entered these interactions as a gendered being (Warren 2001; West and Zimmerman 1987), and it may be the case that my gender primed the men clients to talk about their feelings more than talking to a man would have (Kilmartin 2010) or be perceived as non-threatening. Also, if the interviewees perceived me as a therapist/social worker, then they may have opened up more than they typically would have.

On the other hand, I did not share many status characteristics with the poor, drug-addicted men I studied, and all interviews were conducted in English. Although in some

social research this may limit participation of the most disadvantaged, clinic staff reported that at most three clients at the clinic did not speak English. Also, what the respondents said to me may differ from what they would tell someone with different characteristics than me (Bailey 2007). Because I had a vastly different social position than the men I interviewed, it is also possible that they viewed the interview and the questions I asked of them as exploitative (Duneier 2001; Rubin and Rubin 2005). Despite my outsider status, I believe I was able to collect rich interview data.

In order to establish rapport with the clients, I made sure to mention that I did not work for the methadone clinic or parent behavioral health organization, though some clients viewed me as having a position of authority at the clinic where I could suggest changes like having the entrance cleaned. I also dressed casually instead of professionally so I did not alienate the impoverished men with whom I was interacting.[14] Most of the time, my responses to interviewee's statements were neutral—intentionally so—in order to not shut down conversation or appear to be judgmental. Many of the men clients I interviewed engaged with me in a friendly manner. The older clients tended to treat me like a student and often ended the interview by telling me they hoped I learned something or that their thoughts were valuable. The younger clients tended to view me as a peer and seemed to find me a comfortable conversation partner, and our interviews tended to run longer than the older clients. Some clients initially started the interviews more coolly, giving short answers, or by informing me that they had a deadline to meet, but quickly opened up. As discussed in Kvale (1996), the interview was often a pleasant

[14] I often wore jeans, a t-shirt, and a hooded sweatshirt.

experience for those interviewed—both workers and clients—because as he notes: "It is probably not a very common experience in everyday life that another person—for an hour or more—is interested only in, sensitive toward, and seeks to understand as well as possible another's experiences and views on a subject" (36).[15] Mirandé (1997) also suggests that interviews are an "opportunity to vent" and are "carthartic" (21-22).

Hesse-Biber (2007) notes that a researcher's insider/outsider status can change during any particular interview. Though clients often explicitly recognized me as an outsider during the interviews by asking me if I knew what a word they used meant or if I was familiar with a particular practice, at other times they would reference a perceived commonality between us. This was most often the case with the white participants and the class-privileged or educated participants. Some of these white men would admit their racism to me, tell me they were afraid of or would disparage other clients (who were called "gangbangers" and "scumbags"), would emphasize their educational attainments or good background. Other clients would begin referring to me as "man" during the interview probably because their comfort level increased while we were talking and because I do not do typically femininity such as constant smiling and affirmation (West and Zimmerman 1987). Though our status characteristics did not often match, it appears

[15] For example, one respondent said the following at the conclusion of the interview: "Yeah, I thought it was really good talking with you. You seem like you're gonna go a long way. You know, I've talked with people before – you're young, you seem like you got – you know, I don't know. I've talked to other people that didn't seem to hit on things that you did, and I don't know – it made, it made me feel good, you know. Things – getting it out – I haven't talked about my folks in years, you know. Or even think about my kids, and you brought it up."

that we were able to decrease the social distance between us during the interview (Bailey 2007). I am certain that such was the case.

Summary

In sum, I interviewed 33 men enrolled in a single methadone clinic in Arizona in the fall of 2010. This research design enabled me to collect data on men clients' perspectives on how their family relationships mattered for their opiate addiction and treatment. The semi-structured interview schedule allowed men to talk about their relationships, and my outsider status often pushed them to explain aspects of their experiences that may be left implicit in interviews with "insiders."

CHAPTER THREE: FATHERHOOD

This chapter will focus on one very gendered experience for men methadone clients: fatherhood. Rosenbaum (1981) and Friedman and Alicea (2001) argue that scholars and treatment providers should focus on women's gendered experiences in treatment for heroin addiction because women are mothers. Their assumption is that women are tied to children in a way that men are not and that women's treatment should address their role as parents. However, McMahon and Rounsaville (2002) call for researchers to address the fact that men on methadone can also be parents, and so this chapter will address the following questions: *What is the state of fatherhood among men who are clients at Second Chances? How do men perceive that their status as fathers influences and is influenced by their participation in the opiate drug world? Are there ethnic variations in fatherhood ideals and practice? What do these men's narratives mean for fatherhood and masculinity more broadly? Has the "new father" ideal reached this marginalized and stigmatized population?* The data reveal that many of the men in methadone maintenance treatment for heroin addiction are fathers, and I argue that the "new father" cultural ideal is predominant among this group of men, even if in practice they are not always "good" fathers.

The 33 men interviewed as part of this study can be divided into three groups: fathers with young children, fathers with adult children, and men who are not fathers.

The next section will closely examine each group of men and explore their level of engagement with fatherhood.[16]

FATHERS WITH YOUNG CHILDREN

Twelve of the clients interviewed had young children, and eleven of these men were still in contact with their children, even if they did not have custody of them. Most of the men described their children as motivation for trying to get or remain free of illicit substances. Some of the men had had their children removed from their custody by Child Protective Services (CPS) because of their substance abuse problems. Even if they had had interactions with CPS, however, these men had tried or were trying to regain custody of their children. There were a small number of men, though, who had custody of their children, but were continuing to use illicit substances with no plan to stop using. Each of these groups of men will be described below.

Fatherhood as Motivation to Get or Stay Clean

Many of the men interviewed described how becoming fathers or caring for children served as motivation to discontinue opiate use. They often admitted that using drugs negatively impacted their relationships with their children, and that their relationships with their children got better once they entered methadone treatment or that by entering methadone treatment, they hoped their relationships would get better.

---

[16] One of the men interviewed will be excluded from analysis because he intimated during the interview that he once had a son who had died as a child, but it was difficult to verify this information because this respondent had a traumatic brain injury that made him incoherent at times during the interview.

Frank, a Latino man in his late 30s, describes how a police officer diverted him to drug treatment when the officer saw that he was a drug-addicted father who was stealing both to support his heroin habit and his children.

> I: And what was the reason for getting off heroin? Was it just the police officer, or were their other reasons?
> R: It was just what he said, you know. It just made s—you know, my kids, you know I always had that. He saw, he's all, because of the stuff that I had stole was all baby stuff, and he's all, "Why are you stealing baby stuff?" I said, "Because if I can't sell it, I can keep it for my kid." [laughs] And he's all, "Oh, my God. You need help."
> I: How many kids did you have at that time?
> R: At that time, two.

Even though he sought treatment and was able to remain free of heroin for eight years, financial stress led to a six-month drug binge, and Frank was on the verge of getting kicked off clinic services. His family was upset, however, and so he made a deal with his children that if they did well in school, he would do well in treatment.

> I: What made you come back?
> R: My kids.
> I: And so when your wife found out that you were getting kicked off, what was her reaction?
> R: She was upset. She was upset. Very upset.
> I: And do your kids know that you come to the clinic or anything?
> R: Yeah, I'm very open with them. Yeah, I try to let them know what's going on and what happened in my life, what are my downfalls. My oldest is graduating [local high school], and he's got scholarships to ASU [Arizona State University], Northern Arizona [University], something else, all in like Phoenix, but he wants to stay in town, so I don't know if he's going to go to the U of A [University of Arizona] or, but I know he has scholarships for Northern Arizona and ASU.
> I: And so your kids were a motivation to come back to the clinic?
> R: Yeah, cuz my kids tell me, "If you want us to do good in school, you do good." I'm like, alright.
> I: Ok, kind of like a deal.
> R: Yeah, kind of like a swap.

Frank is now doing well in treatment, and he has "excellent" relationships with his seven children with his current wife. He is not in contact with his oldest son from a previous relationship, however, because he claims that this son "didn't want to know about [him] no more."

Rick, a white man in his early 30s, is partnered to a woman who has two young children (one of whom has special needs), but because he has been with her for eight years, he considers himself the father of her children even though he has no legal or biological tie to them. His desire to be a more involved parent helps motivate him to not use opiates.

> Um, yes. Definitely motivation not [to use]. Especially, yeah, the kids definitely helped me motivate me to not to use. You know, cuz I wanna be more involved with the kids, you know. You know, be there for them. You know, go out and just throw the ball, you know, anything. You know, I feel that's what they deserve. You know, and if I'm all, if I'm using or if I'm, you know, I won't be around. You know, that's another big thing that definitely helped me, you know, stop using is the kids. You know, especially [name of child], the youngest. He's a special boy. He's—I love that kid, so that's uh—he's helped me mature and grow a lot. You know, so. Yes, they're very, very supportive and very helpful.

Rick also frames fatherhood in terms of maturity and responsibility. His girlfriend was a former alcoholic, but they decided that their sons are more important than their desires to use drugs and alcohol.

Xavier, a Latino man in his late 30s, frames fatherhood as an incentive to get stabilized on methadone in order to be able to work to support his family. Like Rick, Xavier says "it's not just about [him] anymore."

> No matter what, so right now, methadone right now, has got me just in a stable— it's got me stable where I can function. I can hold a job. I can think rationally, you know. I just got married. I have a little girl and stuff

> like that. Now it's not about me anymore, you know. Back then it was always just about me, but now, I have two other mouths to feed, you know, and two other lives to worry about, and stuff like that, so.

Xavier has an infant daughter with his new wife (and a teenage daughter from a previous relationship who lived in a different state with whom he is in regular email contact).[17] He chose to go on methadone because he has a family now that he has to take care of, support, and worry about. Although methadone enables him to keep a job and he spends a lot of time with his baby, figuring out how to financially support her is stressful and triggers his use of prescription pain pills.

> You know, cuz I got so much coming up. You know, like my baby was coming up and I was like almost being evicted out of my house and stuff like that, so.

Although he was struggling with money problems and relapsing on drugs, Xavier emphatically declared that both his teenage daughter and his infant daughter are strong motivation for staying clean.

Jeremy, a Latino man in his late 20s, is a single parent of two young sons, and they live with him in his aunt's home. He has a contentious relationship with his aunt who wants him and his sons to move out.

> I don't do anything like that, and yesterday, she—cuz I had hair on the shirt and shorts, and I washed them by themselves so they didn't get hair on anything else— and she tell me, "Oh, well, you, why you wash only two things when you could have washed other stuff, and you don't do nothing here. You gonna have to get out and find another way to take care of your kids." And I'm like, you know, ff—I wasn't, if I didn't have my kids or strong enough to keep going forward, I probably would have gave up already.

---

[17] Scholars have noted that men who maintain contact with their children can be good fathers even if they are not geographically close to their children (Palkovitz 1997).

His sons not only act as motivation to maintain their housing situation even though he has conflict with his aunt who houses them, but they also are clear motivation for remaining off illicit substances. While fatherhood acts as motivation for him, his children's mother still uses illicit substances and cannot handle how active the children are, so he parents alone (obviously, with his aunt's help).

> R: No. Every now and then their mom will give me food stamps for the kids.
> I: But does she have a lot of contact with them?
> R: She says she like wants them, but I give her to them, I give them to her on the weekends, and she like can't handle them. She tells me, "They're too bad." She can't take them, so she makes me have them. And I won't see her for two or three weekends, and then another weekend, well, she'll be like, "Can I have my kids?
> I: Is she using at all?
> R: She does weed. She smokes weed. Contin. She does pills. I know she does something.
> I: Would you say she's addicted to pills, or she's just using them?
> R: She's probably addicted.
> I: And uh, so does, the, are they just kind of more active kids, and she—
> R: They are, they're pretty bad.
> I: [laughs]
> R: They're like, you tell them something a couple of times, and they don't listen, so you gotta be on them, you know. I love my kids, so I couldn't dream about, you know, ditching my kids. So I stick [with them]. They're stressful, but they're kids, you know.
> I: Yeah. Well now they're in school a lot of the time, so.
> R: Yeah, well that gives me a good break, a big chunk of time away from them. And then when I'm there and they're there, and I'm like, "Oh my God."
> I: [laughs]
> R: Go to the park or something. Let them release it.

Even though his kids require a lot of energy to parent, Jeremy loves them and says he would not consider giving them up. Because he is a single father, however, he does not have the time to attend the groups offered at the clinic, which might well aid in his drug recovery and his parenting abilities.

John, a white man in his late 40s, talks about how methadone treatment has allowed him to have custody of his young daughter.

> I: How's your treatment going right now?
> R: Good. I've been clean for several months now. But I knew that my daughter was coming back into town. Her grandmother had taken her back to [Northeastern state] supposedly for a couple of months, and it turned out to be over a year. And she's real piece of work. Anyways, I wanted the opportunity to see her, and this will be the best way. I never planned on having a family. I thought I was too old, and it turned out the girlfriend I had when I was just released from prison like a year or two earlier, in early 40s…she told me she was on protection, and she wasn't, so and I don't believe in abortion. So, we have a beautiful little girl that's six, you know.

John never thought he would have children and that he was too old to have a family. But he unexpectedly had a child with his girlfriend, he took the necessary steps—getting on methadone—to be able to take care of his daughter.

In sum, many of the fathers with young children have or want relationships with their children, and even though fatherhood is often challenging, these men make decisions that take their parenting role into consideration.

Addiction Outweighs Fatherhood Responsibilities

For two of the twelve men with young children, the fact that they were fathers did not outweigh the demands of their addiction to heroin and other substances. One of the fathers interviewed was still using heroin several times a month. George, a white man in his early 50s, has been on methadone for years and has earned the privilege of only having to come to the clinic twice a month. His wife and son disapprove of methadone

maintenance as a form of treatment for opiate addiction, but tolerate it, although apparently if his wife knew that he was still using, she would divorce him.

> R: I don't think I ever told him. I think [pause]—well, I guess I had to have told him. I used to bring him here when he was small, and I had to, when I had to come here more often many years ago. And he'd always wonder what this place was, and he'd hate it here cuz he said—he just didn't like it here, so I think that's how he found out about it.
> I: Ok, and do your wife and son know that you still use heroin?
> R: No.
> I: So is your relationship with your family pretty good?
> R: It could be better.
> I: It could be better. Do your son and your wife ever act as motivation for not using?
> R: [pause] Yeah, I-I would s—yeah, definitely. Yeah. Yeah. More time—yeah. Cuz otherwise I'd probably…yeah, definitely. Otherwise I'd probably still be getting high every day.

Despite George's family's disapproval of any opiate use, family stress triggers continued opiate use, and his family acts only as motivation for not using every day rather than discontinuing illicit opiate use altogether. Xavier, discussed above, also mentioned that he coped with family stress by using opiates, but unlike George, Xavier emphasized that his family responsibilities also motivated him to try to be successful in treatment.

Ben, a white man in his early 40s, has seven children, six of whom live at home with him and his wife. All but the youngest children know that he receives methadone treatment for a morphine addiction, but he keeps his continued crack use a secret.

> I: And how did your family find out about your morphine addiction?
> R: I told them. Yeah, because I would get sick and shake, and they're wondering what the hell is going on? Like, what's up with you?
> I: So what was their reaction?
> R: At first, it was like, "Ah, Dad. You just need to stop that shit and don't do it anymore." And I would get sick. I couldn't bear it anymore. I'd have to go get some because I couldn't fucking stand it anymore. Fucking shaking and just terrible. I felt like I wanted to die, so I would go get

> some, and then that's when we decided I needed to get something sorted out. I found out about this place.
> I: And are your children and your family motivation to kick the morphine and kick the crack addictions?
> R: Well, they don't know about the crack. I keep that.
> I: And that's something you don't want them to know about?
> R: Yeah, no. No, absolutely not.

Even though he did enter treatment for opiate addiction, he is actively using crack cocaine and keeps this drug use secret from his wife and his children. When pressed about whether his children are motivation for discontinuing his crack use, he sidestepped the question and framed his desire to stop using crack in terms of being tired of spending money on it.

In sum, only two men indicated that they did not intend to stop using illicit substances despite the presence of young children in their home. While this is a minority of the men interviewed, their experiences illustrate that family stress can induce drug use and that sometimes fatherhood enough of an incentive to stop using.

Fatherhood and the State: Child Protective Services

Four of the men interviewed had Child Protective Services (CPS) remove their children from their custody due to the men's drug abuse. Two men had their rights permanently severed from their children because of their substance abuse problems. In both cases, however, their children are being raised by family members, and the men still have contact with their children. Bryan, a white man in his mid 20s, is currently homeless, still using drugs, and has an on-again, off-again relationship with the mother of

his one daughter. His parents live in a Midwestern state and are raising his three year old daughter.

> I: Did you have any relationship at all with your daughter before?
> R: Yeah, yeah I did. We actually….we took pretty good care of our daughter. I mean, for being strung out and everything, too. She never went without anything. Um…so I mean, I know it sounds pretty stupid, saying we were pretty good parents despite the fact that we were addicted to heroin, but [laughs] we did take care of her, and she still knows who I am. Not so much her mom cuz her mom hasn't so much as even talked to her since she's gone to live with my parents, but my mom will call me every now and then cuz she keeps asking to talk to me and stuff, and so she still knows—she remembers me. She knows who I am.
> I: Do you have any plans of ever living with her again or?
> R: I don't think I could ever live with her again. I don't think the courts would ever allow that, but I could live somewhere like nearby and see her probably on a daily basis, which yeah, that'd be something I'd wanna do.

Even though he does not have custody of his daughter, he is in occasional phone contact with her, which is something his mother allows when she calls him twice a month. Bryan emphasizes that his daughter still knows and remembers him, and wants to communicate with him, and that he would like to live near her and see her daily even though he knows he will never have legal custody of her again. He argues that even though "it sounds pretty stupid," he and his daughter's mother were good parents when they did have custody of their daughter even though they were abusing heroin.[18] Now, however, his daughter's mother has no contact with their child, and as he describes below, she never made any real efforts to clean up, which Bryan contrasts with his efforts, even though they were not successful, to sober up to regain custody of their daughter.

---

[18] Friedman and Alicea (2001) also found that some of the heroin-addicted women in their study defended themselves against charges of child neglect and claimed to be good mothers. Similarly, Baker and Carson (1999) found that even though drug-abusing mothers knew that their drug abuse negatively impacted their children, they still claimed that their good parenting practices made them good mothers.

> Well, when they first took her [daughter] away, I came here, and I was doing real good. Going to [dual diagnosis treatment program], and I was passing all my drug tests for CPS, and she [daughter's mother] was always talkin' 'bout getting' clean, but just never did. So it seems like it might just be availability for women, but it seems like it's a little harder for them to make a commitment to getting clean, or I don't even know about commitment cuz it's never real—at least to this point, hasn't stuck with me—but I've at least been able to get six months clean here and six months there whereas she couldn't even manage to get, you know, a day.

Matthew, a Latino man in his late 20s, had a child with a woman who was using meth while he was using opiates. CPS got involved, and his mother had temporary custody of his child, which turned into permanent custody. Because of a bad relationship with his mother, this permanent custody also meant not having a relationship with the children.

> So, they let my mom have him, and then she—the whole CPS process, it's long. So she had him 'bout a year before it came down to the last court hearing when they were gonna decide where he's gonna go to. And I felt bad that to take that away from my mom, you know what I mean. She had that close bond to my son, so I tried to get joint custody, but every time I would try to prove that I had income coming in, she'd fuck that up, and she turned on me. "Oh, he's a drug dealer." And going on and on and on, and then my family was like, "Dude, you're gonna get caught up. You're mom's telling on you. They're gonna be watching you." So I just ignored everything. Every letter, every letter that came through the mail, every phone call.

Because Matthew feared that CPS was "watching" him while he was dealing drugs, he ignored correspondence from CPS and did not fight to regain child of his son. Despite the fact that Matthew no longer has custody of his son and feels bitter about the fact that his mother fought for sole custody and told the court that he was still dealing drugs, he discusses how his son and his mother have a great relationship. His son calls his grandmother "mom," and she provides a nice life for her grandchild with a good deal of

financial security. Matthew also maintains a relationship with his son who he calls on the phone every day. This man may have another child who is currently two. However, he is uncertain of his paternity (see Furstenberg 1995 for a discussion of "contested paternity").

> I: And how about the younger one? You said he's two?
> R: Yeah, well, I feel bad because, you know what I mean, that—it's like, I'm not sure if he's my kid, you know what I mean. He doesn't really have, it's—that's a long story. Me and her—well me and her. She's the one that got me in trouble actually. I'm the one who got locked up. I got busted cuz of her and her brother actually. I mean, I stayed in his life. I did my time and came out and got back with her even though she did to me, and…I don't know. We just split up recently, and I just think to myself, "Why would I? Like you guys laugh at me and talk shit to me if I do give you money because I'm a sucker and everything. ' So ha ha, that's not even his kid, and he giving me money for it.' And if I don't give you money, I'm a deadbeat dad, so I'm a piece of shit either way. You know what I mean, so I'm now I'm gonna just stay away from you."
> I: And you said you have a DNA test.
> R: Oh, I'm waiting. I tell her, "You give me a DNA test. I'll pitch—I'll support." I don't give a shit—it's my son.
> R: Do it, do it. I'll do a DNA test. I'll pay for it. And I tell her, "Put down me for child support. I don't care. I'll take a DNA test, whatever." And she doesn't do it, she won't do it, so obviously that's. If you don't wanna do it, obviously, looks like you're saying that you don't wanna look stupid, cuz you know that's not my son.
> I: Do you have a relationship with him at all?
> R: Mm hmm. He was—yeah, he calls me dad, but I—he's a baby still, so I'm—right now, I haven't seen him for like a month. But yeah, we've been with each other just recently. Like I saw him, I saw him more than I saw my first son.

Matthew describes the conundrum he faces. If this child is his, he wants to financially support him and not be considered a "deadbeat dad." But he also does not want to support some other man's child, especially since he is not in a romantic relationship with the child's mother, and be a "sucker." And even though he does not know if this child is biologically his, Matthew still sees him, and the child calls him "dad." This is an

example, I believe, that illustrates that cultural ideas about the "good" dad have found their way to this population of opiate-dependent men, and like Gerson (1997) asserts, men do not desire to be deadbeat dads.

Nick[19] has an active case with CPS, which has removed two of his three children because he was abusing drugs. He had two sons with a woman who died from a heroin overdose. He was a single father before CPS got involved, and his family currently has custody of his sons. He is now married to a different woman and has a daughter with his wife, but is currently separated from her. He is taking the Parenting classes offered at Second Chances and fighting to regain custody of his sons who he sees on the weekends. He visits his infant daughter three times a week. He reports that the Parenting classes are helpful because they teach him things he did not know about children.

> I: Is [counselor's] parenting class helpful?
> R: Yeah, very helpful. Teaching me a lot of things that I didn't know about kids.
> I: Like what?
> R: Discipline. Um, what their needs are. Things like that, you know. And, you know, how to give them time for and space.

There was only one man who did not have any contact with his young children. Mike is a white man in his mid 30s whose wife is also opiate-dependent and a client at the clinic. His narrative of the termination of his parental rights follows below.

> I: Ok. And how would you say the pain pills and heroin impact your life?
> R: I lost my children because—they weren't taken because of drugs, but they were eventually, they terminated our rights and stuff because we did drugs.
> I: How many kids do you have?
> R: I have three and a stepdaughter, but my two youngest, my sons, they were [removed at] like two months old.

[19] Missing data on ethnicity and age.

> I: And so, what happened with that? Did someone call CPS on you? Or did you—
> R: No, we—my wife—my son was born. He had an emergency C-section, and he had transferred over the state line to hospital in [Midwestern state], and young people dealing with babies that are having trouble, you know, and stuff—they have like a social worker people that they can talk to. And the lady…she stereotyped me or just whatever. You know, she saw the ankle thing on my wife, and she's putting her nose where it didn't belong anyway, and called because [she thought we were criminals]. It was—they got involved because of that. And then, they'd do UAs, and she was on whatever, so then she dropped dirty, so that was, that was that. And we given a list of l50 things that has to do with neglect or abuse and that kind of stuff, and when they petitioned to the court, if the judge thinks that there's a possibility that one of those things are true, then they automatically, you know, that's all that that it takes for them to take your kids is for the judges to assume that it's possible. Which I mean, it's possible anybody that had that list, I mean, they could be the best parent in the world, and one of the things they would have on there would be, you know.
> I: Yeah. So were all three of the children taken at once?
> R: No, my daughter was with my ex-wife, and…I lived in [Southern state], and her and I split up then. Now she's living with her grandma and grandpa for the last ten years cuz her mom was in prison. And then my boys were taken [Midwestern State].

This man places the blame for the removal of his children on "stereotypes" of criminals and drug addicts and argues that the parental standards the legal system has are so stringent that anyone could have their children taken away, regardless of how good of a parent they are. However, he also admits that both he and his wife are poly-substance abusers who have committed many crimes to support their habit and are currently homeless. Scholars have claimed that women bear the brunt of public condemnation for parenting while addicted (Bourgois and Schonberg 2009; Friedman and Alicea 2001), but Mike's experiences illustrate that men, too, are negatively sanctioned for being addict-parents.

Although Mike does not consider himself responsible for the loss of his children, he did attempt to do drug rehabilitation in order to get his children back before his parental rights were completely severed and his children adopted. Still, he and his wife were unable to successfully complete rehab. Mike also expressed sadness about the loss of his children and noted that seeing other fathers with their children triggered a desire to use heroin to deal with his grief.

> What are my triggers? Like when I'm dealing with panic attacks, which I don't get very often. That'd be one. And sometimes I'll see dads walking in the store with their boys, and…the boy would be about my kid—my oldest son's height. I'm wondering if they're happy, so it's just like memories and for me, seems like you're grieving, and I can't really fight. And they say, "Fake it to you make it." But you're sitting in group and you got people in there, you know, man.

It is significant that only one opiate-dependent man out of the twelve fathers with young children was not in contact with his young children at all. That a third of the men interviewed had young children they had custody of or contact with demonstrates a need to take fatherhood into account during treatment interventions.

FATHERS WITH ADULT CHILDREN

Ten of the men interviewed were fathers of adult children. A few of the men were not in contact with their adult children for various reasons, but it was not uncommon to hear these men voice regret that they did not have relationships with their children and wanted to reestablish contact. Some men who were formerly estranged from their children were able to reestablish contact. Other men had grandchildren with whom they enjoyed close relationships. Most of the men with adult children and grandchildren

described how these relationships served as motivation to attempt recovery from opiate addiction. In some cases, men had such close relationships with their adult children that they relied on them heavily for support.

Desiring Contact

Three of the men interviewed had adult children with whom they were not in contact. Of the three, two desired contact. Steve, a white man in his late 50s, used heroin most of his life and had spent decades in prison. He describes how heroin ruined his life, including his family life.

> I: Ok. And how did using heroin impact your life?
> R: [coughs] It ruined it. I mean, you know. Sent me to prison. I just did twenty years in prison just now.
> I: You did a full twenty?
> R: Well, I did 16. I was out for a couple months, and they violated me. Back and did three and a half, so. Yeah, I'd say it's, yeah. Yeah, I was out three months, so yeah, it wasn't enough not to count, so.
> I: Did you go for drug related things? Like dealing?
> R: No, yeah, well they—yeah, yeah. They were all related to drugs, yeah. And it's ruined my life. I lost two wives, two families. Um…you know I lost everything. Twice. Everything, you know, uh—I have a dau—granddaughters. She's 14 years old, I've never seen [her]. I'm embarrassed to go see her because of my—I don't wanna see her…in the shape that—I don't wanna see her. She doesn't even know me. But my daughter does, and my son does. And I don't want them to tell her, "same old dad," you know, "heroin addict, this and that," you know, so.

He notes that he divorced twice and now has a granddaughter with whom he is not in contact because he feels shame about being perceived as a heroin addict. However, as Steve later describes in the interview, he regrets cutting off contact with his family when he went to prison, and although he regrets his lack of contact, it may have been better for his children (Bourgois and Schonberg 2009).

> I: But you haven't seen your family in [city where clinic is located]? But they're in contact with your parole officer?
> R: They were, yeah. And they were in contact with my other one. They asked me, you know, how I was, and to write them and all that. And—
> I: Are they supportive of your treatment?
> R: Uh, I'm not in cont—I—I have no-when I got sentenced, I was just like [makes a cutting gesture]—I'm done with you guys, you know. Live your life, I'll live my life. If we meet again, happy trails, good luck, everybody God bless, later. Cuz um…I didn't think that they should have to do my time with me. Now I regret it. I'll be honest with you. Now I regret it.
> I: Why do you regret it?
> R: Well because…now I have to work in order to build a relationship with them. Where if I would have stayed… …stayed with them, you know, in contact and all that, which my sister was our contact, I wouldn't be in this situation here, trying to locate them or anything. I would have all that established. Now I gotta do it, you know, I have to redo it. And it was a selfish move on my part. Made my time easier. You know, I'll admit, I'll admit that. That it was selfish.
> I: When are you planning on contacting them?
> R: As soon as I get—after I get this Interferon [treatment for Hepatitis C] taken care of. And, you know, just get a few little things in a row, you know. And then, you know, I'll get some, you know…there's a few things I have to get together, you know, and that, but I want my life to be—I wanna be some sort of …I don't know how to say it, but I want them to see me as, as…I don't want them to see me as I was. I wanna them to see me as I truly wanna be. You know, that's what it is. I don't want them to see me as I was. I wanna them see as I, as I wanna be. You know.

Steve desires to reestablish contact with his adult children and to see his grandchild. Before he sees his family, though, he wants to be fully integrated into society as a "citizen" or a "square." Steve wants his family interactions to be "normal," and he wants his family to look at his living situation—he has a couch, can make dinner, drink coffee, etc.—and be able to see that he is no longer a "dopefiend."

> I: I was just asking about contact with your family [respondent had just nodded out].
> R: Oh, yeah. Um. No, they—that's what I'm working towards. That's what I'm working towards. That's my goal. [Name of friend], the guy

> that's letting me stay at the house out back, that's not just my goal. It's his goal to help me do that. That's what I wanna do. I don't wanna do it, like I said before, I don't wanna do it as the old dopefiend. I wanna do it as, they come cuz we're remodeling this place. I want, you know, sofa, couch, you know, make them dinner. Have some coffee or whatever and sit down and talk and…get all the old stuff and get it hashed out, and get it over with. Yeah. And just to see them, just to have a cup of coffee or something. I just wanna—that's my goal. That is my true, honest, I could die happy then. I could actually die fulfilled, you know, so. But I don't wanna go at it [coughs] as—I don't wanna s-to be a dopefiend. When I see them. I wanna be a citizen. I wanna be, you know, "Well, look. You finally got your life in order." That's how I want it to be. So.

Like Hamilton and Grella (2009) found in their study of older heroin addicts, Steve does speak about how his heroin addiction led to losing relationships with his family, but he speaks about the impact it has had on him rather than the impact it has had on his family.

Paul is the other man in the sample with adult children with whom he wants to reestablish contact. He is a white man in his mid 50s who has two children and six grandchildren. His female partner also has adult children who had been removed from her custody by the state and long ago adopted. His adult children lived on the East Coast, and he explains the lack of contact with his children as a past custody issue. According to him, his children's mother and his mother-in-law had kept him away from his children, in part because they were Mormon, and he was not. He did report wanting to reestablish contact, however, in part because he is aging.

> I: And are you planning on getting in contact with your kids and grandkids?
> R: I think about it a lot, lately. Especially more now.
> I: And why do you think you're thinking about them more lately?
> R: Probably because I'm getting older and [pause] and I don't know how much time I have left, you know. It's a matter of—you know you get—but you see, I'm not sure you know. I could tell you that and still not see them, you know. I don't know how it's gonna go.

Only one man in this sample had adult children with whom he was not in contact and with whom he did not report a desire to reestablish contact. Carlos is a Latino man in his early 50s with one adult daughter. He has not had contact with her since he and her mother separated.

> No, no. Me and her mom, we don't get along. Since we split up, I haven't talked to her since, and she hasn't talked to me. But anyways, she—they live in [West Coast state]. So my daughter never calls me, never bothers me, so I don't do anything, too. You know, talk to her cuz she's gotta take the step first. And my mom tells me, "Why don't you call her and do this and that?" I go, "How am I gonna call her when she lives with her mom, and her—me and her mom don't get along?"

Carlos and Paul had a similar situation wherein their former partners controlled access to their children, making it difficult for the men to maintain relationships with their children post-parental separation (see Pasley and Minton 1997 and Doherty 1997 for a discussion of "maternal gatekeeping" post-divorce). However, Carlos has a much different response. Even though his mother urged him to reestablish contact with his daughter, he views it as his child's responsibility to begin a relationship with him.

Re-establishing Contact

Some men had lost contact with their children because of custody issues or because they were incarcerated for long periods of time. When their children were adults, however, these men reestablished contact with them. Roger, a white man in his early 50s, describes how his daughter's mother "kidnapped" her when she was a young child, and that this emotionally devastated him. When he got out of prison the last time

and finally decided to stop using heroin, his primary motivation was reestablishing a relationship with his daughter.

> R: Ok, this clinic. There was another time that I said, "Ok, enough is enough. I'm not gonna go to prison. My next prison term, I'm gonna be there forever. For the rest of my life." Uh…my daughter was kidnapped from me when she was four, by her mother. And she wouldn't tell me where she was, and I just kind of, that's another thing that did it, too. I just lost it. I didn't care about myself, I didn't give a care about anybody. Nothing, nothing, nobody, I didn't care. But I didn't have the guts to kill myself [laughs]. Told myself when I saw my brother hanging in a tree like that I wouldn't do it. Said, "It's a chicken way." So I got, you know, why I quit was I, you know, I wanted to be in my daughter's life. So I went into this place [drug treatment center].
> I: So when you were in [drug treatment center] in downtown [California City], were you clean at that time?
> R: Yeah. Cuz I actually—I really wanted something different. So I did, and I also within that time I got in contact with my daughter. Her high school graduation—
> I: Were you able to go?
> R: --was the first time I seen it. I saw her.
> I: So you hadn't seen her since she was four.
> R: Since she was four. I didn't even know if she, you know, where she was.
> I: And where was she?
> R: She was at her great-grandma's house. She was going between [Midwestern City] and [other Midwestern City]. Where she was born.
> I: Ok. And was it a good experience to see her?
> R: It wasn't good. It was great. Most excellent. Broke down in tears, yeah. At the airport for about an hour. But I very rarely cry in front of people.
> I: Right. And was she a motivation to stay clean?
> R: Oh, yeah. Oh, yeah. [laughs] Oh, yeah.

He was able to see his daughter graduate from high school, and his reunion with her was very emotional and provided a motivation to stay clean. His adult daughter now has children, but none of them know Roger is on methadone maintenance. Roger also is uncertain about whether he has another child, and like Matthew, requested a DNA test.

> Yeah, I have one daughter. I don't know if I have any other kids. I think there might be a son somewhere. Some lady, some lady [laughs]—some lady, this girl I knew popped her head up, said, "Yeah, well. You know I was pregnant with your kid, and you have a son?" "Well, let me see him. Where's he at? Let's do a blood test, you know?" She, "Yeah, yeah. We'll see, we'll get around to it." And I've never seen her since, so.

Robert, a white man in his mid 50s, talks about how his adult daughter's mother refused to allow him to see his daughter when she was a child, and he did not reestablish contact with her until she was an adult.

> Me and her [adult daughter] got a strange relationship cuz I didn't—I knew of her, but I didn't get to know her until she was 18. Her mother was playing some game, and then when she turned 18 and started getting a little wild, her mother decided to, she meet you she can—you might be able to help her. It's like [scoffs] it's kind of late for me to do anything for her. She's going to look at me like I'm some stranger who—where have I been, and why should I listen to me. And that's basically the way she looked at it, but since then we got along better. We're on speaking relationship. You know, she likes me. I like her. She doesn't…you know, it's not like she comes to me for advice or anything. Shh, I'm nothing to her. You know, which she feels about me probably a little bit better than I feel about my dad, so you know, I give myself credit for having a little bit more of I feel about my dad, but that's about it.

While Robert is ambivalent about the quality of his current relationship with his daughter who he says he is not really close to despite his perception that they like each other, he does say that he is a better father than his own father was. Several of the men's narratives about losing touch with their children post-divorce suggest that maternal gatekeeping (Pasley and Minton 1997; Doherty 1997) negatively impacted the men in this study, and still impacts the quality of their relationships with their adult children.

Grandfathers

Four of the men in the sample are grandfathers, and they report close relationships with their grandchildren or that their grandchildren are motivation for getting clean. Victor, a Latino and Native American man in his early forties, has two daughters in their early 20s who both have children of their own. Even though he and his wife used opiates throughout their children's lives, this man reports that his grandchildren are a big motivation for him to stop using.

> I: Ok, so you have some grandkids. And were either your daughters or your grandchildren motivation for not using or for staying clean?
> R: Well, yeah that for sure, yeah. That's a big thing. Of course. I wanna take, you know, I like to spend time, more time with my grandkids. And not just that, but like, take them places.

Not only does he desire to stop using in order to spend more time with his grandchildren, he also is implicitly describing his desire to get off methadone because he wants to be able to take his grandchildren places.

Similarly, Roger, a white man in his early 50s discussed above, reports that he does not like methadone because it prevents him from traveling to see his grandchildren who live in a different state.

> I: What haven't you liked about your experiences with methadone and the clinic?
> R: I don't like the control it has over me. I have to be here every morning. I don't have any—well I had take homes when I was working. And now they've been taken away from me cuz I relapsed, and I did the methamphetamine, and I gave them a dirty test, so they took those that I had gradually worked up to. Like if I wanna go on vacation to go see my daughter or my grandkids, you know, it's in their hands. You know, they have control over that if they'll give me the take alongs or if I go to another clinic while I'm there. My, daughter doesn't know that I'm on this now. And I'd prefer that my grandmother don't know—my great-

> great-grandma don't know. She doesn't know, and whereas if I have to go there and then go to another clinic while I'm there they'll know.
> I: Why don't you want them to know?
> R: [long pause] Just another disappointment that I've given them.

In addition to methadone treatment preventing him from traveling to see his family, he also does not want his family to know he is on methadone because it will prove a disappointment to them, and having to travel to see them without take home bottles and, thus, having to guest dose at another methadone clinic means that his secret will be revealed.[20]

> I: And you have grandchildren from this daughter?
> R: Two.
> I: Two, ok.
> R: Granddaughter and grandson.
> I: And you have a relationship with them?
> R: Well, I mean, I'm not in [Midwestern state] right now, so.
> I: Right.
> R: "Hi, how you doing?" You know? Send them Christmas presents, birthday presents, stuff like that, yeah. Cards. My daughter wants me to move out there. That's another thing. See, I move out there, how can I do that with this?
> I: Are you considering it if you weren't—
> R: I am. I am thinking about it. But, man I got kick this, I gotta kick the methadone. Before that happens.
> I: But you would like to be around your family?
> R: My daughter—if I have a dying wish, that would be it. To be able to spend it with my daughter and my grandkids. I mean, mind you, they're going through a lot. Well my grandson's going through a surgery with his ears. They have to put tubes down their ears. My granddaughter had to have it, and then we find out that my grandson had to have it. Not coming from my side of the family cuz none of my [laughs]— Comes from her

---

[20] When methadone maintenance clients at Second Chances have tested negative for opiates and other drugs three times, they are eligible to receive a take home bottle once a week, which means that they have to come to the clinic one less day each week. As they continue to demonstrate that they are no longer using illicit substances by producing negative drug screens, they gain additional take home bottles. If a client wishes to travel and does not have any take home bottles, he must arrange to dose at a methadone clinic at his destination.

> side of the family. Grandma wants me there, too, so. It's her grandmother, but—She'd rather have me there than have her granddaughter [laughs].

Roger has such a strong desire to be geographically close to his daughter and grandchildren that he is thinking about detoxing off of methadone. This would be a necessary condition of him moving closer to them because it shames him so much to be on it. This is similar to Steve (described above) who does not have contact with his grandchildren, but as soon as he has a normal life that does not resemble that of a heroin addict, he will get in touch with them.

Being a grandfather is also important to some of the men described above who do not have contact with their grandchildren. It seems as though grandfatherhood may serve as a second chance to have family relationships that these men may have missed out on before because of custody issues, incarceration, or relationship disintegration due to the men's substance abuse. Or it could be that these men are not immune to larger cultural trends where men spend more time with grandchildren when they retire (Kahn, McGill, and Bianchi 2011). In this case, "retirement" is from opiates rather than the labor force.

Children as Quasi-Parents

Some men who are in contact with their adult children have relationships in which the traditional parent-child dynamic is inverted, and their children become quasi-parents to their opiate-dependent fathers. By this I mean that the direction of emotional support goes from the adult children to their fathers rather than from the fathers to their adult children. Tom, a Latino man in his mid 50s, talks about how he has an adult daughter in

her mid 20s who is a schoolteacher. His ex-wife had custody of their daughter when she was younger, and they lived in a different state. His daughter now lives in Arizona and has children of her own.

> Oh yeah, I live very close to my grandkids. Cuz, you know, my daughter, she's like, you know, me and her like now because the way she sees me, you know what I mean, I was working, you know what I mean. I have a car, you know, I'm fatter, I'm healthier than to where I was before, you know what I mean. I was like thinner because I was always, you know what I mean, up and down from what I was doing. And like now, she knows that I, I mean, I don't sell drugs, and I'm more like involved in other activities. So she's like, you know, she's kind of happy about me cuz, you know, that's the way she wants to see me.

Tom describes his daughter's happiness based on the fact that he is doing well in treatment at the methadone clinic and notes that she can see that there is a significant difference between his present and former life. He is healthier and no longer sells drugs. His description of his relationship with his daughter is not in terms of how he feels about her, however, but more in terms of how she feels about him, which inverts the dynamic that parents typically have with their children.

Will, a Latino man in his late 40s who was a heroin addict all through his children's lives, has an adult son and daughter. His son is currently in a Masters program for Social Work and works for CPS, and Will reports that both his adult children are supportive of his methadone treatment.

> I: Do they know you're on methadone and want you to be okay?
> R: Yeah, that's my son and my daughter. They know about it. They're supportive. My son's very supportive of it. And he already knows what I want to do. He's with it. He knows that I want to get off of this. And he's bringing down to 100. He's supportive about it. And I told him, if I need to take it forever 'til I die, well that's what I'm gonna do.

His son's involvement in Will's treatment seems to reverse the parent-child role as the son helps his father achieve his goals of stabilization on methadone, and if possible, his eventual detox.

Luis, a Latino man in his late 50s, has adult children from a previous relationship, and his current female partner also has adult children from a previous relationship. He describes the concern their adult children have with their parents' wellbeing and how the children take an active role in both their parents' relationship and drug treatment.

> I: And does she have any children?
> R: Oh, you know, well they're all grown up, you know. I have kids of my own, and she's got kids of her own.
> I: But they're older?
> R: But they're older. They're all grown up, and they're grown, and I got to meet them, and she got to meet mine, and you can tell that they feel good. They feel good that we get along. The way that we both get along, you know. Very well. And they're very, you know outgoing about that, you know. And they, we just, the, the very best, you know. And make sure that, you know, we both doing good, you know. And they're always very asking, you know, like, "Hey, how you guys doing, man? How's he's treating, how's it going between you two?" "You know, your relationship—is it coming along? Is it going along just fine, or, do you need any help or anything to, you know." Yeah, you know, and those are the kinds of things, you know, that they want to see. That not to be afraid to ask for help when we really need it.
> I: And how many kids do you have?
> R: Not many of them. I just had three of them.
> I: Three. And they're all adults now.
> R: Yeah, they're all adults, yeah.
> I: And do they know that you're on methadone?
> R: Mm, they all know.

Their children know that their parents are on methadone treatment, and Luis and his partner see their children as a resource to use if they need help. His children are also pleased when treatment is going well.

In these cases, similar to Roger who is described above, the men seek approval from their adult children. Unlike other men with adult children, these men are open with their children about their opiate addiction and treatment, and get support from their adult children.

NON-FATHERS

Eleven of the men interviewed did not have biological children, and if their female partner did have children, they did not identify as fathers to those children. Some of these men still discussed fatherhood and parenting, however, and so their perspectives are included below.

Concern about Being Parent or Judgment toward Using Parents

Some of the childless men expressed concern about becoming a parent. Dan, a white man in his early 30s, explained his decision to not enter into romantic relationships or have children.

> But my life's on hold until I get this repaired. You know, I don't even date because of it. You know, I don't wanna get into a relation—you know, I hear about all this stuff, pregnancy an' stuff. And babies being addicted to methadone, or when the male's doing it that it causes retardation, and stuff like that. And don't get me wrong, if I had a child that had problems, you know, I would treat it the same, but the problem with me is, I don't want to bring a child when it's my fault. When I could have, you know, date and say, after using methadone for a couple of years it affects your, you know, what happens to your children and stuff, so. You know, I think I'm the only one out of my family that doesn't have kids, you know. There's seven of us, and I just always believed bringing a kid into the world, that you need to totally support them. You know I got a home and stuff, but I can't totally support a kid. You know, I got seven dogs, and I have a hard time taking care of them, you know, so [laughs].

Dan's reservations about fatherhood are twofold: he is concerned that taking methadone will directly impact his child's health and possibly cause developmental problems, and he is concerned that he will not be able to adequately care for his child. He conceptualizes care not solely in terms of economic support, but also in terms of the quality of the relationship. He notes that he owns a home, but would not be able to "totally support" a child just like he has difficulty taking care of his dogs. Additionally, he refuses to get into a dating relationship until he is off of methadone, which in a different part of the interview, he calls a "prison sentence" because it keeps him in Arizona and does not allow him to travel to where higher paying jobs might be. His ideas about the need to be stable before having a child and then being responsible once one has a child are most likely the product of his race and social class background. He has a Masters degree, his parents are in the professional class, and even though he is only 31 years old, he has earned up to $120,000 a year as an adult.

Similarly, Ethan, another white client who also identified as being partially Native American and who is in his mid 30s discussed how he was "careful" to not ever have children. Also, other men expressed judgment about methadone clients who are parents. Jake, a white man in his early 20s, describes people who are pregnant and on methadone or who lose custody of their children because of drug problems as "scummy."

> I: Is there anything you don't like about methadone?
> R: Having to go around scummy people.
> I: Really? At this clinic?
> R: [coughs] I'm sorry. I'm really blunt sometimes. Yeah, that bothers me sometimes. When I can't go and get my dose, and I have to listen to people that are pregnant and they take methadone. And their kid—and they're talking about, "Oh, yeah. My kid did get the detox off methadone."

> And I don't—and, "Yeah, I have two kids in foster homes, and my mom adopted one, and blah-blah-blah-blah-blah." And hear these two people. I don't wanna surrounded by crap like that.

Similarly, Sam, a white man who is in his late 30s, describes how he has an issue with a woman client at the clinic.

> R: Yeah, these are the clients. It's just one girl. She just—I don't even wanna get into it. It's not even worth it. Just trying to help her out, and she thinks that people hate her, and it's like not that. It's just, she lost her kid. You know, she got her kid back, and then she lost him again, and it's like, we saw some things I'm not even gonna repeat because it's not worth it for her to even, to get back to the counselor. We helped her out the first day, and the second day it was like we saw her driving down the road. It was like, we had to tell her boyfriend and stuff. And now their kid's gone again, now they're broken up, you know, and I feel partly responsible cuz I told, but it's one of those things where when you have kids and stuff, you gotta be responsible, you know. I'm not gonna let somebody hurt a kid or, you know, hurt themselves just because they wanna be drugged out, you know.
> I: And so she knew you were the one that reported?
> R: She knew that I was the one that told her husband, but the reason why I'm mad at her is that she told me that I called the cops on her. Which I didn't do. And in prison that's a big—you don't call me a cop-caller, you know. That's just ground for, it's a fight after that, you know. And I can't hit any girls, so I just make comments to her, you know, and that's not really fair either. I shouldn't do that either. That's not right either, but you know, it's one of those things where she needs to learn that, you know, "You're a little girl. You're only 18, 19 years old. You've lost your kid. You need to get your shit together." Cuz I never had kids, that's why I never had kids because I knew I wouldn't and couldn't take care of them. So, and then I don't like people that are young and have kids and have drug problems. I don't agree with it. Don't have any kids. Put a condom on. Be smart.
> I: Ok. And so, she is the only one—
> R: That's the only one I have any problem with.

Sam has a specific problem with this mother who he thinks is engaging in behavior that would hurt her child, and he explains that he refuses to allow a child to be hurt. But he also extends his critique to drug-using parents generally, and argues that they should not

have children they cannot take care of. Finally, he also notes that he chose not to have children because he knew he could not take care of them, which echoes Dan's discourse of parenthood requiring responsibility. It is not unusual for women-addicts to be judged as poor mothers, something that previous literature has found (Rosenbaum 1981; Friedman and Alicea 2001).

FATHERHOOD AND ETHNICITY

The table below summarizes the fatherhood status by ethnicity of the men in the sample.

Table 2: Fatherhood by Ethnicity

		Ethnicity		
		Non-Latino[21]	Latino	Missing
Father	Yes	10	10	1
	No	8	2	
	Missing	1		

In this sample, Latino men are much more likely to be fathers than non-Latino men,[22] and the variation in fatherhood status is much greater among non-Latino men than among Latino men. Of the 21 fathers in the sample, there is an even ethnic split. Of the 10 non-fathers in the sample, however, 80% of them are non-Latino while only 20% are Latino. And of the twelve Latino men interviewed, 83% are fathers while only 17% are not fathers. Whereas of the 19 non-Latino men interviewed, 53% are fathers, and 42% are not fathers.

---

[21] Non-Latino men consist of 17 white men as well as two white men who identified as white and Native American (from tribes not indigenous to Arizona), but who appeared to be white.

[22] This finding has also been documented elsewhere (Anglin et al. 1988).

There are three other prominent patterns related to ethnicity and fatherhood. First, the only men who had reservations about becoming a parent or who expressed judgment about parents who used drugs or received methadone treatment were white men. Second, only Latino men had relationships with their children wherein the children had a caretaking relationship with their father, which may be due to strong intergenerational family obligations for Latinos (Andrade and Estrada 2003; Fuligni and Pedersen 2002). Third, the only fathers who report continued drug use with young children in their home with no intention to discontinue such use are middle-aged white men. These differences support previous research that has found that parenting and family ideals and norms are raced and classed (Glauber and Goziolko 2011).

DISCUSSION

Scholars have found evidence of a shift in fatherhood ideals, but most studies have been of relatively privileged men (e.g., Coltrane 1996; Griswold 1993). Some work has examined marginalized populations, such as men of color or poor men (e.g., Furstenberg 1995). And recent work by McMahon and colleagues (2007) has examined fatherhood among one especially marginalized population—opiate-dependent men. This research builds upon McMahon's work and previous sociological research by examining the culture of fatherhood for poor, opiate-dependent men, many of whom are Latino.

This research highlights men's descriptions of fatherhood in their own words, something missing from previous research, which has been largely quantitative in nature.[23]

Opiate addicts constitute a group that prioritizes the needs of the self over care for others. This is both because of the nature of addiction generally and the nature of opiate addiction specifically.[24] The findings from this study suggest that even in this self-centered population, being a father is an important part of these men's lives. An overwhelming majority of the fathers in this study have ongoing relationships with their children, even in cases where one might expect relationships to have been terminated. The presence of children in these men's lives often acts as a catalyst for them to seek treatment and motivates them to continue to abstain from drug use while in treatment. Some of the men report a desire to economically support their children, something they view methadone treatment as enabling them to do, while others focus more on being emotionally involved and caring for their children.[25] They note that having a family means they must be mature and responsible, even if their children's mother is not. When addicted men's children are removed by the state, they make efforts to maintain relationships with them, which is often possible because children have been placed with a family member. And in the single case where a father was unable to remain in contact, he reported a deep sadness that his children were taken out of his care.

---

[23] Bourgois and Schonberg's (2009) ethnography of a group of homeless heroin addicts in San Francisco is a notable exception. Though they were not studying fatherhood specifically, they did describe men's family arrangements.

[24] Without daily opiate use, the addict goes through severe physical withdrawal.

[25] And in the case of a few men, they are emotionally invested in children to whom they are not biologically related or to whom they are unsure if they are biologically related.

Men with adult children also report that their relationships with their children matter to them. Most of those not in contact with their adult children express regret about this, and for some of them, their motivation for successfully abstaining from heroin use and making it through methadone maintenance treatment is reestablishing relationships with their children and, in some cases, grandchildren (Hamilton and Grella 2009 also found that methadone allowed older adults to reunite with family members). Some men who have reconnected with their adult children talk about the joy of their reunion. Other men emphasize their role as grandfathers and talk about how important their grandchildren are to them, and how methadone treatment both enables them to be grandfathers (because they are not prioritizing heroin use), but also constrains their ability to see their grandchildren as often as they would like and to participate in certain activities with their grandchildren (because the need to dose daily at their local methadone clinic prevents them from traveling or because they are ashamed of methadone maintenance and would like to keep this treatment a secret from family members).

Finally, when some of the men without children explained why they chose not to have children, they discussed their decision in terms of not only financial responsibility, but also not being in a state of mind where they could provide adequate emotional care to children. While the fathers in the study espouse the "new father" ideals, the fact remains that they are opiate-dependent, and the heroin world, which includes methadone treatment, still in large part determines the quality of their family ties.

Similar fatherhood ideals are found in all three groups of men and are independent of life stage or fatherhood status, and this indicates that the dominant cultural norm of fatherhood is one of an emotionally involved father who cares about his children in contrast to the disciplinarian or provider roles of the past (Coltrane 1996; Griswold 1993). Given that all of these men are poor, the presence of this ideal indicates that it is no longer just a middle-class norm (Griswold 1993). The two men with young children who did not express a desire to stop using illicit substances despite having custody of their children, and the one man with an adult daughter with whom he did not care to reestablish contact with are not at all typical of the majority of fathers interviewed. Importantly, the "new father" ideal is found among young Latino men, as well. Mirandé's (1997) work indicates that this ideal has probably always existed in this population. It should also be noted that there was a sub-cultural father-child relationship wherein Latino men became dependent upon their adult children for emotional support while going through treatment. Whether there is a generational fatherhood ideal difference among Latino men or whether Latino men's expectations for and practices of fatherhood shift over the life course was not a focus of this study.

Notably, only two fathers referenced economic provision as a part of fatherhood. This could be evidence that the cultural shift in fatherhood no longer includes economic support, or it could be that for this population, providing for children is almost impossible and thus is not in their cultural vocabulary for fatherhood. Only two men in the study have jobs (one of whom is a father), and sixteen who receive government support, which

in the United States is a small amount. The remaining men have no legal source of income.

Some may argue that these men emphasized the importance of fatherhood and children because they lack access to other signifiers of manhood (Gerson 1997; Griswold 1993). While this may be true, however, other research has shown more class-privileged men to also hold these ideals (Coltrane 1996; Shows and Gerstel 2009); thus, these findings seem to suggest that fatherhood is becoming more important for all groups of men. In fact, by examining fatherhood ideals in a group of men who are multiply disadvantaged and finding a match to the "new father" reported in the empirical literature, there is stronger evidence that there has been a firm and widespread cultural shift in fatherhood ideals.

In sum, even though these men have been addicted to opiates, may currently be using illicit substances, are in a stigmatized form of treatment for a stigmatized condition (Agar and Reisinger 2002; Hunt and Baker 1999), and in some cases have had state interventions in their family life, they still care about their children. Just as previous literature has found that motherhood is a motivation for opiate-addicted women to go on methadone (Friedman and Alicea 2001), fatherhood is likewise a motivation for men to go on methadone, which supports previous literature that has found evidence that opiate-dependent men do take seriously their fatherhood responsibilities (McMahon et al. 2007). The larger cultural shift in men's attitudes toward fatherhood has found its way even to this multiply marginalized group of men. The men interviewed express "new father"

ideals, emphasizing that they value their children and want to have nurturing, emotionally involved relationships with them.

Because fatherhood is tied up with masculinity (Hearn 2002; Hobson and Morgan 2002; Griswold 1993), it seems as though marginalized masculinity (Connell 2000, 2005) has come to include nurturing relationships with children and grandchildren. It is impossible to determine from these data whether this is because of shift in hegemonic masculinity to include nurturing, or because structural conditions such as poverty force interdependence for this group of men. For the Latino men in this study, drug abuse that negatively impacts family relationships is a sign of not being a responsible man (Mirandé 1997), and when these men indicate that their children motivate their decision to sober up, they begin to demonstrate the positive aspects of machismo (Quintero and Estrada 2000). For all the men in the study, while drug abuse may have been a sign of masculinity in public culture (Bourgois and Schonberg 2009; Pyke 1996; Quintero and Estrada 2000), it may be the case that once in the methadone clinic, impoverished men emphasize other signs of masculinity, such as their emotional investment in their family relationships (Pyke 1996).

CHAPTER FOUR: FAMILY OF ORIGIN

The previous chapter explored men's relationships with children and their views on fatherhood. However, I also asked the men in this study about their relationships with their family of origin. To date, the literature on men in methadone treatment has tended to focus primarily on fatherhood (e.g., McMahon et al. 2007) rather than other family relationships with some notable exceptions (e.g., Binion 1982; Clark et al. 1972; Nurco, Blatchley, Hanlon, O'Grady, and McCarren 1988), thus limiting our understanding of the role of family connections for treatment. This chapter will situate men on methadone within a larger family context, providing more information about the ways that family relationships (beyond parent-child relationships) help or hinder men's attempts at treatment. This analysis also makes a contribution to the literature on sociology of the family because it examines adult men's relationships with their families of origin, something that is not often the focus of research on the family (Knoester 2003).

This chapter will focus on how men talk about their family relationships, answering the following research questions: *How do men on methadone talk about their families of origin? How do men perceive the quality of their family relationships? What role in men's opiate addiction and treatment do men ascribe to their family of origin? Are there racial and ethnic differences in family dynamics with these men? What do these findings mean for masculinity more generally?*

The first section will discuss how men describe their family background and how this relates to their opiate addiction. The second section will describe men's perception

of their family's reactions to their opiate addiction and treatment. The final section will highlight men who are currently estranged from family and contrast them with men who currently provide care for family members. This chapter argues that these men, and their experiences with opiate addiction and treatment, cannot be taken in isolation. Their family relationships seem to both hinder and help their attempts at sobriety.

FAMILY BACKGROUND

Men's discussion of their families of origin (parents, grandparents, siblings, and parents' siblings) can be grouped into two broad categories: 1) negative, troubled, destructive relationships; and 2) positive, supportive relationships. It is important to note, however, that this distinction is conceptual rather than concrete. That is, men often reported both positive and negative aspects of their family relationships, or positive relationships with some family members and negative relationships with others, or relationships that had changed from positive to negative (or vice versa) over time. This section will discuss the negative aspects of opiate-dependent men's family background. Men's family members often enabled their opiate use and addiction, in some cases even providing drugs to them.

Family Introduction to Drug World

Ten of the men in the sample described how their families of origin either enabled them to use drugs by providing financial support or actually provided them with illicit substances. Dan, a white man in his early 30s who has wealthy parents, describes how as

a child he watched his parents casually take pain pills. Dan's family set an example that drug use was normal and permissible. Furthermore, his father even helped him procure painkillers from doctors in his professional network.

> I: So, did you only ever get painkillers from a doctor?
> R: No, there was a couple times—how it worked was that if I couldn't get them here, my doctor—I would just make a phone call and—see, my dad and this doctor were friends for—went to high school and everything so all I had to do was make a phone call and he call the pharmacy here and transferred them. Well the law has changed.

Apparently this was not an uncommon practice within Dan's social network. His notes that he and his friends did not have to have drug dealers because their parents gave them access to prescription drugs.

> You know, when I was a kid, you know, I could buy any kind of [drug] at school. And I went to a private school, you know, private Catholic school. And more kids had drugs that they got from their parents' house. We didn't need drug dealers, you know. "My mom's taking this, your mom's taking that, blah blah blah." They had parties where they mixed everything into a bowl. They didn't even look at what they were taking. And that's very popular. You know, in college I was just amazed how many over the counter drugs that there, you know. I mean, not over the counter, but prescription drugs that people would take, you know. First question that I was asked to me by my roommate was, "What medications are you on?"

Finally, Dan's parents enabled his painkiller addiction by sending him thousands of dollars to purchase the pills.

> I had to be at work and I was feeling like crap, and it was, you know, I would call my parents and lie to them and say, "Hey, I, you know, whatever blah, blah," and they would send me couple thousand dollars, and I would just buy enough pain pills to last. Because here, I mean it's expensive, you know. Thousand dollars would be a month supply of pain pills for me, you know, and that's if I didn't over-do it, [laughs] you know?

Although Dan's parents had a casual attitude toward drug use, and his mother is currently using what Dan perceives to be an excessive amount of pain medication, Dan also claims that he comes from a good family background and that his parents raised him with strict, "old-fashioned" morals.

Similarly, Jake, a white man in his early 20s, described how in his wealthy neighborhood, teenagers get prescription drugs from their parents and grandparents.

> I: But a lot of people were using like pain pills?
> R: Yes, a lot. And I mean, it was a pretty heavy market because a lot of people were getting it from their parents or their grandparents or stuff like that. And pretty steady supply cuz the pharmaceutical companies have really—a couple years ago—really just started handing them out to people. You could get OxyContin for all kinds of stuff.

Unlike Dan, Jake's parents did not help him procure illicit opiates, but his older sister did introduce him to drugs when he was in the fifth grade. She brought him around her friends who were using and dealing various drugs. When he reflects on his entry into drug usage, he is angry with his sister for giving him drugs when he was young.

> I: Do you have any siblings?
> R: I have an older sister, and she's the one who got me into drugs.
> I: How did that happen?
> R: She's six years older than me, and she got into her rebel stage. Let me try pot when I was in fifth grade. Her friends that were all fucked up on angel dust. Uh, spiked one of my drinks when I was young and made me trip out on PCP. I didn't know until I was older that it happened, but I put the pieces together, and I wasn't really happy. But my sister was the one—she ran away when she was 16 to go live with her 23-year-old Mexican Mafia drug-dealing boyfriend. And she took me to places that were stash houses, and there were kilos. Shit, I went to a mansion. A little mansion, and there was a kilo broken out on the table just like was nothing, some Scarface [reference to the movie of the same name that dealt with drug dealing] shit. Like I've been to some places when I was young that I never want to see cuz my stupid sister.
> I: Is she still using?

> R: I don't know if she is. No, I don't know—I hope to God she's not. I know she smokes pot, but she doesn't use my Contins like she used to. She stopped doing that for a long time.

Even though Jake's sister was the person who introduced him to drugs, he has kept his opiate addiction and treatment a secret from her, hoping that she does not know because he is embarrassed by his addiction.

Joe, a white and Native American man in his mid 50s, talks about how all of his older siblings used.

> I: Ok. And you said your sister also was using?
> R: Yeah, yeah. She started using back in [Eastern state], and she and her husband left [Eastern state] and came to come out here to get away from it, and they didn't do nothing but jump from the frying pan into the fire. Cuz that—it was more plentiful here, and it was cheaper. I mean, you could get a gram—you go down to Mexico and get a gram for fifty bucks back then. But I can get a gram here for forty bucks now.
> I: Did any of your other siblings use?
> R: Just, no. My two older sisters did. But my middle—I got my oldest sister and then I have another sister. And she blew out one of the valves in her heart shooting cocaine, and they had to give her blood transfusions. And back then, nobody knew anything about AIDS. So she got AIDS.

While Joe did not say his older sisters facilitated his use, he was surrounded by illicit drugs while growing up. Like Dan, Joe's parents also gave him hundreds of dollars, which he used to purchase drugs.

Jeremy, a Latino man in his late 20s, has been using painkillers since he was 15, and his mother was the person who initially provided him with the pills. Several other family members in the generation above also used drugs.

> R: Painkillers. I had messed up my shoulder, and then my mom's the one that got me started. She told me what they were for, and I got them, liked them. Taken them ever since. The pain's stopped a little bit in my shoulder, and I still take them. I guess I got addicted.

I: Did your mom get you to a doctor who gave you the painkillers, or did she—
R: No, she'd give them to me. She had them. When I get a prescription run out, and she'd have them, so.
I: Ok. Was she prescribed them or—
R: Yeah.
I: Yeah. So does she have chronic pain?
R: She did. She died. She OD'd.
I: On the painkillers?
R: Yeah. Painkillers and a mixture of opiates and psych meds.

Jeremy's father was absent a majority of the time, but whenever he dropped in, he also gave Jeremy pills. Jeremy credits methadone with saving his life and preventing him from dying of a drug overdose like his mother did. He says, "It kind of saved my life cuz if I wouldn't have had it, I'd probably be with my mom right now." His mother never tried methadone, but he thinks if she would have, it would have helped her.

Roger, a white man in his early 50s, explains a lifetime of heroin use, beginning when he was 15 and continuing into his 40s, as the result of his family's drug use. He had several older siblings who gave him access to various psychoactive substances. His older brothers gave him alcohol when he was eight years old, which started a period of drug experimentation. He would also steal his mother's prescription medications, and as a teenager, he smoked marijuana with a sister two years his senior. While Roger's older brothers used various drugs, and even were responsible for introducing him to alcohol, he was not permitted to use drugs in their presence. However, he and his sister, who are only two years apart in age, did smoke marijuana together, though she did not know about his other substance use.

I: Were your older brothers giving you access to this stuff, or was it through friends?

> R: [pause] Beginning it wasn't they—my brothers, my brothers were doing it. But I wasn't allowed to do it in front of them. I wasn't allowed to do it as to their knowledge, but my sister [sister's name] and I—we're only two years apart, so. It was really a lot of weed with her. She didn't know about the other stuff.

Roger also revealed that he was molested when he was a child, but his mother did not believe him, and he also attributes his heroin addiction to this.

Sam, a white man in his late 30s, also describes how the family who adopted him introduced him to drugs. Even though his family did not give him heroin, they did provide cocaine, marijuana, and methamphetamines. His first drug experiences were with his family.

> R: My whole life I've dealt, I mean my family, everything—it wasn't like I learned drugs on the street. It was from my family. Even my first line of coke was done with my family, my first line of meth was done with family, my first marijuana was done with family, you know, so it's kind of hard to—how do you decide what's right and what's wrong when everybody, from when you're a kid up until the time you're my age now, it's still acceptable, you know?
> I: And were your parents users or your siblings users?
> R: They're actually my adopted parents. My actual parents, my biological parents, all I know of them, is that I came from Arizona Children's Home and that I was adopted, but both my biological parents were heroin addicts. Somewhere I read, I think they said, it's not genetic, so it doesn't, that doesn't make you want to be a heroin user, you know. Just because your parents are doesn't you're going to be. You just happen to turn out that way, you know.

Sam's birth parents were heroin addicts, but his adoptive parents used other substances such as alcohol and marijuana. He does not think there is a genetic component to addiction and does not blame his biological parents for his heroin addiction. However, he does think that the environment in which one is raised influences later substance use by noting that he did not learn about drugs "on the streets," but rather from his family's use.

One man had both a biological and social reason for the link between his family of origin and his subsequent heroin addiction. Xavier, a Latino man in his late 30s, was actually born dependent on heroin because his mother was using while pregnant.

> I: How did you start using heroin in the very beginning?
> R: Mmm. My parents were addicts. My mom was a heroin addict.
> I: Ok. And so the stuff was around?
> R: Always around.
> I: And from the time you were little?
> R: Yeah. I was actually born having withdrawals.

He explains that he became a heroin addict because he was surrounded by it growing up. In fact, he had even used heroin with his mother who had been an addict his entire life. He found out about methadone from his mother and stepfather who had both tried and failed at this form of opiate addiction treatment.

> I: Had you heard about methadone before you came to Arizona?
> R: Oh, I heard about methadone when I was like 15 years old. My mom's been like on methadone. My stepfather was on methadone and stuff like that.
> I: How did it help them? Did it help them out?
> R: Um…I don't know. Uh, my mom's still an addict. Uh, my stepfather's dead. You know, he died of HIV and I don't think it did, no. I think it stopped them from using and stuff like that, but it kept them still wanting, you know, to use and stuff as well.

Xavier's mother's heroin use resulted in CPS removing him from her custody at times, and he also ran away from home multiple times as a teenager. He notes that he had truant officers assigned to him and that he has been on his own since he was twelve years old.

Other men had family members who enabled their drug use in a less direct way. Will, a Latino man in his late 40s, had parents who provided housing for him. Because living with them meant that his expenses were low, he could drop out of high school and divert money to support his drug habit.

> Well, during my life, consequences was that I dropped out of school cuz I was—I was a senior member. I dropped out of school, and the thing about it is that I was staying at my parents, you know, when you're with your parents, well you know you don't have to pay rent, you don't have to buy food, you don't have to worry about your clothes.

Additionally, when Will was married to a woman who did not use drugs, his parents home provided a place to stay when his wife threatened to kick him out if he did not stop using.

Frank, a Latino man in his late 30s, talked about how his parents inadvertently facilitated his entry into the drug world by their ignorance of the rampant drug use in the neighborhood in which they lived and because their work schedules meant he was not closely supervised as a child.

> I lived in [the Northeast]. It was just a drive across the bridge. I got older brothers, and just…parents worked a lot. My parents were constantly working. They migrated here from [South America], so they didn't know what was going on, you know? Yeah, I just, you know, I don't blame them. It's not their fault. I mean, of course, they're trying to achieve the American dream, have everything everybody else had. Cars, house, they gave it all to us. And when it came down to [laughs] knowing about drugs, they didn't know much, so we'd go loaded to the house, they wouldn't know a damn thing. I was twelve years old when I started doing dope, and that was because the neighborhood my parents bought the house in, they got taken there. The only time they had off to go buy a house believe it or not was early morning, so the people that sold them the house took them there, and they had them believe it was like this excellent neighborhood. It was right by my mom's job, so my dad felt comfortable, and he bought the house. Well, within a month of moving there, he realizes we just moved, we're the only Hispanic family in an all-black neighborhood. Yeah, so, it just, drug use was like, if we didn't do drugs, it was like get beat up or, you know, be the outcasts. Everybody our age was doing it, so it was more of a hang out and survival thing.

Frank's parents were immigrants from South America, and they both spent most of their time away from their home, which meant that they were not supervising their children

and did not know that their sons were using drugs at home. Frank's parents also unwittingly moved their family into a crime-ridden neighborhood where drug use was the norm.[26] Additionally, his parents made large sums of money and gave it to him, which allowed him to finance his drug habit.

> I: And how did you end up at [Second Chances]?
> R: Um…I got in trouble a few times. They found out I had a problem, and they called it "self-medicating." I call it "I'm still a drug addict regardless," but they said I was using drugs to medicate voices cuz I'm bipolar-schizophrenic, and they said that's all from drug use or from trying to calm things down. I just say, "Honestly, I was a spoiled brat." My parents—they didn't know what we were doing. They would just give us money and they didn't know what—you know what I mean? I mean, my parents, my dad made a thousand a week. That's four thousand dollars a month in 1978. You know how good that is?
> I: Really, really good.
> R: Yeah. My dad's house, my parent's house sold for $750,000 in New Jersey. So all that money they used to like help my oldest brother and my sister. They hooked us all up, but I wasted mine stupidly, you know?

Frank notes how his counselors have told him that the absence of his parents because of their busy work schedule left a void in his life that he tried to fill with heroin, but Frank has resisted this interpretation and says he was just "a spoiled brat" with parents who ignorantly facilitated his drug use.

In sum, five of the men interviewed were given drugs of some sort by their parents, four were given drugs by their older siblings or had older siblings who used around them, and four were given material resources that facilitated their substance abuse. A third of the Latino men in the sample had families who facilitated their entry

---

[26] Gil and Vega (2010) also point out that a lack of supervision due to work responsibilities coupled with living in "low-resource, disorganized urban neighborhoods" (115) can explain Latino adolescents' low educational attainment and subsequent substance abuse.

into the drug world, and about the same proportion of white men also had families who facilitated their entry into the drug world. There do not appear to be any ethnic differences in this respect.

FAMILY REACTIONS TO ADDICTION AND TREATMENT

The men interviewed described varying reactions that their families of origin had to disclosures of opiate addiction and treatment. Sometimes family members expressed negative judgments about addiction and treatment, but other times they were supportive of the men's attempts at sobriety.

Judgment about Opiate Addiction

Opiate addiction is a stigmatized condition, and family ties do not necessarily shelter men from the stigma. Several of the men interviewed talked about the negative reactions their families had upon learning of their opiate addiction. Ron, a white man in his late 40s, explains how his mother feels about addicts.

> I: Are you in contact with your family at all right now?
> R: Oh yeah.
> I: And do they know that you're in treatment?
> R: I keep it to myself. I'm kind of conservative.
> I: Were there periods that you didn't talk to them because of substance abuse?
> R: No…maybe when I was a kid, but, you know, I just kept that from them. But when I was at [drug treatment center], they talked me into telling and I regret telling really. Cuz my mother is such a, how would I put it? She says, she'll make a comment like, "You'll go back to drinking one of these days." Well, she won't even say the word drug addict. You know what I mean. Cuz to her a drug addict is—like a child molester is up here, and a drug addict's down there [gestures with hands], you know what I mean.

> I: Ok. So she won't acknowledge it now?
> R: Yeah, she won't. But, I mean, at the same time, she can tell that I'm doing better and we have a pretty good relationship.
> I: Good.
> R: Best to keep some things to yourself.

Ron thinks his mother considers drug addicts beneath child molesters in the status hierarchy and cannot even bear to admit that her son is a drug addict, calling him a drunk instead. While Ron has a "pretty good relationship" with his mother now that he is in treatment for heroin and alcohol addiction, he regrets ever telling her about his addictions, even though a drug treatment program he participated in insisted this was a necessary step.

Other men described their addiction and treatment as a secret, something they are embarrassed by. Jake, the white man in his early 20s described above, talks about how though he does not regret much in his life, he wishes he had not used painkillers because it caused, embarrassing, "weird social behavior."

> You know, I can honestly say there's some embarrassing times, and looking back, you know, I'm someone that don't—I haven't regretted anything in my life. But that's something that I wish I could have changed cuz fuck, it's just embarrassing. You know, cuz I saw all my friends do it. And that was another thing that bothered me. When you got a house full of eight people, and they're all passed out. Fucking weird [laughs]. It's weird behavior. It's weird social behavior. You go to someone's house, and every one is drooling on themselves, passed out. It's fucking disgusting.

He emphasizes his shame over using opiates and says he does not want his family to define him by his former use for the rest of his life. Though he currently smokes marijuana, he contrasts this use to heroin use and thinks his family should be happy that

his drug use is limited to this relatively benign drug. They know he smokes pot and do not approve.

> It's a big, dark secret. I don't want them to know for one. I'm embarrassed myself. I don't want everyone to judge me for the rest of my life for a mistake that I've done. They judge me for pot, and pot isn't as bad as heroin. But they think pot's bad? Shit. Look at heroin. And when you have the audacity to judge me for pot, whatever.

Bryan, a white man in his mid 20s, describes how using heroin led to the loss of his family of origin. His parents live in a Midwestern state, and even though he occasionally talks to them on the phone and they have custody of his daughter, he does not receive any financial help from them and is currently homeless. He was kicked out of his parents' house for using drugs, and in his words, they didn't "like finding needles in the garbage." Matthew, a Latino man in his late 20s, also had his mother fight him for custody of his son through the CPS process because of his opiate addiction.

Kevin, a white man in his early 30s, tells how his family was really upset when he told them about his opiate use and disappointed when he relapsed multiple times.

> I: What were the consequences of using opiates?
> R: I never had any close calls or any like overdoses that went bad or anything. Just, I guess, physical repercussions with my family, I guess. Friends. Really upsetting my parents. You know, really disappointing them time after time when they found out, and trying to get clean and relapsing a number of times, and, you know, it really put a stress on my relationship with them.
> I: So how did they find out? Did you tell them?
> R: Yeah, originally they didn't know for, I think I was 25, so there's what? Seven years of heavy using going by that they didn't know about. And then my behavior had just really changed drastically, and they started noticing something. And they thought I was just having psychological problems. They knew I was depressed, but they didn't know to what extent. And then finally, one night I just, I got really depressed. I broke down, cried, and I told them about everything I was doing, how long it'd been going on, and they were pretty shocked to find out. And the very

> next day, they tried to put me into a rehab program. One of those in-patient detox programs.

Kevin describes the disappointment his parents felt as his revelation, and noted that his repeated unsuccessful attempts to sober up put a stress on his family relationship. When they found out that his opiate use was coupled with severe depression and suicidal ideation, they arranged for him to go to in-patient rehabilitation. He did not last long in this program, however, because he was afraid of the other patients who were "gangbangers" on meth who stole a bracelet from him while he was sleeping. This "was the last straw" and really hurt him because the bracelet was a gift from his parents. When he left the program, he began using again, and when his parents discovered his continued use, they gave him an ultimatum, which led him to seek treatment again, this time at a private methadone clinic.

> They knew I had used, but after the rehab they thought I was clean. They didn't pick up that I was starting to use again, which I did for like the next year. And, how'd they find out? Oh, they actually found like paraphernalia in my room at the time cuz I was living at home with them. They found evidence of paraphernalia that I was using. Confronted me about and said, "Well, you have to do something. You know, you can't do this if you're going to live here or anything. You have to do something with your life." So at that moment, I tried a um—I didn't want to do the rehab thing again, so I tried um—I used a private methadone clinic.

Eventually Kevin left that clinic to come to Second Chances, and he is currently living with and being financially supported by his parents. He still feels guilt over stealing from his parents when he was trying to support his heroin addiction.

The men who talk about the shame or embarrassment that accompanies their family's knowledge of their opiate addiction, or who frame their discussion of their family in terms of disappointment or revulsion, are all white men. Bourgois and

Schonberg (2009) also found that white men frame discussion about their families of origin in terms of feeling ashamed at being rejected by their families. It could also be the case that Latino men have not experienced familiar rejection because maintaining family relationships is very important in Latin cultures (Gallardo and Curry 2009).

Judgment about Methadone Treatment

Many of the men clients interviewed described how their family members were judgmental of their choice to receive methadone treatment. This form of condemnation is distinct from family's negative reactions to disclosure of opiate addiction. Men's family members often did not perceive a distinction between legal and illegal opiates—or the addiction and the treatment for the addiction[27]. Dan, a white man from a class-privileged family in his early 30s discussed above, describes his mother's perspective on methadone maintenance.

> And you know, I got the stipulation that my parents think there's no difference between methadone and me taking, you know, pills. So, but she's fine with the idea, you know, "I'd rather see him on methadone, than to be seeking drugs, drug seeking." And she's took me counseling and stuff for it. And, I kind of put the ropes on her too and said, "You know there's a lot of these medications that you really don't need yourself." And she got upset at first, she thought about it and she said, "You know you're probably right, I shouldn't." And you know, so ever since then, she's been on a pain clinic thing.

Dan also notes, however, that his mother is happier to have him on methadone than to continue to use pain pills illicitly because it reduces negative behaviors such as lying. This does not seem to have been her first treatment choice for her son's opiate addiction,

---

[27] Friedman and Alicea (2001) also found that family members do not view methadone maintenance as a legitimate form of treatment.

however, because she took him to counseling first. Dan also describes how his mother inappropriately uses pain medication, though, and she concedes his point. Not only does his mother judge methadone, but Dan's younger siblings have also criticized his addiction and treatment.

> My brothers and sisters—you know, I'm the oldest. They tried to push this whole, "What do you think you're doing, blah blah blah, we looked up to you," and they still, you know…But yeah, they were—at first they weren't supportive. But, you know, I'm not any different from what I was. I'm still a supportive brother. I've bailed them all out and helped them out in different ways. You know, I sign their checks for school and stuff. My dad sends me the money, you know, and I take care of all their financial. They're all in college, so they all need that financial backing. And they all need a place to stay when they come to [Arizona], and stuff, so. It, you know, out of respect, they started supporting me. You know, it's not the family joke anymore, you know. It was for a while, you know. I didn't do Christmas or Thanksgiving. You know, to them, that hurt them because, you know, it's Christmas, Thanksgiving. I don't care if you robbed the bank, [laughs] you know, you need to be here with your family. Our family's very close like that.

His younger siblings lost respect for him when he admitted his addiction and when because of his addiction he missed out on important family gatherings, but he argues that he was still the responsible older brother who has helped them out by offering them a place to stay and taking care of them financially. Because he demonstrated his responsibility, he has regained their respect and is no longer "the family joke."

Similarly, John, a white man in his late 40s, talks about his parents' negative impression of methadone maintenance treatment.

> I: Has your mother been supportive of treatment?
> R: Yeah, I would say so.
> I: How about your father? Did he know about this?
> R: He's supportive of treatment to an extent. He's very anti-drug, you know, he's no-nonsense. He flew spy planes, and…we had quite the difference in lives, believe me.

> I: Did either of them have any opinion about methadone as a form of treatment?
> R: I think they both definitely preferred it over, you know, drug use. Uh, illicit drug use, but then there's the issue of it continuing. When you get off the methadone.

John's father openly disapproves of any sort of drug-based treatment intervention, while his mother is more supportive of treatment because she can see positive changes in her son's behavior. However, although both parents prefer methadone over heroin use (similar to Dan's mother's reaction), they continue to ask John when he will get off of methadone.

Jake also experienced family judgment about methadone treatment. He is currently living with his grandparents, and his grandmother is upset that he ever used drugs and that he is on methadone, though she does drive him to the methadone clinic everyday.

> I: Are your friends and family supportive of your treatment?
> R: My family is mixed. My grandma's really old-fashioned, and that's who I'm living with right now. And she has the philosophy that I should have never used drugs in the beginning. But she is happy that I stopped using drugs. My defense is, "What the hell do you want me to do when I've spent five years addicted to drugs? You weren't happy then? Why can't you just give me six months and let me get off of 'em completely?" You know.
> I: So is she okay with the methadone?
> R: Oh, yeah. She's okay. She takes me, you know. If I can't take myself, she helps me. You know, she's supportive. My grandpa's a bit more understanding. Like I could go to him and talk to him about my problems with addiction and stuff. Before he helped me buy suboxone[28] cuz he realized that I was in a situation that, you know, I—you know, what do you do when you're sick? You know, what do you do when you want to quit and your body says, "Fuck you. Get the drug." Your fucking mind says, "No, I don't want it."

---

[28] Suboxone is one brand name for a drug called Buprenorphine, which is a synthetic opiate and an alternative to methadone treatment.

> I: Right. So your grandfather helped you out sometimes?
> R: Oh, yeah. My grandpa's pretty supportive. My grandma's a little harder to get the help. I mean, like that. But she's still supportive.

His grandfather is more supportive of methadone, however, and has even paid for Jake's suboxone treatment in the past. Jake also notes that his mother is "a bit more understanding," but still dislikes his opiate dependence.

Kevin's family also dislikes his methadone treatment, although they like that he is no longer using heroin or painkillers.

> I: Are they [family] supportive of methadone?
> R: They are for the fact that it helps me stay off the, you know, that it's helping me stay off the drugs. They'd prefer if I wasn't. And many instances they—like where my cycle of going up and down on doses is because of them. They wanted me to get off of it. So I'd go down in dosage, you know, try to please them to get off, you know, cuz you have to go down, taper yourself off. And then that's right around the time that I started like cravings and started screwing up. And I don't—and that's just a pattern, so. And I just finally had to tell them I can't, you know, I can't get off of it. Every time I try, I end up using. And I guess that's just for me to stay in the program, stay at a steady dose. Then, you know if, where I'm at. I'm not gonna use, and if it goes on for years, then it goes on for years. If it's the rest of my life, then it's the rest of my life. You know, I just finally have to get them to accept it.
> I: And why are they not the biggest fans of methadone?
> R: They're really old-fashioned. Their whole thing is, if you have an addiction, if you have a problem, all you need is a really good night's sleep, and you'll be fine the next day. That's their philosophy on everything. Whether it's depression, anxiety. "All you need is a good night's sleep, and then you'll feel better tomorrow. A good breakfast, and you'll be happy again." And it's not like that. They don't understand the whole idea that it's a disease and, and it's genetic. They don't want to admit that. There's alcoholics on both sides of my parents, both sides have suffered from alcoholism. But they don't want to admit all that.

Kevin's family is not anti-methadone so much as they are anti-drug. They understand how methadone works because Kevin has helped them research it on the internet, and they have read pamphlets he has brought home. However, they think that any illness,

including addiction and depression, can be cured with positive lifestyle changes such as getting more sleep and eating nutritiously. Their pressure to get off methadone has led Kevin to decrease his dose, but because of the withdrawal symptoms he had to subsequently increase his dose.

Mario, a Latino man in his mid 40s, is not in contact with his one living parent or his brothers and sisters, half of whom live in a West Coast State. When asked about his family's thoughts on methadone treatment, he notes that they still consider him to be a junkie.

> I: And have they ever said anything about their thoughts about methadone?
> R: [laughs for a few seconds] Not to my face.
> I: Have you heard their thoughts about—
> R: Well, I mean, I'm a junkie.
> I: Is that what they say?
> R: Well, yeah. Nobody in the family has ever used, and then here I am, so what's the first thing they think? [pause] Right.

Because Mario is the only person in his family of origin to have used heroin, they do not recognize that while he is still opiate-dependent, he is no longer a heroin addict.

Chris, a white man in his mid 20s, admits that he chooses to keep his methadone treatment a secret from some of his family members—in particular his father—because his father has had friends overdose while using heroin and methadone.

> I: Why did you choose to tell your mom and your stepdad, but not your dad and your stepmom?
> R: My dad and my stepmom—like my dad, he's had a couple of friends overdose on heroin and methadone. So when I was taking morphine, he would just talk shit to me every time he saw me. Bag on me, you know. He just, he hates pills. He even like would get pissed if like if you were taking Tylenol. He just hates pills. And so like, he told me, he would ask me all the time, "Are you still taking that shit?" And I'd be like, "No, I'm not taking it no more." And I think somebody might have slipped and said

> something to him cuz last time I saw him, he was kind of hinting on how much he hated it and it's like, I just know that if he were to find out, it would a big problem that I don't want to deal with.

Chris does not want to risk his father's disapproval and judgment, but fears someone might have told his father already. However, the rest of his extended family is supportive of his methadone treatment even though is mother is concerned about possible negative side effects of methadone.

Robert, a white man in his mid 50s, talks about how his family has been informed about his opiate dependence, but that they do not really want to hear about it.

> I: And would you say that your friends and family are supportive of your treatment?
> R: Um…probably not. Probably not. My friends are. My family, no. My family fucking no.
> I: Does your family know you're on methadone?
> R: I'm sure. At one time they all knew. I mean whether or not they have any memory of it, or if they still think I am or what, I don't know. But most of them don't wanna know. [scoffs] They'd rather not hear about it.
> I: And uh, so are you still in contact with them?
> R: Yeah, I just went—had a chance to see my mom, so I—I pretty much done the whole family and nephews and the whole works when I was back there then.

Robert is still in contact with his family, and in fact just saw his mother and all of his nephews when he went back home to visit her. While his addiction and treatment are not a secret, his family would rather ignore those aspects of his life.

Frank, a Latino man in his late 30s described above, talks about the negative impact that discovery of his addiction and treatment choices has had on his relationships with his parents.

> I: Did your parents know that you guys were using?
> R: You know, um [laughs] oh God, it sucks. They finally find out when they're moving, you know, that their perfect kids weren't so perfect. It

> just, it hit them in the face hard. My dad died of a stroke in his sleep. That's how much worries we put on him. And he died in '95 and, you know, look at it like, you know, it just. It was just too quick. You know, he got his pension in '90, lived five years on pension and just died. So he didn't even get to enjoy himself, you know. And it all was because his two younger ones were drug addicts.
> I: How did your mom react?
> R: Real bad, too.
> I: Is she still alive?
> R: Yeah, thank God. She comes to visit. She [inaudible] with treatment, but you know, she still says, "All you did was substitute an addiction for another addiction." Which is true, you know, uh methadone helps, but if you don't help yourself, you'll be like the rest of us, which take it forever. That kind of sucks, too.

He blames this shocking revelation of he and his older brother's use for his father's death from a stroke; he likely assigns this blame because he violated cultural norms of being a good son (Andrade and Estrada 2003; Gallardo and Curry2009; Mirandé 1997). Frank's mother is still alive and visits him, but she judges methadone, calling it an "addiction" and wants her son to be opiate free. However, she prefers methadone treatment over heroin addiction.

Tim, a white man in his late 30s described above, reports how he gets upset when his wife, who is not and never has been opiate dependent, tells other people that he is on methadone. He fears that others will judge this form of treatment because they do not understand it. He tells of an instance where his wife's revelation of his methadone treatment caused his family members to become upset.

> I think they'd be judgmental, yeah. I don't tell anybody that I'm on it. Sometimes I get mad at my wife because she'll tell someone right away. Like that I'm on methadone, you know, and in one instance like I told you about my father how he passed away. He overdosed on heroin. Well his mother, it's my grandmother. My mom didn't let me see her after I was like six years old. I just reunited with her a few years back.

> And my wife went with me to [West Coast city]. We flew out there, and, you know, we stayed a couple days, and then we—oh, I met my sister the same time, too. I didn't know I had a half-sister. My dad had from someone else. So I met them the same time. She flew down from [West Coast city]. Well, the first thing my wife said was, we talked about my dad died of a heroin overdose. And that really upset my grandmother. And she said that I was using methadone. That just really blew up. I was like really upset. And so my wife—she does that. I don't, you know, we discuss it. She likes to think—she wants—I don't know why she wants to tell everybody. But it's like, you got to understand. People judge. You know, they don't understand it. It's not something you tell them, someone you just meet right off the bat. You work into that. You build, you have to build a friendship, a relationship. And then they'll understand a lot better. But if you go right in, "Hey, I'm on methadone," they think, "Oh, that's bad." You know. You know, people die from—I guess. You know or Nicole or whatever her name was—the girl that died from it. In Texas, that playboy.

Because Tim's biological father was a heroin addict who died of an overdose, when Tim's wife revealed that Tim is in recovery for heroin addiction, Tim's grandmother and half-sister were really upset. Tim notes that revelations of methadone use require a friendship or a relationship and should not be one of the first things that someone learns about a person, which is an example of stigma management. Tim's mother and stepfather, while supportive of his treatment, do not want him to be on methadone forever because of all the negative side effects (e.g. dental problems, weight loss and gain, etc.) that they have heard about.

Fear of Family Judgment about Methadone Maintenance

The men discussed above experienced stigma because they were on methadone, but other men preempted stigma by keeping their methadone treatment a secret. Jeremy, a Latino man in his late 20s, chooses not to disclose his methadone treatment to his

family because he fears that they will judge him. He lost a job because his employer found out that he was on methadone, and he does not want more losses in his life because of the stigma of opiate dependence. He also has conflict with his aunt, with whom he lives, and because they fight often about unrelated issues, he does not want his methadone treatment to become yet another point of contention.

Victor, a Latino man in his early 40s, has chosen to not reveal to his family that he is currently in treatment for heroin addiction, though they have been aware of his treatment in the past.

> I: Are your friends and family supportive of your treatment?
> R: I didn't let them know this time. Because I was supposed to be…
> I: Did they know last time?
> R: Yeah. I finally had to let them know. It was hard—hardest thing for me to let my family know. None of my family's like, like a lot of people that come here, their family—not all of them, but uh most of them—their family or some kind of relative where they'd know about it. My family, you know, don't know heroin and stuff like that. And you know, not even alcoholism or nothing too much.
> I: And so did they know that you were using at all?
> R: I finally had to tell them I had, yeah. You know, I had to tell them, but I mean, I wasn't me. You know, I was never like, I was always ambitious, worker, good attitude, this, that, everything. I was not me.
> I: And how did they react when you told them you were using?
> R: Well, you know, they weren't happy, but, you know, as long as I was serious about quitting, good.
> I: So were they--
> R: But then when I went, you know, that was, that was the hardest [inaudible phrase] that's, you know, never do it again. You not, you're not looked at the same after that.
> I: So they knew that you went to the first methadone clinic.
> R: Yeah.
> I: And were they supportive of that treatment?
> R: Well, I also told them, "You know, I wanna get off cuz it's really bad, too." So they, at that time when I told them and everything, which I did wanna get off, what my talk about it wasn't real positive. They'll say, "It's really another drug." Actually, so they understood, "Oh yeah, yeah it's good. You should get off, too, then." And so, you know what I mean?

> And, and so like, I didn't want to re-explain that I did it again. Let's make sure I don't, you know, mess around. And that's another part, too, is I mean, people notice [laughs]. I mean, especially your loved ones. If they really love you and everything, and they're not high themselves, they notice.
> I: So you didn't tell them?
> R: It's embarrassing. It's awful. I don't—you know. I got grandkids. No, I just—you know, like I said, I never thought I'd be where I am now at this age, never.

Victor describes how his first revelation to his family of substance use and treatment was "the hardest thing" because none of his family used drugs or had alcohol problems, unlike many of the methadone clients' families of origin. He notes that after people know about opiate addiction, the addict is never "looked at the same way after that." His family considers methadone to be just a substitute for heroin, and he shares their opinions. Now that he has relapsed and reentered treatment, he does not want to experience the same form of judgment from his family. In fact, he feels embarrassed, and he cannot believe that he is still struggling with opiate addiction at his age, especially because he is a grandfather.

Matthew, a Latino man in his late 20s, keeps his methadone treatment a secret from his father with whom he lives and from his mother, though his brother knows and has even brought him to the clinic on occasion.

> I: Why don't they [some family members] know? Do you think they wouldn't approve?
> R: Motherfuck, they don't. Man, my family, they're all—I don't want to hurt them, first thing. They'll just—it's not, [I don't want to] tell them. I don't know. My mom probably break down crying, and—it's just something that, you know what I mean, not—them not knowing.

Matthew keeps his treatment a secret because he thinks his mother would "break down" if she knew. His brother knows, however, because they have a close relationship and tell

each other everything. His brother, who abstains from drugs, understands Matthew's desire for drug treatment and is supportive.

Sam, a white man in his late 30s, talks about how he keeps his methadone treatment a secret from his mother who has been sick.

> I: Why doesn't she [mother] know you're on methadone? Why haven't you told her?
> R: Cuz I don't want to tell her. Just because she's had problems herself, and like four months ago, she had bacterial pneumonia, they had to self-induce a coma for four months, and she was in the hospital and stuff, so I kind of just, you know, there's never been a right time to tell her, you know.

Even though Sam's mother knows he is a heroin addict and that he has been doing better lately because he has a stable living situation, because she has been hospitalized and even in a coma, he has not found "a right time to tell her."

Ten of the men have families who dislike methadone treatment and have negative reactions when told about this form of treatment. Four other men know or fear that their families would have this reaction, and so they choose not to reveal that they are in methadone treatment. Eight of the ten men who have had family members react negatively to their opiate addiction treatment choice are white, and three of the four men who intentionally choose to not reveal information about their treatment to their families are Latino. That white men experience judgment from family members could be considered an instance of the loss of racial privilege that comes with addiction (Bourgois and Schonberg 2009; Friedman and Alicea 2001), and that Latino men choose not to discuss their treatment with family members could be an example of Andrade and Estrada's (2003) point that it is important for Latinos to preserve their family's reputation

(in this case by not drawing attention to a culturally stigmatized treatment option), a point also made by Gallardo and Curry (2009).

Supportive Family

Not all men experienced judgment when their family members found out that they were opiate addicts. Many men reported that their family members were concerned about them, took care of them, and supported their attempts at drug treatment.[29] One way that family members showed support is by showing concern. Carlos, a Latino man in his early 50s who is both opiate-dependent and bipolar notes, that his mother worries a lot about him and tries to make sure that he is taken care of.

> I: Do you think that's why you were using because you were bipolar?
> R: Oh, yeah, yeah, yeah. Sometimes what happens to me is I get real hyper, you know, I'm always here, walking with this, doing that. And my mom tells me, "What's wrong with you." I go, "Mom, I'm sick, you know. Leave me alone. I—you know, I—you don't have to know as long as I know." But she worries a lot about me being sick. "Why? What's wrong with you today?" Like, "Mom, I—just one of those days, and I don't feel good." I'll be here, and next minute I'll be over there, and I'd get into. And then it makes you eat a lot of food, too.

Carlos describes how he lives with his elderly mother and does not want to use heroin anymore because his mother is too old to bear the burden of his bad behavior.

> So I live with my mom. And my mom, you know, she's such a good lady that I wouldn't put her through this hassle no more, me using drugs because she's getting old and stuff, and I wouldn't mind putting that pressure on her so, yeah me, my mom, everybody get along good. I do smoke marijuana, though. I'm not going to lie.

---

[29] Rosenbaum (1991) found that people who were able to successfully detox from methadone maintenance often credited family support—both positive (e.g., encouragement) and negative (e.g., threats of leaving).

However, Carlos says that he has no intention of quitting his marijuana use. It may also be the case that Carlos' concern is less about his mother's feelings regarding his drug use and more about him being able to continue to live with her because he later notes in the interview how he is fortunate to live with her considering housing would be too expensive otherwise.

Another form of support that family members offered to some of the men was being actively involved in their treatment. This ranged from transporting them to the clinic, talking to the clinic counselors about methadone treatment, and researching methadone and other treatment options. Paul, a white man in his mid 50s, does not have much family left given that his parents died while he was in prison, but when his parents were alive, they were supportive of his methadone treatment.

> R: No, I've got a sister and brother I hadn't seen in years and years. But when I was in the hospital and I almost died in December, my sister came to see me. But my wife, she's really supportive of me as far as that goes, you know, considering me and her been using for [pause] forty years, thirty years [laughs].
> I: Does your sister know you're on methadone?
> R: She doesn't even know what methadone is.
> I: Did she know that you were using at all?
> R: Oh, God yes.
> I: Did your parents know you were using when they were alive?
> R: My dad, yeah. And my mom, yeah I'm sure they did. They both died when I was in prison, but they knew, yeah. Matter of fact my dad used to give me a ride to the clinic years ago when I lost my license and I didn't have a vehicle for a while [laughs]. He'd sit there, give me a ride to the clinic, and he thought it was a good thing, thought it was medicine, you know. They told him it's a medicine, you know. You know, as long as I wasn't sticking a needle in my arm, and I'd go there and he, you know, it was medicine, which is supposed to be, and that's what he knew about it, you know. And a lot of people think it just the same as using heroin.

Paul's parents were aware of his heroin addiction and methadone treatment, and in fact, his father even drove him to the methadone clinic when Paul was unable to get there any other way. Paul's father was happy that his son was no longer injecting heroin, and the clinic staff told him that methadone was a medicine, and so he was okay with this form of treatment. Though Paul's father supported his son's treatment, he chose not to leave Paul any money upon his death.

> I: So your dad owned two bars and he made pretty decent income?
> R: Oh yeah, he did real good. And then when he met my mother, she was twenty-something years younger than him, and she used to work in the bars, and the next thing you know he sold his bars and he came out here, he bought land and, you know. I got nine brothers and sisters, you know. He had so many, and he dealt his money right, so when he got old, he didn't die all the way broke, you know what I mean. But because I was using dope and everything, when he did die, he left the land to my sisters and he left the money to them. He didn't leave me anything. [laughs] And it didn't bother me, you know. I think it bothered [my wife] more than it bothered me, right? You know what I mean? I was just kind of heartbroken that I was in—I was locked up, I didn't even know. They didn't even tell me until a year later, I found out.

Paul does not feel anger about being disinherited, but he notes that his wife was upset and that he was sad that he did not even know about the situation because he was in prison when he found out. Paul is only in limited contact with his sister to whom he does not disclose the fact that he is on methadone maintenance, and he is not in contact with his brother, children, or grandchildren.

Rick, a white man in his early 30s, notes that his parents were actually the ones who looked into methadone treatment for him, which is another way that families can show support. Rick talks about how the reason he decided to get on methadone

maintenance was to work on rebuilding trust in his family relationships, something his heroin use had eroded.

> I: Ok. And what exactly were you seeking treatment for when you came here?
> R: Mainly…um…building family relationship was one big thing I wanted to work on. Obviously staying clean, working on a relapse prevention program. Also some sort of plan or treatment to, during the process of, you know, keeping clean—meetings and group sessions, but that was mainly it. Just family, working on my family, and my relationships was another big one, too.
> I: So your family knows about methadone.
> R: Yes.
> I: And are they supportive of this particular form of treatment?
> R: Um, yeah. They are. Um…yes and no. They are concerned about the long term, you know, I mean, so am I. Eventually, I want, I do, would like to get off it, but, they are. Yes and no. [laughs once] Yes and no.
> I: Are some more supportive than others?
> R: Yeah.
> I: Who's the most supportive?
> R: Um…my parents are, but by my brother, his views on it, he doesn't think I should be on it at all. Which, you know, I understand too. He doesn't understand—he's never used drugs or nothing, so it's harder for him to understand, but my parents are pretty much supportive of it as well.

His parents are supportive of methadone treatment, even though they are concerned about the long-term implications of methadone maintenance. In fact, Rick's parents have even met with his counselor in the past in order for the family to learn how to communicate again. Rick's brother is less understanding of methadone treatment, however. Rick, like Jake and Tim, has both supportive and unsupportive family members.

Tim, a white man in his late 30s described above, also has family involved in his treatment. His mother reads up on opiate addiction treatment and has advised her son to look into suboxone treatment, an alternative to methadone.

> And then you can start taking suboxone. There's only a selected few doctors in Tucson that can prescribe it. But that's something that even my

> mom has said to look into it, you know. She's the one who actually told me about it. She said she read about it, and so that's when I kind of did a little bit of research on it, and it's just the medication. It's something that you get from a doctor, and they prescribe it to you. You don't have to go to a clinic or anything. You just go to get it at pharmacy, that's it. So, that's something that could be a potential thing that I would want to maybe try to get into because, you know, I definitely don't want to relapse and go back into using, so it's something that I know right now that I can't at my dosage, but it's something that I'm looking into.

Other men were actually referred to methadone treatment by family members who were concerned about their addiction. Often these family members were addicts or recovering addicts as well, and were able to see the warning signs of opiate addiction and pass on their knowledge about methadone clinics. Jeremy, a Latino man in his late 20s, talks about how he first learned about methadone treatment from one of his uncles.

> R: Nah, I didn't really know about methadone until this place until somebody told me, "You can get help. Methadone's a way of treatment."
> I: So who told you that?
> R: an uncle who was addicted to heroin.
> I: Ok, and he had used methadone and found it successful?
> R: Yeah. He tried it a little while, stopped doing heroin, and then went back to heroin. And he died recently. About a week ago.
> I: But when he was, he was trying to get you help?
> R: Yeah, he told me. He said, "The pills gonna lead to other things." I didn't really believe him cuz I didn't. You know, I didn't take other things. I just stayed on pills and started getting withdrawals and wanting them. And then I started figuring it out, so.

Jeremy's uncle was a heroin addict who saw that his nephew was using pills and tried to warn him that such use would lead to addiction. Jeremy did not heed his uncle's advice to stop using the pills, but he did follow up on his uncle's referral to methadone treatment. Unfortunately, methadone treatment did not work for his uncle who at the time of the interview had recently died from a heroin overdose.

Like Jeremy, Will, a Latino man in his late 40s, also heard about methadone from family members. His brothers, brothers-in-law, and cousins—all family members with whom he had used heroin and other drugs—referred him to methadone treatment.

> I: How did you end up at [Second Chances]?
> R: Well, I was living in, I was born and raised in [Southwestern state] all my life. Before I would come to visit. I remember, I have a brother and a sister over here. And I also had some brother-in-laws and everything, and they were alive back then. Now they're not—they're dead. But I used to come over here and visit him, and come on a getting high binge and do all that kind of stuff. But this last time that really brought me here was the fact that my wife had passed away, and back then where I was living, I was living in [Southwestern city]. I was staying in [Southwestern city], and [Southwestern city], I was in one of their methadone clinics. And they closed down the methadone clinic, so there was no clinic to go to, and I needed a clinic. And, so I came over here. I have a brother that's here, and he's in the methadone clinic. He's here, and he said, "Come over here, you know, and make your life." So that's what I did. I came over here. And also, to get away from memories from my—you know, there's stuff with my wife and places we used. And it just—it allows stuff to just to help me get out of there for a while. And that's what really brought me here, and this is where I am, and this is where I believe I want to stay. Hopefully, I can maybe come to a girl, a lady, and a nice one and maybe get together. Who knows? And just take it from there.
> I: How did you first hear about it?
> R: This was over there in [Southwestern city]. From my brothers, from my brother [name of brother], from my cousins, from friends. I heard it from them. And, so that's when I decided I was strung out, I didn't want to kick cuz I know the [groaning noise], so we talked about methadone. It will help you. You drink it. And then, "Ok, that sounds nice." So that's how I got into it.

Will talks about how all of his family members are supportive of his methadone treatment, including his adult son, his parents, and his siblings. His brother is also on the methadone program.

Some of the men reported that their families helped them financially. Victor, a Native American and Latino man in his early 40s, received help from his father in getting

officially recognized as Native American so he could take advantage of healthcare benefits available to members of this tribe.

> But if you don't have AHCCCS or like—you being [a member of local Native American tribe], you know my first surgery, I was self-pay because I was hurting so much. I was young. I thought it was a muscle, but then I kept working it. God, I went down and messed up my nerve and everything, and then I was in so much pain, I tried to have—apply for AHCCCS. They said, no, that I had to be off work for a month or two, and I was in so much pain, I couldn't wait that long, and so I went self-pay. And here I didn't know that my father, me and my father went and registered me in'89. Here I didn't know that, you know, that I could have free medical.

Frank, a Latino man in his late 30s described above, also received financial assistance from family members. He talks about how financial stress triggered a relapse after eight years clean from heroin. He had purchased a home, and it was about to go in foreclosure. Fortunately, however, Frank's older sister helped him out. That his family provided a financial safety net protected him against future relapse, and shows how supportive his older sister is.

> Stress. Bills. I own a house. I bought a house, and I was almost losing it foreclosure. Yeah, luckily my sister helped me out. She came through. She found out I had a relapse, and she asked me what was going on, and I explained it to her. "You know, I don't want to hurt nobody. I just, I don't know how to do it no more. I'm tired." She's all, "What's stressing you out so much?" And I explained it to her, and the next day, my house was already taken care of, everything's up to date. I just got to keep paying on it, you know. So it's cool. She's a good sister.

Frank's oldest brother also helped him in the early stages of his heroin addiction by paying for an expensive, in-patient rehabilitation treatment. Frank did not feel comfortable in this treatment facility, however, because so many of the people there were incredibly wealthy.

> R: Yeah, I went to rehab in [Northeastern state], and it was an in-house treatment, but it didn't, I don't know, it was more of—everybody there was like…real, real wealthy, and I was like so broke. I felt out of place, so I didn't even stay.
> I: How did you get in there?
> R: My brother paid for it. My oldest brother like that's where he used to live. He lived in [Northeastern state] for like fifteen years.
> I: So he knew that you were using?
> R: Yeah, he knew.
> I: He's like, "I'll pay for rehab."
> R: Yeah.
> I: But when you went there, most people were really rich.
> R: Yeah, and I was like, "Whoa. What is this?" And I even told them, "Can you put me somewhere else?" He's like, "I already paid for that. I can't just tell them that you don't want to be there."
> I: How much did it cost?
> R: I don't know.
> I: Did it help at all?
> R: For a while it did. Cuz I felt guilty towards using cuz I felt like I would let my brother down, my oldest one, but after a while I just drifted away and moved back.

When Frank did not successfully abstain from heroin use, he felt guilty and as though he had let his older brother down when he did use because his brother had made serious efforts to help him clean up. The financial assistance that his brother provided to help Frank get off heroin did not end up being helpful because Frank felt uncomfortable being around wealthy people.

Frank was not the only one to have a family member pay for rehab. Like Rick, Tim, a white man in his late 30s described above, also talked about how one of the major consequences of using heroin was losing family trust. However, despite the stress that his addiction put on his family relationships, his parents were interested in helping him out and paid for a really expensive rehab for him to attend.

> I did try rehab. It was in [West Coast city]. My parents put me up in this really expensive rehab. It's like one of those kind of richy rehabs like

> where it was in a nice house, they had nice pools, a view of the ocean. All that kind of stuff. And I remember being there, and they really medicated me to where I was like, I couldn't move because I was go through the withdrawals. They were giving me Thorzine and Valium. Anything to kind of keep me just immobilized, for about a week they did that. And I would still—I told them, "Look, I'm still going through. I'm not ready to go, to get out of bed and go into meetings and stuff right now. I need to—let me get stronger." And they were like, "No, you need to go. Get, get up." And I would tell them, and that's when I got really pissed off and I left.

In sum, nine of the men interviewed reported that their family members were supportive of their methadone treatment. Family support included expressions of concern, providing transportation to the methadone clinic, educating themselves about opiate addiction and treatment, communicating with clinic counselors, referring the men to methadone treatment, providing financial support, or paying for rehab.

Of the nine men with supportive families, six are Latino and three are white. This means that half of the Latino men have relationships with their families of origin that include honest disclosure about their addiction and treatment coupled with family support. However, two of these men also admitted that their family members also use heroin and methadone, which may be one reason why judgment and rejection are lacking. Only three white men have families who support their methadone treatment, which is about 18% of the white men in the sample. And as evidenced by Paul, there are sometimes limits to this support. Even though Paul's father drove him to the clinic and maintained a relationship with his son, he disinherited him because he was still using drugs and in prison. It may be the case that white families have more negative reactions to opiate use and are less supportive of an opiate-based treatment because opiate addiction violates raced and classed norms and is thus more heavily stigmatized

(Bourgois and Schonberg 2009; Friedman and Alicea 2001). It may be the case that Latino families are more supportive of family members who are addicted because of the centrality of family relationships in their lives (Andrade and Estrada 2003; Fuligni and Pedersen 2002; Mirandé 1997).[30]

It is also important to note that the men's family's reaction to their opiate addiction and treatment decisions tended to be divided and complex. For example, Tim, Rick, and Jake all report how some of their family members were supportive, and some were not. That these men are white may mean that there is a tension in white families between showing care for the men and rebuking their racial and class transgressions.

LIVING WITH OR WITHOUT FAMILY

The men interviewed often discussed their family relationships in terms of estrangement. Sometimes their families had rejected them (not necessarily because of their addiction), and some had chosen to cut off contact with their families. Other men described how while in contact with their families, being on methadone maintenance made it more difficult for them to be as close geographically to their families as they would have liked. In contrast, some men were actively involved in providing care for their families of origin—typically their parents, though in one case, siblings as well.

---

[30] It might also be that Latino men get the benefits of a culture "which celebrates a son's privileged relationship to a saintly, long-suffering mother whose self-sacrificing love enables her to forgive a son's youthful masculine transgressions" (Bourgois and Schonberg 2009:135).

Rejection

Some of the men are no longer in any contact with their families of origin or some of their family members, even if they miss their families and would desire contact.[31] This lack of contact could be because the men's families rejected them, or because they rejected their families. In the case of Mike, a white man in his mid 30s, he does not have any family because he has been "at odds" with his father for decades, and he thinks that none of his older siblings have ever liked him.

> I: And are your friends and family supportive of your treatment?
> R: I don't have any friends or family. My mom's the first person I outed myself to about being an addict, and, you know, I love her. And my dad and I always been, we been at odds for twenty years, so I don't really talk to him. I got seven sisters and a brother, and I only talk to one sister. She just appeared four years, something like that. But my older sisters, they're all my mom's kids because and they—none of them really got along with me because they had a little brother who was killed when he was seven by a car, and when they adopted me, the girls swore up and down that my mother just did it to replace their brother, you know. And then, of course, all the kids grew up and gone, so I got the benefit of being spoiled, and none of them really cared too much for me.

However, he really loves his mother who he turned to when he first became addicted to heroin. This is similar to other documented recollections of heroin addict's relationships with their mothers, who are more fondly remembered than fathers (Binion 1982; Nurco et al. 1988).

David, a Latino man in his early 40s, has been out of contact with his family since 1995, but recently had a brief meeting with his parents.

> R: Matter of fact, I just talked to my parents since '95, the other day. Sunday. Saturday.

---

[31] Knoester (2003) finds that positive relationships between parents and their adult children provide well-being for both parties.

I: That was the first time?
R: Yeah, since '95. The only reason why cuz I was doing a job over there where they live. They live over there in the south side of [city in Arizona].
I: How did that go?
R: It went real well.
I: Yeah. Do they know that you're at this clinic?
R: Uh, no.
I: No. Do they know that you use—or used in the past?
R: Yeah, yeah.
I: Are they supportive of you?
R: No, not really. I mean, they're not negative or nothing. They're, like I said, I haven't spoke to them.
I: Did you have a better relationship with your grandparents than your parents?
R: Oh, yeah. Most definitely.
I: Are your grandparents still alive?
R: Yeah, actually they are. [laughs] 91, 92 years old. I thought, I mean, I thought they were dead—uh, they passed, so, my dad was saying, "Yeah, he's not doing too good, but they're still alive."
I: Have you been in contact with them at all?
R: No, but I think after this trip, I'm definitely gonna. They live in [Arizona county]. So I'm definitely gonna take a trip up there.

David never felt accepted by his parents and siblings because he was adopted, though he was closer to his grandparents. He reestablished contact with his parents because he was working in their neighborhood and decided to stop by their home. Though their conversation was okay, he notes that they are not supportive of him, and he seems more excited about the chance of reuniting with his grandparents. He did not mention any plans to visit with his parents again or contact his siblings.

Ethan, a white and Native American man in his late 30s, had family members react so negatively to his heroin addiction and subsequent methadone treatment that they refused to allow him into their home.

My family has never been, and I don't even talk to my family anymore, not even my own brother. They're not in support of it because they look at

> it as, "If you're on methadone, you're still a drug addict," you know, they look at it as that, yeah. I mean, even at the times where I've held down a better job than my own brother for three years, and was doing much better, I was still looked upon as just a screw up beyond all belief. Like even my own aunt who actually raised me for several years when I was a kid, when my mother was very sick from Hepatitis C, you know, they didn't want me in her own home because she thought I would steal things from her, and she actually accused me of stealing some things. Later on my cousin sent her some photographs—and what happened was she accused me of stealing these two Indian rugs that were worth quite a bit of money, and in these pictures you see up on her walls, the two Indian rugs hanging up on their walls– but I never got an apology or anything. And she totally wouldn't speak to me. This went on for like a year and a half. You know I'd send her Christmas cards, writing to her saying, you know, just trying to communicate with, try to call her, she would hang up on me. Even, you know the very last time that I called her, it was—she said, "If you call here again, you know, I will call the police and say you're harassing me," you know, and it got that bad. But my brother later told me about that she got those pictures, and she told my brother, you know, I feel very bad about it, and all this stuff, but she never apologized about it. And it's all to do with the drug thing, you know. If it wasn't for—if I got off methadone—that's the first question that comes out of a family member is—amounts to this: "Are you still on the meth?" They call it "meth." They have no idea what it is, even when I try to explain to them. I bring them the pamphlets on it. My aunt for years thought it was actually methamphetamines. That I actually, that they actually prescribe methamphetamines in place of opiates and somehow that would make you better, and no matter what I told her she did not understand that and finally someone who she had to listen to, a doctor, you know, explained to her exactly what it was and then she had to accept it, you know, really what it was, but she still doesn't accept that it's right, or anything, you know. So I'm just a big fuck-up with my family. Friends on the other hand, I have friends who I look at as really family, you know, and who have always been there, you know, lots and long time friends and have always helped, and have stuck around through the thick and thin. And my family might as well be dead to me, you know, at this point, you know. Hopefully one day they'll open their eyes, you know, something different, but yeah. For family, I see a lot of that in the methadone, I think. Families just do not understand, you know, what's going on. They all think you're trading one for another. That's usually what I hear and what I get as well, you know.

Ethan was falsely accused of stealing from his aunt, and he is upset that not only was he accused of this, but that when his aunt found out the truth that she did not apologize to

him. His family members were also confused by methadone treatment and mistakenly believed that Ethan was using methamphetamines; they did not accept his explanation of his treatment. His family's lack of understanding of methadone maintenance is similar to that described by other men. Even though Ethan's family rejected him, he has since rejected his family who he considers unwilling to understand his addiction and treatment. Rejection is complete as Ethan describes how he is a "big fuck-up" in the eyes of his family, but also that his family "might as well be dead to [him]."

Sam, a white man in his late 30s, has not had contact with his father for ten years because of a "falling out," although he is still in contact with his mother (his parents are divorced). He is also not in contact with his two adult sisters.

> I don't talk to either one of them. They come up in the world, and they don't want anything to do with me. My one sister, she's a Mary Kay salesperson. Her husband works for the gas company, and they do really well. And my other sister, she's an accountant, and she owns a bar, so. They do really well, so they don't want anything to do with me because they think every time I come around, all I want is money or something, so I just don't talk to them.

He notes that his sisters have "come up in the world," and references their economic success and upward mobility as partial reasons for the lack of relationship that he has with them. Sam also says that they think that all he wants is money and thus do not want to have anything to do with him, so he does not attempt to have a relationship with them. Because Sam was cut off from his family of origin, he lacked the social support necessary to maintain sobriety after getting released from prison.

> I: And did you use in prison?
> R: No, no I didn't use in prison. I actually went to AA in prison. I got clean. I used prison as a rehab, and I got clean out of prison, so that's why when I came out and I got off the, you know, off probation and all that,

> and I started using again, I'm like, "What am I doing? I just, you know, I went two years without it. What am I doing?" And then I ended up, that's why I ended up here because I didn't want to do it. And now I'm really trying to get off the methadone, too.
> I: So you kicked it in prison, you were at AA, and you got out of prison. What made you use when you came out?
> R: Um…actually it was a combination of the court system and just being, not knowing what to do. I mean, I go—to make a long story short—I got out of federal prison. I had taken care of all my warrants the first time was when I had a violation, I get out of federal prison, and they take me over to Pima County, keep me there for three days. I get out at nine o'clock at night. I'm supposed to go report to a halfway house, and I've got no money. So who do you call? You call the first person you know that money and drugs. You know, and there was nobody there to pick me up and take me to the halfway house. I didn't know which halfway house to report to. So, I blame myself, but I also blame them, you know.

Sam got clean in prison, attending AA while incarcerated. When he was released from prison, however, he did not have social or family supports in place, and when he was released at night to go to a halfway house, he did not have transportation or anyone to call to help him figure out where to go and how to get there. The only contacts he did have were drug contacts, so he called them and began using again. Perhaps if Sam had relationships with his family and had been able to call them upon his prison release, he would have been able to maintain his abstinence from heroin.

Similarly, Roger, a white man in his early 50s, discusses how estrangement from his family of origin led to relapsing on heroin after being discharged from military service.

> I: So you got out of the military? Did you start using heroin again?
> R: Yeah.
> I: What led you to that?
> R: I guess it was like just I don't know. Something to do or, I don't know. To be honest, I haven't really thought about that, but if I think—I don't have anything to say. Just I felt like the government abandoned me.

> Cuz I had nothing. I had a family, but they really didn't give a care where I was at and what I was doing.

Roger's mother is dead, and he is only in limited contact with his siblings. When he recently lost his job and was waiting for unemployment, he had to contact them to request money, which was a humiliating experience, given that his family members do not recognize his children and grandchildren as his, something that is important to him.

> I: So you're on unemployment right now?
> R: Yeah, 13 weeks later [laughs].
> I: A lot of 13 weeks without income.
> R: And I hated that everyday cuz I had to beg from my family [older siblings], and I can't stand doing that.
> I: Did they know that you were using when you were using at the—
> R: No.
> I: --like in the past? They never knew?
> R: I don't get in contact with them very much. Christmas time is about the only time I, "Hey, how you doing? Yeah, what's going on with family? Yeah, ok." The oldest sister, what do you call her? The matriarch? My oldest sister—that's who I call and find out what's going on with the rest of them. There's some other, you know, family issues, too. You know, some don't, you know, recognize my daughter as being mine. My grandkids, no. You know, that kind of thing.

Roger says that no matter what he does, he will always be looked at as "a disappointment" and a "lowlife" to his family members.

> And I'm looked upon a lot as a disappointment the rest of my siblings—they're all law-abiding, upstanding citizens. I mean, I can probably work the rest of my life as hard as I could, paying taxes and all that, be a A, Number One Citizen, still be a lowlife.

Frank, a Latino man in his late 30s, is still in contact with his mother and an older sister, but he expresses a deep regret that he no longer has a close relationship with one of his older brothers who is also a client at Second Chances.

> R: Honestly, my oldest brother never got high. My other brother did. My sister, never. My two older siblings were like the perfect kids for my

> parents. Me and my other brother were like the outcasts. I mean, because he comes here too.
> I: Your brother comes here, too?
> R: Yeah, I'm pretty sure he'll come to this. But anyway, it's even broken up our relationship as brothers, you know. Drugs just suck like.
> I: So the brother that comes here, you don't talk to him?
> R: Yeah, like not like we used to, you know what I mean. It's more like of a "What's up?" That's it. And that kind of sucks because we grew up together. At that age, I blamed him, but he always says, "You blame me for, you know, whatever happened." He's older by ten years, but it wasn't his fault.

Seven of the men interviewed mentioned that they were not in contact with at least some of their family members. There do not appear to be ethnic differences in regards to which men lost contact with family members, which is different from what Bourgois and Schonberg (2009) found in their sample of homeless heroin addicts. When talking about this lack of contact, some of the men expressed sadness, regret, anger, or bitterness. For two of the men, the absence of family relationships meant that they relapsed on heroin when they had nowhere to turn for social support.

Methadone Impeding Family Relationships

While many of the men noted how *opiate addiction* was a stress on family relationships, some also talked about how *methadone treatment* prevented them from being as close to their families as they would have liked. Because methadone is dispensed from a local clinic, without a significant number of take home bottles, men cannot travel unless they can guest dose[32] at a methadone clinic at their travel destination.

---

[32] If a methadone patient has planned ahead and received prior approval from their clinic's physician and from the methadone clinic in their travel destination, they can receive a dose of methadone from the other clinic.

Rosenbaum (1991) also found that travel restrictions are a common motivation for both men and women methadone clients to get off methadone. Dan, a white man in his early 30s described above, has family that live in the Southeast, and he describes how he was not able to attend his brother's wedding because there was no methadone clinic there.

> And I did go down [on methadone dose], and they stopped me. They said, "No, no, no. Why don't you wait? Why don't you be on it for a while? To me, you know, six months is a while. You know, I have all these plans that I want to do, and stuff. My brother got married in Key West, and for me to go back home is a big—but they don't have a methadone clinic in [Southeastern city]. And see, to them, they said, "Well you got to go to a local methadone clinic." Well the local methadone clinic is a homestead, which is a hundred sixty-five miles away.

Jake, a white man in his early 20s described above, also discusses how being on methadone makes it difficult to travel to see his extended family.

> But, I'm going on a trip here on Sunday for two weeks. I'm going to [western state] to visit family. [Midwestern state] and [Southern state] just basically to see a bunch of family members. And they're [clinic staff] probably not going to help me. So, I'm kind of in the dark. I mean, there's still legal alternatives to using opiates. There is. You can go online and buy poppies. It's opium poppy to make a tea. Basically using opium, and that's legal. Floral decorations. But, you can still get around the legality of things.

Even though he does not anticipate being given take home bottles for his trip, Jake is going to go anyway. He is already planning on how he is going to prevent methadone withdrawal by buying poppies online to make an opium tea. In this case, the threat of the law and withdrawal are not enough to keep him in Arizona and away from his family.

Roger, a white man in his early 50s, has a daughter and two grandchildren who live in a different state. While in methadone treatment at Second Chances, he used methamphetamine and thus lost some of his take home bottle privileges, which impacts

his ability to travel to see his family because he does not want to have to guest dose at a clinic and have them know he is on methadone (see the quote about this in the chapter on fatherhood). This example shows how the combined effect of fear of stigma and reality of opiate dependence and subsequent withdrawal leads to difficulties in maintaining close family relationships.

Rick, a white man in his early 30s, also talks about how coming to the clinic each day prevents him from camping with both his children and his family of origin.

> I: So you don't like the fact that you have to come here everyday?
> R: Yeah, yes, it's um—oh, I don't mind really. But it's just the fact I don't…yes and no. I mean, it, I can't go, you know, leave for a few days and go camping with the kids or the family. You know, I got to make sure I'm here. You know, I do have certain privileges. Weekends I don't have to come down. Or once during the week, but you know, it's kind of inconvenient at times.

Interestingly, it was only white men who mentioned how methadone maintenance impeded closer family ties.

Caring for Family Members

Some of the men in methadone treatment are currently living with, caring for, or supporting their parents or siblings, which is not atypical given that adult children often provide care for their parents (Umberson et al. 2010), but is somewhat surprising as often it is women who provide such care (Kahn et al. 2011). In some cases, caring for family members is stressful; in others, it provides men with opportunities to improve their life chances. Dan, a white man in his early 30s, had his sick mother move in with him. She

is in the middle of a bad divorce with his father, and has no income. He provides housing and helps her manage her medical issues.

> And then I support my mother right now, but she's going through divorce. I mean my dad's not an ass, but he doesn't want to get stiffed either, so um. Right now everything's all tied up in the courts so, until she gets something out of it, neither one of them can touch it until the divorce is over, so.

John, a white man in his late 40s talks about how both of his parents are currently sick, and how their illnesses sadden and stress him. His mother has had to be institutionalized because of Alzheimers, which is something he and his other adult siblings pay for, and his father is coming down with a serious illness as well.

> I: So you mention that you have a daughter. Do you have other family in the area?
> R: My mother. And just the last couple years has come down with rapid onset Alzheimers, and that was—my mother's very bright, and just it was the last thing I expected to happen to her. She's had a very high IQ and just, it's very sad. And then my father just last month he's had stuff on his arms, his forearms, that I wanted to have checked out. I thought it was cancer at first, but then he started to getting these blisters deep underneath the skin and kept on suggesting he go see a doctor…And sure enough, when he went out to the VA, and he's got an autoimmune disease, and his skin is trying to reject, you know, his body's trying to reject his skin, and he got caught over here, and it got bad. All of sudden, it was on his whole body. And, he's stuck in a motel right now, and I've crying over that. It's been really stressing me.
> I: Do they live here? Do they live in [Arizona city]?
> R: Father lives in [Southwestern state]. I have my mother in a home just a little ways from where I'm at. All us kids are pitching in a little bit and thankfully it's a nice place, but yeah, her amount of needed care right now, it's a couple thousand a month still.
> I: So you have other siblings who are helping to take care of her, too.
> R: Yeah, it worries me if it, you know, like when, when it goes up, and you know, you know how much it will go up, how much more care she'll need. The thing is you don't want to put your mother in a home, but she wanders off, you know, and it's really dangerous. You know, she would take the care somewhere, come out, forget where she parked. Call it in stolen.

John's parents' illnesses are a source of sadness and stress for him.

Jeremy, a Latino man in his late 30s, has been responsible for caring for his younger siblings given that his mother was mentally ill and addicted to multiple substances including opiates and crack and his father was absent most of the time and when present, he was using drugs and giving Jeremy drugs to use.

> Oh no. I didn't really, I had to drop out of—my mom got like really addicted to crack and I had to drop out of high school to take care of my brother and sisters so they didn't go to a foster home. And, I got a job, like got a house with a girl I was with. And she didn't know I was taking, you know, pills a lot, but she knew I was taking them. Just because she knew my shoulder was, I'd wake up in pain, so you know, I'd get them and take them. Then it was alright cuz I wasn't strung out strung out, so I'd go to work, come back, take a pill, wake up, take a pill, go to work, you know. That kind of stuff. Until I was old enough, until my brothers and sisters were old enough to get, you know, their own stuff, so as soon as that happened, they you know, left home where we were at, and we broke up and just went on from there.

Although Jeremy had to drop out of high school in order to take care of his younger siblings, he was able to keep them out of foster care. Jeremy's early experiences with caring for his family probably contribute to the fact that when his own children's mother refused to care for their sons, he kept custody and cares for them by himself.

Five of the men described caring for family members in some way, which is significant given that the literature shows that women are more often involved in elder care than men (Kahn et al. 2011). Such care took the form of providing a place to live, financial support, or caring for elderly parents. The two white men provided housing, financial support, and medical care for their parents, two Latino men provided care for their parents in exchange for financial support, and one Latino man provided housing and

financial support for his younger siblings. Perhaps it was because none of these men were partnered that the family responsibilities fell to them. For some of the men, caring for family members was a way to sober up and become more responsible. For others, caring for family members was an added stress.

DISCUSSION

Men often talked about their family early in the interviews, and much earlier than the question that was meant to prompt them to discuss their family relationships.[33] Men discussed their family of origin when answering questions about how they began using opiates, what the consequences of using opiates were, and why they decided to seek treatment. It seems, therefore, that these men and their experiences with methadone maintenance, cannot be considered separately from their family relationships. Their relationships with parents, grandparents, and siblings need to be considered when trying to understand men's opportunities and constraints in treatment. Sometimes families of origin permit or encourage drug use, but often they also offer some resources necessary for abstaining from drug use.

Men reported both negative and positive relationships with their families of origin, although the majority of the discussion tended to focus on the negative aspects of these relationships. Many men described how their families facilitated their entry into the drug world by either giving them drugs or money for drugs and by using drugs in their presence, which made drug use seem less deviant. This finding contradicts Binion's

---

[33] One of the final questions asked was: "Are your friends and family supportive of your treatment?"

(1982) assertion that heroin addicts tend to come from stable, happy families. A small minority of men emphasized that they came from a good home, however. These accounts were somewhat inconsistent, however, because the two men who took care to mention that their families of origin were good also had parents who abused opiates. Their framing of "good families" is likely a reference to the fact that their parents are upper class and white and has less to do with whether their parents used drugs or not.

Almost half of the men noted that their families of origin reacted negatively to their opiate addiction and subsequent methadone treatment. Some of the men talked about how they regret telling their families about their drug use, and they spoke about shame, embarrassment, and disappointment. The men with family members who do not like methadone because they see it as replacing one drug with another, tend to feel upset about the lack of understanding and support they get from their family. Other men have chosen not to reveal anything about their addiction and treatment because they fear their family's disapproval of their choice of treatment. The vast majority of the men who keep methadone maintenance a secret from their families of origin are Latino, and it may the case that their decision to not reveal that they are methadone comes from a cultural dictate to not shame their families (Andrade and Estrada 2003; Gallardo and Curry 2009). Having unsupportive family members may make it more likely that men relapse, and not being able to reveal methadone treatment may mean that men are unable to take advantage of resources potentially understanding family members could be able to provide. Because many of the men mentioned that their families did not understand

methadone maintenance, perhaps some sort of educational material should be provided for men to give to their families.

Other men are fortunate enough to have families who provide various forms of support to them while they are trying to overcome opiate addiction. For some men, their family members show support by becoming actively involved in their treatment, learning about heroin addiction and various treatment options and even, in some cases, talking to the men's counselors. For other men, their family members refer them to methadone treatment. Other forms of support that some men receive include financial assistance or transportation to the clinic each day. It is likely that family support is positively correlated with good treatment outcomes. There are often limits to family support, however. Even if the men's families provide emotional or material support, their perceptions of these men may be forever negatively skewed. Additionally, some men admitted that they diverted resources provided by their family to drug use, so the relationship between familial support and staying clean is mediated by men's relationship to addiction.

Some of the men are no longer in contact with their families of origin or some members of their family of origin. Given that addiction is very disruptive to social bonds, the group of men who are not in contact with their families is surprisingly small. There are no ethnic differences in whether or not the men on methadone have been rejected by or have rejected their families of origin. It is important to note, however, that in two cases, the lack of family support meant that the men relapsed on opiates after a period of abstinence when they were in prison and the military. If the men had had

family or other social support, they may have been able to remain opiate-free. Treatment for opiate addiction should address building up supportive social networks so that when men are able to get off opiates, they do not relapse.

Methadone maintenance in some instances keeps men away from their families, and this is potentially problematic because family relationships can provide a source of emotional and financial support for men—support that is likely related to positive treatment outcomes. When men express a desire to be able to travel to see family members, it may be wise to try to help the men do so even if this means relaxing clinic policies, especially if the men are determined to travel and are willing to start using illicit opiates again in order to do so and not experience opiate withdrawal. The men who complained that methadone treatment prevented them from seeing their families are all white.

Some men interviewed are still so involved with their families of origin that they provide care for family members or live with and are cared by family members. In some cases, these living arrangements can be positive. For example, one man in the study cared for his elderly parents, and this arrangement allowed him to go to school full-time, which will most likely improve his chances at remaining sober and getting a decent job. In other cases, living with family can be problematic. For instance, when caring for family members who are ill and on prescribed painkillers, having drugs nearby could be an issue for a recovering opiate addict. There are not any ethnic differences in regards to living with families of origin.

The role of families of origin in adult men's lives and masculinity is under-theorized. When scholars discuss men and masculinity, they often focus on men's relationships to their children and men's relationships with women partners, but rarely on their relationships with their parents and siblings. Even when masculinity theorists do focus on men's relationships with others, they tend to focus on dominance, authority, autonomy, coolness, and even violence. That so many men talk about the loss of relationships with their families of origin, speak with regret about how they have disappointed their families, and how they would like to reestablish contact with family members highlights the importance of family to adult men, and seems to indicate that men value connections with others as a part of masculinity. Many of the men do express caring about their family members, which indicates that ideas about masculinity need to incorporate these other family relationships.

CHAPTER FIVE: PARTNERS

Men on methadone have significant relationships with women partners, and these relationships influence their opiate use and treatment just as do their relationships with their children and other family members. This chapter will focus on opiate-dependent men's relationships with partners and former partners, relationships that have not been the focus of much prior research, excepting studies by Clark et al. (1972), Moore et al. (2011) and Bourgois and Schonberg (2009). Previous research on methadone patient's family relationships has tended to ignore men's perspectives and experiences (Friedman and Alicea 2001 and Rosenbaum 1981) or only asked close-ended survey questions about incidences of domestic violence and disruption (Moore et al. 2011). This chapter will address these gaps in knowledge by answering the following research questions: *How do these men talk about their partners and former partners? Are there any ethnic differences in men's relationships with their partners? How do men describe the impact their partners have on their opiate addiction and treatment? What might these men's relationships with their partners say about masculinity more broadly?* This chapter foregrounds men's perspectives on how their relationships with partners have impacted and are impacted by their opiate addiction and treatment.

There is diversity in the experiences of opiate-dependent men and their relationships with partners, but even within this diversity important trends can be isolated. This chapter will describe how for many men, using drugs with their female partners is not an uncommon activity. Partners often introduce one another to drugs, and

once addicted, using together becomes a large part of their shared life. Part of their shared drug world also includes attempts to get clean, a process perhaps more difficult for an addicted couple than an addicted individual. However, not all men have partners who are also addicts. Regardless of whether their partner has used drugs, many of the men emphasized the importance of their partner's support (or threats) in making the decision to seek drug treatment.[34] The highs and lows of a (recovering) drug addict's life negatively impact men's relationships with their partners, however, sometimes leading to separation or divorce. Regardless of whether men are currently partnered, the participants in this study note the important roles that partners have played in their lives.

USING TOGETHER

Many of the men were or are partnered to women with whom they have used opiates. In some cases, their partner or partner's family introduced them to opiates. In other cases, they introduced their partner to opiates. Once a pattern of use had begun within a partnership, many men described the economic stress that comes with supporting multiple habits and how they and their partners would have to "hustle" to come up with some way to get money for drugs.

Partner and Family Introduce to Opiates

Three of the men described how their partner's family members were their gateway to opiate addiction (Lindesmith 1968 also described cases of this phenomenon).

---

[34] Rosenbaum (1991) also found this to be the case.

Mike, a white man in his mid 30s, was first introduced to drugs by his partner's family. His in-laws were the ones to first give him pain pills, and they gave them to him in order to make the effects of his alcohol consumption more intense.

> A brother-in-law of mine, he got me started on Vicodin. I was a drinker back then, and he said, "You know, this makes the buzz better, you know. You just take one, use it, you know, and drink, you know. It's better that way," and so I started doing it that way. And then my father-in-law he'd get prescriptions for me. He would give us some money every month, and I didn't develop an addiction until I got a hernia surgery. And I'm a big baby, and that was the worst thing I'd ever been in, and my tolerance had already been built up enough to—I could take a bunch of, you know, then my doctor gave me 90 extra strength Vicodin after the surgery. And I ate them up in the first week. And then I would call and get a refill, and he would refill 90 of them.

By the time Mike had a legitimate need for painkillers following a surgery to repair a hernia, his opiate tolerance was too high to have the dose prescribed be effective. Mike's wife was also introduced to drugs by her father.

> She had [been using pills before we met] cuz her dad was a pillhead. And she like took them on occasion, you know, once in a very long while. And then it, we both ended being addicted. So yeah, my money spent on drugs.

Interestingly, Mike's in-laws were also the ones who recommended methadone treatment and referred him to Second Chances.

> I mean we came over here from [Midwestern state], you know. The AHCCCS here, you know, the stuff is too expensive, and my brother-in-law, he used to be here. My sister-in-law didn't know where any of the other ones were, but she just came here because this where she came with her husband, so she knew how to get here. Just did it that way. And didn't know anybody here, so, you know, we couldn't get heroin once we got here. But my sister-in-law, she's prescribed morphine, and she would give us three morphine tablets a day, so we wouldn't be sick between the time we got here and we got in the program.

There were significant consequences to Mike's drug addiction. He and his wife are both still addicted to opiates, have had their parental rights terminated by Child Protective

Services, have spent time in jail, and are currently homeless. Mike's wife still facilitates his illicit drug use even though both are clients at Second Chances. Mike describes how his wife gets him drugs in order to ease opiate withdrawal symptoms.

> I mean, I would started feeling sick, you know, by morning, but I would always go and take that and get a buzz if I didn't have anything else, and my wife went and got a prescription for me, so I could get, you know, so I could take it in the evening, and I took the last of them one night, and when I got up the next morning to come down to get my dose, I was miserable. I mean, I just, I could hardly walk. It was terrible.

Like Mike, Steve, a white man in his late 50s, was also introduced to heroin by a partner's family. When he was a teenager, he and his girlfriend went to visit her older sister who was away at college. When they arrived, her sister gave him heroin.

> I: So, how did you start using?
> R: Well, it's a strange story. I went to see my sister, and I was a student—well she turned out to be my sister-in-law. My girlfriend is a few years older than me, and her sister was going to Cal State Berkeley. And we went up there to visit, and she says, "What kind of drugs you guys want?" Well, I'd heard this song by Velvet Underground called "Heroin." And everyone got their hash and their acid and everything, and she said, "What about you? What do you want?" I said, "I could use some heroin." She says, "Heroin. Why's that?" I said, "I heard this song." And she's, "Great song." She's leading it the whole while. So her boyfriend comes over and same story about what I want. Jim Morrison from the Doors is the first one to turn her on. So we went into the bathroom, ok. She pulls up her sleeves. She's a heroin addict, just. And I did it, and I fell in love with it, the first shot. I didn't get sick or nothing. I fell in love with it, and I went home to my homeboys and told them it was unbelievable.

This teenage introduction to heroin led to a lifetime of drug addiction for Steve.

Bryan, a white man in his mid 20s, also described how although he was a poly-substance abuser when he met his girlfriend, he had not tried heroin until his girlfriend and several of her family members introduced him to opiates.

> I: So you started using again and then things just kind of fell apart.

> R: Yeah. Within about two years after I started using again.
> I: So you got clean, you got with this woman, you got clean, you had a job, and you had your own place to live—what made you start using again?
> R: Well she started using with her brother, and I mean, like I wouldn't ever try to blame somebody else for my addiction, but it was—they were kind of bringing it around me, and I mean already being an addict, just it being there in front of me, it makes, I mean not impossible not do it, but—
> I: Yeah, so her brother was using heroin, and then she started using it?
> R: Yeah, I had never even, I had never seen or touched heroin before ever. Didn't even really know what it was at first, like really until I was already pretty much hooked on it. [laughs]

Bryan had a child with this woman, and similar to Mike described above, CPS removed their child from their custody. Bryan and this woman are both homeless and are in an on-again, off-again relationship. Both still struggle with addiction.

Ten percent of the men interviewed describe how their partner and partner's family introduced them to opiates. Their romantic relationships with women opened the door to opiate use by introducing these men to a new network of drug users. Their initial use was likely to continue because drug use was normalized in their new family relationships. These three men are all white and all have had children. Two of the three men had the state remove their children from their custody.

Introduced Partner to Drugs

Three of the men interviewed were responsible for introducing a romantic partner to opiates. Chris, a white man in his mid 20s, routinely gave his prescription painkillers to his fiancée because she claimed to be in pain and was unable to get prescriptions from doctors.

> She injured her back a long time ago, and that's when she started taking my medicine. Because like we'd take her to doctors and stuff, and they couldn't find anything wrong with her cuz she didn't have insurance, and we couldn't take her to get any stuff. So they just, you know, they would say that she was a drug seeker and a shopper and so, I just give her my pills.

While Chris may have had good intentions when giving his fiancée pain pills, she became dependent on them, and she is now a client at Second Chances as well.

Victor, a Latino man in his early 40s, inadvertently introduced his wife to prescription painkillers.

> I: And your wife is also here as well?
> R: Mm hmm.
> I: Did you all start using together?
> R: I used it first, and then I didn't know she was sneaking, using my stuff.
> I: Was she using the pills?
> R: Uh, yeah.
> I: Yeah. And why did she start using some of your pills?
> R: Because I guess cuz I was doing it. I don't know.

Victor claimed not to know that his wife was using his pain pills. When asked to reflect on why his wife started using his drugs, Victor's response is that she started using because he was using. Regardless of Victor's intent, he brought drugs into his home, making it more likely that anyone also living there would have access to them.

Paul, a white man in his mid 50s, describes how when he became involved in the drug dealing business, he became addicted, and his partner started using as well.

> When did I become addicted to it? (pause) When I had money. In eighty-six I started bringing pounds of weed to [West Coast state] so I had a lot of money and I started buying, and the girl that was with me, the woman that was with me, she got addicted too, and we spent a fortune on it.

While Chris and Victor had partners who used their prescription painkillers and who may not have known about the addictive qualities of opiates and been using them to relieve pain, Paul and his partner's heroin use was intentional and recreational.

In sum, three men were responsible for providing their partner's with access to opiates. It is possible that the women were drug seeking and would have eventually done opiates even without this access, but it is also possible that easy access to drugs through their partners directly caused use and subsequent addiction.

Supporting Multiple Habits

Regardless of how they and their partner had been introduced to opiates, many of the men had, at one point in their lives, been partnered to a woman who also used heroin. Opiate addict couples often had to "hustle" to get money to support their expensive habits (Simmons 2006). John, a white man in his late 40s, once had a girlfriend whose habit got them in trouble with law enforcement.

> Long story short, it turned out that girlfriend had a much greater habit than I had known. And she had these so-called friends that I saw every once in a while when I'd come home from work that would be over visiting, and it turned out that they were doing burglaries of businesses.

Like John, Mike, a white man in his mid 30s described above, also broke the law in order to get money for drugs. He discusses how he inadvertently got his wife in trouble with the police when he was trying to hustle someone.

> I: So how did you get on drug court?
> R: Being stupid. [laughs] Cuz I did panhandling so I didn't even make any money off this guy. But he's an old man, you know, he sits down on [central bus station], and he's got cancer real bad. And I told him, "You're buying the world's best script. I'll give it to you, you know, if

> you can pay for for the prescription, I'll give you 50 of them, you know." And he's like, "Ok." So I was like, "You're going to need it," and so he gave me the money, I went out and got them, and then he put them in a bag. And put them in his pocket, I thought. And then my wife is coming, she wasn't even there. She knew that I was coming, but she wasn't there. And she got off the bus and said something about, "Let's go." And I'm like, "Alright." And she was on the bus, and I was coming up towards the bus, and I was still quite aways from her. She says, "Hurry up. You have my ID." And I said, "Yeah, I have to get on the bus." And we got on the bus, and he [bus driver] was like, "I can't have you guys arguing on my bus." We argue. Basically he got off the bus, literally call the cops, cuz they rolled up on us, and he got off the bus and put me in handcuffs. And my wife was, you know, "What's going on?" Cuz she didn't, she knew I was going act out my plan, but she didn't know that I had already done it. So I told her what was going on, and this was before they searched me. They had me in handcuffs. And she went down to that guy and said, "Can I get those, the pills that [Mike] was planning on bringing back as soon as the cops leave?" And when she got them back down there, she managed to get them into my pocket, but the things are separated, and then they were separated into a bag that was, and they got me for possession for sale. And they gave my wife the same charge, and I feel bad about it because she's got to do some [inaudible]. You know, do something stupid. All drugs got in trouble [laughs].

Mike was at a busy bus station where he was selling drugs to an older man with cancer. After the transaction was over, Mike's wife arrived. They had a minor argument unrelated to the drug transaction, which attracted the attention of police who arrested both Mike and his wife. Mike felt bad that his wife was arrested for a hustle he had done alone, even though she knew he was planning to do it. The cost of Mike and his wife's opiate addiction was great; it took up most of his money when he was working in the legitimate economy and forces him to "hustle" now like he noted above.

> Oh, for my wife and I both, it was like when I was making that like $2500 a week, I'd spend a grand in a two day period just on pills and stuff, and then I'd pay somebody a hundred bucks to bring it to me.

Jake, a white man in his early 20s, also described how expensive it was to maintain both his and his girlfriend's habits. Because the cost of their combined opiate addicts was too great, Jake is no longer in a relationship with this woman.

> I had a girlfriend. Lived with her. She milked a lot of my money. Can't have two addictions. I can't support two habits.

Paul, a white man in his mid 50s described above, tells how he and his wife were both addicted to heroin. Their habits were so large that it cost them "a fortune" to maintain.

> I: What were the consequences of using in your life?
> R: [pause] I lost a lot of people that I love. Everybody that knew me, they started judging me so I lost friends, by death and through—financially I started doing things that were against the law. Nothing good came out of it back then even when my wife inherited three quarters of a million dollars. We spent that in eight months, and then we ended up selling two big houses in [Eastern state]. Nothing good came out of it, you know. We've had nice things and ended up selling it. You know, I sold my Harley Davidson, and I paid twenty-three grand for it, and ended up selling it for four, you know. Just stupid stuff.

Even though they had a large amount of money because Paul sold a lot of marijuana and his wife inherited a large sum of money, they lost everything because of their heroin addiction.

Robert, a white man in his mid 50s, describes how the financial (and potential legal) cost of his and his partner's habit served as motivation to seek treatment for addiction.

> I: At what point in your use would you say you got addicted to heroin? Was it 15 or was it a little bit later?
> R: No, it wasn't until I was about 20. The first I was about 21 or something. Somewhere around there. It wasn't that bad. It was just I had a real small habit then. It was a real small habit. It was only like two papers a week. I couldn't even believe I was sick, but I could get my stuff

> and was good for a while. Stayed away from it for a while, and then when I did get back on it, I was just, I was monitoring myself to make sure I didn't get a habit again. And then after I got out of prison, about four years after I got out of prison, I met this lady, and me and her had a lot in common. We got hooked up together, and somewhere down the road, we started partying, using, doing some speedballs [heroin and cocaine]. And, I was kind of, I was dealing to support us, so we had a lot of money. So our habit kept getting bigger and bigger to where [laughs] it was either we were going to go to prison or we had to clean up, so that's when we decided to clean up.

The cost of Robert and his partner's habit was about $600 each day between their cocaine and heroin use. They supported this habit by dealing drugs.

Interestingly, all of the men who described the expense associated with having a partner who also used are white men. None of the men talked about their partners prostituting themselves to support the couple's heroin habit, something described by previous researchers (Rosenbaum 1981). This does not mean, however, that this practice did not occur. Because prostitution is stigmatized, the men interviewed may have an incentive not to mention this particular kind of hustling.

GETTING CLEAN TOGETHER

The men who used with their female partners often talked about the couple's attempt to get clean together. Some men believed that doing drug treatment with their partner was a positive experience. Others noted that they had difficulties doing methadone treatment with their partner and that when their wife or girlfriend relapsed, it was difficult for them to not follow. With the exception of Victor, all the men who discuss having problems with treatment are white. And Luis is the only Latino man to discuss the benefits of having a partner who is in treatment with them.

Trouble Trying to Do Treatment Together

Some of the men's partners were also on methadone treatment at Second Chances. As discussed above, Mike and his wife are both clients at Second Chances. He tells how they have had some negative experiences at Second Chances over what he perceives as counselors meddling in their relationship, trying to take away their privileges, or attempting to remove them from the methadone program.[35]

> I: How are things with [wife's counselor]?
> R: I don't like her cuz she always was like blackmail, you know, she's always threatening my wife. "I'm going kick you out of here," or, you know, like, so I really have issues with her about that. But we get along good now. I like [my wife's counselor]. If I got a problem, I'll talk to her before I'll talk to [my counselor].
> I: What was she trying to kick your wife out for?
> R: Well because we started using benzos like everybody else around here cuz, you know. And when she had two dirty UAs in a row, so it was basically.
> I: Did you get them from a doctor?
> R: Yeah, well. I was doctor shopping. But then, my wife tried to help me with AHCCCS through here. Arresting officer and [her counselor], and they were all, "We're going let you guys slide, but you have to get them from one doctor and use one pharmacy." Cuz we were going, cuz as long as you change the…the prescription guidelines, they'll refill them with AHCCCS, so I would get 90 Klonopin ones, 92 cuz it was a different milligram, and then I'd get 90 Xanax, and my wife would get Xanax, so we were taking them out of those for the most part, selling them.

Mike does note, however, that even though his wife's counselor was threatening his wife with dismissal from the clinic, they were indeed violating clinic policies by taking unprescribed benzodiazepines and also selling them to other clients.

More significantly than continuing to use together or perceiving counselor interference in their romantic relationship, the structure of drug treatment has worked

---

[35] Simmons (2006) also documents similar counselor reactions to addict-couples.

against Mike and his wife's sobriety goals. Although both Mike and his wife have done rehab in the past, in part to try to regain custody of their children, because of the way rehab is structured, he and his wife were unable to successfully complete it.

> I went to one of the places somebody told us about, and so I went in the rehab. And we did it because CPS had our boys, and so we got into rehab. And it always was bad because being married you can't go to treatment together, so she would go for 14 days, and then I'd have to wait for a bed to open for me. So sometimes there was like three or four day time frame when we were out there together, and then, you know, I'm still using, and she sees me high, and so, you know, she started doing the same thing.

The drug treatment programs are unable to accommodate both Mike and his wife, so while one is in rehab, the other is still using drugs. Then, when released from rehab, the drug use starts all over again because the couple has not gotten clean together. Mike's wife is currently in an in-patient rehab, and he misses her.

> I: Do you get to see her at all? Do they let visitors?
> R: First 21 days you got—you don't get to talk to anybody. No phone, you don't get letters, you don't get nothing. [coughs] And then after that, you have to write an autobiography and supposed to be at least five, you know. Then after that, then you can put in passes for visits, go home, that kind of stuff, but she went in that day. She got there, and all she had on her was [inaudible], so I get her clothes and bring them up to her, and that was after she'd been there a week and a half already. And I was already having a hard time about her being gone, and then she saw me standing outside the door when the lady answered it, and she goes, "She could be glad to see you." She's like, "Hey, you come in. I get to see you for ten minutes." She didn't realize that she had a ten minute visit. Within the first five days. She had a doctor's appointment yesterday, so I got to see her then too.

Ethan, a white man in his late 30s, also is partnered to a woman who receives methadone from Second Chances. He says that the clinic discourages romantic relationships among clients, and that his refusal to abide by counselors' advice to refrain from becoming involved with this woman led to some trouble. He claims that Second

Chances threatened to kick them off clinic services, and that this led to him calling a regulatory agency about the problem.

> R: So I left this girl, and there were some disagreements there, you know, with counseling, cuz I got with another woman that I know from [Second Chances], which of course they discourage, you know, clients seeing each other, but you know. I've known her in and out of the clinic for ten years, and that actually caused a lot of trouble here. That's the only problem I ever had with [Second Chances] that I actually had to call [organization responsible for coordinating behavioral health] to get involved with them because they were getting a little too involved in my personal life and hers as well, you know, to the point of, you know, cuz this happened twice. The first time I got together with her, I was literally threatened to be kicked off the program for seeing this woman, which is completely unethical on their part, you know, completely. I won't say who did that, but I was threatened. Someone said, "Look I'll just put it in a nutshell: within the next month you will be off this program if you continue seeing this lady."
> I: What was the reason for that? Did they tell you?
> R: Naw, no. A lot of it from what I see is, a lot of people don't particularly like this person because she speaks her mind, you know, and in a place like this you can't always do that because you're dealing with people who don't, you know, well you know, may have some mental [problem] who probably shouldn't be hearing that. So, but she has to speak her mind, which, you know, I liked and sometimes it's not a likable trait, and some of the counselors don't agree with some of the things she says. And that was part of it. There's a bit of an age difference, which I think is completely ridiculous. You know an age difference, if I was sixteen and she was thirty or something, ok, now that's, yeah, because you know what's a kid going to have in common with an adult? But we're talking an age difference within twenty years, you know, but we're both grown adults, you know. And seeing how there was no rational explanation ever given to me besides they discourage that, but I'm sure since you've been doing your studies where you've seen couples walk in and out together, holding hands and stuff, who have met here and done other thing. And, so they actually broke us up, and it was really a rough thing for six months, you know, and then we got back together and immediately called [organization responsible for coordinating behavioral health] because I started getting shit immediately, and had a meeting and I said, "Look, me and [girlfriend] will come here, and we'll dose and we'll leave, and that's it. And we will not hang around. We won't, you know, we won't come in here, hold hands, make out in the lobby, nothing like that. We'll come here, get our medicine, see our counselors if we have to,

> and leave." You know, "And that's our part of the deal. What are you guys going to do?" And, it was agreed that they would not give us any shit for that. Well that didn't happen, but you know what's said and what's done are two different things, and which really surprised me because [organization responsible for coordinating behavioral health] giving them their funding, you'd think they'd be a little bit smarter about that, but you know, I had a pretty bad beef with that, but it's mellowing out. I'd rather not stir the waters, really, and just get my treatment and stuff, but that has mellowed out since then. I think we just needed to show them that that wasn't going to be a problem because they look at us as a problem as, "Ok, these two are going to run off the deep end," you know. "Not only one of you, but one's going to take the hand of the other, and take that person with you," you know. So, but, that has not happened, actually it is a lot better, you know, we have a good house, we keep our bills up. We're doing pretty good.

Ethan argues that despite the clinic counselors' prediction that couples on methadone will bring each other down and trigger one another to use (Simmons 2006), he and his girlfriend are actually doing well in their romantic relationship and are able to maintain a semblance of stable life by keeping up on their bills. However, they are both currently using methamphetamines. He also notes that they are unable to continue attending some of the groups at Second Chances, even though these groups have been helpful for him, because of gossip about their relationship amongst the counselors and clients.

> I mean, and the girl I'm dating right now both attended that, and we stopped attending it as soon as we got back together because there's a lot of backstabbing, you know, little, you know [pss, pss, pss sounds]. Whispering in the corner kind of things going on, even, I hate to say it, amongst the counselors, you know. So we just decided to stay away from that. You know, even though we love the support of it, it's not worth the aggravation of the hell of dating each other. We really enjoy each other's company, and we're not going to, you know, anybody tell us not to, you know, so. So I've been involved in quite a few of the programs and they're very good, very good.

Victor, a Native American and Latino man in his early 40s described above, discusses how at one point he went to a public detox center in an attempt to get off of

methadone. He became ill when detoxing off of methadone and was hospitalized. Unfortunately, however, his wife was unable to detox at the same time.

> I: And so you were just really sick while you were at the detox?
> R: Oh gosh. I had to go to the hospital. They took me to the hospital. I was—couldn't hold my food or nothing. Oh, I felt good when I go to the hospital, and I know they get no drugs, but the IV and stuff, if I ever did again, I wish I go to the hospital, and have that IV in you and stuff. Oh, cuz it take—cuz you know, I don't need, I don't even want to see the world. I'll be cuddled up, and oh God. And when I went to the hospital, when I came back, it felt good. And then my wife, she had to leave, but I could stay, and she got all upset. We would have got clean at that time, and then I go, I'm leaving, too, and then I went and did it.
> I: So you think if she'd been allowed to be—
> R: Yeah, I would have did it that time. Yeah, we would have did it cuz I mean, I was there, you know what I mean. I was just, I was just right there where I know two more days, I would have felt no more weakness at all, right. It would have been cuz the suffering went away. Maybe I was a little weak, but the suffering just went away. Ah, I was upset.

Because his wife was not hospitalized with him and was not permitted to stay in the hospital, Victor chose to leave the hospital early, right before he would have been off methadone completely. He thinks that if his wife had detox as well, that they could have both been free of methadone at that time.

Robert, a white man in his mid 50s described above, originally entered methadone treatment with his wife at a private clinic. He paid for both of their treatments, and the cost was $130 per week. They were on methadone for 12 years when Robert had an accident that prevented him from working. Soon he could only afford to pay for his wife, and then both had to leave to find a more affordable treatment option.

> I: So you ended up at [Second Chances] because they kicked you off? You lost your job, and you weren't able to pay at the pay clinic anymore.
> R: Yeah, and the good Christians that they were up [private methadone clinic], says [laughs], "No money. Get out of here."
> I: How did you hear about the [Second Chances]?

> R: Actually one of the nurses that worked there told us that, you know, she felt bad cuz they kicked me out. Two days I went from 120 milligrams to nothing. And I was sicker than shit, and she told my old lady cuz I kept paying for my old lady, so she could be detoxed slowly. And then she told my old lady to, you know, that I was not going to be able handle it, and I was already starting to lose it. Had to come down and see these guys, so that's what we did.

The cost of private methadone treatment was too great, and so Robert and his wife transferred to Second Chances, a more affordable treatment option. If this more affordable treatment option had not been available, Robert and his wife likely would have begun using heroin together again because, as described below, it would difficult for Robert's wife to remain heroin-free if Robert began using again to deal with methadone withdrawal.

Difficulty Staying Clean When Partner Uses

Many of the men talked about how difficult it was to become or remain opiate-free if their partners were using. Paul, a white man in his mid 50s described above, spent some time in prison, and while there he got clean from heroin. He describes how he felt healthy and was being productive upon his release, but that he was unable to remain heroin-free because his wife was still using.

> When I went to prison and I cleaned up there and I felt healthy and was working and built a bike and everything when I got out, and I wasn't using, what would have been the best thing to do was just stay off the dope, period. But when I came out, my old lady was using. She was writing to me all the whole time I was down, telling me she wasn't, and we were going to do this. Ah, she was using, but I'm not going to blame her because I knew when I hit that gate, it was in the back of my head. It's always there, you know, it's something—it's really, you know.

Though Paul is careful to emphasize that he does not blame his wife for his addiction, which is always present in his head, he was unable to withstand the temptation to use when heroin was in such close daily proximity.

Chris, a white man in his mid 20s described above, is partnered to a woman who is also a client at Second Chances. Chris admits that it was difficult to not use pain pills when his partner used them in front of them.

> I: So you said you tested dirty for weed. Were you doing other stuff as well?
> R: No. Actually I was just taking my medicine and, I wasn't taking it like I was supposed to. I was taking less than I was supposed to. Cuz my fiancée, she got injured, too, and to just like have her right there in pain, and I have pills, you know, so she was taking them, too. It was just like, and both of us were taking them, and that makes it even harder to quit and stuff, so.

Robert, a white man in his mid 50s discussed above, talks about how difficult it is to refrain from using heroin when his wife uses. Although he does not want to be on methadone for life, he recognizes that because his wife struggles immensely with addiction, that he will either be on heroin or methadone the rest of his life.

> I: How did you hear about methadone in the first place?
> R: When it came down to where the cops were really trying hard to throw us in jail, me and my old lady had tried to quit a couple times, and it just—neither one of us had the fucking…couldn't fucking handle the sickness, neither one of us could deal with it. We're both babies that way. And we knew other people that were on it, that were still using, but they were on it. And they were the ones that told. The ones that were on it and still using is the ones that told us about it. If you can pay and that way you won't have to worry. But if you go to them at the pay clinics, all they care about is their money. You know, as long as you bring them their money, they warn you when you got to piss, so you can make sure you're clean. Nnn, that's how it went there cuz when we went there, we were serious about getting clean cuz we had, our habits too big, and I was trying to go back to work cuz there was no way I could stay clean and sell. Cuz my old lady [laughs], she can't be around it and not do it. I got more willpower than

> that, but I can't watch her get high and me not be high. So, that's where my willpower ends. I can have it around me and not get high, but old lady's getting high, I got to get high, too, so.
> I: How much longer do you think you'll be on methadone?
> R: I don't know. I said I would like to get off. See my problem is my old lady fucking going to be using all her life. Runs in her family. Very addictive personality, and she got mental issues in her family, too. And so far she ain't showing none the mental issues. I guess addiction is kind of a mental issue, but she not showing any of the real crazy mental issues. Um, but she'll probably be using her whole life, so I think it's going to be for me to get off totally as long as she's still using. Even though, I mean, I'm planning on it. I'm planning on getting off whether she does or not, but I figure, once I get clean and she's still using, and just the crowd of people that you see down her everyday, I'll either get back to using dope or something that will tie me back into methadone again. Unless we both walk at the same time.

Robert believes that it will be impossible for him to be opiate-free unless his wife is also opiate-free, and that this would have to happen at the same time. In a study of addict-couples, Simmons (2006) also found that "[c]ouples realized if they were to have even a slim chance of staying clean after detox or treatment both partners must be clean" (6).

Positive Experiences Doing Methadone Treatment Together

Five of the men interviewed talked about the benefits of having a partner who also was receiving methadone treatment. Even though having an addicted partner can make it difficult for men to get clean as discussed above, having a partner committed to successfully completing treatment is also something that some men perceive as helpful. Sam, a white man in his late 30s, has a girlfriend who is also a client at the clinic.

> I got out of prison, I started using again, I didn't want to use. My girlfriend at the time was coming here, and she still comes here now. And we've going to treatment together and stuff, and we work as a team. We're like a team.

Sam and his girlfriend attend AA together at the clinic as well. His girlfriend is Catholic, and religion is important to her, so Sam is learning about it as well and is attending Mass with her. He is even considering converting to Catholicism. He thinks of their mutual attendance at Second Chances as being on a "team," that is, tackling their addiction together.

Chris, a white man in his mid 20s described above as having some difficulty abstaining from opiates with an opiate-dependent partner, also argues that going into treatment together has been really great. He says that his fiancée can understand what he is going through with trying to overcome addiction, and her ability to provide support has been beneficial to him.

> I: Is your fiancée supportive of your treatment?
> R: Yes. She's actually being treated here, too. So, to have her like in the same boat as me and still be right there and have my back, that's really cool.
> I: And did you meet her here, or did you meet her beforehand?
> R: No, I met her long time ago. Um, we've been together little over seven years.
> I: Ok. And is she doing well in treatment, too?
> R: Yes. She hasn't had any relapses except smoke some weed with me…We try to stay on a good schedule. We get up everyday and do the same thing. We get up, take medicine, come here, go home, take a shower, and just do what we got to do.

Chris and his fiancée have established a routine together that includes daily methadone maintenance, and though they are doing well at remaining free from painkillers despite the fact that they both suffer from chronic pain, they do routinely smoke marijuana together.

Mike, a white man in his mid 30s discussed above, describes how even though drug treatment counselors warned him that he and his wife would probably divorce when they both sobered up, they have been able to maintain their relationship.

> Yeah, we had five years where we didn't use but like maybe three times a month or something taking pills, but you know, in rehab they always try to talk you out of relationships. And then they tell you not to start dating for a year and all this other stuff because there's triggers and stuff, and people say usually when a couple uses together, then they quit, the marriage or relationship falls apart. But we have the benefit of knowing each other and getting to know each other and being sober, so when we got off the drugs, it was not, it was a non-issue because, you know, it wasn't our whole relationship wasn't based on drugs.

Although Mike perceives that he and his wife are exceptions to the norm of addicted couples, it is important to note that neither he nor his partner have sobered up, and both continue to use illicit drugs.

Paul, a white man in his mid 50s discussed above, is married to a woman who receives methadone at a different clinic in town. She is currently detoxing from methadone, which encourages him to consider detoxing.

> I: How much longer do you think you'll be on methadone?
> R: You see, that's one question I can't answer right now because I haven't even started coming down off of it. I've been eighty-five for a long time. And my lady friend, she's been coming down and she's on thirty – twenty-six right now. And if she can do it, I know I can.

While Paul does not know how much longer he will be on methadone, the fact that his "lady friend" has been able to successfully detox from 100 milligrams to her current 26 gives him hope that he can one day be able to successfully detox as well.

Luis, a Latino man in his late 50s, is also married to a woman who attends Second Chances. They both share the same counselor and support each other through treatment.

> R: Mmm, I have a family of my own, and right now, I have someone that I live with, you know, someone that I really care, you know, that I really care about, and we both share that with one another, you know. And we get along real good. We get along real good. We both know what it's all about, and the outcome out of it, man, is, is good. It's something that is good, you know, it's, I mean, I don't see anything wrong with it, so.
> I: And is she a client here as well?
> R: Yeah, she's a client here, too, you know. And she's very supportive, and I'm very supportive with her, too, you know. And, [counselor] both of ours, and you know, case managers, you know, so it's all good, you know.

Luis notes that his partner being in treatment as well means that they "both know what it's all about," which is a good thing because they can support one another well. Simmons (2006) also found that addict-couple's relationships "were characterized by 'care' and a commitment to preserving the relationship, despite the many hardships, and in many ways because of the hardships, these couples endured" (10-11).

STRESS, SEPARATION, AND DIVORCE

Relationship troubles and substance abuse occurred together for several of the men interviewed. Many talked about how problems in their romantic relationships triggered substance abuse, and many also talked about how their addiction led to relationship disintegration. Some men also talked about how their relationships broke up because their partner refused to stop using, and for others separation and divorce sometimes led to concerns about paternity and to child custody problems, issues discussed in the chapter about fatherhood.

Relationship Stress Triggers Use

For men who struggle with addiction, tensions rising from their romantic relationships can lead to relapse. Ethan, a white and Native American man in his late 30s discussed above, talks about how when he learned that his partner was cheating on him, it caused him to start drinking.

> [Counselor name], yeah she's been my counselor for fifteen years since I've been here and very good, you know, she's saved my life, you know. You know, just like with all relationships, relationships have ups and downs and sometimes you know, you have disagreements, and there was a disagreement cuz, you know, I was with this girl that I was even planning on marrying and stuff for like five years, and I was pretty stable during these times, but towards the end, things started being a little rough, you know, and she started seeing somebody, cheating on me, and, you know, I started actually drinking, which was never a drug of choice with me. And that was very concerning especially cuz of the Hepatitis C, and I was also drinking when I was on Interferon at the same time which, I mean, that was just totally stupid, but it was because I did not want to, which it would make more sense to buy some extra benzos or something. At least more healthier. I had almost this pride like, you know, I wasn't going to do that, so I'll just have a few drinks, you know, and then the few drinks turned into a fifth a day, you know, after a couple of months, and then that was a pretty rough time.

Although Ethan is an opiate addict, relationship stress caused him to start abusing other substances, such as alcohol, and he even considered using benzodiazepines.

Paul, a white man in his mid 50s described above, discusses how alcohol use precipitated his entry into in-patient rehabilitation, and the reason he began drinking was because he and his wife were not getting along.

> Yeah, yeah, yeah. I started drinking, I started drinking since I been here. Yeah, I drank. It was winter time, me and [wife's name] weren't getting along, and I told her, I said, "Rather than put you through any of my bullshit and pain, and you know, I'll just leave." And it was winter time, and I started drinking and I played guitar so, I ended up on [local street] playing every night, drinking, you know.

George, a white man in his early 50s, also notes how conflict with his wife leads him to use heroin.

> I: What do you think their [wife and son] reaction would be if they knew? Because they don't like the methadone. But what do you think their reaction would be if they knew that you were using sometimes?
> R: I'd be divorced. No ifs, ands, or buts about it.
> I: And you said that it's the ultimate high when you're using now, which is why you're still using. Is there anything specifically that triggers your use? Besides having money?
> R: My wife's ragging on me. But yeah, that would be about it. If my wife's ragging on me, or crap's going crappy at home.

His wife is going blind, and her short-term disability is currently their family's sole source of income as George is not currently employed. The irony is that stress at home leads George to use heroin, but at the same time, if his heroin use were discovered, his wife would leave him. Other scholars have also documented that unemployment and economic hardship cause conflict and can lead to divorce or separation (Amato 2010; Hardie and Lucas 2010).

Joe, a Native American and white man in his mid 50s, describes how when he and his current wife temporarily separated, it led to a severe drinking binge.

> And he—actually I should have got kicked out of this program a long time ago because I started drinking. Me and my wife separated for a while, and it kind of put me in a rut. So I started drinking and I would go—there's a liquor store around the corner. You know. And the vodka is only two dollars a bottle, so it was easy to get liquor. And I would get smashed. I'd come back, and I'd sit by the front door and fall out in the flower bed. Pass out, you know. And one time I was up by [nearby part of town], and I went up. I got two pints of liquor, and I gave my buddy one and I drank one, and I just dosed. And I drank it all. And I fell out, and they had to call the paramedics. So I should have been out of this clinic a long time ago. If it wasn't for [counselor], I would have. You know.

Joe suggests that the separation from his wife was the reason for alcohol abuse, which when combined with methadone led him to require serious medical attention. He also notes that his counselor is the reason he is still able to receive methadone because if it was not for the advocacy of his counselor, Joe would have been kicked out of the clinic for violating policy.

Other men talked about how using drugs helped them through divorce. Dan, a white man in his early 30s, tells how when he married a woman from Eastern Europe, she did not inform him that she had a lover in her home country. When she left Dan for this man, she took with her their shared home and car, and he lost the business they had together. Dan had a car accident, and this coupled with the loss of his marriage led him to rely on painkillers to get through this emotionally troubled time.

> You know, I don't have kids or anything. I was married for four years, but it was more of a marriage of convenience, you know, to please our parents and stuff. But you know, she was a flight stewardess. She was never home, and you know, I'm never home living in [Southeastern state]. It's just a funny relationship and going through divorce with that, it was kind of crazy. First home I ever owned, you know, I lost. I just had my car accident, so I'm all, you know, in a body cast, and I'm half, you know, and you know feel like fighting [laughs]. So I lost all that, and we had a business thing too, you know. I just went ahead and gave everything up. And I think a lot of that had to do with the fact that, you know, there was an emotional thing that was going on, not only—I felt like nobody was there to support me, but the pain pills were there.

That so many men turned to substances to deal with the emotional lows of romantic relationships speaks to the importance of these relationships in the men's lives. The five men who reported relationship problems leading to further substance use are all white. That only white men reported this reaction may be due to the dictates of a raced masculinity, which dictates that men not express sadness (Kilmartin 2010). In order to

deal with this forbidden emotion, the white men in this sample may turn to substances to numb this feeling. It may also be the case that Latino men had more family support when their romantic relationships failed, which provided a resource other than drugs for dealing with emotional hardships.

Separation and Divorce

Addiction caused strain in many of the men's relationships. Several of the men interviewed described how they had separated from their partners or how their romantic relationships ended in divorce. When asked what the consequences of using heroin were, Carlos, a Latino man in his early 50s, notes that his addiction resulted in divorce and subsequent separation from his only daughter.

> I: How would you say that you using heroin impacted your life?
> R: Oh, heroin impacted my life real bad. I was married. I got divorced. I was in and out of jails. Stealing here. Stealing there, and you know, to tell you the truth, I lived a real hard life.

His daughter is now an adult, and he has not been in contact with her since she was a child because she and her mother moved to a different state.

Likewise, Steve, a white man in his late 50s described above, talked about how going to prison for drug charges ended two marriages. Steve expresses regret that heroin addiction led to crime, which led to decades in prison, which led to the loss of his romantic relationships and his relationships with his child and grandchildren (see Steve's perspective in the chapter on fatherhood). Additionally, Steve is so embarrassed by his life that he has not reestablished contact with his family.

Tom, a Latino man in his mid 50s, also described how using heroin resulted in the loss of his family. His addiction led him to sell drugs to support his heroin habit, and eventually he was arrested and sent to prison.

> I: How would you say that using heroin impacted your life? What were the consequences of that?
> R: Well, I ended up, you know, losing my family, and you know, I ended up losing practically everything that I was working, I had a good job and everything. Then after that, you know, started getting into drugs, you know selling drugs and supporting my habit, so then from there just ended up going to prison. In and out.
> I: And what happened when you started using heroin?
> R: Well, at first, it was kind of under control back then. I could say that. Then my ex-wife, you know what I mean, we were young. We got married real young, and we met each other when were like 16. Then we got married like when we were like 18. So we practically like, you know, experiment with like with being married, so then after I started getting out of hand, and then I got arrested, so then mean so I was facing a lot of prison time at that time because I had five felony counts. So, I just, knowing I was going to go to prison, I just filed for a, asked her for, you know, for a divorce because six years that we were going through all this, you know what I mean, and I just said, "You know, [you not done what]." And so she went—we went back to [Southwest]. That's where she's from, and she stayed there, and I came back and that's when I turned myself in, and ended up going to prison.

Right before Tom went to prison, he requested a divorce, which is something that Steve also did. When Tom got out of prison, he became involved with another woman who had never used drugs. He began using and selling drugs again, however, and cut off contact with his girlfriend and moved in with his mother who wanted him to take care of her (see Bourgois and Schonberg 2009 for a discussion on Latino men's relationships with their forgiving mothers).

> I mean as much as I don't like it. You know what I mean, but the thing is, I know what it's like. When I was involved in this relationship—I just broke up. You know a few years I was with this person, and she didn't do no drugs. She didn't—nothing. I mean, she was clean. So I was clean. I

> mean then like six months, and like I started using again. I got laid off, so I started having a lot of time to myself, and she was at work, so I wasn't so. So after a while, you know what I mean, I tried to get a job. I worried then I would, you know, go back, I mean, to the neighborhood and run into this and that. So I started using again, so then I got myself in the methadone, so then I stayed clean, and I was going to that labor place every day, you know what I mean, because I have to make sure I am taking, you know, take care of the bills and stuff like that, but now since I moved out, and I'm with my mom now, and then she asked me to move in with her cuz she wants me to take care of her. And I noticed like, you know, I been doing more there now than I was when I was, you know, with this person.

None of Tom's romantic relationships have survived his heroin use. His first serious relationship ended when his heroin addiction led to a prison sentence, and upon his release from prison, even though he tried to be clean like his girlfriend was, his lack of employment and his girlfriend's participation in the labor force gave him a lot of time to begin using again. Tom's mother knows that he is on methadone treatment and is supportive of his treatment.

Xavier, a Latino man in his late 30s, also noted that a consequence of using heroin was the loss of his first wife and daughter.

> I: What were the consequences of using heroin and the painkillers?
> R: Consequences? Oh my God, there's a lot of consequences. Oh man, I caught Hepatitis C. Lost, God good jobs, union jobs…uh, lost everything. Had to start all over. My apartment, my car, motorcycle, my wife, my kids. It's like never ending consequences (laughs) to be honest. I'm still paying for things that I basically I've done in the past, stuff like that, so.

Although Xavier is no longer with his first wife, he has recently remarried, and he has an infant daughter.

Joe, a white and Native American man in his mid 50s, described how heroin addiction resulted in two divorces. He says: "Oh man! Let's see. I've been—uh cost

me like two wives, a business, a house, everything I owned. [pause] The cocaine had a little bit to do with it, too." And even now while in treatment, Joe has relationship problems with his wife.

Many of the men interviewed described how one of the major costs of their addiction was the disintegration of their relationships with women, and this also meant a corresponding loss of relationships with the children they fathered with their female partners (Doherty 1997; Pasley and Minton 1997), a phenomenon described more fully in the chapter on fatherhood. In several cases, the men's divorces were associated with their periods of incarceration, a phenomena that has been documented elsewhere (Lopoo and Western 2005). There are no evident ethnic differences in regards to the effects that men's opiate addictions had on their romantic relationships.

Children's Mother Refuses to Sober Up

Some of the men described how their children's mother refused to stop using drugs. Matthew, a Latino man in his late 20s, describes how both of the women with whom he fathered children have used psychoactive substances.

> I: Your oldest son's mother was using meth? Is she still using?
> R: No, she's good. No, she's been real good now. She lives in [city], she's pregnant right now. She has a boyfriend. She moved out to [Midwestern state]—her family moved out to [Midwestern state]. Her grandma's like a millionaire. So, that's like, "You know, you need help." They took her to [Midwestern state] cleaned her up, and she met some guy. They moved to [city].
> I: And the two year old's mother, did she ever use anything?
> R: Mm hmm. She smokes a lot of weed. She's not really—she's a real big pothead, but no, she don't.
> I: Like no heroin, no meth.
> R: No, hell no. She throws that in my face so much.

Though neither of these women used heroin, his oldest child's mother was addicted to meth, and CPS removed their son from their custody. Her family had the financial resources to get her away from drugs and into some form of treatment, and she is now sober and partnered to someone else. Matthew's youngest son's mother uses marijuana, and often draws a comparison to Matthew's opiate use.

Nick talks about how his children's mother was unable to clean up from heroin, and thus died of a heroin overdose. While he currently does not have access to his children, he is on methadone and attending Parenting classes in an attempt to regain custody of his children.

> R: I was on AHCCCS. My kids, when their mom passed away, and it was—then I was forced to raise them, so I have my AHCCCS with them.
> I: And how did your kid's mom pass away?
> R: [Heroin] overdose.
> I: So did you guys use together?
> R: Yes.

Similarly, Bryan, a white man in his mid 20s described above, was also formerly partnered to a woman who could not give up heroin even though CPS had removed their daughter from their custody. In all cases, the consequences of the men's partners unwillingness or inability to give up their heroin habits meant that these women no longer have relationships with their children.

MAINTAINING RELATIONSHIPS

Some of the men noted that maintaining their relationships was a motivating factor in their pursuit of drug treatment and sobriety. Some of these men had partners

who had never used opiates and who provided emotional support necessary for the addicted men in their lives to tackle their opiate addiction. Even partners who were former users could be a source of support.

Getting Treatment to Maintain Family Relationships

Many of the men interviewed emphasized the importance of their family relationships, and how a desire to maintain these relationships inspired them to seek treatment for their addiction.[36] In most cases, these men were not partnered to women who were also in methadone treatment. Steve, a white man in his late 50s described above, talks about how the reason he first got on methadone in the early 70s, was in an effort to not lose his family relationships.

> I got on methadone '71, something. I don't know. '73, somewhere in the '70s. And I came out here, and I got on the clinic out here. Cuz I was using, I didn't want to, you know, I didn't want to lose my family, so I come down and get on at [Second Chances]. You know, when it got so bad that it was doing that [letting heroin use negatively impact his work], that's when I came to methadone. You know, my wife said, "Come on, you got to get on methadone." When it got so bad that I couldn't keep my job, and maintain my habit, it was time to get on methadone.

Unfortunately for Steve, his treatment was unsuccessful, and his incarceration for drug charges led him to terminate his family relationships, something he regrets. He is still not in contact with his children or grandchildren.

Similarly, Tom, a Latino man in his mid 50s described above, also got on methadone to maintain his family relationships.

---

[36] Previous research has documented that wives (both addicted and non-addicted) of drug-addicted men report that their husbands spend more time with them and their children after going on methadone maintenance (Clark et al. 1972).

I: What made you decide you wanted to come off heroin?
R: Because, you know, I'm always kind of like been family going type of person, you know, I was kind of maintain a job, you know what I mean, so this, you know, it's always helped.

Mario, a Latino man in his mid 40s, also got on methadone treatment in order to stay with his wife and children. He even overcame his fear of methadone, something inspired by a special news segment he saw on the topic, in order to have a second chance with the mother of his children.

R: No, no because I only took methadone for maybe two months. And then I quit. I seen something on ABC, you know on the news, and I didn't want to take it anymore. But this time around, it's—I'm—it's different. I'm with somebody, and I'm trying to make a life, you know, so.
I: And so you came back to [Second Chances].
R: Right.
I: And so you said that your eventual goal is to get off of methadone. Can you envision a future without methadone?
R: Mm hmm.
I: And how far away is that for you?
R: Like I said, I need to really start doing what I say I'm going to do here.
I: And the reason for that—you said you someone new in your life.
R: Mm hmm.
I: And who is this?
R: The mother of my children.
I: Oh, ok. And so has she said anything like, "You need to get off of heroin" or?
R: Well, yeah. We've been down that road already. So she's like….[gestures]
I: And how long have you been with her?
R: 'Bout ten years.
I: And has she ever said, "There are going to be consequences if you don't stop using heroin?"
R: Yeah they—she has. But there haven't been.

Mario's partner has previously given him the choice between using heroin and being part of their family unit, but in the past there were not consequences for his continued use.

Likely this is because she, too, had used heroin, though she had managed to successfully abstain from illicit opiate use through methadone.

Sam, a white man in his late 30s, noted that the reason that he sought methadone treatment was to maintain a good relationship with his girlfriend's family with whom he and she were living.

> She was already at [Second Chances], and I didn't get on [Second Chances] right away. I started living with her, and then I started using again, and she didn't. You know, and I didn't want her parents to get mad at me because that's, they're not, they're really nice people. I didn't want them to think I was a bad person, so "I'll get off of this. I'll go to the [Second Chances]. Least that way there, they'll know I'm an addict, but they'll know that I'm doing the right thing by trying to get help." So that's why I came here.

He describes his girlfriend's parents as "really nice people," and he did not want them to think poorly of him. Even though he was using, he thought that getting treatment for his opiate addiction would mitigate his use and make it more likely that her parents would not dislike him. Sam and his girlfriend are currently residing with her parents, and while supportive of their methadone treatment, they want Sam and his partner to move out.

> I: Are they [girlfriend's parents] supportive of the treatment?
> R: Yeah, yeah, yeah they want us definitely to move out, you know. It's been a long time coming, but, we just, my girlfriend's been trying to get her Social Security, so I'm the sole provider. And I'm on unemployment, so. I think you can see where that goes.
> I: And are you guys doing well in treatment together?
> R: Yeah, yeah, we're definitely we actually help each other out, so.

Joe, a Native American and white man in his mid 50s, notes that methadone has been effective in keeping him from using heroin, something he is happy for because he has a good wife who he does not want to lose.

> It [methadone] keeps me from shooting dope. Because I don't want to do it no more. I'm sick of it, man. You know, I'm 54 years old, man. You know. And I got a good lady, and I ain't trying to lose that.

Six of the men interviewed discussed how maintaining relationships with their partners, partner's families, and children served as motivation to get treatment for their opiate addiction. There do not appear to be ethnic differences in this respect.

Partner Not a User

Many of the men were partnered to women who were not addicts and had never used opiates. Xavier, a Latino man in his late 30s described above, tells how he met a woman he eventually married who encouraged him to move to Arizona and get out of a drug-environment.

> And I met a lady that lived here in [Arizona city], and she was great, you know, she was a great support, you know, she was really nice and stuff. She was like, you know, "You should come out here. I think you would actually be able to get away from [Southeastern state], get away from that type of environment, this stuff. And you know, I think you could be able to make it." I've been doing great ever since I got out here, you know. Other than when I first came, I did come with an addiction, and I've been now clean now for almost like three years.

He did move to Arizona and has since been able to abstain from heroin use with the support of his wife.

Will, a Latino man in his late 40s, is also married to a woman who has never used drugs. Unfortunately, even her threats were unable to convince him to give up his addiction.

> I: So did she use sometimes, too?
> R: No, my wife never did. Never in her life.
> I: But she knew that you did?

> R: Yeah, she knew that I did. And what would happen is that we would be together, and she'd tell me, "You know what, if you're going to keep using, you better just take off because I'm not going to have you using, and there's the kids." Cuz I have two children. Boy and a girl. They were starting to grow up, and "I'm not going to let them see you," and all this stuff. So, what did I do? I just go to my folks' house. And I just stayed there.

George, a white man in his early 50s, married a woman who has never used any sort of illicit substances whatsoever. When he married her when he was in his early 20s, he had already been using opiates for eight years and did not consider his use a problem until he blew through their family money and his wife found out he was using, which was also an indication of addiction for the women in Rosenbaum's (1981) study.

> I: At what point did you think you had a problem?
> R: [long pause] I probably never really thought it was a problem. [long pause] Until I was probably 21 years old maybe. I always thought, never really thought about it, but it obviously became a problem when I was 21.
> I: What made it problematic when you were 21?
> R: I was married, just had a kid. Um…and went through a lot of money that we had saved up, and my wife found out about it, so that's when it became, I guess, a hit-you-in-the-face kind of thing.
> I: Was she using at all or no?
> R: Oh, no. Straight as straight can be.
> I: What happened when she found out?
> R: Well, at first, she wanted to, she thought she could cure me and all that, but she soon found out that didn't work, so we ended up splitting up.

His wife tried to help him stop using heroin, but this did not work, and they ended up temporarily separated. George has been on methadone for decades, but is still actively using heroin, something he keeps secret from his wife for fear of divorce.

> R: Plus, you know, I got a son at home and a wife at home that hate methadone to begin with.
> I: Why don't they like it?
> R: Cuz they think all I did was go from one drug to another.
> I: But have they noticed any differences in your behavior?
> R: Oh I'm sure they've noticed differences in my behavior. My son, he

> was too small to really know it, but my wife I'm sure has definitely noticed it. She still…[pause], she doesn't like methadone.
> I: Does she want you to come off?
> R: She wants it, but she know, she know, I think she knows that I probably never will.

George's wife and son disapprove of methadone even though his wife has noticed positive changes in his behavior since entering this form of treatment.

Frank, a Latino man in his late 30s, is also partnered to a woman who does not use any drugs or even cigarettes.

> R: And he's [police officer] the one, he's like, "Don't waste your life, man." He's like, "You're going to end up in—" And plus, I got seven kids here, so yeah, I made a new family here. That's another thing I love about Arizona. I found a wonderful wife that doesn't do anything. Not even smoke cigarettes. Yeah, she's like so into like nature and stuff. It's tight. She helps me stay clean a lot, too. But then I went off and get dirty again. This last run, I did eight clean, eight years clean, and this last, I just got off it. I went on a six month binge on pills.
> I: What led to that?
> R: Stress. Bills. I own a house. I bought a house, and I was almost losing it foreclosure.

He respects that his wife is "into nature and stuff" and that she does not use any sort of psychoactive substances. His wife also helps him stay clean, but sometimes financial stress does lead to relapses despite his wife's support and positive influence. Frank kept his most recent relapse a secret from his wife, and she only found out when he was about to be kicked out of the clinic for so many positive drug tests.

> I: You just mentioned your relapse from methadone. You had eight years clean, and then you relapsed on heroin?
> R: I started on heroin, and then I ran into pills to get off the heroin. Cuz all I did was like an eighty piece of heroin. I was like, well I don't want to do no more of this. Then this one guy I met at this bus stop told me about pills. And I was like, "No way an oxy can make me feel as good as some heroin." And he's all, "Dude, it will." And it just went on after that.
> I: Did your wife know that you—

> R: No. She found out cuz [laughs] I was getting kicked out of the program. And she was like, "What do you mean, you're getting kicked out?" And I was like, "Ok, I'm dirty."
> I: Why were they kicking you off?
> R: Because after so many dirty UAs of you're not trying, they know what you can do after a while, you know what I mean? So they know if you're not trying, they're not going to let you do both, you know what I mean. You're either going die of an overdose or something, so they try to like warn you. Like "Hey, you can either clean up or you're going to be out of luck."
> I: What, what made you come back?
> R: My kids.
> I: So when your wife found out that you were getting kicked off, what was her reaction?
> R: She was upset. She was upset. Very upset.

Frank's wife has a nursing background, so she has a better understanding of what methadone does compared to some of Frank's other family members who believe he is merely substituting one addiction for another. However, her understanding does not mean that she views her husband as "clean."

> *I*: And they're supportive? And your wife?
> R: She's supportive.
> I: She's supportive, too. Does she think the same thing as your mom, that it's just a substitution of one for the other?
> R: She understands more like in-depth cuz she's a registered nurse, so she's like, she just couldn't understand like how I could do it to myself after being clean, to fall back into it, you know, and like she said, "So your excuse of falling back in is cuz you were on methadone, so it wasn't like you were clean." I'm all, "Shut up." It kind of was like that, but it's not, you don't hurt yourself on methadone unless you're jonesing for it or whatever, but it's not like dope when you need it whenever it wears off. Like, methadone lasts for a while.

Frank's wife, her sister, or her mother drive Frank to the clinic each day, so they are invested in his treatment.

Tim, a white man in his late 30s, is married to a woman who has never used. Not only does she not understand why he wants to keep his methadone treatment private (see previous chapter), but she also does not like the clients who come to the clinic.

> I: And is your wife supportive of your treatment here as well?
> R: Yeah. She doesn't like it here, though. She doesn't like the people like that, you know, that are out there. That come here.
> I: Is she a client, too?
> R: No, no, no. She doesn't do, she's doesn't do any drugs. She's…totally different. [laughs] I met her when I was working for [media company].
> I: But she comes here sometimes and sees the people?
> R: No, I mean, you know, like she'll come, she'll take a ride with me or something or some drive or we had to go do an errand or something on the East side or something. She'll go come by, and she's seen it. I mean, she hasn't been here in a while, seen people in a while, but she's sees them outside, so, and she just thinks, you know, she just doesn't like them.

Some of the men with partners who had never used were able to successfully abstain from opiates while others were not. Several of the respondents mentioned that their partners, while providing motivation to stop using or providing emotional support, often do not fully understand the men's opiate addiction and dislike methadone maintenance, which may make it more difficult for men to recover from opiate addiction.

Partner Supportive

Each of the men interviewed was asked whether his family was supportive of his treatment. Several of the men mentioned that their partner was supportive of their treatment. While some of the men seemed to interpret this question as whether their partner was generally supportive even when she explicitly expressed disapproval of methadone maintenance (see some of the above quotes), others talked about how their

partners were proud of them or took an active role in their treatment by, for example, providing transportation to the clinic each day. Jeremy, a Latino man in his late 20s, describes how his girlfriend is proud of him for seeking out methadone treatment.

> I: Has anyone else had negative reactions to you being on methadone?
> R: No, my girlfriend's the one who told me to like, she actually was proud that I came and did this. Cuz I needed help. And she knew it. And I knew it, so I came and did it. We had broke up, and she thought, "Oh, well, he's not going to go through with it." I did. She seen it, and she was like, "Yeah, I'm very proud of you. Do it yourself." So.

Ben, a white man in his early 40s, is also married to a woman who has never used. She drives him to the methadone clinic everyday.

> I: Are your friends and family supportive of your treatment right now?
> R: Absolutely.
> I: So, do they know that you're on methadone?
> R: Yep. My wife drives me here everyday.
> I: Has she ever used?
> R: No. She doesn't, she's a homemaker and takes care of the children. I always did this stuff outside of the home and be at friends' houses and stuff. Right after work, I'd go party and stuff.

Despite the fact that his wife takes care of the children, Ben is unemployed and currently using crack, something he keeps secret from his wife and children.

Rick, a white man in his early 30s, has a girlfriend who has never used heroin, though she was an alcoholic and did use cocaine. She has two children from a previous relationship, of which Rick considers himself to be the father. She is supportive of Rick's methadone treatment.

> I: And is she supportive of your treatment?
> R: Yes.
> I: And was she ever a user?
> R: Yes. Alcoholic. And she used cocaine.
> I: But not heroin.
> R: But no, no. And she's very supportive, yes.

> I: Has your girlfriend given you a similar ultimatum?
> R: Yes and no. Cuz when we first met, she was still drinking somewhat. But, yeah, we kind of gave it to each other. You know. And the main concern is we're always, you know, it's not about us. It's the, you know, the kids, you know, too. And I think it, we just eventually grew out of it, and you know, wanted to live.

Rick and his girlfriend have given one another ultimatum's about substance abuse. They have decided to give up substances in order to focus on their children. Like Sam described above, Rick's girlfriend is Catholic, and he attends church with her and is open to going deeper into this particular faith.

Joe, a Native American and white man in his mid 50s described above, talks about how his wife is so supportive of his treatment that she transported him to the clinic each day when he was confined to a wheelchair.

> I: And are your friends and family supportive of your treatment?
> R: Well I don't have a whole lot of family left. But yeah, my wife is.
> I: Has she ever used?
> R: No.
> I: No. And she knows you're on the program and everything.
> R: Yeah. Who do you think pushed me down here in a wheelchair everyday? Yeah, every day for six weeks.

Almost half of the men interviewed talked about the importance of their female partner in terms of their methadone maintenance. Maintaining these relationships provided motivation to seek treatment, and the women were often a source of support to these troubled men even if they did not fully understand their partner's addiction or condone methadone treatment.

DISCUSSION

Men's relationships with women partners are important and complex. Men on methadone are no exception to this. Their romantic relationships are sometimes responsible for bringing men into the drug world, and are sometimes responsible for bringing men's wives and girlfriends into the drug world. Men opiate addicts' women partners can serve as a barrier to successful drug treatment, but they can also be a primary form of support that motivates men to leave opiates behind and work toward having successful family relationships.[37]

Given that the interview was not centered on men's family relationships, I was surprised at how often men talked about their experiences in the drug world in terms of their female partners.[38] Early in the interviews, in response to the question about the consequences of using heroin, many of the men discussed how opiate addiction led them to lose their wives, children, and other family members. For these men, any current romantic relationships may be all the more important because so many other social bonds have been severed.

Many men described being partnered to an opiate-addicted or dependent woman and mentioned how treatment is difficult when this is the case, particularly given that methadone maintenance and other treatment options are based on treating an individual rather than a couple or family unit (Simmons 2006). Sometimes one member of the couple is given an opportunity to sober up by going to an in-patient program or through

---

[37] Hamilton and Grella (2009) also found that addict-couple's relationships could be supportive or problematic.

[38] Doucet (2006) also was surprised at how men talked about fathering in terms of their relationships with women.

hospitalization. Because these opportunities are not simultaneously available to both partners, however, when the drug-free person leaves the institution, their partner's continued addiction or dependence triggers their use again.

For men on methadone who are partnered to women that also use, treatment outcomes could potentially be improved by treating the couple together. Several of the men noted that going through treatment with their partner was a great experience, while others emphasized how their treatment could be better if counselors were less discouraging about the prospects for treatment success for addict-couples.

And even for men not partnered to women users, treatment outcomes could be improved if treatment included an acknowledgement of the importance of the men's romantic relationships. For example, many men talked about how relationship stress triggered use, and if counseling incorporated attention to resolving these relationships problems, then a potential trigger would be removed. Additionally, several of the men emphasized how important their relationships with wives and girlfriends are, and how preserving or improving upon these relationships often serve as an impetus to seek or remain in treatment. Counselors could reinforce this motivation by actively referencing family relationships. And given that many of the men's partners disapproved of methadone, but were otherwise supportive and involved in their partner's treatment, counselors could invite the men's partners to become more informed on methadone treatment and to participate in treatment decisions.

An ethnic difference worth noting is that it appears that white men are more intimately connected with addicted women than are Latino men. It is predominantly

white men who use with their partners and who enter drug treatment with their partner or who become partnered to another recovering addict while in treatment. That almost none of the Latino men mentioned having this type of relationship with their partners could mean that their partners are not users, or it could be that there is a cultural norm to not disclose stigmatized family activities (Andrade and Estrada 2003; Gallardo and Curry 2009). If it is the former, then it may be the case that Latino men have better treatment outcomes; however, it also begs the question of why a significant number of white men are members of addict-couples. Previous literature has shown that women are more likely to be part of addict-couples than men are (Friedman and Alicea 2001; Rosenbaum 1981).

The men on methadone interviewed as part of this study often emphasized how important their romantic partners were to them. The significance of these relationships was noted when men described caring for their partners—for example, giving them drugs when their partner was in pain, hustling to get money to support two addictions, and when money was tight, even going through withdrawal so their partner did not have to. Such significance was also highlighted when men discussed caring about their partners—such as working through drug treatment together, risking counselor disapproval by remaining in relationships with addicted women, seeking treatment to maintain their romantic relationships, and using drugs to soothe emotional pain caused by relationship stress. Many of the men also mentioned that they valued the emotional support they received from their partners, something that may contribute to greater physical and

psychological well-being (Fincham and Beach 2010), although this was not directly assessed in this study.

Masculinity is often defined through opposition to femininity, and one defining feature of femininity is caring for and about others. Given that the men interviewed clearly care for, and about significant others may mean that achieving traditional, socially expected masculinity is not as important to them as it is for other men, that hegemonic masculinity is broadening to include care, or that the marginalized masculinity of opiate-dependent men allows men to openly express their interdependence with women in a way that other men are not permitted to.

The second and third explanations are probably both true for the case of men on methadone. Just as hegemonic masculinity is shifting to include caring for children ("new father" ideals and practices), it is likely that being more emotionally involved with women partners is also becoming part of masculine practice. Additionally, men living in poverty need to use their social networks to gain access to scarce resources (Bourgois and Schonberg 2009; Stack 1974), and one way to maintain a social network is to have tightly interdependent relationships.

CHAPTER SIX: CONCLUSION

Drug abuse is a serious social and public health problem. Opiate use is a small subset of substance abuse, but is particularly destructive to opiate addicts, their families, and their community. Methadone maintenance is the most common form of treatment for opiate addiction, and although it is often heavily criticized by social scientists,[39] given that methadone will continue to be prescribed, scholars can at least try to understand how patients experience this treatment, which might result in more positive treatment outcomes.

This dissertation positioned men receiving methadone treatment for opiate addiction as gendered beings, asking how their experiences as fathers, grandfathers, sons, grandsons, brothers, husbands, and boyfriends mattered for their participation in the opiate drug world of addiction and treatment, and how this participation matters for men's relationships and masculinity more broadly. The findings are also relevant for drug treatment policy.

---

[39] There have been a variety of negative reactions to methadone. Some examples include the concern that methadone is a drug used to treat drug addiction (some assume abstinence is best); some argue that methadone maintenance is a way to keep minorities oppressed and it just a form of social control; some have noted that methadone is dangerous and people can overdose on it; some complain that federal legislation about methadone takes away a doctor's right to prescribe a particular medication (see, for example, Agar and Reisinger 2002; Bourgois and Schonberg 2009; Bourgois 2000; Courtwright 2001; Fox 1999; Friedman and Alicea 2001; Hunt and Baker 1999; Kleinman, Lukoff, and Kail 1997; Rosenbaum 1981).

Summary of Findings

The men's attitudes toward fatherhood indicate that the "new father" ideals have reached even this most marginalized group of men and that masculinity may be expanding to include an ethic of care. Two-thirds of the men are fathers, although the Latino men are much more likely to be fathers than are the white men in the study. The men who have young children report that their children act as motivation to remain free of illicit opiates, and fathers with adult children often speak with regret about the fact that their addiction led to a disintegration of the father-child relationship or, if they are still in contact with their children, how they value these relationships and, where grandchildren are concerned, how they enjoy the role of grandfather. The men in the study who were not fathers often expressed judgment towards those individuals who parented through an addiction, although those who expressed this judgment were only white men. Given that such a high proportion of men on methadone are fathers and state that they value their relationships with their children, a focus on parenting should be included in methadone treatment for men.

Men's relationships with their families of origin had mixed effects on their drug usage, likelihood to pursue treatment, and their ability to stay off opiates. I find that it is often the case that men's family members introduce them to drug use. However, many of the white men also discussed how their family judged them for their opiate addiction and choice of drug treatment, and many Latino men chose not to disclose their opiate-dependence for fear of such judgment. Some men report that stressful family relationships led to continued drug use, and others mentioned that they are estranged

from their families. Other men were fortunate enough to have at least some family members who provided financial and emotional support. Some of these men reported living with and caring for family members. Several men also mentioned that healthy family relationships enabled them to be successful in methadone treatment. It was not uncommon for men to report both positive and negative relationships with their families of origin, and these relationships had both positive and negative effects on treatment.

While definitions of masculinity often include independence, this group of men was also very reliant on and influenced by female partners, again suggesting that masculinity is shifting to include important relationships with intimate others, at least for this group of men. Some of the men were introduced to drugs by their partners, and some of the men introduced their partners to drugs. For many addict-couples, it is often difficult to get clean together as drug treatment is focused on individuals rather than pairs. Some men reported positive experiences going through drug treatment with a partner, however. White men in the study were more likely to be in a relationship with drug-using women than Latino men. Many of the men had troubled relationships that triggered drug use or led to divorce. Some of the men were able to partner with non-drug-abusing women who, while often supportive, failed to fully understand their partner's experiences. Half of the men emphasized the importance of a female partner in their life and how maintaining this relationship served as motivation to seek treatment.

These findings confirm that men on methadone should be considered not just as individuals, but as embedded in family contexts, which offer both opportunities and constraints in treatment.

Contributions to Theory

The 33 men participants in this study are some of the most marginalized men in American: drug-dependent, and in most cases drug-addicted, sick, impoverished, and stigmatized. But with few exceptions, they all discuss how important their family relationships are to them, and how they desire to get clean and use methadone maintenance to maintain or rebuild their relationships. It seems as though Doucet's (2006) observation that masculinity is beginning to incorporate caring holds for this population as well.

The cultural shift in masculinity may have begun with the most privileged (Griswold 1993), but it has made its way to the marginalized. In fact, the structural conditions of poverty may permit these men to express that they are dependent upon others for satisfaction of their emotional and material needs. It may be at the very bottom where "new man" and "new father" ideals and practice actually meet. While some ethnic differences in family structure and relationships were noted in the findings reported throughout the dissertation, there did not seem to be ethnic differences in how men reported valuing their family relationships. Thus, it may the case that when examining the intersection of masculinity and family relationships, drug-dependent, impoverished men should be treated as a class. Although race and ethnicity matter in many different contexts, in this case the similarities in men's narratives about their family relationships likely come from their shared social location as impoverished, drug-dependent men. However, my sample may have been too small to find any important ethnic differences.

The family is a potential site of gender transformation as Deutsch (2007) notes. While men are the group with the power (Connell 2000, 2005), Deutsch (2007) argues that: "Men sometimes need and want love and care from women enough to be willing to trade power for it" (122). Whether this means that men are "undoing" gender (Deutsch 2007) or "redoing" gender (Doucet 2006; West and Zimmerman 2009) is beyond the scope of this dissertation, but my findings indicate that the men in my sample are doing gender differently than the hegemonic ideal.

Policy Recommendations

The research questions addressed in this dissertation have significance beyond better understanding marginalized men and their family relationships. These findings can also be used to inform methadone treatment policies—both within methadone clinics and beyond. Lorber (2005) argues that despite the fact that women are increasingly working in the paid labor force and that men are increasingly sharing responsibility for childcare, policies are often based on the assumption that women will be the primary parent. In the case of drug treatment policies, this assumption disadvantages both men and women. Gender inequality is furthered for women because structural support is removed for men's parenting, and disadvantages men because they are denied things they want and need—for example, affordable drug treatment, opportunities to have relationships with their children, and parenting skills.

Rosenbaum (1982) and Friedman and Alicea (2001) argue that women heroin addicts and methadone clients should be examined and treated as mothers. This

dissertation extends their assertions that gender matters in methadone treatment to men, and along with McMahon's work (McMahon and Rounsaville 2002; McMahon et al. 2007), demonstrates that men are not genderless, and that they should be examined and treated as members of family units, including as fathers. While methadone clinics and behavioral service agencies often have programs directed at women with children,[40] there needs to be a shift to recognizing that men may need parenting programs and child care services as well.

Because many men report that their children are a motivation to seek treatment and remain on services for opiate addiction, a focus on parenting should become central to the provision of methadone treatment. Dienhart and Dollahite (1997) claim that clinicians often do not ask men clients about fathering. Clinic workers need to recognize that most men in treatment are fathers, desire to be good fathers, and want to discontinue opiate use so that they can be better fathers. Upon intake to methadone treatment, men should be asked about their fatherhood status and, if they are fathers, about the quality of the relationship with their children. Where applicable, counselors should refer their male clients to Parenting skills classes (which means the clinic should offer Parenting classes),[41] or in the case of individual counseling, making a discussion of fatherhood

---

[40] In fact, during interviews with workers, I was given four different readings on women's special needs during treatment. The information was either produced by the behavioral health organization I studied, or by someone who studied their clients.

[41] Second Chances did have a Parenting class at one point, but because counselors determine what groups they facilitate, when the counselor running the Parenting class left the clinic, the Parenting group stopped. It is my understanding that the replacement counselor will be mandated to begin facilitating a Parenting group again.

central to treatment. Previous studies have shown that men express a desire to gain parenting skills and would attend such classes (McMahon et al. 2007).

It may be the case that more explicit focus on involved fathering and helping men reestablish relationships with their children and develop parenting skills could produce more positive treatment outcomes for men. If methadone maintenance hinders relationships with children or grandchildren, counselors should help the client come up with a plan to successfully detox from methadone maintenance or relax the clinic policies for client access to take home bottles to make travel with or to see family easier. For clients with CPS cases, counselors could act as facilitators between the state and fathers. Counselor or clinic staff could also help with client job searches, so that men could economically support their children. Additionally, providing an area for children to engage in supervised play while their parents dose and attend individual and group therapy would be helpful for men who bring their children to the clinic because they are primary caregivers. Finally, it might also be helpful for the clinic to have a Men's Issues group, which could cover topics like divorce, single parenting, domestic violence, employment, and so forth.

Additionally, clinic workers should recognize that men have other important family relationships that can be leveraged to motivate men to abstain from illegal drug use, and workers can help with family reunification in the cases where men desire such familial contact and contact would not be unhealthy for the men or their family members (Bourgois and Schonberg 2009; Coltrane 1995; Kidorf, King, Neufeld, Stoller, Peirce, and Brooner 2005). Clinic workers should not encourage unhealthy family relationships

(e.g. cases where family members use drugs together), but should build on existing healthy relationships (e.g. where family members offer emotional or material support). Individual counseling sessions with men could be a space to sort out which family relationships are healthy, and which are not. As Graff and Ball (1976) note: "If the family and community are part of the problem, their needs must be included in the therapy" (145). Binion (1982) also advocates for family members, particularly methadone clients' mothers, to participate in treatment, and Nurco and colleagues (1998) assert that addiction's negative effects on family relationships can only be mitigated when the family system (rather than solely individuals) are treated. Gallardo and Curry (2009) note that involving family members in treatment might be especially helpful for Latinos.

When it comes to men and their partners, there are multiple issues to be considered. For men who are partnered to addicted women, workers can remove barriers to addict-couples entering and completing treatment together. Like Simmons (2006) recommends, addict-couples on methadone should be treated as couples and not just as individuals. Perhaps the clinic could have the addict-couple treated by the same counselor or have a special treatment program for addict-couples. The clinic could institutionalize couples counseling for anyone who wanted to make use of it whether they were partnered to an addict or not. Men's relationships with their partners are important to them, and counselors might lose an opportunity to positively impact men's treatment outcomes if they do not focus on these relationships in treatment.

Additionally, while this methadone clinic does have informational flyers about methadone that clients can take and distribute to their family networks, a more formal system of education about methadone treatment may be helpful. Many of the men's families were judgmental or lacked understanding about their addiction and treatment; however, many of the men had family members and partners who were interested in learning more about methadone maintenance. Any way to ensure that men are supported in their path out of drug addiction is helpful, and educating potential sources of support may be necessary. It is also important to stress, however, that men should not be pressured to reveal anything about their addiction and treatment if bearing the burden of stigma would outweigh the benefits of revelation. In sum, clinic workers should talk to men in individual counseling and in group therapy session about their children, families, and partners, and strategically use these relationships to help men abstain from illicit drug use. All interventions should be culturally sensitive, however, acknowledging that Latino and white substance abusers may have different experiences (Gallardo and Curry 2009; Vasquez 2009).

There should also be changes beyond the methadone clinic. In Arizona, there is a local program called Mother/Child Addiction Services (MCAS, commonly called Mothers Caring about Self) for drug-abusing adult women who are pregnant or have a child below age two. The program provides "gender specific treatment for women," arguing that women as a group may have common experiences that can be addressed by this special program. Additional benefits of this program include individual, group, and family therapy; nutrition and hygiene classes; help obtaining housing; parenting training;

and education (Arizona Department of Health Services 2007). While programs such as this are helpful, additional programs that offer the same benefits to fathers are also necessary.

Changes can be made on the federal level, too. I want to suggest how federal grants can be more inclusive in social policies geared towards opiate addicts and thus possibly result in better treatment outcomes. Second Chances and other methadone clinics have access to the Substance Abuse Prevention and Treatment Block Grant (SAPT), which can provide funding for methadone treatment, but this is how the limited funds are prioritized:

> *1. What populations are to be served with SAPT Block Grant funding?*
> The following populations can be served (*in order of priority*):
> - Pregnant females who use drugs by injection;
> - Pregnant females who use substances;
> - Other persons who use drugs by injection;
> - Substance using females with dependent children and their families, including women who are attempting to regain custody of their children; and
> - *As Funding is Available* - all other clients with a substance use disorder, regardless of gender or route of use (Arizona Department of Health Services, 2011).

One simple fix is to allow the SAPT grant to be used for parents with young children, realizing that often it will be mothers who are responsible for children, but also not denying fathers with children priority access to treatment. This would reduce the likelihood that there would be an intergenerational transmission of addiction and other problems. To address concerns that men might try to "game the system" and claim that they are parenting when they are not, counselors could assess the extent of regular child involvement upon intake and subsequent meetings with men clients.

Limitations and Future Research

There are several limitations to this study. First, it is important to note that these findings are not generalizeable to all methadone-treated men because the sample was not randomly selected. However, there is no reason to think that this sample is atypical for this particular clinic or for clinics that treat similar populations; additionally, because my sample is diverse, the findings describe a range of experiences. Second, it is also important to note that these men may have misrepresented the extent of their parental and family involvement or desired parental and family involvement because of social desirability bias or interviewer effects. However, because many of the men were willing to reveal undesirable attitudes and behaviors, I do not expect their narratives about their family to be fabricated. Additionally, because I did not interview the men's children's mothers, the men's children, or other relatives, I have no way to verify their accounts of their family relationships. Third, the research design does not allow me to make inferences about how family relationships actually matter for treatment outcomes; all the data can speak to is how men describe the impact of such relationships. However, even given these limitations, the ways that the men talked about their relationships with their children, families, and partners support the idea that there has been a cultural shift in masculinity that has reached even the most marginalized of men, and that better support for these relationships may help men who are trying to abstain from drug abuse.

As part of a larger research project, I also interviewed 34 women in methadone treatment at the same clinic and ten of the clinic workers, and I spent six months doing field research where I attended clinic team meetings and observed the process of

treatment decisions. While Hunt and Baker (1999) critique social scientists for not including the perspectives of clients in much of the research on addiction treatment, another group that is often ignored are drug addiction workers. My future research will examine clinic worker's perspectives on the treatment they provide and how gender matters in the treatment process and for treatment outcomes.

Because I also have data on motherhood and women's family relationships, I can also focus on differences between men and women clients in this methadone clinic. This may be especially fruitful for the clients included in the study who are partnered to each other. It is rare to have drug-using couples be the unit of analysis in research (Simmons 2006), and this paper has the potential to further our understanding of how this particular dynamic increases or decreases the likelihood of treatment success.

Summary

This dissertation study took men's experiences as men seriously in an attempt to understand the role of men's family relationships in opiate addiction and treatment. Although sometimes these relationships initiated or encouraged use of substances, they also frequently motivated men to stay clean and provided supports to do so. These findings help refine ideas about changing definitions of masculinity and suggest policies that may aid in treatment.

APPENDIX A: HUMAN SUBJECTS APPROVAL

THE UNIVERSITY OF ARIZONA

Human Subjects
Protection Program

1618 E. Helen St.
P.O. Box 245137
Tucson, AZ 85724-5137
Tel: (520) 626-6721
http://orcr.vpr.arizona.edu/irb

HSPP Correspondence Form

Date: 01/05/12
Investigator: Megan Wright, Graduate Student **Department:** Sociology
Advisor: Celestino Fernandez, PhD
Project No./Title: 09-1022-02 Opiate Addiction Treatment and Health Disparities: A Role for Sociology?
Current Period of Approval: 01/26/12-01/25/13
Submit the "FORM: Continuing Review Progress Report" no later than 45 days prior to the end of the approval period listed above.

IRB Committee Information

IRB2 – IRB00001751 **Expedited Review – Continuing Review**
FWA Number: FWA00004218

Documents Reviewed Concurrently

F212: Continuing Review Progress Report (signed 11/03/11)
Consenting Instruments:
Disclosure (version 11/14/11)

Description of Submission

Revised Subject's Consent forms: Administratively adding numbering down the side

Determination

Approved as submitted effective 01/05/12

Comments

- **Continuing Review Category Status:** Enrollment in progress or still planned

Regulatory Determination(s)

- **Criteria for Approval has been met (45 CFR 46.111):** The criteria for approval listed in 45 CFR §46.111 have been met (or if previously met, have not changed)
- **Eligible for Expedite Approval (45 CFR §46.110):** Identification of the subjects or their responses (or the remaining procedures involving identification of subjects or their responses) will **NOT** reasonably place them at risk of criminal or civil liability or be damaging to the their financial standing, employability, insurability, reputation, or be stigmatizing, unless reasonable and appropriate protections will be implemented so that risks related to invasion of privacy and breach of confidentiality are no greater than minimal.
- **Expedite Approval (45 CFR 46.110 Category 5):** Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for nonresearch purposes (such as medical treatment or diagnosis).
- **Expedite Approval (45 CFR 46.110 Category 7):** Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.
- **Waiver of Documentation of Informed Consent (45 CFR 46.117(c)(2)):** **(as previously determined)**

Elaine Jones

01/05/12

Elaine G. Jones, PhD, RN
Chair, IRB 2 Committee
UA Institutional Review Board
EGJ:ae

Date

Reminders: **No changes to a project may be made prior to IRB approval except to eliminate apparent immediate hazard to subjects.**

REFERENCES

Agar, Michael and Heather Schacht Reisinger. 2002. "A Tale of Two Policies: The French Connection, Methadone, and Heroin Epidemics." *Culture, Medicine and Psychiatry* 26:371-396.

Allen, William D. and Michael Connor. 1997. "An African American Perspective on Generative Fathering." Pp. 52-70 in *Generative Fathering: Beyond Deficit Perspectives*, edited by Alan J. Hawkins and David C. Dollahite. Thousand Oaks, CA: SAGE Publications, Inc.

Amato, Paul R. 2010. "Research on Divorce: Continuing Trends and Developments." *Journal of Marriage and Family* 72(3):650-666.

Anderson, Kristin L. 2010. "Conflict, Power, and Violence in Families." *Journal of Marriage and Family* 72(3):726-742.

Andrade, Rosi and Antonio L. Estrada. 2003. "Are Hispana IDUs Tecatas?: Reconsidering Gender and Culture in Hispana Injection Drug Use." *Substance Use & Misuse* 38(8):1133-1158.

Anglin, M. Douglas, Timothy M. Ryan, Mary W. Booth, Yih-Ing Hser. 1988. "Ethnic Differences in Narcotics Addiction. I. Characteristics of Chicano and Anglo Methadone Maintenance Clients." *The International Journal of the Addictions* 23(2):125-149.

Arizona Department of Health Services. 2007. "Mother/Child Addiction Services/Mothers Caring About Self (MCAS)." (http://w3.cpsa-rbha.org/docs/10.23(3-10-10).pdf)

Arizona Department of Health Services. 2011. "Substance Abuse Prevention and Treatment Block Grant (SAPT) Frequently Asked Questions." (http://www.azdhs.gov/bhs/pdf/SAPTFAQs.pdf)

Baca Zinn, Maxine. 2001. "Insider Field Research in Minority Communities." Pp. 159-166 in *Contemporary Field Research: Perspectives and Formulations*, 2nd ed., edited by Robert M. Emerson. Long Grove, Illinois: Waveland Press, Inc.

Bailey, Carol A. 2007. 2nd ed. *A Guide to Qualitative Field Research*. Thousand Oaks, CA: Pine Forge Press.

Baker, Phyllis L. and Amy Carson. 1999. "'I Take Care of My Kids': Mothering Practices of Substance-Abusing Women." *Gender & Society* 13(3):347-363.

Binion, Victoria Jackson. 1982. "Sex Differences in Socialization and Family Dynamics of Female and Male Heroin Users." *Journal of Social Issues* 38(2):43-57.

Bourgois, Philippe. 2000. "Disciplining Addictions: The Bio-Politics of Methadone and Heroin in the United States." *Culture, Medicine, and Psychiatry* 24:165-195.

Bourgois, Philippe and Jeff Schonberg. 2009. *Righteous Dopefiend*. Berkeley, CA: University of California Press.

Broman, Clifford L., Mark D. Reckase, and Carol R. Freedman-Doan. 2008. "The Role of Parenting in Drug Use among Black, Latino, and White Adolescents." *Journal of Ethnicity in Substance Abuse* 5(1):39-50.

Carlson, Marcia J., Natasha V. Pilkauskas, Sara S. McLanahan, and Jeanne Brooks-Gunn. 2011. "Couples as Partners and Parents Over Children's Early Years." *Journal of Marriage and Family* 73(2):317-334.

Carr, Deborah and Kristen W. Springer. 2010. "Advances in Families and Health Research in the 21st Century." *Journal of Marriage and Family* 72(3):743-761.

Clark, June S., William C. Capel, Bernhard M. Goldsmith, and Gordon T. Stewart. 1972. "Marriage and Methadone: Spouse Behavior Patterns in Heroin Addicts Maintained on Methadone." *Journal of Marriage and Family* 34(3):496-502.

Clatterbaugh, Kenneth. 1997. 2nd ed. *Contemporary Perspectives on Masculinity: Men, Women, and Politics in Modern Society.* Boulder, CO: Westview Press.

Coltrane, Scott. 1989. "Household Labor and the Routine Production of Gender." *Social Problems* 36(5):473-490.

------. 1995. "The Future of Fatherhood: Social, Demographic, and Economic Influences on Men's Family Involvement." Pp. 255-274 in *Fatherhood: Contemporary Theory, Research, and Social Policy*, edited by William Marsiglio. Thousand Oaks, CA: Sage Publications, Inc.

------. 1996. *Family Man: Fatherhood, Housework, and Gender Equity*. New York, NY: Oxford University Press.

Connell, R.W. 2000. *The Men and the Boys*. Berkeley, CA: University of California Press.

------. 2005. 2nd ed. *Masculinities*. Berkeley, CA: University of California Press.

Corsi, Karen F., Carol F. Kwiatkowski, and Robert E. Booth. 2007. "Treatment Entry

and Predictors among Opiate-Using Injection Drug Users." *The American Journal of Drug and Alcohol Abuse* 33:121-127.

Courtwright, David, Herman Joseph, and Don Des Jarlais. 1989. *Addicts Who Survived: An Oral History of Narcotic Use in America, 1923-1965*. Knoxville, TN: The University of Tennessee Press.

Courtwright, David. 2001. *Dark Paradise: A History of Opiate Addiction in America*. Cambridge, MA: Harvard University Press.

Craig, Lyn. 2006. "Does Father Care Mean Fathers Share? A Comparison of How Mothers and Fathers in Intact Families Spend Time with Children." *Gender & Society* 20(2):259-281.

Crosnoe, Robert and Shannon E. Cavanagh. 2010. "Families with Children and Adolescents: A Review, Critique, and Future Agenda." *Journal of Marriage and Family* 72(3):594-611.

Day, Ed, Josja Eggen, Julie Ison, Alex Copello, and Qulsom Fazil. 2006. "Ethnicity and Attempts at Self-Detoxification from Opioid Drugs." *Drugs: Education, Prevention, and Policy* 13(1):93-103.

Deutsch, Francine M. 2007. "Undoing Gender." *Gender & Society* 21(1):106-127.

Dienhart, Anna and David C. Dollahite. 1997. "A Generative Narrative Approach to Clinical Work with Fathers." Pp. 183-199 in *Generative Fathering: Beyond Deficit Perspectives*, edited by Alan J. Hawkins and David C. Dollahite. Thousand Oaks, CA: SAGE Publications, Inc.

Doherty, William J. 1997. "The Best of Times and the Worst of Times: Fathering as a Contested Arena of Academic Discourse." Pp. 217-227 in *Generative Fathering: Beyond Deficit Perspectives*, edited by Alan J. Hawkins and David C. Dollahite. Thousand Oaks, CA: SAGE Publications, Inc.

Dole, Vincent P. and Marie E. Nyswander. 1965. "A Medical Treatment for Diacetylmorphine (Heroin) Addiction—A Clinic Trial with Methadone Hydrochloride." *Journal of the American Medical Association* 193(8):80-84.

Dollahite, David C., Alan J. Hawkins, and Sean E. Brotherson. 1997. "Fatherwork: A Conceptual Ethic of Fathering as Generative Work." Pp. 17-35 in *Generative Fathering: Beyond Deficit Perspectives*, edited by Alan J. Hawkins and David C. Dollahite. Thousand Oaks, CA: SAGE Publications, Inc.

Doucet, Andrea. 2006. *Do Men Mother? Fathering, Care, and Domestic Responsibility*.

Toronto: University of Toronto Press.

Duncan, Greg J., Bessie Wilkerson, and Paula England. 2006. "Cleaning Up Their Act: The Effects of Marriage and Cohabitation on Licit and Illicit Drug Use." *Demography* 43(4):691-710.

Duneier, Mitchell. 1999. *Sidewalk*. New York, NY: Farrar, Straus and Giroux.

Fincham, Frank D. and Steven R. H. Beach. 2010. "Marriage in the New Millenium: A Decade in Review." *Journal of Marriage and Family* 72(3):630-649.

Friedman, Jennifer and Marixsa Alicea. 2001. *Surviving Heroin: Interviews with Women in Methadone Clinics.* Gainseville, FL: University Press of Florida.

Fox, Kathryn J. 1999. "Ideological Implications of Addiction Theories and Treatment." *Deviant Behavior: An Interdisciplinary Journal* 20:209-232.

Fraser, James. 1997. "Methadone Clinic Culture: The Everyday Realities of Female Methadone Clients." *Qualitative Health Research* 7(1):121-139.

Fuligni, Andrew J. and Sara Pedersen. 2002. "Family Obligation and the Transition to Young Adulthood." *Developmental Psychology* 38(5):856-868.

Furstenberg, Frank F., Jr. 1995. "Fathering in the Inner City: Paternal Participation and Public Policy." Pp. 119-147 in *Fatherhood: Contemporary Theory, Research, and Social Policy*, edited by William Marsiglio. Thousand Oaks, CA: Sage Publications, Inc.

Gallardo, Miguel E. and Shannon J. Curry. 2009. "Shifting Perspectives: Culturally Responsive Interventions with Latino Substance Abusers." *Journal of Ethnicity in Substance Abuse* 8(3):314-329.

Gavanas, Anna. 2002. "The Fatherhood Responsibility Movement: The Centrality of Marriage, Work and Male Sexuality in Reconstructions of Masculinity and Fatherhood." Pp. 213-242 in *Making Men into Fathers: Men, Masculinities and the Social Politics of Fatherhood*, edited by Barbara Hobson. New York, NY: Cambridge University Press.

Gerson, Kathleen. 1993. *No Man's Land: Men's Changing Commitments to Family and Work.* New York, NY: Basic Books.

------. 1997. "An Institutional Perspective on Generative Fathering: Creating Social

Supports for Parenting Equality." Pp. 36-51 in *Generative Fathering: Beyond Deficit Perspectives*, edited by Alan J. Hawkins and David C. Dollahite. Thousand Oaks, CA: SAGE Publications, Inc.

Gil, Andres and William Vega. 2010. "Alcohol, Tobacco, and Other Drugs." Pp. 99-122 in *Health Issues in Latino Males: A Social and Structural Approach*, edited by Marilyn Aguirre-Molina, Luisa N. Borrell, and William Vega. New Brunswick, NJ: Rutgers University Press.

Glauber, Rebecca and Krisit L. Goziolko. 2001. "Do Traditional Fathers Always Work More? Gender Ideology, Race, and Parenthood." *Journal of Marriage and Family* 73(5):1133-1148.

Gouch, Margaret and Alexandra Killewald. 2011. "Unemployment in Families: The Case of Housework." *Journal of Marriage and Family* 73(5):1085-1100.

Graff, Harold and John C. Ball. 1976. "The Methadone Clinic: Function and Philosophy." *International Journal of Social Psychiatry* 22:140-146.

Griswold, Robert L. 1993. *Fatherhood in America: A History*. New York, NY: BasicBooks.

Hamilton, Alison B. and Christine E. Grella. 2009. "Gender Differences among Older Heroin Users." *Journal of Women & Aging* 21:111-124.

Hardie, Jessica Halliday and Amy Lucas. 2010. "Economic Factors and Relationship Quality Among Young Couples: Comparing Cohabitation and Marriage." *Journal of Marriage and Family* 72(5):1141-1154.

Hearn, Jeff. 2002. "Men, Fathers and the State: National and Global Relations." Pp. 245-272 in *Making Men into Fathers: Men, Masculinities and the Social Politics of Fatherhood*, edited by Barbara Hobson. New York, NY: Cambridge University Press.

Hesse-Biber, Sharlene Nagy. 2007. "The Practice of Feminist In-Depth Interviewing." Pp. 111-148 in *Feminist Research Practice: A Primer*, edited by Sharlene Nagy Hesse-Biber and Patricia Lina Leavy. Thousand Oaks, CA: Sage Publications, Inc.

Hobson, Barbara and David Morgan. 2002. "Introduction." Pp. 1-21 in *Making Men into Fathers: Men, Masculinities and the Social Politics of Fatherhood*, edited by Barbara Hobson. New York, NY: Cambridge University Press.

Holzman Kleinman, Paula, Irving F. Lukoff, and Barbara Lynn Kail. 1977. "The Magic

Fix: A Critical Analysis of Methadone Maintenance Treatment." *Social Problems* 24(2):208-214.

Hunt, Geoffrey and Judith C. Baker. 1999. "Drug Treatment in Contemporary Anthropology and Sociology." *European Addiction Research* 5:126-132.

Kahn, Joan R., Brittany S. McGill, and Suzanne M. Bianchi. 2011. "Help to Family and Friends: Are There Gender Differences at Older Ages?" *Journal of Marriage and Family* 73(1):77-92.

Kerr, David C. R., Deborah M. Capaldi, Lee D. Dowan, Margit Wiesner, and Katherin C. Pears. 2011. "Changes in At-Risk American Men's Crime and Substance Use Trajectories Following Fatherhood." *Journal of Marriage and Family* 73(5):1101-1116.

Kidorf, Michael, Van L. King, Karin Neufeld, Kenneth B. Stoller, Jessica Peirce, and Robert K. Brooner. 2005. "Involving Significant Others in the Care of Opioid-Dependent Patients Receiving Methadone." *Journal of Substance Abuse Treatment* 29:19-27.

Kilmartin, Christopher. 2010. 4th ed. *The Masculine Self*. Cornwall-on-Hudson, NY: Sloan Publishing, LLC.

Knoester, Chris. 2003. "Transitions in Young Adulthood and the Relationships between Parent and Offspring Well-being." *Social Forces* 81(4):1431-1457.

Kvale, Steiner. 1996. *InterViews: An Introduction to Qualitative Research Interviewing*. Thousand Oaks, CA: Sage Publications, Inc.

Lindesmith, Alfred R. 1947. *Opiate Addiction*. Bloomington, IN: Principia Press.

------. 1968. *Addiction and Opiates*. Chicago, IL: Aldine Publishing Company.

Lopoo, Leonard M. and Bruce Western. 2005. "Incarceration and the Formation and Stability of Marital Unions." *Journal of Marriage and Family* 67(3):721-734.

Longwood, W. Merle. 1996. "Changing Views of Fathering and Fatherhood: A Christian Ethical Perspective." Pp. 238-251 in *Redeeming Men: Religion and Masculinites*, edited by Stephen B. Boyd, W. Merle Longwood, and Mark W. Meusse. Louisville, KY: Westminster John Knox Press.

Lorber, Judith. 2005. *Breaking the Bowls: Degendering and Feminist Change*. New York, NY: W.W. Norton and Company, Inc.

Madden, Raymond. 2010. *Being Ethnographic: A Guide to the Theory and Practice of Ethnography*. Thousand Oaks, CA: Sage Publications, Inc.

Majors, Richard and Janet Mancini Billson. 1992. *Cool Pose: The Dilemmas of Black Manhood in America*. New York, NY: Touchstone.

Mandara, Jelani, Sheba Y. Rogers, and Richard E. Zinbarg. 2011. "The Effects of Family Structure on African American Adolescents' Marijuana Use." *Journal of Marriage and Family* 73(3):557-569.

Marshall, Catherine and Gretchen B. Rossman. 2006. 4th ed. *Designing Qualitative Research*. Thousand Oaks, CA: Sage Publications, Inc.

Marsiglio, William, ed. 1995a. *Fatherhood: Contemporary Theory, Research, and Social Policy*. Thousand Oaks, CA: Sage Publications, Inc.

------. 1995b. "Fathers' Diverse Life Course Patterns and Roles." Pp. 78-101 in *Fatherhood: Contemporary Theory, Research, and Social Policy*, edited by William Marsiglio. Thousand Oaks, CA: Sage Publications, Inc.

May, Larry. 1998. *Masculinity and Morality*. Ithica, NY: Cornell University Press.

McMahon, Thomas J. and Bruce J. Rounsaville. 2002. "Substance Abuse and Fathering: Adding Poppa to the Research Agenda." *Addiction* 97:1109-1115.

McMahon, Thomas J., Justin D. Winkel, and Bruce J. Rounsaville. 2007. "Drug Abuse and Responsible Fathering: A Comparative Study of Men Enrolled in Methadone Maintenance Treatment." *Addiction* 103:269-283.

McMahon, Thomas J., Justin D. Winkel, Nancy E. Suchman, and Bruce J. Rounsaville. 2007. "Drug-abusing Fathers: Patterns of Pair Bonding, Reproduction, and Paternal Involvement." *Journal of Substance Abuse Treatment* 33:295-302.

Meier, Petra S., Michael C. Donmall, and Patrick McElduff. 2004. "Characteristics of Drug Users Who Do or Do Not Have Care of Their Children." *Addiction* 99(8):955-961.

Messerschmidt, James W. 1993. *Masculinities and Crime: Critique and Reconceptualization of Theory*. Lanham, MD: Rowman & Littlefield Publisher, Inc.

Mirandé, Alfredo. 1997. *Hombres y Machos: Masculinity and Latino Culture*. Boulder, CO: Westview Press.

Moore, Barbara C., Caroline J. Easton, and Thomas J. McMahon. 2011. "Drug Use and Intimate Partner Violence: A Comparative Study of Opioid-Dependent Fathers." *American Journal of Orthopsychiatry* 81(2):218-227.

Morgan, David. 2002. "Epilogue." Pp. 273-286 in *Making Men into Fathers: Men, Masculinities and the Social Politics of Fatherhood*, edited by Barbara Hobson. New York, NY: Cambridge University Press.

Morris, Edward. 2008. "'Rednecks,' 'Rutters,' and 'Rithmetic: Social Class, Masculinity, and Schooling in a Rural Context." *Gender & Society* 22(6):728-751.

National Institute on Drug Abuse. 2012. "Heroin." Retrieved 11 March 2012. (http://www.drugabuse.gov/drugs-abuse/heroin)

National Institute on Drug Abuse. 2012. "Prescription Medications." Retrieved 11 March 2012. (http://www.drugabuse.gov/drugs-abuse/prescription-medications)

Nurco, David N., Robert J. Blatchley, Thomas E. Hanlon, Kevin E. O'Grady, and Maureen McCarren. 1998. "The Family Experiences of Narcotic Addicts and Their Subsequent Parenting Practices." *The American Journal of Drug and Alcohol Abuse* 24(1):37-59.

Palkovitz, Rob. 1997. "Reconstructing 'Involvement': Expanding Conceptualizations of Men's Caring in Contemporary Families." Pp. 200-216 in *Generative Fathering: Beyond Deficit Perspectives*, edited by Alan J. Hawkins and David C. Dollahite. Thousand Oaks, CA: SAGE Publications, Inc.

Pascoe, C.J. 2007. *Dude, You're a Fag: Masculinity and Sexuality in High School*. Berkeley, CA: University of California Press.

Pasley, Kay and Carmelle Minton. 1997. "Generative Fathering after Divorce and Remarriage: Beyond the 'Disappearing Dad'." Pp. 118-133 in *Generative Fathering: Beyond Deficit Perspectives*, edited by Alan J. Hawkins and David C. Dollahite. Thousand Oaks, CA: SAGE Publications, Inc.

Pyke, Karen D. 1996. "Class-Based Masculinities: The Interdependence of Gender, Class, and Interpersonal Power." *Gender & Society* 10(5):527-549.

Quintero, Gilbert and Antonio L. Estrada. 2000. "'Machismo,' Drugs and Street Survival in a US-Mexico Border Community." *Free Inquiry in Creative Sociology* 28(1):57-64.

Ranson, Gillian. 2001. "Men at Work: Change—or No Change?—in the Era of the

'New Father'." *Men and Masculinities* 4(1):3-26.

Ragin, Charles C. 1994. *Constructing Social Research*. Thousand Oaks, CA: Pine Forge Press.

Risman, Barbara J. 2004. "Gender as a Social Structure: Theory Wrestling with Activism." *Gender & Society* 18(4):429-450.

Rosenbaum, Marsha. 1981. *Women on Heroin*. New Brunswick, NJ: Rutgers University Press.

------. 1991. "Staying Off Methadone Maintenance." *Journal of Pscyhoactive Drugs* 23(3):251-260.

Rubin, Herbert J. and Irene S. Rubin. 2005. 2nd ed. *Qualitative Interviewing: The Art of Hearing Data*. Thousand Oaks, CA: Sage Publications, Inc.

Sassler, Sharon. 2010. "Parenting Across the Life Course: Sex, Relationships, and Mate Selection." *Journal of Marriage and Family* 72(3):557-575.

Schutz, Christian G., Elisabetta Rapiti, David Vlahov, and James C. Anthony. 1994. "Suspected Determinants of Enrollment into Detoxification and Methadone Maintenance Treatment among Injecting Drug Users." *Drug and Alcohol Dependence* 36:129-138.

Segal, Lynne. 1990. *Slow Motion: Changing Masculinities, Changing Men*. New Brunswick, NJ: Rutgers University Press.

Shows, Carla and Naomi Gerstel. 2009. "Fathering, Class, and Gender: A Comparison of Physicians and Emergency Medical Technicians." *Gender & Society* 23(2):161-187.

Simmons, Janie. 2006. "The Interplay between Interpersonal Dynamics, Treatment Barriers, and Larger Social Forces: An Exploratory Study of Drug-Using Couples in Hartford, CT." *Substance Abuse Treatment, Prevention, and Policy* 1(12):1-13.

Stack, Carol. 1974. *All Our Kin*. New York, NY: BasicBooks.

Umberson, Debra, Tetyana Pudrovska and Corinne Reczek. 2010. "Parenthood, Childlessness, and Well-Being: A Life Course Perspective." *Journal of Marriage and Family* 72(3):612-629.

Vasquez, Melba J.T. 2009. "Latino/a Culture and Substance Abuse." *Journal of*

Ethnicity in Substance Abuse 8(3):301-313.

Wall, Glenda and Stephanie Arnold. 2007. "How Involved is Involved Fathering: An Exploration of the Contemporary Culture of Fatherhood." *Gender & Society* 21(4):508-527.

Warren, Carol A.B. 2001. "Gender and Fieldwork Relations." Pp. 203-223 in *Contemporary Field Research: Perspectives and Formulations*, 2nd ed., edited by Robert M. Emerson. Long Grove, Illinois: Waveland Press, Inc.

West, Candace and Don H. Zimmerman. 1987. "Doing Gender." *Gender & Society* 1(2):125-151.

------. 2009. "Accounting for Doing Gender." *Gender & Society* 23(1):112-122.