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"I'm Stuck": Women's Navigations of Social Networks and Prescription Drug Misuse in Central Appalachia

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Abstract

This study utilizes anthropological analyses of kinship, care, gendered inequalities, and the state to examine how social networks affect women's substance use in a rural Appalachian county where the primary drug of choice is prescription opioids. Of 503 participants from a larger study of social networks among rural drug users, 16 women who reported using drugs with four or more other study participants (drug network members) were interviewed from November 2011 to February 2012. The purpose of interviews is to analyze the substance use patterns among participants who are highly connected in their networks. Female participants say they feel "stuck" in cycles of prescription drug misuse because of entrenchment in moral economies, intensive caretaking responsibilities, and violence from those in their networks. Although women demonstrate agency in their navigations of drug use, relationships, and economic and health inequalities, the factors that constrain women's actions culminate to create barriers for women accessing substance abuse treatment or decreasing substance use outside of treatment. This study adds to understandings of the relational and situational aspects of women's drug use and efforts to decrease use. Recognizing these aspects of women's lives will aid policies and programs in becoming more relevant to substance abusing women.

Keywords: substance use; kinship; care; gendered inequalities; Appalachia;

Introduction

"I say it all the time that I'm stuck." (Kim, age 30)

Recent ethnographic work shows that drug users cannot be simply categorized as "isolated addicts," but are instead embedded in families and communities (Garcia 2010). In the face of economic austerity measures limiting access to health care and social services, kin, especially female family members, may represent the only form of care available to individuals (Anglin 2010; Garcia 2010; Raffaetà and Nichter 2015). Thus, female drug users often take responsibility for caregiving in their family and must rely on other kin for support. Although social support is important in women's lives, support may intermingle with coercion, and support and risk networks often overlap (Miller and Neaigus 2001; Mitchell Fuentes 2011; Montgomery et al. 2002).

The emphasis on personal responsibility in the current neoliberal context places the burden of self-care on individuals. Women may misuse prescription drugs as they attempt to care for themselves. In several qualitative studies, women began or continue misusing prescription drugs to self-medicate for pain, stress, weight-loss, or mental health issues (Quintero et al. 2006; Schlosser and Hoffer 2012). Yet care, whether provided by kin or the self, can be constrained. Qualitative research among female substance users suggests lives complicated by multiple avenues of violence associated with gendered oppression, including interpersonal and structural (Baker and Carson 1999; Bourgois and Schonberg 2009; Campbell 2008; Epele 2002; Flavin and Paltrow 2010; Garcia 2010). State agencies, such as child protective services (CPS), along with social discrimination form a "dense coalescence of punitive forces" that intervene in the lives of female drug users (Dewey 2014:1139). These interventions are deeply gendered as they attempt to alter women's reproduction, kinship networks, and caregiving strategies.

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While women do develop survival strategies, their ability to do so is limited by unequal power relations (Collins 2000; Gunewardena and Kingsolver 2007; Mullings 2006). Women who use drugs may undertake activities that decrease immediate threats to survival, but, at the same time, increase long-term risks of harm (Baker and Carson 1999; Bourgois and Schonberg 2009; Epele 2002). Prescription drug misuse may be the most accessible form of self-care in US rural areas, such as in the case of self-medication for chronic pain. This form of self-care is fueled by socioeconomic inequalities and subsequent participation in illicit economies and lack of adequate and affordable health care and social services (Anglin and Collins White 1999; Kingsolver 2011; Kobak 2012; Leukefeld et al. 2007).

Examinations of US treatment programs and the intersections of personal, structural, and historical violence reveal some of the barriers women face, and negotiations women must make while in substance abuse treatment (Carr 2011; Garcia 2010; Hall et al. 2001; Prussing 2007). There has been little research on female prescription drug misusers, especially rural opioid users, and their efforts to decrease or cease substance use, even though women are the largest consumers of prescription opioids and benzodiazepines (Tuchman 2010) and prescription drug abuse is increasingly associated with drug overdoses, HIV, and hepatitis C in US rural areas (Centers for Disease Control and Prevention 2011a; Centers for Disease Control and Prevention 2011b; Conrad et al. 2015; Havens et al. 2011; Paulozzi and Xi 2008; Rossen et al. 2013). The connections among social networks, caretaking responsibilities, gendered inequalities, and women's drug use, especially in rural areas, remains unclear. The purpose of this study is to examine how social networks can influence self-identified drug users' substance use in a rural Central Appalachian county where the primary drug of choice is prescription opioids. This study reveals how enmeshment in moral economies and kinship networks, caretaking responsibilities, gendered oppression, and state interventions are articulated in women's prescription drug misuse. Women's narratives focus on forms of relatedness and speak to anthropological analyses of social and biological aspects of kinship, feminist approaches to family, and the relationship between the state and the domestic.

Methods

Setting and study participants

This study was conducted in a rural Central Appalachian county. Like many other Central Appalachian counties, the county is economically distressed, with over 25 percent of residents falling below the federal poverty level (Appalachian Regional Commission 2015; Chubinski et al. 2014; U.S. Census Bureau 2015). As in other regions globally, neoliberal forces exacerbate inequalities by encouraging nonunionized workforces, decreased wages, and increased pressure on individuals and families, especially women, to take responsibility for safety-net services (Amason 2015; Anglin 2010; Fletcher 2014; Kingsolver 2011; McNeil 2005; Smith 2002). Still, the polarized class economy that persists in rural Central Appalachia is rooted in a particular political economic history where white male elites control local politics and material resources (Dunaway 1995; Duncan 1999; Goan 2008; Pudup et al. 1995). Political corruption has created public institutions that cannot effectively address such issues as economic stagnation (Billings and Blee 2000). Continued political manipulation often confines access to jobs and welfare entitlements according to an individual's personal connections (Duncan 1999). Currently, formal employment that provides a living wage and benefits is limited, especially for women (Amason 2015; Anglin 2010; Fletcher 2014). Stereotypical portrayals of Appalachia from outside the region serve to mark the population as antiquated and sexually deviant and to deflect criticism of exploitive industries, such as timbering and coal extraction (Billings et al. 1999; Ferrence 2012; Hartigan 2004; Massey

2007; Powell 2007; Scott 2010). Although Appalachian isolation is overemphasized in constructions of the region, geographic barriers to health care and other social services are associated with prescription drug misuse (Anglin and Collins White 1999; Leukefeld et al. 2007) and women's intensified experiences of domestic violence (Grama 2000; Shannon et al. 2006; Websdale 1995).

Participants were selected from a larger study. Specifically 503 self-reported substance users who resided in the county and were age 18 or older were recruited via respondent-driven sampling (RDS) and consented to participate in the larger study of social networks and infectious disease transmission risk among rural drug users. RDS allows researchers to reach hidden populations, especially those who may be participating in stigmatized activities (Barendregt et al. 2005). Seeds, or initial participants, were recruited via flyers targeting substance users. Once the seed was interviewed, they were given three coupons and asked to give these to other substance users. The seed was compensated for each redeemed coupon. The purpose of qualitative interviews for this study is to more fully understand substance use among women who are highly connected in their social networks. Of the 503 participants in the overall study, 40 were initially eligible for this qualitative study because they self-reported four or more members in their drug network and self-identified as women. Participants were contacted by telephone or in person to be interviewed. A total of 22 women were successfully contacted; 16 agreed to be interviewed. This study includes findings from semi-structured open-ended interviews with 16 women.

Data collection and analysis

The first author conducted face-to-face semi-structured interviews with the 16 self-identified female substance users from November 2011 to February 2012. Interviews lasted approximately one hour. An interview guide including open-ended questions about the participant's drug network and substance use focused the interview, permitting comparability across interviews. Although the interviews were structured, the interviewer had flexibility in clarifying and exploring topics introduced by participants. Field notes were taken during interviews and 14 participants agreed to being audio recorded. All audio recordings were transcribed. Two women asked not to be audio recorded, so extensive field notes are used. Information on participant characteristics and drug use history are incorporated from the baseline quantitative survey data and provide context for participants' perspectives. Consequently, the data consist of transcribed interviews, field notes, and selected quantitative survey data. Qualitative data were analyzed using ATLAS.ti (Muhr 2010). The coding framework was discussed among and solidified by the authors, the staff in Central Appalachia who aided in participant recruitment, and a small University of Kentucky working group of graduate students and mentors focused on social networks and drug use in Central Appalachia. The first author completed all data coding. All names of participants and places are changed to protect confidentiality. The University of Kentucky Institutional Review Board approved the study and all participants provided written informed consent. Participants were compensated $50 for their participation in the interview.

Results

Participant characteristics

The mean age of participants was 38. Quintero et al. (2006:904) define prescription drug misuse as "the use of medications without a prescription or contrary to a doctor's direction." More specifically, the women in this study characterize their misuse as having a negative impact on their lives. The

majority of women (N = 13) self-report current misuse of instant release oxycodone, which was the most readily available prescription drug at the time. Women also report using benzodiazepines (N = 7), buprenorphine (N = 3), and methadone (N = 3) illicitly. Participants say they use the opioid replacement therapies buprenorphine or methadone to "stay normal" or keep away "dope sickness," but a few (N = 3) inject buprenorphine or snort methadone to get high. Two women indicate they have never dealt prescription drugs. Only one woman self-identifies as a current prescription drug dealer. Yet several women (N = 3) have been incarcerated for dealing prescription drugs in the past and over half of participants (N = 10) identify as "connections." These "connections" distinctly separate themselves from drug dealers and say they receive a small amount of money or drugs from buyers or drug dealers when they connect potential buyers with dealers.

Enmeshment in moral economies

Participants were asked about relationships around drug use, sexual activity, and material and emotional support. Women speak most positively about ties to their parents and children and repeatedly use the phrase that Schneider (1968) critiqued as Euro-American centric, "blood is thicker than water." Every participant says they value their family and the women who decreased or ceased drug use in the past were driven by familial obligations or expectations. Women see drug use as limiting who they care for, especially at times when they use heavily. Yet women never stop caring for their families and differentiate between the crimes committed against kin and non-kin. Some women admit stealing from family members, but say they feel guilty for such actions and use these thefts as examples of how deeply they withdrew into addiction. On the other hand, participants freely speak about stealing drugs and money from fellow users. Although they do not necessarily see this positively, women define these thefts as being part of an addicted life, "You change buddies and stuff, just because you might like rip this buddy off or this buddy ripped you off, but I mean, it's a bad game, you know, and you're constantly being shady" (Cindy, age 28).

Yet kinship in this context is not static and is based on a sense of place and a moral economy as much as blood or biology. Although women's caring and sense of obligation consistently encompasses their children and parents, these relationships wax and wane according to women's drug use, legal status with the criminal justice and CPS systems, and economic situation. Women "create" (Howell 2009) kin as those who financially and emotionally support them become aunts, siblings, or grannies who are not biologically related. This study supports new kinship research that focuses on "practice and process" rather than structure and understands kinship as imbued with uncertainty (Herzfeld 2007; Levine 2008:377). Who women consider kin fluctuates as they leave violent sexual partners, destroy relationships with sober kin, or cut ties with other users, whether biological or created kin, when they decrease use. This fluctuation does not indicate, however, that participants feel free to end relationships or find relinquishing relationships easy, even when women say they are harmful. Women's care for long-term partners and the fathers of their children, for instance, motivates them to remain in intimate relationships with drug users, which makes it difficult for them to decrease use, "We have a daughter together and he has come from a bad life I mean as far as being throwed down and nobody wanting him and having to grow up by his self and I just can't leave him. I mean I feel sorry for him and you know, everybody else in his life has walked out on him and I just can't do it" (Mary, age 34).

Women's sense of relatedness to other people is intertwined with their relatedness to place. Participants' care and love for their community causes them to remain in a space where it is difficult to cease or decrease drug use. Several women are only able to decrease their use when they travel away from their home community, but they cannot stay away because the community is always home:

> If I moved away, this would always be home to me, I know this, I know every little holler around here and I know and I love it here, but I hate it too, I hate it because there's no way to grow as a person to expand and have a better life…you feel so caught…you're just trapped and you shouldn't feel like that in your hometown. (Lela, age 33)

As explicated by Carsten (2004), trading resources blurs the boundaries between the social and biological and serves to create relatedness through both aspects. While Carsten (2004) focuses on eating, participants in this study primarily trade drugs, money to buy drugs, food, and cigarettes. Wanting to show they are a "good hearted person" motivates women to share resources with kin and at times peripherally related friends. These demonstrations of care create a moral economy where drug users show support by helping each other obtain drugs and prevent suffering from withdrawal symptoms. Cindy, for example, maintained her only long-term intimate relationship through reciprocal exchanges of drugs, money, shelter, and food, "Me and him, we would help one another, you know, like he would be in certain predicaments and I would help him, and then I would be in certain predicaments and he would help me and a lot of times, it would go back and forth that way and I think that right there for so long was what kept us from cutting ties from one another."

As described by Bourgois (1998), these moral economies are part of women's survival strategies to build a social network that can help stave off such hazards as withdrawal, overdose, and arrest. Many women in this study only use with biological or created kin to lessen their perceived risks of overdosing, being given a used instead of new needle, and being stolen from or reported to law enforcement. Unfortunately, these kin are the same who are most likely to commit violence against women or coerce them to remain in drug using networks to maintain women as drug sources. Thus, the moral economy becomes a site of "mutual solidarity and betrayal" where care and intimidation are intertwined (Bourgois and Schonberg 2009:5). Some women do not want to leave their drug network because that would entail losing contact with those whom they care for and depend on. Further, if women do not abide by the obligations of the moral economy to provide drugs to others, network members use violence and threats of state intrusion through incarceration and CPS to coerce women to stay in their drug network. By remaining in these networks, women maintain access to drugs and mitigate immediate threats of violence but increase the long-term risks associated with drug abuse. Although women remain in their drug networks for a variety of personal and social reasons, we contend that helping women find supportive networks that do not overlap with risk networks may be important to reduce deleterious drug use.

Caretaking responsibilities and gendered oppression

Early feminist critiques focus on the role of marriage and kinship in oppressing women (Blackwood 2005). Later analyses take a more nuanced approach as they show that such entities as government and medical authorities may attempt to control women's bodies through their reproduction and kinship ties, but these relationships also offers avenues of resistance (Flavin 2009; Martin 1987). In this study, kinship relations intersect with socioeconomic inequalities to place the burden of family care on women, to support violence against women, and to trap women in drug networks. Yet women's relationships with kin, primarily parents and children, may represent the only support and care women receive.

Participants spend substantial time caring for children, siblings, and disabled family members. This intensive work socially isolates women from sober adults and prevents women from having time to talk about their problems to anyone, counselor or layperson. The majority of women desire to decrease their drug use because of familial obligations. Despite this motivation, women are overwhelmed by the stress and social isolation of caretaking work. Women use prescription drugs as a form of stress relief

or self-care from their everyday work. Kim (age 30), who is responsible for her children, additional children in her household, and her husband who heavily abuses prescription drugs, connects her caretaking work to her prescription drug misuse and feelings of being stuck, "In the evening, after I've had all day with the kids and I get the baby laid down, I don't [snort prescription drugs] to like get blowed away to where I can't take care of my kids and stuff, but when you live like I do, it seems like it helps. I mean, if I could just get away, it would probably help, but since I can't, and I'm stuck, it's like the only thing I can do." This study supports previous research which indicates that drug users are not socially isolated (Garcia 2010), but women in this study are isolated from those who would support them ceasing drug use because of their socially demarcated roles as caregivers and enmeshment in drug networks. Lack of social support is a barrier to women accessing substance abuse treatment (Jackson and Shannon 2012), and in this study, decreasing misuse outside of treatment.

Even though study participants are burdened by their caretaking work, women's care figures strongly into narratives of how they actively navigate their lives. As Arthur Kleinman (2009) notes, caregiving is important because through the caregiving practices of empathy, responsibility, and building solidarity with others, our humanity is affirmed. Women's care and desires to remain in their drug networks suggest that we should not dismiss women's ability to develop survival strategies. These strategies include self-medicating with prescription drugs, using with close family members and friends to decrease risks associated with drug use, and sharing material resources with those in their network. Yet material, social, and political factors limit women's options in navigating caregiving responsibilities, self-care, drug use, and economic inequalities (Buch 2014; Campbell 2008; Garcia 2014; Han 2012; Kleinman 2009; Van Vleet 2002).

Women indicate that socioeconomic inequalities, including poverty, unemployment, and lack of affordable health care, limit their care strategies and their ability to decrease substance use: "And you know like there's no way to get help, there's no way for us to change, you feel like you're deadlocked, there's no way to get better because we can't afford rehab, you can't get a good job 'cause there's not very many around here" (Lela). Half of participants said that employment is difficult to find and that there are no "good" jobs or jobs that pay a living wage for women, especially if there are no family connections that could lead to employment. Lela added that it is difficult to find employment if you have a criminal record and said the only "good" jobs are for male coal miners. The idea that only coal mining can provide "good" jobs and only to men is part of the industry's discourse in Central Appalachia (Scott 2010). Unemployment leads to feelings of hopelessness and provides an incentive to remain in illicit drug economies. Several women sell prescription drugs to pay for food, rent, and their children's health care costs.

Women complain that mental health care and substance abuse treatment are inaccessible in the area because of the expense, the waiting time for less costly treatment services, and transportation issues. This inaccessibility constrains women's self-care options and participants feel driven to begin or increase prescription drug misuse to self-medicate for stress, anxiety, depression, and grief. It is difficult to access mental health services, and when women do, time spent waiting for services is as much as a barrier as affordability, especially at the publicly funded local facility that provides counseling services on a sliding scale:

> You'll be sitting in the waiting room two hours before you get to see somebody and then you're in there for like 30 minutes and they're rushing you, try to rush you so that they can see the next person and just get what is on their agenda so if you're a counselor and you have 100 people a day on your agenda, then how are you supposed to help anybody that way? Just too many people and not enough options around here I guess. (Mary)

Despite diversion and misuse of opioid replacement therapies, national and international health organizations recommend medication-assisted treatment provided by trained physicians in combination

with psychosocial support as an effective recovery tool (American Society of Addiction Medicine 2013; Center for Integrated Health Solutions 2014; World Health Organization 2009). Financial barriers and the burden of administrative paperwork prevents women from accessing buprenorphine and methadone through two local clinics. Though most women view these clinics as paths to recovery, a few fear entering the methadone clinic because they know someone who overdosed from the combination of methadone and benzodiazepine. Four women say the methadone clinic would be unhelpful because methadone is or had been their drug of choice. Twelve Step groups are sporadically available in the community and four women utilized such groups when attempting to decrease use. Yet these groups form and dissipate quickly and women cite transportation issues when attempting to access these services. Furthermore, two women ceased attending Twelve Step groups because they say most group members are court-ordered to join, do not have a desire for sobriety, and actively deal drugs at group. The only additional local substance abuse treatment is a detoxification service at the psychiatric unit in the hospital. This service does not provide opioid replacement therapy and aftercare is not offered following detoxification. Lela is amenable to substance abuse treatment, but does not have financial or local access. She says affordable services may be available in non-Appalachian urban areas, but those require extensive travel, obtaining childcare, and being placed on multi-month waiting lists.

Some women continue using because it is the only means they have to cope with physical and emotional pain. Other participants stay in drug networks because they want to keep their drug supply. Although they are not simply victims, women are violently coerced to stay in drug networks as well. Women fear leaving drug networks because they would be labeled a "snitch" and face violent repercussions. This fear is not unfounded. Kim's father was murdered because he stopped dealing illicit drugs. Fay (age 41) had a physical altercation with another female drug user because she refused to give the woman any drugs.

Participants connect domestic violence to their drug use. The geographic isolation of Fay's home in combination with her husband's controlling and violent behavior prevented her from leaving a drug using environment in which she was socially isolated:

> I was mainly stuck back up in a holler with my husband and couldn't never get out, I never did get socialized with anybody, and the drugs was all I had to turn to. He would go and leave me up there with no way out, I'd be there weeks at a time…I mean I was afraid to go out, if I seen one of my friends, if I was with him, I would have to drop my head and go to another aisle to keep that friend from speaking to me or I'd get beat to death.

Although Doris (age 41) was misusing prescription drugs at the time of the interview, she previously used cocaine to numb the pain of domestic violence, "I guess my ex-husband who used to beat on me a lot and that's when I stayed on cocaine, I said I'll stay numb, that was kind of like my, the one I was having the affair with was cocaine because I didn't have to feel." Social isolation exacerbates the connection between domestic violence and substance use as women without social support are more likely to abuse drugs or alcohol to cope with violence (Mitchell Fuentes 2011).

Some participants remain in violent relationships because male partners provide access to financial support and drugs, but others stay because of culturally shaped expectations of women that are often espoused by kin. Family members coerce women to stay in marriages regardless of violence: "My momma, she didn't believe in divorce, no matter what you stick it out…and I did as long as I could…I just told her, I said, mom, I can't do this. If I don't walk away now, I'm not ever going to walk away because they'll be carrying me away" (Fay). Women's constructed roles as caregivers and domestic violence experiences overlap in different ways. Women stay in cycles of violence and drug use because they care for their male partners and they want their children to have fathers in the home. Yet women's same obligations to their children sometimes cause them to leave violent partners. Although she stayed

with her abusive husband for years because he provided economic stability and drugs, Barb (age 49) eventually left, "When I divorced my husband was when my oldest drawed back to hit me, that's when I knew I couldn't stay no more because he was going to do what he seen his daddy do to me, and I couldn't handle that, I couldn't handle that. I mean what I took from [my husband] was one thing, but to have it be passed down to my boys, no, it wasn't going to go on no more." These interactions demonstrate that women must navigate "webs of power" (Van Vleet 2002) in kinship networks both while they are using and attempting to decrease use.

Participants remain in their current situations because they want to show care to others, particularly kin, but economic inequalities constrain care strategies. Socially constructed gender roles in the context of limited financial access to childcare place the burden of child and disabled family member care on participants in rural Appalachia. These women indicate that kin and the community expect them to sacrifice their physical and emotional health to provide family care and sometimes women themselves have these same expectations. As in other Appalachian studies (Dorgan et al. 2013), these women indicate that if they do not meet the unrealistic expectations of an "ideal" and self-sacrificing mother, they fail at being a mother as well as a woman. Women feel extremely guilty when they do not fulfill caretaking responsibilities to kin, which often escalates drug use. This guilt is generated from women, but also from non-using family members, "I could never meet [my mother's] expectations and whenever I couldn't get to where she wanted me to be, I was a bad mom or you know I've done this wrong and I've done that wrong and just somebody constantly putting you down and never giving you a good part for anything then, it just it's bad, you start to believe the bad things about yourself" (Mary).

With little hope of employment that pays a living wage and limited access to social safety-net services, women say the only way to financially care for themselves and their children is to stay in illicit drug economies or remain with violent partners who nonetheless provide some vital resources. In the context of limited economic opportunity and intense engagement in drug networks, women show care to those in their network by providing drugs to prevent withdrawal symptoms. Even women's care in this moral economy is constrained by such forces as addiction and poverty and they steal from the same people who they care for (Bourgois and Schonberg 2009). Poverty intersects with social isolation and lack of access to mental health care and substance abuse treatment to constrain women's self-care options as well.

Despite the intersection of socially constructed caretaking responsibilities and socioeconomic inequalities in limiting women's actions, kinship relations provide one of the primary motivations and family members offer one of the few avenues of support for women to decrease or stop prescription drug misuse. Fay had recently decreased her drug use for her children, "My two boys is really, when they tell me they're proud of me, that's really what keeps me going you know, is my two kids." Although they continue drug use, some women attempt to reduce the amount of harm their use causes family members. Barb stopped injecting drugs because she does not want her children to have a mother who died of an overdose or hepatitis C. Doris stopped lying to or stealing from her family because she is tired of disappointing them, "I don't want to have to feel guilty no more, I'm done." Many kin support women's sobriety, but their care is constrained, they may be isolated from women, and they have often reached the limits of their care. Families may inadvertently increase women's enmeshment in drug using networks because family members may be using or unable to provide a sober living environment. For example, Doris lived with her sober mother who supports Doris' sobriety, but also her brother who she uses with.

When kinship ties are cut, particularly when they lose child custody, women's drug use often increases because they value their role as a caregiver, miss their children, feel they lose the incentive to stop drug use, and feel guilty for not raising their children. Mary's mother took custody of her children:

> It was like she took my responsibility away, instead of using it as a chance to get better, I used it as a chance to be wild and you know, I didn't have to get up in the middle of the night to feed one…I just didn't have that responsibility so I went wild and just the depression of losing them and them not being there you know threw myself into trying to not think about it and it made it worse for me, a lot worse.

Research shows that separating mothers from their children exacerbates women's existing mental health issues and drug use (Flavin 2009; Radcliffe 2011). Although there are several gender-specific substance abuse treatment programs in the region that work with CPS to help women maintain custody of their children, there are no published studies evaluating these programs.

This study shows that caregiving, especially for children, may not just be a motivator for reducing drug use (Prussing 2007), but the strategies women must develop to navigate constrained caregiving may make sobriety more difficult to achieve. The aim of this discussion on care is not to discover a pathological motherhood type, which has been attempted in numerous stereotypical portrayals of Appalachia and subsequently dispelled by Appalachian scholars (Barney 2000; Becker 1998; Billings et al. 1999; Massey 2007). Furthermore, although we attend to women's roles as mothers since these roles are prominent in their narratives, we do not intend a discussion of care to "motherize" women and ignore their positions beyond this single role (Dorgan et al. 2013). Instead, the aim of examining care is to understand the implications of women's placement in the socially constructed role of "mother," the complexities of and constraints placed upon care and network relationships by structural forces such as economic inequality and institutional bureaucracies (Han 2012; Mol et al. 2010), and how this constrained care effects navigation of prescription drug misuse.

Kinship and the state

Previous research demonstrates how the state intervenes in families as part of nation-making (Carsten 2004; Özyürek 2006). The state, as exemplified in the US, attempts to create "ideal" nuclear family units that are male-headed and based on white middle-class norms (Blackwood 2005; Flavin 2009; Levine 2008). Although some suggest the state is becoming more involved in family life in the form of governmentality as the welfare state expands (Howell 2009), from this study and previous US research (Flavin 2009), while the state expands interventions through the criminal justice and CPS systems, welfare services are drastically cut. In its interventions in women's lives on behalf of children, US legal systems construct a view of conflict between women and children (Flavin 2009). This study in Central Appalachia demonstrates one of the many consequences of this assumed conflict as some in the drug network attempt to garner state power to threaten women because of their caregiving responsibilities.

If women attempt to remove themselves from the moral economy in which they are entrenched, male partners, family members, or friends threaten to tell women's prescribing clinician, law enforcement, or CPS about her prescription drug misuse because they do not want to lose their drug source. Fay said, "They threaten to turn you in…you got to give, people hang stuff over your head. They do that, 'well if you don't let me have [the prescription drugs], I'll call your doctor and I'll tell them what you've been doing,' so there you go, you're stuck, you're giving them what they want."

Network members use child custody and threats of calling CPS to coerce women to stay in drug networks and violent intimate relationships: "[My husband's] mom, she gets mad at me, and she'll be like well, 'I'll call social services and you won't have your kids.' And then up there there's some people who live up the road that every time they get mad at you, they call in on you, call social services" (Kim). Neighbors use these threats to maintain access to prescription drugs through Kim. Kim complained that CPS does not offer her any way out of her situation:

> I've had [CPS] out on me and one time they came out on me because of where we live, because we live in [a stigmatized neighborhood]. They told me I don't need to have my kids there and…I was like well, if you can find me somewhere to live outside of here that I can afford, I said that's okay, but for now, there's not a lot I can do about it, you know. The economy sucks, I'm unemployed right now, so, it's not easy.

Kim wants to leave the community to stay with her non-drug using mother in another county, but CPS said she cannot leave until her CPS case is closed. CPS does not acknowledge the hardships women face, such as unemployment and homelessness. Women indicated that CPS does not target their children's fathers for intervention.

The use of CPS to coerce women should be contextualized within the societal stigmatization of women who use drugs as "bad" mothers (Bourgois and Schonberg 2009; Flavin and Paltrow 2010; Goodwin 2011). This characterization of drug using mothers as "bad" is often used to justify increased surveillance of mothers and decreased funding for substance abuse treatment and additional social services (Kandall 2010; Ortiz and Briggs 2003; Springer 2010). Although CPS is important in protecting children from harm, women view CPS as intrusive and coercive, even when they were not directly involved with CPS. Of course, in the context of neoliberal reforms, state agencies such as CPS are limited in what they can provide and often focus on self-improvement instead of the structural issues that constrain women's lives (Cox 2013). Previous research has shown that male partners and other family members use child custody to threaten women to stay in abusive relationships (Conwill 2007). In this study, threats of CPS are used to keep women in abusive relationships and drug networks. Instead of constructing the state as a monolithic site of intervention, these findings show one pathway through which the power of the state is targeted at some women and the blurring of the lines between the public and private. Although there is stigma attached to bringing the legal into the domestic (Levine 2008), these participants indicate that while they fear calling law enforcement to intervene in their lives when they face violence, those in their network do not make such hesitations in calling upon the law. Women fear law enforcement for reasons that have been cited elsewhere, such as not trusting law enforcement or the courts to help them (Flavin 2009; Hautzinger 2007; Van Vleet 2000) and unwillingness to risk losing relationships with those they care for (Van Vleet 2000).

Conclusions

This study adds to understandings of the relational and situational aspects of women's drug abuse and efforts to decrease use. Although their kinship networks fluctuate and they actively develop survival strategies, women are entrenched in moral economies with blood and created kin who simultaneously provide support to women's social and biological needs while constraining women's actions. These kin actively utilize the power of the state and women's socially constructed caretaking roles to threaten them to remain in networks. Caretaking responsibilities and socioeconomic inequalities further ensnare women. Unemployment and poverty drive women to remain in the illicit drug economy, increase women's stress and feelings of being stuck, and create barriers to accessing substance abuse treatment. As in other regions of the US, neoliberal forces exacerbate longstanding economic inequalities in Central Appalachia through such mechanisms as increasing pressure on individuals and families, especially women, to take responsibility for such services as caretaking and maintaining health (Anglin 2010; Kingsovler 2011; McNeil 2005). Women's greater economic responsibility along with fewer opportunities leads marginalized women to participate in illicit drug markets or other illegal activities to survive financially (Campbell 2008). Unfortunately, limited access to drug treatment appears to be a longstanding issue in rural areas, including rural

Central Appalachia (Anglin and Collins White 1999; Jackson and Shannon 2012; Leukefeld et al. 1992, 2007).

There are study limitations. The sample size is small and sample selection was purposive since participants were selected according to how connected they were in a social network analysis. The women who agreed to be interviewed and were more entrenched in their drug networks may have different trajectories than women who reported fewer drug network members. All information is self-reported. Women's narratives should not be dismissed as simply constructed, but participants may actively build particular identities to claim respectable citizenship, femininity, or motherhood to shun stigmatizations as "junkies" (Radcliffe 2011; Roche et al. 2005).

This study suggests that helping women remove themselves from drug networks and strengthening non-drug using relationships is important for women to leave violent relationships, access substance abuse treatment, and ultimately cease drug use. Women may be embedded in drug networks and if asked to break ties with a network, they are simultaneously being asked to remove the social supports these networks provide. In addition, women's care for others and their self-care methods need to be further examined and recognized in policies and agencies that serve drug using women, including substance abuse treatment facilities and CPS. Although women's roles as primary providers of childcare may be overemphasized (Carr 2011; Prussing 2007; Zigon 2011), self-care is rarely considered. This study suggests that women's self-care is constrained. Recognizing the needs of self-care should go beyond teaching non-drug using coping mechanisms. Changing self-care strategies requires time and financial access to services. Ethnographic research indicates that individuals may be inclined to seek health care when they reach the limits of self-care (Yates-Doerr 2012), but health care must be made available. To successfully serve women, policies must be crafted to acknowledge the gendered oppression as well as the economic and health inequalities that shape women's lives. If state agencies, such as CPS, are funded and willing to offer or coordinate access to the housing, employment, and treatment services women require, these agencies may limit their unwitting production of gendered discrimination. Focusing on women's behaviors should not excuse reduced social services or public substance abuse program funding.

It is important to better understand with further research how structural and interpersonal violence prevent women from seeking treatment or decreasing substance abuse. Overall, more research is needed to understand treatment successes and failures, particularly in rural areas, that provide services for such issues as domestic violence, child custody, and homelessness to reveal further needs. This study supports the idea that childcare may be vital for women and this service is not currently available to women in this study. Although there can be barriers that limit the efficacy of substance abuse treatment, this study suggests that if the structural barriers to treatment (e.g., availability, insurance, child care) are removed, women in Central Appalachia would utilize such services.

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