Psychology of Addictive Behaviors
1994, Vol. 8, No. 4, 235-242

0893-164X/94/$3.00

Perceived Social Support for Help-Seeking Behaviors of Black Heterosexual and Homosexually Active Women Alcoholics

Vickie M. Mays, Linda J. Beckman, Eric Oranchak, and Bridget Harper

Seventy African American women in alcoholism treatment centers completed a self-administered questionnaire assessing their perceived emotional and tangible support for entry into treatment for alcoholism and alcohol abuse. Heterosexual women perceived more sources of family, casual, male, and overall support than did lesbian or bisexual women. Quality of perceived emotional support did not differ significantly for heterosexual and lesbian or bisexual women. Findings of differences in sources of perceived support particularly from family of origin as a function of sexual orientation suggest that the same social network may provide different levels and types of support to lesbian and bisexual versus heterosexual Black women alcoholics.

Most ethnic-specific studies of alcoholism and alcohol abuse have focused primarily on male African Americans and Hispanics or presented findings without reference to gender. Yet, results from a variety of studies indicate that although Black women show lower rates of alcohol abuse than Black men, they have more severe alcohol problems than White women. National and regional studies underscore that both the prevalence and consequences of alcohol abuse are greater and more severe among Black than White women (Caetano, 1984; Clark & Midanik, 1981; Herd, 1985, 1989; Rimmer, Pitts, Reich, & Winokur, 1971; Robins, 1989). Data reported from the Epidemiologic Catchment Area community survey found Black women had significantly higher rates of lifetime alcohol abuse than did White women (Robins, 1989). Another difference that points to the seriousness of alcoholism among Black women is the finding that, despite their later age of onset of alcoholism, Black women enter treatment, often not for the first time, at a younger age than do White women (Amaro, Beckman, & Mays, 1987; Gorowitz, Bahn, Warthen, & Cooper, 1970). Black women also appear to have poorer treatment outcomes than White women (Corrigan & Andersen, 1982; Lex, 1987) perhaps because they have lower social class status, income, and educational levels, all of which have been associated with poorer treatment outcomes.

Because almost no research exists on Black women alcoholics and their entry into treatment, those interested in this topic have examined more general research on women alcoholics not specific to ethnic women. These studies find that women face many difficulties surrounding entry into treatment ranging from stigma to unavailability of child care (Beckman & Amaro, 1986; Beckman & Kocel, 1982). Other barriers that are likely to influence women's underuse of treatment services relative to men's include greater opposition to treatment entry from family and friends and perhaps more negative attitudes of physicians toward alcoholic women than alcoholic men. In addition, to the barriers faced by White women, African American women may experience several

Vickie M. Mays and Bridget Harper, Department of Psychology, University of California, Los Angeles; Linda J. Beckman, California School of Professional Psychology; Eric Oranchak, New York University.

This research was funded in part by an Academic Senate grant, United States Public Health Service Biomed grant from the University of California, Los Angeles, and grants from the National Institute of Mental Health and the National Institute of Allergy and Infectious Diseases (R01MH42584 and R01MH44345) to Vickie M. Mays. We acknowledge the assistance of several dedicated University of California, Los Angeles students in data collection and input, the time of the treatment center staff, and the women who gave of their time to complete the questionnaires.

Correspondence concerning this article should be addressed to Vickie M. Mays, Department of Psychology, University of California, 405 Hilgard Avenue, 1283 Franz Hall, Los Angeles, California 90024-1563.

other problems including inappropriateness of services because of cultural norms and attitudes that may negatively influence their attempts to seek help for alcohol problems (Amaro et al., 1987).

The help-seeking behaviors of women alcoholics is one area that has sorely been neglected despite the increasing literature on alcoholic women (Amaro & Beckman, 1984). In particular, the role of social support in seeking or staying in treatment is an area that merits investigation as a critical issue in women's treatment process. Social support networks have been found to affect seeking help (Birkel & Reppucci, 1983; McKinlay, 1974) and to influence a person's decision to seek medical care (Zola, 1964). Social support networks can act as buffers to stress, offer information, and convey attitudes and norms toward help-seeking behaviors. Research suggests that family and friend support networks can effectively be used to facilitate alcohol treatment (Amaro & Beckman, 1984). These support networks along with a spouse threatening to leave a relationship may serve as forces that cause alcoholic women to enter treatment. On the other hand, alcoholic women in treatment have reported less social support than nonalcoholic women. Although no difference existed between alcoholic women and their nonalcoholic counterparts in giving or receiving of tangible support or in the giving of emotional support to others, the alcoholic women were less likely to receive emotional support (Schilit & Gomberg, 1987).

To date, most of these studies have focused on White women alcoholics. Little is known about the support system of Black women alcoholics and its role in facilitating or obstructing entry into alcoholism treatment. This lack of focus has prevailed despite the fact that the support systems of Black women are different from White women alcoholics in some very important ways. White women entering treatment are two times more likely to be married than their Black counterparts (Gary & Gary, 1985). More than 50% of the Black women alcoholics are divorced or never married and a spouse is a source of support for less than one third of these women. Yet the one study comparing Black and White alcoholic subjects (Amaro et al., 1987) suggests Black women experience more social support for treatment entry.

As all of the past research has centered on heterosexual Black women alcoholics little is known of how these factors of social support and entry into treatment function in other alternate support networks such as those of African American bisexual or lesbian women. Although studies of drinking patterns of lesbians are hampered by small sample size, lack of controls, nonrepresentative samples, and inconsistent definitions of homosexuality (Mosbacher, 1988), lesbians generally are reported to have high rates of alcohol abuse (Lewis, Saghir, & Robins, 1982). There apparently are no comparisons, however, of the support networks of heterosexual and lesbian women alcoholics among either ethnic or White samples. More general literature on the social support networks of lesbians suggests that their most frequent sources of support in descending order are friends, partners, family, and coworkers (Kurdek, 1988), and lesbian couples perceive less emotional support from family than do married heterosexual couples (Kurdek, 1988). Although we had not attempted to specifically recruit a lesbian sample, the high percentage of bisexual and lesbian women in our sample (35%) presented an opportunity to investigate the social support networks of this group and to compare their patterns with those of heterosexual women.

In view of the limited knowledge about sources of emotional and tangible support for Black women entering alcoholism treatment, our study examined potential sources of social support and how they were influenced by the relationship status and sexual orientation of the sample women. We investigated who gives emotional support for treatment entry and who provides tangible support, such as information and assistance in getting to a specific treatment center, for African American women.

Method

Seventy African American women in alcoholism treatment centers in Los Angeles county completed a self-administered questionnaire that included both structured and open-ended questions. The questionnaire, which took about 35–45 min to complete, was adapted from interview schedules used in two earlier studies of barriers of entry into alcoholism treatment (Beckman & Amaro, 1986; Beckman & Bardsley, 1986) that focused primarily on White women and men and a comparison study of Black and White women entering treatment (Amaro et al., 1987). Two pretests using Black women in treatment were

conducted on this initial questionnaire to assess interpretation of specific questions and ambiguities in the questionnaire that may have been the result of culture, class, or literacy-level differences. We modified wording of questions when necessary so that questions were relevant, readable, and language-appropriate for an African American sample.

Subject Characteristics

The women in our study ranged in age from 20–68 years with the mean age being 31 ($SD = 7.3$ years), indicating that our respondents were younger than the reported mean age of most other studies of Black women alcoholics (Amaro et al., 1987; Herd, 1989; Robins, 1989). The median education of our sample was some college, though 22% had not completed high school. The median income was in the $9,000–11,000 range, with over 20% earning $20,000 or more and 33% earning less than $5,000. Our sample was about evenly divided in the area of employment. Approximately 29% were currently employed, 36% were unemployed but looking for work, and 27% were never employed or had stopped looking for work. One quarter of our sample had children living at home. Because of the geographic area in which data were collected (southern California) and perhaps because of the specific treatment agencies sampled, the sample was diverse in their sexual orientation—of the 59 women who identified their sexual orientation, 64% were heterosexual and 36% were lesbian or bisexual. Of significance, when asked to indicate how often in the past they used a variety of specific drugs, a large percentage of the women reported they often used cocaine and marijuana, 78% and 45%, respectively. These drugs were frequently used in combination with alcohol. When polydrug abuse was defined as frequent use of drugs other than alcohol, only 8 women in our sample emerged as alcoholic without abuse of any other drug. Thus, a majority of sample members appears to have been polydrug abusers rather than solely alcohol abusers.

The 70 women in the sample had recently entered in-patient treatment at nine local alcoholism agencies, 4 of which were women only. One of the four women-only agencies primarily treated lesbian and bisexual women alcoholics.

In general, women in our study were approximately equally divided between those who entered voluntarily and those who sought treatment as a function of some other pressure (i.e., court mandated or job). In many instances determination of voluntary versus court mandated treatment was difficult as legal charges were frequently dropped if the woman agreed to seek treatment. Thirty-seven percent of the women reported they were in treatment for the first time. The nine facilities varied in how the recovery programs were structured.

Instruments and Procedures

Questionnaires were anonymous and self-administered. The women were informed that their participation was voluntary and unrelated to the treatment they were receiving. Treatment center staff informed all Black women in their facility of the study and left questionnaires available for them, which were collected by our research staff on an appointed day and time after the announcement. Because of the data collection methods used, it is not possible to ascertain the number of potentially eligible women who refused to participate.

The structured and open-ended questionnaires asked about perceived emotional and tangible support, use of other drugs, sexual preferences, and other demographic and background questions. Sexual preference was determined through self-designation as "heterosexual–straight," "bisexual," or "homosexual, lesbian, or gay."

The women completed a *perceived emotional support* instrument adapted from the work of Porritt (1979) and Stewart (1983) and additional questions to determine their perceptions of tangible and emotional support specific to their entry into treatment for alcoholism. The questionnaire listed 16 categories of people: one's spouse, coworkers, friends, parents, siblings, relatives, and ministers–priests. Participants were asked to rate each on a 5-point scale ranging from *extremely supportive* (5) to *extremely unsupportive* (1). A 6th point on the scale allowed women to indicate that there was no such person. Emotional support was defined as feeling helped, cared for, or understood in their attempts to get treatment for their alcohol problems. Additional questions included the following: "Who was the most important person that helped them to get into treatment?" and "Who convinced them they needed inpatient treatment?" Tangible support items consisted of

questions assessing where they go for information and how they got to treatment facilities.

We categorized the 16 different sources of possible perceived emotional support into six overlapping groups. The Appendix shows the categories and the procedures used to analyze the data. The family category included close family members: children, mother, father, and sisters and brothers. The casual category consisted of men and women friends and coworkers. Although one can argue that friends should be in a category of close relationships, we chose not to list them as such because our measure did not provide enough information to determine the closeness of the relationship. For the professionals category, physicians, counselors, social workers, and ministers–priests were included. The next two categories, male and female support, considered all possible sources of female or male support. For instance, for female support, mother, sister, female relatives, and female friends were used, and when the respondent indicated she was a lesbian the partner category was included. The last category was total support, which consisted of all 16 sources of support.

We analyzed the five categories in three ways as a method of not biasing our data if a person either did not have a person available in a particular category or was a lesbian. The first set of analyses was based on a count of the number of sources of support within each of the five subscales. As an example in the family category, a person would have five potential sources of support. The second method was based on the sum. The amount of support signified by the 1–5 ratings was added together for a total sum within each category. If a source is not applicable, then it merely limits the potential sum for that category. Finally, a third way we analyzed the data was by averaging the ratings of support. In this method we divided the total amount (as measured by the 1–5 ratings) within each category by the actual number of sources, omitting women who had no support source for that category. This method eliminated the effects of number of available sources of support.

Results

Emotional Support

Using the social support categories and techniques described in the Method section, we performed a series of one-way analyses of variance (ANOVAs) to determine the effect of relationship status—involvement or noninvolvement with a partner–significant other—or sexual orientation on perceptions of social support for getting help for alcoholism treatment. In the first analyses, we examined respondents involved in a relationship with a significant other versus those who were uninvolved. The results of the one-way ANOVAs indicate no significant differences on any subscale of social support for any of the three analyses. The only difference found was, as expected, those women involved in relationships perceived more support from a partner–significant other.

Because our sample was large enough to examine the effect of sexual orientation on perceived support, we then divided it into two groups: heterosexuals ($n = 38$) and lesbians and bisexuals ($n = 21$). Lesbians ($n = 12$) and bisexuals ($n = 9$) were considered a single group because of the small number of subjects. Table 1 shows the results of the three types of analyses of perceived social support based on sexual orientation. Looking first at patterns for all three sets of analyses, results indicate that the two groups did not consistently differ on all three measures of perceived social support. For four categories of support, the two groups differed consistently on the number of sources and the amount of perceived support. Heterosexual women consistently perceived more family, casual, male, and total support than did lesbian and bisexual women. They perceived a greater number of these sources of support and reported more overall support for these categories, as indicated by the sum. For all categories of support, however, the average, which controls for the number of sources, showed no significant difference between the groups. In general, the sources of support that the lesbian–bisexual group had appeared to be quite supportive.

Tangible Support

Open-ended questions explored tangible support sources. When asked who brought them to the treatment facility, after self, the next two largest responses were friends and parents at approximately 14% for each ($n = 6$). Women were asked where they got information about alcohol treatment programs, including their cur-

Table 1
Means and Standard Deviations for Sources of Support by Sexual Orientation

	No.				Sum				Average			
	Hetero-sexual		Lesbian or bisexual		Hetero-sexual		Lesbian or bisexual		Hetero-sexual		Lesbian or bisexual	
Support	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Spouse	—	—	—	—	—	—	—	—	3.26	1.46	3.14	1.70
Family	3.16	1.35	2.33*	1.53	12.47	6.01	7.62**	5.47	4.01	1.04	3.38	1.32
Casual	2.03	1.26	1.29*	0.96	7.55	5.56	4.62*	3.63	3.71	1.23	3.72	1.07
Professional	1.55	1.20	1.28	1.27	6.26	5.30	5.43	5.44	3.98	1.44	4.46	1.09
Female	2.68	1.16	2.71	1.45	10.45	5.62	9.67	6.12	3.85	1.14	3.53	1.26
Male	3.21	1.58	1.86**	1.62	11.55	6.13	6.05**	6.12	3.71	0.99	3.08	1.33
Total	8.68	3.25	6.33*	3.69	33.16	13.87	22.76**	14.94	3.90	0.90	3.61	1.10

Note. We ranked the sources of support on a scale ranging from *extremely unsupportive* (1), *not very supportive* (2), *fairly supportive* (3), *very supportive* (4) to *extremely supportive* (5). Dashes indicate data not applicable to source of support.
*$p < .05$. **$p < .01$.

rent one. The largest single answer was television (21%), followed by friends (18%) and relatives (15%). When two answers were given, television and friends were the most likely combination.

Other Support

To learn more about the positive and negative impact of sources of support, we asked respondents several additional open-ended questions. Approximately 60% of the sample reported that someone convinced them that they needed inpatient treatment. Only 10 women out of 69 (14%) reported that someone was against their getting treatment. In 7 of these 10 cases, a man was listed as the person resistant to treatment. In response to a question asking how much they thought their present relationships contributed to their drinking, over 44% of the women indicated a great deal, whereas only 19% felt not at all. When asked, "Who was the most important person that helped them get into treatment?" after naming self, the next largest response categories were children at 18% ($n = 12$) and parent at 14% ($n = 9$). Respondents were also asked if someone made them go into treatment and, if so, who was that person. For the 21 persons who answered that "someone made them go into treatment," the largest response category was employer (43%, $n = 9$). A related question asked, "Who, if anyone, convinced the women to enter inpatient treatment?" Over 60% of the women stated that someone convinced them to enter treatment. The most frequent responses were friends (30%, $n = 13$), parent (28%, $n = 12$), and family members (21%, $n = 9$).

We conducted additional analyses to investigate possible effects of age and income on perception of receipt of social support for entry into treatment. Although age was not significant, income was related to total amount of casual support and number of sources of male support. The women were divided into two income groups: less than $15,000 per year, considered poverty level income ($n = 37$) and $15,000 or greater per year ($n = 21$). Women who earned more than $15,000 per year received more casual support, $F(1, 57) = 5.14$, $p < .05$, and had a greater number of sources of male support, $F(1, 57) = 4.42$, $p < .05$, than lower income women.

Discussion

The women in our study present a profile that is younger, more diverse in level of income, educational attainment, and sexual orientation than other Black women alcoholic samples in the literature (Amaro et al., 1987; Herd, 1989; Robins, 1989). This profile, supported by results of an earlier study (Amaro et al., 1987), alerts us to a potentially different at-risk group—younger, multiply addicted, and better educated African American women. This profile of the Black woman in treatment may require a change in

treatment, prevention, and intervention methods in which the primary focus is currently on alcohol problems to an emphasis on polydrug abuse treatment services for urban Black women (Fernandez-Pol, Bluestone, Missouri, Morales, & Mizruchi, 1986).

Early thinking about Black women alcoholics, particularly the multiply addicted, viewed them as victims of poverty, social isolation, and disruptive family styles (Okpaku, 1985; Primm & Wesley, 1985). Results of our study indicate a need to recognize the diversity of Black women alcoholics. Although approximately 50% of our sample earned less than $11,000 per year, over 20% reported a personal income greater than $20,000, and 62% reported at least some college education.

Results of the present study provide some insight into the perceptions of alcoholic Black women concerning specific sources of support for their efforts to seek treatment. Overall these women had more family and female support than other categories of support. They perceived most sources as fairly supportive and saw female sources on the average as the most supportive. There were few differences in social support by relationship status, age, or income. Findings concerning sexual orientation should cautiously be interpreted because of the small number of lesbian and bisexual women ($n = 21$). It is noteworthy, however, that heterosexual women perceived more sources of family, casual, male, and total support than did lesbian or bisexual women, and each of these categories provided more total support for them. The quality of support from each source—that is, the average level of support—did not differ significantly for heterosexual and lesbian or bisexual women. This suggests that although the number of resources may vary as a function of sexual preference, the overall quality of the support does not differ significantly. Research showing that quality of support is more important than quantity (Beckman & Houser, 1982) suggests that lesbian and bisexual women may no more be hindered by lack of social support in their efforts to seek help for their substance abuse problems than are heterosexual women.

Family, female, and male sources are perceived to be most supportive for heterosexual Black women in seeking treatment, whereas female sources appear more supportive for lesbian and bisexual Black women. Our results are supported by Kurdek and Schmitt's (1987) findings that lesbian couples perceived more emotional support from friends than from families and that they perceived less emotional support from family than did married couples. Significantly in the Kurdek and Schmitt study only friend support was associated with low psychological distress.

The findings of differences in support particularly from family of origin as a function of sexual orientation suggest that the same social network may provide different levels and types of social support to different subgroups. Although in many studies on Black Americans, family is pursued as an important variable, it may be necessary for alcoholism researchers to be more diverse in their explorations of social networks and to examine the role of "gay families" as extended family networks for Black lesbian and bisexual women. Treatment centers may find it useful to integrate diverse supportive sources into treatment planning as a way of maintaining abstinence once residential treatment is completed. Specific female relationships such as with female relatives, female lovers and ex-lovers, or a mother may be undervalued by some treatment providers in comparison to heterosexual relationships.

This study has several limitations to its generalizability. First, the sample consisted of inpatient women who recently entered treatment, which may bias it toward women who experienced higher levels of support for treatment entry. This may be particularly important in light of our finding of a not very supportive role of the spouse or significant other. Second, the sample is a regional one. We conducted this study and our previous study (Amaro et al., 1987) in urban areas of California, although in different geographic regions of the state. Third, most women indicated a history of polydrug use, with cocaine and marijuana ranking as the most used drugs. It appears that most Black women in alcoholism treatment have also frequently used or abused other drugs. Patterns of social support may vary for alcoholic women with different patterns of abuse of other drugs. In particular, use of illicit drugs, for instance cocaine, may be associated with different perceived sources of support for treatment entry than use of other drugs.

Several reasons have been given for the underutilization of alcohol treatment services by

ethnic minority clients (Amaro & Beckman, 1984). Often these reasons focus on economic or structural barriers (e.g., location and lack of financial resources) or cultural inappropriateness (e.g., restriction of visitation rights to husband and immediate family when live-in lover and extended family may be the primary sources of support). Little exploration has been given to interpersonal dynamics such as the role of sources of informal support—positive or negative—on the help-seeking behavior and retention in treatment of Black women alcoholics. Social support appears to be an integral factor in seeking help for alcohol problems. Future studies should more closely investigate the types and functioning of the informal, emotional, and tangible sources of support of heterosexual, lesbian and bisexual women and compare men and women from ethnic minority populations. Results of such studies could be very useful to the alcoholism and drug treatment communities in their efforts to provide effective education, prevention services, and treatment programs.

References

Amaro, H., & Beckman, L. J. (1984). Patterns of women's use of alcohol treatment agencies. *Bulletin of Psychologists in Addictive Behavior, 3* (3), 145–154.

Amaro, H., Beckman, L. J., & Mays, V. M. (1987). A comparison of Black and White women entering alcoholism treatment. *Journal of Studies on Alcohol, 48,* 220–228.

Beckman, L. J., & Amaro, H. (1986). Personal and social difficulties faced by women and men entering alcoholism treatment. *Journal of Studies on Alcohol, 47* (2), 135–145.

Beckman, L. J., & Bardsley, P. E. (1986). Individual characteristics, gender differences and dropout from alcoholism treatment. *Alcohol and Alcoholism, 21,* 213–224.

Beckman, L. J., & Kocel, K. M. (1982). The treatment delivery system and alcohol abuse in women: Social policy implications. *Journal of Social Issues, 38* (2), 139–151.

Beckman, L. J., & Houser, B. B. (1982). The consequences of childlessness on the social–psychological well-being of older women. *Journal of Gerontology, 37,* 243–250.

Birkel, R. C., & Reppucci, N. D. (1983). Social networks, information-seeking, and utilization of services. *American Journal of Community Psychology, 11,* 185–205.

Caetano, R. (1984). Ethnicity and drinking in northern California: A comparison among Whites, Blacks, and Hispanics. *Alcohol and Alcoholism, 14* (1), 31–44.

Clark, W., & Midanik, L. (1981). Alcohol use and alcohol problems among U.S. adults: Results of the 1979 national survey. In W. Clark, L. Midanik, & G. Knupfer (Eds.), *Report of the 1979 national survey* (pp.). Berkeley, CA: Alcohol Research Group.

Corrigan, E. M., & Andersen, S. C. (1982). Black alcoholic women in treatment. *Focus on Women: Journal of Addictions and Health, 3* (a), 49–57.

Fernandez-Pol, B., Bluestone, H., Missouri, C., Morales, G., & Mizruchi, M. S. (1986). Drinking patterns in inner-city Black Americans and Puerto Ricans. *Journal of Studies on Alcohol, 47* (2), 156–160.

Gary, L. E., & Gary, R. B. (1985). Treatment needs of Black alcoholic women. *Alcoholism Treatment Quarterly, 2,* 97–114.

Gorowitz, K., Bahn, A., Warthen, F., & Cooper, M. (1970). Some epidemiological data on alcoholism in Maryland based on admission to psychiatric facilities. *Quarterly Journal of Studies on Alcohol, 31,* 423–443.

Herd, D. (1985, September). *A review of drinking patterns and alcohol problems in U.S. Blacks.* Paper presented at the National Institute on Alcohol Abuse and Alcoholism conference on the epidemiology of alcohol use and abuse among U.S. ethnic groups, Bethesda, MD.

Herd, D. (1989). The epidemiology of drinking patterns and alcohol-related problems among U.S. Blacks. In D. L. Spiegler, D. A. Tate, S. S. Aitken, & C. M. Christian (Eds.), *Alcohol use among U.S. ethnic minorities* (DHHS Publication No. ADM 89-1435, pp. 3–51). Washington, DC: U.S. Government Printing Office. (NIAAA Research Monograph No. 18)

Kurdek, L. A. (1988). Perceived social support in gays and lesbians in cohabitating relationships. *Journal of Personality and Social Psychology, 54,* 504–509.

Kurdek, L. A., & Schmitt, J. P. (1987). Perceived emotional support from family and friends in members of homosexual, married and heterosexual cohabitating couples. *Journal of Homosexuality, 14,* 57–68.

Lewis, G. E., Saghir, M. T., & Robins, E. (1982). Drinking patterns in homosexual and heterosexual women. *Journal of Clinical Psychology, 43,* 277–279.

Lex, B. W. (1987). Review of alcohol problems in ethnic minority groups. *Journal of Consulting and Clinical Psychology, 55,* 293–300.

McKinlay, J. B. (1974). Social networks, lay consultation and help-seeking behavior. *Social Forces, 9,* 275–292.

Mosbacher, D. (1988). Lesbian alcohol and substance abuse. *Psychiatric Annuals, 18,* 47–50.

Okpaku, S. O. (1985). State of the art on the multiply addicted: Treatment models for blacks. *Alcoholism Treatment Quarterly, 2* 3/4, 141–151.

Porritt, D. (1979). Social support in crisis: Quantity or quality? *Social Science and Medicine, 13,* 715–721.

Primm, B. J., & Wesley, J. E. (1985). Treating the

multiply addicted Black alcoholic. *Alcoholism Treatment Quarterly, 2* 3/4, 151–174.

Rimmer, J., Pitts, F. N., Reich, T., & Winokur, G. (1971). Sex, socioeconomic status, and race in two hospitalized samples. *Quarterly Journal of Studies on Alcohol, 32,* 942–952.

Robins, L. N. (1989). Alcohol abuse in Blacks and Whites as indicated in the Epidemiologic Catchment Area Program. In D. L. Spiegler, D. A. Tate, S. S. Aitken, & C. M. Christian (Eds.), *Alcohol use among U.S. ethnic minorities* (DHHS Publication No. ADM 89-1435, pp. 63–74). Washington, DC: U.S. Government Printing Office. (NIAAA Research Monograph No. 18)

Schilit, R., & Gomberg, E. L. (1987). Social support structures of women in treatment for alcoholism. *Health and Social Work, 12,* 187–195.

Stewart, A. L. (1983). Measuring and coping with serious illness (Doctoral dissertation, University of California, 1983). *Dissertation Abstracts International, 43,* 2395B.

Zola, I. K. (1964). Illness behavior of the working class. In A. E. Shostak & W. Gomberg (Eds.), *Blue collar worlds: Studies of the American worker* (pp. 350–361). Englewood Cliffs, NJ: Prentice Hall.

Appendix
Categories and Methods of Analyses of Social Support

Data in Table 1 are the means of the individual scores that are calculated as described below.

No. Support

This calculation counts the number of sources of support within each subscale.

Family (5 sources). Children, mother, father, sister, and brother.

Casual (4 sources). Female friends, male friends, boss, and coworkers.

Professional (4 sources). Physician, counselor, social worker, and minister–priest–preacher.

Female (4 + 1 sources). Mother, sister, female relatives, female friends, plus partner–significant other.

Male (4 + 1 sources). Father, brother, male relatives, male friends, plus partner–significant other.

Total (16 sources). Sum of the above unique sources.

Sum Support

This calculation adds the 1–5 ratings together within each category for a sum score for each subcategory.

Spouse (Sum range 1–5).

Family (Sum range 5–25).

Casual (Sum range 4–20).

Average Support

This calculation adds the amount of support (1–5) within each subscale divided by the number of sources of support within that subscale. Women with no sources of support for that subscale were omitted.