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## John Henryism Active Coping as a Cultural Correlate of Substance Abuse Treatment Participation Among African American Women

**Danelle Stevens-Watkins,**

University of Kentucky

**Joi-Sheree' Knighton,**

University of Kentucky

**Kristin Allen,**

Florida State University

**Sycarah Fisher,**

University of Kentucky

**Candice Crowell,**

University of Kentucky

**Carlos Mahaffey,**

University of Kentucky

**Carl Leukefeld, and**

University of Kentucky

**Carrie Oser**

University of Kentucky

### Abstract

The rates of illicit drug use among African American women are increasing, yet African American women are least likely to participate in treatment for substance use disorders when compared to women of other racial groups. The current study examined family history of substance use, perceived family support, and John Henryism Active Coping (JHAC) as correlates to seeking treatment for substance abuse. The underlying theoretical frame of JHAC (James, 1983) suggests that despite limited resources and psychosocial stressors, African Americans believe hard work and self-determination are necessary to cope with adversities. The current study is a secondary data analyses of 206 drug-using African American women (N = 104 urban community women with no criminal justice involvement and N = 102 women living in the community on supervised probation) from urban cities in a southern state. It was expected that African American women

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Please direct correspondence to, Danelle Stevens-Watkins, Ph.D., University of Kentucky 235 Dickey Hall Lexington, KY 40506, Phone: 859-257-7889, d.stevenswatkins@uky.edu.

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with a family history of substance abuse, higher levels of perceived family support, and more active coping skills would be more likely to have participated in substance abuse treatment. Step-wise logistic regression results reveal that women on probation, had children, and had a family history of substance abuse were significantly more likely to report participating in substance abuse treatment. Perceived family support and active coping were significant negative correlates of participating in treatment. Implication of results suggests coping with psychosocial stressors using a self-determined and persistent coping strategy may be problematic for drug-using women with limited resources.

## Keywords

African American; Women; Coping; Treatment; Culture

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## 1.0 Introduction

Recent rates of illicit substance use among African American women are estimated to exceed the national average of 6.2% for women of all races/ethnicities (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013). Despite disproportionate rates of drug use, unmet need for treatment is significantly higher among African Americans compared to other racial/ethnic groups (SAMHSA, 2013) and is an important public health concern as it has disproportionate adverse social and health impacts on African Americans (Saloner & Lê Cook, 2013; Schmidt, Greenfield & Mulia, 2006; Wells, Klap, Koike, & Sherbourne, 2001). The purpose of the current study is to examine correlates of treatment participation for alcohol and drug problems among African American women. The primary focus of the study and contribution to the literature is examining John Henryism Active Coping (JHAC), a culturally-defined construct, as a correlate of receiving treatment for drug and alcohol problems among African American women. Specifically, after controlling for criminal justice probation status, other demographic and psychosocial variables, we sought to examine whether JHAC was associated with substance abuse treatment participation. The current study contributes to the substance abuse literature specific for African American women, a group with increased rates of substance use.

### 1.1 John Henryism Active Coping

Many African American women experience barriers to seeking and actually completing treatment for substance abuse problems. The culturally-relevant construct, John Henryism Active Coping (JHAC; James, Hartnett, & Kalsbeek, 1983), was uniquely defined for African Americans and may add to understanding African American women and their decision to seek treatment for drug and alcohol problems. The underlying theoretical frame of JHAC (James, 1983) suggests that poor African Americans with limited economic resources and chronic psychosocial and environmental stressors believe that hard work and self-determination are required to cope with and overcome adversities.

Previous studies which examined John Henryism Active Coping, have largely focused on the negative effects on African American men's physical health (e.g., James, Hartnett, & Kalsbeek, 1983; James, Strogatz, Browning, & Garrett, 1992; James, Strogatz, Wing,

Ramsey, 1987). The limited research on JHAC among African American women (Dressler et al., 1998; Light et al., 1995; Stevens-Watkins, Sharma, Knighton, Oser, & Leukefeld, 2014) suggests that this culturally specific coping strategy may result in beneficial outcomes. For example, Light and colleagues (1995) found that women with high John Henryism and lower job status had significantly lower blood pressure levels compared to men. In a larger study of African American men and women from the South, Dessler and colleagues (1998) found that among African American women, as JHAC increased, risk for hypertension decreased, whereas for men as JHAC increased risk for hypertension increased. Dressler (1998) concluded that for African American women, high-effort coping when encountering stressful circumstances may be a cultural expectation. Some posit that JHAC may be beneficial for African American women in certain contexts that require significant effort and resilience (Bennett et al., 2004), such as coping with daily stressors and potential consequences of substance abuse.

In one of the few studies specifically examining JHAC and substance use, Fernander and colleagues (2005) studied smoking status and JHAC in African Americans who had previously received treatment for nicotine dependence. The results indicated that low levels of education and low levels of JHAC were associated with greater severity of nicotine dependence. Lower levels of education were also associated with smoking more than 20 cigarettes a day, however, there were no gender differences noted.

The current study offers several unique contributions as it relates to JHAC and health service utilization. Specifically, this study examines JHAC as a correlate of participation in substance abuse treatment. There are no known studies that have examined JHAC relationship to health service use. In addition, this study focuses on women and the health issue of alcohol and drug use.

## 1.2 Factors Associated with Participating in Substance Use Treatment

Education level, income, and age have been identified as socio-demographic factors associated with substance abuse treatment participation. For example, Oser and colleagues (2012) noted having a high school diploma increased the likelihood of voluntarily attending treatment by 69% in a sample of urban and rural probationers. In contrast, the inability to pay and lack of insurance was the primary reason cited for not receiving substance use treatment among a national representative sample of illicit drug users (SAMHSA, 2013). Higher poverty rates among African American women make them especially vulnerable to socioeconomic barriers that impede voluntary treatment utilization (Peltan & Cellucci, 2011) and may account for the historically low use of services among African American women (Wu, Kouzis, & Leaf, 1999). For example, in a recent study using data from the National Treatment Improvement Evaluation Study (NTIES), Guerrero and colleagues (2014) noted that compared to White women, African American women were more likely to be uninsured and rely on government sources for payment of substance abuse treatment. The potential lack of access to adequate funding sources that support substance abuse treatment is a single example of the complex issues surrounding poverty, socioeconomic status, and treatment utilization among African American women.

African American women are disproportionately represented in the criminal justice system when compared to White women often due to drug-related offenses (U.S. Department of Justice, 2014). Individuals on criminal justice probation have been found to use illicit substances twice the rate of those not on probation (SAMHSA, 2008). Due to issues related to access to treatment and court mandates, criminal justice involvement is also associated with increased likelihood of substance abuse treatment participation (Booth, Curran, Han & Edlund, 2013; Cook & Alegria, 2011). Despite these associations, females involved in the criminal justice system have unique needs and circumstances that may impact substance abuse treatment participation when compared to males. For example, using the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), Mahmood and colleagues (2013) compared lifetime rates of substance use treatment utilization between female and male ex-offenders. The prevalence of a substance use disorders was higher among the female ex-offender population (36.9%) compared to community females that did not have criminal justice involvement (7.1%). However, female ex-offenders were 52% less likely to utilize substance-related treatment services compared to male ex-offenders (Mahmood et al., 2013). Reasons cited for lower rates of drug and alcohol abuse treatment among women included inadequate social support, lack of child care, and fears concerning child custody issues (Greenfield, Brooks, Gordon, Green, Kropp, McHugh, et. al, 2007).

There are cultural factors often associated with participating in treatment for substance use disorders. An African American women's tendency to cope with competing and numerous demands simultaneously may compromise her use of substance use treatment. The complex needs of women, such as parenting, child care, family planning, and assistance with navigating the child welfare system, are rarely addressed in treatment models (Taylor, 2010). While child care responsibilities are a barrier to treatment utilization for women of all races (Taylor, 2010), African American women are more likely to be single mothers and live in poverty (Mendenhall, Bowman, & Zhang, 2013), which further reduces the likelihood of acquiring adequate support. Furthermore, mothers who use substances are at risk for multiple, interrelated difficulties, including mental health issues, trauma symptoms, poor parenting skills, children with emotional and behavioral disorders, interpersonal difficulties, low social support, financial strain, unemployment, and poor housing (Schaeffer et al., 2013).

African American women in drug treatment programs have reported that motherhood is a significant motivator for their abstinence from substance use. Using data from the National Treatment Improvement Evaluation Study (NTIES) examining gender differences among racial/ethnic groups, African American females were more likely to access services and had greater reductions in substance use when compared to the African American males (Guerrero, Marsh, Cao, Hee-Choon, & Andrews, 2014). This finding was highlighted in terms of motherhood being a possible contributor. However, when compared to African American men, African American women were less likely to participate in outpatient settings, received fewer counseling sessions, and were more likely to report higher post-treatment drug use (Guerrero, Marsh, Cao, Hee-Choon, & Andrews, 2014). The study findings have been consistent with previous studies consistently citing gender as a moderator in the relationship among services and outcomes (Marsh, Cao, Guerrero et al., 2009; Guerrero, Marsh, Cao, Hee-Choon, & Andrews, 2014). While these studies provide

relevant information, the NTIES data were collected between 1992 and 1997. The current study presents more recent data collected between 2008 and 2011 and examines culturally relevant variables in a sample of African American women. Motherhood and assuming a care-giving role has historically been a valuable asset in African American culture and families. Examining parental status and participation in substance use treatment could provide important culturally-relevant information.

Family history of alcohol and/or drug use is another known risk factor for substance abuse. From a cultural perspective family history may also be influential in treatment seeking. The relationship between parental substance use and use by a child during adulthood is a complex cycle of events. Specifically, children of substance using parents are more likely to endure childhood abuse (Wilson, Bennett, & Bellack, 2013) and neglect (SAMHSA, 2009). Furthermore, these children are more vulnerable to psychological distress (Green, Zebrak, Robertson, Fothergill, & Ensminger, 2012) and may be less equipped with healthy coping mechanisms to manage distress. For these reasons, examining the family history of substance abuse and substance abuse treatment seeking among African American women is important.

The role of the family within African American culture is a highly influential source of support, even extending to individuals who may not be blood-related but known as fictive kin. Evidence suggests that family members can have an important role in confronting and participating in substance use treatment. When family members confront, a substance user, that person is significantly more likely to seek treatment (Liepman, Nirenberg, & Begin, 1989). For example, results of a randomized clinical trial reported almost 75% of the participants convinced a family member to enter substance use treatment after intervention training (Miller, Myers, & Tonigan, 1999). However, studies examining the role of familial support in substance abuse treatment are mixed (Kuo et al., 2013; Liepman, Nirenberg, & Begin, 1989; Miller, Myers, & Tonigan, 1999).

Healthy social support plays an important role in buffering stress (e.g. Hunter, Robison, & Jason, 2012), and can serve as an important protective factor for persons with substance abuse problems. However, substance users are more likely to be alienated from their non-using social networks and report significant relational problems (Lemieux, 2002). Kuo and colleagues (2013) found family members to be both supportive and unsupportive. Family members were a source of encouragement and help for remaining abstinent, but were often a source of condescension, judgment, and reinforcement of low self-esteem. The complexity of familial support may also contribute to the frequent co-occurrence of substance use, child abuse, and familial substance abuse (Kuo et al., 2013).

In summary, rates of illicit drug use among African American women have surpassed women in all races/ethnicities (SAMHSA, 2013), yet African American women are less likely to receive substance abuse treatment and report higher post-treatment drug use (Guerrero, Marsh, Cao, Hee-Choon, & Andrews, 2014). Therefore, the current study adds to the literature by examining John Henryism Active Coping as culturally-relevant correlates to better understand participation in substance abuse treatment among a high-risk and a high-need group of African American women. Based on prior studies that demonstrated a positive

relationship between John Henryism Active Coping and health related outcomes: after controlling for probation status, demographic variables, family history of substance abuse and perceived family support, it is hypothesized that John Henryism Active Coping will be positive and significantly correlated with participation in substance abuse treatment.

## 2.0 Materials and methods

### 2.1. Study Sample

Data for this current study are from a larger stratified study examining epidemiological outcomes among drug-using and non-drug using African American women across the criminal justice system (Stanton-Tindall, Duvall, Stevens-Watkins, & Oser, 2013; Stevens-Watkins, Sharma, Knighton, Oser, & Leukefeld, 2014; Stevens-Watkins, Perry, Harp, & Oser, 2012). Participants were asked if they had used an illicit substance in the past year (0 = “No” and 1 = “Yes”). The women who answered “yes” were classified as drug users and were retained in the study sample. The current study sample includes 206 African American women ( $n = 104$ , residing in an urban community with no criminal justice involvement and  $n = 102$  residing in the community on criminal justice probationary supervision) in a southern state. Table 1 describes the frequency of self-reported alcohol use to intoxication and illicit drug use among the study sample within the past year.

The age range was 18 to 58 years old ( $M = 33.6$ ) and the majority were single without a partner (91%) and almost three-fourths (73%) reported having children. About two-thirds (62%) reported graduation from high school or GED equivalent, with an average of 12.8 years of education. Forty percent reported working full or part-time at the time of the baseline interview, the majority of participants (90%) reported earning less than \$20,000 in the past year. Table 2 describes the demographics and study variables. Due to the overall study stratified sampling procedures and targeted recruitment, participant socio-demographics are not nationally representative of African American women. Specifically, the study participants have less education, lower annual income, and more criminal justice involvement compared to a nationally representative sample of African American women (U.S. Census American Fact Finder, 2013).

### 2.2. Study design and procedures

Study procedures were approved by the University Institutional Review Board (IRB). Participants were recruited in two ways. For the community sample, study recruitment procedures included posting advertisements describing a women’s health study in women-specific local magazines as well various shops and public transportation access points throughout the targeted urban area. Interested women were asked to call the research study office using a toll free number. Research staff conducted a phone screening with potential participants for eligibility (i.e., over 18 years of age, racially self-identified as African American, no current/ongoing criminal justice system involvement).

Recruitment procedures differed for the African American women on criminal justice supervised probation. African American female research staff members visited probation offices, approached African American women on probation, asked for a few minutes to



provide an overview of the study and simultaneously conducted the same screening noted above for eligibility.

Due to the sensitive nature of the material discussed in the interview (e.g., drug use), participants were assured that their responses would be kept confidential and protected by a Certificate of Confidentiality from the Department of Health and Human Services. Interviews were conducted using Computer Assisted Personal Interview (CAPI) software by trained female African American interviewers in a private location (e.g., room at the University, public library, or community based organization). Study participants were compensated \$20 for their time.

## 3.0 Measures

### 3.1 Dependent and Independent Variables

The descriptive characteristics of the study sample and study variables are presented in Table 2. The dependent variable of interest was past treatment participation. Participants were asked “Have you ever participated in a drug or alcohol treatment program”? Responses were coded as 0 = No and 1 = Yes. The primary independent variable in the current study was John Henryism Active Coping (JHAC). Related covariates were family history of substance abuse, perceived social support from family and demographic variables.

**3.1.2. Family History of Substance Misuse**—The study participants were asked a series of questions regarding whether or not their biological relatives (i.e., mother, father, grandmother, grandfather, or siblings) had problems with alcohol and/or drugs. The response options for each relative was either “yes” or “no”. The scale was created by summing the “yes” responses for each participant, indicating the higher the number the more relatives had problems with alcohol and/or drugs.

**3.1.3. Perceived Social Support from Family**—There are three subscales of the Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet et al., 1998) that assess perceived social support from family, friends, and significant others. The current study focused on familial factors and only used the family support subscale. Responses were on a 7-point Likert scale from 1 = “Very strongly disagree” to 7 = “Very strongly agree”. The mean for the subscale is calculated such that higher scores indicate greater perceived social support. The family support subscale consists of 4-items with mean responses that can range from 1.00–7.00. For the subscale measuring perceived family support the study sample ( $M = 5.12$ ,  $SD = 1.77$ ) had an alpha reliability of 0.94. A sample item from the perceived family support subscale is, “I get the emotional help and support I need from my family.”

**3.1.4. John Henryism Active Coping**—The John Henryism Scale for Active Coping (James, 1996), measures an individual’s propensity to actively cope with psychosocial stressors. The 12-item scale was specifically designed for African American populations, and emphasizes mental and physical vigor, commitment to hard work, and single-minded determination to achieve one’s goals (James, 1996). Responses are on a five-point Likert scale from 1 = “Completely True” to 5 = “Completely False”. Responses to all items were

reversed coded and are summed so that higher scores indicate an increase in the propensity to cope actively. The responses ranged can range from 12.00–60.00. Sample items include: "It is not always easy, but I manage to find a way to do the things that I really need to get done" and "When things don't go the way I want them to, that just makes me work even harder." The John Henryism Scale for Active Coping has an alpha reliability of 0.76 for this study sample.

**3.1.5 Covariates**—Probation status, age, years of education, having children, and partner status were included as covariates in the current analyses. Probation status was a dichotomous variables (1=recruited while on probation, 0=recruited in the community). Age and education were measured in number of years. Participants were asked, "How many children, biological, adopted, foster, or step do you have (any age)?" Parental status was a dichotomous variable coded as 0 = No children and 1 = One or more children. Participants were asked, "What is your marital status?" and options selected included "legally married, not married but living as married, remarried, widowed, divorced, separated or single-never married". Partner status was also a dichotomous variable coded as 0 = No current partner and 1 = Partnered. Responses coded as 0 included widowed, divorced, separated or single-never married. Responses coded as 1 included legally married, not married but living as married, and remarried.

**3.1.6. Data analytic plan**—Spearman Rho correlations were conducted between dichotomous variables and Pearson correlations to examine possible multicollinearity among independent variables. Significant variables in the bivariate model were used in multivariate analyses. List-wise deletion was used resulting in one missing case in the multivariate model. Using Stata 13, *stepwise*, *logistic*, and *robust* commands, a step-wise logistic regression with robust standard errors was conducted to distinguish between drug-using African American women who had ever participated in treatment and those who had not. The study sample included all self-identified drug-using women. Since the sample included women that were on criminal justice probation and women who had no prior criminal justice involvement in Step 1 we controlled for probation status, in Step 2 we entered age, years of education, parental status, family history of substance misuse and perceived family support and in Step 3 we entered JHAC to examine the relationship between this culturally specific variable after accounting for other known variable associated with treatment participation.

## 4.0 Results

### 4.1 Bivariate analyses

Results from the initial bivariate correlations (see Table 3) revealed that participation in drug or alcohol treatment was significantly negatively associated with years of education. Probation status, age, and parental status were each significant positive correlates of participation in drug or alcohol treatment. In addition, perceived family support and active coping (as measured by the JHAC scale) were significant negative correlates of participation in drug or alcohol treatment. Family history of substance misuse was positively associated with drug or alcohol treatment participation among African American women. Partner status was not significant at the bivariate level and was not retained in the multivariate model.



## 4.2 Logistic regression

The results of the step-wise logistic regression which examined correlates of participation in drug or alcohol treatment are displayed in Table 4. The final model (Model 3) classified 80% of the cases. Probation status was entered as a control at step one. Age, years of education, and parental status, family history of substance misuse and perceived family support were entered as co-variates in Step 2 and John Henryism Active Coping (JHAC) was entered in step three.

In the final model, the African American women on probation were 2.15 times more likely to have participated in treatment compared to women in the community with no history of criminal justice involvement ( $p < .05$ , CI 95% –1.08, 4.29). With regard to the covariates, for every year increase in age, women were slightly more likely to have participated in treatment ( $OR = 1.06$ ,  $p < .01$ , CI 95% –1.02, 1.09) and for every one year increase in education, the women were 21% less likely to have participated in treatment ( $p < .05$ , CI 95% – 0.67, 0.94). The women in the study that reported having one or more children were 2.45 times more likely to have participated in treatment ( $p < .05$ , CI 95% –1.07, 5.58). Family history of substance misuse was not significant in the final multivariate model. However, perceived family support and John Henryism Active Coping (JHAC) were significant. For every one unit increase in perceived family support, women were 18% less likely to have participated in treatment ( $p < .05$ , CI 95% – 0.67, 0.99). In the final model after controlling for all other variables, for every unit increase in the JHAC scale, women were 9% less likely to have participated in treatment ( $p < .01$ , CI 95% – 0.86, 0.97).

## 5.0 Discussion

This study adds to the substance abuse literature by examining John Henryism Active Coping as a culturally-relevant factor associated with participating in substance use treatment among drug using African American women. Specifically, women on probation, those who had children, and those with a family history of substance abuse were more likely to have participated in substance abuse treatment for their alcohol and/or drug problems. Previous studies focused on JHAC and women indicated beneficial health outcomes (Dressler et al., 1998; Light et al., 1995; & Stevens-Watkins et al., 2014). Therefore, we expected a positive relationship between JHAC and health service use, specifically participation in substance use services. Contrary to our hypothesis, the higher JHAC scores, the less likely women in the study had participated in treatment. The findings of the study are in some ways consistent with other studies that focused on men and demonstrated JHAC may have negative outcomes, in that, African American drug-using women who endorsed high effort coping were less likely to have participated in treatment (e.g., Clark, Adams, & Clark, 2001; Williams & Lawler, 2001). From a cultural perspective, these women endorsed the need to control and cope with psychosocial and environmental stressors through hard work and self-determination, which suggests relying on oneself to cope rather than participate in treatment (Grella & Greenwell, 2007; Keen, Whitehead, Clifford, Rose, & Latimer, 2014; Williams & Lawler, 2001). With limited economic resources, these women may not have treatment as a viable option (MacMaster, 2005; Young, Washington, Jerman, & Tak, 2007).

Women in the current study with higher perceived family support were less likely to participate in treatment. Yet, women who were mothers were more likely to participate in treatment. Perhaps women who are mothers, knowing their family will assist with child care may be more likely to participate in treatment (Kliewer & Zaharakis, 2013). Women who perceive higher family support may experience enabling (Tracy, Munson, Peterson, & Floersch, 2010), whereas family members may have informally protected them from the adverse legal and other consequences of substance abuse. For example, caring for their children knowing the mother is abusing substances as opposed to reporting possible neglect or abuse; providing basic necessities such as food, clothes, and shelter without requiring a financial contribution (Hines-Martin, Brown-Piper, Kim, & Malone, 2003). Therefore, this may be perceived as stable support which could preclude treatment participation. Substance abuse within African American families is a topic that is often not openly discussed until it is perceived as a larger issue as a result from adverse legal or health consequences, such as, incarceration (Moore & Elkeovich, 2008) or HIV diagnosis (Neblett, Davey-Rothwell, Chander, & Latkin, 2011).

'Taboo' topics such as substance abuse within the African American family (Hines & Boyd-Franklin, 2005) have historically perpetuated the cycle of generational substance abuse and other related risk factors like sexual abuse (Wilson, Bennett, & Bellack, 2013) and domestic violence (Boyd, Mackey, Phillips, & Tavakoli, 2006). Our finding that family history of substance misuse was not a significant correlate of individual substance use treatment at the multivariate level was unexpected, yet consistent with the notion of cultural norms regarding substance abuse within African American families (Bell-Tolliver, Kramer, Lynch, & Small, 2012; Doherty, Green, Reisinger, & Ensminger, 2008). Extant literature highlights the interrelationships of familial substance abuse (Weston et al., 2009), and trauma (Johnson, Striley, & Cottler, 2006; Staton-Tindall et al., 2013) associated with individual substance abuse among African American females. Recently modified treatment initiatives also underscore the importance of integrating family support and trauma into substance abuse treatment for women (SAMHSA, 2009).

While the current study adds to the limited literature on the cultural correlates of participating in substance abuse treatment among African American women, it was not without limitations. The cross-sectional data did not allow for causal inferences. Moreover, clinical measures of substance dependence were not included in the study and the self-reported data may have resulted in biased or inaccurate reporting on measures of a sensitive nature (e.g., drug use). Lastly, the study design of over-sampling African American women on criminal justice probation limits generalizability, as participants on probation have less education and lower income compared to the general population. However, although the women in the current study are not nationally representative of all African American women, these women represent a group that are at high-risk for substance abuse problems and the results can provide needed information regarding their culture that may impact treatment participation.

Future studies could incorporate within-group longitudinal data analyses to examine culturally-relevant factors predictive of treatment participation and recovery among African American female drug-users. Also, while parental status could not be examined as a

moderator of perceived family support and treatment participation due to cross-sectional data analyses, future research could examine this relationship using longitudinal data particularly among African American women and demographics who value the role of the family and motherhood.

Despite these limitations, within group studies which examine important culturally-relevant factors, as opposed to comparative racial/ethnic group studies are important for several reasons. The current study adds to the literature in several ways: it is one of very few that specifically examines health services as opposed to health problems and John Henryism Active Coping (JHAC) among African American women; the study adds to the limited literature on African American women with few economic resources; and highlights the importance of understanding the influential aspects of the African American family including the protective as well as, potentially enabling factors within the family system. These results provide useful information for researchers, clinicians, and can inform social and healthcare policies.

The intersecting socio-demographics among substance using African American women create individual, social, and systemic stressors often resulting in barriers to treatment and health disparities (Brown et al., 2015; Donohue, Holland, Lopez, Urgelles, & Allen, 2014; Mendenhall et al., 2013) which are important to understand. The Affordable Care Act increases access to services for disadvantaged populations (Frescoln, 2014; Veysey, 2011) which will also necessitate consideration of culturally-sensitive interventions in order to engage African American women in treatment (Andrulis, Jahnke, Siddiqui, & Cooper, 2013). John Henryism may be important to consider when working with African American women (e.g. Fernander et al., 2005). That is, encouraging drug-using women to participate in substance abuse treatment is indeed consistent with persistence and self-determination to stop using or remain sober. Specifically, incorporating a cultural assessment of factors discussed in the study along with validating the chronic stress associated with having multiple marginalized social locations (Latkin et al., 2013), is critical when conceptualizing treatment with African American women.

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**Table 1**

Self-reported frequency substance use in the past year among African American women, N= 207

	None/No Use	Monthly Use (1+ times per month)	Weekly Use (1+ times per week)	Daily Use 1+ times per day
Alcohol Use to Intoxication	43%	35%	12%	10%
Marijuana	16%	42%	12%	30%
Crack/Freebase	69%	11%	8%	12%
Powder Cocaine	77%	14%	5%	4%
Heroin & Cocaine (e.g., “Speedball”)	96%	1%	1%	2%
Heroin	97%	1%	-	2%
Other <sup>a</sup>	70%	16%	5%	9%

Note: Percent of women by type of substance used and frequency of use.

<sup>a</sup>Other represents self-reported ‘other opiate use, club drugs, sedatives, tranquilizers, amphetamines, and hallucinogens.’

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**Table 2**  
 Descriptive sample characteristics (African American female drug users, N=207)

	<i>M</i>	<i>SD</i>	Range	$\alpha$	%
<u>Ever Participated in Alcohol or Drug Treatment</u>					
Yes					49.80
No					50.20
<u>Demographic Variables</u>					
Age (years)	33.94	11.30	18.00–58.00		
Education (years)	12.20	2.08	5.00–20.00		
<u>Parental Status (1 = Yes; 0 = No)</u>					
Yes					72.90
No					27.10
<u>Partner Status (1 = Yes; 0 = No)</u>					
Yes					8.70
No					91.30
<u>Family Hx of Substance Misuse</u>					
	2.09	1.88	1.00–8.00		
<u>Psychosocial Measures</u>					
Perceived Social Support-Family Subscale	5.12	1.77	1.00–7.00	0.94	
John Henryism Active Coping	50.41	6.15	33.00–60.00	0.76	

**Table 3**

Correlation Matrix Among Study Variables (N = 206)

	1	2	3	4	5	6	7	8
1) Participated in Treatment <sup>a</sup>	-							
2) Probation Status <sup>a</sup>	.25**	-						
3) Age	.29**	.04	-					
4) Years of Education	-.22**	-.20**	.17*	-				
5) Family Hx of Substance Misuse	.21**	.13	-.10	-.06	-			
6) Parental Status <sup>a</sup>	.29**	.19**	.42**	-.03	.10	-		
7) Partner Status <sup>a</sup>	-.00	.04	.08	.01	.05	.11	-	
8) Perceived Social Support-Family	-.25**	-.12	-.05	-.07	-.21**	-.12	-.05	-
9) John Henryism Active Coping	-.25**	.01	-.02	.10	-.21**	-.05	-.07	.25**

Note.

<sup>a</sup> = Spearman Rho coefficients reported;

\* =  $p < .05$ ;

\*\* =  $p = .01$  (two-tailed test)

**Table 4**  
 Step-Wise Logistic Regression Examining Correlates of Participation in Alcohol or Drug Treatment among Drug-using African American women  
 (N=205)

	Model 1		Model 2		Model 3	
	OR (SE)	95% CI	OR (SE)	95% CI	OR (SE)	95% CI
Probation Status	2.60 (0.30)**	[1.47, 4.59]	1.87 (0.34)	[0.97, 3.62]	2.15 (0.35)*	[1.08, 4.29]
Age			1.06 (0.02)***	[1.02, 1.08]	1.06 (0.02)**	[1.02, 1.09]
Years of Education			0.78 (0.86)**	[0.66, 0.93]	0.79 (0.09)**	[0.67, 0.94]
Parental Status			2.43 (0.41)*	[1.09, 5.43]	2.45 (0.42)*	[1.07, 5.58]
Family Hx of Substance Misuse			1.25 (0.09)**	[1.05, 1.49]	1.17 (0.09)	[0.98, 1.41]
Perceived Support-Family			0.77 (0.10)**	[0.64, 0.94]	0.82 (0.09)*	[0.67, 0.99]
John Henryism Active Coping					0.91(0.03)**	[0.86, 0.97]
Model $\chi^2$		11.11***		41.82***		67.78***
Nagelkerke $R^2$		0.07		0.25		0.38

\*  $p < .05$ .  
 \*\*  $p < .01$ .  
 \*\*\*  $p < .001$