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Coping Skills, Social Support, and Quality of Life Among Puerto Rican Women Undergoing Drug and/or Alcohol Treatment

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Undergoing Drug and/or Alcohol Treatment

By

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of the Requirements for the Degree
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MASTER'S THESIS

Cheryl A. Vázquez-Colón

July 2016.

Coping Skills, Social Support, and Quality of Life Among Puerto Rican Women

Undergoing Drug and/or Alcohol Treatment

A Thesis
Presented to
The Faculty of
Western Washington University

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Abstract

The aim of this study is to examine how Puerto Rican women undergoing illicit drug and/or alcohol treatment cope with stress and how specific coping strategies may relate to greater well-being. Thirty-five participants were recruited from six different treatment centers in Puerto Rico. Participants described two stressful events, one with internal control and other with low internal control. Problem and emotion-focused coping strategies were measured with the Spanish version of the Brief COPE inventory. Quality of life was measured with the Spanish version of the WHOQOL-BREF, both measures have good internal reliability and have been used among Hispanic samples. Moreover, social support was measured using the Spanish version of the MOS Social Support Scale to test its effect over coping strategies and quality of life. We expect that when there is low control, emotion-focused will be positively related with quality of life insofar that emotion-focused coping will be positively associated with emotional social support which will then predict quality of life. Additionally, when there is high control, problem-focused coping will be positively related with quality of life insofar that problem-focused coping will be positively associated with instrumental social support which will then predict quality of life. This was one of the first studies that examined coping strategies and quality of life among Puerto Rican women undergoing illicit drug and/or alcohol recovery. Understanding how women cope and its relation with quality of life might provide a better insight to treatment development and long-term recovery.

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Drug and/or Alcohol Treatment

Alcohol and substance related disorders represent a major problem in Puerto Rico. Puerto Rico has the highest number of cases of drug injection-related AIDS (CDC, 2009), as well as a high prevalence of substance abuse when compared to the continental United States. As a United States territory, Puerto Rico receives 1.3 million dollars (14.2% of State Budget) of federal funding for substance abuse and addiction; this is an amount comparable to what states on the mainland receive (The National Center on Addiction and Substance Abuse at Columbia University, 2009). However, in 2009, Puerto Rico only spent .03% of the state budget allocated for substance abuse and addiction in treatment and prevention for substance disorders, the lowest investor when compared to all 50 United States (The National Center on Addiction and Substance Abuse at Columbia University, 2009). Colón et al. (2002) reported 7.5% (~186,000 individuals) of the Puerto Rico population needed services for substance abuse, and among these, just 3.7% (~6,800 individuals) individuals received treatment. Although drug prevention and treatment need is increasing, most treatment centers in Puerto Rico do not have the necessary funding to fulfill the high demand for services. Santiago-Negrón, ex-director of *Administración de Servicios de Salud Mental y Contra la Adicción,* argues that this lack of action from the government is highly influenced by the criminalization of drugs because it funnels economic resources to law enforcement, negatively impacting the amount resources that drug treatment centers receive (personal communication, November 18, 2013).

The lack of resources for drug treatment may mean that women's health and recovery needs are not being fully addressed. Warner, Alegría, and Canino, (2004) examined predictors

of drug remission (e.g. lessening severity of symptoms) using three years of data (1997-2000) from 275 Puerto Rican women. They examined different components of well-being to include individual (e.g., physical and mental health) and interpersonal (e.g., social support). Additionally, they examined how drug treatment and the use of social services influenced drug remission. They found that women with higher well-being—lower depressive symptoms, higher physical functioning, and higher social support were more likely to remain abstinent than women with lower well-being. Institutional care (i.e., drug treatment, social services) was associated with less improvement in symptoms and had no significant relationship with drug use cessation. The authors pointed out that these results might be because drug treatment services tend to focus on cessation of drug use but do not treat factors that may influence continued drug use. According to the findings some risk factors included having a drug using partner, family member, or friend, trading sex for money or drugs, lacking social support, sexual abuse during childhood, and mental and physical health conditions. These findings point out the importance of treating alcohol and drug addiction as a multidimensional phenomenon in which treatment should focus on promoting well-being in all domains; physical, mental, and social in order to promote recovery.

Health care disparities are another aspect that can influence drug recovery. Robles et al. (2006) examined disparities in health care and drug treatment utilization by gender, among Hispanic Puerto Rican drug users residing in Puerto Rico and in New York City. The results showed that women in both sites experienced greater disparities in health care and drug treatment when compared to men. Puerto Rican women were more likely to report lower well-being, higher chronic illnesses, higher depressive symptoms, and lower social support than men and than women residing in New York. Drug-using women residing in Puerto Rico were

less likely to use drug treatment services, more likely to be homeless and to lack resources such as health insurance when compared to both groups of men and women residing in New York. This study showed the lack of services that address well-being and the lack of social support that Puerto Rican women have might decrease the likelihood of treatment use and long-term recovery.

These finding show that drug and alcohol treatment services in Puerto Rico often lack of specialized services that target women specific needs such as counseling, strengthening family and friends relationships, medical care, and financial advice. Additionally, women may lack skills to deal with these stressors that come as part of their drug recovery process. Understanding how women manage stressful situations and how these may influence their well-being may serve as an effective predictor of treatment retention and long-term recovery.

Addiction and Recovery

Addiction is a chronic, relapsing brain disease that affects reward, motivation and memory neural circuitry. It is characterized by compulsive drug seeking and use, inability to abstain from drug use, impairment in behavioral control, and diminished recognition of problems with one's behaviors and interpersonal relationships (ASAM, 2011). Drug addiction is related to physical (e.g., HIV, Hepatitis) and psychological (e.g., depression, anxiety) health conditions. How addiction is conceptualized and treated can be particularly important in order to effectively address individuals' needs.

Recovery from alcohol and illicit drug use has been defined as an ongoing process through which individuals actively manage to abstain from drug use, improve their physical and psychological health, and enhance family and social relationships (White, 2007; Betty Ford Institute, 2007; Laudet, 2007). However, recovery does not only encompass abstinence

but it also means achieving good health, which is not only the absence of a particular disease but also maintaining healthy and positive social interactions, as well as psychological well-being (WHO, 1946). The American Psychiatric Association's position is consistent with this conceptualization of health and emphasized that recovery among severe mentally ill individuals lies within the person's capacity to construct a meaningful and healthy life. Thus, treatment should focus on the individuals' own physical and psychological needs, considering his or her cultural and personal ideals. Moreover, treatment should promote individuals' well-being by targeting not only the mental condition but promoting psychological, environmental, and social well-being. Thus, understanding the role of health in the recovery process is important in order to provide services that not only target the physical symptoms of drug and alcohol withdrawal but also the social and psychological dimensions.

Recovery from severe mental illness such as alcohol and/or drug disorders may be influenced by how individuals cope with stressful events related with their ongoing recovery process. The appraisal of the event (i.e., controlled versus uncontrolled) and the coping strategies used may influence individuals' quality of life. Two main coping skills have been identified in the literature: problem-focused and emotion-focused coping skills. Problem-focused coping skills (e.g., seek information, planning) have been related to greater quality of life and lower levels of stress, whereas emotion-focused coping skills (e.g., avoidance) have been related to poorer quality of life and higher levels of stress. Understanding how individuals appraised stressful events and how they cope with the recovery process could inform treatment centers on what strategies they should promote in order to improve quality of life and foster recovery.

Stress Appraisals and Coping Strategies

Stress is experienced when individuals feel that they cannot meet the demands being made or when a situation is appraised as disruptive or threatening. According to Lazarus (1965) stress occurs when an individual perceives a threat — something that endangers his or her physical and psychological stability. The Transactional Stress and Coping Theory (Lazarus & Folkman, 1977) posits that stressful experiences are composed by the individual-environment transactions, in which the impact of an external stressor, is mediated by the person's appraisal of the stressor, as well as the psychological, social, and cultural resources available. Cognitive appraisals consist in how the event is categorized and described, with respect to its significance for well-being. Cognitive appraisals can be divided into two categories: primary appraisal and secondary appraisal. Primary appraisals consist in categorizing the event as threatening or beneficial for well-being. Primary appraisals can be divided into three categories: irrelevant, benign-positive, and stressful. In the first two categories, the situation does not possess any threat to the individual, thus no action needs to be taken. However, if the event is construed as stressful it could include a threat or a challenging situation. A threat involves the anticipation of harm or loss, it centers on the negative implications of that event for the future (e.g., illness). On the other hand, challenging situations are centered on the potential gain or growth that could be taken out of the situation. In secondary appraisals the individual examines or evaluates if he or she can do something to change the stressful situation. In this stage, individuals may decide which coping strategies they will engage to manage the situation.

When managing stressors, situational and individual factors may play an important role on how the event is appraised. When the event is perceived as controllable and the

individual feel confident about his or her abilities to deal with the situation, the event may be perceived as challenging. Thus, the individual identifies specific actions to solve the problem (e.g., seek treatment), focusing on the potential gain out of the situation. On the other hand, when the individual lacks control over a situation this may create a state of vulnerability and lack of mastery and confidence to deal with the situation. The lack of control over ones' situation may cause psychological distress (e.g., anxiety, depression) and may reduce healthy behaviors (e.g., information seeking, follow-up visits). Thus, the situational factors and the appraisal of the event influence the way individuals cope with specific stressors (Lazarus & Folkman, 1977).

In the Transactional Stress and Coping Theory, Lazarus and Folkman (1977) define coping as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person." Coping involves actively searching for ways to deal with a stressful event by developing strategies to solving the problem and lessen the consequences of the event. Two major coping strategies have been broadly studied: problem-focused coping and emotion-focus coping. Problem-focused coping centers on developing specific strategies to solve the problem, weighting the alternatives by their possible gains and costs, and choosing the best option to resolve the problem. Problem solving strategies focus on the environment (e.g., barriers) and on the individual (e.g., motivation, involvement). Similarly, Carver, Scheir, and Kumari (1989) developed a multidimensional coping inventory — COPE that assesses different ways of coping with stressful events. The COPE inventory, as well as the brief version of the COPE (Carver, 1997) is commonly used to assess different strategies that individuals may use to deal with stressful situations. The inventory could be divided among

problem-focused coping strategies and emotional-focused coping strategies. Problem-focused coping strategies include: active coping (taking active steps to remove or ameliorate the stressor), planning (coming up with strategies), suppression of competing activities (putting projects aside), restraint coping (waiting for an appropriate opportunity), and seeking social support for instrumental reasons (seeking advice). This type of coping typically occurs when the event is perceived as controllable, thus the individual is able to identify specific strategies and act upon them to solve the situation. Perceived control over the event (e.g., illness) may improve physical and psychological well-being because the individual will tend to adopt healthy behaviors reducing the physical symptoms and psychological distress.

Emotion-focused coping involves distancing from the problem, lessening emotional distress, and avoidance. Instead of dealing directly with the problem, emotion-focused coping deals with the meaning of the situation directly.. Typically, this coping strategy is used when there is a lack of control over the situation. In this case the individual deals with how she or he understands the problem and not in changing directly the situation. Emotion-focused strategies include: seeking support for emotional reasons (understanding), focusing on and venting of emotions (focus on the stressor), behavioral disengagement (reducing one's effort to deal with the stressor), positive reinterpretation or growth (managing distress emotions), denial (refuse to believe that the stressor exists), acceptance (accommodate to the situation), and turning to religion (spirituality) (Carver, Scheit, & Kumari, 1989). Emotion-focused coping could be adaptive when the situation is uncontrollable (e.g., terminal disease), however, adopting solely this coping strategy may cause the individual to avoid the situation and to not engage in healthy behaviors that could improve their quality of life.

Forysthe and Compass (1987) examined the interaction between cognitive appraisals and coping with stressful life events and their relationship with psychological distress. They found that when the event was perceived as controllable more problem-focused coping strategies were used and this was correlated with lower psychological distress. On the contrary, if problem-focused coping strategies were used when the event was perceived as uncontrollable this caused higher psychological distress. Emotion-focused coping strategies were more predominately used when the event was perceived as uncontrollable and this was correlated with lower psychological distress. Thus, how the event is appraised influences how individuals cope and the strategies used will influence psychological distress.

Taken together, these studies illustrated the importance of examining how stressful events are appraised in order to promote the appropriate coping skills. According to the Transactional Stress and Coping Model, problem-focused coping skills have been related to greater psychological well-being, mostly when the event is perceived as controllable. When a person believes that he or she has the ability to change or influence their current situation coping skills such as planning, and seeking information may be more beneficial. Whereas when an event is perceived as uncontrollable, changing the meaning of the event and seeking social support may contribute to well-being. However, it is important to note that although these coping strategies may be seen as opposites they can work together, especially during the course of recovery in which the individual is learning how to deal with their stressors.

Coping Strategies and Quality of Life

Quality of life is defined by the World Health Organization (WHO) as "individuals' perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns." Quality of life

involves different domains such as physical health (e.g., work capabilities, pain), psychological health (e.g., self-esteem, spirituality) social relationships (e.g., social support), and environment (e.g., financial resources, home environment). The WHO developed a Quality of life assessment - the WHOQOL-BREF, which is a shorter version of the WHOQOL-100 – and has been validated cross-culturally for its assessment of well-being (WHOQOL Group, 1998). The WHOQOL-BREF contains 26 items that assess the four dimensions of quality of life (i.e., physical health, psychological health, social relationships, and environment). Examining quality of life is of particularly importance when examining substance use disorders. According to the American Psychiatric Association (1994) substance abuse typically affects nearly all areas of functioning— vocational, social/family, physical and mental health, residential status, and access to services. Examining each of these domains may be beneficial for treatment development and outcome measures.

da Silva, Fleck, Pechansky, Boni, and Sukop (2005) examined the WWHOQOL-BREF and its convergent validity with the Medical Outcome study Short-forms and the Symptom Check List among male alcohol dependent patients who were in treatment at two treatment centers in Brazil. The results showed that quality of life was related with alcohol dependency severity. Participants with higher severity of alcohol use showed lower quality of life, especially in the psychological and social aspects. These results show the importance of targeting the severity of alcohol dependency as well as promoting coping skills to manage the stress that comes with mental health conditions and poor social support. Furthermore, Laudet and White (2009) conducted a study examining the priorities among individuals in drug and/or alcohol recovery. In addition to remain abstinent, participants expressed concern in different domains: employment, education and training, housing, emotional and physical

health, and family and social relationships. These concerns are consistent with the idea that individuals in recovery not only need to remain abstinent but they need to achieve a healthy quality of life in order to achieve long-term recovery. Understanding how the different domains of quality of life may influence treatment is important, well-being assessment may serve as a predictive measure to assess treatment adherence, in which higher quality of life predicts better treatment compliance and it also serves as treatment outcome predictors (i.e., long term recovery).

Tracy, Laudet, Mon, Kim, Brown, Kyoung, and Singer (2012) examined predictors of quality of life using WHOQOL-BREF among women in substance abuse treatment. The results showed that trauma symptoms predicted physical and psychological quality of life; women with fewer trauma symptoms scored higher on the physical and psychological domains of quality of life. Social support was a strong predictor across all domains of quality of life, women with strong social support bonds showed greater quality of life. Drug treatment and recent alcohol or drug use did not predict quality of life. This suggest that, the extent of alcohol or drug use may not be the most salient factor in determining quality of life among women in drug and/or alcohol recovery. This further points out the importance of addressing other areas of functioning (e.g., interpersonal relationships) along with abstinence or reduction of drug and/or alcohol use.

How individuals cope with their recovery and how they manage stressful situations may influence the extent to which quality of life is achieved. Problem-focused coping strategies have been associated with greater quality of life. Being able to actively change a stressful situation may promote healthy behaviors and lessen psychological distress. Gattino et al. (2014) examined coping strategies and quality of life among women and men. They

found that problem-focused coping strategies (e.g., active coping, positive reframing) increased quality of life, whereas emotion-focused coping (e.g., self-blame) diminished physical and psychological quality of life. Moreover, Weaver et al. (2000) examined depressive symptoms, stress, and coping among women recovering from addiction. They examined psychological and social stress during two time periods: pre-recovery (6 months before their recovery) and during recovery (time of the interview). Coping strategies were also assessed to examine how participants cope with various stresses in their lives. The study showed that the most prevalent stressors during pre-recovery and recovery were economic problems, emotional health, physical health, family members, and parenting. In order to cope with these stressors during pre-recovery participants used more maladaptive coping strategies such as complaining, blaming others, and criticizing themselves. However, during recovery participants tend to develop better adaptive strategies such as developing plans to handle problems, seeking help, and developing spirituality. Depressive symptoms were related with higher levels of perceived stress and the use of maladaptive coping strategies. This study shows that it is important to promote healthy coping skills (e.g., problem solving strategies) in order to promote well-being among recovering women. Additionally, drug treatment needs to be collaborative effort with other health and social services providers in order to address women's primary stressors (e.g., physical and emotional health).

Social Support and Quality of Life

Social support encompasses the quality and frequency of relationships and it can be categorized into four types of supportive behaviors: emotional support, instrumental support, informational support, and appraisal support. Emotional support involves providing empathy, love, trust, and caring about the other individual. Instrumental support involves direct action,

in terms of tangible aid and services that will directly assist the person in need. When you provide advice, suggestions, or information that the person can use to address their problems these actions fall into informational support. Lastly, when you provide constructive feedback and affirmation it is categorized as appraisal support (Heaney & Israel, 2008). Perceived social support may influence one's well-being. Higher levels of perceived social support have been associated with better perceived quality of life (Brown, Kyoung, Meeyoung, and Tracy, 2013; Berkman, & Glass, 2000).

Strine, Chapman, Balluz, and Mokdad (2008) examined social and emotional support and health-related quality of life among people the United States and its territories. They found that 8.6% of U.S. adults aged 18 years or older reported that they rarely/never received social support, and out of this percentage Puerto Ricans were one of the highest regions (10.8 %) that reported rarely/never social and emotional support. Low levels of social and emotional support were related to poorer mental and physical health. These findings are consistent with previous research that shows that low levels of social and emotional support are related with poorer quality of life, as well as risky behaviors such as drug taking. Brown et al. (2013) examined the role of social support, specifically social support related to the recovery process among women undergoing drug treatment. They found that social support predicted greater quality of life among all domains; psychological, physical, environmental, and social. Laudet, Morgen, and White (2006) found similar results among a sample of recovering substance abusers. Social support worked as a buffer between stress and quality of life, meaning that higher perceived social support was related with greater quality of life. These results, highlight the importance of perceived social support on quality of life among individuals recovering from drug and/or alcohol disorders.

Social support may also be seen as a coping mechanisms in which individuals may seek for emotional social support in order to vent about their current situations and seek for advice. Additionally, individuals may seek instrumental social support in order to deal with their stressors. Thus, the extent of social support may affect how individuals cope and these mechanisms may influence their quality of life.

The Current Study

The aim of this study is to explore the influence of coping strategies and quality of life among Puerto Rican women undergoing drug and/or alcohol recovery. According to the Transactional Stress and Coping Model, adaptive coping skills (i.e., problem-focused coping) are related with lower stress and higher quality of life. Whereas, maladaptive coping skills (i.e., emotion-focused coping) are related to higher stress and low quality of life. However, according to the theory, this relationship is influenced by the perceived controllability of the stressful event. Thus, this study examined the most prevalent stressors among women in drug and/or alcohol recovery, and how they perceive the stressful event (e.g.," There isn't much I can do to help myself feel better about the event"). Additionally, we assessed how women cope with this stressful events and what is the relationship between the coping skills used and quality of life. Social support will be assessed to examine its relationship with quality of life.

According to the Transactional Stress and Coping Theory we expect that when there is low control, emotion-focused will be positively related with quality of life insofar that emotion-focused coping will be positively associated with emotional social support which will then predict quality of life. Additionally, when there is high control, problem-focused coping will be positively related with quality of life insofar that problem-focused coping will

be positively associated with instrumental social support which will then predict quality of life.

Method

Participants

Thirty-five Puerto Rican women 21 years or older undergoing drug treatment were recruited. Participants were recruited by contacting six different long-term residential treatment programs in Puerto Rico. In order to participate in the study participants must have been in drug and/or alcohol recovery at least two months. Forty-eight percent of participants reported to be in treatment for two to six months, 31.4% six months to one year, 14.3%, one year to two years, and 5.7 % two years to four years. The mean age of the sample is 39.17 years old. The majority of the sample had at least 1 child (94.3 %). The majority of the samples' highest form of education was high school diploma (31.4%), followed by some education ranging from 4th grade to 9th grade (31.4%), Associate Degree (17.1%), Bachelor's degree (14.3%), and no education (5.7%). Forty-nine percent reported depression, 11.4% reported having HIV, 11.4 % reported having Hepatitis, 8.6 % reported anxiety, and 14.3% % did not report any medical condition. Sixty-six percent of the sample had a family history of drug abuse. The onset of drug use occurred at about 22 years old. Most of the sample had previously sought treatment (62.9%), whereas 37.1% haven't been in treatment before their current treatment. Furthermore, 57.1% of the sample reported they entered treatment voluntarily, whereas 31.4% were court ordered, and 11.4% were due to family pressure. Most of the sample was somewhat satisfied (48.6%) with their current treatment. Thirty-four percent of the sample felt somewhat supported by health service providers, 40% perceived a lot of support, 20 % perceived little support, and 5.7% did not perceived any support.

Procedure

  Recruitment procedure. Contact was made with six long-term residential facilities for alcohol and drug disorders in Puerto Rico (see description below). During the month of December 2015, the principal investigator met with the Director of the treatment center and the Case Manager to provide them with a description of the study, the surveys, and a consent form. After answering all the questions regarding privacy and data collection a written permission was obtained. The data was collected during the period of March 14th to March 31st, 2016 and from June 14th to July 1st, 2016.

  Data collection. Participants were provided with a consent form and questions and concerns regarding their participation in the study will be answered. All the interviews were individual and were conducted by the principal investigator in Spanish. The interviews took place in a private room inside the treatment facility. Participants were provided with a packet of questionnaires (i.e., Brief COPE inventory, WHOQOL-BREF, MOS-Social Support Scale, Demographics). Participants were greeted upon entry and were handed the packet of questionnaires. The interview started by asking participants to talk about a stressful event or something they have been dealing with for the past two weeks or are currently dealing with. Their answers were recorded. After this, participants answered the Brief COPE inventory, MOS Social Support Scale, WHOQOL-BREF, and the demographic questionnaire. The completion of the questionnaires took approximately one hour. If needed participants took a break during the interview. Participants could also stop at any moment during the study and if they felt any major discomfort and the case manager of the treatment facility was available to talk with them. After participants complete the questionnaires they were debriefed and thanked for their participation.

Treatment centers. The participants were selected from six substance and/or alcohol abuse treatment centers.

Guara Bi Inc. The program serves women that are homeless, have a substance abuse disorder, and/or are referred by court to enter treatment. The services offered are: drug counseling, psychological services, educational workshops, and individual and group therapy.

Hogar Crea de Mujeres San Juan y Coamo. Treatment here is structured in phases or steps. These phases are: induction, introspection, identification and growth, intensive growth, and follow-up. The treatment is centered in re-educating individuals in order to modify their behavior and rejoin the community. The re-education program has two principal components: internal therapeutic environment (e.g., residents, therapeutic team, facilities) and the community support groups. The re-education program is mostly focus in provide role models regarding behavioral moral, and spiritual values.

Hogar Posada la Victoria. It is a long-term residential facility for women that have a substance abuse disorder. The services offered are: counseling, case management, individual and group therapy, and educational workshops

Casa la Providencia. It is a long-term residential facility for women that have substance abuse disorder and/or other mental health conditions. The services offered are: basic education, vocational courses, art classes, individual and group therapy, pharmacotherapy, pre and post-natal medical services, and spiritual counseling.

Hogar Refugio. The program serves primarily homeless women and women with children. It offers substance abuse treatment, counseling, educational workshops, medical assistance, individual and group therapy, and financial advice. Additionally, it has a shelter

for women and their children in which they can raise their children while recovering from drug and/or alcohol abuse.

Materials

This study examined appraisal of the event by describing two stressful events, one uncontrollable and another controllable. Additionally, coping strategies were measured using the Brief COPE inventory. Carver, Scheir, and Kumari (1989) developed a multidimensional coping inventory — COPE to assess different ways of coping with stressful events. The COPE inventory, as well as the brief version of the COPE (Carver, 1997), is commonly used to assess different strategies that individuals may use to cope with stressful situations. The inventory can be divided between problem-focused coping strategies and emotional-focused coping strategies. Problem-focused coping strategies include: active coping, and planning. Emotion-focused strategies include: seeking support for emotional reasons, positive reinterpretation or growth, acceptance, humor, and turning to religion. The Brief COPE inventory has been translated into Spanish and has been used in Spanish speaking populations, thus it is an appropriate and reliable measure to examine coping strategies in this population. To examine quality of life the WHOQOL-BREF questionnaire will be used. The World Health Organization (WHO) developed a Quality of life assessment - the WHOQOL-BREF, which is a shorter version of the WHOQOL-100 - is a cross-culturally validated assessment of well-being (WHOQOL Group, 1998). The WHOQOL-BREF contains 26 items that assess the four dimensions of quality of life (i.e., physical health, psychological health, social relationships, and environment). This questionnaire also has been translated into Spanish (Lucas-Carrasco, 2012; Benitez-Borrego & Guardia-Olmos, 2014) and it is a commonly used measure to assess quality of life among Hispanic populations (e.g., Costa

Rica, Cuba, México, Spain) . Thus, each of the questionnaires selected have been previously

used in Spanish speaking samples and have been commonly used in other areas of research to

examine coping strategies and quality of life.

Brief COPE Inventory (Carver, 1997). This inventory assesses 12 different coping

strategies (i.e., 2 items per scale) that can be categorized by adaptive and maladaptive coping.

Participants will be asked to think and provide a description of a stressful event that occurred

in the last two weeks or that it is currently occurring and answer according how they acted in

the situation. Each factor had an internal reliability of .50 or more. For this study we will use a

modified version of the COPE inventory. The inventory will be comprised by 24 items, five

different sub-scales for emotion-focused and five different sub-scales for problem-focused

coping, a composite score for each scale will be gathered. Emotion-focused coping consisted

of use of emotional support, positive reframing, acceptance, religion, and humor. Problem-

focused coping consisted of active coping and planning. The rest of the items consisted of

behavioral disengagement, venting, denial, substance use, disengagement, and self-

distraction. Perczek, Carver, and Price (2000) translated the Brief COPE inventory to Spanish.

Correlations between the English and Spanish versions were above .72 for each factor except

Behavioral Disengagement that had a correlation of .43 between the versions. For this study

the Brief COPE Inventory had an alpha Cronbach reliability of .72. For the emotion-focused

subscale it had an alpha Cronbach of .81 and for the problem-focused .42 (see Table 1).

WHOQOL-BREF (WHO, 1996). This is a 26-item survey that is the short version of

the WHOQOL that was develop by the World Health Organization (WHO, 1996). The

WHOQOL-BREF survey assesses four dimensions of quality of life: physical health,

psychological health, social relationships, and environment. The survey has been translated

and validated in Spanish with a good internal consistency for each of the dimensions, ranging

from .75 to .80 (Lucas-Carrasco, 2012). For this study the composite score of WHOQOL-

BREF had an alpha Cronbach reliability of .91 (see table 1 and table 2).

Medical Outcome Study, Social Support Scale (Donald & Stewart, 1991). This

measure consists of 18-items that assess four different aspects of social support (i.e.,

emotional/informational, tangible, affectionate, and positive social interaction). This

questionnaire has a good overall internal reliability of alpha .97. This questionnaire is

currently under validation in Puerto Rico as part of the Center of Evaluation and

Sociomedical Research at the University of Puerto Rico.). For this study we used a short

version of the Social Support Scale that consists of 8 items. The composite score of the

Medical Outcome Study, Social Support Scale had an alpha Cronbach reliability of .79. For

emotional social support subscale, it has an alpha Cronbach of .65 and an alpha Cronbach of

.82 for instrumental social support (see table 1).

Results

Bivariate correlational analyses were conducted using SPSS 23.0 to examine the

relationship between each of the demographic variables and quality of life. Women who

reported being more satisfied with their current treatment also reported greater quality of life,

$r = .40$, $p = .016$. Also, women who reported greater perceived support by health care

providers also reported being more satisfied with their current treatment, $r = .50$, $p = .002$, and

reported greater quality of life, $r = .49$, $p = .003$. Women who reported higher levels of

education reported having a higher perception of the effectiveness of the treatment, $r = .38$, $p =$

.024.

Bivariate correlations were also conducted to examine the relationship between demographic variables and emotional social support. The number of family members was positively associated with emotional support, such that women with a greater number of family members indicated higher emotional social support $r = .43$, $p = .011$. Women who reported having a greater number of friends also reported greater perception of treatment effectiveness, $r= .43$, $p =.010$, greater satisfaction with treatment, $r =.35$, $p =.039$, and greater perceived support of health care providers, $r = .38$, $p =.023$.

Coping and Quality of Life

Bivariate correlational and regression analyses were conducted using SPSS 23.0 to test the hypotheses. The first theoretical model examined stressors that the participants reported not having control over. This model explored the meditating relationship between emotion-focused coping and quality of life with emotional support as the mediator. Bivariate correlations showed that emotion-focused coping was statistically significantly related to greater quality of life, $r =.35$, $p < .05$. Emotional social support was marginally significantly related to quality of life $r = .30$, $p = .08$. However, emotion-focused coping and emotional social support were not significantly correlated with each other, $r = -.25$, $p = .149$ (see Table 3). Because there was not a statistically significant relationship between emotion-focused coping and emotional social support, a mediation analysis predicting quality of life with emotion-focused coping and emotional social support was not conducted.

Multiple regression analysis was conducted using emotion-focused coping and emotional social support predicting quality of life. The overall model was statistically significant, $F(2, 32) = 6.32$, $p = .005$, and accounted for 28% of the variance in quality of life. The results indicated that both predictors were statistically significant for predicting quality of

life. Emotion-focused coping was associated with higher quality of life, $\beta = .46$, SE = 3.60, p = .006, whereas emotional social support was associated with higher quality of life, $\beta = .41$, SE = 3.00, $p = .012$.

A stepwise linear regression analysis using forward selection was conducted to predict quality of life. Stepwise linear regression analysis was conducted because we were interested in seeing what combination of variables helped explain the most statistically significant variance in quality of life. Stepwise linear regression analysis was conducted rather than a hierarchical linear regression analysis because we did not have a theoretical framework to help determine what variables were better predictors of quality of life than others. Thus, the stepwise linear regression is an exploratory measure because it uses the data to determine what the most significant predictors of quality of life are. Emotion-focused coping, emotional social support, perceived support by health care providers, and satisfaction with treatment were entered into the model. The final model included emotion-focused coping, emotional social support, and perceived support by health care providers, and excluded satisfaction with treatment. The final model explained 49% of the variance in quality of life. At step 1, perceived support by health care providers was entered into the equation and statistically significantly predicted quality of life, $F(1,33) = 10.37$, $p = .003$, explaining 24% of the variance in quality of life. At step 2 emotion- focused coping was entered into the equation $F(1,32) = 11.52$, $p < .001$, explaining an additional 18% of the variance in quality of life. At step 3 emotional social support was entered into the equation $F(1,31) = 9.97$, $p < .001$, explaining and additional 7% of the variance in quality of life (see Table 5).

The second theoretical model examined stressors that the participants reported having control over. This model explored the meditating relationship between problem-focused

coping and quality of life with instructional support as the mediator. Bivariate correlations showed that problem-focused coping was not statistically significantly associated with quality of life, $r = .19$, $p = .288$. Instrumental social support was not statistically associated with quality of life, $r = .14$, $p = .408$, nor was it statistically significantly associated with problem-focused coping, $r = .09$, $p = .635$ (see Table 4). Because there is not a statistically significant relationship among problem- focused coping, social support and quality of life, no further analyses were conducted.

Demographics, Coping, Social Support and Quality of Life Domains

Bivariate correlations were conducted to examine emotion and problem-focused coping, and social support with the physical, psychological, social, and environmental domains of quality of life. Emotion-focused coping was related to greater physical, $r = .34$, $p = .048$, and psychological, $r = .37$, $p = .029$, quality of life. Emotional social support was related to greater environmental quality of life, $r = .34$, $p = .046$, and was marginally significantly related with social quality of life, $r = .32$, $p = .066$. Perceived satisfaction with treatment was related to greater social, $r = .59$, $p < .001$ and environmental quality of life, $r = .42$, $p = .013$. Similarly, perceived support of health care providers was related to greater social $r = .49$, $p = .003$ and environmental quality of life, $r = .62$, $p < .001$. Problem-focused coping and instrumental social support were not related to any of the quality of life domains.

Summary of Results

Our hypothesis for the low-control over a stressful event was partially supported by the data. Emotion-focused coping was statistically significantly related with greater quality of life, and social support was marginally significantly related with greater quality of life. Furthermore, multiple regression analysis showed that both, emotion-focused coping and

emotional social support predicted quality of life, accounting for 28% of the variance explained in quality of life. Stepwise regression analyses revealed that emotion-focused coping, emotional social support, perceived support by health care providers were statistically significant predictors of quality of life, and explained 49% of the variance. In terms of the high-control over a stressful event, our hypothesis was not supported. The use of problem-focused coping and instrumental social support were not statistically related with quality of life.

Additional exploratory analyses examining each of the domains of quality of life revealed that emotion-focused coping predicted higher physical and psychological quality of life, whereas emotional social support predicted greater environmental quality of life. Emotional social support and social support networks were also examined. Results showed that greater numbers of family members were related to greater perceived emotional social support, whereas greater numbers of friends were related to greater perception of effectiveness of treatment, greater satisfaction with treatment, and greater perceived support of health care providers. Higher levels of education were related with greater perception of treatment effectiveness, and greater perceived support of health care providers was related to greater quality of life. Satisfaction with treatment was related with greater social and environmental domains of quality of life. Perceived support from health care providers was also related with greater social and environmental domains of quality of life.

Qualitative Results

The qualitative analysis provides a deeper understanding of the stressors that these women were/are experiencing during their recovery process. Participants were asked to describe two stressful events, one in which they felt little to no control, and one in which they

felt control over the situation. The common themes were: domestic violence, death of family member/significant other, sexual abuse, chronic illness, loss of child custody, and seeking help/treatment. In the following sections quotes from women are provided to add the most complete picture for each theme that emerged. These quotes were translated from Spanish to English and are reproduced verbatim.

Uncontrollable Stressful Events

    Domestic violence. While coding the interview transcripts, domestic violence was frequently reported when asked for an uncontrollable stressful event. Participants reported being abused by their fathers and/or their romantic partners. One participant expressed the following: *"The most difficult thing in my life, for the moment has been surviving a homicide attempt, while having [Ley 54]—a protection order to prevent domestic violence. This homicide attempt made me relapse and get to reach my limits."* This quote captures the trauma that most of participants experienced before being able to obtain the treatment they needed for their substance abuse problem. Moreover, domestic abuse by the father figure was prevalent in this sample. One participant reported being abused since her childhood by her alcoholic father. *"I haven't been able to deal with this. I was abused since I was a child by my dad. I did not deal with this well, he was an alcoholic and he abused us a lot. The first time I did something to deal with this was when I was 12 years old. I tried to hit him and hurt him badly, I could not stand anymore his abuse"*

    Not only physical violence was reported by participants there was also psychological abuse. One participant talked about how her husband prohibited her from working at a job. She worked for more than 10 years and after she got married he told her that she could not work anymore and that her place was at home taking care of their children. She expressed

how this relationship made her depressed and introduced her to substance abuse. *"Being at home all day taking care of my children made me really depressed. I started taking depression medications and I started taking more and more pills, this escalated when I started to consume pills for migraines and for chronic pains. This caused my divorce and being marginalized by my family because my addiction"* This quote captures the psychological abuse that some women experienced and how this abuse lead them to start consuming illicit drugs.

Death of family member and/or significant other. Death of a close relative was commonly described by women when asked to talk about an uncontrollable event. Losing a parent, was the most prevalent loss, followed by the loss of a grandparent. Usually these family members were described as close and supportive figures in their lives. Thus, losing this close and supportive relationships caused a great burden within this sample. Participants typically did not want to offer details about how they felt during that moment and how they coped with that event. One participant clearly expressed, *"I lost my sister and that affected me greatly, but I do not want to talk about it"*. Women often were not able to voice their feelings towards this particular negative life event. However, one participant talked about how she blamed herself for the death of her grandmother, who raised her. She talked about how she was not in the house when she died and she thought that her grandmother's death might have been prevented if she was with her. *"...a relative called me that day to tell me that he found my grandmother in the shower, she had fallen in the shower. Minutes later, I received a call saying that she died. I wasn't there when all this happened. She was the one that raised me, she gave me all and I wasn't there for her in that moment"* This quote captures how this

participant blamed herself for the death of her grandmother, an event that was mostly out of her control.

Sexual abuse. Sexual abuse is prevalent among some Puerto Rican women. Some participants described instances of sexual abuse when they were younger by siblings and/or by their step-fathers and/or dads. One participant recalled being sexually molested by her half-brother, who had a mental health condition. She talked about how she thought his actions were justifiable because of his condition. However, when she was older she understood that his behavior was not appropriate and let her mom know. She recalls that her mom did not believe her and that she had to leave her house in order to escape from that unhealthy family dynamic. She stated that she still hasn't been able to forgive what her brother did to her and forgive her mother who did not do anything to help her through with her situation. Another participant described how she was constantly molested and physically abused by her father. These events were highly traumatic for these women, thus they felt they often did not have the appropriate control and/or resources to deal with their situation.

Chronic illness. Some women reported being diagnosed with HIV, cancer, emphysema (i.e., a condition in which the air sacs of the lungs are damaged and enlarged, causing breathlessness), endometriosis (i.e., causes pelvic pain), and Lupus. These women talked about how difficult it has been dealing with their diagnosis and how frustrated and hopeless they felt at times. A participant talked about how having emphysema has changed drastically her daily routine. *"...this illness has affected me a lot. I sleep almost all day and I cannot do any chores or engage in any activity."* Moreover, participants also talked about how little control they felt over their diagnosis and how that has affected them in terms of seek treatment and obtain the help they need. A participant diagnosed with HIV talked about

how sometimes she did not want to take her pills and how she constantly felt depressed when thinking about the consequences of her illness.

Loss of child custody. Some women were trying to obtain back the custody of their children while completing drug and/or alcohol treatment. Some of them had a family member who was taking care of their children, however, others did not have any family support and their children were removed from their care and place in foster care. One participant talked about how the police entered to her house and took her children due to her chronic drug use. *"... police officers broke down my door and took my children away. I was begging to them to not do that, but they called the family department and they took away my children. They put me in jail for two weeks and I haven't been able to have my children back since that happened."* This quote captures the frustration and impotence this woman experienced when her children were removed from her care and placed in foster care. Another participant talked about how her youngest child was recently given up to adoption. She said that there was nothing she could do, because she was still finishing her treatment and did not have any family member that could help her regain custody of her child. The loss of child custody is highly common among women with chronic illicit drug and/or alcohol use. Often law enforcement agencies and child advocates prefer to remove children from their mother's care without considering women's possibility of recovery and how the child might be affected by being placed in foster care. One participant talked about how she was trying to regain custody of her child but although she is almost finishing her treatment, her child's psychologist and case manager did not want her to be close to her child. These barriers were described by participants as uncontrollable events and often the cause of depression, anxiety, and relapse.

Controllable stressful events

Women were asked to describe a stressful event over which they felt they had managed to control. The most common stressors described were: seek help for their chronic drug and/or alcohol use and complete treatment in order to be able to reconnect with family members and in some cases try to regain child custody. Also, they talked about leaving an abusive relationship and how they decided to seek help to deal with the abuse they experienced.

Seek help for chronic drug and/or alcohol use. When asked about a stressful event that women perceived as controllable they typically talked about entering treatment voluntarily. One participant expressed the following *"I was tired of being homeless. I started smoking marihuana and then I started snorting cocaine. When I started with cocaine I told myself, this is not for you, you should get help. I got tired of sleeping under bridges, being hungry, and not having a safe place to sleep. So one day I decided to seek help and get in treatment."* Not only did the women experience being homeless but some of them also talked about exchanging sex for money to buy illicit drugs. One participant said that when she started working as a prostitute that was the moment she knew she was "rock bottoming". After one night where she almost died of an overdose she decided to seek help and enroll in treatment. Participants also mentioned that the reason they sought treatment was often guided by the desire of having their children back and reestablishing family bonds.

Seeking help and completing treatment are highly related. Participants reported their desire and determination to complete treatment in order to be able to regain custody of their children. They talked about how hard it was to adhere to treatment and how often they thought of giving up. However, they always mentioned that their determination to stay in

treatment was to reestablish their relationship with their children. One participants mentioned how she usually dropped out of treatment, but that this time was different because recently her child was removed from her custody and she was determined on getting her child back. Thus, finishing treatment was highly important for her, as well as for the majority of the women interviewed.

Summary of findings

Participants often described experiencing highly traumatic events, such as, sexual abuse, domestic violence, and death of a relative. These stressful events influenced how they coped and how their well-being was affected by those negative life events. Sexual abuse by relatives was prevalent within this sample, as well as domestic violence by partners and/or relatives. In terms of controllable stressful events women often described that they felt control over their decision of entering treatment and their efforts to successfully finish treatment. Additionally, women talked about how they decided to leave abusive relationships and seek help to deal with the negative consequences of abuse. Taken together these results provided us with a deeper understanding of women's stressful experiences before entering treatment and current stressful events. This allowed us to put in context our quantitative results and provided us with a better description of what was going on for our sample.

Discussion

Uncontrollable Events, Emotion-Focused Coping, and Emotional Social Support

This study is the first study to examine problem and emotion-focused coping strategies, perceived social support, and quality of life within Puerto Rican women undergoing illicit drug and/or alcohol treatment. To explore these psychosocial factors, we framed our study using the Transactional Stress and Coping Theory, which proposes that

problem- and emotion-focused coping strategies can be beneficial for individuals' well-being according to how the event is appraised. We explored controllable and uncontrollable stressors, and assessed how they coped with these stressors. Our study tested two main hypotheses that examined emotion- and problem-focused coping. We hypothesized that emotion-focused coping would predict higher quality of life with low control stressors, and that emotional social support would mediate this relationship. This hypothesis was partially supported. When participants considered a stressor over which they had little control over, the use of emotion-focused coping was related with higher quality of life. However, there was no relationship between emotion-focused coping and emotional social support. We also hypothesized that problem-focused coping would predict higher quality of life with controllable stressors, and that instrumental social support would mediate this relationship. This hypothesis was not supported. However, our results showed that there were no significant relationships between problem-focused coping, instrumental social support, and quality of life.

Our first hypothesis supports the Transactional Stress and Coping Theory (Lazarus & Folkman, 1977), emotion-focused coping was beneficial when the event was perceived as uncontrollable. According to Lazarus and Folkman, emotion-focused coping consists of changing the meaning of the situation and regulating the emotions associated with the stressful event. Typically, emotion-focused coping has been viewed as a maladaptive way to cope with stressors (Austenfeld & Stanton, 2004). Emotion-focused coping might limit the amount of effort individuals put in to actively change their stressful situation. In addition, by engaging in emotion-focused coping, individuals may constantly dwell on the stressors, thereby generating greater distress. However, Austenfeld and Stanton (2004) suggest that

researchers may not be accurately measuring emotion-focused coping. Austenfeld and Stanton examined commonly used measures of coping, Ways of Coping Questionnaire (Lazarus & Folkman, 1985), the COPE (Carver, Scheier, & Wintraub, 1989) and the Coping Inventory for Stressful Situations (Endler & Parker, 1990, 1994) and found that these measures often included items of self-blame and denial— factors that could lead to greater distress, depression, and lower well-being. The inclusion of these maladaptive coping items as part of emotion-focused coping measure could be one of the reasons that most studies find a relationship between emotion-focused coping and lower quality of life. Our Brief COPE emotion-focused coping measure included use of emotional support, positive reframing, acceptance, religion, and humor. Thus, our measure did not encompass items related to denial, venting, and self-blame. The exclusion of these items (i.e., self-blame, venting, denial) in our study may explain why we found a positive relationship between emotion-focused coping and quality of life.

Moreover, some research supports these findings, in which emotion-focused coping have been related to greater quality of life when a stressful event is perceived as uncontrollable. For example, Forsythe and Compass (1987) examined the interaction between cognitive appraisals—when a stressful event is assess as threatening or challenging, and what, if anything could be done to change the stressful event—and coping with stressful life events and their relationship with psychological distress. Consistent with other research, they found that when the event was perceived as controllable, greater problem-focused coping strategies were used and were correlated with lower psychological distress. However, when the event was perceived as uncontrollable, more emotion-focused coping strategies were used and were correlated with lower psychological distress. Similarly, Stanton et al. (2000) examined

emotionally expressive coping and psychological and physical adjustment among women with breast cancer. They found that women with high emotional expressive coping had greater psychological and physical health than those with low emotional expressive coping. In addition, women that perceived they had a stronger social support system engaged in more emotionally expressive coping than those who had a weaker social support system. However, even when social support was controlled for, emotional expressive coping remained a significant predictor of psychological and physical health by itself. Therefore, emotional expressive coping is an important variable when examining quality of life.

The research described above supports the idea that engaging in emotion-focused coping strategies might be adaptive while dealing with significant negative life stressors. Our results are consistent with these findings. Participants' common uncontrollable events were related to domestic violence, sexual abuse, child custody, chronic illness, death of a family/friend, and chronic drug and/or alcohol use. These women described these stressors as highly traumatic and uncontrollable. Thus, women's quality of life was positively influenced by expressing their feelings, accepting that the event happened, modifying the way they look at that event, engaging in religious practices, and seeking emotional social support. The use of these emotion-driven coping strategies may provide women with a deeper understanding of their situation and help them reappraise the stressful event and/or change the meaning of their situation. The reappraisal of events has been identified as beneficial when experiencing significant negative life events and quality of life (Gross & John, 2003; Troy, Wilhelm, Shallcross, & Mauss, 2010). Furthermore, engaging in emotion-focused coping might be especially beneficial for Puerto Rican women, particularly when Puerto Rican women perceive that they have a strong social support network composed of family and friends. In

addition to perceived social support from family and friends, feeling supported by health care providers within their treatment facility was beneficial for women's quality of life. Thus, having someone who offers support both within the treatment facility and within the patient's family and friends network is essential to improving their quality of life. These findings showed that for Puerto Rican women undergoing alcohol and/or drug treatment, having a strong social network composed of family, friends, and health care providers can improve their quality of life. This might be of particular importance for treatment development and delivery. Health care providers could emphasize on creating strong bonds with their patients and encourage the involvement of family members in the course of treatment to strengthen the family network support of these women.

The relationship between perceived emotional social support and quality of life within this sample is supported by previous research examining the influence of perceived social support and well-being among individuals undergoing substance abuse treatment. Brown et al. (2013) examined the role of both social support and support relating to the recovery process among women (e.g., "The people in my life understand that I am working on myself") who have experienced traumatic events and were undergoing drug treatment. They found that greater social support and specific recovery support predicted greater quality of life. This result supports our finding that perceived emotional support and support by health care providers was positively related to greater quality of life among women undergoing substance abuse treatment. Similarly, Laudet, Morgen, and White (2006) examined stress, social support, spirituality, and quality of life within a sample of recovering substance abusers and found that higher perceived social support was related with greater quality of life, that is, social support worked as a buffer between stress and quality of life.

Emotional social support within this sample was an important variable when examining quality of life. Participants' social support network composed of family members was related with higher perceived emotional support, that is, having a strong family social support network contributed to women's emotional support. This is consistent with the Latino culture of familism (*familismo*). Familism—a cultural value that emphasizes close, supportive family relations, and that family should be prioritized over the self—stresses that interdependence should be valued over individualism. Strong bonds with family members have been associated with greater psychological health when there is a higher perceived social support (Campos, Ullman, Aguilera, & Dunkel, 2014). Thus, our findings regarding how larger family social support networks, were related to higher perceived emotional social support is consistent with previous research on familism, social support, and well-being.

Controllable Events, Problem-Focused Coping, and Instrumental Social Support

The Transactional Stress and Coping Theory (Lazarus & Folkman, 1977) posits that problem-focused coping consists on actively changing the stressful situation. This includes creating a plan and focusing on what steps to take in order to be able to change the situation. According to Lazarus and Folkman engaging in problem-focus coping may be beneficial to individuals because by engaging in active coping and planning strategies, stress could be reduced thus improving the individuals' quality of life. Moreover, the vast majority of research have found that engaging in problem-focused coping may be more beneficial than engaging on emotion-focused coping strategies (Gattino, et al. 2014; Weaver, et al., 2000). The adaptive use of problem-focused coping has been also linked to how individuals perceived the stressful event, that is, if they perceived an event as controllable engaging in more problem-focused coping strategies may be beneficial in reducing stress.

Our findings are not consistent with the Transactional Stress and Coping Theory, in which problem-focused coping is viewed as adaptive. However, our sample consisted of women from low socioeconomic background, with low levels of education, and without a stable home. These life circumstances may be affecting the stressors these women experience and the skills and resources they have to manage those stressors. Puerto Rican women's common controllable events consisted of seeking drug abuse treatment voluntarily, completing treatment, overcoming an abusive relationship, and recovering their children. These events could be considered as ongoing or chronic stressors. In other words, women may perceive an initial sense of control over these events but they still need to continue drug abuse treatment, deal with the emotional scars of abuse, and constantly work toward regaining custody of their children, finding stable work, and finding a permanent residence once they leave the treatment facility. Thus, although it may seem that they have control over these stressors, they may require different coping strategies to actively change the meaning of the stressors, as well as actively change their circumstances. Cheng (2001) explores coping flexibility—the use of both emotion and problem-focused coping and points out its importance when dealing with stress. The importance of engaging in flexible coping skills might explain why we did not find results when examining solely problem-focused coping and its relationship with quality of life when a stressful event was perceived as controllable.

Cheng examined coping flexibility, emotion-focused coping, problem-focused coping, and appraisal of stressful events among college students to examine coping flexibility and the use of problem-focused coping when the event was perceived as controllable by participants. Experimental conditions were developing to assess participants' appraisal of the stressor and their coping skills. One stressful task was controllable, that is, improvement was possible with

practice, and the other task was uncontrollable, meaning that improvement was not possible. When the stressful task was perceived as controllable, participants reported using more problem-focused coping strategies than when the event was perceived as uncontrollable. However, when participants perceived greater control over the stressful task than they actually had, and when they engaged in more problem-focused coping strategies, they reported perceiving more stress. Thus, these results suggest that individuals can perceive an event as controllable but this perceived control should match the actual control of the event in order to reduce psychological distress. This might explain the findings regarding problem-focused coping and quality of life. When participants provided responses based on event that they perceived as controllable, the event might not have actually matched the true control of the event. In other words, participants might have felt control over their decision to seek treatment and/or complete treatment, but since recovery is an ongoing process in which cravings, withdrawal, and relapse are events that might come as uncontrollable during the course of treatment, the perceived control might not provide an accurate picture of the relation between problem-focused coping and quality of life.

Implications

These findings have several implications for health care providers. First, services should foster a strong relationship between health care providers and patients, as well as to tailor treatment that addresses family issues in order to strengthen family relationships. Incorporating family therapy as one of the treatment interventions might be able to accomplish this. The involvement of family members may serve as protective factors—it might prevent relapse and promote the completion of substance abuse treatment. Previous research has shown that difficulties with family members can create barriers when seeking

treatment, and perceived less social support of family members might contribute to relapse during and/or after treatment (Rowe, 2012). Incorporating a family-based treatment approach might be of particular importance, considering that our study found that family support was related to higher perceived emotional social support, and this was related to greater quality of life.

Second, women's stressors should be identified at the beginning and during treatment to assess women's perceived controllability over their life events as well as to identify how women choose to address those events. Understanding the nature of women's stressors might help health care providers to tailor treatment that focuses on developing the appropriate coping strategies. That is, that if women's common stressors are perceived as uncontrollable, emotion-focused coping should be prioritized over problem-focused coping strategies. Lastly, this research contributes to the literature by providing information about how Puerto Rican women cope with different stressors, how they perceive their social support network, and how coping and social support networks are related to quality of life. The use of these measures might be beneficial to assess how women's quality of life improve over time and how this might affect their recovery process.

Limitations

This study had several limitations. First, we did not assess what being in control of the participants' stressors meant for them. This lack of a definition might have affected our results, specifically with the lack of effect found for problem-focused coping. It may be that women did not fully understand what being in control over a particular event meant. The lack of understanding may have influenced the stressors women chose and the coping strategies they used. For example, women often described stressful events that could have been

perceived to be ongoing daily events (e.g., entering treatment). Thus, these events might not completely encompass women's control over life events. Additionally, the use of questionnaires might have been a limitation when working with this sample. Half of our sample did not complete high school, thus their literacy levels were low increasing the risk of their not understanding the items. Some participants did not know how to read and/or write, which made it difficult for them to understand the questions and answer them in an effective manner. To reduce this barrier, the interviewer read each question and explained their meaning along with the possible answers, this might have been influence participants' responses. Third, the low reliability for the problem-focused scale may partially explain the lack of findings related to problem-focused coping and quality of life. Furthermore, this low reliability might be indicative of participants' lack of understanding of the items, as well as a lack of understanding of the meaning of perceived control over a stressful event.

Fourth, the questionnaire used to assess social support did not include specific recovery support questions. Specific recovery support measures have been identified as important for individuals in recovery and their quality of life. Also, we did not ask where the social support came from; that is, we did not assess if the support was given by a parent, a sibling, or a relative. This study also lacked questions regarding how social support changed over the course of treatment. Knowing how social support changed and what factors helped strengthen or diminish social relationships, might have been beneficial to further understand women's support network and its impact in their recovery. Also, although we had a question that asked if participants felt supported by health care providers, we did not assess how that support was provided. Exploring how the health care provider support was provided might have given us a deeper understanding of how health care providers support patients, as well as

ways to increase that support. Lastly, although we have a general description of the services offered in each of the treatment centers, assessing specifically how those services are offered might have provided us with a better understanding of what treatment factors promoted social support, as well as quality of life.

Future Research

Future research should explore how Puerto Rican women conceptualize control/empowerment, and how the presence/lack of this control might influence their coping strategies. Exploring how Puerto Rican women define control may be beneficial to developing measures that encompass specific cultural values, as well as to better understand the factors that might influence women's perceived control over stressors. Also it could help inform health care providers of what might help women's sense of control over their life events and which coping strategies might be beneficial for their quality of life and recovery process. Additionally, other coping strategies should be explored. The questionnaire used has not been previously used with Puerto Rican women undergoing treatment, thus, it might not assess all the coping strategies that these women might engage in as part of their recovery process. As part of their recovery process, women might acquire different coping strategies that the Brief COPE inventory does not explore in detail.

Lastly, specific social support related to recovery should be assessed to examine who supports these women in terms of their recovery process and how the presence of this type of support might influence their quality of life. It might be the case that providing specific support towards these participants' recovery process might affect how they cope, and how their quality of life might improve or diminish during the course of treatment.

Conclusion

This is the first study that examines coping skills, social support, and quality of life among Puerto Rican women undergoing drug and/or alcohol recovery. Our findings showed that Puerto Rican women undergoing substance abuse treatment have often experienced traumatic events, such as sexual abuse, domestic violence, chronic illnesses, death of a family member, and chronic substance use. Women believe these stressful events uncontrollable, thus women tend to cope by engaging in emotion-focused coping strategies (e.g., seeking emotional support, spirituality). The use of these emotion-focused coping strategies and the presence of emotional social support was related to greater quality of life. These findings add to the existing literature on women's drug and/or alcohol recovery process and the factors that might be influencing their well-being. Furthermore, this study provides us with a deeper understanding of Puerto Rican women undergoing drug and/or alcohol treatment and how treatment could be improved by assessing their stressors, coping mechanisms, and quality of life.

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Table 1.

Mean, standard deviation, and Cronbach alpha.

Measures	Mean	SD	Alpha
1.Brief COPE - EFC	2.52	.68	. 81
2. Brief COPE-PFC	3.70	.38	.42
3. MOS-Social Support- ESS	2.63	.82	.65
4. MOS-Social Support-ISS	2.83	.89	.82
5. WHOQOL-BREF	3.20	.67	.91

Note: EFC: Emotion-focused coping, PFC: Problem-focused coping, ESS: Emotional social support, ISS: Instrumental social support, WHOQOL-BREF: World Health Organization Quality of Life.

Table 2.

Means and standard deviations of quality of life domains

	Physical Domain 1		Psychological Domain 2		Social Domain 3		Environmental Domain 4		Composite Score	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Total	21.51	5.60	19.82	4.85	8.91	2.39	26.40	6.62	76.65	15.84

Table 3.

Coping strategies, social support, and quality of life for the low control stressors

Variables	1	2	3	4	5	6	7
1 .Emotion-focused coping	1						
2. Emotional Social Support	-.249	1					
3. Physical	.337*	.047	1				
4.Psychological	.369*	.295	.572**	1			
5. Social	.014	.315	.271	.353*	1		
6.Environmental	.285	.340*	.613**	.607**	.482**	1	
7. Composite Score of Quality of Life	.353*	.297	.826**	.816**	.557**	.894**	1

Note. *p < .05. **p < .01.

Table 4.

Coping strategies, social support, and quality of life for high control stressors

Variables	1	2	3	4	5	6	7
1 .Problem-focused coping	1						
2. Instrumental Social Support	.087	1					
3. Physical	.069	.126	1				
4.Psychological	.176	.158	.572**	1			
5. Social	.269	.121	.271	.353*	1		
6.Environmental	.167	.080	.613**	.607**	.482**	1	
7. Composite Score of Quality of Life	.194	.144	.826**	.816**	.557**	.894**	1

*Note. *p < .05. **p < .01.*

Table 5.

Summary of stepwise regression analysis for predicting quality oflLife (n=35)

	Model 1			Model 2			Model 3		
Variable	*B*	*SE B*	β	*B*	*SE B*	β	*B*	*SE B*	β
Treatment Support	5.88	1.83	.49**	6.58	1.64	.55***	5.72	1.61	.48***
Emotion-Focused coping				9.96	3.17	.43**	11.40	3.09	.49***
Emotional Social Support							5.58	2.66	.29*
R^2		.24			.42			.49	
F for change in R^2		10.37**			9.88**			4.41*	

*Note. *p < .05. **p < .01.***<.001*

Appendix A: Brief COPE Inventory- Spanish Version

Cuestionario Brief COPE

Las siguientes son algunas maneras of enfrentarse y adaptarse a situaciones difíciles. Piense en la situación que describió anteriormente. Estamos interesados en saber cómo Usted se enfrentó y adaptó a esa situación difícil.

1	2	3	4
No hice esto en lo absoluto	Hice esto un poco	Hice esto con cierta frecuencia	Hice esto con mucha frecuencia

1. _____ Yo me enfoqué en el trabajo u otras actividades para distraer mi mente.
2. _____ Yo concentré mis esfuerzos para hacer algo acerca de la situación en la que estaba.
3. _____ Yo me dije a mi mismo(a), esto no es real.
4. _____ Yo usé alcohol u otras drogas para sentirme mejor.
5. _____ Yo recibí apoyo emocional de otras personas.
6. _____ Yo me di por vencido(a) de tratar de lidiar con esto.
7. _____ Yo tomé acción para poder mejorar la situación.
8. _____ Yo rehusé creer que esto hubiera pasado.
9. _____ Yo dije cosas para dejar escapar mis sentimientos desagradables.
10. _____ Yo usé alcohol u otras drogas para que me ayudaran a pasar por esto.
11. _____ Yo traté de verlo con un enfoque distinto para que pareciera más positivo.
12. _____ Yo traté de crear una estrategia para saber qué hacer.
13. _____ Yo recibí apoyo y comprensión de alguien.
14. _____ Yo dejé de hacerle frente a la situación en la que estaba.
15. _____ Yo busqué algo bueno en lo que estaba pasando.
16. _____ Yo hice bromas acerca de esto.
17. _____ Yo hice algo para pensar menos en esto, como ir al cine, ver T.V., leer, soñar despierto(a), dormir, o ir de compras.
18. _____ Yo acepté la realidad de que esto haya pasado.
19. _____ Yo expresé mis pensamientos negativos.
20. _____ Yo traté de encontrar apoyo en mi religión o mis creencias espirituales.
21. _____ Yo aprendí a vivir con esto.
22. _____ Yo pensé mucho cuales eran los pasos a tomar.
23. _____ Yo recé o medité.
24. _____ Yo hice gracia de la situación.

Appendix B: WHOQOL-BREF- Spanish Version

Cuestionario WHOQOL-BREF

Este cuestionario sirve para conocer su opinión acerca de su calidad de vida, su salud y otras áreas de su vida. Por favor, conteste a todas las preguntas. Si no está seguro qué respuesta dar a una pregunta, escoja la que le parezca más apropiada. A veces, ésta puede ser su primera respuesta.

Tenga presente su modo de vivir, expectativas, placeres y preocupaciones. Le pedimos que piense en su vida durante las últimas dos semanas.

Por favor lea cada pregunta, valores sus sentimientos y haga un círculo en el número de la escala de cada pregunta que sea su mejor respuesta.

1	2	3	4	5
Muy mal	Poco	Lo normal	Bastante bien	Muy bien

1. _____ ¿Cómo puntuaría su calidad de vida?

2. _____ ¿Cuán satisfecho está con su salud?

Las siguientes preguntas hacen referencia a cuánto ha experimentado ciertos hechos en las últimas dos semanas

1	2	3	4	5
Nada	Un poco	Lo normal	Bastante	
Extremadamente				

3. _____¿Hasta qué punto piensa que el dolor (físico) le impide hacer lo que necesita?

4. _____¿Cuánto necesita de cualquier tratamiento médico para funcionar en su vida diaria?

5._____¿Cuánto disfruta de la vida?

6. _____¿Hasta qué punto siente que su vida tiene sentido?

7. _____¿Cuál es su capacidad de concentración?

8. _____¿Cuánta seguridad siente en su vida diaria?

9. _____ ¿Cuán saludable es el ambiente físico a su alrededor?

Las siguientes preguntas hacen referencia a "cuan totalmente" usted experimenta o fue capaz de hacer ciertas cosas en las últimas dos semanas.

1	2	3	4	5
Nada	Un poco	Moderado	Bastante	Totalmente

10. _____¿Tiene energía suficiente para su vida diaria?

11. _____¿Es capaz de aceptar su apariencia física?

12. _____¿Tiene suficiente dinero para cubrir sus necesidades?

13. _____¿Qué disponible tiene la información que necesita en su vida diaria?

14. _____¿Hasta qué punto tiene oportunidad para realizar actividades de ocio?

1	2	3	4	5
Nada	Un poco	Lo normal	Bastante	Extremadamente

15. _____ ¿Es capaz de desplazarse de un lugar a otro?

Las siguientes preguntas hacen referencia a "cuan satisfecho o bien" se ha sentido en varios aspectos de su vida en las últimas dos semanas.

1	2	3	4	5
Muy Insatisfecha	Un poco Insatisfecha	Lo normal	Bastante Satisfecha	Muy Satisfecha

16. _____ ¿Cuán satisfecho está con su sueño?

17. _____¿Cuán satisfecho está con su habilidad para realizar sus actividades de la vida diaria?

18. _____¿Cuán satisfecho está con su capacidad de trabajo?

19. _____¿Cuán satisfecho está de sí mismo?

20 _____¿Cuán satisfecho está con sus relaciones personales?

21. _____¿Cuán satisfecho está con su vida sexual?

22. _____ ¿Cuán satisfecho está con el apoyo que obtiene de sus amigos?

23. _____¿Cuán satisfecho está de las condiciones del lugar donde vive?

24. _____¿Cuán satisfecho está con el acceso que tiene a los servicios sanitarios?

25. _____¿Cuán satisfecho está con su transporte?

La siguiente pregunta hace referencia a la frecuencia con que Ud. ha sentido o experimentado ciertos sentimientos en las últimas dos semanas.

1	2	3	4	5
Nunca	Raramente	Medianamente	Frecuentemente	Siempre

26. _____¿Con qué frecuencia tiene sentimientos negativos, tales como tristeza, desesperanza, ansiedad, depresión?

Appendix C: MOS-Social Support Scale

Cuestionario de Apoyo Social- m-MOS

1. Aproximadamente, ¿cuántos familiares cercanos tiene usted? (por ejemplo, personas con las que se siente a gusto, en confianza y que puede hablar acerca de todo lo que se le ocurre)
_____

2. Aproximadamente, ¿cuántos amigos íntimos tiene usted? (por ejemplo, personas con las que se siente a gusto, en confianza y que puede hablar acerca de todo lo que se le ocurre)
_____

3. Alguien que le ayude si estuviera encamado. (Escoja una)

       0 Nunca

       1 Pocas veces

       2 Algunas veces

       3 La mayoría de las veces

       4 Siempre

       7 No sabe

       8 Rehusa (No quiero contestar)

4. Alguien que le prepare la comida si no puede hacerlo. (Escoja una)

       0 Nunca

       1 Pocas veces

       2 Algunas veces

       3 La mayoría de las veces

       4 Siempre

       7 No sabe

       8 Rehusa (No quiero contestar)

5. Alguien que le ayude en sus tareas domésticas si está enfermo (Escoja una)

     0 Nunca

     1 Pocas veces

     2 Algunas veces

     3 La mayoría de las veces

     4 Siempre

     7 No sabe

     8 Rehusa (No quiero contestar)

6. Alguien con quien pasar un rato agradable [compartir]. (Escoja una)

     0 Nunca

     1 Pocas veces

     2 Algunas veces

     3 La mayoría de las veces

     4 Siempre

     7 No sabe

     8 Rehusa (No quiero contestar)

7. Alguien que le aconseje como resolver sus problemas personales (Escoja una)

     0 Nunca

     1 Pocas veces

     2 Algunas veces

     3 La mayoría de las veces

     4 Siempre

     7 No sabe

     8 Rehusa (No quiero contestar)

8. Alguien que comprenda sus problemas (Escoja una)

     0 Nunca

     1 Pocas veces

     2 Algunas veces

     3 La mayoría de las veces

     4 Siempre

     7 No sabe

     8 Rehusa (No quiero contestar)