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The sociocultural ecology of resilience: A comparative study among women in the United Kingdom

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ABSTRACT

Resilience is often framed as an internal, individual process. However, this perspective overlooks the complex relationship between individuals and their social and ecological contexts. Drawing on insights from evolutionary anthropology, psychology, and public health, this paper explores how women who use drugs from two regions in the United Kingdom perceive resilience and navigate intricate sociocultural environments of recovery. It also considers factors that promote resilience and those that can cause harm. This study was conducted in two regions of England: Northeast England (n = 14), including Newcastle upon Tyne and Durham, and Greater London (n = 10). Participants, who were actively engaged in recovery services, participated in one-on-one in-depth interviews that included questions about their perceptions of and direct experiences with substance use and recovery. They were also asked to share their journeys into addiction and subsequent recovery while reflecting on the barriers and facilitators to recovery for women in their community. Our findings support a growing body of research that emphasizes recovery as a relational process. Women in Northeast England and London relied on social networks, particularly through peer meetings, to navigate their recovery. Additionally, key themes included the impact of community and institutional harm, particularly in promoting isolation and emotional distress. This study highlights the significance of social learning and relational resilience in addiction recovery, framed within a sociocultural-ecological model. These findings underscore that recovery is not solely an individual process but one deeply embedded in broader sociocultural and relational dynamics.

1. Introduction

Substance misuse, encompassing both legal and illegal drugs, alcohol, cannabis, and prescription medications, are chronic conditions that require ongoing treatment and psychosocial support. While men have historically been at higher risk for misusing substances, the gender gap is narrowing in high-income countries (HICs; Marinelli et al., 2023; Steingrímsson et al., 2012). However, women's experiences with substance misuse remain underrepresented in cross-national research (Slabbert et al., 2020). This gap is partly due to stigma, which frames substance use as a predominantly male issue (van den Brink et al., 2022) and the perception that substance use among mothers is doubly deviant in that it violates both gendered expectations (that women should be polite, accommodating; Meyers et al., 2021a) and parenting expectations (that mothers should be self-sacrificing; DeGroot & Vik, 2021; Moorthi, 2010; Placek, 2024). As a result, women who use substances are often considered a "hidden population" in both treatment and research, limiting their access to recovery resources and research participation (Placek et al. 2021). Given these barriers and the rising rates of substance misuse, there is a pressing need to understand how sociocultural factors shape women's resilience as they navigate recovery. The current study is designed to explore perceptions of resilience among mothers who misuse substances through the lens of sociocultural ecology.

As mothers embark on their recovery journey, interactions with family, peers, and frontline workers to whom they disclose their status can shape their experiences and ability to sustain recovery (Placek, 2024; Stone, 2015). For example, a study conducted by Stone (2015) found that pregnant women isolate themselves and avoid treatment to reduce the risk of being caught by health or criminal justice authorities. Fears of intervention by child services also present a significant barrier to seeking treatment for substance use (Wolfson et al., 2021),

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particularly among women from marginalized groups who have been historically targeted for criminalized drug use (Boyd, 2019). Stigma following child removal, from intimate partners, family members, friends, peers, and child/social service workers, results in further social isolation and poor health (e.g., escalation of substance use; Kenny & Barrington, 2018). These studies, among others, point to the looming role of community and institutional harm against women, and mothers in particular, who use drugs, which can have adverse impacts on health-seeking behaviors and maternal health outcomes (McCartin et al., 2022; Stone, 2015; Weber et al., 2021).

While research is growing on how sociocultural factors, such as stigma, create barriers to seeking treatment, less attention has been paid to how sociocultural factors influence resilience in recovery (Rudzinski et al., 2017) or how institutions and communities can create resilient spaces to better serve vulnerable populations. Rather, resilience and recovery are typically framed as internal and individual processes, within frameworks such as adaptability for resilience (Tomko et al., 2022) and abstinence for recovery (White, 2007). These frameworks, however, overlook the complex interplay between individuals and their broader social and cultural environments. For example, while trauma is a factor in substance misuse for all genders, women's trajectories in addiction and recovery are known to have a central relational component (Covington, 2012; Whitehead et al., 2023, We are With You, 2021). Thus it follows that individual or pathological approaches to substance misuse research, treatment and recovery that are lacking understanding of the self as relational, situated and intersectional, may be derisory for women (Vera-Gray, 2020).

Understanding this sociocultural ecology and its impact on recovery, through a transdisciplinary lens, will broaden the understanding of resilience. To understand the multi-layered social and cultural influences acting on our target populations, we incorporate models from psychology, evolutionary anthropology, and public health. This transdisciplinary approach enables us to conceptualize not only distinct layers of influence on mother's recovery journeys (e.g., individual traits like gender/sex, interpersonal traits like relationship status, community traits like recovery groups, and broader cultural traits like norms and stigma) but the interrelationships between these layers (e.g., the transmission of cultural norms through interpersonal relationships). Furthermore, applying this approach can enhance the cultural competence of investigators and treatment providers working with people recovering from substance misuse (Placek & Wies, under review). Through our application of a sociocultural ecological framework, we will not only describe perceptions of resilience among mothers who misuse substances, but we will also explore how our participants navigate complex sociocultural environments consisting of both factors that enhance resilience and those that cause harm.

The sociocultural ecological framework applied in this study draws on Bronfenbrenner's ecological model (1977) and Stokols' social-ecological model (1996). Originally, these models were designed to provide a comprehensive understanding of the factors influencing health beyond individual characteristics and to promote a community-based framework for encouraging behavioral change (Bronfenbrenner, 1977; Stokols, 1996). These models categorize social-ecological factors across multiple levels, including individual, interpersonal, community, institutional, and environmental. The individual level includes personal factors like genetics, sex/gender, age, and education. The interpersonal level involves close relationships with friends, peers, and family. The community level covers factors like community services, the institutional level considers factors such as healthcare access, while the environmental or ecological level addresses the physical environment and how people interact with and are influenced by it (e.g., air/water quality, climate change).

We expand these models to include sociocultural dimensions from anthropology and psychology, acknowledging that recovery is shaped by dynamic interactions between individuals and broader social and cultural factors, such as norms and traditions, that are not captured in existing social-ecological models. The term "culture" consists of products of social learning, which is an adaptive process enabling the acquisition of complex cultural information (Flinn, 1997; Hewlett, 2004), including specific behaviors (e.g., techniques for gathering and preparing food), values (e.g., prescriptions about what is morally "good" or "bad"), knowledge and beliefs (e.g., the behaviours and traits that are considered normative). Because culture evolves and is socially transmitted through interactions with others, the inclusion of a sociocultural level of analysis in our model permits us to capture recovery-related processes that transect the different levels of the social-ecological model. Including social learning is critical because humans' use of synthetic drugs presents a novel evolutionary challenge for *Homo sapiens*. While humans have co-evolved with psychotropic plants (Sullivan & Hagen, 2002), modern synthetic substances are highly potent and often lack natural warning cues, such as bitterness, that signal harm. This mismatch between human evolutionary adaptations and contemporary drug environments impairs individuals' ability to assess risk based on sensory cues alone (Placek, 2024). As a result, people must rely on social learning and connections with others to navigate substance use and recovery, acquiring knowledge from peers and experts about safe consumption, overdose response, and dependence management.

Specifically, our model captures how people learn social norms about recovery through multiple mechanisms of cultural transmission, all of which interact with the interpersonal, community, and institutional levels. For example, pregnant women who misuse drugs and experience stigma from providers at healthcare institutions are socially learning that their behavior is deviant at an institutional level. Similarly, these norms that substance use is problematic and women are "bad mothers" might be reinforced by family members and peers on an interpersonal level.

Through our expansion of the ecological (Bronfenbrenner, 1977) social-ecological (Stokols, 1996) models to include sociocultural factors, we will henceforth use the term "sociocultural ecology" to capture the contributions of scholars from these different schools of thought to better understand how mothers navigate their unique environments and relationships to build resilience in recovery. Resilience, therefore, is not only an individual trait but also a protective factor shaped by a supportive or adverse sociocultural context that is dynamic and recursive (Moriarty et al., 2011; Cadet, 2016).

2. Study populations

This study took place in two regions of England: the Northeast, including Newcastle upon Tyne and Durham, and Greater London. Given our emphasis on the sociocultural factors that contribute to harm and resilience in recovery, it was important to use a sampling procedure to capture recovery experiences in regions where institutional and community resources are likely to differ. By recruiting participants in both the southern and northern regions of the UK, we can capture the unique challenges and supportive recovery mechanisms in areas that differ dramatically as a function of income (compared to other English regions, the highest proportions of economically deprived households are in the Northeast; (ONS, 2021a), health (the Northeast has the lowest proportion of people reporting that their health is "very good", while London has seen the largest increase in the proportion of individuals reporting "very good" health between the 2011 and 2021 census; ONS, 2021b), employment (a recent labour market survey shows the largest increase in employment rates has been in London, while unemployment rates remain high in the Midlands and the North; ONS, 2024), and drug use and related outcomes (London has some of the highest rates of crack use, the Northwest and Northeast have some of the highest rates of heroin use, the rate of drug-use-related deaths is almost three times higher in the Northeast than in London; Black, 2020).

Nationally, rates of substance misuse in the UK have fluctuated over the last decade (ONS, 2023) with trends influenced largely by social and economic context (Cunningham & Saleh, 2024). National statistics show

that 27% of women either lived with a child or were already parents when they began treatment, compared to 16% of men. However, this number is likely underreported, as many individuals may hesitate to disclose their parenting status due to fears of child services involvement and potential child removal. Removing children from their biological parents' care is "one of the most extreme forms of state intervention into family life;" yet, "child removal cases in England have soared in the last decade," with particularly high increases in the Northeast of England (Van Zyl et al., 2022b). As of March 2023, the Northeast had 113 children per 10,000 in the care system, 1.6 times the national average of 71 per 10,000. Indeed, research highlights that fear of social services involvement and child removal is a major concern for women navigating addiction and recovery. For many, this fear leads to reluctance to seek recovery support or antenatal care during pregnancy (Simpson and McNulty, 2008).

Evidence increasingly highlights the lack of support for mothers struggling with substance misuse, particularly after child removal (Roy, 2023; Devaney et al., 2024). Authorities have faced challenges integrating and sustaining services for parents with complex needs. Although therapeutic support is available, individuals who relapse into substance misuse, often triggered by trauma or grief, may no longer meet the eligibility criteria for such services. This fluctuation in eligibility can lead to disruptions in care and makes consistent, integrated support difficult to maintain (Van Zyl et al., 2022b). Similarly, post-adoption services for birth parents are inconsistent, with therapy being the least frequently offered service (Sellick, 2007a). Recovery services specifically designed for parents remain limited, often due to challenges in documenting outcomes and securing long-term funding (Sellick, 2007b). Mothers have also reported a lack of awareness regarding available treatment options and services (Morkan, 2023). A South London study highlights that substance use treatment services "are not designed to support mothers to retain the care of their children" (Canfield et al., 2023). As a result, research suggests that many parents feel unsupported by existing services (Siverns & Morgan, 2021), and in some cases, engagement with welfare systems can be traumatic, hindering rather than aiding their recovery (Memarnia et al., 2015).

While research on the challenges of women who misuse substances is limited in London, the narratives of mothers in the Northeast tells of childhood and teenage trauma and abuse, often leading their journeys into addiction; state intervention into their adult lives upon becoming pregnant and having children; and then state collusion with violence and harm that they have been subjected to (Van Zyl et al., 2022b; Robson, 2024). Several Northeast studies suggest that health and social care professionals deem mothers who misuse substances as unworthy of support. In pregnancy, these women report experiencing negative stereotyping which coupled with the stigma of substance misuse is the "biggest barrier to care" (Smiles et al., 2022, p. 107; Van Zyl et al., 2022b). The emphasis upon risk to the unborn child and scrutiny is understood to override the need for supporting the mother and child as a unit (Van Zyl et al., 2022a and b; Smiles et al., 2022). Fearing reprisals, judgements, and punitive repercussions, mothers frequently hide problems and remain in dangerous or risky situations rather than seeking support (Van Zyl et al., 2022a). These trends are replicated in national studies in the UK (e.g. Agenda, 2020; Page et al., 2024; Whitehead et al., 2023). One UK-wide study highlights that even when women progress well in recovery from maternal substance use, they report loss of custody of their children, ongoing "experiences of family violence" and "untreated emotional/mental health problems" (Andersson et al., 2021).

This summary illustrates how the challenges faced by mothers who misuse substances are compounded by the trauma of child removal, yet at a time of acute mental health crisis, they often fall through service gaps, lacking essential support (Broadhurst & Mason, 2013; Grant et al., 2023). In the UK, there is a critical need for integrated structural frameworks at both institutional and community levels that prioritize the welfare of mothers, as doing so may also benefit their children. Given these regional trends in substance use and barriers in accessing treatment across the UK, we sought to explore how women's experiences with recovery compare in the Northeast and Greater London.

3. Methods

This exploratory qualitative study was part of a larger Fulbright-funded project on motherhood, drug addiction, and recovery. The research was conducted from January 2024 to March 2024 with mothers aged 18 and older who self-identified as receiving recovery services in Greater London (n = 10) and Northeast England (n = 14). Recovery services were defined as outpatient community groups (e.g., Alcoholics Anonymous), day-treatment centres, residential programs, and grassroots women's recovery groups. Recruitment strategies included contacting recovery service programs and asking them to share information about the study with eligible participants and posting electronic flyers on social media outlets. Ethics approval was obtained from Ball State University's Institutional Review Board (#2068016-3) and from the College of Health, Medicine, and Life Sciences Research Ethics Committee at Brunel University (#45852).

The first author (C.P.) obtained permission from recovery centres by meeting with key stakeholders and directors prior to recruiting participants. C.P. described the nature and purpose of the study, then the key informants announced the study to eligible women and also introduced C.P. as a visiting researcher aiming to learn more about recovery programs in the region. Snowball sampling was incorporated into the study, as participants often knew other eligible women and shared study details with them after completing their interviews. Participants were asked to engage in a one-on-one in-depth interview that lasted 20 min to an hour. Interviews were conducted either on the phone, virtually, or in person, depending on the individual's preference. Questions included demographic information and open-ended questions about their perceptions of (i.e., experiences of those in your community) or direct experiences with aspects of substance use and recovery, such as, "In your opinion, what are the major challenges mothers with a substance use disorder in your city (or country) face in terms of seeking treatment and sustaining recovery?" and "In your opinion, do treatment services you receive create any barriers to recovery for mothers or for yourself? Can you give an example where a barrier(s) prevented you or another mother from recovering? Do you think having children contributed to the barrier?"

In addition, participants were asked to describe their pathways to addiction and subsequent recovery and to reflect on the barriers and facilitators to recovery for women in the community. This method, combined with participant observation - a core anthropological approach involving 'deep hanging out' - was used to examine the role of sociocultural factors in shaping resilience in recovery and was well suited for understanding relational recovery given its inherently relational nature. The first author attended recovery events for women, including day treatment services and a weekly recovery group. In addition, there were many opportunities for informal interactions that helped facilitate the development of rapport. For example, C.P. spent time with S.R., an advocate for the recovery community, which provided an opportunity to informally learn about the gender dynamics of recovery and the specific challenges women encounter in accessing care.

4. Analysis

Qualitative data were coded using an abductive technique with two coders per transcript. First, data were coded around the themes of harm and resilience and labeled according to an appropriate level from the social-ecological model, which included the interpersonal, community, institutional, and environmental levels (this study did not derive any findings at the environmental level, and analyses did not focus on the individual level). Note that sociocultural themes were tagged throughout the coding process and will be reported within each level of the traditional social-ecological framework (interpersonal, community,

and institutional levels). For example, statements centered on stigma against mothers were first labeled as "stigma against mothers who use drugs" and were then placed in the appropriate deductive level, which in this case, the code was always "community-level harm" and was further tagged as sociocultural (i.e., stigma is a product of culture). The two coders independently coded the data and then met to find agreement for the first three transcripts. The first author (CP) completed the consensus for the remaining transcripts and recorded the occurrences of each theme per participant in an Excel document to help visualize the salient themes emerging across participants and within each site. Fig. 1 provides an example of this approach.

5. Results

5.1. Summary statistics

In London, the average age of women was 42.1 (range = 35 to 52). Seven participants were White British, one was South African, and one was Irish and Nigerian. The average number of children was 2.1 (range = 0 to 5), with one participant reporting no children. None of the participants were pregnant at the time of the study. Regarding education level, nine women had completed Upper Secondary Education, two completed a Professional Diploma, one completed a Master's Degree, and one reported no formal educational training.

In the Northeast, the average age of women was 38.9 (range = 22 to 50). Thirteen participants were White British and one was White Scottish. The average number of children was 2.8 (range = 1 to 6). None of the participants were pregnant at the time of the study. In terms of education, four women had completed Upper Secondary Education, three held a Professional Diploma, one had earned a Master's Degree, one reported having no formal education, and data was missing for one participant.

5.2. Greater London

In London, C.P. attended day treatment services at one center and conducted interviews with three women in residential care for homelessness and substance misuse at another center. The remaining interviews took place on the phone through a referral network with Alcoholics Anonymous. In the in-person settings, C.P. observed services for women, such as mindfulness therapy and self-defense classes, and witnessed informal conversations about recovery which aligned with the themes that emerged from the formal interviews, which included 70 themes focused on harm and resilience across interpersonal, community, and institutional levels. Community-level themes of harm and resilience were the most frequently coded levels of the social-ecological model, with 18 themes of community harm and 15 themes of community resilience. There were 20 themes of institutional harms and 4 themes of institutional resilience. Interpersonal themes of harm and resilience were the least frequently coded, with 6 instances of harm and 7 instances of resilience.

5.3. Interpersonal level

For interpersonal harm, *intimate partner violence (IPV)* was the most frequently mentioned interpersonal-level theme, and *strained family relationships* was also frequently mentioned. IPV included emotional, physical, and financial abuse. One participant, Charlotte, had a history of abusive partners. While she was trying to navigate recovery, her abusive partner became controlling about her ability to attend Alcoholics Anonymous meetings. She said:

> "I was with another boyfriend or partner at this point, who, luckily, I didn't marry, but I was now living with, that was very controlling and jealous and didn't like me going to these meetings, and he wasn't involved. He was annoyed at me for going, and also didn't think that I needed it. He didn't understand addiction at all because he never saw how bad I was. I hid so much from him. I don't think he understood the seriousness of it. He didn't get it. I just wanted to please him. He managed to convince me [that she didn't need to engage with 12-step recovery services]. It's not his fault. I don't think anybody could have convinced me because I wasn't fully accepting of the fact that I wasn't going to be able to drink like a normal person."

For another participant, Olivia, being in recovery helped her learn that she had been in a physically and emotionally abusive relationship that had impeded her recovery. She stated,

> "We've been together for 19 years, and when I got clean and sober, I realized that it was a toxic relationship and that he'd been emotionally and physically abusing me for the majority of that relationship. I honestly believed during those 19 years that I deserved the treatment that he was giving me, that it was all part of my drinking, that it was all my fault."

For participants who mentioned experiencing IPV, it was always perceived to play a role in their addiction and recovery journeys. Emma

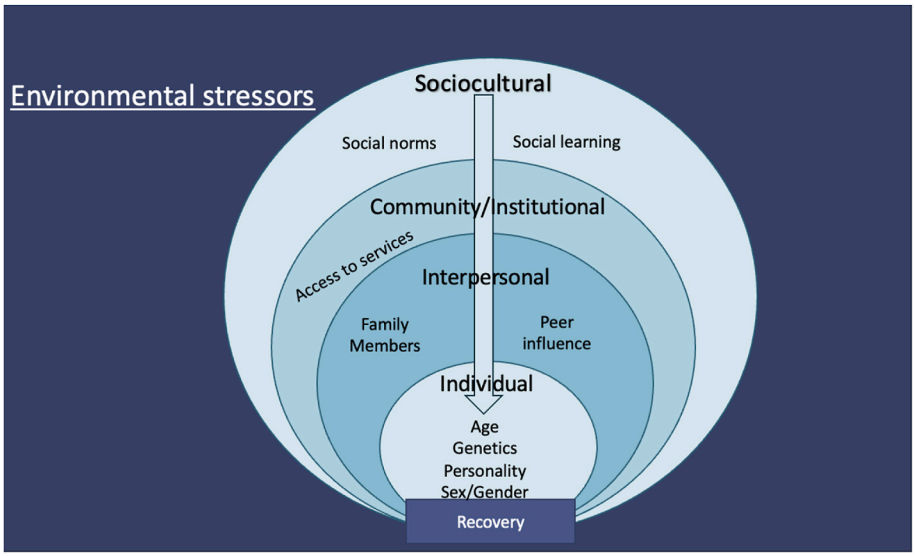

Fig. 1. The combined social-ecological model with the inclusion of the sociocultural level. The arrow represents the sociocultural level's influence on other levels.

describes entering an abusive relationship as part of a pattern in her life where she was "spiraling out of control," this included housing instability (being kicked out of hostels due to substance misuse), an increased frequency of substance use (eventually daily use), and an increased intensity of withdrawal symptoms. To see how violence and abuse can escalate this "spiral," Amelia explains that "When I had my second child … I fell into a domestic violence relationship with that father, and we had to flee … that's when my addiction started …" Our participants' narrative descriptions of IPV clarified that this often acted as a barrier to recovery through several pathways, including encouraging distance from recovery services and escalating substance misuse to manage psychological and emotional distress.

While intimate relationships were frequently mentioned as a source of harm in individual recovery journeys, they were also mentioned in the context of resilience in recovery. For Olivia, gaining resilience through recovery helped her leave an abusive relationship. Specifically, participants mentioned several examples of interpersonal-level themes that helped them build resilience. Interpersonal-level examples of resilience were *social connection*, *family* support, and *romantic relationship*. The theme, *social connection*, was identified in 8 of the 10 transcripts. Participants relied on social connections to help them advocate for themselves. According to Sophia, her friend advocated for her at the hospital while she was in active withdrawal:

> "I phoned my psychologist and she was like, 'You need to stop taking the benzos,' but no one told me that you could die from benzo withdrawal if you'd been on them for that long. Then I just stopped them cold turkey. Then that night, I was in the hospital. I was in the hospital for a week, and then eventually, my friend came and she told the nurse, 'You have to give her some benzos because she's going through withdrawal. That's what's wrong. She doesn't have morning sickness. She's withdrawing from these benzos. You've just made her go cold turkey of all the stuff.'"

In this example, the presence of a social connection helped Sophia get the services she needed to help her through withdrawal. During informal conversations and the formal interviews, many participants and others in recovery talked about connection being the opposite of addiction. Addiction was frequently described as a socially isolating experience (when asked what triggers her experience of relapse, Mia responds "isolation, loneliness, just lack of support"), while recovery processes were described as relational (when considering others struggling with addiction, Emma advised "Get connected. If anything comes out [of this research], encourage people to get connected."). Amelia, a 43-year-old mother of three, affirms this sentiment: "I found, for me, the opposite of addiction is connection. Rather than being so isolated and stuck in it, I need to be around others who are trying to get well as well. I find that inspiring." For most of our participants, resilience in recovery was built through social connection.

Family support was also mentioned across participants as a factor that aided in their recovery and helped them build resilience. When asked to describe what got her into recovery, Emma emphasizes the role that her family played: "I started thinking, 'Is this me for the rest of my life? It'll kill me.' … I just cried to my mum and my cousin. I was like, 'I need some help.'"At the end of the interview with Amelia, the interviewer asked if there is anything she wanted others to know that was not asked during the interview. Amelia replied,

> "Just how important family support is throughout all of this. I think without some support from my … nephew, I don't think I'd be where I'm at today because I think the one thing it [addiction] does is it ruins relationships in a lot of aspects but particularly family ones. I think the family just gave up on me … they didn't think I could get sober and I think for them it was too painful to watch it happen, and so for … their emotional well-being they need to step back and dissociate from me."

Here, we can see that addiction often causes strain, conflict, and distance in family relationships. But, and perhaps because of these common experiences of familial strife, family support is positioned as an important contributor to resilience. To illustrate this push-and-pull relationship, Isabella describes a letter her daughter wrote for her to read during a 12-step meeting: "… They're [her children] very much involved in my recovery … She [her daughter] wrote me a letter and she said, 'Mummy, when you get to your meeting, I want you to read this out.' … It says ' … I used to drink too much and I started coming to meetings because my children were really scared of me … Now my children … love me very much, and [they] aren't scared of me.'" Addiction is described as creating distance and fear in her family relationships and (critically) these family relationships are positioned as not only a key beneficiary of recovery but a key source of resilience in recovery.

Similarly, *romantic relationships* also played an important role in building resilience. Charlotte's boyfriend helped her take the first steps toward recovery. Here is what she shared about this experience:

> "My boyfriend had noticed that I had to drink every evening and got really annoyed at him if he had said maybe I shouldn't. He had raised a couple of times that he thinks I had a problem, and he didn't know about all the day drinking, so he had a point. Just the fact that he thought that I had a problem with what he could see, what I was allowing him to see, made me go, 'Yes.' I was scared. I was getting scared."

We can see that the relationship between romantic connections and recovery is complex and nuanced - such that romantic relationships can be a key source of harm and resilience. Isabella describes her entry into recovery at her partner's insistence: "I was married at the time [that she started her recovery journey] and my husband said to me that I need to stop drinking. I went to an AA meeting because he wanted me to." For some of our participants, romantic relationships were a source of resilience through their relationship to an individuals' motivation to manage their substance misuse ("I … told [my psychiatrist] I needed to go to rehab. I actually went to try to save my relationship at the time.", Sophia).

5.4. Community level

The most frequently coded community-level harm was *stigma against mothers who use drugs* and *internalized community stigma*. Other noteworthy themes were *gender stereotypes*, *experienced/enacted community stigma,* and *maternal instinct should be stronger than addiction.* All of these themes were tagged as sociocultural, given the evidence of cultural scripts in participants' responses regarding what is normative and what is norm-violating (and thus stigmatized).

Stigma against mothers who use drugs was mentioned by seven of ten participants. This culturally transmitted stigma experienced as a mother often prevented women from seeking treatment and caused them to second-guess their ability to mother their children. Olivia, a 41-year-old mother of three, had this to say about the stigma of being a mother who misuses substances:

> "For me, I couldn't hear that, I couldn't accept that because being told that I was an alcoholic made me a bad mother. That label immediately conjures up images of social services being involved, hiding alcohol around the house, being unable to look after your children, when in fact, I was able to look after my children. I was able to do all these different things, so I couldn't accept that label of being an alcoholic."

Ava, a 51-year-old mother with two children, echoed the sentiments about stigma and motherhood in that children should be removed, but also highlighted that men are often not given the same treatment:

> "They'll [people in your community] treat you bad, they'll let you down, they think you can't take care of your kids. Sometimes they'll

take them away from you, even though the man might be there as well doing the same thing [using substances]. [He] might be beating you up, justifying it … There might be traps all there with no one … no family, just got a man there, just an idiot man. Then it's just you there, it's just you who will get the most of the blame for everything."

For our participants, the high expectations associated with mothering (" … We should be able to maintain a household, have a job, still be attractive … look after our children as well", Oliva) were understood as incompatible with addiction. That is, addiction and cultural norms of 'good mothering' were perceived to have an antithetical relationship. When asked what people in her community think makes a 'bad' mother, Charlotte describes this failure to meet unreasonable standards " … If you don't make them into well-behaved children … if you don't provide them with the right food … if you go to McDonald's … if you're not giving them enough attention … if you give them too much screen time …" It is clear that Charlotte sees these cultural standards as not only unreasonable but unachievable ("You're damned if you do and damned if you don't"), and these standards are responsible (at least in part) for the stigma against mothers who use drugs and alcohol: "They're [people in her community] disgusted that anybody could choose a substance over caring for their child … " We can also see this illustrated in Evelyn's description of *internalized community stigma*: "I did put my son in some very dangerous situations … Then … I'd cuddle onto him so tight because he was just so precious and so innocent. I just wanted to take all of that goodness out of him because I was such a bad person. That's how I thought of myself, and I knew that I was letting him down." Overall, participants' narratives described connections between unrealistic (and gendered) parenting expectations, community stigma against mothers who use drugs, and internalized stigma.

Within community resilience, the most frequently mentioned themes were *AA/NA meetings help with recovery* and *Shared understanding/Lived Experience*. These two themes often overlapped, as AA/NA meetings provided a space where mothers could connect with others who had similar life experiences and histories of addiction. For example, C.P. attended an AA event and observed the camaraderie that many participants described as central to their recovery. When asked to describe her experiences in AA, Sophia highlights the role of *shared understanding*, a form of social learning, in building resilience in recovery: "There's this thing of just relating … These people understand me and they love me. I'm not weird and different." For Sophia, connections in the 12-step community with others who share mothering experiences were particularly critical: "… Speaking to another woman who is in recovery about mothering, I find it's very different to speaking to my non-recovery mum … these women [in the AA community] have given me the … mum that I'm never going to have." Across our participants, social connections to those with similar life experiences supported resilience through perceived acceptance and lack of judgment ("… There's someone who probably has … done worse or done the same as you … there's no judgment", Sophia; " … Someone else has been through what you're going through and … [when they] put their hand on your shoulder, or give you a hug, [it] can change anything", Olivia). While these connections are an important source of resilience in recovery, they aren't a 'magic pill'; Amelia talked about how the fellowship meetings helped her, but it was not an immediate change:

"I think the fellowships have been really fundamental because I used to go to meetings, but I would use after. I wasn't ready, I don't think, to really give up drugs. I had become so dependent on them as a solution to trauma, and discomfort, and pain. I didn't really think sobriety was possible for me until I really gave it a go. Until I started doing some step work, actually, that's when I noticed change, change in my thinking and gave me the confidence to carry on."

Other noteworthy community-level themes of resilience were the ability to *bring children to meetings*, *telehealth,* and *access to social activities*. *Bring children to meetings* and *telehealth* were positioned as important aspects of resilience in recovery as they both increase accessibility of services, particularly for those with caregiving responsibilities. When discussing the inclusion of children in AA meetings, Olivia explains that " … For women, the problem is that if you can't take your children somewhere with you, then you can't get that …. help that you need." When asked to reflect on the resources that might help mothers with addiction in her community, Evelyn described ways to make AA meetings more accessible. She reflects on her own struggles to access recovery services ("When [her son] was younger, I did struggle to get to the meetings … there was no such thing as Zoom meetings") and how things are beginning to improve ("… Now it's a lot more accessible. There are meetings that I go to, and I see mothers, and they will bring their babies in, and they are just as welcome … now there are many Zoom meetings available … there's always a meeting that you can get to now, which I think is fantastic for mothers.").

5.5. Institutional level

For institutional harm, the most salient themes were *child removal, lack of access to recovery services*, and *lack of access to recovery services as a mother*. Other noteworthy themes were *cost of services*, *lack of support from providers,* and *addictive prescription drugs in recovery*. *Child removal* was a core theme that influenced substance use and the motivation to seek treatment. When asked to describe things that could be done on a local (London) or national (UK) level to support mothers with addiction, Charlotte explained fear of child removal as a critical obstacle for women who might benefit from recovery services. According to Charlotte, "… There's an awful lot of mums that are struggling with addiction. They're terrified … [to] speak up, that they need help. I'm talking about the mums before it gets to the point where it's dangerous. They're too scared." When reflecting on her own experiences, Charlotte can see how fear of child removal prevented her from accessing institutional support for her substance use before it escalated: "There's absolutely no way I would have said to anybody in a professional world, a doctor or anybody, that I was scared about the amount I'm drinking and that I need help, for fear of them taking the children away." Ava characterizes this fear of child removal as a consequence for 'trapped' women, explaining that " … They've got no one to take the baby, so the baby goes into care."

For some mothers, the interception of child services created harm. Kya's children were taken away, and shortly thereafter, she went to prison. After being asked if she tried to seek treatment for heroin and crack use when she was pregnant, she stated, "Yes … social services were horrible and they made it worse. There was no support there at all. It was just horrible." In addition to the lived experience of child services, the fear of children being placed in another home scared mothers, but oftentimes they did not know where to go for help. This is highlighted by Amelia's situation, who said: "The thing is, even the threat of them taking the kids away, it was actually the weight of the world on my shoulders because I wanted to get sober, but I just didn't know how." Later on in the interview, she elaborated:

"I think it was a catch-22 because I remember them saying, 'Look, we're going to drug test you and have weekly drug tests.' When they did those drug tests, each of them were coming up positive, and so I was saying to them, 'Look, I really want help stopping this. I really want help to stop.' I just couldn't stop. I physically couldn't even though I knew the threat … I'd say, as a parent, I felt more guilt around- I felt that I couldn't stop, and I felt the huge pressure knowing that I needed to stop otherwise they'd remove them."

Many mothers described a *lack of access to recovery services* as a key source of harm. When asked to list institutionalized sources of recovery care in the Greater London area, Olivia explained that "where I've been to the medical centres in the area, to any council office or council area, there is absolutely nothing because I was told … [that] the NHS doesn't support AA … AA, NA, or any other support group can't actually post

any information [in clinics or healthcare centres].” Amelia echoes this description of limited recovery resources, explaining that many resources are inaccessible unless your case is considered to be particularly severe: “You only get access to [social services substance misuse team] if you’re in dire straits … You have to be at a certain level of concern. Otherwise, you don’t qualify for support from the local authorities … you … have to be threatening to take your own life … " Access concerns were also described in the context of institutional failures to signpost recovery services, as Sophia describes “People don’t know enough about 12-step programs. Even doctors don’t really know about them or nurses.” Other access concerns described the unique obstacles mothers face due to childcare responsibilities (“ … [for] an outpatient program, it’s like, ’So, when do you do it?’ If your kid’s at school and you’re working … when do you go … what if you have no one to look after the kids?”, Sophia) and limited accessibility of institutionalized (rather than community-level care) due to cost (“… Accessing the finances to go to treatment in the UK [is] really difficult … because private healthcare … is expensive”, Sophia; “I’ve done so many detoxes … paid thousands of pounds …”, Mia).

In some cases, child services involvement was beneficial for mothers, but this was rare because according to our findings, there were only four themes representing institutional resilience, and none of them were mentioned more than once or twice, meaning that they had low frequency. Themes included *child services, access to housing, medication for substance use disorders*, and *therapy*. For example, Ava describes institutional support that provided access to housing as a key source of resilience for her, explaining that "[she’s] doing quite well now [that she has stable housing] … I’ve put on weight … I’m going back [home] tonight … I’ll … look after myself.” As another example, Charlotte describes positive experiences with a counselor that helped her to process childhood trauma: “Growing up, it [alcohol] was just there all the time … I just learned, really, that is what being an adult is. To be an adult, you drink.” … " … I started drinking when I was about 12 … because home wasn’t safe anymore.” She describes her therapist as “great” and that her applications of cognitive behavioural therapy helped to process “[what] happened to me when I was a child.”. Regarding child services, Isabella had an experience with child services that motivated her to seek help:

> “I actually contacted social services because I wanted some involvement. I needed some help with [my son’s] behavior, never once thinking that his behavior was down to his home life or what I was doing. The woman from social services, she got in touch and she spoke to my son, Josh, and spoke to me. She said, ‘You know that Josh had said that you’re an alcoholic?’ … I always put it down to his behavior and how he was. Honestly, it took that, me getting in touch with social services, and her turning around and saying that to me, for me to actually sit there and finally realize, ‘I think he might be right.’”

5.6. Northeast

In the northeast, C.P. partnered with S.R. who introduced her to participants and community partners. Together, they attended residential and day treatment programs. The informal conversations C.P. had with women overlapped with the themes from the formal interviews, which included 59 themes across interpersonal, community, institutional, and structural levels for harm and resilience. There were 27 themes for community harm and resilience, with 17 themes for harm and 10 for resilience. There were 20 themes for institutional harm and resilience, with 14 themes of harm and 6 themes of resilience. There were 11 themes for interpersonal harm and resilience, with 6 harms and 5 examples of resilience. Participants mentioned one structural harm.

5.7. Interpersonal level

For interpersonal harm, *intimate partner violence* was the most salient, and *death of a close one, strained family relationships, romantic partner negative influence,* and *unsupportive partner* were also noteworthy. At this level of analysis, we can see that romantic relationships are perceived to play a critical role in shaping patterns of substance misuse and in acting as a barrier to recovery. Within the theme *intimate partner violence*, we see that mothers often describe using substances to manage the stress of their abuse, which included physical and emotional abuse (“[my partner] used to make comments like, ‘No one else will ever have you. You’re damaged goods’.” [Lily]) sexual violence, and coercive control (“… Telling us what to wear, who to be with … felt like he was protecting us when it was just pure control” [Isla]). The themes *romantic partner negative influence* and *unsupportive partner* describe another path through which romantic relationships influence addiction and recovery, specifically by modeling and normalizing substance misuse and by discouraging their partners from engaging with recovery resources.

When describing her pathway to addiction, Aria reflects on the role that IPV played in increasing her risk for developing patterns of substance misuse throughout her life:

> “For me, I started using drugs from a very young age. My first substance was alcohol at the age of nine … because of what I had going on at home … I witnessed a lot of domestic violence between my mam and my dad … seeing the domestic violence, I then became a victim of domestic violence which went on for a long time and I believe I used the drugs and the alcohol … because I knew it took us away from all that, it took us out of myself it made us feel good about myself … and it just progressed.”

Later, Aria describes her relapse after two years of recovery: “I relapsed on alcohol. I got into a relationship and he was using and obviously I ended up using with him. I’m just starting my journey all over again. He’s in prison now, so I got myself back on track” … “I was just about to start volunteering [during the 2 year period of recovery] for the police. Life was good and then he came out of jail and it just went tits up and I lost everything again within four months.” Similarly, Lily describes her experiences of escalating substance misuse (including combining substances) as a function or consequence of her intimate relationship: “The guy who I was in a relationship with was in recovery as well, but he was never honestly in recovery. His behaviors were not healthy. He was a bit of a fraud, basically. He was abusing prescription medication whilst saying to fellowship that he was working this 12-step program. There’s another case of ‘seems lovely on the outside’, but on the inside, that turned into a very controlling, manipulating, abusive relationship where he relapsed on alcohol … I’m codependent and because the fear inside of me was like, “Oh my God, I don’t like how he’s reacting now he’s under the influence, I’ve got to join him.” I’ve got to do the same. Because of the fear inside of me, I thought, “Well, if I’m on that same level, I won’t be as scared of what he would do to me.” That led to a three-month relapse on alcohol, crack cocaine, and heroin.” These women illustrate a common pattern across participants’ narratives: that romantic relationships shaped addiction and recovery pathways by creating pain and trauma that needed to be relieved or escaped, and by modeling the use of substances to manage that pain.

On an interpersonal level, intimate relationships are a key force of harm in women’s recovery journeys. Women in our sample experience this as a complex combination of their partners normalizing substance misuse (“My partner … was on drugs. We ended up on the crack together and things just spiraled out of control” [Ivy]) or modeling (“He wanted to buy drugs, I wanted to buy a drink. I ended up buying drugs and that was my introduction to drugs” [Grace]), their partners’ overtly discouraging them from accessing recovery services (“He didn’t want me to get help. Every time I tried to leave the house, he would lock the doors.” [Evie]), and their partners’ abuse creating pain that was managed with substances (“The more I was suffering, the more I would use” [Ella]).

Through interviews and time spent with mothers in recovery, it was clear that our participants’ trajectories into addiction were defined by

social isolation. For some, violence and abuse in intimate relationships led to disconnection ("I wasn't allowed to speak to any of my family, so I couldn't reach out for any help …" [Evie]). For others, loss ("… I felt like a burden to my family … my brother was on drugs so my mam was all up in the air … then I just lost my brother … to drugs." [Ivy]) and/or strained family relationships ("Me and my sister don't speak. She … despises us. My relationship with my mother has really suffered." [Millie]) led to disconnection. When asked to describe what she thinks causes addiction, Isla describes this relationship between isolation and addiction, and recovery and social connection, particularly well: "I had just lack of connection from being born. I sometimes say I felt like I was just dropped into this world and I've just done it alone … what [I'm] doing [in recovery] is connection. It's key in my life."

5.8. Community level

The following themes were prominent for community-level harm: *stigma against mothers who use drugs, internalized community stigma, maternal instinct should be stronger than addiction, unrealistic mothering expectations.* Again, all of these themes were tagged as sociocultural, as they reflect cultural scripts about what meets and fails to meet expectations (particularly gendered and mothering expectations) in their given community. Other noteworthy themes that were mentioned less frequently included: *accessibility of drugs in community, experienced/enacted community stigma* [sociocultural]*, gender stereotypes* [sociocultural]*, lack of awareness of recovery options,* and *sexual violence*.

For *stigma against mothers who use drugs,* our participants were in agreement that mothers who use and misuse substances are perceived as "bad people" [Hannah], "like scum" [Zara], and "unfit … shouldn't have kids" [Annabeth]. This stigma is often directly experienced, with participants sharing that they are "very judged" [Grace], "I felt ostracized … there was no support" [Lily], and even being "shamed and spat on" [Isla]. Furthermore, Hannah claimed that the stigma against mothers who use drugs can last even after women have sought recovery: "It doesn't matter how long you've been clean for. They'll [community members] think that they're [mothers who use drugs] horrible people and they've done horrible things, but they're actually really nice people, genuine people, honest people, caring, loving." Stigma against mothers who use drugs also prevents women from seeking help. Ella stated, "That's why women don't reach out, they don't reach out. That's why I think a lot of women in addiction won't reach out. It's the fear of losing their children and being judged by society as a whole." She further emphasized, "Women with addiction or people that don't look after the kids properly … It's definitely a stigma attached to women in addiction. Definitely."

Our next theme was *internalized community stigma*. For this theme, we see the way that stigma and discrimination experienced in one's community changes the way women see themselves ("I hate myself when I'm in active addiction." [Aria]). Zara described the unique challenges that mothers face when navigating addiction and recovery, particularly being "stuck" because of the social (stigma, discrimination) and institutionalized (lack of adequate support services) harm, "… just parents feeling like a failure and just stuck, even more neglect with addiction. That's even if they're fortunate to still be alive. Well, not fortunate. I can't say 'fortunate' because it's a living hell, [you] just feel there's no way out." She elaborates further on the feeling of internalized stigma by describing her behavior as "I'd always walk about with my head down and never looked up. I think that was just a little bit of guilt and shame …" Similarly, Ella feels ongoing internalized stigma as a result of her substance use, "Oh, I feel massive guilt and shame, and I'm still to this day working on that. I don't think that will ever leave me because even in active addiction, I still used to torture myself about how shit of a person I was, how much of a bad mother I was, and how can I not be normal for my kids. That'll never leave me, but I've just got to learn to live with it." Women in our sample felt that this internalised stigma would persist throughout their recovery journeys; when asked about her perception of recovery, Hazel shared that "I don't think anyone could be fully recovered. That guilt is still stuck in your head."

The internalized stigma of addiction was partially shaped by the next theme, *maternal instinct should be stronger than addiction.* Ella summarized society's views of mothers with addiction: "I think as a woman in addiction, it's slightly worse for women than it is men because women should be seen to be looking after the children, going to work, making sure their home's okay … People's perceptions of women in addiction is totally different because they just say it … 'How come you can't stop for your children?' or, 'Why would you do that when you were a mother?'" She also describes her process of quitting substances when pregnant, which highlights the assumption that pregnancy should surpass the biological urge to use drugs: "[I quit] by myself. … I'd stopped and I don't know how I managed to do that, but something in my head told me that I shouldn't be doing that when I had another life inside of me. I could stop for then, but as soon as I had my children, I was straight back on it. Which, that doesn't make sense to me, because then I think, "Well, why? If I can stop then, why couldn't I stop after that?"

The next noteworthy theme was *unrealistic mothering expectations.* Several women talked about the pressures placed on women to be perfect; when these pressures didn't include explicit or implicit references to motherhood, it was coded within the theme *gender stereotypes (*e.g. "I just think women have got different traumas. We get a lot more stigma." [Isla]). According to Millie, "I think the same thing affects these women, that these women come in with these tropes and these ideas and these messages that have been fed into them, that if they'd be a successful woman, they need to be sober, positive mental health, perfect parents. Actually these women are presented to the world as young women, having had childhoods of abuse and neglect, and they haven't been taught these things. Then there's this expectation given to them because they turned 18, so they're healed now, and they'll have everything they need. It's completely insane." Millie also highlighted how the pressures placed on women to parent often prevent them from seeking help: "In fact, one rehab in Newcastle said that they don't get any women between October and January, because women just batten down the hatches and focus on Christmas for the children rather than getting well themselves …" Women in our sample agreed that some of the unique aspects of mothers' addiction and recovery journeys are attributable to unrealistic expectations for their parenting, particularly the prioritisation of children ("… society's view is the children come first" [Grace]; "… put the children before their own needs" [Zara]) even to the detriment of women's health and wellbeing ("It's really tricky for mothers to juggle everything and still focus on their recovery … when … the children need putting first … what option does a mother have?" [Grace]).

5.9. Community resilience

The following themes were frequently mentioned for community-level resilience: *AA/NA meetings help with recovery, shared understanding/lived experience,* and *women-only* support.

Attending AA/NA meetings was mentioned by several women as a supportive space for recovery. Attendance at meetings helped women work through the emotional aspect of their substance use disorder and helped them cope with their identity as "an addict." According to Aria, "The only thing that has helped me deal with the guilt and shame is my 12-step program. It's getting some acceptance that that is not me [the person in active addiction] because when I'm not using drugs, I can be a present mam … with the 12-step program comes the acceptance that …

it's the drugs that make you do what you do. You're not that person when you're not using drugs." Lily also said, "The only thing that's helped me cope and understand and learn about my disease of addiction is my 12-step fellowship of Narcotics Anonymous. I am an alcoholic, but I choose to describe myself as an addict who was addicted to alcohol." For her, AA/NA meetings were both a source of resilience and an act of resilience, especially her discipline and dedication to the program:

> "I've sat, done my written work, done what I've needed to do, gone to bed normally, got up. I never missed a group … There were days where I couldn't be bothered, days where I didn't feel like going, but I got up, I showed up. I showed up for my recovery, no one's going to show up for me, I am responsible for my own self. I am responsible for my own recovery, my own happiness, my own peace, my own program, my 12-step programme … This recovery has given me a new way of life."

This theme often overlapped with *shared/understanding/lived experience.* That is, AA/NA groups are particularly key contributors to resilience in recovery because acceptance is perceived to come from having shared understanding and similar experiences with fellows in the room. Aria talked about this overlap: "I like sharing in recovery. I can help other people … We give our experience away to a newcomer, and it makes us feel good about ourselves." Connecting through shared experiences gave many of our participants practical tools for their own recovery: "I've got a sponsor who's a woman who's nearly five years clean, who's lived experience gives me a bit of 'Well, I did it like this … if you want to do it like that and see how it works out.'" Sharing experiences and perspectives with others can be a powerful destigmatizing tool, as Annabeth describes: "They were [sharing] … Exactly what I was feeling because I was ashamed of some of the stuff [she'd done when in active addiction] … Thinking [about myself] 'You dirty cow, what have you done that for?' … When I was listening to them all, I was thinking, 'Bloody hell, it isn't just me' … If they can do it … I can certainly do it."

Shared understanding/lived experience was closely related with both *AA/NA meetings help with recovery* and with *women-only support.* Specifically, women in our sample were clear that AA/NA meetings helped with recovery because social support from others who share your experiences/perspectives is uniquely beneficial (e.g., accepting, destigmatizing), and as such women-only groups can be particularly pivotal to building resilience. When asked what was working well in her community for mams who misuse substances, Hazel shared that "… It's the [women-only] groups. All the mams come together and share their stories, and it makes you feel comfortable being a mam. It doesn't make you feel like you are the only mam who's been in addiction. I think it's just hearing other mams' stories, it really helps you." From her perspective, these groups offered acceptance ("They've all been through similar stuff but then no one judges.") and helped her gain confidence in recovery ("… Where there's mams in … the same place as me. We … share stories and then it gives us more confidence in becoming a good mam again." However, Aria mentioned that a reason for the community-level shared experience is because substance misuse was such a widespread problem, "In our community, somebody's got somebody that's affected by this. I think in that way it's getting better, but it's getting better because it's getting worse if that makes sense."

For *women-only support,* the Northeast was unique in that various women in the community had banded together to form networks of women-only support for recovery. The first author attended a women-only group and counted over 40 women in attendance. Lily commented on the size of the group: "The group's grown and grown … and it's become a safe space for women twice a week … There's structure, there's refreshments, there's dinners, there's professionals [that] come in and visitors [that] come in … there's a safe space." She went on to emphasize how important these women-only groups have been for her own recovery: "Women-only spaces, they've been massive for me. Talking to other women about lived experiences, motherhood, childhood, just … women things." Isla talked about how this group was formed during a time when there was no support for women. She said, "There was no groups. It was all male-dominated. We put in for funding to set up something for women, just a safe space for them to be because I truly believe that women recover differently from men." Given the unique challenges that women and mothers face in their lives (particularly in the context of addiction), including those unique challenges highlighted in our findings (e.g., *maternal instinct should be stronger than addiction, unrealistic mothering expectations, gender stereotypes*), it follows logically that communities can build resilience by speaking to these unique challenges. The transformative nature of these spaces designed to meet women and mothers needs specifically was highlighted by many of our participants. To illustrate, Isla shared that women coming together can be life-changing, "I just think when women come together, something powerful really happens. I'm getting emotional. I just think, yes. I think there's just power in women supporting women."

These community-level themes were important for building resilience because addiction was frequently described as a socially isolating experience ("… Never felt so alone … judged," Zara), while recovery processes were described as relational ("It's building up my relationships with women and letting my guard down," Zara).

5.10. Institutional level

The following themes were salient for Institutional harm: *child removal, avoiding services because of child removal, lack of access to recovery services for mothers, medication for substance misuse are ineffective,* and *stigma from social workers.* Other noteworthy themes were *gendered violence and men's involvement in recovery spaces,* and *inadequate addiction care from healthcare provider.*

Child removal was a key source of institutional harm in women's addiction and recovery journeys. For many, child removal was a catalyst for escalating substance misuse ("… my mum came … she took the children, and then I basically just had a breakdown and binge drank for … three days." [Millie]; "[child removal] made it 100 times worse to a point where I was drinking nearly every day." [Hazel]). The stress and trauma caused by child removal, when combined with a lack of therapeutic support in place for women in active addiction ("I didn't really have any support [following child removal]" [Grace]), led to significant negative health outcomes for women in our sample and women in their communities. When asked how she was affected by her children being removed by social services, Hazel shares that she "… Had really bad mental health after, once my daughter got took. I got diagnosed with anxiety and depression … my anxiety got really bad to a point where I couldn't leave the house because I was used to leaving the house with my daughter." For Annabeth, when social services removed her child from her care she started to self-harm to cope with the trauma of their separation: "I started on my legs … cut my legs instead, just so they couldn't see." Zara emphasizes that the health consequences of child removal can be dire: "… Child protection … will come and get the children … and all of a sudden it's very bad … my friend just hung herself not long ago. She lost three of her boys … the mam hung herself. This is just one of many."

One of the primary ways that child removal shaped women's addiction and recovery journeys was through the avoidance of services because of the threat of child removal. Within this theme, *avoiding services because of child removal,* we can see how the fear of child services involvement was the primary barrier restricting women's access to recovery services. In fact, when asked what the major barrier is for accessing addiction treatment, many women mentioned child removal first ("risk of social service involvement" [Zara]; "… It stops women because they're scared … to have their kids removed from their care" [Aria]; "Social work, I would say that's a big challenge because a lot of people are just scared to admit to them because they … think that they're going to get the kids taken off them." [Evie]). When asked to describe the challenges facing mothers with addiction, Isla describes how secrecy and dishonesty makes help impossible: "For the women in

my community … the stigma and fear of 'I can't go to the treatment center … because I'm going to get my children took ,' That's a barrier straight away … being dishonest about what's actually going on. How can you help someone when you don't actually know what's going on?" The fear of child removal keeps women from "opening up for them [social services] to see what's really been going on" [Zara]. Our participants were unequivocal on this point; when asked what challenges mothers face in her community, Millie said "… The risk of social service involvement, the removal of children if they're honest and access services, stops women getting well … I think risk of being reported to services is number one." Given the negative consequences of child removal for children and families directly experienced by our participants ("My ex-husband had a history of domestic abuse, physical, emotional, mental. They agreed that he should take custody of the children." [Millie]), these fears are rooted in lived realities.

Through interviews and time spent with women in recovery, it became clear that there are severe ramifications of this avoidance. Continued substance misuse is one clear outcome associated with avoiding recovery services. Aria reflects on this avoidance when asked what she thinks stops women from going to treatment: "… They're scared [that] their kids [might be] removed from their care as well. They tightly hide [their substance misuse]. Then … as addicts, we use on feelings. We sit … riddled with guilt and shame. The only way to get rid of that is to use." Similarly, Hannah describes how women in her community deal with the fear of social services involvement: "I know loads of people with kids who just struggle on using because they're scared of going to ask for help." When probed if these mothers in her community ever get into recovery, she went on to say that "… Some of them just wait until they're adults [their children] and social services can't touch them. Some of them have died [due to overdose]."

Along with the fear of child removal, a *lack of access to recovery services for mothers* further exacerbated the inability to get treatment. Women struggled to attend services and access treatment, including medications, for their substance use disorders (e.g. "… It's really, really expensive having a child … there's not many mam groups [for mothers who misuse substances] you can go to where you could bring your children …" [Hazel]). Childcare responsibilities represent a critical barrier to accessing treatment and recovery services; as Aria describes, "If they've got little children, getting to a meeting, it can be hard for a mother … what I do in my recovery and what I've done in the last two years, if I was to try and do that with four kids in tow, I probably wouldn't' have been able to do it."

Many of our participants discussed a critical lack of services that focus on families, including keeping the mother and child together, rather than focusing on their separation. When asked what she wanted us to know about motherhood and addiction in her community, Zara shared that "… more support is needed. I definitely feel like we need more mother-and-baby units and more opportunities for parents to keep the children" Isla underscores this access need when asked what she wished the government would do to help mothers:

> "Do you know what? There needs to be some support around keeping mother and baby together. Splitting mother and baby, of course, is more trauma. What I've noticed as well is where's the support for the mother in all this? Children go to social service, foster families, other care, and then mam's just left in a house where she still got her children's belongings. More support around mam and not just children even though obviously, the children deserve and need the support. We don't have any mother and baby units, so let's support mother and baby together, rather than apart from each other. It's just causing more trauma to children and mam."

Similarly, while Aria understood the occasional need to separate mothers and children, she also felt like there needed to be more support for mothers (and their families) in active addiction:

> "I just think that the services lack a little bit around the support rather than just whip in and whip kids away … Sometimes if it was"

> "just a little bit more support, they might not have to take them children. Get a mother to a meeting. A little bit more support."

Overall, it was clear that our participants felt that social services involvement prioritizes the needs of children (necessarily), but often to the detriment of the health of mothers and families as a whole. Our participants' perception was that child removal often left mothers at risk of escalating substance misuse, and without their own sources of institutional support (e.g., "Kids are just took from the parents when all some people really need is just a little bit of help." [Ella]). When asked what was working for mothers with addiction in her community, Ella was emphatic that "… For mams in addiction, they're just not given a chance. I think the system is massively flawed and broken and it needs revamping because it isn't working, especially for mams in addiction. I know loads of parents … mothers especially, who's had their children taken from them through no fault."

Along with the aforementioned barriers, women also discussed the theme, *medication for substance misuse are ineffective.* For many women, getting on methadone enabled their substance use due to a lack of monitoring and ineffective wraparound treatment. Grace stated,

> "I'd go in, get a methadone script, go a couple of weeks, not use, and start using on top. You'd lose your methadone script, then you'd wait a couple of months, go back, get another one, and just repeat the circle time and time again because I knew that I could get a methadone script once it got [her increasing tolerance] … being too bad to give me a bit of a break."

One of the issues around ineffective monitoring is that once women were on methadone, it was difficult to come off of it. Millie said, "My issue with it is that there's no support or emphasis for people to get off it. The public health agenda around harm reduction is just get people on methadone and keep them on methadone, and that's it."

Another one of the challenges with a methadone prescription was the waitlists associated with getting them. Grace said, "I've known people wait 3–6 months for methadone scripts … When you say you want to stop using tomorrow, you might not feel the same way, so you really need that service there when you say you are ready rather than, 'oh well, we'll see you in three weeks' time'. Three weeks time comes, you get paid, and you are like, 'oh well, I'll not bother'."

The other salient institutional barrier for women that intersected with sociocultural learning was stigma from social workers. Women felt as though social workers labeled them and twisted their words (e.g., Evie said, "My social worker was quite bad. She twisted quite a lot of things. She lied about quite a lot of things and got away with it. I've not got a very good experience with social work, to be honest.") which prevented them from getting the help they needed. Hannah expressed, "For social services to actually work with people instead of just labeling them straight away as soon as they hear your drugs, it seems like their mind is made up before they've even done any parent assessments or anything like that. They just hear drugs and that's it." Similarly, Addison said, "You're judged by them. I know they're professionals, maybe they think they're not, but you can bloody tell they are, they come from quite well-educated backgrounds and quite trauma-free childhoods. There's not a lot of understanding, it's more of a lot of judgment."

6. Discussion

This study explored how sociocultural factors shape resilience in recovery. Moving beyond the notion of recovery as an individual trait (White, 2007), we positioned it as a relational process influenced by multi-level sociocultural and ecological factors. In line with Rudzinski et al. (2017), we conceptualized resilience as integral to the recovery pathway.

Our findings support a growing body of research that emphasizes

recovery as a relational process (Brekke et al., 2020;Dekkers et al., 2021; Mudry et al., 2019). Women in Northeast England and London relied on social networks, particularly through peer meetings, to navigate recovery. In the Northeast, participants attended women-only and AA/NA meetings, using these spaces to share experiences and manage challenges such as interactions with child services. Women-only recovery spaces were a unique feature of recovery communities in the Northeast, and provided our participants with access to critical, safe spaces where the challenges of addiction that are unique to women and mothers could be shared. The importance of women-only recovery spaces is underscored by other unique findings in this region; while not salient for our London sample, women in the Northeast mentioned men's involvement in recovery spaces as key sources of harm in their recovery journeys. In London, women similarly valued AA/NA meetings as spaces for connection, shared experience, and harm reduction strategies; a unique feature of narratives in our London sample was the salience of access-related features of these community support structures, including opportunities to bring children to 12-step meetings and online resources (e.g,. Telehealth, options to attend 12-step meetings via Zoom or Teams). In both regions, many echoed the belief that "connection is the opposite of addiction," underscoring the centrality of relationships in resilience. These social bonds helped women navigate harmful sociocultural ecologies, as they faced adversity across multiple levels of the social-ecological model.

Partners often discouraged help-seeking, in some cases exacerbating substance use. Often, partner-imposed barriers to help-seeking were part of a larger picture of coercive control in the context of intimate partner violence (IPV). In both regions, participants mentioned the role that IPV played in their substance use and recovery journeys, and they shared the experience of using substances to manage the psychological and emotional distress that results from this abuse. The relationship between IPV, addiction, and recovery is well established in the literature; specifically, research in this area highlights the relationship between IPV and escalating substance use as well as the role that IPV plays in obstructing engagement with recovery services (see Ogden et al., 2022 for a systematic review). While participants in both regions mentioned the role that partners played in creating distress and trauma (through psychological, financial, and physical abuse) and the use of substances to manage these, women in the Northeast uniquely emphasized their partners' normalization and modeling of substance use.

Consistent with existing research (Burgess et al., 2021; Lochhead et al., 2024; van Olphen et al., 2009), stigma—both experienced and anticipated—at interpersonal, community, and institutional levels further deterred service engagement. Many women avoided child services out of fear, while others lacked access to childcare-friendly support options. Studies have documented how stigma and fear of child removal discourage mothers from seeking community support (Gueta, 2017; Stone, 2015; Weber et al., 2021; Wolfson et al., 2021). Despite these barriers, women forged critical connections through AA/NA and (for participants in the Northeast) women-only groups, reinforcing the role of relationships in fostering resilience. Our findings align with Sanders (2006, 2011), who describes "shared persistent stigma and shame" as a common experience among women in addiction. She notes that women empower themselves through 12-step programs, particularly in women-only meetings and other forms of peer support.

While social connection emerged as a dominant theme in resilience, an equally compelling counterpoint was the isolation and emotional distress resulting from social and institutional harm, internalized shame, and guilt. This struggle is evident in narratives such as Zara, who describes being "stuck" in feelings of failure, and Ella, who expresses guilt and shame she believes will never leave her. These findings raise fundamental questions about the meaning, interpretation, and scope of recovery for women and mothers—and about who defines it. Can women who internalize blame for social and institutional harms ever fully experience recovery? This question underscores the need for recovery models that acknowledge structural and emotional barriers. Our findings suggest that the most promising approach to holistic recovery for women may emerge where self-organized support groups complement NA and AA's 12-step programs.

Our data further support the critical role of social learning within a sociocultural-ecological model, framed through an evolutionary perspective. While humans exhibit biological evidence of co-evolution with psychotropic plants (Sullivan & Hagen, 2002), addiction to synthetic drugs presents a novel evolutionary challenge (Placek, 2024; St. John-Smith et al., 2013). This mismatch between human evolutionary adaptations and contemporary drug environments—exemplified by substances like fentanyl and heroin—impairs individuals' ability to assess risk based on sensory cues, making social knowledge essential for navigating use and recovery. Our findings highlight the importance of social connections in learning about recovery and managing the social harms of substance addiction. However, we did not collect data on the specific sources of recovery-related knowledge across different stages of recovery. Future research using the social-ecological model should examine how different mechanisms of social learning (e.g., peer-to-peer vs. one-to-many) influence perceived recovery throughout addiction and recovery trajectories. Identifying sources of information can help optimize the delivery of recovery services.

This study has several limitations. First, it does not provide a singular definition of recovery, instead recruiting women who self-identified as engaged in recovery services. This decision reflects our focus on exploring recovery as a relational process centered on resilience. Second, recruiting women—especially mothers—in recovery is challenging due to social norms and stigma that limit participation in services (Placek & Wies, n.d.). Consequently, we relied on convenience sampling in both regions. Finally, while these findings provide insight into the sociocultural dimensions of recovery in the UK, they may not be generalizable to other cultural contexts. Future research should explore how sociocultural variation shapes women's experiences of recovery, particularly in regions where gendered expectations, stigma, and access to care differ significantly.

This study underscores the role of social learning and relational resilience in addiction recovery, framed within a sociocultural-ecological model. Our findings show that women navigate complex harms through relationships and social networks, reinforcing that recovery is not an individual process but one shaped by broader sociocultural forces. Future research should examine how social learning and relational recovery models mitigate harms across diverse cultural contexts, offering new insights into more inclusive and effective recovery frameworks.

CRediT authorship contribution statement

Caitlyn D. Placek: Writing – review & editing, Writing – original draft, Visualization, Supervision, Software, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Lora Adair:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis. **Julieta Baker:** Writing – review & editing, Writing – original draft. **Susan Robson:** Writing – review & editing, Writing – original draft, Project administration.

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Declaration of competing interest

The authors report no conflicts of interest.

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